Clinical Supervision and Mental Health Nursing: a polemical review of contemporary issues[#]

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Preface:

Discrete empirical evidence has begun the accumulate to show that Clinical Supervision [CS] may have a positive effect on the well-being of Supervisees, when delivered to a demonstratively efficacious quality standard [White & Winstanley 2010]. However, comparatively little research evidence has entered the public domain to report any effect that CS may have on other nominated outcomes [Pollock *et al* 2017; White 2018].
About four decades ago, Mental Health Nurses became early adopters of CS [White & Winstanley 2014] and this paper identifies key contemporary issues that have emerged over time and raises pertinent questions, to help stimulate a contemporary discussion.

Issue 1:
Lack of a discriminating definition

Whilst Milne [2007] published the requirements necessary for a convincing definition, Clinical Supervision is frequently described in terms of what is not. Such descriptors include Managerial, Professional, Clinical Teaching, Reflective Clinical Facilitation, Buddying, Coaching, Psychotherapy, Counselling, Individual Performance Review, Debriefing, Preceptorship, Mentoring and so on. Moreover, several different models of CS populate the relevant literature; One-to-One, Peer, Group, Reflective, Restorative, Resilience-based*, Educational, Role Development, Solution-Focussed... Furthermore, different theoretical orientations compound the multiplicity of approaches; Psychodynamic, Integrated, Cognitive/Behavioural, Developmental…
The few examples, above, generate 36 possible permutations of what CS is and how it is delivered in practice and upon which theoretical platform it is driven. White *et al* [1993] previously reported an identical 'tautological maelstrom' in

research funded by the English National Board for Nursing, Midwifery and Health Visiting [ENB; then, the Regulatory Authority in England]. Now, thirty years later, the same questions remain; viz, are these various terms mutually exclusive, or a rose by any other name? How well do Supervisors understand which type of CS they provide? Do Supervisees know which type they receive? Either way, does it matter?

Issue 2:
Scarcity of empirical outcome evaluations

Innumerable reviews of the literature identify barriers to the implementation/maintenance of CS, including time-poor clinical staff, organizational funding shortages**, ambivalent managers [Masamha *et al* 2022] and lack of Supervisor training and support [White & Winstanley 2009; Rothwell *et al* 2021].

Such publications tend to focus on the *process* of CS and invariably lament the absence of findings [*outcomes*] from empirical studies. In part, this is because CS outcomes-oriented research is notoriously hard to fund, difficult to design, conduct, interpret and publish [White & Winstanley 2011].

There are relatively few dedicated CS researchers and, by extension, limited opportunities to critically evaluate the efficacy of CS and to test/report any causal effects on many of the claimed nominated benefits.

Such limited numbers may also impact the availability of appropriately experienced individuals to conduct peer reviews of CS-related manuscripts submitted for journal publication; a process which, of itself, is not without long-standing controversy [House of Commons Science and Technology Committee 2011]. A further consequence of the modest size of the active CS research community may also compromise the double-blind anonymity of the author and reviewer [Elliott 2021], violate the requirement of impartiality and increase the risk of bias [Smith 2006].

The scarcity may also help to explain the apparent diminishing level of engagement with an on-line discussion platform [the Clinical Supervision Special Interest Group; CS-SIG] launched by the Australian College of Mental Health Nurses in 2012. As at August 2021, ~9% of ACMHN financial members were CS-SIG members [n=~250]. Over the following nine years, a total of 1181 messages were posted, almost half of which were posted by less than 4% of the CS-SIG membership. Nearly a third were posted by less than 1.5% of members [White and Winstanley 2021].

Moreover, for 13 years an automatically curated *Clinical Supervision Digest* of international CS-related publications has been posted online every Thursday from Cairns, Australia [https://meta4rn.com/tag/clinical-supervision/]. In recent

times, the volume of such curatable material has noticeably declined and in April 2023 the *CS Digest* 'stopped'.
These observations appear to be possible proxy indicators of a waning contemporary discourse and have prompted the question; Is Clinical Supervision niche? [White 2021].

Issue 3:
National/local policy imperatives [Australia]

In 2011, Health Workforce Australia [HWA; an agency of the Federal Government] published the *National Clinical Supervision Support Framework.* HWA had invited 61 stakeholder organisations to make submissions; only three were Nursing. The peak national body for mental health nurses [the Australian College of Mental Health Nurses; ACMHN] was not one of the three invitees. HWA did not identify the College as a key stakeholder [Marks 2010]. In 2013, NSW Health and Education Training Institute [HETI] published *The Superguide: A Supervision Continuum for Nurses and Midwives.* Both documents were widely criticised by individuals and organisations, including the Australian Clinical Supervision Association.
Two years after publication, having refused several direct requests, HETI was required to release documents related to the *Superguide* under Freedom of Information legislation [White 2017]. Close inspection revealed that the CS policy position in NSW was narrowly constructed to fit with the earlier HWA report [HWA was closed in 2014 by Australian Federal Budget]. Of the 17 members of the *Superguide* Reference Group, 10 were service and/or education 'managers'. Eight contributing organisations/groups were publicly credited in the HETI document; 5 were medical colleges. None were nursing organisations; a sobering and intriguing example of supervision in the world of politics [Milne 2017].

National/local policy imperatives [England]

In 2020, a similar close examination of documents released under FoI legislation [White & Winstanley 2020] revealed the CS policy positions of 52 NHS Mental Health Trusts in England [employing ~42,000 MHNs] appeared to be nuanced versions of Care Quality Commission guidance, published [then] seven years earlier [Care Quality Commission 2013]. All CQC references were found to be CS Policy Positions and/or Codes of Conduct of government agencies, professional organisations and regulatory bodies, [then] published up to 18 years earlier. The CQC document was silent on the matter of CS evaluation.

The FoI study also revealed a third of NHS MH Trusts in England did not evaluate the CS they provided. Two-thirds revealed perfunctory in-house evaluations that were limited to Supervisee compliance with local CS policy positions. A myriad of administrative templates were home-spun checklists, usually bereft of a scoring protocol, with no psychometric properties; aka, tick-boxes [White 2018]. Such templates were generally found to record the frequency and length of Supervisee attendance at CS sessions [aka, headcounts] and represented a case of 'never mind the quality, feel the width' [White 2015].
Frequently, templates were accompanied by instructions about how to manage non-compliant staff and/or those whose 'performance' was deemed below the required level of commitment. None of the templates were referenced to published literature and not one of the Trusts had a publicly accessible copy of the latest CS evaluation report.

Issue 4:
Risk of superficial/harmful supervision

Despite the ethical mandate to 'do no harm' and the wise caution against the provision of superficial CS [Gardner *et al* 2010], harmful CS is occurring internationally among mental health disciplines 'at an alarming rate' and appears to be 'largely unacknowledged, unrecognized and not understood, especially from the Supervisees perspective' [Ellis *et al* 2017; McNamara *et al* 2017].
CS was reportedly *mandatory* in ~90% of Mental Health NHS Trusts in England [see Issue 3, above]. The juxtaposition of the near universal policy requirement for all staff to attend CS sessions and the associated risk of harm in so doing, is rarely acknowledged in policy documents. This may be an innocent or an intentional omission [so-called, wilful blindness; Heffernan 2011].

Issue 5:
National research/policy agendas

The grey literature contains countless CS *Position Statements, Frameworks, Policy Expressions, Value Propositions* and so on. Frequently, however, these amount to 'tired discussions' of the CS literature, seemingly cherry-picked to suit the current policy imperative of an agency, that offer no new insights. Each, in their turn, tend to recommend regular evaluation, but often as a token final comment and without guidance about how to conduct it [White & Winstanley 2020].

Issue 6:
Methodological solutions

The recent establishment of the USA-based Clinical Supervision Research Collaborative [CSRC; https://csrcollaborative.org/] has provided a welcome international platform for those interested in advancing the practice of clinical supervision, as scientists and/or practice professionals. Importantly, the CSRC lists 36 questionnaires to evaluate various aspects of CS, including the MCSS-26©, the original version of which [the Manchester Clinical Supervision Scale©; Winstanley 2000] was launched in London by the United Kingdom Government and was reported as 'the first validated tool designed specifically to measure the impact of Clinical Supervision' [Department of Health 2000]. The MCSS© was later further refined following a robust Rasch Analysis of its psychometric properties [Rasch 1960] and, thereafter, was renamed the MCSS-26© [Winstanley & White 2011]. A future-tense version of the MCSS-26© has also been developed by White Winstanley Ltd to capture data from individuals who have no previous experience of Clinical Supervision but have a personal *perception* of what to expect [the so-called MCSS-26P©].
In a further methodological development, when MCSS-26© data are subject to Classification and Regression Tree analysis [CART; Breiman *et al* 1984], the likelihood of the most efficacious CS arrangement in local settings can be predicted [Winstanley & White 2014].
None of the NHS Mental Health Trusts in England [see Issue 3, above] reportedly used of any of these CS evaluation instruments, nor employed any of these analytic methods.

End note:

It is often accepted that mere attendance at CS sessions, of itself, will reap many of the claimed benefits, particularly an improvement in the quality of care and in better outcomes for organisations and for service users. However, scrutiny of the historical development of CS [White & Winstanley 2014] and the evidence base for claims to the many of these benefits of CS published in the international literature [White 2018] revealed it is either silent, or parsimonious, or contradictory. Moreover, the 'donut' analogy [Goodyear and Bernard 1998], even questions the nutritional value of positive CS experience reported by Supervisees and retains a powerful contemporary resonance.
It is contended here that if CS is poorly understood at the conceptual level and/or is delivered superficially, it may waste public money and/or prove ineffectual and/or detrimental to Supervisees and service-users alike. Arguably, the early professional objectives of CS provision appear to have morphed into a *de facto*

managerial staff performance monitoring exercise, which may [or may not] have secondary gains.
Arguably therefore, it is timely to build on the prioritized questions and methods for an international and interdisciplinary supervision research agenda suggested by eight CS scholars [Goodyear *et al* 2016], supported by an appropriate level of funding, to rigorously test prevailing assumptions. Thereafter, to refresh the thinking around CS and apply any/all practical remedies necessary to confidently deliver beneficial outcomes. With concerted effort in the present most challenging of times, mental health nursing may yet retain influence over the CS narrative which, arguably, it once led.

Postscripts:

***A reservation**
Even if/when [say] *resilience-based* CS provision can be shown to be demonstrably efficacious and reap nominated benefits, it may *not* always then be accepted as a wholly positive outcome. This, not least because adaptation may serve to mask structural and stressful problems in workplaces [Mahdiani and Ungar 2021]. Evidently, resilience is the quality all clinical staff should possess in the face of diminishing pay, resources and staffing levels and increasing workloads. Failure to cope is cast as '*our fault*' [Bailey 2023] for not being resilient enough, regardless of any external pressure clinical staff may face. As Ford [2023] recently questioned; why train staff to develop their capacity to withstand known adversity in their health/social care organisations? Alternatively, as Gallagher [2022] has suggested, resilience-based CS can help individuals to question organisational practices which negatively impact on staff and patient wellbeing. If so, the corollary is for such questions to be conveyed to [and be addressed by] relevant others within local organisations with the duty to ensure a positive resolution.

****An apocryphal tale** [often attributed to Peter Baeklund]**:**
If scarce funding is raised as an objection to implement/maintain/evaluate CS [White & Winstanley 2006], consider this:

Chief Financial Officer asks Chief Executive Officer:
"What happens if we invest in developing our people and then they leave us?"

Chief Executive Officer replies:
"What happens if we don't …and they stay?"

[End]

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a One of three research studies conducted in the last 30 years 'that provide the best and clearest directions for further thought about conducting future successful research in the supervision-patient outcome area' [Watkins, 2011, *The Clinical Supervisor*, 30:2, 235-256]

b One the top three most downloaded articles that were published and downloaded in 2014, in each Routledge Health and Social Care journal and the 10th most read article since *The Clinical Supervisor* was first published in 1983

Conflict of Interest:

The author declares that he is a Director of White Winstanley Ltd, a consulting company based in Cheshire, England; the sole world-wide distributor of the *MCSS-26©* and the *MCSS-26P©* research instruments, referred to in Issue 6 above.
White Winstanley Ltd pays an annual royalty to *The University of Manchester Innovation Factory* derived from MCSS-26© Licence fees, to help fund other UoM researchers.

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