Assessment strategies used by clinical supervisors focusing on community mental health care: A cross-sectional study

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Abstract

Clinical supervision is effective for preventing the burnout of community mental health professionals. However, the tacit knowledge of the clinical supervisors who assessed the issues associated with community mental health care has not yet been elucidated. The purpose of this study was to clarify the assessment strategies used by clinical supervisors who are focused on community mental health care. This was a cross-sectional study, in which content analysis was performed on the supervisors' advices regarding the assessment of each community mental healthcare professional. Among the 309 cases, we identified 2 main types of assessment strategies used by clinical supervisors, namely, 'clarification of the present and future health issues of the person with mental illness and his/her family' and 'consideration of a support plan for the person with mental illness and his/her family'. The clinical supervisors assessed the health issues and future problems of the person with mental illness and their family, and also identified inappropriate care provided by the community mental health professionals. Our findings contribute towards improving the quality of care for people with mental illness and their families. Our results indicated that clinical supervisors try to communicate effectively with professionals from multiple disciplines, to enhance collaboration between professionals, and to prevent the burnout of mental health professionals.

Key words: clinical supervision, community, mental health care, assessment, multidisciplinary teams, tacit knowledge

❖Introduction

Preventing burnout syndrome of community mental health professionals is important for reducing their turnover and improving the quality of care for psychiatric patients. Burnout is a type of work-related stress that is characterized by emotional exhaustion and a lack of personal accomplishment. Mental health professionals have a high vulnerability to burnout because of role conflicts, work overload, and high levels of emotional stress[1)2)]. Daily casework is emotionally intensive as the mental health conditions of the patients frequently change[3)4]. Emotional exhaustion of mental health professionals has been associated with reductions in job performance and increases in absenteeism[5)6)]. Furthermore, for an organization, a high turnover of mental health professionals is a financial burden as it requires frequent advertisement and the recruitment of new staff, as well as their training[7)8)].

Clinical supervision is an effective method for preventing the burnout and turnover of community mental health staffs[9)]. It has significantly positive effects on the moral of employees, leading to a reduction in work-related stress, which enables the employees to better reflect on their practice and manage clinical risk, resulting in an improvement in their daily job performance[10)-14)]. Clinical supervision has also become the buffer against negative job experiences and intrapersonal conflict of healthcare professionals[15)]. Improvements in community mental health care and its delivery have led to a demand for collaboration amongst professionals of many disciplines[16)]. In addition, clinical supervisors (CS) are known to play a key role in providing information to

and improving the care for patients and service users in a safe way[17]. Furthermore, CSs also use their tacit knowledge when assessing the issues associated with community mental health care; however this empirical knowledge remains unclear as it has not been shared amongst mental health professionals[18].

In Japan, community mental health care is coordinated by municipal public health nurses and social workers. In 2004, the Japanese policy on mental health changed from providing hospital-centered care to providing community-based care, with the aim of improving the quality of life of mentally ill persons[19]. As a result, although many mentally ill inpatients have been discharged from hospitals into the community, mental health care services have been insufficient[20]. Experiencing difficulties in providing mental health care to the patients, over work, emotional issues related to clinical skills and low job control were identified as environmental factors associated with the burnout of community mental health professionals[3)21]. High workload and lack of social resources have also been found to be triggers of burnout[22]. Problematic factors that were identified from the difficult cases were divided into three areas: patients' factors, social factors and inappropriate care by the healthcare professionals[23)24]. However, clinical supervision programs for community mental health professionals are not widely used in Japan[25]. It is unclear as to how CSs assess the community mental health care that is provided by the mental health professionals despite differences in the sociological issues and characteristics of each patient that the mental health professionals care for. Clarification of the assessment strategies used by the CSs would help to improve the skills of the community mental health professionals, as well as help the mental health professionals to protect their own mental health.

The purpose of this study was to clarify the assessment strategies used by the CSs who focused on community mental health care in Japan.

❖Methods

1 Study design and study sample

A cross-sectional study was conducted to identify the CSs' assessment strategies associated with community mental health care.

The study was performed in one Japanese municipality. A research agreement was signed by both the researchers and the local government office. In 2006, a series of psychiatric supervision services were initiated to assist healthcare professionals who experienced difficulties in carrying out their work in this municipality. The psychiatrists, the public health nurse and the psychiatric social worker supported this clinical supervision program as the CS. We studied five CSs, involved in the supervision services, including 3 psychiatrists, a public health nurse and a psychiatric social worker. By obtaining anonymous data from the public health center, we analyzed 372 cases that used the supervision program from 2006 to 2012. This data included advice of the CSs about the community mental health professionals' care for the people with mental illness. We also obtained the demographic characteristics of the persons with mental illness, including age, sex, years of schooling, business experience, receipt of welfare benefit, living status, existence of a key family person, requirement of long-term care for his/her parents, abuse of the elderly, having children, whether the person had previously committed child abuse, having a primary psychiatrist, history of interruption of psychiatric treatment, past hospitalization history in a psychiatric unit, and risk of self-harm and/or inflicting injury on others.

2 Data analysis

Sixty-three cases were excluded because of a large amount of missing data, thus resulting in a total of 309 cases. Users of the clinical supervision program and demographic characteristics of the persons with mental illness were analyzed using PASW Statistics software (Predictive Analytics Software, version 18.0, Armonk, NY; IBM Corp.).

Qualitative content analysis was conducted on the CSs' advice to each community mental healthcare professional[26]. Written comments from the CSs were used as the basis of analysis. The analysis was performed as follows: (1) comments were read and re-read to understand each person with mental illness and his/her families, (2) the parts of the supervisor's advice that were related to the assessment were extracted of person with mental illness, (3) code and sub-categories were made based on content similarity, and (4) categories were created to contain similar sub-categories, and differences and similarities between each case were compared. The findings are illustrated by the CSs' quotes. To maintain the validity of the results, drafts of the report were written and sent to each CS and all professionals who worked at the relevant public health centers, welfare offices, and departments of elderly care. After confir-

mation of the accuracy of the draft by these individuals, we refined the naming of the categories.

3 Ethics

This study was approved by the Nursing Research Review Board of Tokyo Medical University. Based on the research agreement, all data associated with this study were kept in strict confidence and anonymous.

❖Results

1 Summary of the users of the clinical supervision program and characteristics of the person with mental illness

Among the 309 cases, public health nurses were the most frequent users of the clinical supervision program (Table 1). Approximately 40% of people with mental illness received welfare benefit. Two hundred and twenty-six persons had a primary psychiatrist. The largest group was individuals with schizophrenia (21.6%). About 60% had a history of the interruption of psychiatric treatment, and 77.5% had a risk of inflicting injury on others (Table 2).

2 Assessment strategies of the CSs focused on community mental health care

Based on content analysis, we identified two themes, namely, 'clarification of the present and future health issues of the person with mental illness and his/ her family' and 'preparation of a support plan for the mentally ill person and his/her family'. Table 3 shows the details of these themes, 8 categories and 24 sub-categories. Direct quotations from the CSs are shown in quotation marks.

2.1 Theme 1: Clarification of the present and future health issues of the person with mental illness and his/her family
2.1.1 Category 1: Clarification of the health and life-related issues of the person with mental illness

The community mental health professionals were over-burdened with the care of their patients with mental illness, mainly because the patients' primary health issue remained unclear. The CSs advised them that assessment of "the health issue of the person with mental illness is a basic strategy". At times, the problematic behavior of the patient escalated and healthcare professionals became involved. The CSs assessed "whether the patient had various health issues or not". Very often, difficult cases had more than one health issue. For example, "the person had been diagnosed as having schizophrenia, and abused his grandmother".

Furthermore, the community mental health professionals often felt difficulty in caring for people with mental illness who had a large amount of trouble with human relationships. The CSs explained the strategies of how to identify "difficult interpersonal relationships" and how miscommunication could occur. Meanwhile, the CSs thought that assessing the patients' "life skills" and "intellectual level" were also important. These factors affected the patients' problematic behaviors: "She did not understand the professional's explanation. She made numerous calls to the public health nurse whenever she had a question."

2.1.2 Category 2: Identifying the relationship between the mentally ill person and his/her family

The person with mental illness had their own lifestyle and communication method, which was based on that family's particular 'culture/life style'. A salient ex-

Table 1.   Cross tabulation of the clinical supervisors and professional affiliations of the user of clinical supervision program.

n=309

		Clinical supervisors					
		Psychiatrist (n=265)		Public health nurse (n=17)		Psychiatric social worker (n=27)	
		n	%	n	%	n	%
The user of clinical supervision program	Public health nurses	181	68.3	13	76.4	14	51.9
	Case workers	41	15.5	1	5.9	12	44.4
	Registered nurses and elder care professionals	20	7.6	2	11.8	1	3.7
	Others	23	8.6	1	5.9	0	0

Table 2.   Characteristics of the patients with mental illness.

n=309

Variables		n	%
Age (yrs)	Mean (SD)	41.7	(15.1)
Sex	Men	123	39.8
Receiving welfare benefit	Yes	127	41.1
Years of schooling	Mean (SD)	12.5	(2.6)
Business experience	Yes	236	76.4
Living status	Alone	104	33.7
Existence of a key family person	Yes	96	31.1
Have a child	Yes	129	41.7
Committed child abuse	Yes	84	27.2
Requirement of long-term care for the parents	Yes	29	9.4
Committed elderly abuse	Yes	34	11.0
Have a primary psychiatrist	Yes	226	73.1
Psychiatric diagnosis	Unknown	91	29.4
	Known	218	70.6
Actual diagnosis*	Schizophrenia	47	21.6
	Depression	37	17.0
	Substance abuse	38	17.4
	Personality disorder	22	10.1
	Eating disorder	12	5.5
	Mental retardation	10	4.6
	Epilepsy	10	4.6
	Bipolar disorder	8	3.7
	Anxiety disorder	6	2.8
	Obsessive-compulsive disorder	6	2.8
	Dementia	3	1.4
	Others	19	8.7
Past hospitalization in a psychiatric unit*	Yes	117	53.7
Interruption of psychiatric treatment*	Yes	135	61.9
Having a risk of self harm*	Yes	117	53.7
Having a risk of inflicting injury on others*	Yes	169	77.5

Percentage of committed child abuse was calculated regarding the people who had a child.
＊：Percentages were caluclated based on the people with an acutal psychiatric diagnosis.

ample was "the father had been violent. Now, the power relationship has changed and his son uses violence against the father". If the family had a dominant relationship or co-dependent relationship, the issues became more complex. This was particularly true for those who abused substances; family members would often enhance or foster the continuation of his/her problematic behaviors. In some cases, the mental health professionals' knowledge of the "history of the person" was useful in understanding his/her family relationships.

2.1.3 Category 3: Assessment and identification of persons truly requiring care

Persons with mental illness often discontinue their medical treatment based on their own judgment. For this reason, their condition often deteriorated and problematic behaviors escalated in parallel. The CSs assessed "whether the person got appropriate medical treatment or not" as well as whether they actually required the help of a professionals. However, identifying "the persons who truly require support" was most important. Some mental health professionals needed to support the person with mental illness as well as his/her family concurrently. The CSs considered that "the family members who showed up for the consultation with

Table 3. Assessment strategies of the clinical supervisors focused on community mental health care.

Theme	Categories	Subcategories
1 Clarification of the present and future health issues of the person with mental illness and his/her family	1 Clarification of the health and life-related issues of the person with mental illness	1 Assessing the health issues of the person with mental illness
		2 Considering whether the person has various health issues
		3 Assessing the life skills of the person with mental illness
		4 Assessing the intellectual level of the person with mental illness
		5 Clarifying the person's problems with interpersonal relationships and the cause of miscommunication
	2 Identifying the relationship between the mentally ill person and his/her family	6 Knowing the history of the person with mental illness
		7 Understanding the person with mental illness and his/her family relationships
	3 Assessment and identification of persons truly requiring care	8 Identifying the person who truly requires support
		9 Confirming whether the person with mental illness received the appropriate medical treatment
	4 Identifying the health and life-related issues of the family	10 Assessing the health and life-related issues of the family
		11 Assessing the family members' capability of problem solving
		12 Confirming the growth and development of the child
	5 Forecasting the future issues of the mentally ill person, his/her family, and healthcare	13 Estimating the future issues of the person with mental illness and his/her family members
		14 Judging the necessity of separating the person with mental illness from his/her child or parent as soon as possible
		15 Estimating the risk of harm to the healthcare staff by the person with mental illness and his/her family
2 Preparation of a support plan for the mentally ill person and his/her family	1 Designing a method of support for the mentally ill person	16 Designing a method of support that is suitable for the person's condition and abilities
		17 Cooperating with his/her primary doctor
		18 Identifying a key person in the family and collaborating with him/her
	2 Consideration of the method of support for the family	19 Suggesting a method of support for the person's family
		20 Providing correct information about the health issues of the person with mental illness to improve health literacy of the family
	3 Clarifying the need of cooperating with staff from multiple disciplines and identifying inappropriate care by the professionals	21 Cooperating with related staff and working as a team to support the person with mental illness and the family
		22 Identifying inappropriate care by health care professionals
		23 Identifying the information of the mentally ill person and his/her family that requires future confirmation by the professionals
		24 Cooperating with the police as necessary

the patient often also needed support from the professionals".

2.1.4 Category 4: Identifying the health and life-related issues of the family

The CSs identified "the health and life-related issues of the family", because not only the person with the mental illness but also his/her family members often had issues, such as "his father was an alcoholic", and "families with low intellect". The risk of accidental child abuse as well as poor life skills were augmented in such cases. If child abuse and some other life-related issues had not occurred up to that point, the CSs "monitored the growth and development of the child as well as the family life".

The CSs also assessed "the problem-solving capability of the family". Dysfunctional families often did not have full responsibility for the patients' care, and most of the decisions were left to the community mental health professionals. For example, "the mother had participated in family programs for substance abuse. However, she did not understand her son's disease and could not discourage her son from repeatedly making the same mistake".

2.1.5 Category 5: Forecasting the future issues of the mentally ill person, his/her family, and healthcare staffs

If the problematic condition of the patient continued, the CSs forecasted that more complicated situations might arise in the near future. For example, "if he continues drinking at that pace, he will die soon". The CSs considered that "top priority was protecting the safety of the person with mental illness and his/her family". In particular, the safety of children and elderly persons were considered to be important. The CSs judged "the risk of child and elderly abuse by the person with mental illness". They assessed the necessity of separating the person with mental illness from his/her child or parent as quickly as possible. The CSs also estimated "the risk of harm to the healthcare staffs by the person with mental illness and his/her family". Because ensuring the safety of the healthcare professionals is the basic principal for maintaining occupational health, "he had a risk of using violence toward the healthcare staff. All staff needed to understand the importance of keeping one's own safety".

2.2 Theme 2: Preparation of a support plan for the mentally ill person and his/her family

2.2.1 Category 1: Designing a method of support for the mentally ill person

The CSs considered the type of suitable support for the person with mental illness based on "his/her condition and ability". Some CSs "monitored the patient's condition", whereas others "utilized proper social resources". In addition, the CSs adhered to a policy of "we collaborated with the primary doctor". They shared the patient's episodes with his/her primary doctor, to "know the assessment details of the primary doctor regarding the person with mental illness, such as the patient's condition, treatment status, and capability of self-care and family care by him/her". Despite having a primary psychiatric doctor, the person with mental illness would often discontinue treatment, resulting in the worsening of his/her condition. The CSs considered the need of medical care to improve the patient's condition. If the patient remained untreated, "the staff would make regular visits to support the patient". The CSs identified a key person in the family and collaborated with them to re-start the patient's treatment and to utilize social resources with their agreement: "we had to contact her husband. If the CS was going to suggest to the patient to re-start medical treatment, there was a need to collaborate with her husband".

2.2.2 Category 2: Consideration of the method of support for the family

The CSs suggested "ways to support the mentally ill person's family". There were 2 objectives of family support. One was to improve the health and life-related issues of the family using social resources and medical treatment. The other was to improve the health and life related issues of the patient with the cooperation of his/her family. The community mental health professionals needed to provide correct information about the health issues to improve health literacy of the family. The CSs clarified "the role of the family and the best type of support for them". They stressed that "children's safety was top priority". "Educating family members to understand the disability of the patients" was considered helpful for supporting the patient smoothly: "the mental health professionals tried to educate the mentally ill person's husband so that he understood her disease and the risk of child abuse".

2.2.3 Categories 3: Clarifying the need of cooperating with staff from multiple disciplines and identifying inappropriate care by the professionals

The CSs stressed the importance of cooperating with staff from multiple disciplines and working as a team to support the person with mental illness and his/her family. Some professionals provided excessive care far beyond what is expected from them professionally, and often acted as enablers without realizing it. Sharing of "the role" and assessing "inappropriate care by staff" were important. Some staff members were overly concerned about the issues beyond the normal limits of the governmental framework: "if he was arrested for substance abuse, the social case worker should stop the payment of welfare benefit to him". In other cases, the mental healthcare professionals assessed the issues of the patients with "insufficient evidence". The CSs pointed out that "evidence is needed to confirm your assessment", such as "life history", "family relationships", and "the health condition of the patient and his/her family".

In some cases, there was a need to estimate the risk of the patient harming the community mental health professionals. Here, the CSs suggested that consultation with the police might be necessary when the professionals could not respond to a difficult situation or a crime: "ensuring your safety and monitoring the risk of harm to professionals is important. Please call the police when you are affected by violence from your patients".

❖Discussion

We explored the assessment strategies used by the CSs to clarify the issues related to community mental health care. Our study had three principal findings. First, regardless of the different nature of the patients, all CSs assessed the health issues of the mentally ill persons and their family. Second, the CSs forecasted the future situation of their patients and the risk of work-related violence against healthcare professionals. Third, the CSs tried to communicate effectively with professionals from multiple disciplines, to enhance collaboration between professionals, and to reduce conflicts and misunderstanding about the roles and responsibilities between professions. Our finding should help to improve the skills of the community mental health professionals, as well as to prevent their burnout.

Our results showed that public health nurses most frequently utilized the clinical supervision program. In addition, approximately 40% of the patients were receiving welfare benefit and 60% had discontinued their psychiatric treatment. Public health nurses played a key role in coordinating community mental health care and were highly vulnerable to burnout[21]. Community mental health care professionals experienced various difficulties in their daily practices[25]. Our findings suggested that to reduce the burnout of community mental health-care professionals, the clinical supervision program should be widely applied in community mental health care settings throughout Japan.

Our findings also showed that the CSs assessed the health issues of the people with mental illness and their family. We also demonstrated the importance in identifying the persons truly in need of help, and understanding the family relationships, and the family's capability of problem solving. These assessment strategies should help to improve the quality of care for people with mental illness and their families. Various factors of the patients determine the workload of the healthcare professionals, such as the level of independent living skills and the risk posed to themselves and to others, as well as the capacity of family support[27]. Knowledge of family relationships was important in understanding family culture, which may have affected the persons' life history and family-related issues[28]. Healthcare professionals often lacked the skills required for dealing with difficult cases[25]. The aim of clinical supervision is to provide support to healthcare professionals and to develop their skills[29]. Our results indicate that assessment strategies of the CSs would enhance the quality of management care for people with mental illness and their families as a unit.

We found that the CSs forecasted the future issues of the patient, the family, and the professionals. Consultation with the police is a basic strategy for maintaining the safety of community mental health professionals. Clinical supervision is a way to reduce the anxiety of healthcare professionals and to help them understand the meaning of their experiences[1]. A previous study showed that the seriousness of health issues can be estimated by the CSs; however, it did not fully discuss the risk of harm to healthcare staff[24]. Outreach support in the community may reduce the risk of harm to mental health professionals who visit the houses of mentally ill persons on their own. Front line healthcare staffs often have experiences with work-related vio-

lence and know various methods of prevention[30]. Protecting the safety of professionals in the work environment should contribute to a reduction in their turnover and an improvement in their quality of care for people with mental illness[9]. Our findings suggested that regardless of the differences of the patients, the CSs estimated the future situation of the patients, to reduce the stress felt by and work-related violence against healthcare professionals.

Our findings showed that the CSs advised the healthcare professionals to cooperate with staff and to clarify inappropriate professional care. Each professional group has varying methods of patients care and values, as well as use different decision-making processes. This raises potential dilemmas, conflicts, and misunderstandings about the roles and responsibilities between professions. CSs have knowledge about the backgrounds, roles in forming assessments and treatments, values, and training experiences of professionals from multiple disciplines[31]. Collective clinical supervision of professionals from multiple disciplines would promote detailed discussions amongst these professionals, which would then improve teamwork, enhance critical thinking and increase the understanding of each others' perspectives[15]. Our results suggested that the CSs tried to communicate effectively among professionals of multi disciplines to enhance their future collaboration.

This study has two limitations. First, this survey was conducted in a single Japanese municipality, and thus generalization of the findings is limited. Second, because of the cross-sectional nature of the survey, our data was unable to confirm a cause-and-effect relationship. In the future, a national survey should be performed toward developing a new system for supporting community mental health professionals using clinical supervision programs. Despite these limitations, this is the first study to investigate the assessment strategies of the tacit knowledge used by CSs in identifying the issues related to community mental health care, based on a cross-sectional study design. Our results should contribute toward improving the quality of care for mentally ill persons and to prevent the burnout of community mental health professionals.

❖Acknowledgement

❖References

1) Bégat I SE.: Reflection on how clinical nursing supervision enhances nurses' experiences of well-being related to their psychosocial work environment. Journal of Nursing Management, 14(8), 610-616 (2006).

2) Garner BR, Hunter BD.: Predictors of Staff Turnover and Turnover Intentions within Addiction Treatment Settings: Change Over Time Matters. Subst Abuse, 8, 63-71 (2014). doi: 10.4137/SART.S17133

3) Funakoshi A, Miyamoto Y, Kayama M.: Managerial support of community mental health nurses. Journal of Advanced Nursing, 58(3), 227-235 (2007). doi: 10.1111/j.1365-2648.2007.04229.x

4) Karimi LLS, Donohue L, Farrell G, Couper GE.: Emotional rescue: the role of emotional intelligence and emotional labour on well-being and job-stress among community nurses. Journal of Advanced Nursing, 70(1), 176-186 (2014).

5) Knudsen HK, Roman PM, Abraham AJ.: Quality of clinical supervision and counselor emotional exhaustion: the potential mediating roles of organizational and occupational commitment. Journal of Substance Abuse Treatment, 44(5), 528-533 (2013). doi: 10.1016/j.jsat.2012.12.003

6) Schaufeli WB, Taris TW.: The conceptualization and measurement of burnout: Common ground and worlds apart The views expressed inWork & Stress-Commentaries are those of the author (s), and do not necessarily represent those of any other person or organization, or of the journal. Work & Stress, 19(3), 256-262(2005). doi: 10.1080/02678370500385913

7) Duffield CM, Roche MA, Homer C, Buchan J, Dimitrelis S.: A comparative review of nurse turnover rates and costs across countries. Journal of Advanced Nursing, 70(12), 2703-2712 (2014). doi: 10.1111/jan.12483

8) Li Y, Jones CB.: A literature review of nursing turnover costs. Jounal of Nursing Management, 21(3),

405-418 (2013). doi: 10.1111/j.1365-2834.2012.01411.x

9) Edwards D, Burnard P, Hannigan B, Cooper L, Adams J, Juggessur T, Fothergil A, Coyle D.: Clinical supervision and burnout: the influence of clinical supervision for community mental health nurses. Journal of Clinica Nursing, 15(8), 1007-1015 (2006). doi: 10.1111/j.1365-2702.2006.01370.x

10) Buus N, Gonge H.: Empirical studies of clinical supervision in psychiatric nursing: A systematic literature review and methodological critique. International Journal of Mental Health Nursing, 18(4), 250-264 (2009). doi: 10.1111/j.1447-0349.2009.00612.x

11) Francke AL, de Graaff FM.: The effects of group supervision of nurses: a systematic literature review. International Journal of Nursomg Studies, 49 (9), 1165-1179 (2012). doi: 10.1016/j.ijnurstu.2011. 11.012

12) Gilbreath B, Karimi L.: Supervisor Behaviour and Employee Presenteeism. International Journal of Leadership Studies, 7(1), 114-132 (2012).

13) Gonge HBN.: Model for investing the benefits of clinical supervision in psychiatric nursing: A survey study. International Journal of Mental Health Nursing, 20, 102-111 (2011).

14) Stoyanov DS, Cloninger CR.: Relation of people-centered public health and person-centered healthcare management: a case study to reduce burn-out. The International Journal of Person Centered Medicine, 2(1), 90-95 (2012).

15) Roche AM, Todd CL, O'Connor J.: Clinical supervision in the alcohol and other drugs field: an imperative or an option? Drug Alcohol Review, 26 (3), 241-249 (2007). doi: 10.1080/0959523070124 7780

16) Priest HM, Roberts P, Dent H, Blincoe C, Lawton D, Armstrong C.: Interprofessional education and working in mental health: in search of the evidence base. Journal of Nursing Management, 16(4), 474-485 (2008). doi: 10.1111/j.1365-2834.2008.00867.x

17) Bogo M, Paterson J, Tufford L, King R.: Interprofessional Clinical Supervision in Mental Health and Addiction: Toward Identifying Common Elements. The Clinical Supervisor, 30(1), 124-140 (2011). doi: 10.1080/07325223.2011.564961

18) Milne D, Aylott H, Fitzpatrick H, Ellis M.: How Does Clinical Supervision Work? Using a "Best Evidence Synthesis" Approach to Construct a Basic Model of Supervision. The Clinical Supervisor, 27(2), 170-190 (2008). doi: 10.1080/0732522080

2487915

19) Ministry of Health, Labour and Welfare.: Seishin hoken iryou fukusi no kaikaku bijyon. (2004) http://www.mhlw.go.jp/kokoro/nation/vision.html (accessed 5 November, 2015) (in Japanese)

20) Oshima I, Mino Y, Inomata Y.: How many long-stay schizophrenia patients can be discharged in Japan? Psychiatry and Clinical Neurosciences, 61 (1), 71-77 (2007). doi: 10.1111/j.1440-1819.2007. 01613.x

21) Imai HNH, Nakagi Y, Niwata S, Sugioka Y, Itoh T, Yoshida T.: Prevalence of burnout among public health nurses in charge of mental health services and emergency care systems in Japan. Environmental Health and Preventive Medicine, 11, 286-291 (2006).

22) King R, Lloyd C, Holewa V.: Can identified stressors be used to predict profession for mental health professionals? Advances in Mental Health, 7(2), 97-103 (2008). doi: 10.5172/jamh.7.2.97

23) Macdonald M.: Origins of difficulty in the nurse-patient encounter. Nursing Ethics, 14(4), 510-521 (2007).

24) Wolf ZR, Robinson-Smith G.: Strategies Used by Clinical Nurse Specialists in "Difficult" Clinician-Patient Situations. Clinical Nurse Specialist, 21(2), 74-84 (2007).

25) Yoshioka-Maeda K, Kuroda M.: Characteristics and related factors of individuals who refuse the support of health and welfare professionals. Japanese Journal of Public Health, 62(1), 20-27 (2015). (in Japanese)

26) Graneheim UH, & Lundman B.: Qualitative content analysis in nursing research: concepts, procedures and measures to achieve trustworthiness. Nurse Education Today, 24(2), 105-112 (2004). doi: 10.1016/j.nedt.2003.10.001

27) Henderson J, Willis E, Walter B, & Toffoli L.: Community mental health nursing: keeping pace with care delivery? International Journal of Mental Health Nursing, 17(3), 162-170 (2008). doi: 10.1111/ j.1447-0349.2008.00528.x

28) Carpenter-Song, E. Anthropological perspectives on money management: considerations for the design and implementation of interventions for substance abuse. American Jounal of Drug Alcohol Abuse, 38(1), 49-54 (2012). doi: 10.3109/00952 990.2011.643980

29) Hines-Martin VRK.: Supervision as professional

development for psychiatric mental health nurses. Clinical Nurse Specialist, 20(6), 293-297 (2006).

30) Lipscomb J. A. and Ghaziri ME.: Workplace Violence Prevention: Improving Front-Line Health-Care Worker and Patient Safety. A Journal of Environmental and Occupational Health Policy, 23(2), 297-313 (2013).

31) Townend M.: Interprofessional supervision from the perspectives of both mental health nurses and other professionals in the field of cognitive behavioural psychotherapy. Journal of Psychiatric & Mental Health Nursing, 12(5), 582-588 (2005). doi: doi: 10.1111/j.1365-2850.2005.00878.x