Repositioning practice: A discourse analysis of clinical supervision as part of implementing a psychosocial intervention in cancer care

Sophie Elizabeth Dilworth, RN (hons)

Thesis submitted for the Degree of Doctor of Philosophy
July 2014

School of Nursing and Midwifery
University of Newcastle
Statement of Originality

This thesis contains no material which has been accepted for the award of any other degree or diploma in any university or other tertiary institution and, to the best of my knowledge and belief, contains no material previously published or written by another person, except where due reference has been made in the text. I give consent to this copy of my thesis, when deposited in the University Library, being made available for loan and photocopying subject to the provisions of the Copyright Act 1968.

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I wish to acknowledge and thank those who have contributed to this project and supported me through this journey.

My supervisors, Isabel, Vicki, Brian and Jane, your ongoing support, advice, reassurances and encouragement have been amazing. To Isabel and Vicki I appreciate that you joined this me on this journey. I value our ongoing relationship. Having mentored me through my very early research to the completion of my PhD I hope to continue to work with you both into the future. To Brian and Jane, thank you for involving me in your project I have enjoyed the process and have gained such valuable experience. Thank you all for the hours of reading and editing that have gone into this thesis and the publications along the way.

To the participants in this study, I hope that the critical analysis presented here makes visible some of the tensions that you face in practice. I hope that it will be part of the shift in practice toward care that recognises the need for critical dialogue within healthcare to facilitate the kind of care that we all aim to deliver.

Daniel, thank you for your patience and support, you are wonderful. My darling daughters, Matilda and Grace, I love you. Matilda, it was your arrival that made my decision to start this journey. Grace, your arrival motivated me to publish my work and also to finish. To my parents, Helen and Colin, your magnanimous support, and childcare, were much needed and appreciated to help me to finish my PhD. Thank you for indulging my stubborn nature. To Jan and Rob, your ongoing support has been invaluable. To my friends and peers thank you for your support and encouragement.
List of publications included as part of the thesis


Co-author statement for paper one

I attest that Research Higher Degree candidate **Sophie Dilworth** contributed to the paper/publication entitled:

Patient and Health Professional’s perceived barriers to the delivery of psychosocial care to adults with cancer: A systematic review

By:

- Leading the writing of the manuscript
- Developing the research question
- Extracting data regarding study characteristics from all included studies
- Extracting data regarding risk of bias from all included studies
- Leading data analysis and interpretation

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Co-author statement for paper two

I attest that Research Higher Degree candidate Sophie Dilworth contributed to the paper/ publication entitled:

Finding a way forward: A literature review on the current debates around clinical supervision

By:
- Leading the writing of the manuscript
- Developing the research question
- Extracting data regarding study characteristics from all included studies
- Leading data analysis and interpretation

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Examining clinical supervision as a mechanism for changes in practice: a research protocol

By:

- Leading the writing of the manuscript
- Developing the research question
- Contributing to research design and study methodology

Full name of Co-author  Signature of Co-author  Date

Isabel Higgins

__________________________  18 June 2014

Vicki Parker

__________________________  18 June 2014

Brian Kelly

__________________________  18 June 2014

Jane Turner

__________________________  18 June 2014
Co-author statement for paper four

I attest that Research Higher Degree candidate Sophie Dilworth contributed to the paper/publication entitled:

Exploring the situational complexities associated with practice change in healthcare

By:

• Leading the writing of the manuscript
• Developing the research question
• Contributing to research design and study methodology
• Overseeing data collection
• Leading the data analysis and interpretation

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I attest that Research Higher Degree candidate **Sophie Dilworth** contributed to the paper/publication entitled:

Implementing a psychosocial intervention in cancer care: An examination of the change process through a discourse analysis of clinical supervision

By:
- Leading the writing of the manuscript
- Developing the research question
- Contributing to research design and study methodology
- Overseeing data collection
- Leading the data analysis and interpretation

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List of additional publications and conference presentations


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Abstract

This thesis by publication describes a study that used discourse analysis to explore clinical supervision sessions between supervisors and health professionals trained to deliver a psychosocial intervention for a large multi-site randomised control trial. The research questions asked: Does clinical supervision facilitate changes for Health Professionals trained to deliver a psychosocial Intervention? What influence does clinical supervision have on the discourses of Health Professionals and their practice? What might this reveal about change in practice and barriers/enablers to such changes?

A systematic review of the barriers to psychosocial care revealed that Health Professionals reported organisational, cultural and individual clinician-related barriers. Clinical supervision is recommended to support Health Professionals in overcoming these barriers. Whilst a review of the clinical supervision literature explored confusion about expectation and the quantifiable outcomes of clinical supervision, there is evidence that multidisciplinary, group clinical supervision provides a forum for sharing of knowledge and generation of shared understandings of healthcare.

The participants for the study were thirty Health Professionals (23 nurses, four physio therapists, two radiation therapists and one occupational therapist) and three clinical supervisors who took part in 96 clinical supervision sessions. Discourse analysis was used to critically examine seventeen audio recorded sessions of multidisciplinary, group format clinical supervision. Discourse mapping was used as a vehicle to explore discursive constructions in the data. The method of data collection and analysis represent novel approaches to exploring clinical supervision and its impact on the process of practice change.

Findings showed that clinical supervision facilitated non-linear changes in the clinical practice of Health Professionals trained to deliver a new psychosocial Intervention. Changes included using discourse within the clinical supervision sessions to resist the systemic, organisational, cultural and personal barriers that presented themselves as part of delivering a new psychosocial Intervention. Clinical supervision provided a forum for sharing stories that were used to construct new meanings and reposition the Health Professionals within the experience of delivering psychosocial care in the context of adult cancer care. Health Professionals’ language was used to challenge, or accommodate tensions that were seen to govern the behaviours and language used by Health Professionals. Their discourses illustrated a fragility and potential for change. Discourses within supervision negotiated ways of practicing that may accommodate the tensions allowing change in practice.
Chapter 1   Repositioning the practice of psychosocial support

Cancer is the leading cause of death worldwide (World Health Organisation, 2014). In 2012 there were 14.1 million new cases of cancer, 8.2 million deaths and 32.6 million people who were living with cancer across the world (GLOBOCAN, 2012). Distress, depression and anxiety are common problems associated with a diagnosis of cancer (Bultz & Johansen, 2011). Internationally, the reported incidence of emotional distress ranges from 35% to 70% (Bultz & Johansen, 2011; Carlson et al., 2004; Zabora, Brintzenmhoszoc, Curbow, Hooker, & Piantadosi, 2001). Based on these figures up to 22.82 million people with cancer suffer emotional distress.

Depression is known to independently predict poor survival in advanced cancer, reduce quality of life, reduce compliance with treatment and prolong hospitalisation (Irving & Lloyd-Williams, 2010; Lloyd-Williams, Shiels, Taylor, & Dennis, 2009). Importantly there is evidence that psychosocial interventions can prevent less severe forms of psychological distress among cancer patients from developing into disorders such as Major Depression (Kissane et al., 2007). For these reasons it is of the upmost importance that people with cancer receive optimal supportive and psychosocial care throughout the course of their cancer diagnosis and treatment. However, despite recognition of the high prevalence, adverse impacts on patient outcomes and the amenability of distress to intervention, psychological distress, depression and anxiety remain under-diagnosed and under-treated by clinicians (Bultz & Johansen, 2011; Irving & Lloyd-Williams, 2010; Lloyd-Williams et al., 2009; Lloyd Williams & Payne, 2003).

Attempts to address problems with existing clinical practice have been made internationally. Various national bodies have developed clinical practice guidelines, standards of care or guidance for the most appropriate approaches to psychological and supportive care for adults with cancer (Canadian Association of Psychosocial Oncology, 2010; National Comprehensive Cancer Network, 2003; National Institute for
Clinical Excellence, 2004). Despite the availability of these guidelines their implementation into routine practice is limited (Bultz & Johansen, 2011; Schofield, Carey, Bonevski, & Sanson-Fisher, 2006). Clinical research in this area shows that psychosocial needs of patients continue to be unmet (Beesley et al., 2008; Chen et al., 2009; Sanson-Fisher et al., 2000; van Scheppingen et al., 2011); there is limited service availability, service accessibility and poor uptake of psychosocial interventions (Ayanian et al., 2005; Eakin & Strycker, 2001; Kumar et al., 2012; Whop, Garvey, Lokuge, Mallitt, & Valery, 2012).

The factors limiting the implementation of psychosocial care that aligns with the recommended guidelines are complex (Dilworth et al., 2014a). The heterogeneous nature of study methods, interventions, populations sampled and outcomes measured (Butler, Degner, Baile, & Landry, 2005; Dale, Adair, & Humphris, 2010; Mitchell, 2013; Mitchell, Vahabzadeh, & Magruder, 2011a) have led to a lack of clarity about what a psychosocial or psychological intervention entails within the context of cancer care and the expected outcomes for patients and staff (Canadian Association of Psychosocial Oncology, 2010; Hodges et al., 2011). Indeed, research that details the problems associated with the delivery of psychosocial care suggests there are multilevel barriers related to organisational, cultural and individual patient and clinical factors (Dilworth et al., 2014a; Mitchell, 2013). Importantly for this research, psychological distress is not addressed by increasing access to specialist services. Research shows that referral to specialist services are often not taken up (Carlson, Groff, Maciejewski, & Bultz, 2010; Eakin & Strycker, 2001). Psychosocial care needs to be integrated into routine care (Fann, Ell, & Sharpe, 2012; Institute of Medicine (US), 2008), hence this research focused on cancer clinicians in their everyday work with patients. Clinical factors are important barriers when considering the translation of guidelines into real world practice. Clinical supervision has been shown to be a tool to alter clinical practice, support implementation of guidelines and build clinician skills and confidence in addressing psychosocial needs (Mannix et al., 2006). That is why this research has focused on supervision in psychosocial care as a tool to achieve improved recognition and response to psychosocial needs.
This research examined the conversations during clinical supervision and the impact of delivering a psychosocial Intervention to adults with cancer on the actions of Health Professionals. Particular attention was given to how the language of Health Professionals constructed their experience of providing psychosocial care and the barriers and/or enablers they encountered when delivering the Intervention.

1.1 THE RESEARCH QUESTION

The research questions were developed giving consideration to the topic, context and possible relationships to be explored. The process considered my interests, practicalities and advice from supervisors. The research questions reflected the current literature and the relationships within the project and the RCT study (O’Leary, 2004). The research questions were:

- Does clinical supervision facilitate changes for Health Professionals trained to deliver a psychosocial Intervention?
- What influence does clinical supervision have on the discourses of Health Professionals and their practice?
- What might this reveal about change in practice and barriers/enablers to such changes?

Discourse Analysis was employed in order to examine the conversations between Health Professionals’ and their Supervisors’ within clinical supervision sessions. Particular attention was given to how language constructed the experience of providing psychosocial care and the barriers or enablers they encountered when delivering a new psychosocial Intervention. The Health Professionals were recruited and trained to deliver a new psychosocial Intervention to adults with cancer experiencing moderate levels of distress, as part of a multisite randomised control trial (RCT). The trial was known as Promoting Optimal Outcomes in Mood through Psychosocial Therapies: a randomised trial (PROMPT). The PROMPT RCT measured the effectiveness of the psychosocial Intervention in reducing anxiety and depression in adult patients with cancer and reducing levels of stress and burnout of those Health Professionals delivering the psychosocial
Intervention. The psychosocial Intervention incorporated the development of a tailored treatment plan and appropriate referrals based on the self-reported types of distress identified on the Distress Thermometer (Turner et al., 2011). Analysing the conversations within clinical supervision was considered a novel approach to examining the processes associated with the implementation of the psychosocial Intervention in the PROMPT RCT. Importantly, discourse analysis provided a critical lens through which to question taken for granted aspects of practice within the data.

This thesis comprises a series of five papers. Following the introduction to the research in this chapter, chapter two presents the first two published papers. These two published review papers represent the background literature. The first is a systematic review of the barriers to psychosocial care; “Patient and health professional’s perceived barriers to the delivery of psychosocial care to adults with cancer: A systematic review” (Dilworth et al., 2014a); the second is a critical interpretive review that explores the current state of clinical supervision; “Finding a way forward: A literature review on the current debates around clinical supervision” (Dilworth et al., 2013c). The methods used for the research described within this thesis are presented as a published research protocol paper in chapter 3 A), “Examining clinical supervision as a mechanism for changes in practice: A research protocol” (Dilworth et al., 2013a). The research protocol paper is supported by additional information about the design and methods in chapter 3 B). The findings of the research are represented by two papers. Paper four, “exploring the situational complexities associated practice change in health” (Dilworth et al., 2013b) examines the complex nature of a psychosocial intervention introduced within the context of cancer care. The analysis illustrates the fragility of current practices and highlights the potential for change. The final paper, paper five, explores practice change as it occurred during the delivery of psychosocial Intervention provided to adults with cancer experiencing distress and is titled; “Implementing a psychosocial intervention in cancer care: An examination of the change process through a discourse analysis of clinical supervision” (Dilworth et al., 2014b). The diagram below (figure 1.) provides an outline of the papers presented in
this thesis and is represented in the final chapter to show the elements of the thesis along with the recommendations.
## Figure 1: Published papers presented within thesis

<table>
<thead>
<tr>
<th>Paper 1: “Patient and Health Professional’s perceived barriers to the delivery of psychosocial care to adults with cancer: A systematic review” (<a href="#">Dilworth et al., 2014a</a>)</th>
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</table>
| **Patient barriers**  
No need for services, no information, practicalities, low confidence, negative attitude / stigma, Health Professional communication  
**Health Professional barriers**  
Organisational  
Cultural  
Individual |

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<tr>
<th>Paper 2: “Finding a way forward: Reviewing the current debates around the benefits of clinical supervision” (<a href="#">Dilworth et al., 2013c</a>)</th>
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| Diverse expectations for clinical supervision  
A diffuse evidence base  
Complex interventions are difficult to implement and evaluate  
A culture resistant to change  
Assumptions about commitment  
Time equals money  
Critical reflection to generate shared understanding  
Multidisciplinary team clinical supervision to create shared dialogue and break down disciplinary silos |

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<th>Paper 3: “Examining clinical supervision as a mechanism for changes in practice: A research protocol” (<a href="#">Dilworth et al., 2013a</a>)</th>
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</table>
| • Does clinical supervision facilitate changes for clinicians trained to deliver a psychosocial Intervention?  
• What influence does clinical supervision have on the discourses of Health Professionals and their practice?  
• What might this reveal about change in practice and barriers/enablers to such changes? |

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<th>Paper 4: “Exploring the situational complexities associated with practice change in health” (<a href="#">Dilworth et al., 2013b</a>)</th>
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| **Positionality:** The busy nurse the helpless patient  
**Representation:** Prioritising psychosocial care  
**Subjectivity:** How busy is too busy?  
Organisational demands on the Health Professional  
Generating new meanings |

<table>
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<tr>
<th>Paper 5: “An examination of the change process through a discourse analysis of clinical supervision” (<a href="#">Dilworth et al., 2014b</a>)</th>
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</table>
| Feeling legitimate “going there”: changing confidence  
Wanting to “fix”: solving problems  
Managing “the big conversations”: the extension of new skills  
Changes in legitimacy and confidence  
Need to address stigma |
1.1 A BRIEF OVERVIEW OF THE RESEARCH DESIGN AND METHODOLOGY

The research question and aims subsequently and simultaneously pointed to particular approaches to the research methods and methodology. A brief overview of the research design is provided here as way of introduction to a more detailed discussion in chapter three.

This thesis reports the findings of a sub-study of the PROMPT RCT, introduced above. The sub-study used a qualitative design to explore the discourses used during clinical supervision and the impact of delivering a psychosocial Intervention to adults with cancer on the actions of Health Professionals. The methods used in the study included the analysis of audio-recorded data collected within clinical supervision sessions. The sessions were attended by Health Professionals, primarily nurses, from various health disciplines. The clinical supervision sessions were facilitated by psychiatrists with extensive clinical experience in psycho-oncology and clinical supervision who were also chief investigators at each of the PROMPT Intervention sites. A selection of clinical supervision sessions were transcribed verbatim. A further selection were analysed as audio files in NVivo9.

1.2 DISCOURSE ANALYSIS AS A METHOD TO EXPLORE TAKEN FOR GRANTED PRACTICES

A focus on physical aspects of care within the healthcare system marginalises emotional and psychological aspects of care (Chibnall, Bennett, Videen, Duckro, & Miller, 2004; Kenny, Endacott, Botti, & Watts, 2007; Schulman-Green, 2003; Scott & Pollock, 2008). Discourse analysis aims to expose, critique, and challenge this kind of dominant ideology as it “can point to the ways in which certain practices serve to obscure and therefore perpetuate what is taken-for-granted.” (Wood & Kroger, 2000, p. 13). In this case, was the dominance of biomedical approaches to care, perpetuating the barriers to psychosocial care?

Discourse analysis was used to highlight aspects of practice and provided an opportunity for recognising oppressive practices that may otherwise
be obscured. This enabled the facilitation of alternatives (Crowe, 2005; Wodak & Meyer, 2009). Underpinning the approach to discourse analysis used in this study is the belief that discourse cannot, and does not, occur within a vacuum (Wood & Kroger, 2000). Within the Foucaultian and poststructuralist traditions there is a focus on representation and meaning within discourse (Carabine, 2001; Foucault, 1972, 1973, 1979; Hall, 2001; Sanguinetti, 2000). Exchanges are viewed as situated, there is no clear distinction between discursive and extra-discursive. Words may evoke historical or social relations connecting other utterances, conversations, or documents. These relations can create accepted truths, and ways of understanding what and how things do or should work. An approach that is interested in these discursive associations and the power relations uncovered the patterns that may be creating barriers to care (Wetherell, Taylor, & Yates, 2007).

Chapter two, “Patient and health professional’s perceived barriers to the delivery of psychosocial care to adults with cancer: A systematic review” (Dilworth et al., 2014a) demonstrates in detail the complex interplay of organisational, cultural and individual factors related to the innovation of practice and improving psychosocial care of adults with cancer. It is through an approach such as discourse analysis that this study was able to appreciate the broader context of this situation.

1.1 CENTRAL CONCEPTS AND THEORETICAL POSITIONING OF THE STUDY

The background literature considers the research relating to distress and the need for psychosocial care of adults with cancer, the clinical practice guidelines that have been developed internationally to try to improve care in this area. This is followed by a discussion about the clinical practice guidelines in terms of innovation and the implementation of evidence based guidelines in clinical care. Clinical supervision is introduced and its role in the transfer of knowledge and ability to facilitate changes in practice is detailed. Each of these areas is addressed within this critical review of the literature in order to build an augment as justification for the study. These central concepts theoretically bounded the research. The barriers to psychosocial care for people with cancer and clinical
supervision are covered briefly in the introduction. Chapter two provides
detailed systematic reviews on these topics (Dilworth et al., 2013c,
2014a).

### 1.1.1 Distress and the need for psychosocial care for people with cancer

Distress\(^1\) has been defined by the National Comprehensive Cancer
Network as a multifactorial unpleasant emotional experience of a
psychological (cognitive, behavioural, emotional), social, and / or
spiritual nature that may interfere with the ability to cope
effectively with cancer, its physical symptoms and its treatment.
Distress extends along a continuum, ranging from common
normal feelings of vulnerability, sadness and fears to problems
that can become disabling, such as depression, anxiety, panic,
social isolation, and existential distress and spiritual crisis.” (p. 6)

The term distress has been adopted within the field of psychosocial
cancer care because it is “less stigmatised than psychiatric, psychosocial
or emotional, sounds more normal, less embarrassing and can be
measured by self-report” (National Comprehensive Cancer Network,
2011, p. 7)

The term psychosocial care broadly covers practical, psychological and
emotional assistance. The National Breast Cancer Centre and National
Cancer Control Initiative (NBCC) and (NCCI) clinical practice guidelines
state that psychosocial care encompasses assisting patients facing
challenges such as:

- coping with the shock of their diagnosis and fears over their health
  and future; physical symptoms and adverse effects of treatment
  such as nausea, fatigue and physical changes in body appearance
  and functioning; financial costs, altered occupational, employment

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\(^{1}\) Throughout the thesis where the term distress is used it refers to psychological
distress as defined above.
and financial status; and psychological difficulties ranging from concerns about body image and sexuality to severe disorders such as anxiety and or depression. Some will also have to face progressive illness and approaching death. (p. 11)

The prevalence of psychological distress, depression and anxiety for people diagnosed with cancer has long been established (Zabora et al., 2001). The rates of long term distress are up to 66%, significant anxiety is up to 30% and depression ranges between 20%-35% (National Breast Cancer Centre and the National Cancer Control Initiative, 2003). As a comparative example, 9.6% of the Australian adult population report a long-term mental or behavioural problem, and 3.6% report very high levels of psychological distress (Australian Bureau of Statistics, 2006). Despite its high prevalence distress, depression and anxiety remain under-diagnosed and under-treated (Howell, Hack, Green, & Fitch, 2014; Irving & Lloyd-Williams, 2010; Lloyd-Williams et al., 2009; Lloyd Williams & Payne, 2003).

1.1.2 Evolution of psychosocial care in cancer

Psychosocial interventions to improve the care of people with cancer have been present within the oncology literature for many years. As long ago as 1973, Craig studied the introduction of behavioural science principles to bi-weekly patient-centred conferences to address the pressures on non-physician staff of an oncology clinic providing psychosocial care. The intervention proved useful in promoting improved staff morale and more appropriate patient management. Another example from early in the history of psychosocial care is the seminal yet contentious work by Spiegel Bloom, Kraemer and Gottheil (1989). Their intervention provided weekly supportive group therapy with self-hypnosis for pain as a psychosocial intervention. They found that the intervention increased time of survival for women with metastatic breast cancer at 10 years follow up. The first significant criticism of these findings was in 1998 when Fox (1998) hypothesised that due to an unrepresentative sample there was actually no treatment effect and Spiegel’s results were not replicable. Throughout the years there was debate over this and Spiegel is noted as recognising this debate (Spiegel & Giese-Davis, 2003) and in
response to this in 2007 the intervention was replicated (Spiegel et al., 2007). At this time there was no statistically significant impact on length of survival. A statistically significant intervention site-by-condition interaction was found. The interaction was between oestrogen receptor status and treatment condition. Oestrogen receptor negative patients showed increased longevity and oestrogen receptor positive patients showed no effect. Over the last decade there has been a sharp increase in the amount of attention and research work that explores psychosocial aspects of cancer care.

As the psycho-oncology literature expanded, efforts to synthesise the research findings began to appear. The psycho-oncology literature is replete with evaluation studies, systematic reviews and meta-analysis of the effectiveness of psychosocial interventions across various settings and cancer types. Two of the older, most cited meta-analyses are Meyer and Mark (1995) and Devine and Westlake (1995). These are considered level 1 evidence, meta-analysis of randomised control trials (National Breast Cancer Centre and the National Cancer Control Initiative, 2003). Meyer and Mark (1995) analysed 45 psychosocial interventions. The research was predominantly conducted in the United States of America. Study samples clustered around 50, tended to have more women and approximately 70% were not limited to a single type of cancer or site. The types of Interventions they included were: cognitive-behavioural, information and education, non-behavioural counselling or psychotherapy, social support or unusual treatments (eg. Music therapy). They found that the included interventions had significant beneficial effects on emotional and functional adjustment; treatment and disease related symptoms and medical measures. Global and compound measures remained unchanged (Meyer & Mark, 1995).

Also in 1995 Devine and Westlake (1995) conducted a meta-analysis of 116 psycho educational interventions studies involving adults with cancer. They found significant positive effects on 7 outcomes including anxiety, depression, mood, nausea, vomiting pain and knowledge. They recommended that this provided a strong evidence base to support the use of psycho-educational techniques but further investigation to differentiate the most effective techniques was required (Devine &
Westlake, 1995). Similarly Rehse and Pukrop (2003) conducted a meta-analysis of the effectiveness of psychosocial interventions on quality of life of adults with cancer. The interventions they included were: medical or procedural information giving, social support, psychotherapeutic and the majority were coping skills training (including cognitive and behavioural) interventions. Quality of life measures broadly aligned with many of the categories used in the Meyer and Mark (1995) meta-analysis. They included functional, emotional and global measures. The sample was predominantly based on studies undertaken in the United States of America; the average age was approximately 50 years, and more women than men were represented by a 2:1 woman: man ratio. The analysis supported the usefulness of psychosocial interventions as a means to improving quality of life. Recommendations are made for interventions lasting longer than 12 weeks suggesting that these are more effective than shorter interventions (Rehse & Pukrop, 2003).

In Australia, Newell, Sanson-Fisher, and Savolainen (2002) suggest that reports of psychological therapies that increase immune function, longevity and decrease side effects lack rigour. Their systematic review of 627 empirical studies evaluated 329 interventions and made only tentative recommendations regarding the effectiveness of psychological interventions for the improvement of such outcomes. They reported the lack of methodological quality prevented stronger recommendations. Recommendations were made for further investigations into psychological interventions to increase internal validity through implementation of minimum reporting standards. Recommendations were also made as to which specific interventions would be recommended for use (Newell et al., 2002).

The historical aspects described above highlight that despite a long history with apparently clear recommendations to support the benefits of psychosocial interventions to improve functional, emotional and treatment related quality of life for adults with cancer, it is concerning that distress remains highly prevalent for people with cancer. At the time Meyer and Mark (1995) made note of patient refusal of psychosocial intervention and problems related to the underestimation of need by Health Professionals. They recognised a need to increase the acceptability
of psychosocial interventions. These comments and recommendations continue to be echoed today, as do many of the criticisms of previous research. The major criticism of previous work in this field is the heterogeneous nature of study methods, interventions, populations sampled and outcomes measured. This has led to a lack of clarity about what a psychosocial or psychological intervention entails within the context of cancer care and the expected outcomes for patients and staff (Hodges et al., 2011). Much of the psycho-oncology literature advocates the need for and benefits of psychosocial and psychological interventions that integrate psychosocial care to improve the quality of life and outcomes for patients (Fann et al., 2012). However, there remains a gap between the literature and routine care.

There are potentially many factors contributing to this gap. Research that investigates the barriers to the provision of psychosocial care to patients with cancer is presented below with extensive review in Chapter two; “Patient and health professional’s perceived barriers to the delivery of psychosocial care to adults with cancer: A systematic review” (Dilworth et al., 2014a). However, it is recognised that a deeper understanding rather than a description of these barriers is required if psychosocial care is to be embedded in routine care. The discussion moves now to clinical practice guidelines as a means of changing practice to align with research recommendations.

### 1.1.3 Clinical Practice guidelines for the psychosocial care of adults with cancer

Clinical practice guidelines are "systematically developed statements to assist practitioner decisions about appropriate health care for specific clinical circumstances". (Field & Lohr, 1990, p. 38). They are developed on the basis of current best evidence to improve quality and effectiveness of clinical practice (Burgers et al., 2003; Grol, Cluzeau, & Burgers, 2003).

Clinical guidelines, standards of care or guidance for the psychological and supportive care of adults with cancer have been internationally available for many years. For example, in Australia, The National Breast Cancer Centre Psychosocial Working Group’s Guidelines for the
Psychosocial Care of Women with Breast Cancer have been available for 11 years (NHMRC National Breast Cancer Centre Psychosocial Working Group, 1999) and “The Clinical Practice Guidelines for the Psychosocial Care of Adults with Cancer” were developed nine years ago (National Breast Cancer Centre and the National Cancer Control Initiative, 2003). Similarly, the United States, Canada and the United Kingdom have all developed practice guidelines or standards to guide supportive care of people with cancer (Canadian Association of Psychosocial Oncology, 2010; National Breast Cancer Centre and the National Cancer Control Initiative, 2003; National Comprehensive Cancer Network, 2003; National Institute for Clinical Excellence, 2004).

The Australian National Health and Medical Research Council (NHMRC) has endorsed “Clinical practice guidelines for the psychosocial care of adults with cancer” (2003). The guidelines were developed by the National Breast Cancer Centre and the National Cancer Control Initiative. Early in the guideline document a clear summary statement of recommendations and the associated level of evidence\(^2\) supporting the recommendation are provided. The summary reports level one and two supported recommendations regarding: general interactions, discussion prognosis and treatment options, how to prepare people for treatment, providing emotional support, ensuring continuity of care, how to provide support toward the end of life, and other specific concerns (for example, predisposing risk factors, nausea, pain, and nutrition). The guideline provides extensive discussion that includes challenges of cancer and how people react, the type and amount of care to be provided by the treatment team to all patients with cancer. This is followed by recommendations for how and when to refer to specialised care and the types and benefits of care. The guidelines also include guidance about issues that may require special consideration. This includes age, culture, geography, and sexual orientation. Within the discussion of each of the

\(^2\) Level 1: Evidence is obtained from a systematic review of all relevant randomised controlled trials.  
Level 2: Evidence is obtained from at least one properly designed randomised controlled trial (National Breast Cancer Centre and the National Cancer Control Initiative, 2003, p. 4)
topics listed there is clear articulation of the level of evidence along with
the source of evidence that has been used to make the stated
recommendation. The PROMPT Intervention aimed to implement
elements of this evidence based clinical practice guideline.

The National Comprehensive Cancer Network (NCCN) “Distress
management guidelines” (National Comprehensive Cancer Network, 2011)
are the guideline developed in the United States of America. The
guideline was developed in 1999 and has been updated several times
guideline is a relatively brief, 51 page, document that provides flow
diagrams and algorithms indicating recommendations for care. The
pathways generally involve assessment and referral to appropriate
services external to the oncology team (National Comprehensive Cancer
Network, 2011). The oncology team comprises of Oncologist, nurse and
social worker. The majority of recommendations are categorised as 2A3.

The discussion that follows the flow diagrams presents a summary of
psychosocial problems, prevalence, interventions and screening tools.
The guideline notes that stigma and current model of ambulatory care
represent barriers to psychosocial assessment and treatment. The
guideline advocates the use of the distress thermometer and problem
checklist to assess for distress at various points along the care pathway.

The Canadian Association of Psychosocial Oncology (CAPO) published
“National Standards for Psychosocial Oncology” in 1999, which were
updated in 2010. The standards were developed to assist cancer
facilities, administrators, program leaders and professionals in the
delivery of psychosocial health services in Canada by providing a basic
framework for these services (Canadian Association of Psychosocial
Oncology, 2010). Following an introduction and definition and scope the
Canadian standards sets out key principles of care. The key principles

3 Category 2A) Evidence is obtained from at least one properly designed
randomised controlled trial (National Comprehensive Cancer Network, 2011).
detailed include person/family centred care, ensuring information and access to available services, practicing in line with the ethical principles of autonomy, beneficence, honesty, confidentiality and in line with relevant codes of ethics. The standard advocates respect for culture and diversity, inter professional collaboration, evidence based care along with quality monitoring and improvement (Canadian Association of Psychosocial Oncology, 2010). The standards were developed by a multidisciplinary committee based in the research literature and consensus from broad consultation in the field and subject to review by international experts.

Despite the development of best practice guidelines relating to the psychosocial care of people with cancer (Canadian Association of Psychosocial Oncology, 2010; National Breast Cancer Centre and the National Cancer Control Initiative, 2003; National Comprehensive Cancer Network, 2011) there is little evidence of guidelines being used (Schofield et al., 2006) and little or poor evidence on the implementation and effectiveness of interventions (Redman, Turner, & Davis, 2003). There are gaps in the evidence base within psycho-oncology that may contribute to poor implementation of guidelines (Dzidowska, Price, Butow, & PoCo, 2010). As discussed below, implementing any innovation within the healthcare environment the situation is extremely complex and multifaceted.

### 1.1.4 Clinical practice guidelines as practice innovation and how to change practice

Practice innovation is broadly defined in a similar way to clinical practice guidelines. Practice innovation is “a novel set of behaviours, routines, and ways of working that are directed at improving health outcomes, administrative efficiency, cost effectiveness, or users’ experience and that are implemented by planned and coordinated actions.” (Greenhalgh, Robert, Macfarlane, Bate, & Kyriakidou, 2004, p. 582)

By recognising this definition and the similarities between clinical practice guidelines and practice innovation it becomes clear that that the PROMPT Intervention represents an attempt to innovate practice. As
such, the literature related to the diffusion and dissemination of innovation and the implementation of guidelines become important when considering how a discourse analysis of clinical supervision, included as part of the PROMPT Intervention, may generate an understanding of changes in health professionals’ clinical practice.

In relation to the discourse that surrounds evidence-based medicine innovations are practices that are supported by methodologically sound research. Clinical practice guidelines are developed on the basis of current best evidence to improve quality and effectiveness of clinical practice (Burgers et al., 2003; Grol et al., 2003), as such when being implemented are regarded as innovations. Within the evidence-based medicine tradition the spread of such innovations has seen linear processes aimed at the individual level described by changes in clinicians’ behaviours, usually in line with specific guidelines (Grol, Bosch, Hulscher, Eccles, & Wensing, 2007). Links to the underutilisation of research within nursing and healthcare are recognised here. Individual practitioner attitudes, knowledge and routines have been the focus of research in relation to health care improvements and the utilisation of research (Greenhalgh et al., 2004; Scott & Pollock, 2008). The barriers to research utilization, or change in practice discussed within the literature relate to lack of organisational support, individual and cultural factors.

The literature from the field of nursing cites organisational factors including a lack of time and lack of nursing autonomy (Brown, Wickline, Ecoff, & Glaser, 2009; McCaughan, Thompson, Cullum, Sheldon, & Thompson, 2002; Retsas, 2000; Scott & Pollock, 2008). Barriers at an individual level include lack of skill to interpret research, lack of motivation or negative attitude of individual nurses (Brown et al., 2009; McCaughan et al., 2002). Cultural factors such as devaluing of this type of knowledge, subservient or subordinated nursing roles within the healthcare team, and the perception that research was not “work” are also recognised barriers (Scott & Pollock, 2008). These barriers can be paralleled to the barriers to the implementation of clinical practice guidelines that include factors at varied levels. Barriers at the individual level include: no acceptance of evidence, lack of knowledge about expectations, resistance to imposed working method, lack of knowledge.
Organisational barriers include: Extra work and time needed to comply, lack of support. Cultural barriers include: no support from management, disagreement about optimal performance and devaluing of specific kinds of knowledge (Greenhalgh et al., 2004; Grimshaw et al., 2004; Grol et al., 2007). These barriers in turn can be paralleled to the barriers to psychosocial care of adults with cancer that also exist at organisational, cultural and individual levels (Dilworth et al., 2014a).

Implementing new, innovative practices within the healthcare environment the situation is extremely complex and multifaceted (Greenhalgh et al., 2004). Often, the success or failure of implementing an innovation lies in the multiple, unpredictable interactions that arise from the particular context or setting and it is possible that the obstacles are much broader than the individual (Grol et al., 2007). Attempts to effect change need to take into consideration the complexity of the situation. The need to analyse how micro-systems of care provision can be improved has been recognised (Grol et al., 2007). More recently there has been recognition that implementation of guidelines requires not only change from individuals but systemic and organisational change as well (Grimshaw, Eccles, Lavis, Hill, & Squires, 2012; Grimshaw et al., 2004; Grol & Wensing, 2004). Dissemination and implementation of clinical practice guidelines are influenced by political, cultural and healthcare system differences (Grol et al., 2003). These include interactions between patients, professionals, and teams; and the organisational, economic and political contexts (Grol et al., 2007).

Research that investigates the mechanisms that determine if an innovation will be successful or not in a particular setting is needed (Grol et al., 2007) as is research that examines the processes that sustain innovation (Greenhalgh et al., 2004; Howell et al., 2014). Related to the psychosocial care of adults with cancer specifically, there remains a gap related to knowledge translation (Bultz & Johansen, 2011; Howell et al., 2014). Health Professionals report recognising a need for psychosocial care but not being able to provide it for various reasons (Dilworth et al., 2014a).
There are a range of factors that interact at different levels impacting on the implementation of innovations in healthcare. Overlooking the influence of the interacting factors may result in unsuccessful implementation (Grol et al., 2007; van Achterberg, Schoonhoven, & Grol, 2008). Within the context of this study there were a range of issues that presented potential interacting and determining factors to the successful implementation of this innovative psychosocial Intervention. Chapter two presents the barriers to psychosocial care as a systematic review (Dilworth et al., 2014a). These barriers needed careful consideration as to their influence within the data and their impact on Health Professionals’ ability to change their practices in their presence or absence within the context of this study. The debates surrounding clinical supervision are considered as interacting, potentially determining factors and are discussed in more detail below and in chapter two (Dilworth et al., 2013c). However, of note is the suggestion that there is ambivalence or passive resistance by nurses to clinical supervision and in some cases a “lack of support verging on sabotage” (White & Winstanley, 2009, p. 900) that was considered as a contextual element when analysing the discourse from the clinical supervision sessions.

### 1.1.5 Clinical supervision

A critical interpretive review of the clinical supervision literature is presented in chapter two. The review, “finding a way forward: A literature review on the current debates around clinical supervision” (Dilworth et al., 2013c) explores the debates and criticisms presented by previous research and offers a way forward. The review concludes that locally negotiated, multidisciplinary, group supervision offers a professionally-enriching interaction with others that may result in appropriate, safe patient care that is provided in a satisfying work environment. Clinical supervision represents the opportunity to foster collaborative, inclusive and participatory approaches to care (Australian Resource Centre for Healthcare Innovations, 2012) and critical engagement with colleagues around patient care that has the potential to transform practice (Dilworth et al., 2013c). The brief introduction to clinical supervision presented here is intended to provide a definition of clinical supervision and outline
how the literature informed the conceptualisation and development of the research reported within the thesis.

Within the context of the PROMPT Intervention, clinical supervision was provided as a means of supporting and reinforcing the education delivered to the Health Professionals who were delivering the psychosocial Intervention and to ensure patient and staff safety within the context of the PROMPT RCT (Turner et al., 2011). Clinical supervision is promoted for its supportive and practice development functions within much of the nursing literature (Brunero & Stein-Parbury, 2008; Cleary & Freeman, 2005; White & Winstanley, 2010c). However, there are few models within the nursing literature that are well defined (Buus & Gonge, 2009; Fowler, 1996; Sloan, White, & Coit, 2000). The model of clinical supervision adopted for the research is described and justified in detail in chapter 3B).

Broadly, clinical supervision has been is defined by Fowler (1996) as “a formal process of professional support and learning which enables individual practitioners to develop knowledge and competence, assume responsibility for their own practice and enhance consumer protection and safety of care in complex clinical situations”(Fowler, 1996, p. 472).

Within the research literature about the impacts and effectiveness of clinical supervision a number of factors are noted as impeding clear recommendations about what clinical supervision provides. Sloan et al. (2000) note that nursing clinical supervision fails to acknowledge important supervisory behaviours identified in other fields including; case presentation, observation, role play, and review of recorded practice. This detracts from the traditional premise that clinical supervision is about teaching clinical skill. Instead clinical supervision for nurses is regarded as a means of support, personal development, integrity maintenance, risk management, confidence building, an aid for clinical governance, and a means of surveillance. It is also thought that clinical supervision is capable of reducing stress, burnout, sickness and absenteeism. This is demonstrated in the widespread use of the Maslach Burnout Inventory as a measure for the effectiveness of clinical supervision (Edwards et al., 2006; Teasdale, Brocklehurst, & Thom,
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2001; Winstanley & White, 2003), and is further supported by the fact that there is often no change or significant findings in relation to this measure (Edwards et al., 2006; Hyrkäs, Appelqvist-Schmidlechner, & Haataja, 2006; Teasdale et al., 2001). Evaluations of clinical supervision show little or no effect in terms of reducing levels of stress and burnout or impacting on patient and quality of care outcome measures (Francke & de Graaff, 2012; Teasdale et al., 2001; White & Winstanley, 2010c). This is in part due to the assumptions of researchers and divergent conceptualisations.

Methodological limitations of the quantitative clinical supervision research informed the development of the research reported within this thesis. Limitations noted about the clinical supervision research include being small non-randomised samples, using non-validated tools and basic descriptive statistics for data collection, along with a lack of control or comparison group. This limits reliability, validity and statistical power of the research. Reported analyses rarely took into account confounding factors and researchers’ preconceptions (Buus & Gonge, 2009; Spence, Wilson, Kavanagh, Strong, & Worrall, 2001). The use of supervisee or supervisor as the single source of data adds a potential bias in that there may be a difference between what they do and what they say they do (Heaven, Clegg, & Maguire, 2006; Spence et al., 2001). Feedback from supervisees about the supervisor presents only a part of the experience that may be influenced by the power differential in the relationship (Gonsalvez & McLeod, 2008). By using discourse analysis to explore the discourse as it occurred within the clinical supervision sessions the analysis appreciated the influence of power dynamics previously not considered. Supervisee and supervisor remained the source of data but the self-report element was removed in order to study the discourse as naturally occurring talk. Studying naturally-occurring talk enabled access to real behaviour rather than an account of it (Green & Thorogood, 2009).

In a systematic review of clinical supervision for mental health nurses Buus and Gonge (2009) reported that clinical supervision studies that utilised interview data only had secondary interests in understanding how participants felt about supervision suggesting that a wider focus
along with observational data may “create deeper insights into why nurses are ambivalent about clinical supervision” (Buus & Gonge, 2009, p. 262). In the same review (Buus & Gonge, 2009); there were 5 case studies that generated data during supervision. Unlike the research reported in this thesis previous studies disregarded interpretive attention to the social dynamics of the sessions. In line with recommendations made by Buus and Gonge (2009) I selected a method that interpreted discursive practices and social interactions to enable more detailed investigation into clinical supervision. Discourse analysis views language as social action (Wood & Kroger, 2000) and was used in this study to explore how people used language to construct their identities and the context. The situated nature of the conversations evoked historical and social relations. In the context of the psychosocial care for adults with cancer, research demonstrated that there was a complex interplay between organisational, cultural and individual factors. Discursive constructions were used by participants and the analysis explored how accepted truths developed and how these influenced the delivery of psychosocial care.

Uncritical acceptance of the idea that promoting clinical supervision is good for nurses and patients overlooks these methodological limitations (Fejes, 2008; Gilbert, 2001). Gilbert (2001) proposes that clinical supervision is reaching a point where its value is beyond question, and that this unquestioned acceptance is sterilising debate.

There is a need to identify the mechanisms that facilitate changes in health professionals’ practice (Gonsalvez & McLeod, 2008). Data collected contemporaneously for my study allowed identification and exploration of these mechanisms. Of relevance to this thesis is the work that has explored the idea of reflection within clinical supervision as a governing practice that shapes nursing care (Fejes, 2008; Gilbert, 2001). Both the Fejes (2008) and Gilbert (2001) studies used a Foucaultian approaches to discourse analysis to explore clinical supervision. Clinical supervision was described in terms of reflection as a confessional practice where the nurses’ knowledge was made visible to others or one-self so that problems could be solved, or to scrutinize performance to become a better practitioner (Fejes, 2008). The identity of nurses as responsible
problem-solvers is employed to create desirable attributes amongst the nurses. The limitations of previous work and lack of clarity regarding what supervision offers nurses, and how this is best provided, suggest that an in-depth descriptive/explorative analysis of what occurs in supervision and how this benefits staff and patients is indicated. Whilst there are qualitative studies that explore the experience of clinical supervision (Green Lister & Crisp, 2005; Jones, 2006; Kilcullen, 2007) it is unclear from the evidence if and how clinical supervision creates change in health professionals (Heaven et al., 2006; Spence et al., 2001).

1.1.6 Supervision and the transfer of knowledge

There are a number of randomised or control trials that examine the effects of clinical supervision on staff or patient outcomes (Berg, Hansson, & Hallberg, 1994; Cort et al., 2009; Edberg, Hallberg, & Gustafson, 1996; Mannix et al., 2006; Moorey et al., 2009; White & Winstanley, 2009, 2010c). A number of these papers report different aspects of the same study (Berg et al. (1994) & Edberg et al. (1996) and (Mannix et al., (2006), Moorey et al., (2009) & Cort et al., (2009). White and Winstanley’s (2009, 2010a, 2010b, 2010c) randomized control trial aimed to causally link the implementation of clinical supervision to improved mental health nursing by measuring patient satisfaction with care; a suite of measures related to nurses general health, burnout and effectiveness of supervision and unit staffs perception of the quality of the unit (White & Winstanley, 2010c) . The research reported a null result for overall benefit to patient satisfaction, quality of care and staff’s wellbeing outcomes. Although the research reported no overall effect there was one single clinical setting (ward), where they found statistically significant improvements in the patient satisfaction with care outcomes measure (Psychiatric Care Satisfaction Questionnaire) and the unit staffs perceived quality measure (the Perception of Unit Quality instrument). They note that at this specific site clinical supervision was enthusiastically supported at all levels of the management, the clinical supervisor was supported by their own regular clinical supervision sessions, and held the confidence of management and clinical colleagues. Separately to the report of the RCT outcomes White and Winstanley (2009) report diary accounts, provided by the trainee clinical supervisors.
The research reports the most helpful factors when establishing clinical supervision were demonstrable support from Nurse Unit Managers, regular contact with the research coordinators in their area and enthusiasm of supervisees (White & Winstanley, 2009). Across sites scheduling staff duty rosters presented challenges. Competing demands on the supervisees and supervisors were problematic and there are reports of being made to feel guilty, being bullied and fear of retribution by management for attending. At some sites unsupportive and obstructive management culture was on occasion hostile to implementation of clinical supervision (White & Winstanley, 2009). Threats to the confidentiality of clinical supervision sessions as a result of prying management endangered the efficacy of the sessions and exposed the culture base of the host organisation. Based on the diary accounts the authors report that the implementation of clinical supervision was disrupted by structural features of service provision including: unsupportive management, low staffing ratios with high patient acuity and high staff turnover.

The Berg et al. (1994) and Edberg et al. (1996) study was a non-randomised control study of the implementation of clinical supervision along with individually-planned nursing care on a ward for severely demented patients and a similar control ward. They measured creativity and innovative climate, tedium and burnout (Berg et al., 1994) and the quality of nurse-patient cooperation (Edberg et al., 1996) among the nurses on two wards providing dementia care. Their intervention was conducted over one year. It included systematic clinic supervision combined with the implementation of individualized care. Individualised care included the planning and evaluation of care using nursing diagnosis. Care plans included nursing orders for each nursing diagnosis and were developed based on “the patients' ability to handle rest and activity, mobility, personal hygiene and dressing, elimination and toilet routines, nutrition, social involvement and individual adaptive resources, personal temper and mood” (Berg et al., 1994, p. 774). The two papers (Berg et al., 1994; Edberg et al., 1996) reported significant improvements in innovative climate, decreased tedium and burnout, and improvements in nurse-patient cooperation for the experimental groups and no or
negative changes in controls. Because the clinical supervision was implemented alongside another intervention the confounding nature of the dual intervention meant it was difficult to attribute the results to the influence of clinical supervision.

Clinical supervision has also been employed in attempts to maintain changes in practice established through educational interventions (Heaven et al., 2006; Mannix et al., 2006; Moorey et al., 2009). Heaven et al. (2006) report a small randomised control trial that investigated the effect clinical supervision had on improving the transfer of knowledge from a communication training workshop into practice. The study suffered poor recruitment and high attrition (n = 57, 37.9%) limiting the applicability of the statistical analysis (Mann-Whitney U test)\(^4\). Changes within the group were assessed using the Wilcoxon matched pair test\(^5\). The results showed no significant difference between the experimental and control groups when they were directly compared. However, the experimental group showed significant improvements relating to key interviewing skills; responses to cues and impact on overall interviewing. The control group did not show the same improvements.

Further limitations are noted associated with the brevity of supervision provided (4 half day sessions) within the month following training. It was suggested that this is not long enough to integrate the complex skills. Also due to the brevity the supervisors did not feel it was appropriate to directly challenge some deeply embedded skills and beliefs that were diametrically opposed to the model being taught. This reportedly related to certain aspects of the organisational culture and it is possible that a group supervision session may have had more effect on these embedded

\(^4\) The Mann-Whitney U test requires either a very big shift in the median scores of groups or a very large sample to show a difference in groups. Neither was present in this study.

\(^5\) Wilcoxon matched pair test shows those within a group who improve, remain static or become worse.
beliefs through the use of peer support and group influence (Heaven et al., 2006).

Contrary to the findings of Heaven et al. (2006) the work of Mannix et al. (2006), Moorey et al. (2009) and Cort et al. (2009) report that clinical supervision used for supportive, skill building was a necessary element for palliative care nurses to maintain newly-learnt Cognitive Behavioural Therapy skills and confidence in using the skills within their RCT (Moorey et al., 2009). The intervention included training along with clinical supervision for an initial period of six months. During this initial six months significant gains in Cognitive Behavioural Therapy skills and competency were reported. Following the first six months half of the nurses were randomised to stop receiving clinical supervision. Over the next six months the group who discontinued clinical supervision measured significant decreases in Cognitive Behavioural Therapy and self-reported confidence. Those who continued in supervision gained further skill and maintained confidence. The authors concluded that supervision was necessary to maintain the new skills and confidence to use them.

Cort et al. (2009) report the qualitative data generated from interviews with the nurses participating in the RCT. The researchers conducted semi-structured interviews with the nurses in the intervention and the control arm of the study. The interview schedule covered the experience of being in the research and/ or the control group, the Cognitive Behavioural Therapy training, skills, application of the model and clinical supervision. At the conclusion of the research, interviews also asked about continued use of skills. The control group of nurses, who had not received Cognitive Behavioural Therapy training were also asked if they felt they had learned anything about Cognitive Behavioural Therapy from the study nurses or any other source and if were using any Cognitive Behavioural Therapy techniques in their work. The transcripts of the interviews were analysed thematically. The nurses who completed the training reported overwhelmingly positive comments. Nurses valued the group format and interactive style of training and clinical supervision but at times nurses felt exposed. The research reports that the Cognitive Behavioural Therapy model was relevant and helpful in the palliative care
setting. Helpful aspects of clinical supervision that were reported included: Seeing theory put into practice, seeing another point of view, revision and planning, sharing and learning with others, support, and feedback, hope and confidence (Cort et al., 2009). Time and conflicting demands were reported as concerns for both the intervention and control group, who also recorded patient interactions as part of the RCT. Some but not all nurses continued to apply the model as structured sessions post intervention (Cort et al., 2009).

Throughout the background discussion justification and links to the research presented in this thesis have been made. The introduction shifts now to locate the research within the context of a broader project and to introduce myself as a researcher and some of my assumptions regarding this project.

1.2 POSITIONING THE RESEARCH WITHIN A BROADER RESEARCH PROJECT

As noted earlier, this thesis reports the findings of a sub-study element of a multisite RCT designed to investigate the application of a tailored psychosocial intervention to reduce distress and depression in cancer patients, known as PROMPT; Promoting Optimal Outcomes in Mood through Psychosocial Therapies: a randomised trial. The aim of the PROMPT study was to evaluate the effectiveness of a systematically-introduced psychosocial Intervention in cancer services to reduce depression and anxiety among cancer patients (Turner et al., 2011). The PROMPT Intervention was developed in recognition of the gap between recommended best practice and routine care (Bultz & Johansen, 2011) and was based on selected elements of evidence based clinical practice guidelines.

Of relevance to the research reported within this thesis two of the secondary aims of the PROMPT study were: 1) to examine any impact on stress and burnout and psychological adjustment of Health Professionals who deliver the psychosocial Intervention and; 2) To assess the feasibility of integration of the Intervention into clinical practice and identify Health
Professional, systems and patient barriers to the implementation of this model of systematic tailored psychosocial Interventions in clinical care.

The results of the PROMPT study are yet to be finalised. Statistical analyses and sub analyses along with an economic evaluation are being undertaken at the time of writing this thesis.

Figure 2. Illustrates the design of the overall project and the PhD sub study element.
As shown in figure 2. The sub study: a discourse analysis of clinical supervision added an additional layer to the evaluation of the intervention. The aims of the sub study relating to clinical supervision were to explore:

1. how clinical supervision influenced the actions of health professionals.
2. the barriers and / or enablers encountered when implementing the psychosocial Intervention.
3. how Health Professionals construct the experience of providing psychosocial care through language and conversations within clinical supervision
4. the interconnected nature of the situation to create awareness of the needs of clinicians who are delivering psychosocial care to people with cancer.
5. what clinicians report as the consequences/ outcomes of clinical supervision.
Exploring who was saying what and how that impacted on the Health Professionals’ actions provided critical knowledge about the processes within clinical supervision, as well as insights into how clinical supervision supported changes in practice.

The barriers to the provision of psychosocial care are complex. Investigation of the barriers and possible enablers to the provision of such care form a significant part of the work of this thesis. Chapter two provides a detailed account, in the form of a systematic review, of the barriers as they are perceived by Health Professionals and patients (Dilworth et al., 2014a). To further link clinical supervision as a tool to facilitate change in practice and the barriers to psychosocial care it is in response to the barriers encountered when delivering psychosocial care that clinical supervision has been recommended.

Clinical supervision has been recommended as a means to open professional dialogue and provide formal support structures to assist in improving psychosocial care (Botti et al., 2006; Kenny et al., 2007; Turner et al., 2007; Watts, Botti, & Hunter, 2010). If clinical supervision can provide a means to improve the psychosocial care of people with cancer it is important to understand the mechanisms underlying such improvements; how these sessions function, what was discussed and how this shaped the actions of those involved. Also if supervision is a beneficial strategy, how does it help deliver the desired outcomes? For example how does it bring about reduction in patient distress and a greater ability to meet patients’ psychosocial needs through the transfer of knowledge to clinical practice? Or does it alter attitudes to patients and the general culture of care to embrace psychosocial care? Using a discourse analytic approach this study explored the verbal communications that occurred within multidisciplinary group clinical supervision sessions. Previous work that has examined the barriers to psychosocial care of people with cancer has explored health professional’s perceptions of practice or has measured retrospective perspectives of practice and the associated barriers. Where research included observation of practice it was demonstrated that perceptions of practice and actual practice are different (Griffiths, Ewing, & Rogers, 2010).
Analysing data collected within the clinical supervision sessions, contemporaneous to the implementation of an intervention that aimed to address existing barriers to care represents a novel approach to gaining insights into the barriers that presented themselves as part of the implementation of a psychosocial intervention that was integrated in routine care. The insights could not have been gained through descriptive, retrospective methods because it is only when an intervention is implemented that real barriers become apparent (Schofield et al., 2006).

1.3 POSITIONING THE RESEARCHER WITHIN THE RESEARCH

During the research process and the writing of this thesis I adopted a reflexive approach. In doing so I sought to convey the complexity of the research reported in this thesis and the relationship to a large multisite intervention that was introduced into a complex care context. As a beginning, and in line with the reflexive approach taken, in the following discussion I acknowledge some of my reflections on this project. In doing so, the inherent subjectivity of qualitative research is acknowledged and embraced.

In relation to this project, my primary assumption was that the conversations that Health Professionals had within the context of clinical supervision would generate talk that related to how the Intervention and the supervision processes impacted practice. This assumption was based broadly on the premise that clinical supervision was included in the PROMPT study as a designated forum to discuss the patients for whom they were delivering the PROMPT Intervention, difficulties they encountered and strategies to respond to difficulties (Turner et al., 2011).

I assumed that my findings would support and extend the RCT findings. In selecting an appropriate methodology for the qualitative arm of the RCT study, in conjunction with my academic supervisors and members of the research team, I selected an approach that would not interfere with the RCT process. I assumed the PROMPT RCT would have significant positive impacts on patients’ levels of distress. I assumed that by using
discourse analysis I would reveal underlying issues and complexities that would provide insights and shed light on the outcomes of the RCT for Health Professionals and patients.

I assumed that for the patients in the study that having a cancer diagnosis was distressing. The connotations cancer has are too engrained in our society not to warrant mention here. As I think about the psychosocial domain of caring for people with cancer I reflect on my experiences with cancer. How do I feel? I feel sad; I have a sense of loss and grief. It also leads me to consider my own mortality and that of those I love. As a nurse I know that I can treat someone with cancer but how do I care for them? How do I manage my feelings and use my experiences and of those I love to provide care for someone with cancer. More than anything I want to provide good care that makes this experience positive for them or at least comfortable but perhaps I do not necessarily have to revisit my own personal grief in doing this.

Do personal, subjective experiences impede the implementation of evidence based psychosocial care of people with cancer? The experience of having cancer is perceived as emotive and for some fear provoking. There is research that suggests that health professionals overestimate the poor quality of life associated with cancer but interestingly underdetect and treat the associated distress (Lampic, 2000; Lampic, von Essen, Peterson, & Larsson, 1996; Mårtensson, Carlsson, & Lampic, 2008). Research also demonstrates that all oncology health care professionals display persistently negative attitudes towards cancer (Kearney, Miller, Paul, Smith, & Rice, 2003). When caring for someone with cancer do health professionals project their personal fears, anxieties and emotions onto patients? Does this impact their ability to change their practices relating to their ability to provide psychosocial support?

The barriers and enablers to care form a major part of the background for this study and are discussed in the format of a systematic review reported in chapter two (Dilworth et al., 2014a) and also in discussing the findings of the study reported in chapter four and five (Dilworth et al., 2013b; Dilworth et al., 2014b). It appears from the literature that personal attitudes do influence the behaviours of Health Professionals.
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This is worthy of note because historically the focus of practice change or innovation has been focused at an individual level targeting changes in the behaviour of individual clinicians (Grol et al., 2007).

Research also shows that within the health care system there is a focus on physical aspects of care that devalues emotional, psychological aspects of care (Chibnall et al., 2004; Kenny et al., 2007; Schulman-Green, 2003; Scott & Pollock, 2008). This established psychosocial care as less important, being marginalised by physical and bio-medical dominance.

I have introduced psychosocial care broadly as an area of cancer care that needs to be improved. I have located the PhD research within a broader research project and articulated the assumptions that I bought to the project and analysis. This thesis proposes to elucidate the complex interactions of the PROMPT Intervention, my research, which analysed the clinical supervision and some of the very human elements of conducting clinical research in the real world. This will be achieved by exploring the influence clinical supervision sessions, within the context of an RCT, reveal about change in practice and the barriers/enablers to such changes. The discussion will move now to the structure of the thesis.

1.4 THESIS STRUCTURE

The thesis is submitted as a thesis by publication in line with the University of Newcastle Rules Governing Research Higher Degrees (Rule 000830). Information regarding the submission of a thesis by publication is provided as an appendix 12. The thesis is comprised of an introduction, four published papers, one submitted paper, and a concluding chapter. As a qualitative project the papers and then the final thesis were developed iteratively as living documents. To link the ideas and the journey through the research I provide an introduction to each of the papers. The publications are presented in the format that they have been published in each journal. Each chapter/publication has its own literature review relevant to the article, as well as methodology and reference list.
Chapter one introduces the research, my reflections on the project and the need to change current practice in order to improve clinicians’ response to psychological distress among patients with cancer. Background to the study includes definitional clarification of distress, the current clinical practice guidelines and clinical supervision. The discussion included seminal research in the field of psychosocial psychology to provide background to the study. The development of research questions and an overview of the research design and methodology are included here.

Chapter two provides further review of relevant literature. The chapter contains two pieces of published work. The first presents a systematic review of the literature that considers the barriers to psychosocial care for adults with cancer. This work was disseminated as systematic review of the barriers to psychosocial care, “Patient and health professional’s perceived barriers to the delivery of psychosocial care to adults with cancer: A systematic review” (Dilworth et al., 2014a). The review explores the barriers to psychosocial care as perceived by health professionals and adults with a cancer diagnosis. The review was submitted to Psycho-oncology in May 2013 and published in 2014. This review was also presented at the Clinical Oncology Society Australia (COSA) conference in November 2011 as a poster presentation with a published abstract (Dilworth, Higgins, Parker, Kelly, & Turner, 2011). A copy of the poster is included as appendix 1.

The second piece of work presented in chapter two is a critical interpretive review of the current debates around clinical supervision. This paper, “Finding a way forward: A literature review on the current debates around clinical supervision” (Dilworth et al., 2013c), was submitted to Contemporary Nurse in November 2012 and accepted in May 2013. The paper was published in a special edition of the journal that focused on building a strong and resilient workforce.

Chapter three outlines in detail the research design, methods and methodology. The research design and methods were accepted by the Journal of Advanced Nursing as a protocol paper in May 2013, “Examining clinical supervision as a mechanism for changes in practice: A
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research protocol” (Dilworth et al., 2013a). As a requirement of the thesis by publication guidelines there is additional detail provided within the chapter. This detail is provided after the presentation of the paper in chapter three B).

Chapter four presents the first of two findings chapters. Within chapter four the findings of the research are introduced. The introduction is followed by paper four, “Exploring the situational complexities associated practice change in health” (Dilworth et al., 2013b). This paper was accepted for publication in the Qualitative Research Journal in March 2013.

Chapter five presents the second chapter of the findings of the study. The paper, “Implementing a psychosocial intervention in cancer care: An examination of the change process through a discourse analysis of clinical supervision” (Dilworth et al., 2014b) was submitted for consideration to the Journal of Advanced Nursing in May 2014.

Chapter six concludes the thesis. This chapter further links the published and submitted papers, providing a discussion of the research as a whole. The chapter includes recommendations for research, practice and education based on the findings of the study. To draw the first chapter to a close the following section links the background literature and provides justification for the research by linking the literature to the research.

1.5 LINKING THE LITERATURE TO THE RESEARCH

There is a need to improve the psychosocial care of adults with cancer. This requires change in practice by individuals, systems and cultural aspects. A critical approach to the research was indicated because the desired outcome is change in practice. Clinical supervision has been recommended as a means to improve psychosocial care (Botti et al., 2006; Turner et al., 2007; Watts et al., 2010). Clinical supervision is primarily a verbal interaction. As such, an approach that focused on language and specifically language as a social action was appropriate. The discourse analytic perspective considers talk as action (Wood & Kroger, 2000) then the change is achieved through talk. The audio-
recordings of clinical supervision represent a data set that captured the kind of talk that will enable that change.

The implementation of innovative practice in healthcare services is complex. As described above, clinical practice guidelines represent a means of innovating practice. However, within the context of this research, clinical practice guidelines do not reflect routine care (Bultz & Johansen, 2011). To successfully implement any innovation within this clinical setting the interacting and determining factors need to be identified and considered (Grimshaw et al., 2012; Grol & Wensing, 2004). In order to advance knowledge and build on the previous body of research relating to practice change and innovation a qualitative approach that appreciated the complexities and effects of the cultural and organisational context, such as discourse analysis was indicated (Greenhalgh et al., 2004). Within discourse analysis the discourse is considered within its macro-context, including social and cultural context (Crowe, 2005). The findings of this study provide insights into the mechanisms by which clinical supervision influences the practice of health professionals delivering the PROMPT Intervention to moderately distressed people with cancer.

Described in the overview above clinical supervision is widely accepted and promoted. However, there is limited evidence to support the benefits for staff and patients (White & Winstanley, 2010c) or that clinical supervision can be used as a clinical tool to support translation to practice or practice change (Heaven et al., 2006; Mannix et al., 2006). To address the limitations of previous research that were outlined above, a qualitative exploratory design that critically examined the process of supervision as it unfolded, analysing the sessions directly, aimed to gain new understandings of the processes within clinical supervision rather than accounts of the process.

The opening chapter of the thesis has provided an overview and introduction to the research including the relevant background literature. To conclude the chapter I have linked the background literature to the research that has been briefly outlined. Chapter two will now present a detailed exploration of two key elements of the background
literature. They are, the barriers to psychosocial care of adults with cancer in: “Patient and Health Professional’s perceived barriers to the delivery of psychosocial care to adults with cancer: A systematic review” (Dilworth et al., 2014a) and the current debates around clinical supervision in: “Finding a way forward: Reviewing the current debates around clinical supervision” (Dilworth et al., 2013c).


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Chapter 2  
Grounding the research in the literature

2.1 INTRODUCTION

This chapter builds on the background literature and justification for the study. The aim of this chapter is to ground this research project within the current debates regarding psychosocial care and clinical supervision. This chapter includes two papers the first is a systematic review of the barriers to psychosocial care; “Patient and Health Professional’s perceived barriers to the delivery of psychosocial care to adults with cancer: A systematic review” (Dilworth et al., 2014a). The second is a critical interpretive review that explores the current state of clinical supervision; “Finding a way forward: Reviewing the current debates around clinical supervision” (Dilworth et al., 2013c).

The aim of paper one, “Patient and Health Professional’s perceived barriers to the delivery of psychosocial care to adults with cancer: A systematic review” (Dilworth et al., 2014a) was to focus on the barriers to the implementation of and access to psychosocial services. This work was developed in the preliminary and scoping stages of the study. As a systematic review of the barriers to providing and receiving psychosocial care it links to the overall aims of this study by exploring the barriers and enablers to care. The review makes a contribution to the field by pooling data from 25 qualitative and quantitative studies that included nurses, doctors, allied health and patient perspectives from seven countries. Allowing a coherent discussion regarding the possible reasons that routine care does not reflect evidence based best practices. Highlighting these barriers made it possible to make recommendations as to how those working and researching in the field may best be able to address the gaps.

As discussed in the introductory chapter there are multiple systematic reviews that attempted to evaluate the effectiveness of psychosocial interventions in a range of contexts and settings. These reviews highlight
the gap between the research, recommended practice guidelines and routine clinical care. Further to this gap there was a lack of research that detailed the problems associated with the delivery of psychosocial care in routine clinical practice. The objective of the review reported in paper one (Dilworth et al., 2014a) was to explore the barriers experienced and perceived by health professionals and patients in the delivery of psychosocial care to adults with cancer.

The barriers that were identified from the review of the literature are part of the contextual, historical and societal elements of the analysis relating to this thesis and in particular to the use of discourse analysis in this study. The use of discourse analysis calls for understanding contextual aspects of the setting to be able appreciate the situated nature of language, allowing recognition of what it may or may not be possible to say (Edley, 2001). Discursive constructions relating to the context of and barriers to psychosocial care of adults with cancer were useful to identify what choices were available to people when implementing psychosocial care in this context. It was important to understand how dominant discourses are maintained, resisted or transformed (Edley, 2001).

The review analysed quantitative and qualitative data using aggregation and content analysis. The findings reveal that the most commonly perceived barrier for patients relates to receiving adequate support from elsewhere and a lack of perceived need for psychosocial care. Health professionals report barriers at an organisational level most frequently followed by cultural and then individual clinician-related barriers.

Barriers exist on a variety of levels. People with cancer need clear appropriate information and communication about psychosocial services, including information about the role of psychosocial care in addition to existing supports. Interventions that target the complex interplay of individual, organisational and cultural factors need to be developed. Strategies that improve health professional communication skills, identify clear referral pathways, improve acceptability of interventions and clearly identify the need for services could address many of the barriers identified in this review.
The review was published in a special edition of *Psycho-oncology*. The work was also presented as a conference poster at Clinical Oncology Society Australia (COSA) Conference 2010, Perth Australia. See appendix one. As an addendum to the paper the enablers presented within the literature are described.

The second publication included in this chapter constitutes a critical interpretive review of the clinical supervision literature; *Finding a way forward: A literature review of the current debates around clinical supervision* (Dilworth et al., 2013c). The review was published in a special edition of *Contemporary Nurse* that focused on building a strong and resilient workforce.

The review was initially undertaken to scope and develop the clinical supervision manual used for the PROMPT Intervention (see chapter 3B for description). The aim of the initial review was to determine the most appropriate clinical supervision model to adopt for the PROMPT Intervention. In this review I critically explored research that used clinical supervision to support new interventions or translate knowledge into practice. The debates and uncertainty in relation the use of clinical supervision emerged as a major concern and there are many similarities in the literature about psychosocial care interventions. There are a number of reviews that look to establish the most effective approaches to clinical supervision. Despite this and despite the espoused support and widespread implementation of clinical supervision projects within Australia and internationally there remains debate about the usefulness and best approach to clinical supervision. This second paper (Dilworth et al., 2013c) details the current debates and challenges and explores possible ways of moving beyond the current criticisms and limitations in the literature. The review concludes that despite some confusion about the quantifiable outcomes, clinical supervision presents a professionally enriching activity that provides a forum for sharing of knowledge and generation of shared understandings of healthcare. Through this shared experience it is possible that innovative and creative approaches to healthcare will be born.
The arguments from both papers highlight the complexity of introducing new interventions into complex healthcare environments. They highlight gaps, resistances and debates within the literature around both psychosocial care and clinical supervision. As stated above, understanding this as part of the context for the current study allowed the discourse within the clinical supervision sessions to be situated more broadly than the finite context of the session itself.
Paper 1: Patient and health professional’s perceived barriers to the delivery of psychosocial care to adults with cancer: A systematic review

This is the accepted version of the following article: Dilworth, S., Higgins, I., Parker, V., Kelly, B., & Turner, J. Patient and Health Professional’s perceived barriers to the delivery of psychosocial care to adults with cancer: A systematic review. Psycho-oncology, DOI: 10.1002/pon.3474, which has been published in final form at http://dx.doi.org/10.1002/pon.3474

Sophie Dilworth
RN
PhD candidate, School of Nursing and Midwifery, University of Newcastle, Callaghan, Australia

Isabel Higgins
RN, PhD
Professor of Nursing, Older Person Care, School of Nursing and Midwifery, University of Newcastle, Callaghan; and Centre for Practice Opportunity and Development (CPOD), Hunter New England Local Health District, Australia

Vicki Parker
RN, PhD
Professor of Nursing, Rural Health, School of Nursing and Midwifery, University of New England, Armidale; and University of Newcastle, Callaghan, Australia

Brian Kelly
BMed PhD FRANZCP, FAccPM
Professor, School of Medicine and Public Health, University of Newcastle, Callaghan; and John Hunter Hospital, New Lambton, Australia

Jane Turner
MBBS, PhD, FRANZCP
Associate Professor, School of Medicine, University of Queensland; and Royal Brisbane and Women’s Hospital, Brisbane, Australia
2.2 ABSTRACT

Objective

To explore the barriers experienced and perceived by health professionals and patients in the delivery of psychosocial care to adults with cancer.

Methods

Systematic searches were undertaken using the Psychinfo, Medline and CINAHL electronic databases, up to October 2013. Research reporting health professional or patient experiences and perceptions of barriers to psychosocial care are included in the review. The systematic review includes studies that have non-experimental, exploratory and observational designs, as is appropriate to answer the review question. Included studies were critically appraised. The results of individual quantitative studies were aggregated. Qualitative content analysis was used to analysis the qualitative results.

Results

Twenty five papers met the pre-specified inclusion criteria for the final review. The most commonly perceived barrier for patients relates to receiving adequate support from elsewhere and a lack of perceived need for psychosocial care. Health professionals report barriers at an organisational level most frequently followed by cultural and then individual clinician related barriers.

Conclusions

Barriers exist on a variety of levels. People with cancer need clear appropriate information and communication about psychosocial services, including information about the role of psychosocial care in addition to existing supports. Interventions that target the complex interplay of
individual, organisational and cultural factors need to be developed. Strategies that improve health professional communication skills, identify clear referral pathways, improve acceptability of interventions and clearly identify the need for services could address many of the barriers identified in this review.
2.3 INTRODUCTION

2.3.1 Rationale

A need for improved psychosocial care for people living with cancer is well established (National Breast Cancer Centre and the National Cancer Control Initiative, 2003; National Comprehensive Cancer Network, 2007; National Institute for Clinical Excellence, 2004). Evidence based clinical practice guidelines have been available internationally for many years (Canadian Association of Psychosocial Oncology, 2010; National Breast Cancer Centre and the National Cancer Control Initiative, 2003; National Comprehensive Cancer Network, 2003; National Institute for Clinical Excellence, 2004). Despite the availability of these guidelines, their implementation into routine care is limited (Bultz & Johansen, 2011). Research continues to identify the unmet psychosocial needs of patients (Beesley et al., 2008; Chen et al., 2009; Sanson-Fisher et al., 2000; van Scheppingen et al., 2011), along with limited service availability, service accessibility and poor uptake of psychosocial interventions (Ayanian et al., 2005; Eakin & Strycker, 2001; Kumar et al., 2012; Whop et al., 2012).

Within the extant literature there are reviews, meta-analyses and meta-reviews that examine the role of screening for psychological symptoms among people with cancer (Carey, Noble, Sanson-Fisher, & Mackenzie, 2012; Mitchell et al., 2011a), the efficacy of psychosocial interventions (Dale et al., 2010; Devine & Westlake, 1995; Linden & Girgis, 2012; Meyer & Mark, 1995), and the evidence regarding communication needs with this population (Butler et al., 2005). Less readily available is work that details the problems associated with the delivery of psychosocial care in routine clinical practice.

2.3.2 Objective

This systematic review examines the question: what are the barriers to providing psychosocial components of clinical care to adults with cancer?

Empirical qualitative and quantitative research was reviewed to examine the perceptions of health professionals and patients. The aim of the
review is to generate knowledge about the nature of the barriers to such care and how they may be addressed. Not to evaluate the effectiveness of a specific intervention or interventions. For this reason observational and exploratory research was analysed using methods that allowed the synthesis of both qualitative and quantitative evidence (Dixon-Woods, Agarwal, Jones, Young, & Sutton, 2005; Gough, 2013; Mays, Pope, & Popay, 2005).

2.4 METHODS

The Preferred Reporting Items for Systematic reviews and Meta-Analyses (PRISMA) Guidelines (Moher, Liberati, Tetzlaff, Altman, & the, 2009) were used to develop the review. In recognition of the PRISMA focus on the evaluation of intervention studies the analysis and interpretation of results for this review differ from PRISMA guidelines (Mays et al., 2005). Where possible quantitative data were aggregated to allow descriptive exploration but not synthesised in any comparative or differential meta-analysis. The review also includes analysis of qualitative research through the use of qualitative content analysis (Sandelowski, 2000). Ethical approval is not required for this review.

2.4.1 Eligibility criteria

Inclusion criteria included: qualitative or quantitative primary, empirical research that investigated the experiences and perceptions of staff delivering psychosocial care to adults with a cancer diagnosis; or patients receiving psychosocial care. Papers that only evaluated the efficacy of psychosocial / psychological interventions were not included. The patient participants were adults (over 18) with any cancer diagnosis. Where papers focused specifically on the terminal phase of palliative care, for example, specific psychiatric symptom management in terminal care, family involvement and other concerns very specific to terminal palliation, the papers were excluded, as these were considered to be outside of the scope of the aims (Beckstrand, Moore, Callister, & Bond, 2009). The staff participants were not limited to particular discipline, context or setting. The search was limited to papers published in English due to resource availability. To ensure that rigour could be established only primary research with clear detail of method was
included. In accordance with the study’s objectives, the search was restricted to peer-reviewed published studies rather than grey literature, for example, policy document and reports. As an exploration of staff and patient perception and experience the value of grey literature including policy documents was limited. Systematic reviews and other review papers are not included in the results of this review but their reference lists were examined to identify relevant research.

2.4.2 Search
A list of key words was developed by the research team. The list included: Cancer, Neoplasm, Oncology, “Cancer care”, “Cancer nursing”, Psycho-oncology; psychosocial care, psychosocial support, psychosocial treatment, supportive care, psychological treatment, psychological support, psychological care; and barrier*, obstacle*, problem, stigma*. See Appendix 2 (page 234) for full list of key words and Appendix 3 (page 235) for the full search strategy in Medline. Systematic key word searches were conducted in PsychInfo, Medline, CINAHL. Data bases were searched from inception up to March 2011, with an update in October 2013. Scopus was used to identify additional papers from the reference lists of relevant articles.

2.4.3 Study selection
Study selection involved screening of titles and abstracts to determine if the study met the eligibility criteria and to ensure study relevance. Once relevance was established the whole article was retrieved. If eligibility or relevance was unclear the whole article was retrieved.

2.4.4 Data collection process
Data items for both qualitative and quantitative research included: Citation details, study aim, study design, methods and instruments used, sample and setting details, methods of analysis, results, risk of bias and limitations.

2.4.5 Risk of bias
Critical appraisal was conducted using a tool developed from the resources available on the Centre for Evidence Based Medicine website.
(2011; Greenhalgh, 1997). Appropriate tools were used to assess the quality of each paper (Lohr, 2004). The Strengthening the Reporting of Observational Studies in Epidemiology initiative (STOBE) checklist was used to assess the quality of reporting in the included observational studies (n=10) (Radulescu, Diepgen, & Williams, 2009; von Elm et al., 2007). For qualitative research papers consideration was given to the appropriateness of methods of data collection and analysis, participant and setting selection, consideration of researchers’ perspective, credibility, reflexivity and fittingness (Greenhalgh, 1997). A series of critical appraisal questions were asked of each paper. (See appendices 4, 5 and 6).

### 2.4.6 Synthesis of results

Analysis and synthesis of results included simple descriptive statistics and a qualitative content analysis (Sandelowski, 2000) of the barriers described within the research. The combination of analytic methods allowed the development of a meta-narrative review of both qualitative and quantitative data (Dixon-Woods et al., 2005; Gough, 2013).

Demographic details of participants were tabulated. This allowed calculation of the numbers of patients and health professionals in the sample and comparison between settings. Appendix 7 provides the demographic characteristics of the sample population. Basic descriptive statistics were used to aggregate the results of the individual quantitative studies where possible. This involved grouping the survey responses from the original papers together under similar headings. The broader categories were used to explore and describe the perceived barriers to care, as per Appendix 8.

Qualitative findings were synthesised using qualitative content analysis (Sandelowski, 2000). This is an inductive approach that facilitates the description and re-presentation of the qualitative data (Sandelowski, 2000). The aim of content analysis is to re-present the data descriptively, with little interpretation (Sandelowski, 2000). The use of methods likened to that of primary qualitative research is recommended when conducting a review of qualitative research (Dixon-Woods et al., 2006a; Dixon-Woods et al., 2006b). The individual findings of the qualitative studies, or
themes, were extracted. Common topics, meanings, experiences were
coded, sorted and grouped into similar related categories. The
synthesised categories were used to describe the perceived barriers
thematically. Appendix 9 details the individual findings and categories of
the qualitative papers.

2.5 RESULTS

2.5.1 Study selection

The search strategy identified 1192 papers in total. This included 32
duplicates. Of the remaining 1160 papers 1066 were excluded based on
title and abstract. Ninety four full-text articles were assessed for
eligibility. The final sample includes 25 papers.

Figure 3. Study selection flow diagram
Where the search identified related systematic, critical or descriptive review papers the reference lists were utilised to identify relevant papers (Leung & Esplen, 2010; Pincus & Patel, 2009; Ryan et al., 2005; Schofield et al., 2006). Papers that included description of barriers as well as the experience of receiving/ providing psychosocial care are included with a focus on the barriers (Griffiths et al., 2010).

### 2.5.2 Study characteristics

Of the 25 articles included in the review eleven were qualitative, ten quantitative and four mixed method papers. Thirteen reported staff perspective, eight reported the patient perspective, and four reported the views of staff and patients. Six of the papers had nurse only samples, three had medical practitioners (doctor/physicians) only, eight were patient only, four combined health professions and four included patients and health professionals, two included allied health staff and one included family or carers within their samples.

Details of the included studies, including citation, stated aims, design, methods and/ or instruments, samples and setting details and methods of analysis are included below in table 1.
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<td>plore doctors perceived barriers to psychosocial care at the end of life</td>
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<td>plore how UK district nurses describe and conduct early support visits with palliative care patients</td>
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<td>plore rural nurses’ perceptions of psychosocial care</td>
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<td>plore Health Professionals, and patients perceptions of barriers to psych-oncology service utilisation</td>
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<tr>
<td>plore clinicians’ experiences with supportive care screening and referral, and identify perceived barriers and benefits</td>
</tr>
<tr>
<td>plore perceived role of physicians related to psychosocial aspects of palliative care</td>
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<tr>
<td>plore reasons lung cancer patients reject care despite identifying an unmet need</td>
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<tr>
<td>plore barriers and needs of nurses in delivering psychosocial care to cancer patients</td>
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<td>plore cancer nurses’ perceptions of ability to provide psychosocial care</td>
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<td>scribe approaches to psychosocial care</td>
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<tr>
<td>scribe if current practice concurs with best practice, if not why not?</td>
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## Chapter 2

### Grounding the research in the literature

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<th>Descriptive statistics and simple logistic regressions used to identify any differences in the group. Semi-structured interviews were content analysed using a constant comparative method.</th>
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<td>Men with urinary incontinence after a prostatectomy, 21 (50% consent rate) Cleveland, Ohio, USA.</td>
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</tr>
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<td><strong>Ad hoc survey - dealing with psychosocial support in metastatic breast cancer.</strong> Plus demographics. Study also included a second survey not included in RV.</td>
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</tr>
<tr>
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<td><strong>Self-administered survey: Hospital anxiety and Depression Scale (HADS), assessment for minor or major depression after cancer diagnoses.</strong></td>
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Factors that are associated with SPCS use. Multivariate logistic regression to identify independent predictors of SPCS use, using variables that were significant at the p < 0.10 in X2 analyses. Factor analysis and Varimax rotation used to extract the underlying factors of this study questionnaire.

<table>
<thead>
<tr>
<th>Method</th>
<th>Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-administered survey</td>
<td>Reluctance for emotional disclosure questionnaire (developed for this study) and HADS</td>
</tr>
<tr>
<td>Quantitative</td>
<td>Measured those men who were not interested in attending 136 (57%), were interested but did not attend 55 (23%) and were interested and did attend 47 (19.7%).</td>
</tr>
</tbody>
</table>

Final sample 238/784. Netherlands, inpatient, outpatient community

Two logistic regression analyses. 1. Intention to participate 2. Actual participation as dependent variables.
The literature represents health professionals practicing in developed countries. More nurses than doctors/physicians have been included within the studies. The nurses are predominantly female and work within the hospital setting. The doctors/physicians in the review population are more often male; a variety of specialties are represented within the sample. The patients represent a variety of cancer diagnoses. Other clinically relevant subgroups would be: inpatient/outpatient; early versus advanced disease. These details are not discernible in this sample.

### 2.5.3 Risk of bias within studies

Quality assessment of observational studies based on the STOBE checklist was undertaken (see Appendix 4 and 5 for tabulated data). None of the included papers addressed all of the STOBE criteria. The scores ranged between 25/32 (Endo et al., 2008) and 8/32 (Del Giudice, Leszcz, Pritchard, Vincent, & Goodwin, 1997). Areas that were poorly or inconsistently reported are discussed: None of the papers utilised a CONSORT flow diagram to present participation rates and reasons for non-participation or withdrawal. The reasons for non-participation were not consistently reported with only half of the papers including this information, hence limiting the confidence regarding representativeness of the sample and generalizability of the conclusions for the target population. (Radulescu et al., 2009). The potential for bias and attempts to address bias was poorly reported. The setting, including recruitment periods, time intervals and follow up were only reported by four of the papers.

Qualitative papers were assessed for methodological validity prior to inclusion in the review using a critical appraisal tool as detailed in the methods section and available as an appendix 6.
2.6 SYNTHESIS OF RESULTS

2.6.1.1 Patient perceived barriers

Quantitative data

Patient perspectives are most strongly represented by data gathered in surveys. This allowed for aggregation of some of the results. Figure 4 represents the patient reported barriers from the included studies.

The total patient population (4233) is lowered to 3915. Napoles-Springer et al (2009) (N=118) only report perceived barriers for the patients that have not attended a psychosocial service (N=16) and previous users (21). Voerman et al (2007) were also not able to be aggregated (N= 238).

Figure 4. Patient perceived barriers to psychosocial care

The most frequently reported barrier is “no need for psychosocial services and support”, with 38.77% of patients surveyed reporting this as a barrier to the use of psychosocial services (Carlson et al., 2004; Eakin & Strycker, 2001; Endo et al., 2008; Napoles-Springer et al., 2009; Okuyama et al., 2008). This is followed by lack of information about services which included: not knowing that services existed (Eakin &
Strycker, 2001) and wanting more information (Eakin & Strycker, 2001; Napoles-Springer et al., 2009). Transport and parking are practical barriers encountered (17.01%) and included: inconvenience and difficulty of travel and inconvenient service locations (Carlson et al., 2004; Devitt et al., 2010; Kumar et al., 2012; Napoles-Springer et al., 2009; Zhang, Galanek, Strauss, & Siminoff, 2008). Lack of confidence in services included: feeling “emotional burden cannot be relieved by medication” (Endo et al., 2008), concerns about dependence and addiction and the side effects of counselling (Endo et al., 2008). Negative perceptions and stigma about psychosocial care included: “feeling uncomfortable seeking counselling” (Eakin & Strycker, 2001), “negative attitude” (Okuyama et al., 2008), not wanting to use “medications that act on the mind” (Endo et al., 2008) and “not wanting to participate in a group” (Devitt et al., 2010). Health provider/communication barriers included: “lack of referral” (Kumar et al., 2012), not being asked about or recommended psychosocial services (Eakin & Strycker, 2001; Endo et al., 2008; Napoles-Springer et al., 2009) and “hesitation to disturb the physician” (Okuyama et al., 2008). Being too busy or too unwell are minor barriers (Devitt et al., 2010; Eakin & Strycker, 2001; Kumar et al., 2012; Napoles-Springer et al., 2009; Zhang et al., 2008) whilst being too expensive was reported by one American study (Kumar et al., 2012).

**Qualitative data**

Qualitative patient data are limited. Steele and Fitch (2008) represent the only all-patient sample. In line with the quantitative data they report current ability to manage, assumptions about symptoms and issues, existence of support networks, busyness of clinic, lack of awareness of resources (Steele & Fitch, 2008). Neumann et al. (2010) include nurses, doctors/physicians and patients in their sample. They report the barriers as: patient and physicians’ information deficits about psychosocial oncology services, patient and physicians’ subjective norms, psychosocial care not being seen as integral to routine care/only for terminal illness and patients with specific characteristics. Griffiths et al. (2010) included nurses and patients, however, they did not specifically include patient perceived barriers in their discussion.
2.6.1.2 Health Professionals

Quantitative data

Health professional perspectives about the barriers to psychosocial care are not as strongly represented in the quantitative data. Where possible the data have been aggregated. However, with much smaller numbers and fewer studies the results of one study greatly influence the aggregate data. As such, results are more meaningful when considered as part of the whole data set. Nurses reported a lack of time and resources as the most prevalent barrier. Doctors/physicians reported negative perceptions as the most common barrier. This category includes: perceived lack of scientific validity of psychosocial interventions, potential to cause psychological damage, preference for symptom control drug treatment over psychosocial care and unwillingness to refer before problems were identified (Del Giudice et al., 1997). As noted above all of the findings in this category are from a single study (Del Giudice et al., 1997).

Two studies could not be included in the aggregate because they used likert scales to rate the barriers (Eakin & Strycker, 2001; Gosselin, Crane-Oka-da, Irwin, Tringali, & Wenzel, 2011). Eakin and Strycker (2001) report not knowing enough about the services (2.3/5), not enough time (2.2/5). Gosselin et al. (2011) measured the barriers in oncology nurses practice. Lack of time, followed by lack of insurance coverage and cost, closely followed by “lack of value and support for the provision of psychosocial care in the culture of the practice setting” were the most commonly reported as very much a barrier (Gosselin et al., 2011).

Luxford, Hill, and Bell (2006) report on a small sample of health professionals (N=48), predominantly doctors/physicians. They report that all respondents felt that current practice was not in accord with psychosocial guideline recommendations. The barriers that were reported (without quantification) were limited resources, lack of time, not being recognised as a patient need, lack of knowledge regarding the benefits, lack of referral systems. These findings are in line with much of the qualitative findings as detailed below.
Qualitative data

Qualitative data that reports health professional perceptions are described by a framework developed from the research findings. The framework includes three themes: cultural, organisational and clinician. The framework allows some comparison and recognition of commonality. Appendix 9 presents the individual results of the qualitative studies and the synthesised categories.

The most common barriers relate to the organisational theme (40/81). Organisational themes relate to lack of formal support (Botti et al., 2006; Chibnall et al., 2004; Kenny et al., 2007; Turner et al., 2007); the nature of the workforce (part time); the model of care (primary nursing) and inexperience (Botti et al., 2006; Turner et al., 2007), lack of referral or late referral to appropriate services, haphazard continuity of care for support needs, disputed responsibility for assessment (Lee, 2007; Neumann et al., 2010; Schulman-Green, 2003) including concerns about scope of practice (Ristevski, Breen, & Regan, 2011). A lack of time and the burden of a heavy workload are the most frequently cited barriers to the provision of psychosocial care (Botti et al., 2006; Chibnall et al., 2004; Frost, Brueggen, & Mangan, 1997; Kenny et al., 2007; Luxford et al., 2006; Ristevski et al., 2011; Schulman-Green, 2003; Watts et al., 2010).

The cultural theme accounts for twenty two of the 81 reported barriers. The cultural theme includes barriers related to the multi-skilled nature of work, a lack of team cohesion and working in isolation (Botti et al., 2006; Kenny et al., 2007), including a lack of professional dialogue among nurses (Botti et al., 2006; Watts et al., 2010); training that marginalises psychosocial aspects of care (Chibnall et al., 2004; Schulman-Green, 2003), and a medical practice environment where it is suggested there may be self-imposed “busy-ness” (Schulman-Green, 2003) and a milieu marked by lack of support around emotional concerns (Chibnall et al., 2004). The culture of nursing practice in some settings was identified specifically the tension that arises for nurses between physical and emotional needs, “task” versus care (Botti et al.,
2006). Ristevski et al. (2011) specifically describe clinician hesitance related to stigma of psychosocial interventions.

Finally, barriers that related to the clinician or individual theme (19/81), include the emotional burden of caring, a lack of self-care and issues around personal resonance (Botti et al., 2006; Turner et al., 2007; Watts et al., 2010), the duality of relationships, for example, being a community member versus professional (Kenny et al., 2007); and communication difficulties. The communication difficulties here refer to problems on an individual level, for example, health professionals’ fear of “making things worse” (Turner et al., 2007). This is differentiated from aspects of team cohesion and lack of communication or referral pathway between services as outlined above (Chibnall et al., 2004).

### 2.6.2 Risk of bias across studies

In terms of assessing the limitations in the cumulative results consideration was given to the design of the studies. All quantitative studies are cross sectional, that is, the sample is assessed at the same point in time. Cross sectional surveys are often employed to examine the prevalence of exposures, risk factors or disease (Radulescu et al., 2009). In this case they are examining the prevalence of a perceived barrier or attitude and in some cases trying to establish reasons or risk factors or establish a relationship between the barriers and patient or staff attributes. However, using this design it cannot be establish if the barriers described are causally related to the risk factors or patient attributes described.

Much of the quantitative work is generated in small studies (Frost et al., 1997; Gosselin et al., 2011; Luxford et al., 2006; Napoles-Springer et al., 2009; Zhang et al., 2008). All of the quantitative studies utilise ad hoc surveys developed for the study being presented. The use of tools that have not previously been validated may reduce the validity and reliability of the results. Retrospective cohort or convenience samples were utilised. Low response rates are a common feature (Frost et al., 1997; Gosselin et al., 2011; Napoles-Springer et al., 2009; Voerman et al., 2007).
Much of the qualitative data was collected using group interviews (Botti et al., 2006; Chibnall et al., 2004; Kenny et al., 2007; Turner et al., 2007; Watts et al., 2010). The limitations of focus groups include: censoring and conformity, public versus private accounts, themes may not necessarily represent consensus, cannot measure strength of opinion, accounts presented are linked specifically to this social situation one cannot assume that a person will express the same opinion in any other setting (Carey, 1994). The strengths include: ability to gain rich experiential data using group interaction, addition of social context for consideration in analysis (Carey, 1994). Three of the focus group studies include samples from a single setting (Botti et al., 2006; Neumann et al., 2010; Watts et al., 2010) which may increase the likelihood of censoring and conformity in the participant’s responses. Alternatively, it may create familiarity and promote open discussion. Incomplete description of the methods used to collect and analyse data limit the confirmability / dependability of these studies.

2.7 DISCUSSION

2.7.1 Summary of evidence

This review reveals a set of important barriers impeding the provision of psychosocial care to adults with a cancer diagnosis. The review found 25 papers that explored the experiences and perceptions of staff and patients in relation to psychosocial care. The quality of reporting and research is not high within this sample as determined by quality appraisal tools. However, as a whole, a set of consistent findings emerged.

The main barrier reported by patients is the perception that psychosocial care is not needed (Carlson et al., 2004; Eakin & Strycker, 2001; Endo et al., 2008; Napoles-Springer et al., 2009; Okuyama et al., 2008; Steele & Fitch, 2008; Voerman et al., 2007; Zhang et al., 2008). There is a need to better understand what underpins patient and carer perceived need for psychosocial care in this context. Steele and Fitch (2008) found that despite patients identifying unmet needs there were barriers to asking for help with these. Similarly, Carlson et al. (2004) report that almost half of
those reporting significant distress had not and did not intend to use psychosocial services. Okuyama et al. (2008) found that patients with higher distress levels were significantly more likely to endorse a fear of negative impact from psychosocial intervention whereas those patients with low distress were significantly more likely to endorse no need for support. Eakin and Strycker (2001) report large differences in reported referral rate (70%) and actual service use (8%). Distress screening alone is limited in its ability to identify need for service. Recent criticisms of the cost benefits of screening (Hollingworth et al., 2013) have highlighted the detection of distress as being only one component of an overall service model. Subsequent and more detailed assessment of distress and treatment needs need to be tailored to levels of distress and the patients specific situation (Carlson, 2013; Mitchell, 2013). Strategies for more targeted assessment of patients’ need for services that move beyond distress levels alone are needed. Attention to known psychosocial risk factors may be useful in identifying those with greatest unmet needs such as low social support and cumulative adversity (Turner et al., 2011).

Lack of knowledge about services, lack of confidence in the help services can offer and negative perceptions of psychosocial services highlight the need to inform patients with cancer about what is available, what these services/ interventions may be able to offer, and how these might complement the supports that they already have in place. Stigma is a known barrier to mental health care in population studies (Barney, Griffiths, Jorm, & Christensen, 2006; Schomerus, Matschinger, & Angermeyer, 2009; Schomerus et al., 2012) but there is little study of its impact in perception of need for psychosocial assistance in the setting of cancer diagnosis (Holland, Kelly, & Weinberger, 2010). How services are promoted needs to address patient perceptions of psychosocial care, such as through stigma reduction campaigns (Barney, Griffiths, Christensen, & Jorm, 2009; Holland et al., 2010). Negative patient (and clinician) attitudes to psychosocial care are important and needs to be addressed if those who might benefit from them most are going to be comfortable accessing them when needed.
Practicalities of delivering/ receiving support are important and potentially addressable. It appears that recent interventions have taken into account some of these issues relating to accessibility with interventions being delivered over the telephone or in alternate settings dependant on patient need/ preference (Helmes, Culver, & Bowen, 2006; Marcus et al., 2010; Turner et al., 2011).

The barriers perceived by health professionals are perhaps more complex and the interplay between barriers on different levels may be harder to address. The findings of this review are supported by previous research in the area of practice change and innovation (Greenhalgh et al., 2004; Grol & Grimshaw, 2003). In relation to health care improvements and the utilisation of research, where individual practitioner attitudes, knowledge and routines have been the focus of research (Greenhalgh et al., 2004; Scott & Pollock, 2008) the obstacles are much broader than individual clinician attributes (Grol et al., 2007). Attempts to effect change need to take into consideration the complexity of the situation (Grol et al., 2007) i.e. individual, organisational and cultural factors all need to be considered.

Organisational barriers may begin to be addressed though the implementation of interventions that have formal support, education and clear referral pathways embedded within them (Turner et al., 2011). Communication skills training and clinical supervision represent two strategies to be included. Evidence generally supports the view that communication skills training can improve clinician attitudes to psychosocial care, improve skills and confidence in in recognition of psychological symptoms and concerns (Razavi et al., 2003). Skills based professional development programs may help build such capacity in clinicians, provide clarity around communication strategies and ease the perceived burden of providing support. The identification of barriers that specifically relate to provider communication (Eakin & Strycker, 2001; Endo et al., 2008; Kumar et al., 2012; Napoles-Springer et al., 2009; Okuyama et al., 2008) and failure of clinicians to ask about distress (Endo et al., 2008) recognises the need for clearer communication and further supports the need for communication skills training. Clinical supervision is recommended by some researchers as a means to support
the consolidation and maintenance of such skills over time and translation to practice (Botti et al., 2006; Turner et al., 2007; Watts et al., 2010). Creating more time within busy workloads may not be possible. However, communication skills training along with clinical supervision might reduce the perceived lack of time by allowing health professionals to integrate these skills into their daily practice.

Barriers that relate to the organisational culture of cancer care may be the most difficult to address, however, organisational shifts that promote innovative and collaborative approaches to care may present a way forward (Zwarenstein, Goldman, & Reeves, 2009).

### 2.7.2 Limitations of this review

Limitations of this review include the exclusion of articles primarily on title and abstract. However, where the content was not clear or abstract was not available the whole article was retrieved for further review. This ensured that screening criteria were met. Articles were only reviewed for relevance by one researcher. It is therefore possible that there was bias in the screening and selection process. The author group was consulted during this process and clarification was sought where there were concerns about inclusion and exclusion criteria. The difficulties and limitations of searching electronic databases for qualitative work are documented, as is the difficulty determining relevance of qualitative research (Patel et al., 2010). The search was not comprehensive but databases are identified to ensure a clear audit trail. The review is restricted to English language publications. Broad definitions of psychosocial care present a limitation for this review (Hodges et al., 2011). Is it is difficult to determine what a psychosocial or psychological intervention entails within this context and the expected outcomes for patients and staff (Hodges et al., 2011). In an attempt to address the heterogeneous evidence and diverse contexts a meta-narrative approach to the review and aggregation of evidence was used (Greenhalgh, Wong, Westhorp, & Pawson, 2011). The inclusion of both qualitative and quantitative research is viewed as a strength. An additional strength of the search strategy is the inclusion of all relevant articles. Articles that were not readily available were obtained on interlibrary loan services.
2.8 CONCLUSION

This systematic review describes factors identified by health professionals and patients as impeding the delivery of psychosocial care to adults with cancer. It is recognised that a deeper understanding of these barriers is required if psychosocial care is to be embedded in routine care. However, on the basis of this review some recommendations can be made about how existing barriers can be addressed within clinical practice. The recommendations include clear promotion of psychosocial care among patients with cancer. In the light of patient perceptions, tailoring interventions to improve acceptability to patients is important. Clear and open discussion may lead to decreased stigmatisation and reluctance to engage on the part of patients but necessitates attention to clinician perceptions and stigma.

Lack of time as a barrier needs to be considered when implementing psychosocial care. Strategies that allow health professionals to integrate psychosocial care into their daily practice without creating the perception of an additional workload are needed. Capacity and capability building strategies, such as, communications skills training, clinical supervision and interventions that clearly map care pathways, will address many of the organisational, cultural and individual barriers identified within this review. Cultural shifts may be made possible by this kind of support and the promotion of clear, collaborative strategies and intervention.

2.9 PAPER 1: ADDENDUM:

THE ENABLERS TO PSYCHOSOCIAL CARE

This section is added to the published review. It was not published but its absence may have appeared as an oversight within the context of the thesis. Eight of the studies that were included in the review also reported possible enablers (Absolom et al., 2011; Botti et al., 2006; Frost et al., 1997; Kenny et al., 2007; Luxford et al., 2006; Neumann et al., 2010; Schulman-Green, 2003; Turner et al., 2007). These were initially included in the review for publication. They were later removed as part of the peer review and revision process. I have included them in the thesis in line with the aims of the research project as a whole, that is separate
to the aims of the systematic review as published. Table two, below, reports both the qualitative and quantitative research enablers.

**Table 2: Perceived enablers of psychosocial care**

<table>
<thead>
<tr>
<th>Citation</th>
<th>Enablers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Botti et al, 2006 (Botti et al., 2006)</td>
<td>Building relationship with patients through “nursing tasks” Model of care (primary nursing) – enabled continuity</td>
</tr>
<tr>
<td>Frost et al, 1997 (Frost et al., 1997)</td>
<td>Caring nursing staff (n = 14), primary nursing(n = 12), clinical nurse specialists (n = 11), knowledge of nurses(n = 8), allowing time for patients to verbalize (n= 7), interdisciplinary teams (n = 6), American Cancer Society support programs (n = 6), chaplains (n = 5), building interpersonal relationships (n = 5), patients’ readiness to learn (n= 4), and skill of the nurses on the unit (n = 4).</td>
</tr>
<tr>
<td>Kenny et al, 2007 (Kenny et al., 2007)</td>
<td>Supportive management Forum to discuss and reflect</td>
</tr>
<tr>
<td>Turner et al, 2007 (Turner et al., 2007)</td>
<td>Increasing knowledge Increasing professional confidence Improving communication skills Improving self-care and responding to the burden of caring</td>
</tr>
<tr>
<td>Schulman-Green, 2003 (Schulman-Green, 2003)</td>
<td>Collaboration and appropriate referral</td>
</tr>
<tr>
<td>Luxford et al, 2006 (Luxford et al., 2006)</td>
<td>Funding of multidisciplinary care Provision of resources Education of patients and clinicians about benefits (e.g. promoting awareness of psychosocial care)</td>
</tr>
<tr>
<td>Combined Sample</td>
<td>Combined Sample</td>
</tr>
<tr>
<td>Absolom et al, 2011 (Absolom et al., 2011) (Nurses and Doctors)</td>
<td>Use of screening tools</td>
</tr>
<tr>
<td>Neumann et al, 2010 (Neumann et al., 2010) (Nurses, doctors and Patients)</td>
<td>Patient characteristics perceived to access psychosocial support: education level, conception of psychosocial topics, extroverted, advancement in coping, female,</td>
</tr>
</tbody>
</table>
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PAPER 1: REFERENCES


Chapter 2 | Grounding the research in the literature

results of an Oncology Nursing Society psychosocial survey. Oncology Nursing Forum, 38(6), 729-737. doi: http://dx.doi.org/10.1188/11.ONF.729-737


Paper 2: Finding a way forward: Reviewing the current debates around clinical supervision

This is the accepted version of the following article: Dilworth, S., Higgins, I., Parker, V., Kelly, B., & Turner, J. Finding a way forward: A literature review on the current debates around clinical supervision. Contemporary Nurse 2013. 45(1): p. 22–32., which has been published in final form at http://pubs.e-contentmanagement.com/toc/conu/45/1

Sophie DILWORTH
Registered Nurse, PhD candidate, School of Nursing and Midwifery, University of Newcastle; Callaghan; Australia

Isabel HIGGINS
Professor of Nursing, Older Person Care, School of Nursing and Midwifery, University of Newcastle, Callaghan; and Centre for Practice Opportunity and Development (CPOD), Hunter New England Local Health District; Australia

Vicki PARKER
Professor of Nursing, Rural Health, School of Nursing and Midwifery, University of New England, Armidale; and University of Newcastle; Australia

Brian KELLY
Professor, School of Medicine and Public Health; University of Newcastle, Callaghan; and John Hunter Hospital; Australia

Jane TURNER
Associate Professor, School of Medicine, University of Queensland, Herston; and Women’s Hospital, Brisbane; Australia
Corresponding author: Sophie Dilworth

Corresponding Author’s Email: sophie.dilworth@uon.edu.au

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2.1 ABSTRACT

Nursing research increasingly calls for clinical supervision to support nurses and improve nursing practice. Despite this, clinical supervision is not well established in healthcare organisations. This paper employs a critical interpretive approach to review the clinical supervision literature. The review discusses the current debates and challenges exploring possible ways of moving beyond the current criticisms and limitations in the literature.

The review concludes that despite some confusion about the quantifiable outcomes clinical supervision presents a professionally enriching activity that provides a forum for sharing of knowledge and generation of shared understandings of healthcare. Through this shared experience it is possible that innovative and creative approaches to healthcare will be born.

2.2 KEYWORDS

nursing, clinical supervision, literature review, critical reflection, multidisciplinary team clinical supervision
2.3 INTRODUCTION

The clinical healthcare environment is increasingly complex and changing. Health professionals contend with limited resources, workforce shortages, high demand for clinical services, along with increased acuity and complexity of patients (Health Workforce Australia, 2010). In this challenging environment it has been argued that clinical supervision may buffer the tensions around what is expected and what is achievable in relation to such issues as person-centred care, implementation of clinical practice guidelines and utilization of research in an increasingly evidence based healthcare environment (Australian Resource Centre for Healthcare Innovations, 2012(ARCHI); Butterworth, Bell, Jackson, & Pajnkihar, 2008; McCormack & McCance, 2006). Such diverse expectation of clinical supervision has led to a lack of consensus about role and benefits of clinical supervision.

This paper employs a critical interpretive approach to explore the current debates, challenges and possible ways of moving beyond the current criticisms and limitations of the clinical supervision literature. As the debate stands, there are two major themes that arise as criticisms in the literature. The first relates to the complex nature of clinical supervision as an intervention. As a result of the complexity and diversity of the contexts in which it is implemented the literature reports confusion about the role and structure of clinical supervision; a diffuse unlinked evidence base; challenges measuring the effectiveness of clinical supervision and difficulty in implementing clinical supervision in practice.

The second major theme relates to resistances that arise from within healthcare organisations. Resistance to clinical supervision is perpetuated by organisational cultures within healthcare that are suspicious of change. In this context time, staffing and budgets are used as an excuse by organisational management to maintain current practices (White & Winstanley, 2009).

Attempts to establish clinical supervision in practice are being limited by the current debates. These debates have essentially overlooked the role that clinical supervision can have in strengthening teams through group
critical reflection on practice. Whilst nurses and nursing research are the focus of this paper, the benefits of clinical supervision should not be limited to their applications within nursing. The confusion and conjecture about clinical supervision for nurses resonates across most healthcare disciplines (Farnan et al., 2012; MacDonald & Ellis, 2012; Spence et al., 2001).

The authors contend that if clinical supervision is to achieve patient-centred care and innovation of practice; it first needs to be legitimised as real work. This will involve genuine support from nurses, management and healthcare organisations. In looking forward the authors explore multidisciplinary clinical supervision as a potential framework for supporting practice innovation through collaboration, participation and critical engagement across healthcare teams. This paper will outline the potential role of supervision as a forum for learning to enhance and build interprofessional collaborative practice.

2.4 REVIEW METHODS

The purpose of the review was to scope the current field, identify the main debates and existing evidence around clinical supervision with a view to develop an understanding of current practices that will inform a larger project (Dixon-Woods et al., 2006b; Mays et al., 2005). The project is a post graduate thesis that examines if and how clinical supervision may facilitate change in practice within the context of a randomised control trial designed to reduce anxiety and depression through the implementation of a psychosocial intervention for adults with cancer (Turner et al., 2011). The review questions developed iteratively as an understanding of the field was developed (Dixon-Woods et al., 2006b; Mays et al., 2005). In light of the wide body of literature and the limitations, that will be discussed, finding a way to move forward became a focus of the review.

A snow ball sampling method was used to locate relevant literature (Aveyard, 2010; Pawson, Greenhalgh, Harvey, & Walshe, 2005). This involved several different approaches (Dixon-Woods et al., 2006a). Including: systematic keyword searches in PsychInfo, medline, CINAHL from inception to October 2012. Keywords included: clinical supervision,
supervision, nursing supervisory, mentorship, mentorship or mentors, preceptorship, critical companion; web searched for key policy and guidelines, reference chaining, key author searches and contacting authors in the field (Dixon-Woods et al., 2006a; Dixon-Woods et al., 2006b). These techniques located over 1000 records, 59 of which are included within the review. The sampling strategy was purposive (Dixon-Woods et al., 2006b). Initial selections were based on papers clearly related to relevant nursing literature and then moved to identify literature to inform the emerging analysis. A critical reflexive approach to the analysis that allowed attention to the contradictions and flaws in the evidence followed methods described by Dixon-Woods et al. (2006b). This included “line of argument synthesis” and “refutational synthesis” in a process likened to that of primary qualitative research (Dixon-Woods et al., 2006b, p. 5). The review will initially outline the current debates and then move to a discussion about the often overlooked aspects of clinical supervision, reflective practice and the potential for innovating practice.

2.5 CURRENT DEBATES

2.5.1 Diverse expectations for clinical supervision

In part the complexity and confusion within the literature is generated by the diverse expectations and outcomes of clinical supervision. Clinical supervision is considered by many as a means of supporting and educating nurses and has been employed in attempts to maintain changes in practice established by educational interventions (Heaven et al., 2006; Mannix et al., 2006), to ensure staff and patient safety (Turner et al., 2011), to improve patient satisfaction outcomes (White & Winstanley, 2010c), to increase professional dialogue (Kilcullen, 2007; White & Winstanley, 2010c), to decrease burnout and stress (Hyrkäs et al., 2006; Severinsson, 2003; Wallbank & Hatton, 2011) and to provide formal support structures and facilitate reflective practice (Botti et al., 2006; Kenny et al., 2007; Turner et al., 2007; Watts et al., 2010). There are a plethora of clinical supervision models within the nursing literature but few of them are well defined (Buus & Gonge, 2009; Fowler, 1996; Sloan et al., 2000). Proctor’s model is becoming widely utilised within the nursing research. Despite its increasing popularity, there is criticism that
perhaps this model is too imprecise, failing to identify interventions appropriate to each domain (Sloan et al., 2000). The clinical supervision literature is criticized for lack of clarity related to what is provided in clinical supervision (Sloan et al., 2000; Yegdich, 1998). The lack of clarity about role and structure has led to a large body of evidence that is diffuse. As a result it lacks strength in the claims it makes for clinical supervision.

### 2.5.2 A diffuse evidence base

Despite a large body of evidence, the strength of the evidence as to the impact of clinical supervision is low (Francke & de Graaff, 2012; Hyrkas, 2005). The drawbacks of the existing body of literature relate to the fact there is a large body of research that is in many ways unrelated. The number of reviews points to a recognition of the need to draw together empirical findings to strengthen and link claims about the effectiveness of clinical supervision. All of the reviews appear to reach a similar conclusion: the evidence that clinical supervision is effective is not strong and there is a need to address methodological limitations in order to improve the strength of the evidence (Brunero & Stein-Parbury, 2008; Butterworth et al., 2008; Buus & Gonga, 2009; Farnan et al., 2012; Francke & de Graaff, 2012; Gonsalvez & McLeod, 2008; Spence et al., 2001; Wheeler & Richards, 2007; Williamson & Dodds, 1999).

The methodological limitations include studies generally involving small, non-randomized samples, using non-validated tools and basic descriptive statistics for data collection, along with a lack of control or comparison group (Brunero & Stein-Parbury, 2008; Buus & Gonga, 2009; Wallbank & Hatton, 2011). This limits reliability, validity and the statistical power of the research. The analysis rarely takes into account confounding factors and researchers’ preconceptions (Buus & Gonga, 2009; Spence et al., 2001). The use of supervisee or supervisor as the single source of data adds a potential bias in that there may be a difference between what they do and what they say they do (Heaven et al., 2006; Spence et al., 2001). Feedback from supervisees about the supervisor performance is also likely to be systematically biased due to the power differential in the
relationship (Gonsalvez & McLeod, 2008). The role of researchers as supervisors may also introduce bias (Buus & Gonge, 2009).

Concerns about methodological limitations are echoed across multiple health disciplines including medicine (Farnan et al., 2012), psychology (Gonsalvez & McLeod, 2008) and allied health (Spence et al., 2001). Despite these concerns, no-one is willing to dismiss the potential benefits of supervision and programs of supervision continue to be implemented internationally and across disciplines (Alleyne & Jumaa, 2007; Brunero & Lamont, 2012; Deery, 2005; Fowler, 1996; Health Workforce Australia, 2011; Regan, 2012).

Limitations of the research have resulted in criticisms that there is uncritical acceptance that clinical supervision is good for nurses and patients (Fejes, 2008; Gilbert, 2001). Gilbert (2001) suggests that clinical supervision is reaching a point where it is perceived as beyond question, and that this hegemony is sterilizing debate. Clinical supervision is a complex intervention. For a range of reasons it is not amenable to empiricist research designs. It may be that studies aiming to establish the effectiveness of clinical supervision on improving patient outcomes, staff performance or satisfaction are inevitably going to show limited impacts (White & Winstanley, 2010c).

2.5.3 Complex interventions are difficult to implement and evaluate

The quantitative research reviewed often evaluated the implementation of clinical supervision interventions as either standalone projects (White & Winstanley, 2010c) or through the introduction of clinical supervision alongside other changes to usual practice (BÉGat, Severinsson, & Berggren, 1997; Berg & Hallberg, 1999; Edberg et al., 1996; Hart et al., 2000; Heaven et al., 2006; Kilcullen, 2007). There are several problems associated with this. Where the clinical supervision is implemented alongside other interventions the confounding nature of the dual intervention means that it is difficult to attribute the results to the influence of clinical supervision. Where clinical supervision interventions are implemented alone and then evaluated these often involve small
samples that fail to show significant, generalisable change (BÉGat et al., 1997; Berg & Hallberg, 1999; Berg et al., 1994; Heaven et al., 2006).

Descriptions of the problems experienced as a result of implementing a new intervention are commonly discussed (Hyrkas, Appelqvist-Schmiddlechner, & Paunonen-Ilmonen, 2002; White & Winstanley, 2010c). These problems may be relevant to any change in practice and not specific to clinical supervision. It is suggested that follow-up periods of one year or less are not long enough to integrate the complex skills required when learning new clinical skills or approaches to care (Heaven et al., 2006; Hyrkäs et al., 2006; Kenny & Allenby, 2012). The qualitative data supports this in that there are consistent reports of difficulty implementing clinical supervision (Jones, 2006; White & Winstanley, 2009). This is true whether supervision is implemented alone or with another intervention.

There are few randomized or control trials that examine the effects of clinical supervision on staff or patient outcomes (Berg et al., 1994; Edberg et al., 1996; Heaven et al., 2006; Mannix et al., 2006; Moorey et al., 2009; White & Winstanley, 2010c). Recently, White and Winstanley’s (2010c) randomized control trial (RCT) showed no overall benefit to patient satisfaction, quality of care and staff wellbeing outcomes. Heaven et al. (2006) report a small randomized control trial which investigated the effect clinical supervision had on improving the transfer of knowledge from a communication training workshop into practice. The study suffered poor recruitment and high attrition (n= 57, 37.9%) limiting the applicability of the statistical analysis (Mann-Whitney U test). Contrary to this finding the work of Mannix et al. (2006) report that supportive, skill building clinical supervision was a necessary element for palliative care nurses to maintain newly learnt cognitive behavioural therapy skills and confidence in using the skills within their RCT (Moorey et al., 2009).

Survey-based studies, large and small, have been used to generate a picture of what clinical supervision looks like, who is participating and what is being achieved (Hyrkas, 2005; Hyrkäs et al., 2006; White & Roche, 2006). The majority of the studies that examine the impact of clinical supervision on health, stress and burnout use cross-sectional
survey data (Edwards et al., 2006; Hyrkas, 2005; Severinsson & Kamaker, 1999; Teasdale et al., 2001). By its very cross-sectional design this research is not able to draw causal links between clinical supervision and outcomes. This is not a concern unique to this area. The problem calls for researchers, and research consumers to be cautious about any causal claims inferred by observational research designs.

Following these methodological and research based concerns within the literature the review will now focus on the second major theme that is more organisationally, culturally and practice based. That is, the resistance from within healthcare organisations. The authors attempt to highlight and challenge some of the taken for granted arguments within the literature (Dixon-Woods et al., 2006b).

## 2.6 RESISTANCE FROM WITHIN HEALTHCARE ORGANISATIONS

### 2.6.1 A culture resistant to change

The nature of nursing work remains task focused and routine oriented (Botti et al., 2006; Scott & Pollock, 2008; Watts et al., 2010). In relation to clinical supervision nurses describe feeling that they are not worthy of clinical supervision (Green Lister & Crisp, 2005) or that clinical supervision will be viewed as “skiving” (Stevenson, 2005). Nurses’ attitudes to clinical supervision are describes as ambivalent (Brunero & Stein-Parbury, 2008; Kenny & Allenby, 2012). Clinical supervision is interpreted as not being real work (Kenny & Allenby, 2012; Stevenson, 2005; Strong et al., 2004). As such it is not seen as a priority (Green Lister & Crisp, 2005; Kenny & Allenby, 2012; White & Winstanley, 2009). This is also true for allied health professionals working in mental health, who describe clinical supervision as the first thing to go when there are competing demands (Strong et al., 2004). The result is ad hoc, irregular, informal clinical supervision (Buus, Angel, Traynor, & Gonge, 2011; Cleary & Freeman, 2005; Green Lister & Crisp, 2005; Strong et al., 2004). Along with their ambivalence nurses’ perceive that attendance at clinical supervision may be construed as not coping or linked to performance management concerns (Cleary & Freeman, 2005; Green
Lister & Crisp, 2005; Kilcullen, 2007; White & Winstanley, 2009). When nurses do engage with clinical supervision a level of personal commitment is often required if implementation is to be successful (White & Winstanley, 2010c).

### 2.6.2 Assumptions about commitment

There are multiple examples where a commitment that is ‘above and beyond’ is called on from nurses if they are to access clinical supervision (Jones, 2006; White & Winstanley, 2009). The subtext being that this is not real work and cannot be accommodated within work hours (White & Winstanley, 2009). Jones (2006) praised the dedication of two nurses who attended supervision after night work (p. 160). Other qualitative studies report that attendance at clinical supervision was limited due to nurse unwillingness to attend clinical supervision outside of their shift times (Buus et al., 2011; Chilvers & Ramsey, 2009; Cross, Moore, & Ockerby, 2010; Kenny & Allenby, 2012). Buus et al. (2011) suggest that the nurses’ recreational time off was more valued than clinical supervision. To this point it could be argued that attendance at clinical supervision while off duty equates to a boundary violation as defined by the Australian Nursing and Midwifery Council (ANMC) (2010). To demonstrate, if nurses were contacting patients or providing care outside of their work hours there is no doubt that this would be the case. The guidelines clearly specify behaviour that results in singled out treatment including “visiting the person when off duty or swaps roster allocations to be with the person” (Australian Nursing and Midwifery Council, 2010, p. 10) is a violation of professional boundaries. The implications of such boundary violations relate to professional ethical codes of conduct. This behaviour described as resistance from nurses could be interpreted differently. The expectation for nurses to attend in their own time could in fact be interpreted as creating a moral dilemma. To address this it is necessary that implementation takes into account the needs of nurses working on rotating 24-hour rosters. This is not impossible. White and Winstanley (2009) found that rosters could be negotiated. This was possible where the person implementing clinical supervision had influence over the roster or with support from managers. Commitment aspects of the debate are related to the lack of time argument.
support from management or those administering rosters is necessary to allow dedicated time within work hours to support clinical supervision.

**2.6.3 Time equals money**

Lack of time and busy workloads are consistently noted across specialties and across disciplines as a barrier to implementing and maintaining clinical supervision (Chilvers & Ramsey, 2009; Cleary & Freeman, 2005; Deery, 2005; Kenny & Allenby, 2012; Strong et al., 2004; White & Winstanley, 2009). The value of having time dedicated to discuss clinical work in a reflective forum is one of the benefits of clinical supervision (Cross et al., 2010). The “too busy” argument loses ground if the amount of time is considered. Edwards et al. (2005) explored the factors that impact on the effectiveness of clinical supervision. To be effective they recommend clinical supervision be held monthly for at least one hour. At a managerial and individual level time needs to be allocated to allow such forums to occur.

The discussion around on whose time clinical supervision should be held draws out further discussion around the need to legitimise this as real nursing work. The cost implications of clinical supervision are yet another excuse used to devalue or dismiss clinical supervision. Sometimes this is described overtly. For example, cost cutting and resource constraints to justify irregular and ad hoc clinical supervision arrangements for child protection workers in the United Kingdom’s National Health Service (NHS) (Green Lister & Crisp, 2005). At other times the message is more covert. Managers refusal to pay time in lieu for attendance (White & Winstanley, 2009). Based on fourteen hours of supervision per year, one-to-one, peer supervision the cost of clinical supervision for nurses is 1% of their annual salary (White & Winstanley, 2006). This would be decreased further if supervision was monthly and a group model was implemented. The idea of group format clinical supervision is one of the main concepts that the authors will now discuss in relation to finding a way to move beyond the current debates and criticisms of clinical supervision.
2.7 FINDING A WAY FORWARD

Despite methodological limitations, and resistance from health professionals and organisations there is an argument for positive changes in work satisfaction, decreases stress, burnout nurses well-being and effective clinical supervision (Dawson, Phillips, & Leggat, 2012; Edwards et al., 2006; Hyrkäs et al., 2006; Koivu, Saarinen, & Hyrkas, 2012; Severinsson & Kamaker, 1999; Wallbank & Hatton, 2011). There is also some evidence that clinical supervision can improve patient and staff satisfaction (White & Winstanley, 2010c); enhance education, expand scope of practice (Mannix et al., 2006; Moorey et al., 2009) and provide a forum for critical reflective practice (Cleary & Freeman, 2005; Cross et al., 2010; Hyrkas et al., 2002; Kilcullen, 2007).

Diverse local contextual factors suggest a common understanding and uniform implementation is not possible. For clinical supervision to be successfully established in practice, programs will need to be locally negotiated so that they meet the needs of the staff involved. The National Clinical Supervision Support Framework released recently by Health Workforce Australia (HWA) (2011) offers broad principles and clarification of clinical supervision. HWA (2011) recommend that the framework should inform local planning and strategies in a consistent way and not supersede local arrangements. An appreciation of local and contextual factors is consistent with the organisational change and innovation literature that acknowledges that attempts to effect change need to take into consideration the complexity of the local situation (Grol et al., 2007).

Alongside the fairly limited body of quantitative evidence there is a large body of qualitative research. It is here that many insights about the benefits and transformational aspects of clinical supervision can be explored. The benefits explored are practice change and innovation, new skills/confidence that expand health professionals’ scope of practice and the generation of shared understandings of care.
2.7.1 Critical reflection to generate shared understanding

Many of the reported positive aspects of clinical supervision relate to the benefits of generating a shared dialogue or the impact of working in a reflective way (Cleary & Freeman, 2005; Cross et al., 2010; Hyrkas et al., 2002; Kilcullen, 2007). Clinical supervision is viewed as a supportive forum (Cleary & Freeman, 2005; Kilcullen, 2007) that increases the value nurses put on their work (Kilcullen, 2007). The need to open professional dialogue is noted within nursing research (Botti et al., 2006). The benefit of open communication amongst peers and more broadly across disciplines has been noted as a positive support for nurses when implementing new and innovative roles such as nurse prescribers (Stenner & Courtenay, 2008). The creation of shared meanings of care and experiences are described repeatedly (Cleary & Freeman, 2005; Cross et al., 2010; Holst, Edberg, & Hallberg, 1999; Stevenson, 2005). This creates the opportunity to develop consensual cohesive practices creating new ways of collaborating (Bondas, 2010; Hyrkas et al., 2002). This shared understanding is described as working off the same page (Cross et al., 2010). Through the creation of shared narratives for patients and health professionals radical talk is generated that is able to challenge dominant ideologies and change work practices (Holst et al., 1999; Jones, 2006; Stevenson, 2005). Clinical supervision provides an experiential way for nurses to understand their work and themselves (Holst et al., 1999; Jones, 2006). This is seen to validate and confirm the nurses in their work. Extending this idea beyond nursing, the benefits of creating shared understandings through critical reflection on practice may also be applicable across disciplines.

2.7.2 Multidisciplinary team clinical supervision

The challenges of group work, in particular interprofessional group work, should not be overlooked. Working in a group can potentially provoke anxiety. Some of the concerns voiced by study participants relate to confidentiality of the group. For example, group members’ suspicions about supervisors’ communication with managers (Jones, 2006). Or managers’ mistrust of the process and interrogation of supervisors (White...
& Winstanley, 2009). These anxieties can be exacerbated though open group format in which the group members vary from session to session (Brunero & Lamont, 2012) or when the group is multidisciplinary (Hyrkas et al., 2002). This can be overcome and the group can build and enhance trusting and collaborative relationships (Bondas, 2010; Hyrkas et al., 2002; Jones, 2006; Stevenson, 2005).

Whilst there is a lot of literature that espouses the benefits of interprofessional working (CanNET National Support and Evaluation Service - Siggins Miller, 2008; Hyrkas et al., 2002) there is also literature that suggests that the benefits of interprofessional practice are less clear (Zwarenstein et al., 2009) and that interprofessional practice is hampered by lack of understanding of roles across professions (Mitchell, Parker, Giles, & White, 2010; Mitchell, Parker, & Giles, 2011b). Team clinical supervision is described as strengthening professional identity (Berg & Welander Hansson, 2000; Hyrkas et al., 2002). Clinical supervision has the potential to help nurses reconceptualise our position in relation to the need for critical review of our care and decisions, in relation to the authority that we have to seek support as an entitlement and as best practice.

Models of care that bring together the skills and knowledge of a diverse workforce and from diverse settings are being put forward as a means to improve communication, integrate care, and provide role clarity and coordination of care (NSW chronic and complex care) (NSW Department of Health, 2005). Training and education of health professionals is moving to bridge the divide between health disciplines through interprofessional training initiatives (Health Workforce Australia, 2010). Alongside this there is a growing recognition that complex and chronic care requires multidisciplinary approaches (NSW Department of Health, 2005). Links between clinical supervision and other multidisciplinary forums are described by Buus et al. (2011). They describe parallel forums including interdisciplinary, clinical-case conferences and handovers. However, they found that “the highly-structured agendas for information sharing at these meetings did not leave time for in-depth discussions and reflection on the particular clinical problems confronting the nursing staff.” (Buus et al., 2011, p. 99). The strong focus within the literature on
efficacy using empiricist research designs to evaluate clinical supervision has failed to recognise the role that clinical supervision can have in strengthening teams through group critical reflection on practice.

2.8 CONCLUSION

There is an ongoing debate around the problems with a diffuse evidence base and the confusion about the role and structure of clinical supervision. To address this clinical supervision needs to be locally negotiated so that it may appreciate the complex contextual factors at a local level. This should be guided by an overarching framework. For example, the Health Workforce Australia National Clinical Supervision Support Framework (Health Workforce Australia, 2011). In order to address the argument that support for clinical supervision is unfounded future research needs to consider issues of rigour. Research must clearly identify the intended outcomes and designs should consider the complex nature of clinical supervision interventions (Grol et al., 2007; Grol & Grimshaw, 2003).

Resistance and ambivalence from nurses’ that perpetuate old-fashioned interpretations of nursing practice need to be challenged. Research needs to explore clinical supervision as a potentially professionally enriching interaction with others that may results in appropriate, safe patient care that is provided in a satisfying work environment. If these results are achievable then research needs to further explore the mechanisms by which these changes are achieved, or not, in which contexts.

Transformational practice is achieved through collaborative, inclusive and participatory approaches to care (Australian Resource Centre for Healthcare Innovations, 2012). Critical engagement with colleagues around patient care has the potential to transform practice. Multidisciplinary group clinical supervision presents itself as an approach to clinical supervision that will break down the silos created by not working across disciplines. It will link the work that is being done around building clinical supervision as a viable and valuable intervention to support health professionals. Group supervision will potentially make best use of scarce funding and time resources. Multidisciplinary session will enable generation of shared understanding of care and the health
care experience from a variety of perspectives. This approach will create a space to generate new understandings of difficult or distressing patient encounters. It will also build interprofessional relations and collaborations through the generation of shared meanings of health care. Through this shared understanding health professionals and health care teams will be able to move forward in innovative and exciting new ways.

2.9 ACKNOWLEDGMENTS

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PAPER 2: REFERENCES


Koivu, A., Saarinen, P. I., & Hyrkas, K. (2012). Who benefits from clinical supervision and how? The association between clinical supervision and


Chapter 3  A) The research protocol

3.1 INTRODUCTION

The first section of the chapter, 3 A) includes a published research protocol paper; “Examining clinical supervision as a mechanism for changes in practice: A research protocol” (Dilworth et al., 2013a). The protocol was accepted for publication in the Journal of Advanced Nursing, May 2013. Sharing the research methods publically adds a level of transparency and accountability to the research process that adds to the auditability and overall rigour. The research design presented in this chapter represents a new and innovative approach to combining qualitative and quantitative research approaches.

Submitting the protocol paper for publication was a means of disseminating this new approach to peers within the health research communities. To my knowledge at the time of publication this was the first study to use discourse analysis as a sub-study associated with an RCT. In addition, this is one of few studies of clinical supervision that utilised data collected during and within the supervision sessions. Previous research has predominantly relied on the reports of supervisees and supervisors to evaluate both the process of clinical supervision and its impact of practice (Brunero & Stein-Parbury, 2008; Francke & de Graaff, 2012). The protocol paper presented in this chapter details the research method in accordance with the journals requirements. Because of the journal requirements the protocol paper is necessarily brief at times. Chapter 3 B) is included as an annex or supplemental to the paper.

In section 3B) I have included details of ethical and safety issues, detail regarding data management and retention. Elements of the design that I felt required more attention than given in the protocol paper are also elaborated. This includes some explanation of the stepped wedge design and detail around the structure and format of the clinical supervision sessions. In this section I also articulate in detail issues of rigour and the strengths and limitations of the study.
3.2 ABSTRACT

Aim: This paper describes the research protocol for a study exploring if and how clinical supervision facilitates change in practice relating to psychosocial aspects of care for Health Professionals, who have been trained to deliver a psychosocial intervention to adults with cancer.

Background: There is a recognised need to implement care that is in line with clinical practice guidelines for the psychosocial care of adults with cancer. Clinical supervision is recommended as a means to support Health Professionals in providing the recommended psychosocial support.

Design: A qualitative design embedded within an experimental, stepped wedge randomised control trial.

Methods: The study uses discourse analysis to analyse audio-recorded data collected within clinical supervision sessions that are being delivered as one element of a large randomised control trial. The sessions will be attended primarily by nurses but including physiotherapists, radiation therapists, occupational therapist. The Health Professionals are participants in a randomised control trial designed to reduce anxiety and depression of adults with cancer experiencing distress. The sessions will be facilitated by psychiatrists experienced in psycho-oncology and the provision of clinical supervision.
Discussion: The proposed research is designed specifically to facilitate exploration of the mechanisms by which clinical supervision enables Health Professionals to deliver a brief, tailored psychosocial intervention in the context of their everyday practice. This is the first study to use discourse analysis embedded within an experimental randomised control trial to explore the mechanisms of change generated within clinical supervision by analysing the discourse within the clinical supervision sessions.

Trial registration: Trial registrationACTRN12610000448044
3.3 SUMMARY STATEMENT

Why is this research needed?

• There is a need to reduce high rates of depression and anxiety experienced by adults with a cancer diagnosis.

• Clinical supervision is recommended as a means to support Health Professionals deliver psychosocial care to adults with cancer.

• There is little known about the mechanisms by which clinical supervision may help to facilitate changes in current practice.

What are the key findings?

• Discourse analysis will be used to highlight complex contextual aspects of psychosocial care to enable conceptualisation of alternatives to current practice.

• Discourse analysis is an established critical method. Embedding it as a qualitative element within a randomised control trial will enable exploration of the complex interplay between organisational, cultural and individual contexts that could otherwise not be possible.

• Discourse analysis is a novel approach to understanding barriers to practice change in psychosocial cancer care and the role of clinical supervision in practice change.

How should the findings be used to influence policy/practice/research/education?

• Discourse analysis will enable current practices to be explored along with conceptualisation of alternatives for practice.

• Critical knowledge could be used to create awareness of the needs of clinicians who are delivering psychosocial care to people with cancer. This awareness could be used to generate educational initiatives, interventions and further research.

• Examination of the mechanisms by which clinical supervision can be used as a tool to implement innovative interventions and improve knowledge transfer to practice has implications for clinical supervision policy and utility of clinical supervision in practice which is currently debated in the literature.

3.4 KEYWORDS

Clinical supervision, nurses, psychosocial nursing, cancer, research methods, discourse analysis, theory practice gap
3.5 INTRODUCTION

Internationally recognised evidence based clinical practice guidelines for the psychosocial care of adults with cancer have been available for many years (Canadian Association of Psychosocial Oncology, 2010; National Breast Cancer Centre and the National Cancer Control Initiative, 2003; National Comprehensive Cancer Network, 2003; National Institute for Clinical Excellence, 2004). These guidelines have not been readily translated into routine care or practice (Bultz & Johansen, 2011; Luxford et al., 2006). There is a need to change aspects of clinical practice if the guidelines are to be implemented. The need to meet the guideline recommendations is indicated by high levels of distress, depression and anxiety (National Breast Cancer Centre and National Cancer Control Initiative, 2003) and a range of unmet psychosocial care needs (Beesley et al., 2008; Chen et al., 2009; Sanson-Fisher et al., 2000; van Scheppingen et al., 2011). Implementation of the guidelines calls for integration of psychosocial care in routine practice. Despite evidence to support psychosocial interventions (Devine & Westlake, 1995; Meyer & Mark, 1995) barriers to practice change exist. Some of these relate to staff or organisational factors, others to the processes of clinical practice change required to achieve goals of improved care. Research relating to psychosocial care for cancer patients recommends clinical supervision to support Health Professionals in providing the recommended psychosocial support (Botti et al., 2006; Kenny et al., 2007; Turner et al., 2007; Watts et al., 2010). However, there is debate around the evidence that clinical supervision benefits Health Professionals or patients (Farnan et al., 2012; Fowler, 1996; Mannix et al., 2006; Sloan et al., 2000; Spence et al., 2001; White & Winstanley, 2010c; Wright, 2012) as well as the mechanisms by which change in practice may be affected by clinical supervision (Heaven et al., 2006; Mannix et al., 2006). The purpose of this paper is to describe the qualitative sub-element of research that is embedded within a stepped wedge randomised control trial (RCT). The RCT is described elsewhere (Turner et al., 2011). The study is designed to address the research question: Does clinical supervision facilitate change in attitudes, behaviour and practice relating to psychosocial aspects of care for clinicians such as cancer nurses who have been
trained to deliver a psychosocial intervention? In addition, if there is change, the study is designed to explore the mechanisms by which that change is generated. The qualitative element employs discourse analysis underpinned by poststructuralist traditions focusing on representation and meaning within discourse (Foucault, 1972, 1973, 1980, 1988; Hall, 2001). This approach is interested in revealing discursive associations and power relations to uncover taken for granted practices and assumptions that may create barriers to psychosocial care in the context of adult cancer care (Carabine, 2001; Foucault, 1972; Hall, 2001; Wetherell et al., 2007). This approach and focus was selected as a novel approach to the question of understanding barriers to practice change in this field and the role of clinical supervision in practice change. The study adds an additional layer to the exploration and evaluation of a psychosocial intervention being delivered as part of a randomised control trial that aims to improve psychosocial support for adults with cancer through processes embedded in routine care.

### 3.5.1 Background

There are several factors inhibiting the uptake of guidelines for psychosocial care. These include avoidance of psychosocial and psychological support by Health Professionals because of lack of time, busy workloads, lack of skills, unsuitable environments and the emotional burden (Botti et al., 2006; Chibnall et al., 2004; Department of Health Western Australia, 2008; Kenny et al., 2007; Schulman-Green, 2003; Turner et al., 2007; Watts et al., 2010). There are organisational issues such as short length of hospital stay and lack of continuity of care (Botti et al., 2006; Chibnall et al., 2004; Frost et al., 1997; Turner et al., 2007). The dominance of biomedical approaches to healthcare that focus on physical treatment and related tasks means psychosocial interventions are under-valued (Schulman-Green, 2003). In addition, stigmatising beliefs about depression negatively impact on help-seeking behaviour (Barney et al., 2009; Barney et al., 2006). These factors are all likely to have influenced the uptake of the psychosocial interventions in the care of people with a cancer diagnosis.
Clinical supervision is broadly defined as ‘a formal process of professional support and learning which enables individual practitioners to develop knowledge and competence, assume responsibility for their own practice and enhance consumer protection and safety of care in complex clinical situations.’ (Fowler, 1996, p. 472). It is promoted as a process whereby support is provided for practice development and change (Brunero & Stein-Parbury, 2008; Cleary & Freeman, 2005; White & Winstanley, 2010c). Within this project clinical supervision is being undertaken as a means of supporting Health Professionals who are delivering a psychosocial intervention, as well as reinforcing and enhancing training and ensuring patient and staff safety within the context of the randomised control trial (Turner et al., 2011). Across multiple health disciplines, including nursing, medicine, psychology and allied health, the clinical supervision literature is criticised for methodological limitations (Farnan et al., 2012; Gonsalvez & McLeod, 2008; Spence et al., 2001) including small non-randomized samples, the use of non-validated tools and basic descriptive statistics and a lack of a control or comparison group. Potential bias is introduced when the supervisee or supervisor are the single source of data collected due to the power differential in the relationship (Gonsalvez & McLeod, 2008). The use of ‘self-report’ measures has been considered unreliable as there may be a difference between what participants do and what they say they do (Heaven et al., 2006; Spence et al., 2001). An uncritical acceptance that clinical supervision is good for Health Professionals and patients is a further criticism (Fejes, 2008; Gilbert, 2001).

Although there are qualitative studies that explore clinical supervision as a positive experience (Green Lister & Crisp, 2005; Jones, 2006; Kilcullen, 2007) it is unclear if clinical supervision creates change in Health Professionals (Heaven et al., 2006; Spence et al., 2001). Contrary to Heaven, et al. (2006), Mannix et al. (2006) report that clinical supervision improved the transfer of newly learnt skills from an educational intervention to the workplace. Additionally, clinical supervision was necessary to maintain skills and confidence gained through the training course (Mannix et al., 2006). As the conversation around the benefits of clinical supervision continues there is a need to identify the specific
mechanisms by which clinical supervision produces change in health professions (Gonsalvez & McLeod, 2008).

This project constitutes a sub-study element of a multisite randomised control trial (RCT); Promoting Optimal Outcomes in Mood through Psychosocial Therapies (PROMPT). Figure five represents the design of the overall project and sub study element. The RCT aspect of the study is designed to improve psychosocial care of patients with cancer through a systematic approach to identification of distress and risk and delivery of a flexible psychosocial intervention aligned to individual patient needs. The intervention is brief, tailored and embedded in clinical care by nurses and allied Health Professionals who engage patients in self-care and prevention strategies (Turner et al., 2011). The intervention requires the Health Professionals to complete a self-directed learning manual. This is followed by a full day skill development session and ongoing support through dedicated clinical supervision sessions.

![Figure 5. Design of the PROMPT project and sub study element](image-url)
Clinical supervision will be facilitated by the chief investigator at each of the 4 intervention sites using a multidisciplinary, group format, with approximately 4-6 supervisees. The clinical supervision sessions will be held weekly for up to one hour, for the duration of the intervention, one year. Clinical supervisors will deliver clinical supervision in line with a supervisor's manual, developed for the trial. Supervisors will meet to discuss progress and ensure similar approaches are being maintained. The research team, from all 4 sites, will also meet regularly to discuss the project and its progress. The RCT is a stepped wedge cluster design. This involves each site being randomised to cross over to training and then intervention as the project progresses over 7 epochs. Control measures are collected at all sites during epoch one and continue to be collected at the sites yet to cross over. This is depicted in figure 6 (Turner et al., 2011).

<table>
<thead>
<tr>
<th>Site 1</th>
<th>Epoch 1</th>
<th>Epoch 2</th>
<th>Epoch 3</th>
<th>Epoch 4</th>
<th>Epoch 5</th>
<th>Epoch 6</th>
<th>Epoch 7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Site 2</td>
<td>Control</td>
<td>Training</td>
<td>Intervention</td>
<td>Intervention</td>
<td>Intervention</td>
<td>Intervention</td>
<td>Intervention</td>
</tr>
<tr>
<td>Site 3</td>
<td>Control</td>
<td>Control</td>
<td>Training</td>
<td>Intervention</td>
<td>Intervention</td>
<td>Intervention</td>
<td>Intervention</td>
</tr>
<tr>
<td>Site 4</td>
<td>Control</td>
<td>Control</td>
<td>Control</td>
<td>Training</td>
<td>Intervention</td>
<td>Intervention</td>
<td>Intervention</td>
</tr>
<tr>
<td>Week 1</td>
<td>10</td>
<td>20</td>
<td>30</td>
<td>40</td>
<td>50</td>
<td>60</td>
<td></td>
</tr>
</tbody>
</table>

**Figure 6. RCT stepped wedge design**

The research design described within this protocol is an interdependent sub-element of the RCT. It is a qualitative study designed to explore the discourses within clinical supervision sessions over time (12 months). The clinical supervision sessions are those provided to Health Professionals whilst they are delivering the PROMPT intervention. Transcripts of clinical supervision sessions will be analysed using discourse analysis. Exploration of who is saying what and how the intervention impacts on practice will provide critical knowledge about if and how clinical supervision enables changes in practice. This is an innovative approach to exploring clinical supervision that addresses...
many of the concerns and methodological criticisms of previous clinical supervision research. The design also presents a novel way of embedding a critical, qualitative element in a large RCT in such a way as to extend quantitative findings and link clinical supervision to clinical outcomes.

3.6 THE STUDY

3.6.1 Aims

The aim of the study is to explore the discourse within clinical supervision and its impacts on the actions of Health Professionals delivering a psychosocial intervention to adults with cancer.

The research questions are

- Does clinical supervision facilitate change in attitudes, behaviour and practice for clinicians trained to deliver a psychosocial intervention? If so, by what means?

3.6.2 Design and methodology

To meet the aims of the research and address the research question a qualitative methodology has been chosen. The design of the study and the methods used take into consideration the fact that the study is being undertaken as a sub-study to a large randomised controlled trial. Conscious decisions have been made about how to integrate the two methodologies. The implications of this are that data collection must not influence or contaminate the outcomes of the RCT and the findings should inform or extend the findings of the RCT. Accordingly a non-participatory approach to data collection was determined appropriate. This approach is innovative in that it allows examination of clinical supervision as it unfolds, not retrospective reports or other forms of ‘self-report’ (Wood & Kroger, 2000, p. 26). The addition of analysis of the clinical supervision conversations enables the examination of dilemmas and tensions that would not have been otherwise considered in the evaluation of success of the intervention. In this way this study represents an innovative addition that contextualises clinical supervision as discursive praxis.
To extend the RCT an approach was selected that could appreciate the complexity of the context. This includes consideration of extrinsic or distal context, including social roles, demographics and setting (Wetherell et al., 2007; Wodak & Meyer, 2009). Discourse analysis highlights oppressive practices that may be obfuscated. It enables the conceptualisation of alternatives (Crowe, 2005; Wodak & Meyer, 2009) providing opportunity for transformative praxis through research (Lather, 1991b). Discourse analysis presents a critical approach to the analysis of clinical supervision that appreciates the socially constructed reality of health care and adult learning. It is being applied to better understand barriers to implementation of psychosocial care (Freire, 1972; Lather, 1991b; Mezirow, 1991). The language that Health Professionals use within clinical supervision constructs the experience of providing psychosocial care. The use of conceptual metaphors, euphemisms, binaries, analogies and subject positions are used to represent dominant ideologies or hegemonies that have been largely unchallenged (Foucault, 1988). Highlighting these aspects will make visible the interconnectedness of the situation so that this critical knowledge can be used to create awareness of the needs of clinicians who are delivering psychosocial care to people with cancer.

### 3.6.3 Sample and participants

There are two participant groups within the study. The first group are the Health Professionals who will be recruited to the PROMPT study to deliver a psychosocial intervention. The Health Professional participants will be recruited from 4 sites across Australia. The sites include 3 large quaternary and tertiary referral teaching hospitals with specialist cancer care services and treatment facilities in Queensland, New South Wales and Victoria and a private specialist oncology treatment centre in Queensland. It is anticipated that the major profession represented in the sample will be oncology nurses. The second group are the chief investigators at each of the sites who will be facilitating the clinical supervision groups. There are three investigators who will be delivering clinical supervision to the Health Professionals. They are psychiatrists with extensive clinical experience in psycho-oncology and provision of clinical supervision.
The inclusion criteria for this study are necessarily reliant on the recruitment criteria for the PROMPT study (Turner et al., 2011).

The inclusion criteria include:

- Health Professionals in disciplines of nursing, occupational therapy, speech pathology, nutrition and dietetics, physiotherapy, radiation therapy
- At least 12 months’ clinical experience in oncology
- Currently engaged in patient contact (minimum of 6 hours per week)
- Commitment to undertake the prompt training (the intervention)
- Working in a setting where they can deliver the intervention
- Delivering the medium intensity intervention as per the PROMPT study protocol and participating in weekly clinical supervision sessions.
- Delivering clinical supervision to Health Professionals as per the PROMPT study protocol.

Exclusion criteria are as per the PROMPT study protocol (Turner et al., 2011):

- Psychologists, social workers and psychiatrists whose basic training has incorporated the key elements of training for this intervention
- No current clinical contact in oncology
- Anticipating leaving the current work setting in the next 12 months
- Anticipated period of extended leave during the conduct of the Study
3.6.4 Data collection

Data for the study will be collected during weekly clinical supervision sessions. These sessions will be audio-recorded. There is potential for a total of 140 clinical supervision sessions to be held. All of the clinical supervision sessions will be audio-recorded. For this study a sample of audio-recordings will be purposively selected to capture variability across sites and time. This selection will be transcribed verbatim with a further selection to be analysed as audio files using NVivo9 (QRS International, 2011). All data are to be stored and managed using NVivo9. To ensure that the analysis appreciates the contextual influences and socially situated nature of these sessions the sample will include sessions from each of the four sites during the intervention epochs of the study, see figure 6. The sample will be selected from the beginning, middle and end of the PROMPT trial. The sample size will be determined by the research team based on data saturation. It is anticipated the sample will not exceed 20 sessions. Following data collection the method of analysis will be discourse analysis and mapping.

3.6.5 Data analysis

The method of data analysis is informed by several versions of discourse mapping (Carabine, 2001; Edley, 2001; Foucault, 1979, 1980; Hall, 2001; Sanguinetti, 2000). This approach to discourse mapping aims to explore the current situation as it is influenced by contextual, historical and societal factors (Carabine, 2001; Edley, 2001; Foucault, 1979). Discourse mapping was selected as an appropriate method of analysis given our data: naturally occurring talk within group clinical supervision sessions; and the research question: does clinical supervision facilitate change in practice. Table 3 details the analytic strategy.
### Table 3. Discourse analytic strategy

<table>
<thead>
<tr>
<th>Description</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Familiarisation with the data set:</td>
<td>To understand the institutional contexts, issues, tensions and practices of the Health Professionals (Sanguinetti, 2000).</td>
</tr>
<tr>
<td>Iterate between the clinical supervision data and the literature:</td>
<td>Look for discursive constructions, theories or subjectivities. This includes examination of literature that describes the barriers to psychosocial care, literature related to practice innovation, the guidelines for the psychosocial care of adults with cancer and education manual developed for Health Professionals participating in the research. Consideration is given to contextual, historical and societal aspects (Edley, 2001). This recognises the situated nature of language, allowing recognition of what it may or may not be possible to say (Edley, 2001; Foucault, 1980).</td>
</tr>
<tr>
<td>Consider the use of idioms, euphemisms and metaphor:</td>
<td>These may be used in the construction of interpretive repertoires (Edley, 2001; Sanguinetti, 2000; Wood &amp; Kroger, 2000). This may help identify what choices are available to people when contrasting psychosocial care in this context. How are dominant discourses being maintained, resisted or transformed (Edley, 2001).</td>
</tr>
<tr>
<td>Search for patterns:</td>
<td>Rather than classification of the discourse in terms of the content the analytic strategy attempts to identify what is being done and how it is done by taking apart the talk to understand how it is structured and organised (Foucault, 1976; Wood &amp; Kroger, 2000).</td>
</tr>
<tr>
<td>Collapse and combine threads to form key discourses:</td>
<td>To determine if a pattern of speaking is termed a discourse they should recur across text but not necessarily be in every text; be identifiable associated with a particular institutional sector, tradition, theory and set of practices and reflect a set of power relations and a world view (Sanguinetti, 2000).</td>
</tr>
<tr>
<td>Problematize the discourses:</td>
<td>Scrutinise power, knowledge and subjectivity (Foucault, 1976, 1980)</td>
</tr>
<tr>
<td>Explore what devices are used within the development of knowledge, but not to accept this at face</td>
<td>Examine positionality, representation and subjectivity including ideological dilemmas, or tensions within the discourse (Edley, 2001).</td>
</tr>
</tbody>
</table>
value (Foucault, 1988).

<table>
<thead>
<tr>
<th>Positionality:</th>
<th>What are the relationships? What determines the conduct of individuals (Foucault, 1988)?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Representation:</td>
<td>Whose interests are represented? Who is being empowered? What is this representative of? What does it signify?</td>
</tr>
<tr>
<td>Subjectivity or Ideological dilemmas:</td>
<td>What are the tensions here? What does it mean to hear this? What are the binaries or competing concepts?</td>
</tr>
<tr>
<td>Map the analysis:</td>
<td>How does this all relate? How are the discourses related? What does this mean? This map of the current situation and the factors that have influenced change in practice will be used to answer the research questions (Carabine, 2001; Sanguinetti, 2000).</td>
</tr>
</tbody>
</table>

The mapping process is used to explore how the discourses that emerged from the analysis are related. This will be used to construct a map of the current situation. This map will highlight the factors that have influenced change in practice. This will be used to answer the research questions. Theoretical underpinnings are important. Discourses are seen as productive and constitutive but also fluid and opportunistic (Carabine, 2001; Hall, 2001; Lather, 1991b). For example, a discourse of distress in this context operates to produce a particular truth of the cancer experience and caring for a person with cancer (Carabine, 2001). Discourses also draw on other existing discourses. Dominant discourses may mediate other discourses. These links between discourses highlight normative ideas and common sense notions about an issue (Carabine, 2001). The analytic strategy aims to reveal underlying conceptions, so that insights about what it is possible to think or say related to distress in this context can be explored. The representations or ways of speaking not only convey meaning but have material effects such as influencing what behaviours are acceptable or not (Foucault, 1976, 1980, 1988; Hall, 2001). The mapping process will illuminate these links and new ways of conceptualisation.
3.6.6 Ethical considerations

Ethical clearance has been obtained from all relevant local area health, university human research ethics committees and national ethics application processes. The PROMPT trial is a registered trial funded by the National Depression Initiative Australia, beyondblue. Registration ACTRN12610000448044. All identifying information will be removed from transcripts and participants referred to by their pseudonyms. Any information that could be used to identify the participants will be kept confidential. Information will be securely stored and destroyed in accordance with the Australian Code for the Responsible Conduct of Research data (National Health and Medical Research Council; The Australian Research Council and Universities Australia, 2007). An information sheet will be given to Health Professionals to ensure that their consent to participate is informed. The information sheet includes the details of the study, requirements of the participants, expected outcomes, possible benefits as well as risks. Participants will be informed that they are free not to participate or to withdraw from the study at any time. As chief investigators the supervisors are fully informed of the study and the use and purpose of the data being collected ensuring their consent is free and informed. See appendices 10 and 11 for participant information sheet and ethical approval documentation.

3.6.7 Validity and reliability / Rigour

To ensure trustworthiness discourse excerpts within the analysis will be used to ground the research in the participants’ experience. The requirement of discourse analytic claims to be grounded in participants rather than analysts’ categories mean that they are by definition relevant to participants’ concerns and therefore have the potential to address concerns’ (Wood & Kroger, 2000, p. 14). Coherence, clarity and completeness are used to demonstrate credibility in discourse analysis (Fejes, 2008; Wetherell et al., 2007). Regular research meetings between the investigators will discuss the analysis ensuring interpretations are coherent, clear and complete. The sampling strategy which attempts to capture variability across the different sites will ensure that the findings have relevance for other settings. A research diary will be used for critical
self-reflection, acknowledgment of assumptions and to provide an audit trail. Documentation of assumptions, theories, values and politics are recognised as potential sources of bias. This process acknowledges factors which are guiding the research in an attempt to show integrity and work in a reflexive way with the data (Wetherell et al., 2007).

3.7 DISCUSSION

The implementation of innovative practice in healthcare services is complex. To successfully implement any innovation the potential interacting and determining factors need to be identified and considered in a theoretical framework (Greenhalgh et al., 2004; Grol et al., 2007). To ensure that this complexity and potentially confounding effects of the cultural and organisational context are taken into account a qualitative approach is indicated for this study. A qualitative approach, specifically discourse analysis that uses a post structuralist framework of discourse mapping, will enable in depth investigation of features in the language used, such as the use of idiom and metaphor that have the power to emancipate or perpetuate the existing situation (Wood & Kroger, 2000).

There has long been evidence to support the use of psychosocial interventions (Devine & Westlake, 1995; Meyer & Mark, 1995). This study adds an additional layer to the exploration and evaluation of such an intervention. If there is evidence to support psychosocial care why isn’t it being implemented? Where is the resistance coming from? How can it be addressed?

The barriers have been highlighted and there have been recommendations as to how these barriers may begin to be addressed. Clinical supervision is recommended as a means to open professional dialogue and provide formal support structures that will assist to improve psychosocial care (Botti et al., 2006; Kenny et al., 2007; Turner et al., 2007; Watts et al., 2010). If clinical supervision is in fact a means to improve the psychosocial care of people with cancer it is essential that we have a clear understanding about how these sessions function, what is discussed and how this shapes the actions of those involved. Also if it helps, how does it help deliver the desired outcomes? That is, reductions in patient distress and a greater ability to meet patients’ psychosocial
needs through the transfer of knowledge to clinical practice. Using a discourse analytic approach this study will explore the verbal communications that occur in group clinical supervision sessions, locating them in the wider social structures.

3.7.1 Limitations
Due to the use of non-participatory data collection methods it will not be possible to check understanding by exploring or probing responses from participants. It is possible that video-recording of the clinical supervision sessions could provide additional insights. This would have potentially allowed deeper exploration of group dynamics, the role of non-verbal features of language as well as utterances. However, the logistics, resources and technical skills required to collect this data excluded this option. Analysis of the data using the audio files facilitated by NVivo9 will enable the consideration of tone and nuance of conversations in the sessions.

3.8 CONCLUSION
There is a need to improve the psychosocial care of adults with cancer. This will require change in practice by individuals, systems and cultural aspects of healthcare. As the desired outcome is change in practice a critical approach is indicated. The existing literature recommends clinical supervision as a means to improve psychosocial care. Clinical supervision is primarily a verbal interaction. As such, using the conversations that occur in clinical supervision as research data presents an approach that focuses on language and specifically language as a social action is appropriate. If we consider the discourse analytic perspective that talk is action (Wood & Kroger, 2000) then change is change in talk and change is achieved through talk. The audio-recording of clinical supervision represents a data set that captures the kind of talk that will enable that change. The research design in this protocol aims to reveal both if there is change in the talk of Health Professionals during the clinical supervision sessions by focusing on change as a discursive process. This is a novel approach to enhancing understanding how psychosocial care, in line with the clinical practice guidelines, could be
implemented in routine care, to reduce the levels of distress, anxiety and unmet psychological support needs for adults with cancer.
PAPER 3: REFERENCES


Chapter 3

A) The research protocol


Chapter 3 B) Methods Annex

As described in the introduction to the chapter this section provides further detail related to the research methods not discussed within the protocol paper presented above, *Examining clinical supervision as a mechanism for changes in practice: A research protocol* (Dilworth et al., 2013a). Some of the section headings are repeated however, the content within the sections is an extension to the information within the published protocol paper.

The chapter begins with the research questions and aims followed by detail regarding design elements including the model and format of the clinical supervision sessions, along with the stepped wedge design. Detail of the ethical considerations, aspects of intellectual property and data retention, collection, management and analysis are described. The chapter concludes with a discussion related to issues of rigour.

### 3.9 THE RESEARCH QUESTION

The research questions were included within the protocol paper. The questions are included again here to draw attention to the nuanced changes that were made to the question after the protocol paper was submitted and accepted for publication. The changes were made in response to the data analysis and iterative, reflexive approach to the research and analysis. The research questions were:

- Does clinical supervision facilitate changes for clinicians trained to deliver a psychosocial Intervention?
- What influence does clinical supervision have on the discourses of Health Professionals and their practice?
- What might this reveal about change in practice and barriers/enablers to such changes?
3.10 DETAILED STUDY AIMS

The research aimed to:

1. Explore how clinical supervision influenced the actions of health professionals delivering the PROMPT Intervention so that knowledge could be gained relating to the use of supervision as a clinical tool to support knowledge translation and / or practice change.

2. Explore the barriers and / or enablers that were encountered when delivering the psychosocial intervention for adults with cancer experiencing distress.

3. Explore how the language that health professionals use within clinical supervision constructed the experience of providing psychosocial care. In particular the use of conceptual metaphors, euphemisms, binaries, analogies and subject positions that may be used to represent dominant ideologies or hegemonies that have been largely unchallenged.

4. Make visible the interconnectedness of the situation so that this critical knowledge can be used to emancipate or create awareness of the needs of clinicians who are delivering psychosocial care to people with cancer.

5. Explore what clinicians report as the consequences/ outcomes of clinical supervision for patients and their families and for clinicians themselves, and for care provided in other contexts.

One of the complexities of this project was negotiating how the research reported in this thesis enhanced the RCT study of which it is part. For this reason the aims of the PROMPT RCT are included here. This is intended to clarify the complementary nature of the PhD research.
3.11 DESIGN ELEMENTS

3.11.1 The PROMPT study

The primary objective of the PROMPT study was to evaluate the effectiveness of a brief psychosocial Intervention in reducing depression and anxiety in patients with cancer who are distressed, but not severely depressed, or who are at risk of becoming depressed. The PROMPT study secondary objectives were:

- To examine the impact of the psychosocial Intervention on patient unmet needs, quality of life, and scores of demoralisation, by comparing within patient scores for patients at Intervention Epochs and Control Epochs
- To examine any impact on stress and burnout and psychological adjustment of Health Professionals who deliver the psychosocial Intervention
- To assess the feasibility of integration of the Intervention into clinical practice and identify Health Professional, systems and patient barriers to the implementation of this model of systematic tailored psychosocial Interventions in clinical care.

In line with the secondary objective of the PROMPT study one of the aims of this research was to identify health professional, system and patient barriers to the delivery of psychosocial care.

The PROMPT study comprised two discrete components:

a) Training of Health Professionals who delivered the psychosocial Intervention

b) Delivery of the psychosocial Intervention by the trained Health Professionals.

During the delivery of component b) the trained Health Professionals received ongoing input from the research team in the form of group clinical supervision.
The PROMPT study was designed to improve psychosocial care of patients with cancer through a systematic approach to identification of distress and risk, and the subsequent delivery of a flexible psychosocial intervention aligned explicitly with patient need. To enhance aspects of accessibility and sustainability a flexible approach to the delivery of the Intervention was adopted allowing the Intervention to be delivered at either over the telephone or face to face as suited the Health Professional and the person with cancer. The two-component design aimed to address problems recognised as barriers to psychosocial care. By training Health Professionals working within cancer care the study aimed to address: problems associated with poor access to suitably qualified professionals. The study used innovative approaches to achieve an efficient, sustainable model of care which aimed to be translated across diverse treatment settings including a brief tailored Intervention embedded in clinical care. By improving the knowledge and confidence of Health Professionals working in cancer care represented more efficient use of limited and expensive specialised psychosocial services; an efficient use of the existing workforce through a multidisciplinary educational strategy. The program identified people who were at risk as well as exhibiting current distress and the Intervention engaged patients in self-care strategies, and a preventive element where those identified as at risk or with low levels of distress were given self-directed, educational and practical information that included structured problem-solving and cognitive strategies (Turner et al., 2011). The PROMPT Intervention consisted of up to 4 tailored sessions. The sessions addressed distress by focusing on engaging the patient, eliciting and exploring their key concerns. Through use of The Distress Thermometer and discussion with the patient an agreed treatment plan was created (Turner et al., 2011). Sessions were up to 30 minutes long and were delivered over a 4 week period. The sessions were conducted either face to face or by telephone.

### 3.11.2 A model for clinical supervision

The critical interpretive review in chapter two, “Finding a way forward: A literature review on the current debates around clinical supervision” (Dilworth et al., 2013c) detailed the current debates about the implementation of clinical supervision interventions. One of the largest
concerns is the diffuse evidence base that fails to articulate clear models, expectations or outcomes.

Despite the debates there is research that supports positive changes in work satisfaction, decreases stress, burnout nurses well-being as a result of effective clinical supervision (Dawson et al., 2012; Edwards et al., 2006; Hyrkäs et al., 2006; Koivu et al., 2012; Severinsson & Kamaker, 1999; Wallbank & Hatton, 2011). There is also some evidence that clinical supervision can improve patient and staff satisfaction (White & Winstanley, 2010c); enhance education, expand scope of practice (Cort et al., 2009; Mannix et al., 2006; Moorey et al., 2009) and provide a forum for critical reflective practice (Cleary & Freeman, 2005; Cross et al., 2010; Hyrkas et al., 2002; Kilcullen, 2007).

Within the PROMPT Intervention clinical supervision was conceived as an important element of the research design. Clinical supervision was intended to provide support to the Health Professional participants and act as a safety mechanism both for the novel trained Health Professionals and the adults with cancer experiencing distress. Incorporating clinical supervision within the research design further ensured rigour in delivery of therapy and reduced the risk of attrition of Health Professionals from the study. In line with the aims of the research reported within this thesis clinical supervision gave insights into systems and individual barriers to more wide-spread implementation.

Highlighted in paper one, “Patient and health professional’s perceived barriers to the delivery of psychosocial care to adults with cancer” (Dilworth et al., 2014a) lack of confidence is a significant barrier to the implementation of psychosocial care. Engagement of the Health Professionals in clinical supervision whilst they were delivering the PROMPT Intervention was intended to provide a framework to enhance professional confidence, ensure that the Intervention being delivered by the Health Professional was appropriate for the needs of the patient, to monitor and respond to challenges and ensure Health Professional and patient safety, for example, exacerbation of depression or emergence of suicidal ideation. Inclusion in clinical supervision ensured that all participating Health Professionals felt supported and engaged.
The model of clinical supervision developed for the Intervention is detailed in table the below. This table is revisited in paper five. There is a paucity of literature describing the optimal process and format for clinical supervision. As such a rationale for each element is provided to demonstrate the integrity of the approach employed.
### Table 4. Model of clinical supervision

<table>
<thead>
<tr>
<th>Element</th>
<th>Detail</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequency</td>
<td>1/ week</td>
<td>Frequency of at least once a month has been positively evaluated (Edwards et al., 2005). In this Intervention weekly sessions were chosen because clinical supervision aimed to ensure all participating Health Professionals felt supported, engaged, and able to be assisted to respond to any difficulties including exacerbation of depression or emergence of suicidal ideation.</td>
</tr>
<tr>
<td>Duration</td>
<td>1 hour</td>
<td>Duration of at least 60 minutes is considered more effective than briefer sessions (Edwards et al., 2005)</td>
</tr>
<tr>
<td>Participants</td>
<td>Supervisor + all available Health Professionals on site</td>
<td>On occasions when Health Professionals were not actively seeing a patient it was an intention that their attendance at the supervision session would allow them to learn from others and contribute to the group learning experience.</td>
</tr>
<tr>
<td>Core components</td>
<td>1) Normative (establish a consistent approach to clinical care), 2) Formative (educational – skill and knowledge development), and 3) Restorative (the process of validation and support through peer feedback).</td>
<td>These components were based on Proctors Model (Proctor, 1986). Proctor’s model is becoming widely utilised within the nursing research relating to clinical supervision (Driscoll, 2007). Criticisms that this model is too imprecise were noted, however, it was selected because the core components align with the aims of clinical supervision in this context (Sloan et al., 2000).</td>
</tr>
<tr>
<td>Style</td>
<td>Supportive, building confidence of participants and general encouragement of participants to generate ideas and strategies for responding to clinical issues. It was not usually appropriate for the facilitator to have a highly didactic approach, unless there were specific concerns such as patient safety.</td>
<td>The style adopted recognised supervisees preference for a supervisor who was prepared to act as a sounding board, but who was also prepared to offer guidance (Fowler, 1996). Ideally not prescriptive, rather allowing some degree of creativity and encouraging responsibility (Fowler, 1996). Provision of clinical guidance is rated highly by psychiatric trainees who also value expert knowledge (Clarke, 1999).</td>
</tr>
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<tr>
<td>Confidentiality</td>
<td>Supervision sessions were strictly confidential. Supervisors reminded participants each session that they must respect the confidentiality of other group members.</td>
<td>Establishing confidence of participants that matters discussed during supervision remain confidential, and are not shared with unit managers is critically important (White &amp; Winstanley, 2009).</td>
</tr>
<tr>
<td>Out of session contact/absence</td>
<td>Clinical supervisors were available for out of session contact. In the event of Investigator absence or illness an appropriately-qualified clinician at their site was trained to be able to provide supervision.</td>
<td>This was in line with the supervision aims of support, engagement and safety.</td>
</tr>
<tr>
<td>Scheduling</td>
<td>It was the responsibility of the site coordinator to assist in scheduling the sessions and obtaining an appropriate venue.</td>
<td>Scheduling sessions to accommodate various rostering needs and appropriate facilities are integral to ensuring attendance (White &amp; Winstanley, 2009). Preference for a venue separate to the work area are reported (Edwards et al., 2005).</td>
</tr>
</tbody>
</table>
Clinical supervision sessions were guided by a pre-specified format. The format is detailed below. The format guide was developed to ensure congruence in the approach employed and to provide key information about enablers and barriers related to the implementation of the Intervention. Clinical supervisors met regularly to discuss the sessions. During clinical supervision the participants, Health Professionals, presented an overview of the patient/s for whom they were delivering the RCT Intervention. Discussion overviews included the patient history, their current situation and the measures collected as part of their participation in the RCT, such as The Distress Thermometer and Problem Checklist (National Comprehensive Cancer Network, 2007), Psychosocial Risk Factors (National Breast and Ovarian Cancer Centre, 2008), Hospital Anxiety and Depression Scale (Zigmond & Snaith, 1983), The Functional Assessment of Cancer Scale (Cella et al., 1993), Unmet Psychosocial Supportive Care Needs (Bonevski et al., 2000), EuroQoL (EuroQol Group, 1990) and The Demoralization Scale (Kissane et al., 2004), reflecting current psychological symptoms, levels of distress, key concerns, and risk factors to psychological distress that could inform management.

3.11.3 Format of clinical supervision sessions

Each session commenced with a brief overview by the Supervisor of the themes discussed in the previous session. At commencement of each session, each participant was specifically asked to nominate what aspects of the previous supervision they had applied since the last session and any specific difficulties they encountered. Each participant was asked to present an overview of the patient/s for whom they were delivering the Medium-intensity Intervention. In order to be able to do this the Health Professional brought with them: The Distress Thermometer and Problem Checklist (National Comprehensive Cancer Network, 2007), Psychosocial Risk Factors (National Breast and Ovarian Cancer Centre, 2008), Hospital Anxiety and Depression Scale (Zigmond & Snaith, 1983), and other material provided to them by the site coordinator when they were allocated to the respective patient. The Supervisor invited comment from the treating Health Professional and other group members about core issues, the style and content of therapy
offered and facilitated discussion as appropriate. The Supervisor reminded participants that they were required to maintain an Intervention log book documenting all contacts with the patient, the nature and duration of therapy offered, whether face-to-face or by telephone and themes discussed. The Supervisor asked each participant about their use of the Clinical Referral pathway for any patients for whom they have been delivering the PROMPT Intervention. Referral pathways were locally developed documents that specified the appropriate services and contacts Health Professionals could utilise for a range of issues, such as, allied health or social work referral. Supervisors also reminded Health Professionals to record details of the Intervention on their Intervention log book. At the conclusion of each session the Supervisor briefly summarised the themes discussed and asked individuals to nominate if there were specific strategies or techniques they planned to implement on the basis of that discussion. These themes then formed the basis of discussion at the commencement of the next supervision session.

### 3.11.4 Stepped wedge design

The PROMPT study was a cluster, stepped wedge randomised control trial. To classify the design the word cluster indicates that a cluster, group or community is randomised rather than an individual (Hussey & Hughes, 2007). Cluster randomized trials are used to evaluate interventions where individual randomization may not be possible or not desirable for logistic, financial or ethical reasons. The stepped wedge stipulates the way in which participants were exposed to the intervention (Brown & Lilford, 2006).

In line with the stepped wedge design the PROMPT Intervention was sequentially rolled-out at the four trial sites over a number of time periods, referred to as epochs. The order in which the different trial sites were allocated to deliver the Intervention was determined at random. By the end of the random allocation, all individuals at each of the trial sites had received the Intervention. Stepped wedge designs incorporate data collection at each point where a new group (step) receives the intervention (Brown & Lilford, 2006). At the conclusion of the study all
sites had received training and the Intervention was being delivered by
the recruited Health Professionals who had received training at that site.
A diagrammatic representation of the roll-out of the design was presented
within the research protocol paper, “Examining clinical supervision as a
mechanism for changes in practice: A research protocol” (Dilworth et al.,
2013a). The use of serial measures allowed for clear identification of
changes in each clinical site in temporal relation to implementation of the
Intervention. The stepped wedge design enhanced feasibility as all
recruited patients and health professionals ultimately received the
Intervention and Training respectively (Brown & Lilford, 2006). The
design obviates the difficulty of “contamination” by trained therapists
that potentially occurs when designs randomise patients at each site. It
was hypothesised that patients receiving the Intervention would show
greater improvement in depression scores and reduction in depression
“caseness” than patients receiving usual care. At the ‘population’ level,
the roll-out of the Intervention would be associated with lower rates of
depression and increasing reduction in depression scores over time in
patients of the cancer services (Turner et al., 2011).

3.12 ETHICAL CONSIDERATIONS

As this research project involves the use of human subjects it has had
prior ethical clearance (University of Newcastle, 2008a). Ethical approval
was obtained from each of the intervention sites. Copies of ethical
clearance for each site are included as appendix 11. The proposal was
also approved through the National Health and Medical Research Centre
(NHMRC) application process using the National Ethics Application Form
(NEAF) with site specific details submitted for each of the participating
sites.

Documentation related to the ethics approval and participant information
sheet are included as an appendices (see appendix 10 and 11).

3.12.1 Voluntary and informed consent

Following information sessions and in-service sessions at each site
Health Professionals were provided with information and consent sheets
to ensure that their consent to participate was informed. The information
sheet included the details of the study, the nature of the Intervention, requirements of the participants, expected outcomes, possible benefits as well as risks. Participants were informed that supervision sessions would be audio-recorded and a subset of sessions transcribed and analysed to examine the process of supervision. Participants were informed that they were free to not participate or to withdraw from the study at any time without this affecting their clinical care or relationship with any treating staff or research team. See appendix 10.

### 3.12.2 Privacy, confidentiality and disclosure of information

Health professionals participating in the study were assigned a code number as part of the process of being a participant in the PROMPT study. This code number was used when data from the clinical supervision sessions was de-identified. For the purposes of disseminating the findings pseudonyms were then assigned. Any information that could be used to identify the participants has been kept confidential. Only the student and supervisors involved in this study had access to this information and it would only be disclosed with the permission of the participant or if required by law. All electronic audio files were password-protected. In the dissemination of findings, pseudonyms have been used for Health Professional participants and Clinical Supervisors are referred to only as “Supervisor”. Any information that could potentially identify participants has been removed. This included: Hospital or ward name, name of suburbs, or other locations.

Individual participants could be identifiable by other members of their group through their attendance at training, and clinical supervision sessions and provision of the intervention, however, this was not deemed a risk for Health Professionals. Non-participating staff retained their access to specialist support/advice in patient care if needed, access to other sources of training if they wished, and it was not anticipated that the conduct of the study would adversely influence their work.


3.12.3 Potential risks for participants

The clinical supervision sessions were conducted by experienced consultation-liaison psychiatrists as described previously. In the event that a participating Health Professional became distressed as a result of participation in the study appropriate assistance was offered through the Employee Assistance Program at each site. No instances of assistance were reported.

3.13 INTELLECTUAL PROPERTY

As per the University of Newcastle Policy (00831) the supervisory panel and I had discussions relating to the intellectual property generated within this project and the thesis. All publications generated from this work include “appropriate recognition of any verifiable contributions by the supervisor or any other person in relation to the generation of the intellectual property.” (University of Newcastle, 2007)

3.14 DATA RETENTION

In line with the Australian Code for the Responsible Conduct of Research data that will enable justification of the research and any challenge to the outcome will be retained for a period of 15 years from the completion of the project. After such time they will be destroyed with the necessary security. An accurate and detailed record of the research and methods has been recorded. During the active phase of research all records were kept in a locked filing cabinet in a locked office within the school of nursing and midwifery, that of the student. All audio files of clinical supervision sessions were password protected. At the completion of the study all paper records that have been converted to an electronic format will be destroyed appropriately. The remaining research data and primary materials will remain in the custody of the University (University of Newcastle, 2008b). Or in this case where required will be collated with the primary materials from the PROMPT study.

3.15 DATA COLLECTION

Data for the study reported within this thesis was collected during weekly clinical supervision sessions. Data also included demographic
details collected at recruitment to the study. In accordance with the stepped wedge design, described above, data was collected as each site moved to the Intervention stage. As each site began to deliver the PROMPT Intervention, one hour, once a week was dedicated to clinical supervision sessions for those Health Professionals delivering the Intervention. The groups were facilitated by the chief investigator at each site. The sessions were audio-recorded (Turner et al., 2011). This formed the dataset for the study reported in this thesis. Throughout the PROMPT intervention a total of 140 sessions were anticipated. For this study a selection of sessions were selected for analysis.

The selected sessions targeted: (1) group interaction, only sessions where more than one Health Professional was in attendance are included in the data (2) variability across sites, aimed to ensure that the findings had relevance for a variety of settings (3) variability over time, to allow exploration of change. To ensure that differences between sites and variability could be explored the strategy was intended to be flexible. At each site a group of participating Health Professionals was identified and recruited but it was not possible to have attendance by the same Health Professionals at all sessions, due to shift work and rostering. Due to the changes in attendance at the supervision sessions, and the large number of sessions, it was not possible to track a cohort of Health Professionals over time in a meaningful way. This also meant that at a number of sites more than one clinical supervision session was offered per week to try to accommodate the various rostering of staff.

The final number of sessions included for analysis was determined by the research team when the data included rich text that was representative of the character and dynamics of sessions across a range of sites and participants.

The audio-recordings of the clinical supervision session were selected for analysis in an attempt to capture more naturally-occurring discourse than, for example, data generated within an interview (Wetherell et al., 2007; Wood & Kroger, 2000). This decision was made because it presented the opportunity to analyse the implementation process in a way that was less affected by the interests and formulations of the researcher (Green &
Thorogood, 2009). Audio-recordings of the clinical supervision session were collected because verbal details are critical to the analysis. A reporters’ recollection of an event, even if taken contemporaneously or immediately after an observation of the discourse, are insufficient for analysis. This is because reports of events necessarily include interpretation (Wood & Kroger, 2000).

It was hoped that the routine recording of each session would create familiarity with the audio equipment and as each session was recorded but not necessarily analysed that the presence of the recorder would not affect the process of the discourse. The use of the records was made clear and the confidential nature of the sessions explained to the participants in an attempt to alleviate any concerns regarding the repercussions associated with the content of the sessions (Wood & Kroger, 2000).

The sample selection was dependent on the order that sites were randomised. To ensure that the analysis could appreciate the contextual influences and socially situated nature of these sessions the sample included sessions delivered by each of the three investigators at the different sites. To ensure that the data was rich and captured the detail of what, why and how was happening in the sessions the following sampling strategy was developed. The selected sessions are depicted in table 5) based on the design of the PROMPT study. The method of sampling staggered the collection of data to allow emersion within the data over time.
### Table 5. Sampling strategy

<table>
<thead>
<tr>
<th>Site</th>
<th>Control</th>
<th>Training</th>
<th>Intervention 3 sessions</th>
<th>Intervention 1</th>
<th>Intervention 0</th>
<th>Intervention 1</th>
<th>Intervention 0</th>
<th>Total sessions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Site 1</td>
<td>Control</td>
<td>Training</td>
<td>Intervention 3 sessions</td>
<td>Intervention 1</td>
<td>Intervention 0</td>
<td>Intervention 1</td>
<td>Intervention 0</td>
<td>5</td>
</tr>
<tr>
<td>Site 2</td>
<td>Control</td>
<td>Control</td>
<td>Training</td>
<td>Intervention 3 sessions</td>
<td>Intervention 2</td>
<td>Intervention 1</td>
<td>Intervention 1</td>
<td>7</td>
</tr>
<tr>
<td>Site 3</td>
<td>Control</td>
<td>Control</td>
<td>Control</td>
<td>Training</td>
<td>Intervention 1</td>
<td>Intervention 0</td>
<td>Intervention 2</td>
<td>3</td>
</tr>
<tr>
<td>Site 4</td>
<td>Control</td>
<td>Control</td>
<td>Control</td>
<td>Control</td>
<td>Training</td>
<td>Intervention 0</td>
<td>Intervention 2</td>
<td>2</td>
</tr>
</tbody>
</table>

The sessions selected for analysis were not pre-identified. It was considered that this strategy provided sufficient flexibility to allow for the possibility that attendance at some sessions may lower than anticipated. Difficulty in establishing group supervision has been noted due to staff roster availability, competing demands, resistance from unsupportive or obstructive management and concerns about confidentiality (White & Winstanley, 2009).

### 3.16 DATA MANAGEMENT

This project generated and managed large quantities of confidential qualitative data. The data management strategies took into account data security when transferring data across sites and the large volumes of data that were generated. The clinical supervision sessions were intended to be 60 minutes, weekly over the course of the intervention phase at each site in a group format. The groups were comprised of between one and six health professionals and a facilitator/Supervisor. The audio files created within these sessions were saved by the various research
assistants at the participating sites. The audio files were transferred to me via a digital drop box\(^6\).

Each audio-recording was saved by the research assistant at the intervention site to an online secure shared file. I listened to the file to determine if it met inclusion criteria. From this initial listening a brief summary of each session was recorded for future reference. The summary included who was in attendance, the number of patients allocated, the duration of the audio, and some detail of what was discussed by whom. As the analysis progressed the summaries were used as a form of memory aid to identify the presence of ideas and concepts that were relevant and where appropriate probe the data or test ideas. Each audio file was uploaded to NVivo9.

To manage the large amounts of data generated at each of the sessions the software package NVivo9 was employed. NVivo9 is designed to assist in the management and analysis of unstructured data, such as is generated in qualitative research. NVivo9 supports discourse analysis as a research method (QRS International, 2011). NVivo9 also supports audio file format as an alternative to verbatim transcription. Some of the analysis of the data was carried out using this function. This allowed repeated listening required for analysis. This also captured the tone and nuances within the conversations and eliminated problems associated with fidelity that can be associated with verbatim transcription (Wood & Kroger, 2000). To ensure the supervisory team and I had coherent data to work with; sections of audio data from the selected sessions were transcribed verbatim. Where whole sessions were transcribed a professional transcriptionist was employed to carry out the transcription. I worked closely with the transcriptionist to ensure data fidelity. Excerpts of the verbatim transcriptions were used within the results.

\(^6\) Digital drop box is a secure method of sharing files with others over the internet. The storage capacity of this tool enables the transfer of the large audio files generated within the clinical supervision sessions to be transported between sites without posting CD’s or external storage devices.
If the session met the inclusion criteria, as specified above in section 3A) (Dilworth et al., 2013a), and was to be included in the sample it was transferred to a separate secure online shared file to be transcribed. The de-identified transcription was then e-mailed back to me. Once returned to me there were a number of processes that occurred:

The word document was formatted to ensure it was suitable for NVivo9. This included formatting speakers’ names to a heading style. This allowed the option to code what each person said using an NVivo9 auto code option.

The audio-recording and transcript were reviewed concurrently to verify the accuracy of the transcript. At this point additional nuances, pauses and corrections were made to the transcript.

As the process evolved it became apparent that with repeated listening the level of detail that I heard increased. The transcripts that I worked with became evolving documents. The transcript was essentially a translation to help remember what was going on and guide understanding of the interaction, enabling aspects of the audio-recording to be captured and reflected on (Rapley, 2007). To this end, although transcripts were used in the analysis much of my immersion in the data was undertaken by re-listening to the audio-recording and making alterations to the transcripts along with analytical notations. Repeated re-listening to recording offered a way to re-engage with exactly what was happening at that time and provide detail and nuances that were not portrayed in the transcript. The level of notation in the transcripts increased over time. This meant the inclusion of pauses, interruptions, laughter, noting when participants were quoting or mimicking another person. Transcripts were then uploaded to NVivo9.

The NVivo9 software package was used to manage data and aid the analysis of audio. Where the audio-recording was not to be transcribed it was transferred directly to NVivo9. The audio function of NVivo9 is less well known. I have included a screen shot below to clarify how the program was used.
Figure 7. NVivo Image

The dot points below correspond to the numbers on the screen shot above.

1. Shows source files. In this case I grouped audio files and transcripts separately.

2. Shows the details of the source files. This included file name, how many nodes (categories) have been coded, and detail about who made modifications and when.

3. Shows the waveform of the audio. As the audio-recording played sections of the waveform were selected with the mouse. Highlighted selections can be annotated (see point 5); linked to sections of audio within the same file or others or coded.

4. Shows the transcription function. While listening to the audio-recording either notes or verbatim transcription were added. The timespan column shows the time section where notes have been made and notes can be used to navigate the audio. This made it easy to move to points of interest in the audio. Once the notes/transcription were made the text was treated in a similar way to a transcript. Or similar to the wave form, sections of the text were highlighted and annotated, linked or coded. These text entries were also linked to the time point on the audio. Where text
summaries were made these could also be included in text searches and text based queries.

5. Shows an example of an annotation. The blue highlighted text has been annotated. Tabs next to annotations include links and relationships.

6. Shows coding stripes. These showed node (coding category) of the text summary, this also corresponded to the audio.

By linking the audio-recordings to the text summaries using the transcribe function of NVivo9 I found it was easier to navigate the audio-recording and transcript concurrently. This led to my decision to analyse a selection of the audio files without full professional verbatim transcription.

### 3.17 DATA ANALYSIS

An inductive approach that moved from particular to general or concrete to abstract was used. Data analysis was guided by the aims of the research and the research questions, also by the data itself (Wood & Kroger, 2000). Rather than classification of the discourse in terms of the content the analytic strategy, I attempted to identify what was being done and how it was done by taking apart the talk to understand how it is structured and organised (Wood & Kroger, 2000). Categories shown as activity or utterances of the participants and not the interpretation of the analyst were grounded in the specific discourse. Analysis included attention to the use of idioms, euphemisms and metaphor, which may be used in the construction of interpretive repertoires which are “discursive resources that can be used by speakers and writers to construct versions of events, actions, persons, internal processes, ... and perform a variety of other actions (e.g., the justification of particular practices such as discrimination)” (Wood & Kroger, 2000, p. 43). For this project in particular, interpretive repertoires were relevant. For example, within the literature around the barriers to psychosocial care (Watts et al., 2010) along with the literature related to underutilisation of research within nursing (Scott & Pollock, 2008) it could be argued that busyness is used as justification for not providing evidence based care.
Discourse analysis aims to expose, critique, and challenge this kind of dominant ideology. “Discourse analysis can point to the ways in which certain practices serve to obscure and therefore perpetuate what is taken for granted.” (Wood & Kroger, 2000, p. 13). A critical approach to discourse analysis aims to highlight aspects of practice and provided opportunities for recognising oppressive practices that were in some way hidden. By highlighting hidden practices, conceptualisation of alternatives becomes possible (Crowe, 2005; Wodak & Meyer, 2009) providing opportunity for transformative praxis through research (Lather, 1991b). As noted previously, discourse analysis recognises that discourse cannot and does not occur within a vacuum (Wood & Kroger, 2000). The approach I have taken is in line with poststructuralist traditions (Carabine, 2001; Foucault, 1972; Hall, 2001; Sanguinetti, 2000) that focused on representation and meaning within discourse. I argue that exchanges are always situated; that there is no clear distinction between discursive and extra-discursive. Words may evoke historical or social relations connecting other utterances, conversations, or documents. These relations can create accepted truths, and ways of understanding what and how things do or should work (Foucault, 1973, 1979, 1988; Hall, 2001). An approach that is interested in these discursive associations and the power relations will uncover these patterns that may be creating barriers to care (Wetherell et al., 2007). There is a complex interplay of organisational, cultural and individual factors related to the innovation of practice and improving psychosocial care of adults with cancer. It was through an approach such as this that I proposed this study would reveal the broader context of this situation.

### 3.17.1 Discourse mapping

The method of discourse analysis adopted for this study was a form of discourse mapping broadly informed by the work of Foucault (Foucault, 1972, 1973, 1979, 1980) and those who have followed his work adding their own interpretations (Carabine, 2001; Edley, 2001; Hall, 2001; Sanguinetti, 2000). There are several versions of discourse mapping as an approach (see (Carabine, 2001; Edley, 2001; Mills, 2004; Sanguinetti, 2000)). Foucault has been criticised for the lack of detail he provided around his methods of analysis. In response to the lack of detail provided
by Foucault and in terms of documenting my own methods of analysing
the data the work of Carabine (2001) and Sanguinetti (2000) provide
more detailed processes that have informed my own processes.

Discourse mapping makes sense given the nature of the data for this
study; that it was naturally occurring talk within group clinical
supervision sessions and that the research question asked: does clinical
supervision facilitate change in practice? The process of data analysis
has been detailed in table three within the published research protocol
paper (Dilworth et al., 2013a) presented in chapter 3A. Discussion of
discourse analysis is included here to support the table. Data analysis is
also revisited in chapters four and five within the findings papers, paper
four and five (Dilworth et al., 2013b; Dilworth et al., 2014b).

The process used for data analysis included:

1. Listening to audio-recorded clinical supervision sessions followed
by reading and re reading of the transcribed sessions to achieve
familiarisation with the data set. Concurrent reading and listening of the
transcripts and audio-recording was also undertaken to ensure that
nuances, tone and inflection were considered.

2. Iterating between the clinical supervision data and the literature
looking for discursive constructions, theories or subjectivities. This
included examination of literature that describes the barriers to
psychosocial care, literature related to practice innovation, the guidelines
for the psychosocial care of adults with cancer and the education manual
developed for health professionals participating in the research.
Consideration was also given to contextual and societal aspects such as
the portrayal of cancer patients and the portrayal of mental health in the
media. Attention was given to the use of idioms, euphemisms and
metaphor to be used in the construction of interpretive repertoires.

3. Searching for patterns, asking what is going on here? Discourse
was classified by what was being done rather than in terms of the
there are various kinds of discourses from micro to macro. It is suggested
that some elements of micro discourses can be used to ground or move
up the discursive ladder to macro discourse or concepts. In this way features of the talk itself are seen to represent the broader organisational and cultural issues within the data.

4. Collapsing and combining the conceptual threads to form key discourses. To determine if a pattern of speaking was termed a discourse they: recurred across text but not necessarily in every text; were identifiably associated with a particular institutional sector, tradition, theory, and set of practices and reflected a set of power relations and a world view (Sanguinetti, 2000). In line with Foucault, Hall (2001) suggests that issues can only exist meaningfully within the discourses about them. The example Hall (2001) used was madness (p. 73-74). Following this example change was identified as a discourse within the data. Detailed analysis of the discourse of change is presented in chapter five (Dilworth et al., 2014b). To identify change as a discourse the following elements were identified: Statements about change that give a particular kind of knowledge about it were identified; rules which prescribe certain ways of talking about these topics and exclude other ways; subjects personified the discourse – the madman (the Health Professional); examples of how knowledge about the topic acquired authority, a sense of embodying the ‘truth’ about it; constituting the ‘truth of the matter’ at a historical moment; practices within institutions related to the subjects whose conduct is being regulated; and acknowledgement that a different discourse or episteme will arise producing in turn new conceptions of ‘madness’ (change)…, new discourses with the power and authority, the ‘truth’, to regulate social practices in new ways.

5. Problematising the discourses to explore notions of power, knowledge and subjectivity (Foucault, 1976). This process attempted to understand what discursive devices were used within the development of knowledge, but not to accept this at face value (Foucault, 1988). Important to this aspect of the analysis were the concepts of positionality, representation and subjectivity. Positionality focused analysis on the subject positions and relationships examining what was determining the conduct of individuals. Representation considered whose interests were being represented, and what this might have signified
particularly in terms of power and empowerment. Examining the subjectivities and tensions highlighted, competing concepts and binaries within the data. The application of these concepts is clearly described in chapter four (Dilworth et al., 2013b) where these ideas are used to critically examine the data to reveal how Health Professionals were able to challenge aspects of the complex care settings in which they were trying to integrate their new psychosocial skills.

6. A mapping or linking process was carried out. Questions I posed were: How are the discourses related? What does this mean? How is this related? This mapped the current situation and the factors that influenced change in practice. This was used to answer the research questions. Theoretical underpinnings were important. As described in the research protocol, paper three (Dilworth et al., 2013a), discourses are seen as productive and constitutive but also fluid and opportunistic (Carabine, 2001; Hall, 2001; Lather, 1991b). For example, a discourse of distress in this context operates to produce a particular truth of the cancer experience and caring for a person with cancer (Carabine, 2001). Discourses also draw on other existing discourses. Dominant discourses may mediate the distress discourse for example the distress discourse may be meditated by a mortality or mental health discourse, in this way producing new ways of conceptualising the issue. How these link to other discourses highlights normative ideas and common sense notions about an issue (Carabine, 2001). To give an example, discourse about distress is mediated by concepts related to mortality such as survival being conceptualised as strong and death conceptualised as defeat. In mental health discourse coping is normal and distress is deviant. Understanding the potential for discourses to influence each other produces insights about the messages being conveyed. The representations or ways of speaking do not just convey meaning but have material effects such as influencing what behaviours are acceptable or not.

3.18 RIGOUR

Rigour refers to the stringency of conduct and judgement that was used to ensure the steps in the project are clear, and undertaken with attention to detail. Attention to rigour ensures that the results and
conclusions made can be trusted (Taylor, Kermode, & Roberts, 2006). To ensure that the project was of high quality attention was given to particular aspects of recording and reporting so that rigour could be established. To ensure that important aspects of the research were accurately and clearly articulated standardised reporting guidelines were followed for a number of the submitted papers. Paper one, “Patient and health professional’s perceived barriers to the delivery of psychosocial care to adults with cancer: A systematic review” (Dilworth et al., 2014a) was written in line with “The PRISMA Statement for Reporting Systematic Reviews and Meta-Analyses” (Liberati et al., 2009). Paper five, “Implementing a psychosocial intervention in cancer care: An examination of the change process through a discourse analysis of clinical supervision” (Dilworth et al., 2014b) adhered to the guidelines set out in the consolidated criteria for reporting qualitative research (COREQ) (Tong, Sainsbury, & Craig, 2007). Papers two (Dilworth et al., 2013c), three (Dilworth et al., 2013a) and four (Dilworth et al., 2013b) followed guidelines as set out by the various publishers. Each provided clear detail to ensure methods and conduct were sound.

3.18.1 Credibility

Participant and reader recognition of the experience demonstrates credibility (Taylor et al., 2006). Within discourse analysis, coherence, clarity and completeness are used to evaluate credibility (Fejes, 2008). The use of verbatim excerpts within the reporting of the analysis were utilised to ground the research in the participants’ experience. This addressed “[t]he requirement of discourse analytic claims to be grounded in participants rather than analysts’ categories” (Wood & Kroger, 2000, p. 14). This ensured relevance to participants’ concerns. Within this project two of my academic supervisors were also chief investigators of the PROMPT RCT and Clinical Supervisors at the intervention sites. Their input in the data analysis was sought following the initial analysis and development of the key discourses. Their feedback regarding recognition of the experience as participants was a valuable aspect of their involvement and added to the credibility of the analysis. This is described in more detail below in relation to reflexivity.
3.18.2 Fittingness

Fittingness refers to the extent to which findings fit, having meaning and relevance in other contexts (Taylor et al., 2006). It was hoped that the sampling process which attempted to capture variability across the different sites would ensure the findings had relevance for other settings.

3.18.3 Auditability

Auditability is related to the transparency of a project and ease with which another researcher may be able to follow the decision-making process and arrive at similar conclusions (Taylor et al., 2006). Consistency between the project method and processes increase auditability. Publication of the research protocol, paper three (Dilworth et al., 2013a), aimed to increase the auditability of the project. A research diary was also used for reflection, acknowledgment of assumptions and to provide an audit trail.

3.18.4 Reflexivity

Reflexivity refers to the ways in which the researcher and the research process shape data collection and influence interpretations (Mays & Pope, 2000). Assumptions, theories, values and politics are recognised as potential sources of bias. Documentation of these acknowledges factors which are guiding the research in an attempt to show integrity (Wetherell et al., 2007). Some argue that the identification of patterns within a data set necessarily depends on theory and prior assumptions (Wetherell et al., 2007). Personal and intellectual biases that may have influenced this study included my own personal values, assumptions generated through the review of previous research and previous personal experiences related to the care of people with cancer and the cancer experience. As such my personal assumptions in relation to the research are articulated as part of the introductory chapter of the thesis.

As described above, two of my academic supervisors played key roles within the PROMPT study as chief investigators, designers of the intervention, facilitators of clinical supervision, and as key participants in clinical supervision sessions. Ostensibly bias is not a concern in relation to qualitative research. However, the potential issues that were
discussed around this related to the influence that they may have had on the interpretation of the data. Initially we discussed the possibility of analysing only the data generated by health professionals. We decided that this would limit the research in the light of the aims which were to investigate clinical supervision, which is essentially an interaction between the Supervisor and Supervisee. We also considered disregarding the duality of their role. In recognition of the work around “allegiance bias” (Leykin & DeRubeis, 2009) or therapeutic allegiance of the researcher and the critical approach adopted for this research we decided it was not appropriate to ignore the duality of their roles. Allegiance bias accounts for distortion of findings because of investigators’ preferences for the intervention being implemented (Leykin & DeRubeis, 2009). In the end we decided that the two academic supervisors who were also chief investigators and clinical supervisors would be one step removed from initial interpretation of the data. That meant that initially I analysed and developed the main discourses with supervision from supervisors Higgins and Parker. Subsequent involvement of supervisors Kelly and Turner included a process consistent with member checking for verification of findings. We sought their recognition of the analysis as participants. They also had a role in developing the coherence and clarity of the analysis. The discourse analytic approach was also viewed as having a mediating impact on their influence. Because categories are grounded in the specific discourse they must be an activity or utterances of the participants and not the interpretation of the analyst (Wood & Kroger, 2000).

The role of supervisors within the supervision sessions was also considered in terms of their influence over the data. But we decided that because their allegiance was in line with the aims of supervision, to provide high quality supervision that enabled change in practice, this was considered acceptable. Further to this point if this data were collected by interview or focus groups the researcher would guide participants through issues that had been construed as relevant. In this sense perhaps the researchers had less influence on the data through this method. This concludes the chapter. The thesis moves now to the
findings of the research in chapter four and chapter five. Each chapter is represented by a paper (Dilworth et al., 2013b; Dilworth et al., 2014b).
CHAPTER 3B) REFERENCES


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4.1 INTRODUCTION

The following two chapters present the findings of this research. In conjunction with my supervisors I decided that in order to responsibly disseminate findings in a meaningful way it was necessary to write multiple papers. Two papers were submitted and one has been accepted for publication. The published paper, “Exploring the situational complexities associated with practice change in health” (Dilworth et al., 2013b) is presented in chapter four. The paper that is currently under review, “Implementing a psychosocial intervention in cancer care: An examination of the change process through a discourse analysis of clinical supervision” (Dilworth et al., 2014b) is presented in chapter five.

As context to the findings some detail of the participants is provided within the introduction. The contextual data aims to orient the reader and highlight the complexity of the intervention and the complex nature of its implementation.

4.2 THE PARTICIPANTS

Forty four Health Professionals expressed interest in the PROMPT study. Seven participants withdrew prior to training due to change in circumstances. Seven withdrew before completion of the study. Withdrawals related to personal illness, family illness, conflicting or changed work commitments or other reasons not stated. Thirty Health Professionals completed all aspects of training and Intervention.

The participants who completed the study included: 23 nurses, four physio-therapists, two radiation therapists and one occupational therapist. The average age of participants was 42.57 (range 24- 61). The average number of years worked in oncology was 11.88 (range 1-34). 16 out of 30 (53%) had previous communication skills training; 3 out of 30
(10%) had undertaken a counselling course; 3 out of 30 (10%) had other training in psychosocial care.

### 4.3 SUPERVISION SESSIONS ACROSS SITES

Ninety six clinical supervision sessions were recorded; 33 at site one, 33 at site two, 18 at site three and 12 at site four. Sixty one sessions (approx. 45%) were not recorded due to poor attendance due to conflicting/lack of availability, equipment failure or equipment user error. In line with the sampling strategy, which targeted group interaction, 29 sessions were excluded because they were one-to-one clinical supervision sessions. From the remaining 67 sessions 17 sessions were selected for analysis in this study. Nine clinical supervision sessions were transcribed verbatim and eight were analysed as audio files from within NVivo9 (QRS International, 2011). The selected sessions targeted: group interaction, variability across sites and variability over time.

Attendance at clinical supervision sessions across all sites was sporadic. Participant numbers and the length of sessions at sites one, two and four decreased over time. At site three participant numbers remained relatively constant but the length of sessions decreased over the period of the trial. The number of sessions anticipated differed from the number of sessions that took place as part of the PROMPT study. In recording the details of the clinical supervision session my record included some weeks where more than one session was held due to the location of Health Professionals and the extension of the data collection period of the RCT protocol to account for the dropout of one site from the intervention. Table six below, details period of data collection, the number of clinical supervision sessions at each site and the length of sessions.
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Table 6. Supervision sessions across sites

<table>
<thead>
<tr>
<th></th>
<th>Site 1</th>
<th>Site 2</th>
<th>Site 3</th>
<th>Site 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Period of data collection</td>
<td>28/11/2011-10/12/2012</td>
<td>01/02/2012 - 23/11/2012</td>
<td>17/04/2012 - 20/11/2012</td>
<td>20/06/2012 - 05/12/2012</td>
</tr>
<tr>
<td>No of recorded sessions</td>
<td>33</td>
<td>33</td>
<td>18</td>
<td>12</td>
</tr>
<tr>
<td>Sessions with</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>more than one health</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>professional</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No of participants</td>
<td>2.5</td>
<td>2.6</td>
<td>2.4</td>
<td>2.7</td>
</tr>
<tr>
<td>(average)</td>
<td>(1.6)</td>
<td>(2.8)</td>
<td>(1.6)</td>
<td>(1.9)</td>
</tr>
<tr>
<td>Duration of session (mins)</td>
<td>7.14 to 60.08</td>
<td>9.3 to 59.28</td>
<td>9.5 to 54.39</td>
<td>15.5 to 64</td>
</tr>
<tr>
<td>Average duration of</td>
<td>14.24</td>
<td>26</td>
<td>11</td>
<td>17</td>
</tr>
<tr>
<td>session</td>
<td></td>
<td></td>
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</tbody>
</table>

Statistical analyses and collation of the PROMPT findings are being undertaken at the time of writing this thesis. To date Turner et al. (2014) report no significant changes in Health Professionals self-reported levels of burnout, as measured by the Maslach Burnout Inventory (Maslach & Jackson, 1981) or general wellbeing as measured by the General Health Questionnaire (Goldberg et al., 1997).

Paper 4: “Exploring the situational complexities associated with practice change in health” (Dilworth et al., 2013b) was accepted for publication in the Qualitative Research Journal. The paper was published in a special edition that was generated from conference delegates at the annual Association for Qualitative Research conference in 2013. The Qualitative Research Journal is an interdisciplinary, international qualitative journal. It is indexed on Scopus and was awarded an ‘A’ ranking in the 2010 Excellence in Research Australia (ERA) initiative.

The paper focuses on:

• how the language of Health Professionals constructed their experience of providing psychosocial care;

• the barriers and/or enablers they encountered when delivering the Intervention and;
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- what was revealed about changes in practice and barriers/enablers to such changes?

As such, this paper draws on material presented in the systematic review of the barriers to psychosocial care in paper one (Dilworth et al., 2014a). Key barriers which are cited in the literature are: a lack of time and burden of a heavy workload (Botti et al., 2006; Chibnall et al., 2004; Frost et al., 1997; Kenny et al., 2007; Luxford et al., 2006; Ristevski et al., 2011; Schulman-Green, 2003; Watts et al., 2010); organisational issues (Chibnall et al., 2004); attitudes (Botti et al., 2006); limitations posed by part-time work (Botti et al., 2006; Turner et al., 2007); lack of referral pathways and uncertainty about responsibility for provision of psychosocial care (Lee, 2007; Leung & Esplen, 2010; Neumann et al., 2010; Schulman-Green, 2003).

These barriers were all identified in analysis of the clinical supervision sessions. The analysis in paper four is deepened by applying a critical lens to the data. As described in the previous chapter, the analytic strategy that aimed to challenge taken-for-granted assumptions reveals how the status quo was challenged by the Health Professionals’ discourse. Through critical questioning I extended this analysis to explore knowledge, power and subjectivity (Foucault, 1976). For the purposes of this paper problematisation of the data focuses specifically on how the organisational demands described as a barrier to psychosocial care play out when examined from a critical perspective, as described in chapter three.

Within the forum provided by clinical supervision Health Professionals generated new meanings by constructing stories in which they repositioned themselves as being able to provide supportive care. The results of paper four reveal how the Health Professionals resist the complex and competing demands that create tensions within clinical practice. Health Professionals work within the pressures of systemic barriers to provide much-needed psychosocial support for adults with cancer experiencing distress. The thesis will now present the paper as published.
Paper 4: Exploring the situational complexities associated with practice change in health


The Authors

Sophie Dilworth, *School of Nursing and Midwifery, University of Newcastle, Callaghan, Australia*

Isabel Higgins, *School of Nursing and Midwifery, University of Newcastle, Callaghan, Australia*

Vicki Parker, *School of Nursing and Midwifery, University of New England, Armidale, Australia*

Brian Kelly, *School of Medicine and Public Health, University of Newcastle, Callaghan, Australia*

Jane Turner, *School of Medicine, University of Queensland, Herston, Australia*

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4.4 ABSTRACT

**Purpose** – The purpose of this paper is to critically examine multidisciplinary, group clinical supervision sessions and to extend current understandings of the barriers/enablers to the implementation of an innovative psychosocial intervention for adults with cancer experiencing distress.

**Design/methodology/approach** – Discourse analysis was used to analyse audio-recordings from clinical supervision sessions delivered as part of a psychosocial intervention within the context of a randomised control trial (RCT).

**Findings** – Examination of subject positions, representation and tensions reveals that Health Professionals can resist the pressures of systemic barriers to provide much-needed psychosocial support for adults with cancer experiencing distress. Critical examination of multidisciplinary clinical supervision sessions describes how Health Professionals are able to construct new meanings and reposition themselves as being able to provide supportive care within the context of their everyday practices.

**Research limitations/implications** – This paper reports only a small part of a larger analysis that aims to explore how discourse maps the current state of psychosocial care for adults with cancer and illustrates the fragility and potential for change in this area.

**Originality/value** – Extension on the previous literature is seen within the data through the presence of positive resistance against systemic barriers. Previous exploration of clinical supervision has not collected data generated within the sessions. It is also novel in the use of discourse analysis being used in association with a randomised controlled trial to understand the situational complexities associated with bringing about practice change.
4.5 INTRODUCTION

Globally, evidence based practice is being embraced as the gold standard for healthcare (Brown et al., 2009). However, there is a gap between the desired ‘best practice’ and actual clinical care (Bultz & Johansen, 2011; Grol & Wensing, 2004). As such, there are calls for research designs that aim to critically examine service delivery processes and the contextual factors that impact effectiveness and efficiency in healthcare (Fixen, Naoom, Blase, Friedman, & Wallace, 2005). Over time there has been a shift in theorizing about how to bring about innovation or change in health practices from the traditional focus on the individual (Greenhalgh et al., 2004; Grol et al., 2007). This shift in theorizing recognizes a range of factors interact at different levels impacting on innovation and change in healthcare. These interactions occur between patients, professionals, and teams; and the organisational, economic and political contexts (Grol et al., 2007).

The aim of this paper is to describe discourse analysis as a method for understanding the situational complexities associated with bringing about practice change with particular reference to the introduction of changes in the psychosocial care of adults with cancer experiencing distress. In the following discourse analysis was used to analyse the audio-recordings from clinical supervision sessions that were integral to an intervention in a cluster randomised control trial. The aims of the intervention in the trial are to reduce the levels of psychosocial distress of adults diagnosed with cancer and to reduce stress and burn out of those Health Professionals providing care to distressed patients (Turner et al., 2011). The patients who are recruited to the trial are offered up to 4 individualised sessions. Each session is up to 30 minutes in length delivered by a nurse, occupational therapist, speech pathologist, dietician, physiotherapist or radiation therapist. Clinical supervision is provided to these Health Professionals once a week. The sessions are multidisciplinary group sessions facilitated by a consultations liaison psychiatrist.

The purpose of using discourse analysis in this study was to critically examine the discourses during the clinical supervision sessions. The
researchers’ were interested in what and how discourse shapes the actions of health professionals to change practice or not. A critical approach to the analysis of discourses within the context of clinical supervision appreciates the socially constructed reality of healthcare and adult learning. This will help to understand barriers to implementation of changed practice so that these barriers can be addressed and change facilitated (Freire, 1972; Lather, 1991b; Mezirow, 1991). Discourses from selected clinical supervision sessions are presented. The result illustrates how discourse analysis can be applied for the purpose of elucidating change. The analysis illustrates the complexity of the issues faced by Health Professionals when embracing practice change within healthcare. Discourse analysis presents a way of generating a deeper understanding of the situational complexities which are associated with changes in Health Professionals practice.

### 4.5.1 Discourse analysis applied to practice change

The language that health professionals use within clinical supervision constructs their experiences of providing psychosocial care. The use of conceptual metaphors, euphemisms, binaries, analogies and subject positions are used to represent dominant ideologies or hegemonies that have been largely unchallenged (Wood & Kroger, 2000). Highlighting aspects of language used by these Health Professionals during clinical supervision makes visible the interconnectedness of current psychosocial care practices and possible ways to facilitate changes or innovate practice. This knowledge may then be used to create awareness of the needs of clinicians who are delivering psychosocial care to people with cancer. It may also lead to their emancipation through the exploration. Relationships of dominance, social inequality, power and control that may be creating or perpetuating the barriers to providing psychosocial care can be explored through discourse analysis so that the barriers can be addressed. As the desired outcome is change in practice a critical approach is indicated.

The existing literature recommends clinical supervision as a means to improve psychosocial care of adults with cancer (Botti et al., 2006; Watts et al., 2010). Clinical supervision is primarily a verbal interaction. As
such, an approach that focuses on language and specifically language as a social action is appropriate. If we consider the discourse analytic perspective that talk is action (Wood & Kroger, 2000) then the change is change in talk and change is achieved through talk. The audio-recording of clinical supervision represents a data set that captures the kind of talk that will enable that change. The barriers and/or enablers that are encountered when delivering the intervention will illustrate how health professionals transition between what they know they should be doing to what they are actually doing within their practice. Critical examination of positionality or subject positions, representation, i.e. whose interests are being represented and subjectivities, dilemmas or tensions within the data reveals individual versus organisational tensions; exposes power and its effects along with ways of resisting or constructing alternatives to the current situation.

4.5.2 The need for change in the care of people with cancer

Whilst there are a range of evidence based guidelines for the psychosocial care of people with cancer (Canadian Association of Psychosocial Oncology, 2010; National Breast Cancer Centre and the National Cancer Control Initiative, 2003; National Comprehensive Cancer Network, 2003; National Institute for Clinical Excellence, 2004) long term distress anxiety and depression are high (National Breast Cancer Centre and the National Cancer Control Initiative, 2003). Of concern is that despite the availability of guidelines for psychosocial care this evidence has yet to be translated into routine care (Bultz & Johansen, 2011). In the context of cancer care there are a number of factors preventing the uptake of guidelines into routine care including: cultural, organisational and individual factors (Dilworth et al., 2011).

4.6 THE PROJECT

The research presented here is a qualitative “sub” study of a large, multisite, randomised control trial (RCT)(Turner et al., 2011). The RCT measures the effectiveness of a brief psychosocial intervention to reduce distress levels of adults with cancer. The intervention involves health
professionals who have otherwise not received specialised training in psychological support skills, being trained to provide a brief intervention to adults with cancer experiencing moderate levels of distress. During the intervention phase of the trial, when the Health Professionals are delivering the psychosocial support, clinical supervision is used to provide safety and support facilitated by experienced consultation liaison psychiatrists. During the sessions the progress of the intervention and details of each ‘case’ are discussed. Health Professionals and Supervisors discuss any issues and concerns that may have arisen as part of the intervention, reflections on the experience and the plans for continuing the intervention. Whilst many aspects of the practice innovation are being evaluated the researchers are seeking to understand the change process and the factors that may facilitate and / or inhibit the process.

Analysis of the discourse data generated through audio-recordings of the clinical supervision explores the barriers and / or enablers encountered by health professionals who are delivering the intervention. Another aim is to explore if clinical supervision be used as a mechanism to translate knowledge into practice.

Data is being collected from four sites across Australia. Ethical approval has been given by all local Health Service and University human ethics boards. For the purposes of this analysis data from 8 clinical supervision sessions is included. The number of health professionals in the session’s ranges between 3 and 6. There is a broader data set of 56 sessions that is not specifically considered in this analysis but inevitably will have influenced the analysis. The analysis and discussion presented here focuses on the situational complexities.

### 4.7 APPLICATION OF DISCOURSE ANALYSIS TO THE DATA

The example presented here is a small part of the larger data analysis process that is taking its course as part of the first authors PhD research. This example was chosen for the clarity it provides around the situational complexities of this context. The example also sheds light on the complexities of practice change and innovation.
Following familiarisation with the data set I recognised a discourse around the barriers to psychosocial care. These barriers are complex and multifaceted. The data reflects the literature. Iterating between the literature, the data, policy and practice guidelines reveals complex systems of care and interactions that work against the Health Professionals delivering this psychosocial intervention. The systemic constraints included: limited time, practicalities of space or transport is clearly articulated in the supervision sessions. Health professionals describe not having had a chance to call their allocated patients; patients not being able to or not attending sessions, not having an appropriate place to talk with their patients, difficulties contacting the patient via the telephone. Where we see an extension on the previous literature in the data is the presence of positive resistance against these barriers. In terms of time pressures there are examples of Health Professionals delivering this intervention on their days off, after hours, as a priority to other work (asking other staff to cover for ½ hour). To address transport difficulties support is offered and delivered over the phone. If the patient is difficult to contact on the phone accounts of up to 15 phone messages, varying the time of day that calls are made, and “detective work” to find out appointment times. The difficulties of the environment are discussed in more detail below.

In the excerpt below Mary describes how she used her new skills in the course of her everyday practice. This interaction takes place between Mary and her Clinical Supervisor in the context of a group supervision session. Mary has described that she is using her new communication skills in her day-to-day practice. She is reporting an example of:

“a patient who you know we couldn’t sort of || from the outside see just a grumpy old man but... tried to break through, like, down a few walls today which was sort of semi successful.

**Supervisor**

*But you stopped, reflected or listened did you?*

**Mary**
Yes, well as much as I could he was very difficult to, but we established you know that he was the kind of person that has always been in control and how this was lack of control, a complete lack of control now and you know that that was his way of sort of saying I am going to regain control but. In the end established that he did want to see out the treatment, he wasn’t just going to top himself. (loud exhale)

**Supervisor**

So stopping to have that conversation in the middle of your normal, what you normally do, is that possible or is it disruptive?

**Mary**

(small reluctant laugh) Sort of umm listening to pumps going off and thinking I want to get that, I want to get this or do this or do that but I am going to try and focus here for five minutes. I think it feels a lot longer than it actually is when you notice, when you are aware of other things you have got to do umm …

Initially my thoughts about this exemplar were that it highlighted organisational and environmental barriers to psychosocial care. It demonstrates the lack of an appropriate environment and the busy workload of the Health Professional as factors impacting on the Health Professionals ability to provide the psychological support for this person. Through critical questioning I extended this analysis to explore knowledge, power and subjectivity (Foucault, 1976). For the purposes of this paper problematisation of the data focuses specifically on how the organisational demands described as a barrier to psychosocial care play out when examined from a critical perspective.

### 4.7.1 Positionality: The busy nurse the helpless patient

Mary positions herself as a busy but concerned Health Professionals. She describes a heightened awareness of the environment both as a busy environment with “pumps going off” but also as an open, not private environment. There is a sense of being preoccupied or distracted by the tasks she has ‘got to do’ as opposed to this ‘listening’ which she is choosing to do. The exemplar implies a tacit knowledge of the ward
environment. Mary uses this implicit recognition of alarms ringing equals tasks to construct herself as a nurse. This dictates a particular position, a busy nurse. Mary’s position as a nurse then has implications for the expected behaviour in this situation.

In relation to her patient Mary constructs this man in contrasting lights. There is a facade to his character which Mary tries to “break through”. What initially was a “grumpy old man” gives way to reveal vulnerability. His previous life experiences have meant he has “always been in control”. The changes in health status and related treatment leave him feeling hopeless. Mary reports him saying “if this doesn’t end soon then I will end it”. This man’s distress at his “complete lack of control” positions him in an unfamiliar role which is distressing. The nurse-patient relationship positions both Mary and the patient. Mary is in a position of power, with a duty to care for this “grumpy man”. The patient is positioned as powerless in this environment and in respect to his illness.

**4.7.2 Representation: Prioritising psychosocial care**

Mary as the supervisee describes her choice to take the time to listen and explore this person’s motivations and intentions to establish his safety. This exchange represents a heightened awareness of her patient’s mood, also a willingness to prioritise his distress. This excerpt is an example of how the Health Professionals are able to transfer the skills from the trial they are participating in to their everyday practice. This is where conceptions of knowledge come into the discussion. This new knowledge has enabled the Health Professionals to exercise power against the status quo. In the example above the Health Professional takes the time to establish a relationship in which she is able to determine the extent of this person’s distress and the potential for harm to come to this person. Having the confidence to “probe”, being able to tolerate the distress of the patient. In addition to this point, the analysis reveals the fragility of the current situation. The barriers and systemic limitations can be seen as hurdles that can be overcome.

Mary uses the subject/object property of language to construct two selves. Mary says “but I am going to try and [make myself] focus”. This implies a “recalcitrant, unwilling self and a powerful controlling self”
(Potter & Wetherell, 1987, p. 107). This is an example of the multiplicity of self. The conceptualisation and construction of self, in this case multiple selves, is not viewed as neutral (Potter & Wetherell, 1987). It produces a changed sense of self. The powerful self claims credit for her effort to establish a supportive, therapeutic relationship with this man. The earlier claim of being “somewhat successful” implies that perhaps this change is not a linear process. This iteration between changed and not, fixed or successful and failed is common. “Credibility and the power to persuade others of what one wants them to accept only come through the use of some routes of self-expression... the pressure to be accountable and intelligible to others sustains and gives power to certain communal organisation of self-experience.” (Potter & Wetherell, 1987, p. 106).

4.7.3 Subjectivity: How busy is too busy?

The tensions here lie around the task versus care argument often described, in particular in relation to nursing work. That is the pressure to get tasks completed or ‘focus for five minutes’. How busy is too busy to listen? Mary recognises that despite feeling torn the time taken “feels a lot longer than it actually is.” This is not just an issue for nurses, within the healthcare system there remains a focus on physical aspects of care that marginalises emotional and psychological aspects of care (Chibnall et al., 2004; Kenny et al., 2007; Schulman-Green, 2003; Scott & Pollock, 2008). Traditional work practices have tended to value task-focused interventions, with psychosocial interventions being seen as “soft” or less valuable (Schulman-Green, 2003). Again, Mary’s choice here is to prioritise her ability to support this man.

4.8 DISCUSSION

4.8.1 Organisational demands on the Health Professional

For Health Professionals a lack of time and the burden of a heavy workload are frequently cited barriers to the provision of psychosocial care (Absolom et al., 2011; Beckstrand et al., 2009; Botti et al., 2006; Frost et al., 1997; Kenny et al., 2007; Watts et al., 2010). The cultural
tradition of nursing, in particular, described as task versus care is reported as a source tension when nurses recognise a need for psychosocial support (Botti et al., 2006; Kenny et al., 2007; Turner et al., 2007). This analysis adds depth to the “too busy” argument put forward in the literature. Some of the arguments strength is lost. Sharing of her story in the context of a group clinical supervision session recognises the tensions. This story also allowed Mary reposition herself as someone who despite being busy is able to listen to these concerns as a priority to particular tasks.

The literature reports that nurses’ ability to form meaningful relationships with patients is limited due organisational factors such as shorter length of stay and part-time nature of work force (Botti et al., 2006; Frost et al., 1997; Turner et al., 2007). Experienced nurses have reported working only part-time and therefore not being allocated as primary nurses removing their ability to form a meaningful relationship with their patients (Botti et al., 2006). In this exemplar Mary describes a brief encounter with a person. Neither his length of stay nor the hours she works are relevant to this kind of support.

4.8.2 Generating new meanings

Some have argued that the evidence based practice (EBP) discourse is exclusionary. Despite the premise of improving patient outcomes there is an established hierarchy of evidence within EBP that privileges the randomized controlled trial (RCT) and excludes other ‘ways of knowing’ (Holmes, Murray, Perron, & Rail, 2006). A socially constructed view of cancer care means that sharing stories generates shared meaning (Mezirow, 1991). The newly generated meanings allow the health professionals to reconstruct the meaning of psychosocial care from something that is not achievable to something that is. If we consider that discourses are not just groups of linked utterances, but that there are also internal rules and may also be regulated by their relationship to other discourses (Foucault, 1972). Mary’s self-discourse can be seen to be challenged by and in turn challenge the organisational discourse, that is, busy and time poor. The difficult patient discourse personified or represented by the “grumpy old man” description has also been
influenced by Mary's respositioning of herself within a changed discourse. This brief example of data analysis demonstrates a method by which a complex intervention might be mapped to a broader context. Critical questioning of the data highlights the links between what is known and what is happening. Also how through the generation of new and shared meanings change could be achieved.

4.9 CONCLUSION

An important finding from the healthcare quality improvement research is that change is hard to achieve (Grol et al., 2007). All the same, there is a need to improve the psychosocial care of adults with cancer. This requires change in practice by individuals, systems and cultural aspects. This excerpt of a broader exploration of how discourse maps the current state of psychosocial care for adults with cancer illustrates the fragility and potential for change in this area. This change will be driven by sharing and creation of shared meaning of Health Professionals. This new meaning making has potential to transform practices and outcomes for people with cancer.

4.10 A CRITIQUE

Paper four provides a platform for examining supervision in more detail. The approach that I used was to critically analyse the description of barriers that I recognised from my systematic review of the barriers to psychosocial care (Dilworth et al., 2014a). This approach helped me to uncover not just the barriers but how Health Professionals resisted them in their practice.

Health Professionals were able to reposition themselves in relation to the tensions through the generation of new and shared meanings about the tensions in practice and the challenges faced when working in complex, busy and not private environments. The organisational obligations of task-focused practice were challenged and Health Professionals chose to prioritise psychosocial support. The fragility of current practices was recognised to reveal how practice change could be achieved. Links between this paper and the next can be seen in discussion about the
influence of professional identity on practice. Professional identity is seen in both papers to be a governing aspect of how Health Professionals construct themselves. A focus on physical aspects of care is present in both papers. Above the tension was recognised and Mary repositioned herself as busy but able to listen. In paper five below (Dilworth et al., 2014b), Health Professionals use the familiarity of providing physical care to build rapport or position themselves as knowledgeable. The multiplicity of self and change as a non-linear process further link the papers.

Mary used discourse to construct two selves, one changed, able to provide supportive care, the other reluctant to change. Below (Dilworth et al., 2014b), increased confidence in talking to people about their distress was juxtaposed with their reluctance to cause distress. The thesis will now present paper five, “Implementing a psychosocial intervention in cancer care: An examination of the change process through a discourse analysis of clinical supervision” (Dilworth et al., 2014b). Paper five is the final paper presented within the thesis. Chapter six then presents a discussion, recommendations and conclusion to the thesis.
PAPER 4 REFERENCES


Chapter 4 | Exploring the introduction of a complex intervention in a complex environment


Chapter 4 | Exploring the introduction of a complex intervention in a complex environment


Chapter 5  Implementing a psychosocial intervention in cancer care: An examination of the change process through a discourse analysis of clinical supervision

5.1 INTRODUCTION

Chapter five was submitted to the Journal of Advanced Nursing. The paper was submitted for review 28th April 2014. The expected turn around for the journal is ten weeks. Reviewers’ comments are expected by July 2014. The paper was submitted to the Journal of Advanced Nursing for a number of reasons; the journal editors indicated that with the acceptance of the protocol paper there was an expectation that findings of the paper would be submitted for consideration; The research fits with the international, nursing focus scope of the journal; and because the journal is highly ranked in the field with an impact factor of 1.527.

The paper describes a discourse of change that emerged from the data analysis and builds on the analysis presented in the previous paper, Chapter four (Dilworth et al., 2013b).

Three themes represent the discourse of change. The first described changes in the Health Professionals willingness to accommodate new knowledge and skill. The second theme related to Health Professionals’ desire to solve the participant’s problems. The third theme related to changes in the way Health Professionals approached distressing situations in their daily clinical practices.

The language Health Professionals used challenged, or accommodated tensions that arose in practice. The tensions influenced their ability to deliver psychosocial care in the form of the brief tailored PROMPT psychosocial Intervention. Discourses within supervision negotiated ways of practicing that at times were able to accommodate the tensions. This allowed the Health Professionals to change their practice.
Paper 5: Implementing a psychosocial intervention in cancer care: An examination of the change process through a discourse analysis of clinical supervision

5.2 ABSTRACT

Aims

To explore what influence clinical supervision had on the discourses of Health Professionals trained to deliver a new psychosocial Intervention to adults with cancer.

Background

Clinical practice guidelines for the psychosocial care of adults with cancer are not reflected in routine clinical care. Clinical supervision is recommended as a means to support Health Professionals in providing the recommended psychosocial support.

Design

A qualitative design embedded within a step wedged randomised control trial.

Methods

Discourse analysis was used to analyse audio-recorded data collected within multidisciplinary, group format clinical supervision sessions. The sessions were delivered as one element of a randomised control trial. Data was collected from November 2011 to December 2012.

Results/Findings

30 Health Professionals (23 nurses, four physio therapists, two radiation therapists and one occupational therapist) and three Clinical Supervisors took part in 96 clinical supervision sessions. 17 sessions were selected for analysis. Three themes represent the discourse of change. The first
described changes in the Health Professionals willingness to accommodate new knowledge and skill. The second theme related to Health Professionals’ desire to solve the participant’s problems. The third theme related to changes in the way Health Professionals approached distressing situations in their daily clinical practices.

**Conclusion**

Health Professionals language was used to challenge, or accommodate tensions that arise in practice that influence their ability to deliver psychosocial care in the form of a brief tailored psychosocial Intervention. Discourses within supervision negotiated ways of practicing that may accommodate the tensions allowing change in practice.
5.3 SUMMARY STATEMENT

• Why is this research needed?

• Routine clinical care does not reflect the recommended guidelines for the psychosocial care of adults with cancer.
• The gap between ‘best practice’ and clinical care in health services has prompted calls for research to critically examine the process of health service delivery and the factors that influence effectiveness and efficiency.
• Clinical supervision with Health Professionals has been recommended as a tool to enhance practice change, however, evidence regarding its effectiveness and the mechanisms for changing practice are debated.

• What are the key findings?

• Tensions that arose in practice influenced the Health Professionals’ ability to deliver psychosocial care in the form of a brief tailored psychosocial Intervention.
• The Health Professionals’ language was used to challenge, or accommodate elements of clinical practice environment that limited the delivery of psychosocial care within this setting.
• Clinical supervision provided a forum for the negotiation of some of the tensions evident when implementing a new Intervention.

• How should the findings be used to influence policy/practice/research/education?

• Clinical supervision should be considered as a tool to influence the implementation of complex interventions that extend Health Professionals’ scope of practice.
• Future research should consider discourse analysis as a useful approach for the critical examination of the implementation process of a complex intervention in the healthcare setting.
• Educational interventions should consider the use of clinical supervision to extend the use of skills into routine clinical care.

5.4 KEY WORDS:

Cancer, neoplasm, clinical supervision, multidisciplinary, nursing, discourse analysis, implementation, theory practice gap
5.5 INTRODUCTION

The gap between ‘best practice’ and actual clinical care in health services has prompted calls for research that examines the process of health service delivery and the factors that influence effectiveness and efficiency (Fixen et al., 2005; Grol & Wensing, 2004). Of concern to this paper is that psychosocial care of adults with cancer is inconsistent with clinical practice guidelines (Bultz & Johansen, 2011; Luxford et al., 2006; National Breast Cancer Centre and the National Cancer Control Initiative, 2003). This paper describes the changes in practice associated with the implementation of a psychosocial Intervention for adults with cancer. The paper reports selected findings from a qualitative study that was embedded within a step wedged randomised control trial (RCT) (Turner et al., 2011).

5.5.1 Background

The RCT evaluated a psychosocial Intervention provided by trained Health Professionals for supporting adults with cancer (Turner et al., 2011). The Health Professionals were nurses, physiotherapists, radiation therapists and occupational therapists. Training, provided as part of the Intervention, focused on teaching supportive/expressive; cognitive-behavioural; and dignity conserving strategies. Health Professionals provided up to four, 30 minute, face-to-face or telephone sessions, conducted over a four-week period to consenting adults with cancer. Support sessions focused on engaging the patient, eliciting and exploring key concerns, and establishing an agreed treatment plan with an emphasis on dealing with distress. The Health Professionals received regular clinical supervision by psychiatrists throughout the Intervention. Clinical supervision reinforced training, monitored patients’ and Health Professionals’ safety, progress and concerns. The overall aim of this paper is to describe change processes and taken-for-granted practices influencing the implementation of the psychosocial Intervention (Carabine, 2001; Foucault, 1972; Hall, 2001; Wetherell et al., 2007).

A systematic review of the literature, conducted by the authors, explored the barriers to psychosocial care of adults with cancer (Dilworth et al., 2014a). Organisational, cultural and individual barriers were identified.
Clinical supervision with Health Professionals is recommended to enhance practice change, address gaps in clinical care and support psychosocial interventions for patients (Botti et al., 2006; Dilworth et al., 2014a; Kenny et al., 2007; Mannix et al., 2006; Turner et al., 2007; Watts et al., 2010). There is limited evidence regarding the effectiveness of clinical supervision (Farnan et al., 2012; Fowler, 1996; Mannix et al., 2006; Sloan et al., 2000; Spence et al., 2001; White & Winstanley, 2010c; Wright, 2012) and the mechanisms underlying the change processes (Heaven et al., 2006; Mannix et al., 2006).

5.6 THE STUDY

5.6.1 Aim/s
The aim of this qualitative study was to explore the discourses used by Health Professionals during clinical supervision and how the process impacted the delivery of a psychosocial Intervention to adults with cancer. Attention was given to how language constructed the experience of providing psychosocial care and the barriers and/or enablers encountered when delivering the Intervention. The research questions asked: What influence does clinical supervision have on the discourses of Health Professionals and their practice? What might this reveal about change in practice and barriers/enablers to such changes?

5.6.2 Design
A qualitative design was used for this sub study underpinned by discourse analysis (Dilworth et al., 2013a). Discourse Analysis was selected as a novel approach to understanding practice change in this study. Discourse is defined as a way of representing a topic that creates knowledge and meaning associated with that particular topic bridging the gap between language and action (Foucault, 1972; Hall, 2001). This definition of discourse “attempts to overcome the traditional distinction between what one says (language) and what one does (practice)” (Hall, 2001, p. 72). When discourse is defined in this way it can be seen to govern the way a topic can meaningfully be talked about (Foucault, 1972). In doing so it influences how something can or cannot be talked, thought, written about or acted on (Foucault, 1972, 1976; Hall, 2001).
For this study the analysis focused on how positionality, representation and subjectivity influenced meaning and practice (Carabine, 2001; Foucault, 1976, 1980; Hall, 2001; Sanguinetti, 2000).

### 5.6.2.1 Clinical supervision model

The model of clinical supervision developed for the Intervention is detailed below in table seven.

**Table 7. Model of clinical supervision**

<table>
<thead>
<tr>
<th>Element</th>
<th>Detail</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequency</td>
<td>1/ week</td>
<td>Frequency of at least once a month has been positively evaluated (Edwards et al., 2005). In this Intervention weekly sessions were chosen because clinical supervision aimed to ensure all participating Health Professionals felt supported, engaged, and able to be assisted to respond to any difficulties including exacerbation of depression or emergence of suicidal ideation.</td>
</tr>
<tr>
<td>Duration</td>
<td>1 hour</td>
<td>Duration of at least 60 minutes is considered more effective than briefer sessions (Edwards et al., 2005)</td>
</tr>
<tr>
<td>Participants</td>
<td>Supervisor + all available Health Professionals on site</td>
<td>On occasions when Health Professionals were not actively seeing a patient it was an intention that their attendance at the supervision session would allow them to learn from others and contribute to the group learning experience.</td>
</tr>
<tr>
<td>Core components</td>
<td>1) Normative (establish a consistent approach to clinical care),</td>
<td>These components were based on Proctor’s Model (1986). Proctor’s model is becoming widely utilised.</td>
</tr>
</tbody>
</table>
2) Formative (educational – skill and knowledge development), and
3) Restorative (the process of validation and support through peer feedback).

Style

Supportive, building confidence of participants and general encouragement of participants to generate ideas and strategies for responding to clinical issues. It was not usually appropriate for the facilitator to have a highly didactic approach, unless there were specific concerns such as patient safety.

The style adopted recognised supervisees preference for a supervisor who was prepared to act as a sounding board, but who was also prepared to offer guidance (Fowler, 1996). Ideally not prescriptive, rather allowing some degree of creativity and encouraging responsibility (Fowler, 1996). Provision of clinical guidance is rated highly by psychiatric trainees who also value expert knowledge (Clarke, 1999).

Confidentiality

Supervision sessions were strictly confidential. Supervisors reminded participants each session that they must respect the confidentiality of other group members.

Establishing confidence of participants that matters discussed during supervision remain confidential, and are not shared with unit managers is critically important (White & Winstanley, 2009).

Out of session contact/absence

Clinical supervisors were available for out of session contact. In the event of Investigator absence or illness an appropriately-qualified clinician at their site was trained to be able to provide supervision.

This was in line with the supervision aims of support, engagement and safety.

Scheduling

It was the responsibility of the site coordinator to assist in scheduling the

Scheduling sessions to accommodate various rostering needs and
Clinical supervision sessions were guided by the format detailed in table eight, below. The guide was developed to ensure congruence in the approach employed and to provide key information about enablers and barriers related to the implementation of the Intervention. Clinical Supervisors met regularly to discuss the sessions. During clinical supervision the participant Health Professionals presented an overview of the patient/s for which they were delivering the RCT Intervention. Discussion overviews included the patient history, their current situation and the measures collected as part of their participation in the RCT, such as The Distress Thermometer and Problem Checklist (National Comprehensive Cancer Network, 2007), Psychosocial Risk Factors (National Breast and Ovarian Cancer Centre, 2008) and Hospital Anxiety and Depression Scale (Zigmond & Snaith, 1983), reflecting current psychological symptoms, levels of distress and key concerns, and risk factors to psychological distress that could inform management.
Table 8. Guide to format for clinical supervision sessions

<table>
<thead>
<tr>
<th>Format of clinical supervision sessions</th>
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</table>

Each session commenced with a brief overview by the Investigator of the themes discussed in the previous session.

At commencement of each session, each participant was specifically asked to nominate what aspects of the previous supervision they had applied since the last session and any specific difficulties they encountered.

Each participant was asked to present an overview of the patient/s for whom they were delivering the Medium-intensity Intervention. In order to be able to do this the Health Professional brought with them: The Distress Thermometer and Problem Checklist (National Comprehensive Cancer Network, 2007), Psychosocial Risk Factors (National Breast and Ovarian Cancer Centre, 2008), Hospital Anxiety and Depression Scale (Zigmond & Snaith, 1983), and other material provided to them by the site coordinator when they were allocated to the respective patient. The facilitator invited comment from the treating Health Professional and other group members about core issues, the style and content of therapy offered and facilitate discussion as appropriate.

The facilitator reminded participants that they were required to maintain an Intervention log book documenting all contacts with the patient, the nature and duration of therapy offered, whether face-to-face or by telephone and themes discussed.

The facilitator asked each participant about their use of the Clinical Referral pathway for any patients for whom they have been delivering the Medium-intensity Intervention and reminded them to record details on their Intervention log book.

At the conclusion of each session the facilitator briefly summarised the themes discussed and asked individuals to nominate if there were specific strategies or techniques they planned to implement on the basis of that discussion. These themes then formed the basis of discussion at the commencement of the next supervision session.

5.6.3 Participants

Health Professional participants were recruited from four sites. There were three large teaching hospitals in Queensland, New South Wales and Victoria, Australia with specialist cancer care services and a private specialist oncology treatment centre in Queensland (Turner et al., 2011).
There were three Clinical Supervisors who were psychiatrists with expertise in clinical supervision, and psychosocial care for adults with cancer. They were also investigators in this study.

Information sessions were held at each site. Health Professionals that registered interest and met the inclusion criteria were invited to participate. The inclusion criteria were: (1) Professional training in disciplines of nursing, occupational therapy, speech pathology, nutrition and dietetics, physiotherapy or radiation therapy (2) at least 12 months’ clinical experience in oncology (3) currently engaged in patient contact (minimum of 6 hours per week) (4) commitment to undertake the necessary training and (5) working in a setting in which they can deliver the Intervention. Exclusion criteria were: (1) Psychologists, social workers and psychiatrists whose basic training has incorporated the key elements of training for this Intervention (2) no current clinical contact in oncology (3) anticipating leaving the current work setting in the next 12 months (4) anticipated period of extended leave during the conduct of the Study (Turner et al., 2011).

5.6.4 Data collection

Data was drawn from audio-recordings of the conversations held within the clinical supervision sessions during the Intervention period of the RCT study. Data also included demographic details collected at recruitment to the study. Clinical supervision sessions were held weekly for up to one hour from November 2011 to December 2012. Ninety six clinical supervision sessions were recorded, 33 at site one, 33 at site two, 18 at site three and 12 at site four. Sixty one sessions were not recorded due to poor attendance, equipment failure or equipment user error. Twenty nine sessions were excluded because there was only one Health Professional present. Nine clinical supervision sessions were transcribed verbatim and eight were analysed as audio files from within NVivo9 (QRS International, 2011). All audio-recordings and transcriptions were securely stored and managed using NVivo9 (QRS International, 2011).

Seventeen clinical supervision sessions were purposively selected for analysis. Selection targeted: sessions with more than one Health Professional in attendance, variability across sites and over time. Due to
rostering of Health Professionals it was not possible to track the same cohorts over time.

The final number of sessions included for analysis was determined by the research team when the data included rich text that was representative of the character and dynamics of sessions across a range of sites and participants.

5.6.5 Ethical considerations

Ethical approval was obtained from relevant human research ethics committees. All identifying information was removed from transcripts including ward, hospital or health service names, and location details such as suburb names. Health Professional participants are referred to by pseudonyms. Clinical Supervisors are referred to as the “Supervisor”. Transcript and audio data are securely stored in accordance with the Australian Code for the Responsible Conduct of Research data (National Health and Medical Research Council; The Australian Research Council and Universities Australia, 2007).

Informed consent was obtained from study participants. Participants were given an information sheet outlining the details of the study. Participants were informed that they were free to withdraw from the study at any time. The Clinical Supervisors were fully informed about the study, use and purpose of the data collected during clinical supervision sessions. Appendices 10 and 11 detail this material.

5.6.6 Data analysis

The data were analysed using discourse analysis (Carabine, 2001; Edley, 2001; Foucault, 1979, 1980; Hall, 2001; Sanguinetti, 2000) (see (Dilworth et al., 2013a) for details). Table nine details the analytic strategy (Dilworth et al., 2013a).
Table 9. Discourse analytic strategy

<table>
<thead>
<tr>
<th>Description</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Familiarisation with the data set:</td>
<td>To understand the institutional contexts, issues, tensions and practices of the Health Professionals (Sanguinetti, 2000).</td>
</tr>
<tr>
<td>Iterate between the clinical supervision data and the literature:</td>
<td>Look for discursive constructions, theories or subjectivities. This includes examination of literature that describes the barriers to psychosocial care, literature related to practice innovation, the guidelines for the psychosocial care of adults with cancer and education manual developed for Health Professionals participating in the research. Consideration is given to contextual, historical and societal aspects (Edley, 2001). This recognises the situated nature of language, allowing recognition of what it may or may not be possible to say (Edley, 2001; Foucault, 1980).</td>
</tr>
<tr>
<td>Consider the use of idioms, euphemisms and metaphor:</td>
<td>These may be used in the construction of interpretive repertoires (Edley, 2001; Sanguinetti, 2000; Wood &amp; Kroger, 2000). This may help identify what choices are available to people when contrasting psychosocial care in this context. How are dominant discourses being maintained, resisted or transformed (Edley, 2001).</td>
</tr>
<tr>
<td>Search for patterns:</td>
<td>Rather than classification of the discourse in terms of the content the analytic strategy attempts to identify what is being done and how it is done by taking apart the talk to understand how it is structured and organised (Foucault, 1976; Wood &amp; Kroger, 2000).</td>
</tr>
<tr>
<td>Collapse and combine threads to form key discourses:</td>
<td>To determine if a pattern of speaking is termed a discourse they should recur across text but not necessarily be in every text; be identifiable associated with a particular institutional sector, tradition, theory and set of practices and reflect a set of power relations and a world view (Sanguinetti, 2000).</td>
</tr>
<tr>
<td>Problematize the discourses:</td>
<td>Scrutinise power, knowledge and subjectivity (Foucault, 1976, 1980)</td>
</tr>
<tr>
<td>Explore what devices are used within the development of knowledge, but not to accept this at face</td>
<td>Examine positionality, representation and subjectivity including ideological dilemmas, or tensions within the discourse (Edley, 2001).</td>
</tr>
</tbody>
</table>
Positionality: What are the relationships? What determines the conduct of individuals (Foucault, 1988)?

Representation: Whose interests are represented? Who is being empowered? What is this representative of? What does it signify?

Subjectivity or Ideological dilemmas: What are the tensions here? What does it mean to hear this? What are the binaries or competing concepts?

Map the analysis: How does this all relate? How are the discourses related? What does this mean? This map of the current situation and the factors that have influenced change in practice will be used to answer the research questions (Carabine, 2001; Sanguinetti, 2000).

### 5.6.7 Rigour

To ensure analytical interpretations were credible, coherent and clear authors one, two and three met regularly to discuss analysis and interpretations. Authors four, five and six were not involved in the initial coding and development of the key discourses as their role in the research as Clinical Supervisors may have influenced the interpretation of the data (Leykin & DeRubeis, 2009). Once initial coding and key discourses were developed authors four, five and six participated in research meetings. Their involvement at this later stage ensured interpretations were in accordance with their understandings as participants. A research diary was used by the lead author for reflection, assumptions, influencing theories and values and provided evidence of reflexivity and an audit trail (Wetherell et al., 2007). The consolidated criteria for reporting qualitative research (Tong et al., 2007) was used to help ensure important aspects of the research were reported.

### 5.7 FINDINGS

Forty four Health Professionals expressed interest in the study. Seven participants withdrew prior to training due to change in circumstances. Seven withdrew before completion of the study. Withdrawals related to personal illness, family illness, conflicting or changed work commitments.
or other reasons not stated. Thirty Health Professionals completed all aspects of training and Intervention.

Participants included: 23 nurses, four physiotherapists, two radiation therapists and one occupational therapist. The average age of participants was 42.57 (range 24-61). The average number of years worked in oncology was 11.88 (range 1-34). 16 out of 30 (53%) had previous communication skills training; 3 out of 30 (10%) had undertaken a counselling skills training; 3 out of 30 (10%) had other training in psychosocial care.

Three themes represent the discourse of change that emerged from the conversations within clinical supervision. The first theme, a willingness to “go there”, describes changes in the Health Professionals willingness to accommodate new knowledge and skills. The second theme, wanting to “fix”: solving problems, captures the Health Professionals desire to solve the participant’s problems. The third theme, managing “the big conversations” describes the extension of new skills, related to change in Health Professionals practice beyond the RCT, specifically changes in the way they approached situations that confronted them in their daily clinical practices.

5.7.1 A willingness to “go there”

Health Professionals described new ways of engaging with people that reflected a difference in how they understood and related to distress and emotional issues. They described having the confidence to “go there”. Below, Nancy, a registered nurse explained that the new skills developed from the training provided as part of the RCT had changed the way she approached emotionally charged circumstances that were common in her clinical practice.

**Nancy, Registered Nurse, Site 3**

The training day has helped with gynae [cological] losses. Just managing emotion and the listening techniques. They are terribly traumatic situations and there is a little voice in the back of my mind. Well I could probably go a bit further rather than leaving it where I would have. Just by talking and
listening. Picking up on cues and acting on them. Exploring, and being brave enough to go there. Instead of thinking I know what they are going to say and I don’t want to go there. You didn’t want to be that person that upset them.

The Health Professionals reluctance to talk about emotional distress, depicted above, was also identified in the literature (Dilworth et al., 2014a; Turner et al., 2007). Above, fear was grounded in the assumption that the Health Professional knew what was causing distress. Previously the Health Professional assumed what was distressing and avoided conversations. Emphasising communication skills, such as listening and talking, helped the Health Professional challenge this assumption. Her use of language conveyed a sense that the Intervention was difficult. Words such as “brave” and “courage” were used when Health Professionals challenged their usual practices to talk openly with people about their distress.

When discussing their allocated patients within clinical supervision Health Professionals often included a diagnosis, staging or other clinical indicator of person’s physical health. This information was used by Health Professionals to construct an understanding of the person’s current situation. For example: where a patient had lung or brain cancer there was a sense of urgency or desire to “push” issues. Recurrence of disease or metastatic disease also conveyed a particular understanding of the patient’s situation. The “push” metaphor in the excerpt below was used often. Health Professionals discussed whether they would “push” participants to “go there” or not. Pushing suggested deliberation about whether gains or benefits could be seen in addressing distressing or confronting issues. Health Professionals reflected on whose interests were being represented. Not pushing was used when it was perceived that a participant may not need or want “to go there”.

In the exemplar below, Bernadette talked about a 37 year old woman who had a “speedy” relapse of ovarian cancer 7 months after diagnosis. Bernadette described her reluctance to “push” the woman to discuss her thoughts and feelings about prognosis.
Bernadette, Registered Nurse, Site 2

And she ... I didn’t really feel comfortable to be honest, to push her ... I mean I have my little questions which is always my prompt, you know “what do you fear the most?” I had that ready and I just, I didn’t think I could go there.

Supervisor

What held you back?

Bernadette, Registered Nurse, Site 2

[pause 5] I think just.... just still that worry of putting something in her head that isn’t there.

Supervisor

Sorry HELLO she is 37, she has got ovarian cancer that has relapsed and she is on a trial and what would you be putting in her head that is not there Bernadette?

Bernadette, Registered Nurse, Site 2

But how much more open could I be? Sitting there talking about funerals, talking about wills, talking about ministers. If she doesn’t go that step herself who am I to drag her there.

The Supervisor challenged Bernadette’s position listing reasons that Bernadette would not make things worse; reasons that this woman has had more distressing thoughts. Listing is a discursive strategy that aims to increase believability or the authority from which it is spoken (Potter & Wetherell, 1987). Bernadette defended her position; she felt she had been open. Metaphors like, “opening the door”, “laying it on the table”, and “a smorgasbord of options” described offering cues or leading the person, as Bernadette described above. In defending her position Bernadette listed topics to reinforce that she had offered cues. But she felt she was not in a position to discuss this any further with the young woman. Legitimacy was an underlying issue for many of the Health Professionals’ actions and Bernadette deferred to the patient that final step explicitly voicing
her distress. Inappropriate or inadequate cue response or blocking are communication techniques reported by Health Professionals and patients.

As with Nancy, Bernadette expressed a fear that she may distress this young woman. This was a recurrent theme for Bernadette and for other Health Professionals. She feared that her knowledge of the disease process or her fears for the patient were worse than those that the patient had. She worried that she would make the problem bigger, cause distress, or cause the patient to have thoughts she had not previously had. In the literature this is described as a fear of saying the wrong thing or making things worse (Turner et al., 2007). Educational interventions have been shown to reduce this fear (Turner et al., 2009). However, despite previous reassurances, research findings and training to suggest otherwise. This thought remained a determining factor in Bernadette’s decision not to discuss this issue further. In response, in the same session, Bridgette related the following story.

**Bridgette, Physiotherapist, Site 2**

*But with patients who were lying there who I was treating and I thought umm well you know you have metastatic disease, yes we can control it but there might be an end for you not too far and they are skirting around and skirting around and then I ... I probably feel now more comfortable but I would have exactly thought the same thought in a sense.*

“Skirting around” issues was recurrent across time and sites. It was referred to elsewhere in the data as “the elephant in the room” or “don’t mention the war” or as discussed above “not going there”. Here Bridgette indicated that she recognised this in her own practice. Health Professionals understandings of disease trajectories put them in a position that influenced their interactions with people with cancer. At times Health Professionals, like Bridgette, feel more comfortable and this was a change.
5.7.2 Wanting to “fix”: solving problems

In this study Health Professionals saw themselves as “doers”. Nurses and physiotherapists, in particular, felt that part of their role was to be able to identify problems and solve them. The exchange below illustrated how the desire to help was expressed.

**Mary, Registered Nurse, Site 1**

*I guess I feel like I wanted to be able to help her feel better but I am not quite sure...*

**Supervisor**

*That is the nurse in you. You want to help.*

**Melissa, Registered Nurse, Site 1**

*Just give us a task. (laughing)*

**Mary, Registered Nurse, Site 1**

*I know, I know, I know. It is so true, so true. I feel like I have to have a goal for the conversation and something for her to achieve ... I think she has listed all these things here but I, I feel that I don’t know how much talking and chatting to her whether either by the phone or face to face is actually going to fix any of this.*

The idea of doing something was integral to what constituted helping or fixing. Listening or empathising was more difficult for Health Professionals to qualify as “help”. The urge to provide answers, reassurances and “fix” problems described a position where the Health Professional felt inadequate. The desire represented the Health Professional as lacking in confidence, or skill in particular situations. From this position Health Professionals described “rushing in” or trying to “fix” problems because they didn’t know what else to do. As presented in the excerpt above Health Professionals couldn’t see that “talking” would “fix” anything.
Patient distress related to physical problems was represented as “fixable”. This positioned Health Professionals in a familiar role. Pain, fatigue, treatment side effects, nausea, and decreased appetite were seen to be amenable to “fixing”. Health Professionals had a repertoire of interventions that were familiar and delivered easily. Below Melissa’s tone was jovial as she described herself as lucky in her most recent Intervention with a woman who had indicated she was distressed related to a loss of appetite.

Melissa, Registered Nurse, Site 1

I am lucky that my [allocated patient’s] problems are PROBLEMS! (laugh) I have got physical side effect PROBLEMS! So we talked about the steroids and whether that is actually helping.

At times the familiarity of addressing physical problems was represented as a tactical manoeuvre. The purpose being to build trust, or rapport with the patient or “to see if there were anything that I could I could fix or refer to someone that might help emotionally”. The Health Professionals used skills that were comfortable and familiar to lead into what was described as more challenging issues. At times this strategy represented the Health Professionals interests and did not address the person’s most pressing concern. This represented an exercise of power where the Health Professionals positioned themselves as competent, confident and knowledgeable.

Change was evident when Health Professionals described resisting their desire to rush in and fix. Instead they described being confident to allow the person space to express their distress, concerns and worries. Below is an example of how Health Professionals expressed realisation or change in awareness about their communication strategies.

Bernadette, Registered Nurse, Site 2

And she is somebody in particular who has a terrible life, who will carry on having a terrible life, that won’t change … but she, you know I said you know I wish there was something I was able to change for you [patient name] and she said oh you have, you listen to me. And that was lovely
because it did make me realize that... and I might have tried to rush it and tried to fix things before but I can’t really (laughing) ... but you don’t need to.

**Belinda, Registered Nurse, Site 2**

The reassurance thing, yeah that’s true. Instead of going, you just go take a breath and see what happens....

Reassurances represented a tacit or heuristic communication strategy. Over time Health Professionals came to recognise that premature or unfounded reassurances could discourage a person from exploring their concerns. By resisting their desire to reassure or normalise situations it became possible to discuss issues in a way that facilitated open conversations. Where Health Professionals recognised and resisted what was often conveyed as an impulsive action it was empowering for them. They saw a new way of engaging with people who were distressed or may have wanted to explore difficult or upsetting fears or concerns. This idea is extended beyond the trial Intervention in the next theme.

### 5.7.3 Managing “the big conversations”: the extension of new skills

When Health Professionals talked about their own clinical practice there was a strong indication of change in practice. This was important because it described practices not measured within the RCT. Practices that were possible because of the RCT training and ongoing support at the Intervention sites.

Many of the excerpts included in this paper related to care provided outside of the context of the RCT. This represented an extension of skills beyond what was measured by the RCT. Below; Belinda described an instance in her practice outside the Intervention when just being there was a legitimate and helpful Intervention. Previously discussed feelings of legitimacy are voiced. It was Bernice’s response that clearly articulated this theme.

**Belinda, Registered Nurse, Site 2**
I went and talked to her and there it was helpful just to be there. To use those few words. Even if we were doing it before like it seems to - we are allowed to actually do it. Like I don’t know how to say it but it is ok. I felt that it was ok to say those words.

**Bernice, Physiotherapist, Site 2**

I would totally concur with that. Out of the 4 prompt patients, I am talking face value, 2 it went well, 2 maybe not so well, so 50% but no, that's not correct because it is the others, the overflow into other areas and how much better you manage the big conversations with your other patients that is the big fact.

For the Health Professionals in this study change was a realisation that some things would not be fixed. The most valid Intervention was one that allowed the person to express their emotion. Health Professionals described just letting the person talk, cry, or vent. It was these kinds of Interventions that “overflowed” and became part of the Health Professionals routine clinical practice.

### 5.8 DISCUSSION

The findings from this study suggest that change in practice occurred for the Health Professionals who took part in this Intervention. Change was represented by; increased confidence albeit juxtaposed with reluctance to address the patient’s distress; altered perceptions about the need to “fix” patients’ emotional and existential concerns, and the ability to work differently in their routine work roles.

In previous research concerns about causing distress related to feeling inadequately trained to address psychosocial concerns (Dilworth et al., 2014b). Within this study Health Professionals understanding of illness, disease trajectories and assumptions about the causes of distress were underlying issues that have not previously been explored. Education and ongoing support in the form of clinical supervision provided a forum to voice tensions about the “elephant in the room”. However, this remained a tension that influenced Health Professionals decision to “push” or not. There were positions participants adopted based on their experience,
views and perceptions about a situation that were seen to influence practice change. As ‘doers’ Health Professionals ability to resist their desire to solve problems represented an important change and was seen to increase confidence and legitimacy in delivering psychosocial care. Task focused subject position limited the actions of participants.

Changes in the daily practices of these Health Professionals within clinical supervision are supported by previous research (Heaven et al., 2006; Mannix et al., 2006). Unlike previous RCT’s the qualitative element of this study was able to explore the complexities of such changes highlighting some of the contextual and situational intricacies that were negotiated when implementing new interventions particularly one that required the expansion of the Health Professionals role and scope within routine practice.

Stigma has been shown to negatively impact on help seeking behaviour (Barney et al., 2006). This is an important issue that requires further investigation. Health Professionals understanding of cancer, disease trajectories and treatments represented stigmatised understandings of a person. Population studies have shown stigma to be a barrier to mental health care (Barney et al., 2006; Schomerus et al., 2009; Schomerus et al., 2012) but there is little study of its impact in perception of need for psychosocial assistance in the setting of cancer diagnosis (Holland et al., 2010). Stigma reduction campaigns may be useful in addressing both Health Professionals’ and patient avoidance of psychosocial concerns (Barney et al., 2009; Holland et al., 2010).

5.8.1 Limitations

Large volumes of available data meant there was a need to purposively select data for analysis. In order to address concerns that important data may have been overlooked the first author listened to all recorded sessions and created text summaries. In doing so, the excluded data potentially influenced the researchers and the analysis. To ensure the analysis was grounded in the selected sample, direct excerpts of data are included.
The Clinical Supervisors were not involved in the initial analysis of the data in order to address the notion of “therapeutic allegiance”, a belief in the superiority of a treatment (Leykin & DeRubeis, 2009). Instead, their input was sought following initial analysis.

### 5.9 CONCLUSION

The findings describe subject positions, representations and tensions that influenced practice (Foucault, 1980). The Health Professionals’ language was used to challenge, or accommodate elements of the clinical practice environment that limited the delivery of psychosocial care. The Health Professionals’ ability to deliver psychosocial care was moderated by: How they positioned themselves, the patient and their willingness to engage with the Intervention and emotional concerns. The educational element of the RCT with clinical supervision provided a forum for negotiating some of the tensions when implementing a new Intervention and practice change. Discourses within supervision showed ways of practicing that may accommodate the tensions.
PAPER 5: REFERENCES


National Health and Medical Research Council; The Australian Research Council and Universities Australia. (2007). Australian Code for the Responsible


Chapter 6  Mapping clinical supervision within cancer care to facilitate practice change

The aim of this chapter is to pull together the published papers and link them to a coherent discussion of the major findings. The first section of the chapter focuses on drawing links between the papers, the research aims and the research question.

A conceptual map was developed in order to draw together the key findings of the research. The map makes clear the interconnections between all of the published papers, in line with research aim four; to make visible the interconnectedness of the situation so that this critical knowledge could be used to emancipate or create awareness of the needs of clinicians who were delivering psychosocial care to people with cancer. Through this visual representation I demonstrate the complex interplay of multiple factors as they impacted on the discourse used by Health Professionals implementing a new psychosocial Intervention.

Multiple links between the published papers reveal synergies between the barriers to psychosocial care, clinical supervision, and tensions within clinical practice that impacted on Health Professionals ability to deliver this Intervention in the context of their routine practice. Figure seven, below, represents the published papers as previously shown in chapter one with the addition of links between the papers, the PROMPT RCT and recommendations from the research reported in this thesis.
Chapter 6 | Mapping clinical supervision within cancer care to facilitate practice change

**Paper 1:** “Patient and Health Professional’s perceived barriers to the delivery of psychosocial care to adults with cancer: A systematic review” (Dilworth, Higgins, Parker, Kelly, & Turner, 2014a)

- **Patient barriers**
  - No need for services, no information, practicalities, low confidence, negative attitude / stigma, Health Professional communication

- **Health Professional barriers**
  - Organisational
  - Cultural
  - Individual

**Paper 2:** “Finding a way forward: Reviewing the current debates around the benefits of clinical supervision” (Dilworth, Higgins, Parker, Kelly, & Turner, 2013c)

- Diverse expectations for clinical supervision
- A diffuse evidence base
- Complex interventions are difficult to implement and evaluate
- A culture resistant to change
- Assumptions about commitment
- Time equals money
- Critical reflection to generate shared understanding
- Multidisciplinary team clinical supervision to create shared dialogue and break down disciplinary silos

**Paper 3:** “Examining clinical supervision as a mechanism for changes in practice: a research protocol” (Dilworth, Higgins, Parker, Kelly, & Turner, 2013a)

- Does clinical supervision facilitate changes for clinicians trained to deliver a psychosocial Intervention?
- What influence does clinical supervision have on the discourses of Health Professionals and their practice?
- What might this reveal about change in practice and barriers/enablers to such changes?

**PROMPT findings: A null result**

- No significant quantitative findings
- No changes to Health Professional burn out or stress
- No changes in patient distress or other measures

**Paper 4:** “Exploring the situational complexities associated with practice change in health” (Dilworth, Higgins, Parker, Kelly, & Turner, 2013b)

- **Positionality:** The busy nurse the helpless patient
- **Representation:** Prioritising psychosocial care
- **Subjectivity:** How busy is too busy?

**Paper 5:** “An examination of the change process through a discourse analysis of clinical supervision.” (Dilworth et al., 2014b)

- Feeling legitimate “going there”: changing confidence
- Wanting to “fix”: solving problems
- Managing “the big conversations”: the extension of new skills
- Changes in legitimacy and confidence
- Need to address stigma

**Recommendations:**

- Need to change dialogue about cancer to address stigma
- Need to determine how to appropriately measure non-linear changes in practice
- Need to explore the sustainability of changes
- Need to change dialogue about cancer to address stigma
- Education supported by ongoing clinical supervision is a model to facilitate practice change that could be transposed in other areas of practice
- Clinical supervision training should be introduced at an undergraduate level as part of interprofessional curricula

**Figure 8. A conceptual map linking the research findings, published papers and recommendations**
The second section is included as part of the reflexive approach to research. This section follows up on the assumptions articulated in the opening chapter of the thesis and discusses the impacts of these assumptions as they played out within the research project. This discussion points to the following section in which I make recommendations for practice, research and education. Concluding comments bring the thesis to a close.

This research analysed the conversations held during the clinical supervision sessions. The aim was to:

- Explore the discourses used during clinical supervision and the impact of delivering a psychosocial Intervention to adults with cancer on the actions of Health Professionals.

Particular attention was given to how the language of Health Professionals constructed their experience of providing psychosocial care and the barriers or enablers they encountered when delivering the Intervention. The research questions asked:

- Does clinical supervision facilitate changes for clinicians trained to deliver a psychosocial Intervention? What influence does clinical supervision have on the discourses of Health Professionals and their practice? What might this reveal about change in practice and barriers or enablers to such changes?

Discourse analysis was employed as a method to highlight taken-for-granted aspects of practice. This provided the opportunity to recognise oppressive practices and to facilitate alternative practices (Crowe, 2005; Wodak & Meyer, 2009). The thesis explored changes in practice as a non-linear process that was negotiated within complex work environments. Extrinsic or distal contexts that were seen to influence the practice of Health Professionals and their ability to deliver the PROMPT Intervention included organisational demands and cultural norms, such as having limited time in the context of busy workloads that remained primarily task focused. Discourse was used to construct identity, for example in paper four, as busy but concerned (Dilworth et al., 2013b). Discourse was also used to govern practice. At times Health Professionals’
discourses challenged the status quo. Examples are included in paper four (Dilworth et al., 2013b) where despite being busy a choice was made to prioritise psychosocial support. In paper five (Dilworth et al., 2014b) Health Professionals described feeling legitimate to “go there”. The idea of “going there” was indicative of a change in Health Professionals’ discourse and practice. Also described in paper five (Dilworth et al., 2014b) was increased feelings of legitimacy that facilitated the transfer of new skills to routine practice situations.

Discourse analysis was proposed as a novel and innovative method of examining clinical supervision as a potential tool for changing practice. Directly examining the conversations within the clinical supervision sessions provided a new perspective to the analysis. This enabled examination of the real behaviour during supervision as opposed to second hand accounts of it (Green & Thorogood, 2009). As well as the interactions within clinical supervision social and organisational contexts were accessible for consideration through the Health Professionals’ and Supervisors’ conversations. Through direct observation of the interaction the data were not influenced by the researcher in the same way that an interview would be.

Paper four, “Exploring the situational complexities associated with practice change” (Dilworth et al., 2013b) and paper five, “Implementing a psychosocial intervention in cancer care: An examination of the change process through a discourse analysis of clinical supervision” (Dilworth et al., 2014b) explored the discourses used during clinical supervision.

Chapter four, “Exploring the situational complexities associated with practice change” (Dilworth et al., 2013b) illustrated the fragility of current practices that see psychosocial care marginalised by barriers described in the literature as being task orientated and too busy (Dilworth et al., 2014a). The analysis demonstrated how the organisational demands on the Health Professionals, such as a lack of time and the burden of a heavy workload that are frequently cited barriers to the provision of psychosocial care (Absolom et al., 2011; Beckstrand et al., 2009; Botti et al., 2006; Frost et al., 1997; Kenny et al., 2007; Watts et al., 2010) were challenged through the sharing of stories in the context of clinical
supervision. The stories shared within the clinical supervision forum allowed the Health Professionals to reposition themselves as able to provide psychosocial care within their routine care. The paper added depth to our understanding of and challenged the perceived barriers to care described in paper one, within the systematic review of “Patient and health professional's perceived barriers to the delivery of psychosocial care to adults with cancer” (Dilworth et al., 2014a). Critical questioning provided a link between what was known and what was happening. The analysis revealed that despite being busy, Health Professionals were able to listen to the concerns of distressed patients. They did this as a priority to particular tasks that competed for their attention in the context of a busy work setting. The analysis suggested that if Health Professionals have the appropriate skills and support there is an opportunity for them to provide supportive care during brief encounters with people with cancer in the context of their routine care. Paper four, “Exploring the situational complexities associated with practice change” (Dilworth et al., 2013b) presents an extension on the previous literature highlighting the presence of resistance against systemic, organisational and cultural barriers. The resistances illustrate the fragility of current practices that see psychosocial care marginalised and highlight the potential for change.

Chapter five, “Implementing a psychosocial intervention in cancer care: An examination of the change process through a discourse analysis” (Dilworth et al., 2014b) explored a discourse of change. Clinical supervision provided a forum for facilitating change through the sharing of dialogue, the sharing of experiences and ongoing support for the implementation of skills provided by the Training element of the PROMPT Intervention.

Change was represented by; fluctuations in confidence; altered perceptions about the need to “fix” patients’ emotional and existential concerns; and their ability to work differently in their routine work roles. Change was not described as a linear process but a process that was negotiated.

The analysis revealed underlying issues related to Health Professionals’ concerns about causing more distress to already distressed people with
cancer. Health Professionals’ understanding of illness, disease trajectories and assumptions about the causes of distress represented underlying issues that have not previously been explored. Stigma was an important issue that was highlighted as requiring further investigation. Health Professionals’ understandings of cancer and disease trajectories represented stigmatised understandings of a people with cancer. Within the clinical supervision sessions the actions of Health Professional participants were seen to be influenced by their previous experiences with cancer. As ‘doers’ Health Professionals ability to resist their desire to solve problems represented an important change and was seen to increase confidence and legitimacy in delivering psychosocial care. The task focused subject position limited the actions of participants.

The changes in routine practice were an important aspect of the analysis. Health Professionals described changes in their routine practice in relation to their ability to deliver psychosocial care to adults with cancer experiencing distress whom they encountered as part of their care outside the context of the PROMPT Intervention. Paper five (Dilworth et al., 2014b) explored the complexity of changes that represented an extension of the skills and knowledge acquired as part of the PROMPT Intervention. The analysis highlighted the contextual and situational intricacies that were negotiated when implementing the PROMPT Intervention that required the expansion of the Health Professional’s role and scope within routine practice.

6.1 LINKING THE FINDINGS AND THE PAPERS

**Paper one** presented “Patient and health professional’s perceived barriers to the delivery of psychosocial care to adults with cancer” within a systematic review of relevant literature (Dilworth et al., 2014a). The barriers perceived by patients were: no need for services, lack of information, practicalities, low confidence in services, negative attitude or stigma and Health Professionals’ communication. Health Professionals perceived organisational, cultural and individual barriers. The paper was presented as part of the background to the study. Importantly, in terms of the discourse analytic methodology adopted for the research the systematic review provided contextual understanding of psychosocial
services for people with cancer. The barriers were then able to be considered when exploring how discourse was seen to rule in and rule out particular practices (Hall, 2001) related to psychosocial care and the process of change in the context of the PROMPT Intervention. The review is an important contribution to knowledge in the area of psycho-oncology in its own right. The review included 25 papers and provided a useful synthesis of the barriers, perceived by patients and Health Professionals, to implementing psychosocial interventions across seven countries and varied clinical settings. By disseminating the work within a peer reviewed journal it has been made available to a broad community. The findings of the review should inform the development of new psychosocial interventions because consideration of barriers has been identified within the field of knowledge translation as a crucial step in the successful implementation of changes in practice. Clear identification of the barriers or obstacles, at a variety of levels, ensures that interventions can be tailored to minimise the impact of the barriers (Grimshaw et al., 2012; Grol & Grimshaw, 2003; Grol & Wensing, 2004).

**Paper two**, “Finding a way forward: A literature review on the current debates around clinical supervision” (Dilworth et al., 2013c) presented a critical interpretive review of the diverse expectations for clinical supervision. Parallels between the barriers to psychosocial care and clinical supervision are revealed when papers one and two are considered as part of the whole thesis. Both the psychosocial care and clinical supervision literature present diffuse, heterogeneous evidence bases. Confusion about definitions and intentions has limited the acceptance, synthesis and implementation of both psychosocial care and clinical supervision. Psychosocial care and clinical supervision interventions are inherently complex and are being implemented in complex environments. Complex interventions are difficult to implement and difficult to evaluate (Victora, Black, Boerma, & Bryce, 2011). These factors can then be related to research that explores the translation of evidence into practice. There are aspects of interventions that may promote or hinder successful implementation. Some are relevant to both psychosocial care of adults with cancer and clinical supervision. Given the findings of this research and the existing literature aspects that need close attention in the future.
are: attention to making clear the relative advantage, to ensure the intervention does not conflict with existing practice, roles or norms, to ensure it does not seem complex and difficult to understand and to ensure there is no uncertainty about results and consequences (Grol et al., 2007).

Both clinical supervision and psychosocial care are resisted. Resistance often makes assumptions about the commitment, time and money required for implementation. Putting the debates aside clinical supervision presents a forum for critical reflection to generate a shared understanding of care. The critical interpretive review, in chapter two, argued that multidisciplinary team clinical supervision could potentially break down disciplinary silos through shared dialogue (Dilworth et al., 2013c).

There are links between the critical interpretive review of clinical supervision, (Dilworth et al., 2013c), the PROMPT findings and also papers four and five presented within this thesis (Dilworth et al., 2013b; Dilworth et al., 2014b). The review of clinical supervision (Dilworth et al., 2013c) described a strong focus on empirical research to evaluate clinical supervision. This focus failed to recognise the role clinical supervision can have in strengthening teams through group critical reflection on practice. Similar to previous research that aimed to link clinical supervision to patient and Health Professional outcomes (White & Winstanley, 2010c), the PROMPT study reported a null result, that is, there were no changes in patient or Health Professional outcomes. The findings of this thesis (Dilworth et al., 2013b; Dilworth et al., 2014b) described change as a non-linear, negotiated process. In the same way the critical interpretive review of the clinical supervision literature described ways in which clinical supervision could influence the actions of Health Professionals. This helped to address one of the research questions that asked what influence clinical supervision had on the discourses of Health Professionals. This was further described in the findings, papers four and five, as providing a forum to generate shared meaning, challenge previous assumptions and negotiate the tensions of psychosocial care within the context of the PROMPT RCT and routine clinical care.
In papers four and five we recognise some of the parallels between the implementation of clinical supervision and psychosocial care. Both findings papers four (Dilworth et al., 2013b) and five (Dilworth et al., 2014b) highlighted that the barriers identified by the systematic review of psychosocial care (paper one) (Dilworth et al., 2014a) and the uncertainties or ambivalence about clinical supervision (paper two) (Dilworth et al., 2013c) were present in the current context. The analysis presented in papers four and five (Dilworth et al., 2013b; Dilworth et al., 2014b) highlighted many tensions for the Health Professionals. Many of the tensions related to or highlighted underlying reasons for the previously established barriers to psychosocial care that were described in detail in paper one adding depth to current understandings of the barriers to psychosocial care. The analysis within papers four and five (Dilworth et al., 2013b; Dilworth et al., 2014b) used critical questioning to demonstrate that despite the presence of challenges the Health Professionals were able to reposition themselves to allow space to provide supportive care.

**Paper four**, “Exploring the situational complexities associated with practice change in health” (Dilworth et al., 2013b) explored the organisational complexities of the context and its influence on how the Health Professionals engage with distress in their practice. Within the data the organisational barriers, described in paper one (Dilworth et al., 2014a), presented in the data as demands on the Health Professionals. Through dialogic engagement Health Professionals challenged the status quo. Paper four challenged the “too busy” argument that dominates the psychosocial research. Health Professionals represented themselves as busy but able to prioritize psychosocial aspects of care despite competing demands for their time and care. Cultural barriers were challenged also as Health Professionals challenged understandings of their professional roles, in paper four and five (Dilworth et al., 2013b; Dilworth et al., 2014b). Barriers related to the individual clinician were explored in greatest depth in paper five.

**Paper five**, “Implementing a psychosocial intervention in cancer care: An examination of the change process through a discourse analysis of clinical supervision” (Dilworth et al., 2014b) extended the previous
understandings of the idea of the emotional burden of caring described as a barrier to care in paper one. Health Professionals challenged their individual assumptions about their patients’ distress. The language that Health Professionals used within clinical supervision constructed the experience of providing psychosocial care. Paper five, in particular, explored the use of metaphors to represent dominant ideologies or hegemonies that have been largely unchallenged. The presence of recurring metaphors was indicative that through communicative processes or dialectic engagement within the supervision sessions shared meaning was generated by the Heath Professionals’ and Supervisors’. Because of their connoted meanings there needs to be a shared understanding of the metaphors to be able to appreciate and then use them (Mezirow, 1991). Within the data there are several strong metaphors and idioms. The idea of avoidance is conveyed in paper five within the theme Feeling legitimate “going there”: changing confidence. The term “skirting around” and the metaphor the “elephant in the room” were used multiple times at multiple sites. These phrases are used in a similar way to the phrase “don’t mention the war”. These phrases indicated the presence and power of unspoken issues either in an intervention, or context. This was an example of how within the groups a shared understanding of some of the tensions that arose in clinical practice were constructed through discourse. These tensions crossed disciplinary divides. Nurses, Physiotherapists and Psychiatrists, Radiation Therapists shared narrative accounts of the tensions, and difficulties they had in clinical practice. There were multiple points of overlap. Managing the desire to fix peoples problems is one such tension that was also discussed in paper five.

As discussed above, within the critical interpretive review of the clinical supervision literature (Paper two), I advocated multidisciplinary group supervision as a forum to generate shared meanings of care. The literature suggested that through shared dialogue within a reflective, supportive forum shared meanings could be generated (Cross et al., 2010; Holst et al., 1999; Stevenson, 2005). In the data a common language around psychosocial issues and terminology for the approaches to care developed. Over time the use of terminology shifted from the
Supervisors to the group. Initially Health Professionals may not have had a word for the intervention they had delivered, they described “not doing much”, “just listening” or similar. It was Supervisors who used terms such as “empathic listening”, “empathic validation” to label this. This added validity to the act of listening as an intervention. Reference to the training manuals using similar terminology had a similar effect. For example, “have you re-read the section on “Making empathic statements?” Over time “listening” and “validating” came to be used to describe intentional acts within an intervention. Paper five articulates this in the theme managing “the big conversations”: the extension of new skills. “Just being there” was described as a legitimate and helpful intervention. Previously implicit thoughts and actions were made explicit through the use of these shared labels or terms. This can be likened to what Freire (1972) refers to as giving the words to name their new world. Using dialogue to name the world is an empowering act of creation and re-creation (Freire, 1972).

In light of the study findings and the discourses that became evident within the sessions I will revisit ideas that I used to introduce myself as a researcher. This discussion addresses some issues that could be considered as limitations of the study and points to some of the recommendations that follow.

6.2 RECONCILING THE ASSUMPTIONS OF THE RESEARCHER

In chapter one I introduced some of my assumptions relating the types of things the data would reveal, the context and my reflections on this project. I revisit these assumptions in the following discussion. My primary assumption was that the conversations that Health Professionals had within clinical supervision would generate talk that was related to the impact of the Intervention. I assumed this because clinical supervision was provided as a forum to discuss this Intervention specifically. This assumption was confirmed by the data. I had not anticipated how many of the conversations would be unrelated to the PROMPT Intervention. I had not anticipated how much talk would be about the “spilling over” of skills into routine practice. This was
discussed in paper five, “Implementing a psychosocial intervention in cancer care: An examination of the change process through a discourse analysis of clinical supervision” (Dilworth et al., 2014b) that explores the extension of new skills into routine practice.

I had also assumed that the nature of the Health Professionals’ talk during clinical supervision would be reflective. I assumed that the Health Professionals would report back experiences, make inference about what was done well or not so well and contemplate how different approaches may have impacted past interventions. The data revealed that much of the talk was anticipatory. Forward or anticipatory reflection described reflective dialogue that included consideration of the possibilities of practice. It involved planning, anticipation, speculation and rehearsal of the Intervention they were going to deliver. As a mechanism of change, this process allowed the Health Professionals’ who had not yet had an interaction or had already reflected on a previous interaction the time to plan what might happen next; how to approach particular issues; and allowed speculation/ hypothesising about concerns given the items highlighted on the quantitative measures collected at recruitment to the study.

6.2.1 Clinical supervision as a contested practice within healthcare

Support for clinical supervision was evident within the data. The positive response to clinical supervision is described by increased feelings of confidence and legitimacy within paper five (Dilworth et al., 2014b). However, there was sporadic attendance at supervision, due to rostering, and competing roles. This concurred with previous research (White & Winstanley, 2009) and the discussion presented within the critical interpretive review, paper two (Dilworth et al., 2013c) that suggested that clinical supervision may not be easily implemented.

The clinical supervision sessions selected for analysis in this study targeted: (1) group interaction, only sessions where more than one Health Professional was in attendance (2) variability across sites, which aimed to
ensure that the findings had relevance for a variety of settings (3) variability over time, to allow exploration of change.

At each site a group of participating Health Professionals were identified and recruited but it was not possible to have attendance by the same Health Professionals at all sessions, due to shift work and rostering. Due to the changes in attendance at the supervision sessions, and the large number of sessions, it was not possible to track a cohort of Health Professionals over time in a meaningful way. There were 140 sessions anticipated by the stepped wedge design. In reality the period of data collection was extended increasing the number of clinical supervision sessions. At multiple sites more than one clinical supervision session was held per week to accommodate either Health Professionals working at different campuses or to accommodate various availabilities. Only 96 sessions were recorded, 33 at site one, 33 at site two, 18 at site three and 12 at site four. Sixty one sessions (approx. 45%) were not recorded due to poor attendance due to conflicting or lack of availability, equipment failure or equipment user error. Of the 96 sessions 29 (30%) were attended by only one Health Professional and a Supervisor and as such were excluded from the selection. Critical consideration of these figures recognises that although not considered specifically within the analysis the missed sessions inform an aspect of the analysis that would have otherwise been overlooked by the sampling strategy, which targeted group interaction.

This is an element of the analysis that I hope to pursue as a future publication. The publication will speak to the fact that despite some very enthusiastic and clear indications to support this Intervention and its impact on the way Health Professionals changed there were in fact many sessions that did not proceed due to poor attendance, lack of availability or went ahead with one Health Professional.

The data collection for this study included audio-recordings of each of the clinical supervision session. The analysis for the thesis included a subset of these sessions that focused on group interaction and change over time. As described in the protocol paper (paper three) (Dilworth et al., 2013a). The analysis did not explore how the sessions were
implemented over time at each site. Critical reflection on what could be considered as missing data, highlights what was made clear in the critical interpretive review of clinical supervision (Dilworth et al., 2013c). Despite espoused support for new interventions there are complex competing demands in the real context that limit implementation. This also links in part to the introduction where the barriers to practice innovation and research utilisation were discussed.

Why didn’t Health Professionals attend each week? The audio-recordings of the sessions provided some explanation. The Health Professionals were rostered off duty, unwell or committed elsewhere. Why wasn’t clinical supervision a priority? At times staff chose not to prioritise clinical supervision because they had not been allocated a patient, had not been able to contact or engage their patient or felt they had little to report or as above were committed elsewhere. The motivation for not attending clinical supervision cannot be addressed but we can recognise non-attendance as an exercise of power by the Health Professionals with real effects. Perhaps as suggested in paper two, “Finding a way forward: A literature review on the current debates around clinical supervision” (Dilworth et al., 2013c) clinical supervision continues to be resisted because the nature of work remains task focused and routine oriented (Botti et al., 2006; Scott & Pollock, 2008; Watts et al., 2010). Perhaps health professionals continue to feel unworthy of clinical supervision or clinical supervision is not being perceived as real work (Green Lister & Crisp, 2005; Stevenson, 2005). Future research would aim to triangulate data in attempting to address the questions that have been raised here. This would include some measure of the effectiveness of clinical supervision, for example including the use of the Manchester Clinical Supervision Scale (MCSS- 26) (Winstanley & White, 2011). Some record of reasons for non-attendance may further explain the barriers when implementation is within the clinical setting.

### 6.2.2 Stigma as a privileged understanding of cancer

In introducing myself I revealed my own stigmatised understandings of cancer care. Perhaps it was not stigma in the common sense of the word that relates to shame or disgrace (Oxford University Press, 2014). For
myself and for the Health Professionals there was a sense that their experience of providing cancer care gave them a privileged understanding of the illness trajectory, treatment and outcomes. This determined their perception of the patient experience and their perceived level of distress. This was discussed in detail in paper five (Dilworth et al., 2014b). Within the theme “a willingness to go there” Health Professionals’ understandings of disease processes and outcomes was a factor that influenced their behaviours and at times limited their ability to engage with their patients’ distress. “Skirting around” and not addressing “the elephant in the room” were terms used to describe avoidance of issues. Within the data Health Professionals described a fear of making things worse or putting something in a person’s head that they may not have considered. In previous literature the fear was grounded in feeling inadequately trained to address patients’ distress (Turner et al., 2007). In this data the fear was grounded in what I describe as privileged but stigmatised understandings of the cancer experience and assumptions about what would be the cause of distress for the person with cancer. Within the data Health Professionals expressed surprise when their patients’ most pressing concern did not align to the Health Professionals understanding of the experience. In paper five (Dilworth et al., 2014b) and in paper one (Dilworth et al., 2014a) I recommended stigma reduction strategies as means to improve psychosocial care.

The data suggest that “Cancer” as a distressing experience continues to dominate what can be said, thought and actioned in this area at this time. Health Professionals in this study voiced stigmatised perceptions of the “Cancer” experience that influenced their actions. The data from the clinical supervision session revealed that negative attitudes or attitudes that were influenced by their previous experiences of cancer were a factor that determined the behaviour of the Health Professionals. This was discussed in paper five when Health Professionals were not able “to go there”. This supported what was found in the review of the barriers (Dilworth et al., 2014a) in chapter one and supports previous research (Kearney et al., 2003). Kearney et al. (2003) found that regardless of gender, profession and clinical experience, all oncology healthcare professionals displayed persistently negative attitudes towards cancer.
They suggested that attitudes to cancer may create a barrier to communication between patients and healthcare professionals. Interestingly, previous research shows that nurses overestimate patients’ emotional distress and underestimate patients’ coping resources and quality of life (Lampic, 2000; Mårtensson et al., 2008).

In this study Health Professionals used their understanding of a person’s physical health, including diagnosis, disease staging and treatments to construct their understanding of the person’s current situation. Often this included assumptions that the Health Professional knew what would be causing distress and how much distress it would be causing. Alongside the barriers review and previous research, that indicated patients’ attitude influences help seeking behaviour (Barney et al., 2009; Barney et al., 2006). Stigma reduction is an important factor to consider in future education and research.

Future interventions should take into account recommendations from the practice innovation and change literature (Eccles et al., 2012; French et al., 2012; Godin, Bélanger-Gravel, Eccles, & Grimshaw, 2008; Grimshaw et al., 2011; Grimshaw et al., 2004) that advocates the use of theoretical approaches to study behaviour change and the multiple influences on behaviour change. Within this thesis this was done through an examination of the perceived barriers to the implementation of psychosocial care (Dilworth et al., 2014a). Implementing change is likely to require attention to organisational, cultural and individual barriers concurrently. In light of the documented barriers and the findings of this thesis theoretical understanding of stigmatised or negative attitudes may be useful in terms of understanding what underpins these attitudes and how to address them in order to increase the acceptability of psychosocial interventions for both the people with cancer and the Health Professionals delivering care.

Theoretical perspectives that would be useful to consider regarding negative attitudes toward cancer, specifically, psychosocial care are Berrengerg’s (1989) dual process model and terror management theory (Greenberg & Arndt, 2011; Mosher & Danoff-Burg, 2007). The dual process model theorises that peoples attitude to cancer will be influenced
by their personal experience of the disease. The model predicts that those with a personal history of cancer will have the most positive attitude to the disease. It is proposed that extensive, direct experience dispels negative stereotypes, may reaffirm life meaning, and improve self-esteem having coped with or survived cancer. Those with minimal experience will have the next most positive attitudes. Individuals with little or no experience have not experienced interpersonal failure coping with the disease. It is proposed they are less likely to have a negative attitude to the disease. People with a moderate level of experience will have the most negative attitude. The group used to represent this level of experience in Berrenberg’s (1989; 1991) work is those who have had a family member or friend with cancer. Potentially this could be Health Professionals working in cancer care. The negative attitudes derive from aversive social interactions, and the awkward nature of interpersonal contact with person with cancer (Berrenberg, 1989; Berrenberg, 1991).

Terror management theory relates to the role of our unconscious fear of death (Greenberg & Arndt, 2011; Mosher & Danoff-Burg, 2007). A health model of terror management theory proposes that people will make health decisions in an effort to remove conscious thoughts of death. Unconscious death related thoughts or cognition promotes the maintenance of self-esteem and sense of meaning. Also being reminded of our creaturely nature intensifies terror management concerns and influences health attitudes and behaviours (Greenberg & Arndt, 2011). I also suggest that terror management would be useful in relation to understanding our desire to see people with cancer triumph over their disease. It may also account for negative responses to those not viewed as coping with their disease. In relation to alleviating death anxiety, the theory proposes that the greatest death transcendence is provided by participating in heroic acts, such as helping someone conquer death. Mosher and Danoff-Burg (2007) found that in line with terror management theory death anxiety was associated with social distancing and negative emotional reactions to people with cancer in certain contexts (Mosher & Danoff-Burg, 2007).

There are links to be drawn here between both of these theories and previous research in the area of stigma related to mental health that
found increased public understanding of the biological aspects of mental illness did not result in improved social acceptance of persons with mental illness (Schomerus et al., 2012).

Change is needed in order to address the dual stigma of distress and cancer faced by the large number of people with cancer who will experience distress at some point during the diagnosis, treatment, recovery or death. As treatments advance and the side effects of treatment are lessened there will need to be a new conversation started. A less stigmatised conversation that considers cancer as a chronic illness rather than a life limiting one.

### 6.2.3 A disconnect between the RCT and qualitative findings

As I reflexively engaged with this project I realised I had assumed that the PROMPT Intervention would result in decreased depression and anxiety amongst the adults with cancer who received the psychosocial Intervention and that the Health Professionals would report decreased levels of stress and burnout because these were the main hypotheses of the PROMPT Intervention study. I had assumed that the changes I was exploring within the qualitative data from the clinical supervision sessions would enhance the findings of the quantitative data by supporting the findings. This was not the case. The PROMPT Intervention reported a null result (Turner et al., 2014). There were no statistically significant changes in patient distress or other measures. There were no statistically significant changes in Health Professional stress or burnout.

The findings reported in this thesis revealed changes in the way Health Professionals talked about and positioned themselves in their practice in relation to psychosocial distress and their ability to provide psychological support. This study reported people with cancer being helped by this Intervention. This begs the question: what has created this disconnect?

The PROMPT Intervention adopted an experimental design in which specific clusters of people received an intervention where others did not. Ontological and epistemological assumptions of this kind of RCT intervention study assume that the intervention will be undertaken in a
controlled environment in which the influence of external factors will be kept to a minimum or eliminated (Victora et al., 2011). In the real world, however, “the intervention or programme of interest usually accounts for only a small part of variability in health outcomes” (Victora et al., 2011, p. 85). Because outcomes are affected by many contextual factors real-world effectiveness evaluations present challenges that cannot be properly addressed by the traditional approach of intervention versus comparison group (Victora et al., 2011).

My study was conceived as a novel approach to combining qualitative and quantitative methods and methodologies. To my knowledge, this is the first sub study associated with an RCT to use a discourse analysis methodology. Unlike other RCT studies of this complexity the sub study accounted for the relationship between the RCT and the processes within the RCT. This presented a new way of understanding the results of the RCT. Parallel to the PROMPT RCT the critical analysis of the talk within clinical supervision in the context of an RCT did not take for granted that a rigorously designed and implemented intervention would be free from the bias that experimental research attempts to limit. The very complex and human aspects of the PROMPT Intervention and the context are considered as part of my study and the analysis of the clinical supervision discourses.

From a critical perspective the influence of the research process on its participants and the data needed to be addressed. The data analysed here were drawn only from the clinical supervision sessions. However, the analysis could not ignore the impact of the broader project. The influence of the PROMPT RCT, as part of the context of the discourse analysis findings, is evident within the talk during clinical supervision sessions. There was ongoing input from Supervisors regarding how the Intervention was being delivered. In this way Supervisors were seen to influence the discourse of Health Professionals.

The PROMPT Intervention was intended as a brief intervention that could be integrated into routine care. Within clinical supervision the Intervention was recognised as an exercise that involved more than just the delivery of a delineated intervention. Tensions around the expectation
and extent of indirect effort required to deliver the Intervention were discussed. These issues link to the feasibility of an intervention like the PROMPT Intervention becoming part of routine care. The effectiveness of the Intervention was impacted not only by the research as per the protocol but by the individuals involved with the research. Outcomes for the patients may have been affected by the amount of resistance or determination of the Health Professional to contact them or the patient’s willingness to accept the Intervention. Outcomes for the Health Professionals may have been impacted by the additional time and effort that they put into the research process. The Intervention despite being planned with a manual developed, education delivered, monitored with log books, and clinical supervision; and supported through education, and ongoing clinical supervision was not delivered “as per protocol”. For example the protocol planned for one session per week for one hour. At some points during the intervention clinical supervision sessions were being held twice a week or as individual phone calls to try to facilitate attendance.

Health Professionals and Supervisors went above and beyond what was described within the protocol. The effect of this cannot be measured. We cannot assume that it was necessarily of benefit to the Intervention. Especially because quantitative outcomes for the Health Professionals’ measured stress and burnout did not change. This kind of effort may have blurred the boundaries. Was this intervention seen as work? Why couldn’t time be made in work to do this?

These boundary type issues presented tensions that the Health Professionals attempted to negotiate in achieving the aims of the research. Within the PROMPT Intervention Health Professionals spent a lot of time, more time than anticipated on preparing for the Intervention. Health Professionals spent substantial amounts of time contemplating their interventions. This included review of the patient self-report measures, reading medical records and more informal things such as discussing the person with others who currently care for the patient, or who may have cared for them in the past. At times the amount of time and effort spent increased when the patient was difficult to engage.
The PROMPT Intervention was designed to be a brief intervention (20-30 minutes). Consults were intended to be kept short to keep them targeted. In this study, the length of time actually allocated to the Intervention, as reported in clinical supervision, ranged from 10 minutes to over an hour. How and where the intervention was delivered and if it was viewed as work were tensions for the participants. Some Health Professionals reported making phone calls from their own homes. This is because they felt they were too busy at work, only worked part time, or because access to a private phone or area was difficult. Some Health Professionals reported coming to work on their day off to meet with their allocated patient. All of the issues outlined link to legitimacy and prioritisation on some levels but also to systemic problems with access to appropriate facilities to make phone calls or meet with patients. They also represent boundary and professional issues with implications for risk and litigation. The same kinds of boundary issues were discussed in relation to implementing clinical supervision in chapter two in the critical interpretive review (Dilworth et al., 2013c). Within the clinical supervision literature, as within this data set, there were multiple examples where a commitment that was ‘above and beyond’ was required to access clinical supervision (Jones, 2006; White & Winstanley, 2009). This creates a subtext that this is not real work and cannot be accommodated within work hours (White & Winstanley, 2009). The Australian Nursing and Midwifery Council (ANMC) (2010) guidelines clearly specify behaviour that results in singled out treatment including “visiting the person when off duty or swaps roster allocations to be with the person” (Australian Nursing and Midwifery Council, 2010, p. 10) is a violation of professional boundaries. The implications of such boundary violations relate to professional ethical codes of conduct.

Increasingly, complex interventions include within them process evaluation elements (Gregson et al., 2007). These kinds of process evaluative measures aim to appreciate some of the complexities and variability of practice or behaviour change interventions and to understand why some programs succeed or fail or to account for or justify a null result. The shift toward including mixed methods research to evaluate intervention studies recognises the value of qualitative
research; and recognises the need for a range of analytical techniques to deal with data gaps and biases (Victora et al., 2011, p. 85). While appreciating that some interventions, perhaps like the PROMPT Intervention, do not make a significant change at a population level we have shown through the qualitative analysis that the Intervention that was provided was useful and Health Professionals valued the project. Since completion of the PROMPT RCT one site has made a large shift to focus on the psychosocial domain of care. Two of the staffs have gone on to further education in the field and a role has been developed to screen for and assess distress.

As discussed in the introductory chapter the determinants of diffusion, dissemination and implementation of innovation are complex. (Greenhalgh et al., 2004). It is possible that the education and ongoing support while delivering the PROMPT Intervention tipped the system readiness, which is determined by the tensions for change, the innovation system fit, the balance of supports versus opponents and the level of dedicated time and resources available (Greenhalgh et al., 2004); to the point of implementation. The implementation process involves decision making being devolved to front line teams, hands on approaches by managers and leaders, human resource issues are addressed such as training and there are dedicated time and resources (Greenhalgh et al., 2004).

Clinical supervision included conversations about how the Health Professionals were negotiating the delivery of this intervention within the complex practice environment. This is discussed in detail within paper four. Certainly there are many tensions that arose as the Health Professionals attempted to accommodate this intervention within their existing workloads. The busyness of the setting and the lack of an appropriate environment are discussed. Health Professionals used clinical supervision to recount stories that described their ability to negotiate the situational complexities and how that impacted on the Intervention. This is one way that change is described by the Health Professionals, in paper five, where the Health Professionals challenged expectations or resisted the difficulties presented by making multiple attempts to contact the patient. This was viewed as a change that
contested the status quo. Where patient avoidance was not accepted, Health Professionals describe ‘pushing’, or ‘delving’ to achieve the aims of the research.

The critical element, which made this a novel approach to analysing conversations within clinical supervision, highlighted the tensions of delivering a psychosocial intervention, within clinical care, to people with cancer as part of an RCT. It has highlighted that there are positions and relationships that do in fact limit what it is possible to say, do and think, about distress in clinical practice. The outcomes of this research point strongly to the need for mixed method approaches to evaluate complex interventions. Further, to the usefulness of clinical supervision as a tool that can be used to expand Health Professionals’ scope of practice.

### 6.3 STRENGTHS AND LIMITATIONS OF THE STUDY

Limitations of the research have been described throughout the thesis as they relate to specific aspects of the research. For example, in paper one the limitations of the systematic review of the perceived barriers to psychosocial care were discussed (Dilworth et al., 2014a). The following discussion considered the project as a whole and was written at the completion of the study following reflection and consideration of limitations described elsewhere in the thesis.

Discourse analysis as a methodology is considered part of the critical paradigm of research. Emancipatory researchers within the critical paradigm describe research as praxis and collaboration (Freire, 1972; Lather, 1991a, 1991b). Design elements that linked my research to the PROMPT Intervention did not allow me to pursue questions raised by the data. This limited the possibility of collaborative praxis. However, oppression, subjugation and emancipatory change, the ideas and phenomena described by critical theorists and researchers, were present within the data. This is what Lather (1991b) described as reciprocity between theory and the data. In this way emancipatory knowledge was generated through the analysis. “Emancipatory knowledge increases awareness of the contradictions distorted or hidden by everyday understandings, and in doing so it directs attention to the possibilities
for social transformation inherent in the present configuration of social processes” (Lather, 1991b, p. 52). The critical knowledge generated can be used to inform broader change, and new ways of understanding the current context. This is consistent with Foucault (1972, 1973) who highlights the hegemonies, inequities and also the possibilities of new approaches and ways of understanding.

As a design limitation there was no relationship or collaboration between myself and the Health Professional or patient participants. There was a relationship between myself and the Clinical Supervisors and the entire analysis is based on the collaborative and reciprocal element of the larger project, the clinical supervision session. The relationship and collaboration between myself and the Clinical Supervisors is discussed elsewhere in the thesis (see chapter 3B), emphasised the potential influence of power. I acknowledge that this put me in a position that could allow the imposition of my own interpretations and meanings or to privilege the voices of the Supervisors over the Supervisees in the interpretation of the data. Using an inductive approach to analysis, which aimed to ground the analysis in the data helped to avoid this.

There was a risk of being perceived or perceiving myself as the “master of truth and justice” (Foucault, 1977, p. 12) who intends to demystify the world of the dispossessed by imposing rather than negotiating meanings with participants. Through self-reflection and consideration of my role as the researcher also my role with the other researchers in the project I hope to have avoided this. Future research would benefit from the inclusion of reflexive processes within the design along with discourse analysis to allow collaborative development of the issues highlighted by the discourse analysis.

As a strength the results are not based on retrospective self-report as much of the work around describing the barriers to psychosocial care and clinical supervision have been previously. Data collection methods that captured naturally-occurring interaction provided the opportunity to examine communication as it happened enabling access to data about real behaviour rather than participants account of it (Green & Thorogood, 2009). Analysis of naturally-occurring talk within the context
of the clinical supervision sessions meant interactions, social and
organisational context were accessible for consideration.

There is a flip side to the point above. Because data was collected using
non-participatory methods it was not possible to check participants
understanding. In an interview or focus group the researcher is able to
ask for clarification, probe or guide the participant. It is possible that
through direct interaction with the participant insights about the
experience and meaning may have been gained. The involvement of the
Clinical Supervisors as participants and academic supervisors allowed
me to check my analysis against their understandings as participants.

It is possible that video recording of the clinical supervision sessions
could have provided additional insights. This would have allowed deeper
exploration of group dynamics, the role of non-verbal features of
language as well as utterances. However, the logistics, resources and
technical skills required to collect this data excluded this option.

Analysis of the data using the audio files facilitated by NVivo9 enabled
the consideration of tone and nuance of conversations within the
sessions.

Due to the large volume of data available from the larger study there was
a need to purposively select data for analysis that would help to answer
the research questions. In addressing concerns that important data may
be overlooked, I listened to all of the recorded sessions and created text
summaries. In doing so, consideration needs to be given to the fact that
the excluded data potentially influenced my interpretations and the
analysis. To ensure that the analysis was grounded in the selected
sample, direct excerpts of data were included. The following discussion
makes recommendations for the future in terms of practice, research and
education.

6.4 RECOMMENDATIONS

6.4.1 For practice

The research has highlighted how training and ongoing support in the
form of clinical supervision enabled Health Professionals to change their
perceptions and conceive the skills learnt for this Intervention as part of their routine practice. This was clearly articulated in paper five, “Implementing a psychosocial intervention in cancer care: An examination of the change process through a discourse analysis of clinical supervision” (Dilworth et al., 2014b) within the theme: Managing “the big conversations”: the extension of new skills. The research has revealed that change was not linear and the process of change required the negotiation of barriers that were present in practice. Clinical supervision provided a forum to negotiate the barriers and generate a shared understanding of care that recognised psychosocial care as being achievable within the context of routine care.

Clinical supervision provided a forum for Health Professionals to reposition themselves in relation to previously held assumptions that were revealed as influencing their behaviour. This links to previous research where clinical supervision allowed nurses to question their usual working style. Nurses within the previous research acknowledged that at times they jumped to conclusions and clinical supervision had given them insight into this behaviour (Cort et al., 2009).

The body of evidence discussed in the introductory chapters of the thesis described the reasons that psychosocial care is difficult to implement in routine clinical care. In addition to the practice related barriers research suggests that increasing knowledge about psychosocial care does not create the changes in practice that are needed to improve assessment and management of psychological distress, nor does increased access to specialist services. Critical theorists’ describe the need for technical, practical and emancipatory knowledge to facilitate the kinds of changes that fundamentally shift practices (Habermas, 1987; Mezirow, 1991). The research reported in this thesis suggests that along with knowledge and skill there has to be a transformative process that facilitates change. This research presents dialogue within clinical supervision as that transformative process. In practice the PROMPT Intervention provided the technical, practical skills and knowledge. It was clinical supervision that represented the emancipatory aspect of change that gave Health Professionals the confidence to reposition themselves within their practice as able to provide psychosocial care where they recognised a
need. In practice this presents not only the opportunity to improve the management of distress but to facilitate early and effective intervention mechanisms by enabling front line Health Professionals to provide the kind of care recognised as best practice.

In this thesis clinical supervision has been described as a tool to assist with the implementation of an intervention that expanded Health Professionals’ scope of practice. The model of education followed by ongoing clinical supervision represents a model that could be transposed to other areas, in particular where the intervention being implemented requires changes in practice that may challenge taken-for-granted aspects of clinical practice, cultural norms, individuals’ beliefs or organisational barriers.

Organisational issues are important to consider and implementation does need to take into account that interventions that are integrated into routine care need to clearly map the boundaries both for attending clinical supervision and the delivery of the intervention. Implementation needs to take into account the needs of Health Professionals working on rotating 24-hour rosters. This adds a complexity to the implementation in practice and would require active support from management or those administering rosters to allow dedicated time within work hours to support implementation (White & Winstanley, 2009).

Professional identity was an influencing factor and governed the practice of Health Professionals. In practice clinical supervision provided a multidisciplinary forum where Health Professionals could legitimise their practice, challenging the behaviours dictated by how they positioned themselves. There was an increased awareness of the commonality of many of the tensions in practice. As healthcare, in particular chronic disease management, moves toward multidisciplinary care group format, multidisciplinary clinical supervision could be used to break down the disciplinary silos evident in current practice.

6.4.2 For research

As an exploratory study this research has paved the way for future research projects that build on the concepts within this analysis. This
research has revealed that the process of change was complex. The process was not a one way path. Change was a negotiated process. This understanding of change acknowledges that the participants are not unitary, rational selves who purposefully move from planning to action once they have reflected on the problem (Sanguinetti, 2000). It should be articulated that from a poststructuralist perspective, espoused by the research, that this was an underlying assumption of the methodology applied. Change may not be a linear process from learning and reflection to action but that it is a complex, multidirectional and multifaceted process. This view also appreciates that the participants are “complex, multi positioned, and shaped by a multitude of historical, psychological and social forces. Their actions are constrained by a dynamic and contradictory field of subconscious or conscious beliefs, apprehensions and ways of being – the discourses which constitute their sense of who they are and how they might act” (Sanguinetti, 2000, p. 242). In paper four (Dilworth et al., 2013b) the multiplicity of self is discussed in relation to a changed sense of self. In the example this was created by the juxtaposition of two selves, one powerful, one recalcitrant. The powerful self required the recalcitrant self to “focus here for five minutes” in order to establish a therapeutic relationship with the “grumpy man”. Future research needs to consider how best to measure this kind of change and to explore the sustainability of change. Previous research that has measured changes in practice has shown that clinical supervision does help to sustain changes in practice (Mannix et al., 2006) but the mechanisms are not clear. Nor is the longevity of the change after clinical supervision is ceased.

Further research to link clinical supervision to improved patient outcomes is needed (Heaven et al., 2006; Mannix et al., 2006; White & Winstanley, 2010c). Légare et al. (2014; 2011) developed and validated a 12-item theory-based instrument to assess the impact of continuing professional development activities on the clinical behavioural intentions of health professionals'. The tool is informed by the Theory of Planned Behaviour for predicting health professionals' behaviours (Ajzen, 1991) and Triandis' (1980) theory of values, attitudes and interpersonal behaviour to examine Health Professionals intentions to perform the
behaviours. Such a tool may be appropriate to measure the kinds of changes in practice seen in this research. The tool measures intentions and as such provides a proxy measure of behaviour. To demonstrate a correlation between behavioural intention and observed behaviour observational data of Health Professional / patient interactions would be useful. Using a validated and reliable theory based instrument, as part of a multi-method evaluation, will help standardize the presentation of the many factors that influence the uptake of new clinical behaviours (Légare et al., 2014). This will also address many of the criticisms I noted in “Finding a way forward: A literature review on the current debates around clinical supervision” (Dilworth et al., 2013c), by: facilitating comparisons between similar studies, making systematic review and meta-analyses possible, helping to inform policy makers about how to change clinical behaviours and, extending the theoretical base for translating evidence into clinical practice (Légare et al., 2014).

Paper one, “Patient and health professional’s perceived barriers to the delivery of psychosocial care to adults with cancer” (Dilworth et al., 2014a) reported the most common barrier to psychosocial care from a patient perspective was that there was no perceived need for intervention (Dilworth et al., 2014a). Further that there were a group of people with cancer who despite identifying a need for services declined help (Carlson et al., 2004; Eakin & Strycker, 2001; Okuyama et al., 2008; Steele & Fitch, 2008). This was also the case in this Intervention. The current design and method could not investigate the reasons for this. Future research should aim to understand what underpins their decision. This would aim to ensure that those who identify a need for services are comfortable and able to access them in a timely and efficient manner.

Psychosocial care in cancer care and clinical supervision literature is lacking in strength partly due to the complexity of the interventions, and partly due to the heterogeneous and small scale nature of studies that have evaluated interventions. Future research needs to upscale and diversify its methods of evaluation. Future research would aim to triangulate data and methods (Renju et al., 2010). Elements that would be amenable to further quantitative evaluation include: some measure of the effectiveness of clinical supervision, for example the Manchester
Clinical Supervision Scale (MCSS-26) (Winstanley & White, 2011); changes associated with clinical supervision as a practice development intervention (Légare et al., 2014); and changes in attitude to cancer and stigma reduction (Berrenberg, 1991; Marlow & Wardle, 2014). Patient feedback and evaluation should also be included.

The critical analysis within this thesis described change indicated by Health Professionals dialogue about benefits of the PROMPT Training and Intervention, changes in routine clinical care, and a shift in thinking about distress. The Health Professionals’ dialogues also suggest that the tensions, stress and pressures in the workplace remain. Clinical supervision provided the opportunity for investigators to have ongoing input and influence over the delivery of the Intervention.

6.4.3 For education

In the present research, Health Professionals' understanding of the illness trajectory impacted on their perceptions of what was going to be a problem and how much of a problem it was. Their knowledge and experience in cancer care gave the Health Professionals’ power to interpret the situation in a different way than the person with cancer was able to interpret their own situation. Future interventions in particular educational interventions need to ensure that stigma and stigma reduction are specifically addressed. Some measure of Health Professional and patients' thoughts and feelings around this may serve as an indicator if stigma or negative attitudes are determining factors related to help seeking. Attitude to cancer has previously been measured using, for example, the Burns cancer scale (Burns, 1981), the Beck hopelessness scale (Beck, Weissman, Lester, & Trexler, 1974) and the Hoffmeister cancer attitude scale (Hoffmeister, 1976). Mosher and Danoff-Burg (2007) and recently Marlow and Wardle (2014) have explored stigma in non-patient populations, which may be useful to measure changes in attitude of Health Professionals. In saying this, again the area appears to be diffuse, heterogeneous and poorly defined within the literature. Work from many years ago, eg, Berrenberg, (1991) appears to have been overlooked rather than built on. Knowledge translation research would recommend the use of theory to account for these
findings (Eccles et al., 2012; French et al., 2012; Godin et al., 2008; Grimshaw et al., 2011; Grimshaw et al., 2004).

Recommendations for education include the use of theory to inform education strategies that include attention to the mechanisms within clinical supervision. Elements of transformative, action and reflective learning theory (Argyris & Schön, 1974; Argyris & Schön, 1996; Mezirow, 1991; Schon, 1983) could all be used to inform this process. Education models that introduce multidisciplinary, group format clinical supervision models early and reinforce the mechanisms and processes beginning at an undergraduate level are needed. Interprofessional approaches that use simulation as an educative tool would ensure that clinical supervision skills were developed as part of Health Professionals shared curricula. This would shift clinical supervision from away from being a contested practice. Resources that build clinical supervision models based on transformative learning theory that enable practice change through reflective, reflexive and enabling practice are needed (Argyris & Schön, 1974; Argyris & Schön, 1996; Mezirow, 1991; Schon, 1983).

Testing and strengthening the theoretical premises of clinical supervision education would serve to facilitate clearer, development of clinical supervisory skills and practice. Difficulty sustaining good attendance at clinical supervision was evident in within my research and the existing research (Buus & Gonge, 2009; White & Winstanley, 2009). Elements of Goal Framing Theory (Krishnamurthy, Carter, & Blair, 2001; Levin, Schneider, & Gaeth, 1998) could be incorporated into education models in order to address the ambivalence to clinical supervision evident in existing research. Goal framing theory suggests that goals “frame” the way people process and act upon information with a focus on motivation. Specifically that people are motivated to avoid a loss (Krishnamurthy et al., 2001; Levin et al., 1998). Incorporating this aspect of goal framing theory with clinical supervision training at an undergraduate level may also help reposition clinical supervision as an essential part of clinical practice. This could be done by framing not attending clinical supervision as a loss.
6.5 CONCLUSION

Analysis of conversations within clinical supervision has highlighted tensions in practice for Health Professionals working in cancer care. The analysis has highlighted what can be said about psychosocial care and distress, in cancer care at this time in this context.

The existing literature in the field of psycho-oncology describes barriers to care that interact at organisational, cultural and individual levels (Dilworth et al., 2014a). The barriers perceived by Health Professionals within the literature were present within the data for this study. The Health Professionals in this research describe busy, challenging and complex work. The analysis presented within this thesis demonstrated that given a supportive forum, such as clinical supervision, Health Professionals were able to challenge the barriers and accommodate many of the tensions that were recognised from the existent literature as obstacles to providing psychosocial care. The sharing of stories within the clinical supervision sessions provided a space for Health Professionals to dialogically engage with each other, the PROMPT Intervention and psychosocial care in the context of adult cancer care. By conceptualising discourse as social action the change in talk within clinical supervision is viewed as change in action. The discourse of Health Professionals within clinical supervision did change in a non-linear way that highlighted fragility to the current barriers to psychosocial care.

The nature of conversations within clinical supervision was such that it enabled Health Professionals to engage with distress both within the PROMPT Intervention and their routine practice, as described in papers four and five. The enabling dialogue within clinical supervision points to the need for education, professional development and models of care that undermine the dominance of physical care. Dialogue within clinical supervision made way for integration of psychological supportive care and supported the emancipation of Health Professionals towards cultural change that repositions psychological assessment and support as part of the expected and accepted repertoire of clinical expertise for front line Health Professionals.
Chapter 6  Mapping clinical supervision within cancer care to facilitate practice change


Chapter 6  
Mapping clinical supervision within cancer care to facilitate practice change


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Appendices
APPENDIX 1: A SYSTEMATIC REVIEW OF THE BARRIERS TO PSYCHOSOCIAL CARE (POSTER WITH PUBLISHED ABSTRACT)

The barriers to psychosocial care for adults with cancer

S. Dilworth¹, I. Higgins¹, V. Parker¹, B. Kelly², J. Turner³

¹School of Nursing and Midwifery, University of Newcastle, Callaghan, NSW, Australia
²School of Medicine and Public Health, University of Newcastle, Callaghan, Australia
³School of Medicine, University of Queensland, Herston, QLD, Australia
⁴School of Health, University of New England, Armidale, NSW, Australia

Aim: To explore the barriers to effective psychosocial care for adults with cancer.

Method: A systematic review of empirical research was undertaken. A snow ball sampling method was used to locate relevant literature. Systematic key word searches were conducted in PsychInfo, medline, CINAHL. Scopus was used to review reference lists of relevant articles. Dates included in the searches were from inception to March 2011.

Results: To promote clarity a framework drawn from the literature will be employed. The framework includes three domains: cultural, organisational and clinician or individual. The cultural domain includes barriers related to the multi-skilled nature of work, a lack of team cohesion and traditional work practices that marginalise psychosocial interventions. Systemic or organisational factors include the nature of care in the current healthcare setting. Shorter length of stay, lack of continuity of care and poor referral pathways present further barriers. Finally individual health professionals avoidance of psychosocial support excused by a perceived lack of time, burden of busy workloads, lack of skill to intervene, a lack of a suitable environment and emotional burden of caring.

The literature has several notable limitations. The limitations include: small studies that utilise ad hoc surveys developed for the study being presented. The use of tools that have not previously been validated may reduce the validity and reliability of the results. Retrospective cohort or convenience samples were utilised. Low response rates are a common feature.

Conclusion: The literature presents a complex interplay between several domains. There are a range of factors that interact at different levels impacting on the implementation of evidenced based psychosocial care for adults with cancer. To address these barriers interventions targeting the complexity of the situation need to be developed. Change in health professional attitudes and behaviours along with organisational commitment and support will be required.
Barriers to Psychosocial Care

S. Dilmouth, J. Higgins, V. Parkes, B. Kelly, J. Turner
School of Nursing and Midwifery, University of Newcastle, Callaghan, NSW, Australia
School of Medicine and Public Health, University of Newcastle, Callaghan, Australia
School of Medicine, University of Queensland, Herston, QLD, Australia
School of Health, University of New England, Armidale, NSW, Australia

Psychosocial care of adults with cancer

Evidence based psychosocial care for adults with cancer is not regraded part of routine care. The literature presents a complex interplay of barriers within individual, organisational and cultural domains. Interventions need to integrate psychosocial care targeting the complexity of the situation. Change is needed in health professional attitudes and behaviours along with organisational commitment and support.

Individual

- Emotional burden of caring
- Patient reluctance to discuss
- Health professionals fear of making things worse
- Negative attitudes and scepticism
- Lack of skills, knowledge or training
- Avoidance

Organisational

- Lack of time and the burden of a heavy workload
- Lack of formal support
- Lack of or late referral to services and disputed responsibility for assessment
- Multi-skilled nature of work, a lack of team cohesion and working in isolation

Cultural

- Lack of professional dialogue among nurses
- Marginalisation of psychosocial aspects of care
- Milieu marked by lack of support around emotional concern
- Tension between physical and emotional needs, task versus care

Systematic Review of Barriers

- A systematic review of empirical research was undertaken.
- Review developed in line with the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) Guidelines
- Systematic key word searches were conducted in PsychINFO, medline, CINAHL.
- Dates included in the searches from inception to March 2011.

References

1. [List of references]

Recommendations

Clinical supervision is recommended to improve psychosocial care:
- Open professional dialogue
- Provide formal support structures

Can clinical supervision improve psychosocial care?
- How do these sessions function?
- How does it shape the actions of those involved?
- How does it help reduce patient distress?
- How is knowledge transfered to clinical practice?
Appendices: Paper 1
# APPENDIX 2: LIST OF KEY WORDS

<table>
<thead>
<tr>
<th>Topic</th>
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<td>Cancer</td>
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<td>“psychosocial support”</td>
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APPENDIX 3: MEDLINE SEARCH STRATEGY

1. cancer.mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures]

2. neoplasm.mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures]

3. exp Neoplasms/

4. oncology.mp. or exp Oncology/

5. (cancer adj care).mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures]

6. (cancer adj nursing).mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures]

7. psycho-oncology.mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures]

8. 1 or 2 or 3 or 4 or 5 or 6 or 7

9. (psychosocial adj care).mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures]

10. (psychosocial adj support).mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures]

11. (psychosocial adj treatment).mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures]

12. (supportive adj care).mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures]

13. (psychological adj treatment).mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures]

14. (psychological adj care).mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures]
15. (psychological adj support).mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures]

16. 9 or 10 or 11 or 12 or 13 or 14 or 15

17. barrier$.mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures]

18. obstacle$.mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures]

19. problem$.mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures]

20. stigma$.mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures]

21. 17 or 18 or 19 or 20

22. 8 and 16 and 21
### APPENDIX 4: RISK OF BIAS WITHIN THE CROSS SECTIONAL OBSERVATION STUDIES

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# APPENDIX 5: TABULATED DATA FROM QUALITY ASSESSMENT BASED ON STOBE GUIDELINE

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| 1 | (a) Indicate the study's design with a commonly used term in the title or the abstract | N | Y | Y | N | Y | Y | Y | Y | Y | N |
|   | (b) Provide in the abstract an informative and balanced summary of what was done and what was found | Y | N | N | N | Y | Y | N | Y | Y | Y | Y |

| 2 | Explain the scientific background and rationale for the investigation being reported | Y | Y | N | Y | Y | Y | Y | Y | Y | Y |

| 3 | State specific objectives, including any pre-specified hypotheses | N | Y | N | Y | Y | Y | Y | Y | Y | Y |

| 4 | Present key elements of study design early in the paper | Y | N | N | Y | Y | Y | N | Y | Y | Y |

| 5 | Describe the setting, locations, and relevant dates, including periods of recruitment, exposure, follow-up, and data collection | Y | N | Y | Y | N | N | Y | N | N | Y |

| 6 | (a) Cross sectional study? Give the eligibility criteria, and the sources and methods of selection of participants | Y | Y | N | N | Y | N | N | Y | N | Y |

| 7 | Clearly define all outcomes, exposures, predictors, potential confounders, and effect modifiers. Give diagnostic criteria, if applicable | N | N | N | N | Y | N | N | Y | N | Y |

| 8* | For each variable of interest, give sources of data and details of methods of assessment (measurement). Describe comparability of assessment methods if there is more than one group | Y | N | N | Y | Y | N | N | N | Y | N |

| 9 | Describe any efforts to address potential sources of bias | N | N | Y | Y | N | N | N | N | N | N |

| 10 | Explain how the study size was arrived at | N | N | N | N | N | N | N | N | Y | N |

| 11 | Explain how quantitative variables were handled in the analyses. If applicable, describe which groupings were chosen and why | N | N | Y | N | Y | Y | N | Y | Y | Y | Y |
### Appendices

#### Statistical Methods

| 12 | (a) Describe all statistical methods, including those used to control for confounding | N | N | N | Y | Y | N | N | Y | Y | N | Y |
| (b) Describe any methods used to examine subgroups and interactions | N | N | N | Y | Y | N | N | N | Y | Y | Y |
| (c) Explain how missing data were addressed | N | N | N | N | Y | N | N | Y | N | N | N |
| (d) Cross sectional study? If applicable, describe analytical methods taking account of sampling strategy | N | N | N | N | N | N | N | N | N | N | N |
| (e) Describe any sensitivity analyses | N | N | N | N | Y | N | N | N | N | N | N |

#### Results

#### Participants

| 13* | (a) Report numbers of individuals at each stage of study? eg numbers potentially eligible, examined for eligibility, confirmed eligible, included in the study, completing follow-up, and analysed | Y | Y | Y | Y | Y | N | N | Y | Y | Y | Y |
| (b) Give reasons for non-participation at each stage | Y | N | N | N | Y | N | N | Y | Y | N | Y |
| (c) Consider use of a flow diagram | N | N | N | N | N | N | N | N | N | N | N |

#### Descriptive data

| 14* | (a) Give characteristics of study participants (eg demographic, clinical, social) and information on exposures and potential confounders | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y |
| (b) Indicate number of participants with missing data for each variable of interest | N | N | N | N | Y | N | N | Y | Y | N | N |

#### Outcome data

| 15* | Cross sectional study? Report numbers of outcome events or summary measures | Y | Y | Y | Y | Y | Y | Y | Y | N | Y | Y | N | Y |

#### Main results

| 16 | (a). Give unadjusted estimates and, if applicable, confounder-adjusted estimates and their precision (e.g., 95% confidence intervals). Make clear which confounders were adjusted for and why they were included. | N | N | Y | Y | N | Y | Y | N | Y | N | Y |
| (b). Report category boundaries when continuous variables were categorised | Y | Y | N | Y | Y | N | Na | Y | Na | Na | Na |

#### Other analyses

| 17 | Report other analyses done? eg analyses of subgroups and interactions, and sensitivity analyses | Y | N | N | N | Y | N | N | Y | N | Y | Y |

#### Discussion

<p>| 18 | Summarise key results | Y | Y | N | Y | Y | Y | Y | Y | Y | N | Y |</p>
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<th>Appendices</th>
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<th>Results</th>
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<td>Limitations</td>
<td>19 Discuss limitations of the study, taking into account sources of potential bias or imprecision. Discuss both direction and magnitude of any potential bias</td>
</tr>
<tr>
<td>Interpretation</td>
<td>20 Give a cautious overall interpretation of results considering objectives, limitations, multiplicity of analyses, results from similar studies, and other relevant evidence</td>
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<tr>
<td>Generalisability</td>
<td>21 Discuss the generalisability (external validity) of the study results</td>
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<td>Other information</td>
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| Funding | Give the source of funding and the role of the funders for the present study and, if applicable, for the original study on which the present article is based | Y   Y   N   Y   Y   N   Y   Y   Y   N   Y |

| Score | 16   12   8   18   25   13   11   22   20   13   21 |
### APPENDIX 6: QUALITATIVE CRITICAL APPRAISAL TOOL

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<tr>
<td>Was a qualitative approach appropriate?</td>
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<tr>
<td>How were the setting and the subjects selected?</td>
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<tr>
<td>What was the researcher's perspective, and has this been taken into account?</td>
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<tr>
<td>What methods did the researcher use for collecting data—and are these described in enough detail?</td>
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<tr>
<td>What methods did the researcher use to analyse the data—and what quality control measures were implemented? (Capturing truth- Validity (quant)- or Authenticity (Qual))</td>
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<tr>
<td>Are the results credible, and if so, are they clinically important?</td>
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<tr>
<td>What conclusions were drawn, and are they justified by the results?</td>
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<tr>
<td>Are the findings of the study transferable to other clinical settings? Applicability/ generalisability/ transferability</td>
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<td>Summary Critical Comments - what will you want to know later</td>
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APPENDIX 7: CHARACTERISTICS OF THE SAMPLE POPULATION

Characteristics of the Nurses and Allied Health within the sample

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<th>Absolute et al., 2011</th>
<th>Bold et al., 2008</th>
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<th>Turner et al., 2007</th>
<th>Walls et al., 2010</th>
<th>Luan, 2007</th>
<th>Napoli-Spanier et al., 2009</th>
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<th>Lake &amp; Moravek, 2007</th>
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242
Characteristics of the Medical Practitioners (physicians) within the sample

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<th>(Chinell et al., 2004)</th>
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<td>0%</td>
<td>Total 35.3%</td>
<td>66%</td>
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<td>Years experience</td>
<td>15.8 (SD 7.6)</td>
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<td>63%(5-20yrs)</td>
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## Characteristics of patients within the sample

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<th></th>
<th>(Inhoffen et al., 2010)</th>
<th>(Neumann et al., 2010)</th>
<th>(SIRM &amp; Firth, 2000)</th>
<th>(Sparks &amp; Springer et al., 2008)</th>
<th>(Zhang et al., 2006)</th>
<th>(O'Hara et al., 2004)</th>
<th>(O'Rourke et al., 2010)</th>
<th>(Zbirka et al., 2007)</th>
<th>(Endo et al., 2009)</th>
<th>(O'Byrne et al., 2009)</th>
<th>(Vermoor et al., 2007)</th>
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<td>58 (50-78)</td>
<td>62 (52-80)</td>
<td>60 (32-85)</td>
<td>67 (60-94)</td>
<td>66.4 (59-96)</td>
<td>66.4 (53-94)</td>
<td>68 (53-98)</td>
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<td>-</td>
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<td>371</td>
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<td>Breast</td>
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<td>Lung</td>
<td>Breast, prostate, colon</td>
<td>Lung</td>
<td>Lung</td>
<td>Lung</td>
<td>Lung, breast, other</td>
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<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<td>29%</td>
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<td>42.7%</td>
<td>42.7%</td>
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<tr>
<td><strong>Active treatment</strong></td>
<td>22 (27%)</td>
<td>32 (39%)</td>
<td>29%</td>
<td>29%</td>
<td>29%</td>
<td>35 (47%)</td>
<td>35 (47%)</td>
<td>35 (47%)</td>
<td>35 (47%)</td>
<td>35 (47%)</td>
<td>35 (47%)</td>
<td>35 (47%)</td>
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<tr>
<td><strong>Not active treatment</strong></td>
<td>35 (53%)</td>
<td>35 (53%)</td>
<td>47.10%</td>
<td>61%</td>
<td>61%</td>
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<td>61%</td>
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<td>61%</td>
<td>61%</td>
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</tr>
<tr>
<td><strong>Locoregional disease</strong></td>
<td>48%</td>
<td>48%</td>
<td>48%</td>
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<td>48%</td>
<td>48%</td>
<td>48%</td>
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<td>48%</td>
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<tr>
<td><strong>Metastatic disease</strong></td>
<td>52%</td>
<td>52%</td>
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<td>52%</td>
<td>52%</td>
<td>52%</td>
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<td>52%</td>
<td>52%</td>
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<td>52%</td>
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</tr>
<tr>
<td><strong>Education - high school</strong></td>
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<td>-</td>
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<td>65%</td>
<td>65%</td>
<td>65%</td>
<td>65%</td>
<td>65%</td>
<td>65%</td>
<td>65%</td>
<td>65%</td>
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</tr>
<tr>
<td><strong>Secondary</strong></td>
<td>-</td>
<td>-</td>
<td>51.7%</td>
<td>23%</td>
<td>45%</td>
<td>25%</td>
<td>45%</td>
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# APPENDIX 8: AGGREGATION OF INDIVIDUAL RESULTS

<table>
<thead>
<tr>
<th>Citation</th>
<th>Category from original paper</th>
<th>result %</th>
<th>sample size</th>
<th>Number of responses</th>
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<tbody>
<tr>
<td>No Need/ Support from elsewhere</td>
<td>I get all the help I need from other sources</td>
<td>32.00%</td>
<td>368</td>
<td>1517.968</td>
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<tr>
<td>(Eakin &amp; Strycker, 2001)</td>
<td>Enough support</td>
<td>14.29%</td>
<td>21</td>
<td>117.76</td>
</tr>
<tr>
<td>(Napoles-Springer et al., 2009)</td>
<td>No perceived need for support</td>
<td>44.10%</td>
<td>2776</td>
<td>1224.216</td>
</tr>
<tr>
<td>(Carlson et al., 2004)</td>
<td>Don't really need to attend</td>
<td>47.00%</td>
<td>100</td>
<td>47</td>
</tr>
<tr>
<td>(Endo et al., 2008)</td>
<td>Wonder if I really need medication that acts on the mind</td>
<td>56.00%</td>
<td>100</td>
<td>56</td>
</tr>
<tr>
<td>(Endo et al., 2008)</td>
<td>No need</td>
<td>67.30%</td>
<td>104</td>
<td>69.992</td>
</tr>
<tr>
<td>Lack of information about service</td>
<td></td>
<td></td>
<td></td>
<td>744.163</td>
</tr>
<tr>
<td>(Eakin &amp; Strycker, 2001)</td>
<td>I didn't know it existed</td>
<td>25.00%</td>
<td>368</td>
<td>92</td>
</tr>
<tr>
<td>(Eakin &amp; Strycker, 2001)</td>
<td>Never heard of Community partner (psychosocial service provider)</td>
<td></td>
<td>16</td>
<td>3</td>
</tr>
<tr>
<td>(Napoles-Springer et al., 2009)</td>
<td>Need more information</td>
<td>75.00%</td>
<td>16</td>
<td>12</td>
</tr>
<tr>
<td>(Carlson et al., 2004)</td>
<td>Unaware of what services are provided</td>
<td>19.20%</td>
<td>2776</td>
<td>532.992</td>
</tr>
<tr>
<td>(Kumar et al., 2012)</td>
<td>Did not know about services</td>
<td>22.70%</td>
<td>313</td>
<td>71.051</td>
</tr>
<tr>
<td>Confidence in services</td>
<td></td>
<td></td>
<td></td>
<td>499.804</td>
</tr>
<tr>
<td>(Endo et al., 2008)</td>
<td>I feel concerned about dependence and addiction</td>
<td>54.00%</td>
<td>100</td>
<td>54</td>
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<tr>
<td>(Endo et al., 2008)</td>
<td>Concerns regarding side effects (of counselling)</td>
<td>50.00%</td>
<td>100</td>
<td>50</td>
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<tr>
<td>(Endo et al., 2008)</td>
<td>Emotional burden cannot be relieved by medication</td>
<td>71.00%</td>
<td>100</td>
<td>71</td>
</tr>
<tr>
<td>(Endo et al., 2008)</td>
<td>Hesitant about visiting psychiatrist because unsure what they can do for me</td>
<td>44.00%</td>
<td>100</td>
<td>44</td>
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<tr>
<td>(Endo et al., 2008)</td>
<td>Talking about my emotions to physicians will not alter any radical treatment</td>
<td>30.00%</td>
<td>100</td>
<td>30</td>
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<tr>
<td>(Zhang et al., 2008)</td>
<td>No perceived benefit</td>
<td>10.00%</td>
<td>29</td>
<td>2.9</td>
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<tr>
<td>(Eakin &amp; Strycker, 2001)</td>
<td>Not sure services would help</td>
<td>8.40%</td>
<td>2776</td>
<td>233.184</td>
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<tr>
<td>(Carlson et al., 2004)</td>
<td>Health Provider/communication</td>
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<td>308.881</td>
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### Appendices

<table>
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<tr>
<th>Study</th>
<th>Reason</th>
<th>Percentage</th>
<th>Participants</th>
<th>Significance</th>
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<td>(Eakin &amp; Strycker, 2001)</td>
<td>My HMO provider never recommended it</td>
<td>13.00%</td>
<td>368</td>
<td>47.84</td>
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<td>(Endo et al., 2008)</td>
<td>No physician has asked about distress</td>
<td>55.00%</td>
<td>100</td>
<td>55</td>
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<tr>
<td>(Endo et al., 2008)</td>
<td>None of the physicians have time to discuss</td>
<td>52.00%</td>
<td>100</td>
<td>52</td>
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<tr>
<td>(Kumar et al., 2012)</td>
<td>Lack of physician referral</td>
<td>23.30%</td>
<td>313</td>
<td>72.929</td>
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<tr>
<td>(Napoles-Springer et al., 2009)</td>
<td>More likely to use if their oncologist had talked to them about the CP</td>
<td>63.00%</td>
<td>16</td>
<td>10</td>
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<td>(Okuyama et al., 2008)</td>
<td>Hesitation to disturb physician</td>
<td>68.30%</td>
<td>104</td>
<td>71.032</td>
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<td>Transport/travel/parking/location</td>
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<td>665.936</td>
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<td>Inconvenient location</td>
<td>7.00%</td>
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<tr>
<td>(Eakin &amp; Strycker, 2001)</td>
<td>I don't have transportation</td>
<td>4.00%</td>
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<td>14.72</td>
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<tr>
<td>(Eakin &amp; Strycker, 2001)</td>
<td>Services offered at inconvenient times</td>
<td>4.00%</td>
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<td>14.72</td>
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<td>Distance to centre</td>
<td>47.62%</td>
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<td>Transport</td>
<td>23.81%</td>
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<td>Too far to travel</td>
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<td>235.96</td>
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<td>Parking</td>
<td>8.10%</td>
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<td>Difficulty with transport and parking</td>
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<td>38.38</td>
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<td>Don't want to travel</td>
<td>37.00%</td>
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<td>37.37</td>
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<td>Having to go to hospital to participate</td>
<td>30.00%</td>
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<td>30.3</td>
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<td>Travel inconvenient</td>
<td>24.00%</td>
<td>29</td>
<td>6.96</td>
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<td>Difficulty with transport</td>
<td>7.00%</td>
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<td>21.91</td>
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<td>Too busy</td>
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<td>64.639</td>
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<td>(Eakin &amp; Strycker, 2001)</td>
<td>I'm too busy</td>
<td>7.00%</td>
<td>368</td>
<td>25.76</td>
</tr>
<tr>
<td>(Napoles-Springer et al., 2009)</td>
<td>Too busy</td>
<td>37.50%</td>
<td>16</td>
<td>6</td>
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<tr>
<td>(Zhang et al., 2008)</td>
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<td>lack of time</td>
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<td>29.109</td>
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<td>43.91</td>
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<td>(Eakin &amp; Strycker, 2001)</td>
<td>I am too sick</td>
<td>1.00%</td>
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<td>3.68</td>
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<td>Feeling too ill</td>
<td>31.25%</td>
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<td>Too unwell</td>
<td>30.00%</td>
<td>101</td>
<td>30.3</td>
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<td>(Zhang et al., 2008)</td>
<td>Health conditions</td>
<td>17.00%</td>
<td>29</td>
<td>4.93</td>
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<td>Too expensive</td>
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<td>25.979</td>
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<td>Too expensive</td>
<td>8.30%</td>
<td>313</td>
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<td>Negative perception and stigma</td>
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<td>405.802</td>
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<tr>
<td>(Eakin &amp; Strycker, 2001)</td>
<td>Uncomfortable seeking counselling</td>
<td>6.00%</td>
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<td>22.08</td>
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<td>Counselling can be more upsetting than helpful</td>
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<td>14.72</td>
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<td>My time and energy are focused on treatment</td>
<td>4.00%</td>
<td>368</td>
<td>14.72</td>
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## Appendices

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<tr>
<th>Name of service</th>
<th>% within total sample</th>
<th>Number of responses</th>
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<tbody>
<tr>
<td>No Need/ Support from elsewhere</td>
<td>38.77%</td>
<td>3915</td>
</tr>
<tr>
<td>Lack of information about service</td>
<td>19.01%</td>
<td>3915</td>
</tr>
<tr>
<td>Confidence in services</td>
<td>12.77%</td>
<td>3915</td>
</tr>
<tr>
<td>Health Provider/ communication</td>
<td>7.89%</td>
<td>3915</td>
</tr>
<tr>
<td>Transport/ travel/parking/location</td>
<td>17.01%</td>
<td>3915</td>
</tr>
<tr>
<td>Too busy</td>
<td>1.65%</td>
<td>3915</td>
</tr>
<tr>
<td>Too unwell</td>
<td>1.12%</td>
<td>3915</td>
</tr>
<tr>
<td>Too expensive</td>
<td>0.66%</td>
<td>3915</td>
</tr>
<tr>
<td>Negative perception and stigma</td>
<td>10.37%</td>
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<td>Napoles-Springer (+16 + 21)= 37</td>
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<td>Voerman -238</td>
<td>-238</td>
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<td>sample with exclusions</td>
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* note: Napoles-Springer only reported barriers for non-users (16) and previous users (21). Voerman not included – 238
## Appendices

### Patient perceived barriers

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<th>sample size</th>
<th>Result (%)</th>
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<tr>
<td><em>(Frost et al., 1997)</em></td>
<td>Lack of time</td>
<td>112</td>
<td>60.71%</td>
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<tr>
<td><em>(Frost et al., 1997)</em></td>
<td>Inadequate staffing</td>
<td>112</td>
<td>17.86%</td>
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<tr>
<td><em>(Del Giudice et al., 1997)</em></td>
<td>Time required to explain the study as their greatest concern (35.0% compared with 15.4% of nurses, ( p = 0.002 )).</td>
<td>106</td>
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<td></td>
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<td>Potential psychological damage (21.4% of physicians versus 7.8% of nurses, ( p = 0.005 ))</td>
<td>106</td>
<td>7.80%</td>
<td>8.268</td>
</tr>
<tr>
<td><em>(Frost et al., 1997)</em></td>
<td>Emphasis on tests</td>
<td>112</td>
<td>9.82%</td>
<td>11</td>
</tr>
<tr>
<td><em>(Frost et al., 1997)</em></td>
<td>Lack of comfort addressing psychosocial needs</td>
<td>112</td>
<td>3.57%</td>
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<tr>
<td><em>(Frost et al., 1997)</em></td>
<td>Lack of physician recognition of its importance</td>
<td>112</td>
<td>3.57%</td>
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<tr>
<td></td>
<td><strong>Lack of knowledge / skills</strong></td>
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<tr>
<td><em>(Frost et al., 1997)</em></td>
<td>Not knowing what is available</td>
<td>112</td>
<td>3.57%</td>
<td>4</td>
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<tr>
<td><em>(Frost et al., 1997)</em></td>
<td>Lack of nursing knowledge</td>
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<td>Lack of continuity of care</td>
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<td><em>(Frost et al., 1997)</em></td>
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<td>106</td>
<td>46.20%</td>
<td>48.972</td>
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<th>Number</th>
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## Appendices

### Nurse perceived barriers

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### Doctor perceived barriers

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<td>Preference for symptom control drug treatment over psychosocial</td>
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<td>(Del Giudice et al., 1997)</td>
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## APPENDIX 9: PERCEIVED BARRIERS TO PSYCHOSOCIAL CARE (QUALITATIVE STUDIES)

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<td>(Botti et al., 2006)</td>
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<td></td>
<td><strong>Timing of patient needs</strong></td>
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<td><strong>Lack of professional dialogue</strong></td>
<td>Cultural</td>
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<td></td>
<td><strong>Emotional burden of caring</strong></td>
<td>Individual</td>
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<tr>
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<tr>
<td></td>
<td>- Between nurse and doctors</td>
<td>Cultural</td>
</tr>
<tr>
<td></td>
<td>- Timing of communication (in isolation from nurses or to team without patient)</td>
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<tr>
<td></td>
<td>- Between nurses and nurses</td>
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<tr>
<td>(Kenny et al., 2007)</td>
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</tr>
<tr>
<td></td>
<td>- Variety of patients/ multi skilled</td>
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</tr>
<tr>
<td></td>
<td>- Resource poor</td>
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<td></td>
<td><strong>Duality of relationship</strong></td>
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<td>- Advantages and disadvantaged of rural community, being a nurse v. community member</td>
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<tr>
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<td>- Emotional burden and isolation</td>
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<tr>
<td>(Ristevski et al., 2011)</td>
<td><strong>Time (to complete screening, vs other pt needs)</strong></td>
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<td><strong>Scope of practice</strong></td>
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<td>(Turner et al., 2007)</td>
<td><strong>Pt and family related barriers</strong></td>
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<td>- Being positive</td>
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<td>- Avoidance</td>
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<td>- Intense displays of distress</td>
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<td>- Fear of making things worse</td>
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<td>- Communication skills</td>
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Appendices

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<td>- Goals of treatment</td>
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(Watts et al., 2010)

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<td>Burden of caring</td>
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<td>Inadequate communication</td>
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<tr>
<td>- Lack of professional dialogue</td>
<td>Cultural</td>
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<tr>
<td>- Lack of designated time to discuss</td>
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<tr>
<td>- Lack of suitable environment</td>
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<td>- Uncertain what to say</td>
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<td>- Lack of feedback regarding performance</td>
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<tr>
<td>Anger</td>
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<td>- Toward and from patient and family</td>
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<tr>
<td>- Toward medical staff regarding lack of control over treatment</td>
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</tr>
</tbody>
</table>

Doctors/ physicians

(Chibnall et al., 2004)

| Cultural | |
|----------||
| - Training that marginalises psychosocial care | Cultural |
| - Certain types of people selected through medical training reinforces divide between “soft” and “hard” medicine | Cultural |
| - Practice environment that continues to marginalise psychosocial care | Cultural |
| - Debt related to training costs suppress idealism associated with good psychosocial care | Cultural |
| Organisational | |
| - Dissatisfaction with medicine (problems with workload) | Organisational |
| - Time/ busyness | Organisational |
| Clinical | |
| - Communication difficulties | Individual |

(Schulman-Green, 2003)

<table>
<thead>
<tr>
<th>Role confusion (related to level of experience)</th>
<th>Organisational</th>
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</thead>
<tbody>
<tr>
<td>Disputed responsibility (“It’s not my job”)</td>
<td>Cultural</td>
</tr>
<tr>
<td>- Too busy</td>
<td>Organisational</td>
</tr>
<tr>
<td>Lack of training (“not a real doctor yet”)</td>
<td>Cultural</td>
</tr>
<tr>
<td>Problems collaborating with hospital staff</td>
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</tr>
<tr>
<td>- Lack of understanding of referral pathways</td>
<td>Organisational</td>
</tr>
<tr>
<td>- Too busy to collaborate</td>
<td>Organisational</td>
</tr>
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<td>- Unclear on roles and responsibilities</td>
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Patients

(Steele & Fitch, 2008)

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<th>Individual</th>
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<td>Individual</td>
</tr>
<tr>
<td>Existence of support networks</td>
<td>Individual</td>
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### Appendices

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<td>Limited experience using screening tools</td>
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<td>Scepticisms about benefit of distress screening</td>
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<td>Lack of time</td>
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<tr>
<td>Poor access/ referral pathways to specialist psychological services</td>
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</tr>
<tr>
<td>Lack of skills to manage</td>
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<td>Organisational</td>
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</table>

| (Absolom et al., 2011) (Nurses and Doctors/ physicians) | Regional and metropolitan hospitals not referring to support services | Organisational |
| Privately insured patients missing out |                    | Organisational |
| GPS not referring to support services |                    | Organisational |
| Late referrals to palliative care and district nursing |                | Organisational |
| Haphazard continuity of care for support needs of patients |               | Cultural       |
| Disputed responsibility for initial assessment |                | Organisational |
| Differing professional perspectives |            | Cultural       |

| (Lee, 2007) (Nurses and Allied Health) | Patient and physicians information deficits about psycho-oncology services involve or achieve. | Organisational |
| Patient and physicians subjective norms |                | Individual     |
| - Desire for normalcy and rejection of therapy |            | Cultural       |
| - Not integral to routine care/ only for terminal illness and patients with specific characteristics |      | Organisational |

| (Neumann et al., 2010) (Nurses, doctors and Patients) | Avoidance and blocking behaviours | Individual     |
| Lack of skill to address concerns raised |                    | Organisational |
| Personal resonance |                | Individual     |
Appendices Paper 3: Ethical considerations
APPENDIX 10: PARTICIPANT INFORMATION SHEETS – HEALTH PROFESSIONAL

Study Title: PROMPT study

(Promoting Optimal Outcomes in Mood through Psychosocial Therapies: a randomised trial)

Investigators:

Jane Turner: University of Queensland and Royal Brisbane and Women’s Hospital

Phone: 07 3365 5154; e-mail: jane.turner@uq.edu.au

Brian Kelly: University of Newcastle and John Hunter Hospital

Phone 02 4033 5705; e-mail: brian.kelly@newcastle.edu.au

David Clarke: Monash Medical Centre

Phone: 03 9594 1479; e-mail: david.clarke@med.monash.edu.au

Patsy Yates: Queensland University of Technology

Phone: 07 3138 3835; e-mail: p.yates@qut.edu.au

Sanchia Aranda: University of Melbourne and Peter MacCallum Cancer Centre

Phone 03 8344 0784; e-mail: Sanchia@unimelb.edu.au

Damien Jolley: Monash University

Phone 03 99030251; e-mail: damien.jolley@med.monash.edu.au

1. Your consent
You are invited to take part in this research study. The study is being conducted at 5 sites across Australia - Royal Brisbane and Women’s Hospital, John Hunter Hospital (Newcastle), Monash Medical Centre (Melbourne), Bendigo Health and Peter MacCallum Cancer Centre (Bendigo), and Haematology and Oncology Clinics of Australasia (Brisbane).

This Participant Information Sheet contains detailed information about the research study. If you agree to take part, you will be asked to sign the Consent Form. By signing the Consent Form you indicate that you understand the information and that your give your consent to participate in the research study.

You will be given a copy of both the Consent Form and this Participant Information sheet to keep as a record.

2. What is the aim of this study?

The aim of this study is to determine if mild to moderate depression and anxiety in cancer patients can be treated or prevented through a brief psychosocial Intervention delivered by Health Professionals who have received focused training. Professionals from nursing and allied health disciplines are being invited to participate.

Participation in any research study is voluntary. If you do not wish to take part in this study you are not obliged to. If you decide to take part in the study and later change your mind you are free to withdraw from the study at any stage.

Your decision about whether or not to take part, to take part and then withdraw, will not affect your work status or professional relationship with other members of the treatment team. You will also have the right to withdraw all the data you have provided if you chose to withdraw from the study.

3. What would I have to do if I participate?

Health Professionals who agree to participate will be given a self-directed manual that provides information about the emotional impact of cancer and the strategies which have been demonstrated to be effective in
reducing patient distress. The time for completion of the self-directed manual will vary but is likely to take approximately 10 hours to complete, but this may be considerably less for some participants. After completion of the self-directed training manual, Health Professionals will also participate in a skills development session, led by one of the Psychiatrist Investigators involved in the study (Jane Turner, Brian Kelly or David Clarke). The skills development will be conducted over a single day, approximately 7 hours in duration, including refreshment breaks. A period of 10 weeks is provided for participating Health Professionals to complete the training for the study. After completion of the training, participating Health Professionals will be allocated to deliver the Intervention to patients who meet specified criteria. You will be asked to keep a logbook of the number of patients for whom you provide the Intervention, noting the date, duration, mode (face-to-face or telephone), length of each session and the key themes addressed. The Intervention is described in more detail below.

After completion of the Intervention a subset of five Health Professionals at each Site will be asked to participate in a semi-structured interview lasting about 20 minutes, to seek their opinion of the experience of Training and delivery of the Intervention. You will also be asked at complete questionnaires at two time points as detailed in section 4 below. You may be asked to participate in such an interview, but this is not guaranteed. All interviews will be tape-recorded and you may ask for the tape to be stopped and sections of it deleted or edited at any time of the interview. You may also review and edit a transcript of the interview.

4. **Procedures**: If you choose to participate, you will be asked to provide baseline information about your professional background, experience and some demographic variables. You will also be asked to complete two questionnaires which should take no more than 20 minutes. These questionnaires will ask about your recent general health, emotions and feelings about your work. You will be asked to repeat these questionnaires after you have completed the Training (10 weeks after entry into the study) and again at the conclusion of the study.
The design for this study is a stepped-wedge design in which each of the participating Sites is randomly allocated to commence Training over a 10-week period, immediately followed by delivery of the Intervention over a 10-week period. This is depicted in the Table below. The study is divided into 10 week blocks. The reason for this design is that it is impossible to randomly allocate patients to receive the Intervention at a Site where some Health Professionals have undertaken the focused training, as the new skills and expertise of these Health Professionals would inevitably influence their contact with patients in the control arm. Hence the study will randomly chose when each site begins the intervention. At that time all trained Health Professionals will commence the intervention for all eligible patients. Whereas during the “control” period, information will be collected from patients but the intervention will not be undertaken.

<table>
<thead>
<tr>
<th>Site 1</th>
<th>Control</th>
<th>Training HP A</th>
<th>Intervention</th>
<th>Intervention</th>
<th>Intervention</th>
<th>Intervention</th>
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</thead>
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<tr>
<td>Site 2</td>
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<td>Training</td>
<td>Intervention</td>
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<td>Intervention</td>
</tr>
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<td>Intervention</td>
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</tr>
<tr>
<td>Site 4</td>
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<td>Control</td>
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<td>Control</td>
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<td>Intervention</td>
</tr>
<tr>
<td>Site 5</td>
<td>Control</td>
<td>Control</td>
<td>Control</td>
<td>Control</td>
<td>Training HPB</td>
<td>Intervention</td>
</tr>
<tr>
<td>Week</td>
<td>1</td>
<td>10</td>
<td>20</td>
<td>30</td>
<td>40</td>
<td>50</td>
</tr>
</tbody>
</table>

The period of time over which the Health Professional delivers the Intervention period of 50 weeks, but HPB (Health Professional B) will only be able to deliver the Intervention for a period of 10 weeks.

5. **What is the nature of the Intervention I would deliver?**

If you decide to participate you will deliver the Intervention to those patients who are currently moderately (but not severely) distressed according to a pre-determined algorithm. All patients with severe distress will be referred for Specialised Treatment and you will not have any contact with them other than in the usual course of their clinical care.

The Intervention consists of:

- *Up to a maximum* of four (4) sessions with the patient, either face-to-face or by telephone, depending on convenience.
Appendices

- All sessions to be a maximum of 30 minutes in length
- Sessions to be delivered over a maximum 4-week period.

The precise Intervention will vary depending on the particular needs expressed by the patient. **You will receive training so that you will be able to decide what is most suitable for your patient.**

Common techniques you are likely to use in your Intervention with patients include:

- Supportive/expressive - encouraging expression of emotions; validating the individual’s experiences; empathic listening, and provision of information
- Cognitive-behavioural - teaching skills in problem-solving; identifying and challenging automatic thoughts; reframing; relaxation training and guided imagery
- Dignity-conserving – encouraging reflection on themes of coherence, isolation, hope, helplessness, purpose and courage, as well as practical needs

So, for example, if you are delivering the Intervention to an anxious, socially-isolated 47 year-old woman having treatment for breast cancer you might include some relaxation techniques, and supportive/expressive techniques. In addition, if the patient had Lymphoedema you would make a referral to Physiotherapy. **At each Site there will be a clear pathway for you to follow to ensure that the patient’s practical concerns are addressed.**

6. **How many patients would I be expected to treat with the Intervention?**

This depends on a) when your Site is randomised; b) how many Health Professionals participate at your Site, and c) how many patients are eligible to receive the Intervention during each Epoch (ie each 10 week period).

We will be recruiting 20 patients at each Site at each Epoch, and anticipate that up to half of those patients may be eligible to receive the Intervention. Hence if there are 5 trained Health Professionals at your Site you would be asked to deliver the Intervention to two patients during that Epoch. Depending on whether your Site is randomised early in the
study or not, you would be asked to continue to deliver the Intervention in up to four further Epochs, that is, a total of up to 10 patients over a 50-week period.

7. **What help will I receive whilst I am delivering the Intervention?**

   **You will be supported throughout the delivery of the Intervention.** All participating Health Professionals at each Site will have weekly group discussions with the Psychiatrist Investigator for that Site, a process called Clinical Case Review. During these sessions you will have the opportunity to discuss your treatment plans for each patient, review progress and receive assistance to work on any difficulties you have encountered in delivery of the Intervention.

   These sessions will be tape-recorded to enable analysis of enablers and barriers to delivery of the Intervention.

8. **Possible outcomes or benefits**

   If you decide to participate in this study you will receive focused training and skill development which will be of direct relevance to your clinical work. Although others receiving this training in the past have reported valuable gains in confidence and professional satisfaction, we cannot guarantee that you will experience direct benefit from participating in this study.

9. **Are there any risks?**

   Any participant in the PROMPT study who feels distressed can discuss this with any of the Investigators in confidence, or their Employee Assistance Program.

   The participation of all patients in this study is voluntary.

   Patients will be allocated to receive the Intervention based on their level of distress. **You will not be asked to provide the Intervention to any patient who is severely distressed.**

   The nature of your training means that the potential for you to increase the distress of patients is very low. This risk is further reduced because of the close support you will receive in weekly Clinical Case Review
discussions, when you can receive advice about any challenges or concerns. If you have concerns about the distress of any patient you are treating during this Study you are encouraged to make contact with the Psychiatrist Investigator at your Site to arrange assessment of the patient.

10. What alternatives are there to participating in this study?
You are free to decline participation in the study without any adverse consequences to you personally or to your work. If you choose not to participate but are still interested in professional skill development in this field training programs are periodically provided by State Cancer Councils or the investigators would be able to advise you of other alternatives.

11. Privacy, confidentiality and disclosure of information
If you agree to participate in this study you will be assigned a code number, and the code number will be the only identifying information on any questionnaires that you complete and tape-recorded case review discussions and interviews in which you participate.

Any information obtained in this study which could identify you will be kept confidential. Only the staff involved in this study will have access to this information and it would only be disclosed with your permission, except if required by law.

All information about you in relation to the study, including tape-recorded case review discussions and interviews will be stored electronically and/or on paper, which will be stored in a locked office of the Investigator at the Site where you are working. Once the study has been completed your records will be kept for a period of 15 years, and then disposed of with the necessary security.

12. Results of this study
In this type of study the results will become available only after completion of all of the Interventions at all of the Sites, so it may be up to three years or more after you have participated before results of the study become available. A report will be prepared at the end of the study, and will be submitted for publication in a scientific journal, and may be
presented at scientific meetings both in Australia and internationally. You may obtain a copy of the study results by asking the Investigator for the study at your Hospital.

13. Ethical guidelines
You can contact the principal investigator about any matter of concern regarding this study:

Professor Brian Kelly, Centre for Brain and Mental Health Research University of Newcastle and Dept of Liaison Psychiatry, John Hunter Hospital

Phone 0240335690 email: brian.kelly@newcastle.edu.au

This research project has been approved by the Hunter New England Area research Ethics Committee, HNEHREC Reference No: 10/10/20/4.01

Should you have any concerns regarding your rights as a participant in this research, or you have a complaint about the manner in which the research is conducted, it may be given to the researcher, or if an independent person is preferred to:

Dr Nicole Gerrand

Professional Officer (Research ethics),

Hunter New England Area Human Research Ethics Committee

Telephone: (02) 4921 4950

Fax: (02) 4921 4818

Email: Nicole.gerrand@hunter.health.nsw.gov.au
## PARTICIPANT INFORMED CONSENT FORM - HEALTH PROFESSIONAL

| PROJECT TITLE | PROMPT study  
<table>
<thead>
<tr>
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<tbody>
<tr>
<td><strong>(Promoting Optimal Outcomes in Mood through Psychosocial Therapies: a randomised trial)</strong></td>
<td></td>
</tr>
<tr>
<td>SITE</td>
<td>John Hunter Hospital</td>
</tr>
<tr>
<td>INVESTIGATOR</td>
<td>Professor Brian Kelly</td>
</tr>
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</table>

- I have read the attached Information Sheet and understand the nature and purpose of this study and any side-effects or risks involved.
- The opportunity has been given to me to have a friend or relative present when the study was explained.
- I have had the opportunity to ask questions about this research study and am satisfied with the answers I have received.
- I freely agree to participate in this study according to the conditions in the Participant Information Sheet.
- I understand that I will be able to keep a copy of this Participant Information Sheet and Informed Consent Form.
- I acknowledge that my involvement in the study may not be of benefit to me.
- I understand that taking part in the study is voluntary and I am free to withdraw at any time I wish and this will not affect my work status or relationship with members of the treatment team in any way. If I decide to withdraw from the study I agree that the information collected about me up to the point when I withdraw may continue to be processed.
- I understand that all the information gained in the study will be treated confidentially, and that my identity and personal details will not be revealed if this study is published or presented in a public forum.

Participant Name

(printed)________________________________________________________

Signature________________________________Date:___________________
Appendices

Investigator’s Name
(printed)

Signature_________________________ Date:_________________
REVOCATION OF PARTICIPANT CONSENT FORM – HEALTH PROFESSIONAL

<table>
<thead>
<tr>
<th>PROJECT TITLE</th>
<th>PROMPT study</th>
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<td>(Promoting Optimal Outcomes in Mood through Psychosocial Therapies: a randomised trial)</td>
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<td>John Hunter Hospital</td>
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<tr>
<td>INVESTIGATOR</td>
<td>Professor Brian Kelly</td>
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</table>

I hereby wish to WITHDRAW my consent to participate in the study named above and understand that such withdrawal WILL NOT affect my current or future work status at the John Hunter Hospital.

Participant (printed)__________________________________________

Signature____________________________________Date:___________________
APPENDIX 11: ETHICAL APPROVAL DOCUMENTATION

Royal Brisbane women’s and children’s hospital

Office of the Human Research Ethics Committee
Royal Brisbane and Women’s Hospital
Queensland Health

Appendices

A/Professor John Turner
Discipline of Psychiatry
K Floor, UQ Mental Health Centre
Royal Brisbane & Women’s Hospital
Holland Q 4029

Dear Dr Turner,

Re: Ref N°: HREC/10/QRBW/316: Application of tailored psychosocial therapies to reduce distress and depression in cancer patients: a randomised trial

Thank you for submitting the above project for ethical and scientific review. This project was considered at the Royal Brisbane & Women’s Hospital Human Research Ethics Committee (HREC) meeting held on 16 August, 2010.

I am pleased to advise that the Human Research Ethics Committee has granted approval of this research project on 24 August, 2010. HREC approval is valid for three (3) years from the date of this letter.

Please note a condition of approval is that the Research Assistant will complete the “Record of Participant Decline to Consent Form” but will not ask the patient to sign this form. This information will only be kept for the purpose of collecting CONSORT data.

This HREC is constituted and operates in accordance with the National Health and Medical Research Council’s (NHMRC) National Statement on Ethical Conduct in Human Research (2007), NHMRC and Universities Australia Australian Code for the Responsible Conduct of Research (2007) and the CFIM/UNICPA Note for Guidance on Good Clinical Practice. Attached is the HREC Composition with specialty and affiliation with the Hospital (Attachment I).

You are reminded that this letter constitutes ethical approval only. You must not commence this research project at a site until separate authorization from the District CEO or Delegate of that site has been obtained.

A copy of this approval will also be sent to the District Research Governance Office (RGO). Please ensure you submit a completed Site Specific Assessment (SSA) Form to the RGO for

The Royal Brisbane & Women’s Hospital Human Research Ethics Committee is constituted and operates according to the NHMRC’s National Statement on Ethical Conduct in Human Research (2007).

Office
Post
Phone
Fax

320 Victoria St, Brisbane 4000
Post Office Box 2054
07 3062 2400
07 3062 2499
320 Victoria St, Brisbane 4000
07 3062 2400
07 3062 2499

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authorisation from the CEO or Delegate to conduct this research at the Royal Brisbane & Women’s Hospital Metro North District.

The documents reviewed and approved include:

<table>
<thead>
<tr>
<th>Document</th>
<th>Version</th>
<th>Date</th>
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<td>16 July 2010</td>
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<td>Application: NSAP</td>
<td>2.0 (2008)</td>
<td>17 June 2010</td>
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<tr>
<td>PROMPT Study Protocol</td>
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<tr>
<td>Curriculum Vitae of Margaret Jane Turner</td>
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<tr>
<td>Curriculum Vitae of Lisa McFadyan</td>
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<tr>
<td>Curriculum Vitae of Maryanne Hargraves</td>
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<tr>
<td>Curriculum Vitae of Damien John Jelley</td>
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<td>Curriculum Vitae of David Murray Clarke</td>
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<td>Curriculum Vitae of Professor Paty Yassa</td>
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<td>Curriculum Vitae of Sanchia Kaye Aranda</td>
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<tr>
<td>Curriculum Vitae of Professor Suzanne Chambers (Stegenga)</td>
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<td>Curriculum Vitae of Brian Kelly</td>
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<td>Letter of funding approval from beyondblue - The National Depression Initiative</td>
<td>27 November 2009</td>
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<td>Letter of endorsement of clinical privileges for Dr Margaret Jane Turner at the RBWH from Dr David Alcorn, Executive Director, valid until 26.02.2012</td>
<td>25 March 2009</td>
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<tr>
<td>Letter of acceptance of clinical privileges from Dr Margaret Jane Turner</td>
<td>29 March 2009</td>
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<td>4 – English (Universal)</td>
<td>16 November 2007</td>
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<td>FACT-G Questionnaire</td>
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<td>Log Book of Clinical Contacts</td>
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<td>Semi-Structured Interview with Health Professional</td>
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<tr>
<td>Supportive Care Needs Survey - Short Form 34 (SCNS-34)</td>
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<td>Health Professional Log Book – Recording Details of Therapy and Case Review</td>
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<td>Psychosexual Care Referral Checklist for Patients with Cancer</td>
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<td>General Health Questionnaire</td>
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<tr>
<td>MOH Human Services Survey</td>
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Appendices

| Response to Request for Further Information | 20 August 2010 |
| Participant Information Sheet & Consent Form | 20 August 2010 |
| Response to Request for Further Information | 24 August 2010 |
| Participant Information Sheet & Consent Form - Health Professional | 24 August 2010 |

Please note the following conditions of approval:

1. The Principal Investigator will immediately report anything which might warrant review of initial approval of the project in the specified format, including:
   - Unforeseen events that might affect continued ethical acceptability of the project. 
   - Serious Adverse Events must be notified to the Committee as soon as possible.
   - In addition, the Investigator must provide a summary of the adverse events, in the specified format, including a comment as to suspected causality and whether changes are required to the Patient Information and Consent Form. In the case of Serious Adverse Events occurring at the local site, a full report is required from the Principal Investigator, including duration of treatment and outcome of event.

2. Amendments which do not affect either the ethical acceptability or site acceptability of the project (e.g., typographical error) should be submitted in hard copy to the HREC Coordinator. These should include a covering letter from the Principal Investigator providing a brief description of the changes and the rationale for the changes, and accompanied by all relevant updated documents with tracked changes.

3. Proposed amendments to the research project which may affect both the ethical acceptability and site suitability of the project must be submitted directly to the HREC for review and, once HREC approval has been granted, then submitted to the Research Governance Office.

4. Amendments to the research project which only affect the ongoing site acceptability of the project are not required to be submitted to the HREC for review. These amendment requests should be submitted directly to the Research Governance Office (by-passing the HREC).

5. Amendments to the research project which may affect the ongoing ethical acceptability of a project must be submitted to the HREC for review. Major amendments should be discussed in advance with the HREC Coordinator. Minor amendments should be submitted with a cover letter from the Principal Investigator, providing a brief description of the changes, the rationale for the changes, and their implications for the ongoing conduct of the study. Hard copies of the revised NEAR, the cover letter and all relevant updated documents with tracked changes must also be submitted to the HREC Coordinator in accordance with the HREC SOP. Further advice on submitting amendments is available from http://www.health.qld.gov.au/main/content/researcher_ensureable.pdf

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6. The HRREC will be notified, giving reasons, if the project is discontinued at a site before the expected date of completion.

7. The HRREC will be notified, giving reasons, on any sponsor reports or other information which might affect the ongoing ethical acceptability in line with the requirements of the ICH GCP guideline as annotated by the TGA: http://www.tga.gov.au/docs/pdf/guides/ich-vch13505.pdf

8. The Principal Investigator will provide an Annual Report to the HRREC and at completion of the study in the specified format.

9. The District Administration and the Human Research Ethics Committee may inquire into the conduct of any research or purported research, whether approved or not and regardless of the source of funding, being conducted on Hospital premises or claiming any association with the Hospital, or which the Committee has approved if conducted outside Royal Brisbane & Women’s Hospital Metro North Health Service District.

Should you have any queries about the HRREC’s consideration of your project please contact the HRREC Coordinator on 07 3650 5490. The HRREC terms of Reference, Standard Operating Procedures, membership and standard forms are available from http://www.health.qld.gov.au/rebmss/html/research.htm.

Once authorisation to conduct the research has been granted, please complete the Commencement Form (Attachment II) and return to the office of the Human Research Ethics Committee. The HRREC wishes you every success in your research.

Yours sincerely,

[Signature]

Deputy Chairperson
HRWII Human Research Ethics Committee
Metro North District
20.08.2010
Appendices

University of Queensland

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THE UNIVERSITY OF QUEENSLAND
Institutional Approval Form for Experiments on Humans Including Behavioural Research

<table>
<thead>
<tr>
<th>Chief Investigator:</th>
<th>A/Prof Jane Turner</th>
</tr>
</thead>
<tbody>
<tr>
<td>Project Title:</td>
<td>PROMPT Study: Promoting Optimal Outcomes in Mood Through Psychosocial Therapies: A Randomised Trial</td>
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<tr>
<td>Supervisor:</td>
<td>None</td>
</tr>
<tr>
<td>Co-Investigator(s):</td>
<td>Brian Kelly, David Clarke, Patsy Yates, Sanchia Aranda, Damien Jolley</td>
</tr>
<tr>
<td>Department(s):</td>
<td>Discipline of Psychiatry, School of Medicine</td>
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<tr>
<td>Project Number:</td>
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<tr>
<td>Granting Agency/Degree:</td>
<td>beyondblue</td>
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<tr>
<td>Duration:</td>
<td>31st December 2013</td>
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Comments:

 Expedited review on the basis of approval from the Royal Brisbane and Women's Hospital HREC, dated 26/08/2010.

Name of responsible Committee:-
Medical Research Ethics Committee
This project complies with the provisions contained in the National Statement on Ethical Conduct in Human Research and complies with the regulations governing experimentation on humans.

Name of Ethics Committee representative:-
Professor Bill Vicenzino
Chairperson
Medical Research Ethics Committee

Date: 9-9-10 Signature: ____________________________
Haematology and Oncology Clinic Australia (HOCA)

Dear Assoc. Professor Maryanne Hargraves,

Re: PROMPT study: Promoting Optimal Outcomes in Mood through Psychological Therapies: a randomized trial.
Application No: 2010-11-650
Principal Investigator: Maryanne Hargraves
Application Type: NEW
Review Type: FULL BOARD

The Documents Reviewed and Approved Include:
01_RRWH_Response to Ethics Review Comments Dated 30 Aug 2010.pdf - 08-Nov-10
02_RRWH_Ethics Approval Correspondence Dated 26 Aug 2010.pdf - 08-Nov-10
03_RRWH_Governance 23 Aug 2010 Signed pdf - 08-Nov-10
04_UQ_Ethics Approval 09 Sep 2010.pdf - 08-Nov-10
CV - Maryanne Hargraves.pdf - 10-Nov-10
Health Professional Logbook.pdf - 08-Nov-10
Health Professional MHS Human Services Survey.pdf - 08-Nov-10
Health Professional_MHS Human Services Survey_Reserved.pdf - 14-Nov-10
HOCA_Current Health Professional_PSCF_V1_08 Nov 2010_Clean.docx - 08-Nov-10
HOCA_Current Health Professional_PSCF_V2_09 Dec 2010_Clean.docx - 14-Nov-10
HOCA_Current Health Professional_PSCF_V2_09 Dec 2010_Tied.docx - 14-Nov-10
HOCA_PSCF_V1_08 Nov 2010_Clean.docx - 08-Nov-10
HOCA_PSCF_V2_09 Dec 2010_Clean.docx - 14-Nov-10
HOCA_PSCF_V2_09 Dec 2010_Tied.docx - 14-Nov-10
Participant Log Book of Clinical Contacts.pdf - 08-Nov-10
Participant_Demographic_Scales.pdf - 08-Nov-10
Participant_EQ-5D Health Questionnaire Dated 16 Nov 2007.pdf - 08-Nov-10
Appendices

Participant Outcome Health Questionnaire.pdf - 08Nov-10
Participant Clinical Assessment of Depression Scale (HADS).pdf - 08Nov-10
Participant ANZCN (Nose Thermometer.pdf - 08Nov-10
Participant Supportive Care Needs Survey Short Form 54 (RNNAF54).pdf - 08Nov-10
PHNOM7 (Protest).pdf - 08Nov-10
Prehospital Care Initial Checklist Draft 2008.pdf - 08Nov-10

Date of Meeting: 24Nov-10
Date of Approval: 15Dec-10
Period of Approval: 15-Dec-10 - 31-Dec-13

Thank you for submitting the above mentioned application.

The Bellberry Human Health Ethics Committee (HREC) reviewed this study on the above stated date.

This HREC is constituted and operates in accordance with the National Health and Medical Research Council’s National Statement on Ethical Conduct in Human Research (2009) (National Statement).

I wish to advise that the Bellberry Health Research Ethics Committee has approved this project and that the application meets the requirements of the National Statement subject to the conditions mentioned below.

CONDITIONS:

- IF THIS IS A NEW RESEARCH STUDY YOU MUST ACKNOWLEDGE YOUR AGREEMENT TO THE UNDERTAKING OF THE RESEARCH via email.
- The data collected for this purpose of this research project cannot be used for any other purpose without the approval of the Bellberry Human Research Ethics Committee. Requests to use data for other purposes must be made in the form of a formal research proposal.
- All research data, including electronic data to be used by the Principal Investigator for 11 years after the research has been completed or after the last contact, whichever is the later. Data must be recorded in a durable and appropriately formatted form and comply with relevant privacy protocols.
- Data used in all research reports must be submitted to the Human Research Ethics Committee at the time of the report on the progress of the research will be made to the Bellberry Human Research Ethics Committee on 15-Dec-11 or on completion of the study. The report must indicate whether any adverse events or complications have occurred, particularly side effects, and any other factor which may cause the investigation not producing any result (as distinct from the anticipated result).
- That you will notify the Bellberry Human Research Ethics Committee of any changes that may be required within the research proposal.
Appendices

Bellberry Limited Supporting Research and Ethics

- Delivery Human Research Ethics Committee approved in conditional approval meeting any necessary obligations that you may have in relation to this project.
- Adverse Event reporting should be reported to the Bellberry Human Research Ethics Committee as per the monitoring guidelines posted on the website www.bellberry.com.au.
- Any extension to the initial approval period is to be requested in an application via the eProtocol system together with the inclusion of a progress report.
- You will provide a copy of the sponsor's final report when this becomes available.

This study has been given the above reference number. Please remember to log in to eProtocol for all further correspondence with the Committee.

Please do not hesitate to contact me if further clarification is required.

Yours sincerely,

Michael James
CHAIRMAN
BELLBERRY HUMAN RESEARCH ETHICS COMMITTEE

Principal Investigator Signature: __________________________ DATE: __________________
Peter MacCallum Cancer Centre

Appendices

Peter Mac Project No: 10/121

Project Title:
Application of tailored psychosocial therapies to reduce distress and depression in cancer patients; A randomised trial.

Principal Investigator: Prof Sachia Aranda

Approval Date: 7 February 2011
Approval Expiry: 7 February 2016

I am pleased to advise that the above project has received ethical approval and satisfies Peter Mac research governance requirements and may now be conducted at Peter MacCallum Cancer Centre. Conduct of the project is subject to compliance with the conditions set out below.

Approved Documents:

- Protocol PROMPT study version 5, dated 26 August, 2010
- Participant Information and Consent Form - Patient version 5, dated 2 February 2011
- Participant Information and Consent Form - Health Professional version 5, dated 2 February 2011
- Questionnaire and study instruments as follows:
  - General Health Questionnaire (Psych Med 1979; 9:139-145)
  - MBI Human Service Survey (Consulting Psychologists Press Inc. © 2008)
  - Prompt Study Log Book of Clinical Contacts, undated
  - Prompt Study Semi-structured Interview with Health Professional, undated
  - Protocol Thermometer (National Comprehensive Cancer Network © 2005)
  - Hospital Anxiety and Depression Scale (HADS) (Acta Psych Scand 1983; 67: 361-370)
  - Psychosocial Care Referral (Checklist for Patients with Cancer (National Breast and Ovarian Cancer Centre © 2006)
  - Supportive Care Needs Survey Short Form 41 (SCNS-SF41) (Centre for Health Research & Psycho-oncology 2003)
  - FACT-G (Version 4) (© 1997)
  - EQ-SD (EuroQol Group© 1998)
  - Demoralisation Scale (J Pall Care 2004; 20:269-276)
  - Clinical Trial Research Agreement between Peter MacCallum Cancer Centre and the University of Queensland version (Protocol Number: ACTRN1261000048044 V5) dated March 2010

In order to comply with the National Statement on Ethical Conduct in Human Research (2007), Guidelines for Good Clinical Research Practice and local research policies and guidelines, you are required to notify the Peter MacCallum Cancer Centre Ethics Committee Secretariat of:

- The actual start date of the project at Peter MacCallum Cancer Centre;
- Any proposed amendments to the project including any proposed changes to the Protocol, Participant Information and Consent Form/s or Investigator’s Brochure;

Patron: Professor David de Kretser AC Governor of Victoria
• Any adverse events involving patients of Peter MacCallum Cancer Centre, in accordance with the Peter MacCallum Cancer Centre Guidelines for Safety Reporting;
• Any unexpected developments in the project with ethical implications;
• Your ability to continue as Principal Investigator and any other change in research personnel involved in the project at Peter MacCallum Cancer Centre;
• Any proposed extension to the duration of the project, past the above stated approval date;
• Any decision taken to end the project prior to the expected date of completion or of withdrawal of Peter MacCallum Cancer Centre as a site participating in the project.

You are also required to submit to the Ethics Committee Secretariat:

• An Annual Progress Report every 12 months for the duration of the project. This report is due on the anniversary of HREC approval. Note: Continuation of ethics approval is contingent on submission of an annual report in a timely manner; and
• A comprehensive Final Report upon completion of the project.

Additional Conditions:

• Submit a copy of this letter to the person responsible for radiation safety at Peter MacCallum Cancer Centre. This condition applies only if the project involves exposure to ionising radiation and the Peter MacCallum Radiation Safety Officer has advised that the project needs to be added to the site's Licence for Research Involving Human Volunteers issued by the Department of Health Radiation Safety Section. Note: A project cannot commence at Peter Mac until you have confirmed that the project has been added to the site's licence.

The Peter MacCallum Cancer Centre Ethics Committee may conduct an audit of the project at any time.

Please refer to the Peter MacCallum Cancer Centre Ethics Committee Secretariat website for access to forms, policies and guidelines and other information and news concerning research at Peter MacCallum Cancer Centre.

The Peter MacCallum Cancer Centre Ethics Committee is organised and operates according to the NHMRC National Statement on Ethical Conduct in Research Involving Humans (2007) and in accordance with the Note for Guidance on Good Clinical Practice (CPMP/ICH/135/95) and the Health Privacy Principles enunciated in the Health Records Act 2001 (Vic) and Section 95A of the Privacy Act 1988 (and subsequent Guidelines).

Please be advised that the Principal Researcher and any Associate Researchers named on the application did not participate in deliberative discussions or decision-making regarding the project. A list of those Ethics Committee members present at the review of this project can be obtained upon request.

Yours sincerely,

Dr Deanne Snowden
Acting Ethics Coordinator
Ethics Committee Secretariat
HUMAN RESEARCH ETHICS COMMITTEE A
CERTIFICATE OF APPROVAL

DATE: 21 December 2010
PROJECT NO. 10315A
PROJECT TITLE: Application of tailored psychosocial therapies to reduce distress and depression in cancer patients: a randomised trial

Participant Information Sheet Version No. 3 dated 13 December 2010
Participant Informed Consent Form Version No. 3 dated 13 December 2010
Record of Participant Decline to Consent - Patient Version No. 3 dated 13 December 2010
Revocation of Participant Consent Form Version No. 3 dated 13 December 2010

Participant Information Sheet – Health Professional Version No. 4 dated 13 December 2010
Participant Informed Consent Form – Health Professional Version No. 4 dated 13 December 2010
Revocation of Participant Consent Form – Health Professional Version No. 3 dated 13 December 2010

INVESTIGATOR(S) Prof David Clarke
HREC MEETING DATE 02 December 2010

APPROVAL: 21 December 2010 to 21 December 2013

The Principal Investigator is required to notify the Administrative Officer, Research Directorate of:

1. Any change in protocol and the reason for that change together with an indication of ethical implications (if any)
2. Serious or unexpected adverse effects of project on subjects and steps taken to deal with them
3. Any unforeseen events that might affect continued ethical acceptability of the project
4. Any expiry of the insurance coverage provided in respect of sponsored trials
5. Discontinuation of the project before the expected date of completion, giving reasons
6. Any changes in personnel involved in the research project including any study member resigning from Southern Health &/or the study team.

At the conclusion of the project or every twelve months if the project continues, the Principal Investigator is required to complete and forward an annual report to the Committee.

Annual report forms will be forwarded to the researcher.

SIGNED ………………………………………………………………………………… DATE 21 December 2010
Committee Representative

Please quote Project No. and Title for all correspondence

Southern Health
Monash Medical Centre...
Hunter New England Health

13 July 2011

Associate Professor Jane Turner
Discipline of Psychiatry
K Floor, Mental Health Centre
Herston QLD 4029

Dear Professor Turner

Re: PROMPT (Promoting Optimal Outcomes in Mood through Psychosocial Therapies: a randomised trial) (10/11/17/4.01)

HNEHREC Reference No: 10/11/17/4.01
NSW HREC Reference No: HREC/10/HNE/325
SSA Reference No: SSA/10/HNE/399

Thank you for submitting a request for an amendment to the above project. This amendment was reviewed by the Hunter New England Human Research Ethics Committee. This Human Research Ethics Committee is constituted and operates in accordance with the National Health and Medical Research Council’s National Statement on Ethical Conduct in Human Research (2007) (National Statement) and the CPMP/ICH Note for Guidance on Good Clinical Practice. Further, this Committee has been accredited by the NSW Department of Health as a lead HREC under the model for single ethical and scientific review.

I am pleased to advise that the Hunter New England Human Research Ethics Committee has granted ethical approval for the following amendment requests:

- For the Protocol (Version 7 dated 9 May 2011);
- For the Participant Information Sheet and Consent Form (Version 4 dated 11 July 2011); and
- For the Participant Information Sheet and Consent Form – Health Professional (Version 5 dated 11 July 2011)

For the protocol PROMPT (Promoting Optimal Outcomes in Mood through Psychosocial Therapies: a randomised trial)

Approval has been granted for this study to take place at the John Hunter Hospital site.

Approval from the Hunter New England Human Research Ethics Committee for the above protocol is given for a maximum of 3 years from the date of the approval letter of your initial application, after which a renewal application will be required if the protocol has not been completed. The above protocol is approved until November 2013.

Hunter New England Human Research Ethics Committee
(Locked Bag No 1)
New Lambton NSW 2305
Telephone (02) 49214 950 Facsimile (02) 49214 818
Email:hnehrec@hnehealth.nsw.gov.au

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The National Statement on Ethical Conduct in Human Research (2007) which the Committee is obliged to adhere to, include the requirement that the committee monitors the research protocols it has approved. In order for the Committee to fulfil this function, it requires:

- A report of the progress of the above protocol be submitted at 12 monthly intervals. Your review date is November 2011. A proforma for the annual report will be sent two weeks prior to the due date.

- A final report must be submitted at the completion of the above protocol, that is, after data analysis has been completed and a final report compiled. A proforma for the final report will be sent two weeks prior to the due date.

- All variations or amendments to this protocol, including amendments to the Information Sheet and Consent Form, must be forwarded to and approved by the Hunter New England Human Research Ethics Committee prior to their implementation.

- The Principal Investigator will immediately report anything which might warrant review of ethical approval of the project in the specified format, including:
  - any serious or unexpected adverse events
    - Adverse events, however minor, must be recorded as observed by the investigator or as volunteered by a participant in this protocol. Full details will be documented, whether or not the investigator or his deputies considers the event to be related to the trial substance or procedure.
    - Serious adverse events that occur during the study or within six months of completion of the trial at your site should be reported to the Professional Officer of the Hunter New England Human Research Ethics Committee as soon as possible and at the latest within 72 hours.
    - Copies of serious adverse event reports from other sites should be sent to the Hunter New England Human Research Ethics Committee for review as soon as possible after being received.
    - Serious adverse events are defined as:
      - Causing death, life threatening or serious disability.
      - Cause or prolong hospitalisation.
      - Overdoses, cancers, congenital abnormalities whether judged to be caused by the investigational agent or new procedure or not.
      - Unforeseen events that might affect continued ethical acceptability of the project.

- If for some reason the above protocol does not commence (for example it does not receive funding); is suspended or discontinued, please inform Dr Nicole Gerrand, the Professional Officer of the Hunter New England Human Research Ethics Committee as soon as possible.

The Hunter New England Human Research Ethics Committee also has delegated authority to approve the commencement of this research on behalf of the Hunter New England Local Health District. This research may therefore commence.
Should you have any queries about your project please contact Dr Nicole Gerrand as per the contact details at the bottom of the page. The Hunter New England Human Research Ethics Committee Terms of Reference, Standard Operating Procedures, membership and standard forms are available from the Hunter New England Local Health District website: Internet address: http://www.hnehealth.nsw.gov.au/research_ethics_and_governance_unit

Please quote 10/11/17/4.01 in all correspondence.

The Hunter New England Human Research Ethics Committee wishes you every success in your research.

Yours faithfully

For: Associate Professor M Parsons
Chair
Hunter New England Human Research Ethics Committee
APPENDIX 12: THESIS BY PUBLICATION
INFORMATION SHEET

Office of Graduate Studies
Information Sheet
Thesis by Publication

The Rules Governing Research Higher Degrees allow for a thesis to be submitted in the form of a series of published papers and the additional rules specific to this style of thesis are presented below. It is important to note that the general rules for a University of Newcastle thesis are also applicable. Please ensure you also refer to Rule 38 within the above rule link.

Rule 39.1 A thesis by publication will include:
   i. a full explanatory overview included to link the separate papers and to place them in the context of an established body of knowledge;
   ii. a literature review;
   iii. if detailed data and descriptions of methods are not otherwise given within the separate papers, they must be included in the body of the thesis or as appendices to the thesis;

Rule 39.2
39.2 For a thesis by publication:
   i. the separate papers provided under sub-clause 39.1(i) must be published, in press or submitted to scholarly media only, i.e. refereed publications classified by current national standards and refereed conference papers, however at least 50% of these papers must have been published. Papers published up to three years prior to enrolment may be included provided they were published in scholarly media and do not represent more than 50% of the total papers;
   ii. publications submitted by the candidate for another degree may only be referred to in the thesis literature review;
   iii. the number of papers submitted should be sufficient for the body of work to constitute a significant and original contribution to knowledge;
   iv. the candidate must be the lead author in at least 50% of the papers written in the time of their formal Research Higher Degree candidature. Any published paper of which the candidate is a joint author may only be included in the thesis provided the work done by the candidate is clearly identified. The candidate must include in the thesis a written statement from each co-author attesting to the candidate’s contribution to a joint publication included as part of the thesis. These statements must be endorsed by the Assistant Dean (Research Training);
   v. the Assistant Dean (Research Training) may seek the approval of the Dean of Graduate Studies to include a paper that is outside the scope of these rules.

Issues to consider

- Each discipline area will have different issues to consider in the decision to submit a thesis in the form of a series of published papers.

- It is essential that you discuss your options carefully with your supervisor(s). The thesis must reflect a sustained and cohesive theme, an integrated whole that sits logically in the context of the available literature. Overall the material presented for examination needs to equate to that which would otherwise be presented in the traditional thesis format.

- Some journals take a long time to finalise the review process and waiting for papers to be accepted can delay thesis submission. Time management and selection of journals/publishers is critical. Focusing on publication rather than research may lead to candidates being tempted to publish sections of their work prematurely and missing opportunities to fully capitalize on the significance of the work.

- You need to consider the thesis from the examiners’ viewpoint - if the publications do not have a clear cohesion and the contribution to knowledge is not clearly demonstrated, then the thesis
Appendices

may attract criticism and be rejected by examiners. The content of the thesis remains a matter of professional judgment for the supervisor(s) and candidate.

- Any published paper of which the candidate is a joint author may only be included in the thesis provided the work done by the candidate is clearly identified. The candidate must include in the thesis a written statement from each co-author attesting to the candidate’s contribution to a joint publication included as part of the thesis. The statement(s) need to be signed by the Faculty Assistant Dean (Research Training). A sample statement is provided below.

- We strongly advise you to arrange for the signatures from co-authors to be collected as soon as the paper is prepared or submitted for publication rather than trying to collect them at the time of thesis submission.

- There is no minimum or maximum requirement on the number of papers. Of equal, or perhaps more importance than quantity, is the quality of the journals.

Other options

As discussed above, you need to consider if your publications will form a sufficient body of work to meet the requirements of thesis by publication. You may wish to consider the other option of including publications within a standard thesis format, either in the body or as an appendix as supported in the rule below.

**Rule 38.5.** A thesis may:

i. Include publications arising as a consequence of the research undertaken for a thesis. When the candidate includes a co-authored published paper or co-authored scholarly work, or a substantive component of a co-authored published paper or co-authored scholarly work in the body of the thesis, the candidate must include in the thesis a written statement attesting to their contribution to the joint publication. This statement must be signed by the supervisor. A statement is not required when publications are included as an appendix to the thesis.

Suggested format

1. Title Page

2. Declaration

   “I hereby certify that this thesis is submitted in the form of a series of published papers of which I am a joint author. I have included as part of the thesis a written statement from each co-author, and endorsed by the Faculty Assistant Dean (Research Training), attesting to my contribution to the joint publications.”

3. Acknowledgements

4. List of publications included as part of the thesis

   4.1 List all of the included published work with the full bibliographic citations in the order they appear in the thesis.

   4.2 Provide a statement to indicate that where necessary permission regarding copyright has been obtained from copyright owners. For example, the statement may say “I warrant that I have obtained, where necessary, permission from the copyright owners to use any third party copyright material reproduced in the thesis (e.g. questionnaires, artwork, unpublished letters), or to use any of my own published work (e.g. journal articles) in which the copyright is held by another party (e.g. publisher, co-author).”
5. Statement of Contribution of Others
   Include in the thesis a written statement from each co-author attesting to the candidate’s
   contribution to a joint publication included as part of the thesis. The purpose of this statement is
   to summarise and clearly identify the nature and extent of the intellectual input by the
   candidate and any co-authors.

5.1 Sample co-author statement
   I, (insert co-author’s name in full), attest that Research Higher Degree candidate (insert name)
   contributed (insert outline of contribution) to the paper/publication entitled (insert reference
   details).

   (Signature of Co-Autho)  
   (Full Name of Co Author)  
   Date:  

   (Signature of Candidate)  
   (Full Name of Candidate)  
   Date:  

   (Signature of Assistant Dean Research Training (ADRT))  
   (Full Name of ADRT)  
   Date:  

6. List of additional publications
   List additional publications and conference presentations which have relevance to the thesis,
   but are not included in it. List these alphabetically and chronologically.

7. Table of Contents

8. Abstract
   An abstract of approximately 300 words is required to describe the content of the thesis.

9. Overview
   A full explanatory overview is required to link the published papers to the research thesis. This
   may include sections for Literature Review, Research Design and Review/Discussion. Not all
   of these sections may be necessary. Choose the format that underpins the academic argument
   so that the contents of the thesis are established as a substantial and significant body of work,
   but without unnecessary repetition.

10. Published papers
    Each chapter should have an introduction to explain how it contributes to the overall body of
    knowledge. Where the candidate is relying on publications, the author’s final version of the
    paper (the version of the paper accepted by the journal for publication, including all
    modifications from the publishing per review process) would normally be included. It is not
    necessary to reformat published works in the thesis. Publications can be included in full or in
    parts thereof, where appropriate, to substantiate the contribution to knowledge.

11. Appendices
    Appendices may include permission letters regarding copyright, evidence supporting refereed
    status of publications such as conference papers, and acceptance of papers which have not
    yet appeared in print.

12. Bibliography
    List all references cited in the thesis.
Appendices References


Kumar, P., Casarett, D., Corcoran, A., Desai, K., Li, Q., Chen, J., . . . Mao, J. J. (2012). Utilization of Supportive and Palliative Care Services among Oncology Outpatients at One Academic Cancer Center: Determinants of
Use and Barriers to Access. *Journal of Palliative Medicine, 15*(8), 923-930. doi: 10.1089/jpm.2011.0217


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Razavi, D., Merckx, W., Marchal, S., Libert, Y., Conradt, S., Boniver, J., . . . Delvaux, N. (2003). How to Optimize Physicians' Communication Skills in...
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innovation. *Journal of Psychiatric and Mental Health Nursing*, 16(10), 895-903.


