Received: 21 September 2021 | Revised: 5 December 2021 | Accepted: 31 January 2022

DOI: 10.1111/jan.15191

REVIEW

JAN Leading Global Nursing Research WILEY

Clinical supervision practice by community-based child and family health nurses: A mixed-method systematic review

Anne O'Neill[1] | Kristina Edvardsson[1] | Leesa Hooker[1,2]

[1]Judith Lumley Centre, School of Nursing and Midwifery, La Trobe University, Melbourne, Victoria, Australia

[2]Rural Department of Nursing and Midwifery, La Trobe Rural Health School, La Trobe University, Bendigo, Victoria, Australia

Correspondence
Anne O'Neill, Judith Lumley Centre, School of Nursing and Midwifery, La Trobe University, Melbourne, VIC, Australia.
Email: anne.oneill@latrobe.edu.au

Funding information This research received no specific grant from any funding agency in the public, commercial or not-for-profit sectors.

Abstract

Aims: To systematically search the literature to identify studies related to clinical supervision in child and family health nurse contexts, and to determine the role it has in professional practice and the characteristics required for effective supervision.

Design: A mixed-method systematic review using a convergent integrative approach to data synthesis.

Data source: Studies only in English language were identified from searches of CINAHL, MEDLINE and EMBASE databases covering the years of publication from January 1990 to December 2020.

Review methods: Primary research studies of clinical supervision with child and family health nurses in community settings were included. Studies were critically appraised for methodological quality and data extracted, coded and analysed for themes in keeping with the review aims and key findings of each study.

Results: Of 2185 records screened, 63 full-text papers were assessed for eligibility, which yielded 12 publications for inclusion—11 from the United Kingdom and one from Sweden. The majority (75%) of included studies were qualitative or mixed method. Four main themes with sub-themes were identified: structural features, supportive experience, ensuring safety and strengthening practice.

Conclusion: Clinical supervision across child and family health nurse contexts is limited. This study highlighted organizational commitment to clinical supervision as an important component of safe and quality practice. Supervisor training and supervisee orientation to supervision is required to optimize effective participation, together with shared agreement of the goals and purpose of supervision.

Impact: The findings from this review confirm the potential for clinical supervision to support improved outcomes for children and families. Understanding what models work best and in what contexts will inform workplace policy and educational programs for child and family nurses across diverse settings.

This is an open access article under the terms of the Creative Commons Attribution-NonCommercial-NoDerivs License, which permits use and distribution in any medium, provided the original work is properly cited, the use is non-commercial and no modifications or adaptations are made.
© 2022 The Authors. *Journal of Advanced Nursing* published by John Wiley & Sons Ltd.

1 | INTRODUCTION

Literature related to clinical supervision and its emergence as a feature of nursing practice extends to the 1980s, proliferating in the 1990s in the United Kingdom (UK). Healthcare systems in other countries, namely Scandinavia, Australia, New Zealand and Canada showed subsequent and similar interest in supervision practice (Winstanley & White, 2003).

Definitions and forms of clinical supervision include the training supervision of students and newly graduated nurses and are typically competency based, while other forms of clinical supervision incorporate workplace appraisal processes, client-based activity and staff focused strategies (Davys & Beddoe, 2020, p. 11). The three-function model of supervision described by Proctor (1987) frequently underpins implementation and research related to clinical supervision in nursing and delineates the different aims and types of clinical supervision practice—normative (organizational responsibility), formative (skill and knowledge development) and restorative (support personal well-being) (Butterworth et al., 1996; Proctor, 1987).

Bond and Holland (2011) state that all qualified clinical practitioners need clinical supervision to *'maintain proficiency in practice, ensure their accountability and to aid their specific personal and professional growth and development'* (p. 21).

Winstanley and White's (2003) more detailed explanation defines clinical supervision as '*focused on the provision of empathetic support to improve therapeutic skills, the transmission of knowledge and the facilitation of reflective practice. This process seeks to create an environment in which participants have an opportunity to evaluate, reflect and develop their own clinical practice and provide a support system for each other*' (p. 10).

The theories and concepts of reflective practice (Schön, 1987) and its role in nursing and other human service professions is considered a core element of individual professional practice development and the dominant cognitive process used in clinical supervision (Heffron et al., 2016). A unifying description of clinical supervision includes components of regularity, confidential discussions with one or more experienced others for the purpose of reviewing clinical practice and building self-awareness and professional accountability in the practitioner (Fowler, 1996).

Debate around the definitions, goals and difficulties operationalizing clinical supervision characterizes much of the empirical literature of the topic in nursing (Cutcliffe et al., 2018). In addition, clinical supervision is implemented in different ways across countries and services, which include individual, group and peer models, along with managerial or appraisal processes, further complicating the field (White, 2017).

Previous literature reviews on the subject report a predominance in community contexts, related to mental health and aged care (Brunero & Stein-Parbury, 2008), and learning and disability services (Butterworth et al., 2008). In the United Kingdom, community nurses and health visitors were early recipients of clinical supervision, with midwives having statutory supervision requirements (Butterworth et al., 1996; Dunkley-Bent, 2017).

It is generally agreed that the purpose of clinical supervision however structured or implemented is to improve client care and experience (Rothwell et al., 2019). One of the arguments in favour of the practice and improved client outcomes relates to the assumption that improved education and staff support result in better client care (Winstanley & White, 2003). However, previous reviews and discussion papers point to the ongoing lack of empiric evidence for this belief (Cutcliffe et al., 2018; Dilworth et al., 2013; White, 2017).

2 | BACKGROUND

2.1 | Child and family health nursing

Over several decades, governments and health and social service policymakers have sought to develop and support programs that recognize the social determinants of health as causal factors in individual and community health trajectories (Brunner & Marmot, 2006). The emergence of the field of neuroscience now clearly identifies early life experiences as key drivers of lifelong health and well-being, and conversely the role of government, community services and practitioners in identifying and responding to children and families experiencing vulnerability and risk factors for negative outcomes (Woolfenden et al., 2013).

In developed countries with high performing health and social systems, various models of well-child universal services exist in the primary healthcare sector to monitor the health and development of children in the years from birth to school age (Fraser et al., 2014; Turley et al., 2018).

The literature related to universal well-child services, in community settings, defines child and family health nursing to be a dynamic and complex area of nursing (Greenway et al., 2013). Traditional aspects of the role—health promotion, health education and child growth and developmental surveillance—have undergone a shift towards a greater focus on psychosocial assessment and intervention around issues associated with child vulnerability, perinatal mental illness, family violence, child protection concerns and at-risk populations such as refugees and people experiencing homelessness (Engström et al., 2021; Kimla et al., 2019).

In addition to diverse models of well-child care by nurses internationally, the role has various nomenclatures—child health nurse, public health nurse, child and family nurse, and health visitor—also different training and educational qualifications required for working in the role (Turley et al., 2018). The designation 'child and family health nurse' (CaFHN) will be used in this article where not otherwise indicated.

In countries with comparable services, CaFHNs are registered general nurses often with additional qualifications in midwifery, community, public health nursing and/or child health (Fraser et al., 2014; Greenway et al., 2013). The workforce is governed by regulatory and professional standards and codes of practice, with a discipline specific need for ongoing professional development in accordance with changing community needs, issues and emerging practice (Vandette & Gosselin, 2019).

2.2 | Clinical supervision and child and family health nursing

Child and family health nurses are called on to respond to complex family situations, monitor and assess the presence of risk related to children and the presence of contributing factors in the family (Peckover & Appleton, 2019). Nurses frequently carry out this work in isolation, sometimes in client's homes and with varying degrees of professional support (Fraser et al., 2014).

Professional development through training, education and clinical workshops are mandatory registration requirements in number of nursing jurisdictions, to ensure effective and safe practice (National Council of State Boards of Nursing, 2020). The development of skills in reflective practice and clinical supervision have also been considered necessary aspects of integrating learning, improving skills, knowledge and supporting nurse well-being (Dahlbo et al., 2017).

While clinical supervision has been explored extensively in some disciplines and is provided in some CaFHN settings (Adams et al., 2019), there is a knowledge gap on the practice of clinical supervision by CaFHNs. The nature of the role, context and responsibility for children and families experiencing vulnerability dictate the need for professional clinical support and guidance, including clinical supervision. An understanding of clinical supervision requirements of CaFHNs is needed to ensure whether workforce skills and practice are supported and maintained.

3 | THE STUDY

3.1 | Aims

The aims of this study are to systematically search the literature to identify studies related to clinical supervision practice in CaFHN contexts and to determine the role it has in professional practice and the characteristics required for effective participation.

3.2 | Design

A systematic mixed method review was undertaken to comprehensively search, appraise and synthesize the research evidence (Aromataris & Munn, 2020). The PRISMA checklist was followed to ensure consistency and rigour (Page et al., 2021).

3.3 | Search methods

An initial mapping of the available literature was conducted related to clinical supervision and CaFHN to identify key terms and concepts and to confirm there was no recent systematic review on this topic. A systematic search of CINAHL, EMBASE and MEDLINE bibliographic databases was then conducted using subject headings and keyword search terms: child family nurs*, health visitor, maternal child health nurs*, public health nurs*; clinical supervision or supervis*, reflection supervision, clinical reflection, reflect*, professional development, competence, skill, knowledge, accountability, burnout, emotional wellbeing, preparedness, readiness, clinical practice (see Supplementary File 1).

Search results were imported to Covidence™ (Veritas Health Innovation, 2019), and the following criteria were applied to inclusion/exclusion of papers:

Inclusion criteria:

- Original research studies in English language, peer-reviewed papers, with full text available
- Published between January 1990 and December 2020 (this date range was included to capture any relevant studies conducted since the implementation of clinical supervision in nursing)
- Studies conducted in high-income countries
- Papers reporting on 'clinical supervision' as practiced and described in CaFHN (public health nurse, child family nurse, health visitor and community nurse) nursing services in community settings, for example well-child clinics, 'universal' free primary care contexts.

On further consideration, the following criteria were added after review and discussion by the reviewing team:

- Clinical supervision is core concept of the paper
- Participant responses identified by discipline, that is health visitor (or similar role)

Exclusion criteria:

- CaFHN (or equivalent) providing sustained home visiting service only
- Studies where clinical supervision refers to the observation of clinical practice, that is in student or training context
- Papers reporting on clinical supervision delivered in acute and mental health nursing (including community) settings
- PhD theses, book chapters, reviews, non-peer reviewed publications, opinion pieces and editorials
- Papers with no abstract
- Where clinical supervision is not delivered in a face-to-face mode

In total, 2185 records were screened, 63 full-text papers were assessed for eligibility resulting in 12 publications for inclusion.

3.4 | Search outcome

Title and Abstract screening were conducted in parallel by two authors (AO and KE) and conflicts resolved by a third author (LH).

Full-text Review was conducted by two authors (AO and KE/LH). Conflicts arising from full-text review were resolved by the alternate reviewer (either KE or LH).

Due to conflicts associated with full-text review, the papers for inclusion were reviewed again following amendment to the inclusion

criteria, that is, papers with clinical supervision as a core concept and data reported by discipline (CaFHN), this resulted in exclusion of additional papers.

The database searches were repeated with the addition of 'safeguarding' in the search terms as this term was identified in the original search results; this resulted in identification of an additional three papers. The screening process is outlined in Figure 1.

3.5 | Quality appraisal

Critical appraisal was conducted by AO using the appropriate Joanna Briggs Institute (2021) evidence summary checklists for either quantitative or qualitative designs and allocated an associated grade (included in Supplementary File 2). The appraisal scores were then assessed for agreement by either KE or LH and conflicting opinions resolved by discussion. The assessment of the limitations or methodological weaknesses was used to inform the review findings (Aromataris & Munn, 2020).

3.6 | Data abstraction

A data extraction template (Table 1) was developed by AO, and specific details of the study context, population, methods, concept of interest and outcomes relevant to the review question were recorded.

3.7 | Synthesis

The findings of the included studies were recorded on a spread sheet. The descriptive study findings were coded and analysed according to broad content areas or themes, for example, participant personal responses, clinical supervision process, format (individual or group) and professional outcomes. Repeating patterns and common items were identified using a manual process of colour coding until no further items were identified (Talbot & Verrinder, 2008).

Initial descriptive themes were developed by AO and thematic development followed an iterative process of review and discussion

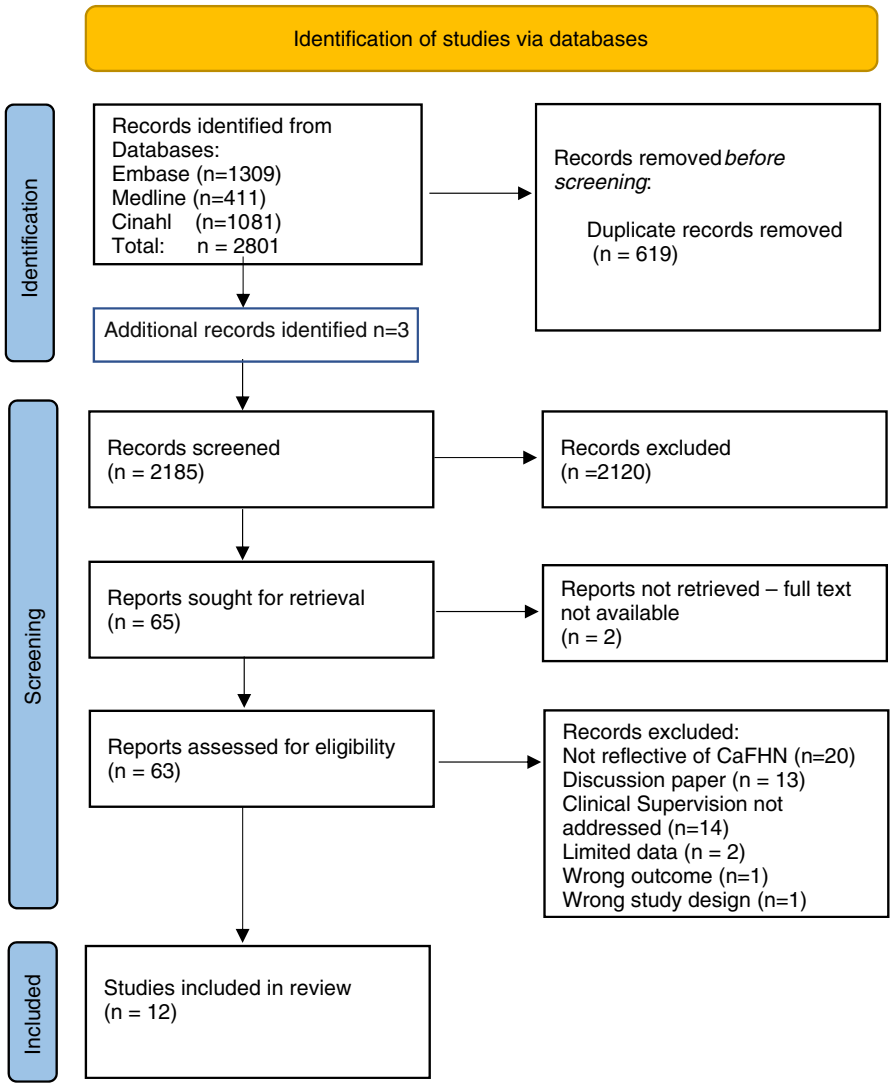

FIGURE 1 PRISMA flow chart (Page et al., 2021)

TABLE 1 Data extraction—included papers

Author	Country	Title	Aim	Design	Instrument measure	Sample	Findings	Strengths/limitations
Cutcliffe and Hyrkas (2006)	UK	Multi-disciplinary attitudinal positions regarding clinical supervision (CS): a cross-sectional study	To describe multidisciplinary attitudes and positions towards/about clinical supervision	Cross-sectional study	Survey	*N* = 74 (nurses/allied health) Health visitor (HV) *n* = 4	General agreement across disciplines that confidentiality and not-direct manager most important HV as group less concerned with direct manager supervisor as supervisor, but less agreed about importance of challenging colleagues. HV ranked status of supervisor lowest of groups Findings acknowledge that preferred was not usual practice	Small study, convenience sample post voluntary attendance at CS training—introduce bias
Draper et al. (1999)	UK	Evaluating an Initiative: clinical supervision in a community health trust	1. To explore the impact of clinical supervision on participants—practice 2. To evaluate implementation of clinical supervision	IMixed method	1. **Questionaire** to participants of pilot supervision groups on three occasions (after first, 4th and 8th supervision group) OTapen and closed questions 2. Focus group of supervisors and managers at conclusion of pilot	*N* = 21 (nurse) *n* = 10 (HV)	HV's report CS provided time to reflect, increase ability to respond, not react in contrast to workplace. Learn from others, increase awareness of support and learning needs Professional role and boundaries common issue Importance of organization/managerial support for preparation and implementation of CS	Limitations—small sample and one group had difficulty attending sessions
Hall (2007)	UK	Health Visitors' and School Nurses' Perspectives on Child Protection Supervision	To identify how HVs and school nurses perceive child protection supervision with the objective being to ensure what is provided meets local need	Qualitative design	Group interviews	*N* = 11 *n* = 6 (HV)	Need to feel 'safe' in supervision Positive about access to experienced other, active listener and being 'challenged' Designation of supervisor not relevant if criteria were met Role of decision-making model in clinical judgement Difficult as work exposed to scrutiny Time-consuming	Responses were recorded separately by discipline Articulated a proposed decision-making model Small study with local relevance, not easily transferrable
Honey and Walton (2008)	UK	An induction program for health visitors	To explore the experience of newly qualified HVs who have participated in program Comparison group—those HV who started in the PCT prior to program	Qualitative design	Focus groups	*N* = 7 (HV)	Findings contrasted with the group of HV who had not received induction Support/supervision groups Build confidence, air concerns Opportunity to reflect Reduce 'reality shock' as new HV Helped transition to personal accountability	Methods described in detail Limitation—small sample

TABLE 1 (Continued)

Author	Country	Title	Aim	Design	Instrument measure	Sample	Findings	Strengths/limitations
Kornaros et al. (2018)	Sweden	A hermeneutic study of integrating psycho-therapist competence in postnatal child health centres: nurses' Perspectives	To explore CH nurses previous experience responding to new parents with 'baby worries' How did they now experience being supervised and collaborating with a psychotherapist	Hermeneutic qualitative design	One-to-one interview	*N* = 15 (child health nurse)	Supervision sessions Mixed response Increased knowledge and integration in positive nurses Identified lack of knowledge and skill in addressing psychosocial issues with families Shift in role expectations of professions without associated training Nurses coped by avoiding or not raising difficult issues Identified informal support strategies use by nurses	Study part of a larger research Author addressed trustworthiness/four researchers in data analysis Possibility of bias in recruitment of the sample Poorly described supervision sessions with psychotherapist
Lister and Crisp (2005)	UK	Clinical supervision in child protection for community nurses	To explore the needs of community nurses of clinical supervision in child protection	Qualitative interviews	Individual and focus groups	*N* = 99 (community roles) *n* = 36 (HV)	The need for formal guidelines and shared understanding of purpose Evidence of ambivalence related to supervision Need for education for supervisees Nurses accountability concerns can be addressed in CS Culture of 'autonomy' and coping in HV – CS seen in negative light, that is surveillance/monitoring Variation across work sites/trusts about provision, timing, regularity	Detailed methods Some 'quotes' are paraphrased Interviews not recorded
Little et al. (2018)	UK	A qualitative evaluation of community nurses experience of safeguarding supervision	To investigate the effectiveness of safeguarding supervision offered by community services and to identify factors that hinder or enhance its delivery	Qualitative study	Face-to-face interviews and online survey 11 = face-to-face interviews 14 = online surveys using the same open-ended questions as for interviews	*N* = 25 *n* = 12 (HV)	HV comments: Allows for flexible thinking, highlights habitual practice/blind spots Assists in remaining child-focused when parental issues overwhelm Practice development transfers to other situations Some expressed ambivalence and experience of 'tick box' approach	Strengths: Addressed an under-researched topic Limitations—Single site and small sample
Moseley (2020)	UK	An evaluation of group safeguarding supervision in health visiting practice	To explore health visitor's and senior nurse advisor's thoughts, feelings and experiences concerning a new model of safeguarding supervision that aimed to inform future practice locally and across Wales	Qualitative interviews	Questionnaires (to all participants Focus groups = HV Individual = SNA's	*N* = 24 *n* = 6 (HV)	Group process beneficial in terms of support, combined experience of members Less effective for those with less than 3 years experience Group size = 9 considered too big for HV to all present a case Ideal numbers approx. 4–6 Effectiveness of individual CS was a barrier for some Group supervision: 58% very important 69% conditional support for group model 25% new HV group less effective	Small study from a single site limits transferability of findings Strength: Use of model for structured supervision employed by participants and in recommendation for future sessions

(Continues)

TABLE 1 (Continued)

Author	Country	Title	Aim	Design	Instrument measure	Sample	Findings	Strengths/limitations
Rooke (2015)	UK	Exploring the support mechanisms health visitors use in safeguarding	To examine the experiences of health visitors who work in child protection and safeguarding To discover what HVs consider is supportive in their role To understand the impact of support on health visitors	Qualitative interviews	Focus group	*N* = 10 (HV)	Themes: Support managing emotions, effective practice and time /training, PD and supervision Lack of leads to poor problem solving and decision-making Use of peer support dominates, some inhibition in group setting More need for support around clients who do not meet threshold for tertiary service	Small sample Participant responses provided
Scott (1999)	UK	The nature and structure of supervision in health visiting with victims of child sexual abuse	To explore how health visitors work with victims of child sexual abuse and the systems that support them	Qualitative grounded theory study	Qualitative one-to-one interviews	*N* = 16 (HV)	Importance of nurse response to parent's disclosure of own abuse Disclosures and impact of history more likely at sensitive periods, for example new baby HV awareness/training and skill in responding to disclosures and dealing with the impact of own history HV rely on non-professional supports Reported ad hoc structure of supervision support and associated governance and accountability	Detailed information re-methods and presentation of themes
Wallbank and Woods (2012)	UK	A healthier health visiting workforce: findings from the restorative clinical supervision programme	To describe the restorative model of supervision and implications for supervision for community professionals	Quantitative evaluation study	Pre and post (training and supervision)-questionnaires using **PROQOL (Stamm, 2009)** Scales for Compassion satisfaction: Burnout and Compassion fatigue **IES scale (Horowitz, 1982)** Stress measure	N = 1805	Results: Reduction in burnout by 43% and stress by 63% Compassion satisfaction maintained Staff more likely to have improved decision-making and resilience Linked to organizational support	Validated measures Large sample size outlines the 'model'
Wallbank (2013)	UK	Maintaining professional resilience through group restorative supervision	To evaluate group supervision as a tool to maintain HV resilience following individual supervision	Quantitative cross-sectional questionnaire	Pre and post-questionnaires using: **PROQOL (Stamm, 2009)** Scales for Compassion satisfaction: Burnout and Compassion fatigue **IES scale (Horowitz, 1982)** Stress measure	*N* = 174 (HV)	Group supervision continued to reduce stress and burnout And improve compassion satisfaction Has benefits for organization and suggests group model enhances individual model via normalizing and managing conflict	Validated model Large sample size Limitation—One time measure

with all team members (KE and LH), with minor adjustments to labelling and presentation of themes, until agreement was reached by all members.

4 | RESULTS

The final total of included papers for review was 12—seven were qualitative designs, two papers were mixed methods (primarily qualitative) and three were quantitative designs. Eleven studies originated in the United Kingdom and one in Sweden.

Results are presented using a convergent, integrated approach (Lizarondo et al., 2020). The following data relate to qualitative studies and the qualitative component of mixed methods papers integrated with descriptive results of the quantitative studies.

Four main themes were identified and ascribed descriptive titles: *structural features*, *ensuring safety*, *supportive experience and strengthening practice*. These themes, while mutually exclusive, are interrelated at different levels.

4.1 | Structural features

The structural aspect of clinical supervision relates to the stated purpose or goals, the relationship of the supervisor to the practitioner and the framework employed. The place of supervision practice in the organizational context and considerations of time, place, regularity, individual, peer and group models comprise the 'structural features' of clinical supervision.

4.1.1 | Organizational context

Organizational facilitation and adequate resourcing of clinical supervision was found to be critical to the successful implementation and sustained practice of effective clinical supervision (Rooke, 2015; Scott, 1999). In addition to the benefits of restorative supervision for health visitors (Wallbank, 2013; Wallbank & Woods, 2012), the perception of organizational support was linked to increased productivity and positive relationships.

Group supervision models were reported to be less resource dependent and likely to ensure sustainability of supervision over time (Moseley, 2020; Wallbank, 2013). The findings in Wallbank (2013) and Rooke (2015) suggest that group supervision alone is insufficient to address risk and accountability needs, whereas Lister and Crisp (2005) identified the need to embed clinical supervision in organizational cultures as a legitimate aspect of work.

4.1.2 | Clinical supervision format

A group model of clinical (safeguarding) supervision, as an alternative to the previous one-to-one format, was accepted by those health visitors studied conditional on access to individual supervision when needed (Hall, 2007). As in Moseley (2020) and Cutcliffe and Hyrkas (2006), these participants felt that the designation (role, discipline) of the supervisor was not important if they filled the necessary criteria. The role of supervisors and the nature of their relationship to supervisees is a determining factor in the acceptability and effective functioning of supervision (Hall, 2007), along with the training and preparation of supervisors (Cutcliffe & Hyrkas, 2006; Draper et al., 1999).

Health visitors considered the preferred size for safeguarding supervision to be four members compared with supervisors' preference of five or six members (Moseley, 2020). This study is singular in identifying a preferred size limit for groups with a group size of nine being reported by universal health visitors in this study as too big for effective supervision. In this setting, however, individual rather than group supervision was found to be a preferred mode for novice practitioners in the initial 3 years post-qualification.

Group restorative supervision following individual restorative supervision was found to reduce burnout and stress levels in health visitors and levels of compassion satisfaction were maintained (Wallbank, 2013). Group experience and format enhanced the benefits of the individual model in this study. The benefits included successful conflict resolution processes in the facilitative boundaries of the group and the group format providing a platform for the normalization of work-related stressors (Draper et al., 1999). The limitations of group models included adequate time for individuals to discuss issues and the need for supervisors to have adequate group facilitation skills (Wallbank, 2013).

The practical aspects of clinical supervision found to be associated with positive experiences included adherence to group rules and timing, a comfortable and private environment free from interruption and of a regular frequency (Draper et al., 1999).

4.1.3 | Framework

When clinical supervision is provided in group format, the importance of group rules and agreed limits of confidentiality were highlighted (Kornaros et al., 2018). This is linked to the inhibition experienced by some nurses about speaking and/or disclosing problems or difficulties in their work (Lister & Crisp, 2005; Rooke, 2015). There was also a potential for discussions of collegial support and empathy to dominate group supervision sessions. This impacted on nurse's capacity to accept constructive feedback and challenge and/or engage in deeper clinical reflection (Rooke, 2015). In a multidisciplinary survey, health visitors rated the statement 'members should challenge each other's practice' lower than did other nurses and disciplines (Cutcliffe & Hyrkas, 2006).

The survey consisted of ranked statements identifying the relative importance of clinical supervision characteristics in an 'ideal' form of supervision. Health visitors in this sample showed greater acceptance of 'normative' styles of supervision, considered to be related to their experience of safeguarding responsibilities. This small

sample of health visitors were less concerned about supervisees being of equal experience than were hospital nurses and ranked the level of supervisor experience in their field as more important than did other groups (Cutcliffe & Hyrkas, 2006).

4.2 | Supportive experience

The theme—supportive experience—refers to the containment of emotional reactions to clinical work via the process of facilitated reflection, active listening and guidance from a non-judging supervisor and/or colleague (Hall, 2007).

4.2.1 | Aspects of support

Clinical supervision was considered to increase the self- awareness of nurses to their own support needs in managing difficult situations and emotions (Draper et al., 1999; Rooke, 2015), help prevent vicarious trauma (Scott, 1999) and as a source of reassurance about shared concerns and dilemmas (Honey & Walton, 2008; Moseley, 2020). Being allowed time away from client work, in training and supervision, was considered supportive by health visitors and allowed an opportunity to think, reflect and evaluate client work (Rooke, 2015).

In Hall's (2007) study of health visitors and school nurse's views of supervision for child protection work, health visitors expressed the element of support not only as a set of defined purposes of clinical supervision, but also as a 'felt' experience derived from support in decision-making and assistance in developing alternate views of situations. The supportive nature of the supervision was founded on positivity, reassurance, acknowledgement of challenges and feeling safe.

The evaluation of the restorative clinical supervision program to health visitors across a region of the United Kingdom (Wallbank & Woods, 2012) confirmed the benefits of the clinical supervision model in reducing levels of burnout by 43% and stress by 62% and demonstrating a small increase in compassion satisfaction scores. Training in the restorative supervision model, followed by six individual supervision sessions, was designed to also qualify that nurse (similar to a train the trainer model) to extend supervision to another four health visitors in a cascade process.

An identified barrier to full participation in clinical supervision was a culture of coping and autonomy existing in some health visitors (Lister & Crisp, 2005), and lack of time or previous negative experiences with the process were also found to be inhibiting factors. Lister and Crisp (2005) also found that health visitors had differing views of the role and definition of clinical supervision and limited uptake by some nurses who expressed negative views of the practice and/or did not prioritize the time. These authors concluded that both supervisors and supervisees required education and preparation to optimize participation in supervisory activities.

4.2.2 | Alternate support strategies

In the absence of regular, effective clinical supervision, study participants utilized alternative diverse forms of support. Scott (1999) reported the use of external, casual sources, such as friends or family, by some nurses and a reliance on colleagues as informal points of support and guidance. Rooke (2015) described peer support as the most frequent form reported by health visitors both formally in peer support sessions and informally. The 'spiral of demand' impacts on the time needed to reflect and consider decisions when supervision and training was not accessed (Rooke, 2015). In this group, the author suggests that both individual restorative and group safeguarding models provided adequate support to health visitors.

Clinical supervision provided support through clarifying roles and boundaries related to client families and their range of issues (Draper et al., 1999) and aspects of their work that nurses were not adequately prepared for (Kornaros et al., 2018). Honey and Walton (2008) identified the experience of group support (clinical supervision) sessions as a necessary resource in the transition to personal accountability and role adjustment for nurses beginning their work in community-based and more autonomous positions. The support needs of novice health visitors were also highlighted by Rooke (2015).

4.3 | Ensuring safety

The study findings relate to different components of safety and clinical supervision; the sense of psychological safety experienced by participants, as a mechanism in preventing work related harm to nurses, safe and effective practice in client work and organizational responsibility towards staff and clients. As reflected in other themes, safety is both a requirement and an outcome of supervision practice.

4.3.1 | Clinical governance and safe practice

Organizational commitment to providing clinical supervision was identified as a requisite in implementing and supporting effective and adequate clinical supervision as a recognized clinical governance strategy (Moseley, 2020; Scott, 1999). The provision of individual and group supervision was considered necessary to address accountability and risk related to child protection work (Rooke, 2015).

Health visitors in Hall's (2007) study of child protection supervision found that while it can cause anxiety it can also be a supportive place to reflect and to be constructively challenged in relation to work with families. Clinical supervision was important for risk-related concerns (Rooke, 2015) particularly where the lines of accountability and responsibility lay solely with a nurse. This was linked with boundaries and role clarity when dilemmas arose about who was responsible for families of concern, particularly in instances when families did not meet the criteria for additional services (Draper et al., 1999; Lister & Crisp, 2005; Little et al., 2018; Moseley, 2020).

A lack of confidence and competence in dealing with psychosocial issues was a source of anxiety in some nurse groups (Kornaros, 2018) and lack of skill in responding to complex issues also meant some nurses failed to explore client or family risk factors at all (Scott, 1999). These papers also identified the potential for vicarious trauma for nurses together with poor identification and response to clients' disclosure of domestic abuse or perinatal mental illness.

4.3.2 | Psychological safety

Incidental findings by Wallbank (2013) support the view that through the establishment of psychological safety, clinical supervision enables the sharing of diverse perspectives on issues of contention and promotes the awareness of common difficulties among peers.

Confidentiality was associated with a feeling of safety in clinical supervision, this related to both group dynamics and the role of the supervisor in relation to the supervisee (Kornaros, 2018). In cases where line managers were also supervisors, the lack of distinction between supervision and performance appraisal resulted in nurses being reluctant to disclose problems.

The feeling of psychological safety arose out of confidentiality, agreed understanding of scope of supervision and facilitation of non-judging and non-blaming, collegial interactions, particularly in group settings (Rooke, 2015).

4.4 | Strengthening practice

4.4.1 | Reflective practice

Findings related to this theme occurred across most studies. Respondents stated that dedicated time to reflect increased their capacity to think about situations and resulted in an increased capacity to respond rather than react in a 'chaotic, problem centred' way (Draper et al., 1999; Rooke, 2015; Wallbank & Woods, 2012). Clinical supervision contributed to the development of a more flexible approach to thinking about clinical situations and addressed habitual practice styles (Little et al., 2018; Wallbank, 2013). It was also reported to increase confidence (Honey and Walton (2008) and aid skill development and knowledge integration following formal training or workshops (Kornaros et al., 2018).

4.4.2 | Shared practice experience

Sharing examples of good practice and learning from peers and experienced others were reported as benefits of group clinical supervision and featured as positive outcomes (Little et al., 2018; Moseley, 2020; Scott, 1999). While health visitors expressed different views about the degree to which 'clinical supervision helped deal with difficult situations', the 'universality' of practice challenges and dilemmas was source of both learning and reflection (Draper et al., 1999). The benefits in the area of practice development were observed in those nurses who had demonstrated open attitudes to learning (Kornaros et al., 2018) and were reported as contingent on the style and relationship to the facilitator or supervisor (Cutcliffe & Hyrkas, 2006; Draper et al., 1999; Moseley, 2020).

5 | DISCUSSION

This systematic review aimed to identify studies on the practice of clinical supervision in CaFHN settings, the role it has in professional practice and the necessary characteristics for effective supervision. Apart from one study from Sweden, this review found no evidence of implementation, models, aims or outcomes of clinical supervision practice in well-child community-based nursing settings outside the United Kingdom. Of the studies in this review, 11 of 12 papers originated from and referred to the UK context. This distribution is not representative of supervision studies in other nursing disciplines and contexts, although much of the scholarship and research in nursing has developed out of the United Kingdom (Brunero & Stein-Parbury, 2008; Cutcliffe et al., 2018).

The impetus behind some of the included UK studies is strongly associated with the local and national healthcare systems and operating structures. Health visitor workforce recruitment and retention problems, challenges resulting from service restructuring and identified workforce practice needs have been drivers for clinical supervision research and implementation across the United Kingdom (Wallbank, 2013; Wallbank & Woods, 2012). There was evidence that prior to researcher-led studies, limited, ad hoc or no clinical supervision was provided in health visitor workplaces outside that of performance, appraisal processes (normative function).

Clinical supervision was considered beneficial when implemented according to best practice, for example non-managerial, regular and with adequate time to allow participants to discuss areas of concern (Winstanley & White, 2003). Health visitors reported workload pressures and difficulties in prioritizing clinical supervision as barriers to participating, suggesting that the potential benefits do not exist in isolation to workplace systems (Buus & Gonge, 2009). Examples of ad hoc and varying application of clinical supervision models across health services demonstrates the need for clinical supervision to be embedded in professional and organizational cultures, and for it to be considered both a right and a responsibility of nurses (Bond & Holland, 2011, p. 93). Clearly articulated and agreed goals and purposes of clinical supervision, in addition to clear distinction between managerial and appraisal procedures, provide the conditions for supervision practice to develop in individuals and groups (Kenny & Allenby, 2013).

Most of the studies in this review provided limited detail on 'what happened' in supervision sessions, that is, the in-process activities, interventions or experience of participants (Pearce et al., 2013). In some cases there was no description at all or only broad outlines.

There was evidence in support of clinical supervision that was aligned to specific training, for example, postnatal depression and responding to disclosures of abuse, which correlate with findings related to other nursing specialties such as cancer nursing and mental health (Bradshaw et al., 2007).

Few papers described or addressed the preparation standards for supervisors, although in some cases, training was provided to undertake supervisor roles in pilot trials. A review of clinical supervision studies in nursing by Cutcliffe et al. (2018) was critical of the lack of attention to training in supervision practice for supervisors and participants and a corresponding lack of a competency framework. The importance of supervisor and supervisee preparation or training in supervision has been established as a necessary condition for effective practice in both reflection and clinical supervision (Butterworth et al., 2008; Davys & Beddoe, 2020, p. 62).

The review findings support the view that CaFHNs have specific clinical supervision requirements due to the nature of their role in identifying and responding to infants and children at risk of harm and/or suboptimal environmental conditions (Draper et al., 1999; Hall, 2007; Honey & Walton, 2008). While the community-based, independent nature of the role is also acknowledged to expose nurses to professional and personal challenges (Fraser et al., 2014).

Clinical governance to ensure safe practice and quality service delivery are features of acute care and traditional community nursing roles (Bishop, 2008). This review identifies the clinical governance aspects of clinical supervision in CaFHN workforce development and its role in supporting effective and safe practice (Bishop, 2008; Botham, 2013). Organizational culture, leadership support and adequate resourcing of clinical supervision for community-based CaFHNs are key aspects in the provision of quality care.

5.1 | Strengths and limitations

Study designs of included papers were predominantly qualitative, with small sample sizes, limiting the transferability of the findings to other settings. The exception to this were quantitative studies on the 'restorative supervision' model (Wallbank, 2013; Wallbank & Woods, 2012). The other quantitative study components in the review were either poorly described or offered limited additional value to the qualitative results. Most of the studies focused on acceptability and respondent experience of clinical supervision in contrast to quality and effectiveness outcomes or process and facilitation in supervision sessions.

This review is limited by the inclusion criteria of English language, primary studies in high-income countries.

The strengths of this review centre on the application of rigour in screening and assessing papers and the use of evidence-based assessment and analysis tools.

While it is possible that some literature was not identified by this review, it remains likely that in contrast to clinical supervision research across other areas of nursing, CaFHN contexts have not been widely investigated.

5.2 | Implications for practice

Practice issues and challenges in CaFHN roles have commonalities across health systems in terms of clinical support needs of nurses to influence health, safety and well-being outcomes for children and families. Local contextual factors impact the provision and implementation of clinical supervision with CaFHNs and the educational preparation for supervisees, newly graduated nurses and to some degree, supervisors remain important areas for further exploration.

Further research should address the views and experiences of nurses, managers and supervisors on the clinical supervision models and frameworks employed across diverse CaFHN settings with a focus on how clinical supervision enhances professional practice and what, if any, barriers exist to effective participation.

6 | CONCLUSION

The findings outlined in this review support the fundamental principles of clinical supervision and professional practice that are consistent over time; systems that 'contain' the risks and demands of child and family practice (structural features), processes that reflect a recognition of these impacts on nurses (ensuring safety and supportive experience) and the skills and attitudes required by supervisors and supervisees to establish open and critical reflection of issues related to service provision (strengthening practice).

ACKNOWLEDGEMENTS

Open Access Funding provided by La Trobe University. [Correction added on 24 May 2022, after first online publication CAUL funding statement has been added.]

CONFLICT OF INTEREST

No conflict of interest has been declared by the author(s).

AUTHOR CONTRIBUTIONS

AO—conceptualization, literature search and review, data collection, appraisal, data analysis, manuscript drafting, and review and editing. KE—conceptualization, review literature, appraisal, data analysis and manuscript review and editing. LH—conceptualization, review literature, appraisal, data analysis and manuscript review and editing.

PEER REVIEW

The peer review history for this article is available at https://publons.com/publon/10.1111/jan.15191.

DATA AVAILABILITY STATEMENT

The data that supports the findings of this study are available in the supplementary material of this article.

ORCID

Anne O'Neill https://orcid.org/0000-0003-1639-0456

REFERENCES

Adams, C., Hooker, L., & Taft, A. (2019). The enhanced maternal and child health nursing program in Victoria: A cross-sectional study of clinical practice. *Australian Journal of Primary Health*, *25*(3), 281–287.

Aromataris, E., & Munn, Z. (Eds.). (2020). *JBI manual for evidence synthesis*. JBI. Retrieved from https://synthesismanual.jbi.global; https://doi.org/10.46658/JBIMES-20-01

Bishop, V. (2008). *Clinical governance and clinical supervision: Protecting standards of care*. Sage Publications.

Bond, M., & Holland, S. (2011). *Skills of clinical supervision for nurses: A practical guide for supervisees, clinical supervisors and managers*. McGraw-Hill Education (UK).

Botham, J. (2013). What constitutes safeguarding children supervision for health visitors and school nurses? *Community Practitioner*, *86*(3), 28–34.

Bradshaw, T., Butterworth, A., & Mairs, H. (2007). Does structured clinical supervision during psychosocial intervention education enhance outcome for mental health nurses and the service users they work with? *Journal of Psychiatric and Mental Health Nursing*, *14*(1), 4–12. https://doi.org/10.1111/j.1365-2850.2007.01021.x

Brunero, S., & Stein-Parbury, J. (2008). The effectiveness of clinical supervision in nursing: An evidenced based literature review. *Australian Journal of Advanced Nursing*, *25*(3), 86–94.

Brunner, E., & Marmot, M. (2006). Social organization, stress, and health. *Social Determinants of Health*, *2*, 17–43.

Butterworth, T., Bell, M. L., Jackson, A., & Pajnikar, M. (2008). Wicked spell or magic bullet? A review of the clinical supervision literature 2001–2007. *Nurse Education Today*, *28*(3), 264–272. https://doi.org/10.1016/j.nedt.2007.05.004

Butterworth, T., Bishop, V., & Carson, J. (1996). First steps towards evaluating clinical supervision in nursing and health visiting. I. Theory, policy and practice development. A review. *Journal of Clinical Nursing (Wiley-Blackwell)*, *5*(2), 127–132. https://doi.org/10.1111/j.1365-2702.1996.tb00238.x

Buus, N., & Gonge, H. (2009). 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. https://doi.org/10.1111/j.1447-0349.2009.00612.x

Cutcliffe, J. R., & Hyrkas, K. (2006). Multidisciplinary attitudinal positions regarding clinical supervision: A cross-sectional study. *Journal of Nursing Management (Wiley-Blackwell)*, *14*(8), 617–627. https://doi.org/10.1111/j.1365-2934.2006.00720.x

Cutcliffe, J. R., Sloan, G., & Bashaw, M. (2018). A systematic review of clinical supervision evaluation studies in nursing. *International Journal of Mental Health Nursing*, *27*(5), 1344–1363. https://doi.org/10.1111/inm.12443

Dahlbo, M., Jakobsson, L., & Lundqvist, P. (2017). Keeping the child in focus while supporting the family: Swedish child healthcare nurses experiences of encountering families where child maltreatment is present or suspected. *Journal of Child Health Care*, *21*(1), 103–111. https://doi.org/10.1177/1367493516686200

Davys, A., & Beddoe, L. (2020). *Best practice in professional supervision, Second edition: A guide for the helping professions*. Jessica Kingsley Publishers.

Dilworth, S., Higgins, I., Parker, V., Kelly, B., & Turner, J. (2013). Finding a way forward: A literature review on the current debates around clinical supervision. *Contemporary Nurse*, *45*(1), 22–32.

Draper, B., Koukos, C., Fletcher, P., Whitehead, A., Reynolds, F., Coleman, M., & Rafferty, M. (1999). Focus on clinical supervision. Evaluating an initiative: Clinical supervision in a community health trust. *British Journal of Community Nursing*, *4*(10), 525–530.

Dunkley-Bent, J. (2017). A-EQUIP: The new model of midwifery supervision. *British Journal of Midwifery*, *25*(5), 278–279.

Engström, M., Hiltunen, J., Wallby, T., & Lucas, S. (2021). Child health Nurses' experiences of addressing psychosocial risk factors with the families they meet. *Acta Paediatrica*, *110*(2), 574–583. https://doi.org/10.1111/apa.15492

Fowler, J. (1996). The organization of clinical supervision within the nursing profession: A review of the literature. *Journal of Advanced Nursing*, *23*(3), 471–478. https://doi.org/10.1111/j.1365-2648.1996.tb00008.x

Fraser, S., Grant, J., & Mannix, T. (2014). The role and experience of child and family health nurses in developed countries: A review of the literature. *Neonatal, Paediatric & Child Health Nursing*, *17*(3), 2.

Greenway, J. C., Entwistle, V. A., & terMeulen, R. (2013). Health visitor professional education and post-qualification clinical supervision: How well does it equip practitioners for dealing with ethical tensions associated with promoting the public health agenda to individual clients? *Primary Health Care Research & Development*, *14*(1), 90–102. https://doi.org/10.1017/S1463423612000278

Hall, C. (2007). Health visitors' and school nurses' perspectives on child protection supervision: The journal of the health Visitors' Association. *Community Practitioner*, *80*(10), 26–31.

Heffron, M. C., Reynolds, D., & Talbot, B. (2016). Reflecting together: Reflective functioning as a focus for deepening group supervision. *Infant Mental Health Journal*, *37*(6), 628–639. https://doi.org/10.1002/imhj.21608

Honey, S., & Walton, C. (2008). An induction programme for health visitors. *Community Practitioner*, *81*(2), 14–19.

Horowitz, M. J. (1982). Stress response syndromes and their treatment. In L. Goldberger & S. Breznitz (Eds.), *Handbook of stress: Theoretical and clinical aspects* (pp. 711–732). Free Press.

Joanna Briggs Institiute. (2021). JBI EBP Database: Critical appraisal checklists. Retrieved from https://wiki.jbi.global/display/JED/Resources%2C+Forms+and+Templates

Kenny, A., & Allenby, A. (2013). Implementing clinical supervision for Australian rural nurses. *Nurse Education in Practice*, *13*(3), 165–169. https://doi.org/10.1016/j.nepr.2012.08.009

Kimla, K., Nathanson, D., Woolfenden, S., & Zwi, K. (2019). Identification of vulnerability within a child and family health service. *Australian Health Review*, *43*(2), 171–177. https://doi.org/10.1071/AH17024

Kornaros, K., Zwedberg, S., Nissen, E., & Salomonsson, B. (2018). A hermeneutic study of integrating psychotherapist competence in postnatal child health care: nurses' perspectives. *BMC Nursing*, *17*(1), 42. https://doi.org/10.1186/s12912-018-0311-1

Lister, P. G., & Crisp, B. R. (2005). Clinical supervision in child protection for community nurses. *Child Abuse Review*, *14*(1), 57–72. https://doi.org/10.1002/car.873

Little, M., Baker, T., & Jinks, A. M. (2018). A qualitative evaluation of community Nurses' experiences of child safeguarding supervision. *Child Abuse Review*, *27*(2), 150–157. https://doi.org/10.1002/car.2493

Lizarondo, L., Stern, C., Carrier, J., Godfrey, C., Rieger, K., Salmond, S., Apostolo, J., Kirkpatrick, P., & Loveday, H. (2020). Chapter 8: Mixed methods systematic reviews. In E. Aromataris & Z. Munn (Eds.), *JBI Manual for Evidence Synthesis*. JBI. https://doi.org/10.46658/JBIMES-2009

Moseley, M. (2020). An evaluation of group safeguarding supervision in health visiting practice. *Primary Health Care*, *30*(3), 18–23. https://doi.org/10.7748/phc.2020.e1611

National Council of State Boards of Nursing. (2020). A global profile of nursing education, regulation and practice. *Journal of Nursing Regulation*, *10*, 1–116.

Page, M. J., McKenzie, J. E., Bossuyt, P. M., Boutron, I., Hoffmann, T. C., Mulrow, C. D., Shamseer, L., Tetzlaff, J. M., Akl, E. A., Brennan, S. E., Chou, R., Glanville, J., Grimshaw, J. M., Hróbjartsson, A., Lalu, M. M., Li, T., Loder, E. W., Mayo-Wilson, E., McDonald, S., … Moher, D. (2021). The PRISMA 2020 statement: An updated guideline for reporting systematic reviews. *BMJ*, *372*, n71. https://doi.org/10.1136/bmj.n71

Pearce, P., Phillips, B., Dawson, M., & Leggat, S. G. (2013). Content of clinical supervision sessions for nurses and allied health professionals. *Clinical Governance: An International Journal*., *18*(2), 139–154. https://doi.org/10.1108/14777271311317927

Peckover, S., & Appleton, J. V. (2019). Health visiting and safeguarding children: A perfect storm? *Journal of Health Visiting*, *7*(5), 232–238. https://doi.org/10.12968/johv.2019.7.5.232

Proctor, B. (1987). Supervision: A cooperative exercise in accountability. In *Enabling and ensuring. Supervision in practice*. MM and PM Leceister, National Youth Bureau and Council for Eduction and Training in Youth and Community Work.

Rooke, J. (2015). Exploring the support mechanisms health visitors use in safeguarding and child protection practice [report]. *Community Practitioner*, *88*, 42–45.

Rothwell, C., Kehoe, A., Farook, S., & Illing, J. (2019). *The characteristics of effective clinical and peer supervision in the workplace: A rapid evidence review*. Newcastle University.

Schön, D. A. (1987). *Educating the reflective practitioner: Toward a new design for teaching and learning in the professions*. Jossey-Bass.

Scott, L. (1999). The nature and structure of supervision in health visiting with victims of child sexual abuse. *Journal of Advanced Nursing*, *29*(3), 754–763.

Stamm, B. H. (2009). *The concise ProQOL manual*. ProQOL.org.

Talbot, L., & Verrinder, G. (2008). Turn a stack of papers into a literature review: Useful tools for beginners. *Focus on Health Professional Education: A Multi-disciplinary Journal*, *10*(1), 51–58.

Turley, J., Vanek, J., Johnston, S., & Archibald, D. (2018). Nursing role in well-child care. Systematic review of the literature. *Canadian Family Physician*, *64*(4), e169–e180.

Vandette, M.-P., & Gosselin, J. (2019). Conceptual models of clinical supervision across professions: A scoping review of the professional psychology, social work, nursing, and medicine literature in Canada. *Canadian Psychology*, *60*(4), 302–314. https://doi.org/10.1037/cap0000190

Veritas Health Innovation. (2019). *Systematic review software*. Veritas Health Innovation.

Wallbank, S. (2013). Maintaining professional resilience through group restorative supervision. *Community Practitioner*, *86*(8), 26–28.

Wallbank, S., & Woods, G. (2012). A healthier health visiting workforce: Findings from the restorative supervision programme. *Community Practitioner: The Journal of the Community Practitioners' & Health Visitors' Association*, *85*(11), 20–23.

White, E. (2017). Clinical supervision: Invisibility on the contemporary nursing and midwifery policy agenda. *Journal of Advanced Nursing*, *73*(6), 1251–1254. https://doi.org/10.1111/jan.12970

Winstanley, J., & White, E. (2003). Clinical supervision: Models, measures and best practice. *Nurse Researcher (through 2013)*, *10*(4), 7–38.

Woolfenden, S., Goldfeld, S., Raman, S., Eapen, V., Kemp, L., & Williams, K. (2013). Inequity in child health: The importance of early childhood development. *Journal of Paediatrics and Child Health*, *49*(9), E365–E369. https://doi.org/10.1111/jpc.12171

SUPPORTING INFORMATION

Additional supporting information may be found in the online version of the article at the publisher's website.

How to cite this article: O'Neill, A., Edvardsson, K. & Hooker, L. (2022). Clinical supervision practice by community-based child and family health nurses: A mixed-method systematic review. *Journal of Advanced Nursing*, 78, 1588–1600. https://doi.org/10.1111/jan.15191

The *Journal of Advanced Nursing (JAN)* is an international, peer-reviewed, scientific journal. *JAN* contributes to the advancement of evidence-based nursing, midwifery and health care by disseminating high quality research and scholarship of contemporary relevance and with potential to advance knowledge for practice, education, management or policy. *JAN* publishes research reviews, original research reports and methodological and theoretical papers.

For further information, please visit *JAN* on the Wiley Online Library website: www.wileyonlinelibrary.com/journal/jan

Reasons to publish your work in *JAN*:

- **High-impact forum: the world's most cited nursing journal, with an Impact Factor of 2.561 – ranked 6/123 in the 2019 ISI Journal Citation Reports © (Nursing; Social Science).**
- **Most read nursing journal in the world: over 3 million articles downloaded online per year and accessible in over 10,000 libraries worldwide (including over 6,000 in developing countries with free or low cost access).**
- **Fast and easy online submission:** online submission at http://mc.manuscriptcentral.com/jan.
- **Positive publishing experience:** rapid double-blind peer review with constructive feedback.
- **Rapid online publication in five weeks:** average time from final manuscript arriving in production to online publication.
- **Online Open:** the option to pay to make your article freely and openly accessible to non-subscribers upon publication on Wiley Online Library, as well as the option to deposit the article in your own or your funding agency's preferred archive (e.g. PubMed).