

REVIEW

Group clinical supervision in adult mental health settings

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ABSTRACT

INTRODUCTION: Supervision in mental health services (MHS) has a long tradition. Aim of this review was to analyze papers focused on group clinical supervision in adult psychiatric services.

EVIDENCE ACQUISITION: A systematic review of the literature was performed, according to the PRISMA guidelines. The review protocol was registered on PROSPERO. Papers were electronically identified through a database search updated up to October 31, 2020, on PubMed, PsycInfo, Scopus and Web of Science. English-written papers were eligible if reporting any data measuring directly or indirectly the outcome of supervision on mental health professionals.

EVIDENCE SYNTHESIS: Twenty-five articles were included: three randomized controlled trials, one cohort study, one cross-sectional and twenty qualitative studies. Although supervision is widely employed among MHSs, the number of studies documenting its diffusion and efficacy is limited. Furthermore, poor operational definitions of supervision limit comparisons among studies. Participants generally reported an improved sense of professional competence and expressed a clear preference for a supervisor coming from outside the work environment. This choice may impact on budget, therefore future studies should address also cost effectiveness of group supervision.

CONCLUSIONS: Improved sense of competence, widely reported by participants, should encourage further studies to better investigate supervision cost; therefore, future studies should also address effectiveness in clinical contexts. In particular, professionals taking part to supervision found that a supervisor coming from outside their organizations was more effective, but this may bring additional costs.

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KEY WORDS: Nursing; Mental health; Burnout, ~~psychological~~; Systematic review.
Psychological

Introduction

Supervision has a long tradition in mental health services, and its cultural background can be found in psychotherapeutic training. Although still widely employed, little data on its real diffusion is currently available. One reason is the lack of a common definition of supervision.

NICE includes supervision in their guidelines.¹⁻³ In order to optimize currently limited resources, it is useful to explore the scientific evidence regarding supervision.

In the psychoanalytic context, supervision is described as “the opportunity to observe, all at the same time, a group of simultaneous interactions; the interaction between patient and therapist, be-

tween therapist and supervisor, and finally the subtle effect of the organizational relationship to the institute.”⁴ Supervision in psychiatric teams is considered “an instrument which activates an analytical way of functioning, particularly useful in the situation where, in treatment relationship with patients difficult to reach, there is a block of thought in the patient-therapist relationship.”⁵ According to cognitivists Butera and Zaratti,⁶ the supervision relationship represents “an interactive process, characterized by a number of emotional experiences, the fundamental parts of which are: the therapist, the supervisor, and the relationship between them” (our translation from Italian). In Medicine, the concept of supervision is linked to the acquirement of therapeutic expertise.

Brigid Proctor⁷ developed a clinical supervision model which is the most used in health contexts. We chose it as a benchmark for our review. She postulated three macro-functions of supervision: “formative,” “normative,” and “restorative.” The first function concerns supervisees’ training and learning. The second function concerns increasing the uniformity and consistency with the theoretical model of treatment of the care delivered (fidelity). The third function is the emotional support of the professionals; it’s concerned with supporting personal wellbeing⁸ which might include the management of work-related stress.

Aim of the first two functions is the integration between theory and clinical practice to improve professional skills. In this way, supervision allows the acquisition of specific models of therapeutic intervention and to boost their use in clinical settings.⁹

Research has identified burnout and work-related stress (together with stalking and violence) as the major threats to mental health professionals’ wellbeing.¹⁰ According to the European Agency for Safety and Health at Work (EU-OSHA), mental health professionals experience work-related stress problems “when the demands of the work environment exceed the employees’ ability to cope with (or control) them.”¹¹ In particular, the meta-analysis by Edwards *et al.*¹² identified dissatisfaction linked to: professional context, poor

offered training, and burnout, among the main causes of voluntary resignation among psychiatric nurses. The association of burnout with the perception of insufficient support provided by the team to the health professional is well known.¹³ According to the EU-OSHA, supervision helps controlling subjective stress experience through sharing it with the team. In literature, clinical supervision in mental health is mainly described in psychiatric and psycho-geriatric contexts.¹⁴

With regard to the setting, supervision can be either on individual or group basis. Group supervision, considered in the present review, usually consists in a clinical case presentation by a mental health professional with the active participation of the other members of the team. Group supervision can optimize time dedicated to clinical traineeship, offering the opportunity to debate clinical experiences. It could maximize learning both between supervisor and peers and among peers. Analyzing the same clinical case from different perspectives and comparing different management choices are two possible advantages provided by group supervision.¹⁵ In general, group supervision in multi-professional teams may promote the sharing of common objectives. By activating a narrative function, it may enhance planning ability to seek coherence and quality in clinical interventions.⁵

The Proctor’s model of clinical supervision guided the Clinical Supervision Evaluation Project (CSEP), developed by Manchester University in 1997, funded by the British Department of Health and the Scottish Home and Health Department⁸ which led to the creation of the Manchester Clinical Supervision Scale (MCSS). Currently, this is the only internationally validated scale to evaluate the perceived effectiveness of clinical supervision.¹³

Although clinical supervision has been widely discussed in literature and investigated through standardized methodology (*i.e.* the MCSS), few studies have evaluated outcomes of supervision of mental health professionals. This was the aim of the present review, which adopted Proctor’s model to explore outcomes of group clinical supervision of mental health professionals.

Evidence acquisition

Search strategy

A systematic review of the literature was performed, according to the PRISMA guidelines.¹⁶ The review protocol was registered on PROSPERO (CRD42019127214).

Papers were electronically identified through a database search, carried out in March 2019, on PubMed, PsycInfo, Scopus and Web of Science. The search was updated in November 2020 up to October 31, 2020. The search terms employed as keywords were: (“supervision” OR “team supervision” OR “clinical supervision” OR “medical supervision”) AND (“burnout” OR “practice” OR “skill*” OR “empowerment” OR “benefits” OR “outcome” OR “satisfaction” OR “impact” OR “effective” OR “anxiety” OR “depression” OR “usefulness” OR “job performance” OR “personal growth” OR “stress-reducing” OR “turnover” OR “well-being” OR “effect” OR “effects” OR “safety” OR “evaluation” OR “training” OR “support” OR “learning” OR “coping” OR “improve” OR “attitude” OR “education” OR “knowledge” OR “evidence-based” OR “feedback” OR “evaluation” OR “validation” OR “implementation” OR “role” OR “impact” OR “resistance” OR “fidelity”) AND (“psychiatrist*” OR “nurse*” OR “psychiatry” OR “psychologist*” OR “psychology” OR “counselor*” OR “social worker” OR “mental health professional*” OR “psychiatric” OR “mental health” OR “prison” OR “jail” OR “community” OR “psychiatric department, hospital” OR “mental health services” OR “mental hygiene”).

In addition, forward citation tracking of included peer-reviewed publications was conducted using Google Scholar. The reference lists of included peer-reviewed publications were hand searched, and references screening of the reviews regarding the topic of interest was conducted.

Eligibility criteria

Studies were included if involving a sample of mental health professionals (*e.g.* psychiatrists, nurses, social workers, psychologists, etc.) working in an adult mental health setting, undergoing any kind of group clinical supervision

(without limitation regarding session duration or frequency).

Papers were eligible if reporting any data measuring directly or indirectly the outcome of supervision on mental health professionals (supervisees).

Studies had to be written in English, but no limitation regarding study design was applied.

Articles were excluded if participants were working in children and adolescent mental health settings. Books chapters, conferences proceedings and editorials were excluded. Reviews’ references were screened for potential articles to be included.

Review strategy

Titles and abstracts of the studies retrieved were imported to the program Zotero® (RRCHNM; Fairfax, VA, USA) and examined by a primary reviewer (MG) to determine articles potentially relevant for inclusion in the review.

A random selection of 25% of citations was independently checked by a second reviewer (JB) using the same inclusion/exclusion criteria in order to minimize potential bias and to ensure consistency in screening. Any disagreement arising was resolved through discussion, or with the help of another reviewer, if needed.

Then, full texts of the articles identified were evaluated using the same inclusion/exclusion criteria.

Data extraction, quality assessment, data synthesis

Two reviewers (MG, JB) independently extracted the relevant data and assessed the articles’ quality using the GRADE (grading of recommendations, assessment, development and evaluation). Any discrepancies arising were resolved through discussion in the review team. Results were described and summarized using Proctor’s three functions model of clinical supervision as framework.⁷

Evidence synthesis

Figure 1 shows the selection process followed for this review.

Results are presented in Supplementary Digi-

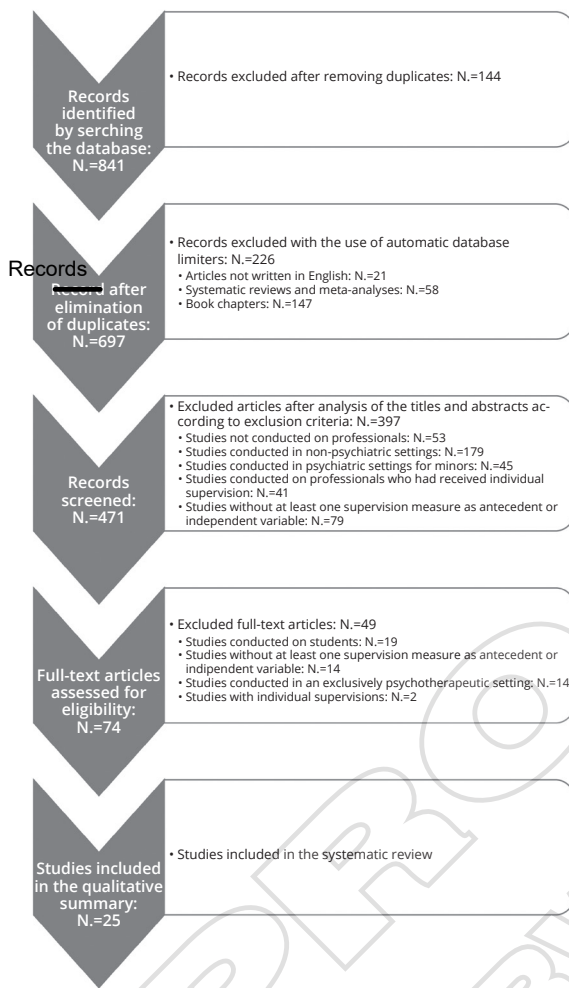


Figure 1.—Flowchart of the selection process of studies included in this review.

tal Material 1: Supplementary Table I. Each study is classified by author, year of publication, title, type of study, setting, nationality, population, intervention, measure, results.

Quality of evidence is presented in Table I^{13, 17-19, 21-27, 29-31, 34-36, 38-40} according to GRADE score (very low: 1, low: 2, medium: 3, high: 4). The GRADE scale assesses the following issues: study limits, precision, consistency, direct measurement of outcomes, publication bias. The articles included in the review were independently reviewed by the two reviewers; the differences regarding the quality assessment of the included studies were resolved by consensus of the working group.

Table II^{13, 17-36, 39, 40} shows the outcomes according to three-function Proctor’s model:⁷ learning, fidelity to the treatment model, contrast to work-related stress.

Fourteen studies (N.=14) concerned training, reporting mostly positive outcomes.^{17, 18, 27, 31, 36} Scanlon³⁴ and Sloan³⁵ noted that professionals, because of feelings of inadequacy and anxiety, preferred a supervisor that did not belong to the same unit of the supervisees. Gonge *et al.*²⁵ noted that greater participation in the supervision sessions did not correlate with the subjective perception of effectiveness of the supervision, as measured by the MCSS. Buus *et al.*²² noted that increasing workloads made it difficult for professionals to find time to participate in the supervision sessions and to stay focused on supervision during the sessions, that high occupancy rates of beds in psychiatric wards and high patient turnover combined with shift work made it difficult for the nurses to be fully updated about their patient’s condition and situation.

Only two studies (N.=2) addressed the fidelity issue. Wimpenny *et al.*⁴⁰ noted that group supervision sessions offered a valuable framework for exploring professional practice issues in different settings. Weingardt *et al.*³⁹ lead a RCT comparing training outcomes obtained by 147 substance abuse counselors who completed eight self-paced online modules on cognitive-behavioral therapy (CBT) and attended a series of four weekly group supervision sessions using Web conferencing software. Counselors in both conditions demonstrated similar improvements in CBT knowledge and self-efficacy.

Fifteen studies (N.=15) concerned work-related stress. Authors found improvement on measures of Maslach Burnout Inventory when scores of Manchester Clinical Supervision Scale were high.^{24, 30, 39} Buus *et al.*²³ and Gonge^{25, 26} found respondents thought that clinical supervision was beneficial, but with very limited impact on their clinical practice. Neither management nor the staff effectively prioritized clinical supervision, which added to a downward spiral where low levels of participation undermined the potential benefits of clinical supervision, without any statistically significant difference in SF-36 and MBI scores in supervised workers vs. the con-

TABLE I.—*Quality of evidence of the included studies, presented according to GRADE score (very low: 1, low: 2, medium: 3, high: 4).*

Authors and year	Limitations of the study	Quality of evidence
Arvidsson <i>et al.</i> ¹⁷ 2000	Small sample size, use of poorly reproducible qualitative methodology (semi-structured interview)	2
Arvidsson <i>et al.</i> ¹⁸ 2001	Small sample size, use of poorly reproducible qualitative methodology (semi-structured interview)	2
Berg <i>et al.</i> ¹⁹ 1999	Small sample size	3
Bergvik <i>et al.</i> ²⁰ 1997	Small sample size, use of poorly reproducible qualitative methodology, single context	2
Berry <i>et al.</i> ²¹ 2019	Small range of potential predictors of burnout	3
Buus <i>et al.</i> ²² 2010	Small sample size	3
Buus <i>et al.</i> ²³ 2011	Small sample size	3
Edwards <i>et al.</i> ²⁴ 2006	High turnover	3
Gonge <i>et al.</i> ²⁵ 2015	Drop-outs	3
Gonge <i>et al.</i> ²⁶ 2016	Drop-outs, short duration of the intervention, low Cronbach alpha value	3
Hancox <i>et al.</i> ²⁷ 2004	Study carried out immediately after the end of the training, difficult to predict the results of the clinical application, application in a single context	3
Ho ²⁸ 2007	Small sample size, application in a single context	3
Hyrkäs <i>et al.</i> ²⁹ 2005	Supervisors' heterogeneity	4
Knudsen <i>et al.</i> ³⁰ 2008	Drop-outs, application in a single context	3
Lakeman <i>et al.</i> ³¹ 2009	Small sample size, use of poorly reproducible qualitative methodology (focus group)	2
Magnusson <i>et al.</i> ³² 2002	Drop-outs	4
Pinney <i>et al.</i> ³³ 1978	The descriptive analysis of the results focuses above all on the training offered rather than on outcomes	2
Scanlon <i>et al.</i> ³⁴ 1997	Small sample size, use of poorly reproducible qualitative methodology (semi-structured interview)	2
Sloan ³⁵ 1999	Small sample size, use of poorly reproducible qualitative methodology (semi-structured interview)	2
Taylor ³⁶ 2013	Use of poorly reproducible qualitative methodology (semi-structured interview)	3
Treves <i>et al.</i> ³⁷ 1998	Small sample size, use of poorly reproducible qualitative methodology (focus group), high turnover	2
Walsh <i>et al.</i> ³⁸ 2003	Small sample size, use of poorly reproducible qualitative methodology (focus group, semi-structured interview)	2
Weingardt <i>et al.</i> ³⁹ 2009	Application in a single context	4
White <i>et al.</i> ¹³ 2010	High turnover	4
Wimpenny <i>et al.</i> ⁴⁰ 2006	Use of poorly reproducible qualitative methodology (focus group)	3

TABLE II.—*Results of the systematic review, divided according to the functions identified by Proctor (1986).*

Education N.=17	Fidelity N.=6	Contrast to work – related stress N.=15
Arvidsson <i>et al.</i> ¹⁸ (2001)	Buus <i>et al.</i> ²² (2010)	Arvidsson <i>et al.</i> ¹⁸ (2001)
Arvidsson <i>et al.</i> ¹⁷ (2000)	Edwards <i>et al.</i> ²⁴ (2006)	Berg <i>et al.</i> ¹⁹ (1999)
Bergvik <i>et al.</i> ²⁰ (1997)	Gonge <i>et al.</i> ²⁵ (2015)	Berry <i>et al.</i> ²¹ (2019)
Buus <i>et al.</i> ²³ (2011)	Hyrkäs <i>et al.</i> ²⁹ (2005)	Buus <i>et al.</i> ²³ (2011)
Buus <i>et al.</i> ²² (2010)	Weingardt <i>et al.</i> ³⁹ (2009)	Buus <i>et al.</i> ²² (2010)
Edwards <i>et al.</i> ²⁴ (2006)	White <i>et al.</i> ¹³ (2010)	Edwards <i>et al.</i> ²⁴ (2006)
Gonge <i>et al.</i> ²⁵ (2015)		Gonge <i>et al.</i> ²⁶ (2016)
Hancox <i>et al.</i> ²⁷ (2004)		Gonge <i>et al.</i> ²⁵ (2015)
Hyrkäs <i>et al.</i> ²⁹ (2005)		Ho <i>et al.</i> ²⁸ (2007)
Lakeman <i>et al.</i> ³¹ (2009)		Hyrkäs <i>et al.</i> ²⁹ (2005)
Magnusson <i>et al.</i> ³² (2002)		Knudsen <i>et al.</i> ³⁰ (2008)
Pinney <i>et al.</i> ³³ (1978)		Sloan <i>et al.</i> ³⁵ (1999)
Scanlon <i>et al.</i> ³⁴ (1997)		Taylor <i>et al.</i> ³⁶ (2013)
Sloan <i>et al.</i> ³⁵ (1999)		Weingardt <i>et al.</i> ³⁹ (2009)
Taylor <i>et al.</i> ³⁶ (2013)		White <i>et al.</i> ¹³ (2010)
White <i>et al.</i> ¹³ (2010)		
Wimpenny <i>et al.</i> ⁴⁰ (2006)		

trol group.²⁵ Berry *et al.*²¹ hypothesized a weak negative correlation between clinical supervision and levels of burnout (depersonalization in particular). Nonetheless, they highlighted that ward environment played a greater role on preventing burnout than clinical supervision.

Acting as a supervisor for others had a significant positive influence on job satisfaction. These respondents had clearly higher external, intrinsic, and total job satisfaction scores compared to their non-supervising colleagues.²⁹

The majority of studies included in this review were qualitative, consistently with a review by Cutcliffe *et al.*⁴¹ and White *et al.*¹³ Questionnaires, semi-structured interviews, and focus groups were mainly adopted to investigate this topic. The poor number of results found among the four databases searched was consistent with literature, as well.⁴¹

Studies included in this review mainly involved nurses working in psychiatric facilities, as pointed out by Lynch *et al.*¹⁴ This is understandable, considering that psychiatric nurses make up the largest group of mental health professionals working in community adult mental health settings. Nurses working in psychiatric settings have close and intense interactions with patients, and benefit of specific training. Without the latter, which is additional to nurse general education,^{42,43} the risk of work-related stress and rapid turnover is very high.¹³

The present review highlighted a substantial lack of research concerning supervision among psychiatrists. Only two studies involved psychiatry residents and were oriented to an educational function, according to the Proctor's model.⁷ We hypothesized, on the basis of common Italian and European experience,^{5,44,45} that psychiatrists might undergo supervision also outside their work environment, *e.g.* in the context of psychotherapy courses for specific groups of patients.⁴⁶ Equally, no studies involving psychologists were found.

It is worth noting that studies agreed on the lack of a consensus definition of clinical supervision. Buus²³ highlighted how, until the late 1990s, supervision was mainly performed in psychoanalytic or management settings.⁴⁷ Currently, clinical supervision is recommended in NICE

guidelines.¹⁻³ The term supervision included a range of interventions involving either group or individual clinical case discussion. Group supervision could be performed either in institutional work settings (*e.g.* a community mental health centers teams) or in *ad-hoc* groups made on purpose.

With regard to the supervisor choice, results were consistent with other studies,^{41, 48} showing that mental health professionals preferred a supervisor coming from outside the work environment.^{34, 35} Scanlon *et al.*³⁴ hypothesized a correlation between this preference and the need of emotional control and processing and pointed out that anxiety and inadequacy experiences prevailed among participants when the supervisor was also the manager or coordinator of one's own team.

The present review highlighted the heterogeneity of psychiatric contexts in which studies were conducted (hospitals, community-based services, psychiatric wards). Differences in mental health care organization among Countries could explain this heterogeneity. Studies included in this review were mostly conducted in Countries that, starting from the 1970s, introduced a progressive deinstitutionalization of mental health services. The process gradually provided community-based services in which a multi-disciplinary team takes care of the patient, preserving domestic and social bonds. A change in professional roles has mirrored the psychiatric reorganization, requiring specific training.^{8,45}

With regard to Proctor's first function of supervision (*i.e.* education and training), this review pointed out the lack of specific courses in clinical supervision in mental health professionals training courses. Moreover, difficulties in scheduling supervision sessions at the workplace, and the gradual decrease of attendance to supervision meetings were shown in the present work.^{23, 25, 27} The same problem is also reported regarding other support models, like mentoring. A recent paper highlighted how arranging a meeting schedule compatible with both the program timetable, and mentees' shift patterns, was a major challenge, especially considering the program's goal of promoting work-life balance.⁴⁹

Measuring the impact of supervision on super-

vises was another critical point. Cutcliffe *et al.*⁴¹ reported difficulties in measuring clinical supervision effectiveness, due to the absence both of a common definition of clinical supervision, and of replicable and validated scales, apart from the Manchester Clinical Supervision Scale (MCSS). This Likert-type questionnaire aims at measuring supervisees' satisfaction with supervision and its effectiveness with regard to clinical care and was developed to assess the effects of clinical supervision among nurses.⁸

Regarding Proctor's second function of supervision (*i.e.* fidelity), our results were consistent with previous studies.^{8, 41} Our review pointed out that supervision is able to increase the level of fidelity of a certain intervention, as measured by the MCSS. In previous studies, participants reported increased professional competence and performance level, and decreased levels of burn-out.³⁹ Yet, it is worth recalling that it is difficult to measure the effectiveness of clinical supervision, because of the lack of a standard definition, as well as of validated scales.⁴¹

Considering Proctor's third function of supervision (*i.e.* emotional support), heterogeneous results emerged about the correlation between clinical supervision and burnout, as previously shown.^{13, 41} Teasdale *et al.*⁵⁰ highlighted the absence of a statistically significant correlation between sick leave days and group supervision attendance. Similar results were found by Buus *et al.*,³¹ Gonge *et al.*^{25, 26} In particular, in the paper by Gonge *et al.*²⁵ two groups, one group undergoing supervision and a control group, were both assessed with SF-36 and Maslach Burnout Inventory, and no statistically significant difference was found between the scores of the two groups. White *et al.*¹³ hypothesized that clinical supervision was associated with positive outcomes when the following conditions were met: participants were inclined to reflective practice, workload was not overwhelming, and patient turnover was not excessively fast.²³ The last hypothesis was also consistent with findings by Weingardt *et al.*,³⁹ Knudsen *et al.*,³⁰ Hyrkäs *et al.*,²⁹ showing no statistically significant changes in Maslach Burnout Inventory emotional exhaustion scores, before and after supervision.

Limitations of the study

The present study has several limitations that need to be acknowledged. First, having restricted the research to four databases (PubMed, PsycInfo, Scopus, and Web of Science), and to papers published only in English, might have excluded some relevant papers published in other languages. Yet, the criteria adopted made the study feasible and were consistent with the PRISMA statement on systematic reviews. Second, we did not perform a meta-analysis of the studies collected, due to the high prevalence of qualitative studies, and to the fact that only a few studies reported measures of associations, such as odds ratios. This limitation may be overcome in further studies when more quantitative studies on supervision will be available.

Conclusions

The present study showed that, although supervision is widely employed in many adult mental health clinical contexts, the number of studies on this topic is limited. Furthermore, generally poor operational definitions of supervision sessions limit comparisons among studies. Considering the importance for the good performance of MHS of the functions of clinical supervision highlighted by Proctor, and the scarcity of research on this topic, two main conclusions can be drawn. First, mental health service research aimed at optimizing processes and widely adopted practices such as clinical supervision should be encouraged and properly funded. Further studies should better investigate supervision cost-effectiveness in clinical contexts. In particular, professionals taking part to supervision found that a supervisor coming from outside their organizations was more effective, but this may bring additional costs. Future investigation should also assess the degree of availability of time and space a clinical service can dedicate to supervision. In fact, as we mentioned, the possible role played by supervision in preventing burnout is less likely when the supervisee's workload is already heavy. Further research should try to define operationalized models of supervision and measure their contribution in tackling the alarmingly high rate

of burnout among adult mental health professionals. Second, mental health professionals involved in group clinical supervision generally report an improved sense of professional competence. Clinical supervision may be helpful in preventing burnout. Supervisors coming from outside the supervisees' organizations are generally considered more effective. The offer of clinical supervision should be accompanied by protected time to participate and included and recognized in professional development plans of mental health trusts.

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