Clinical supervision in a UK military Department of Community Mental Health

Matthew I Wesson,1 D Whybrow,1 N Greenberg,2 M Gould3

ABSTRACT

Objectives Recent service developments in the NHS on the provision of talking therapies such as the Improving Access to Psychological Therapies (IAPT) initiative have made the compliance with clinical supervision (CS) inherent among its service guidelines. This paper presents the findings of an audit, measuring compliance with CS among clinicians providing psychological therapies within a military Department of Community Mental Health.

Method Adherence to the recommended monthly supervision and the presence of an indate CS contract were audited on two separate occasions over 2 years by analysing the departmental electronic CS database.

Results Compliance rates were found to be lower than the Defence guidelines, which are already modest in their expectations compared with IAPT CS standards.

Discussion Potential reasons are hypothesised including high levels of staff rotation, other military commitments, clinicians not keeping up-to-date records and the pressures of meeting performance indicators on other clinical issues. Proposals for improving the uptake of CS are suggested along with areas for further research.

INTRODUCTION

Within mental health settings, clinical supervision (CS) is a core activity that is in line with current clinical governance guidelines.1 CS consists of a working alliance between two or more professionals where the supervisees offer an account of their work to the supervisor who encourages reflection and provides relevant feedback and guidance.2 CS has a number of distinct aims but most definitions emphasise helping the supervisees to develop their knowledge base and increase competence, identifying solutions to problems and safeguarding standards.3 Supervision is perhaps most needed in situations where clinicians develop particularly close relationships with patients which are often most evident in psychotherapeutic settings. This paper details an audit which examines the compliance with CS among clinicians working in a military Department of Community Mental Health (DCMH). Although, it could be argued that there are forms of informal supervision such as discussions with colleagues, personal development strategies and personal reflection about aspects of work. This paper will concentrate on formal supervision which has a specified focus, content and process.

There is still a lack of high quality research, particularly randomised controlled trials (RCTs), which are able to demonstrate a direct link between engagement in CS and improved patient outcomes.4 This remains the biggest weakness of CS and is even more surprising in an age of evidence based medicine and outcome monitoring.5 However, it is argued the absence of RCTs is because most studies of CS reflect an interest in the process of supervision instead of its efficacy due to widespread professional assumptions that there is an inherent virtue to supervision and that it is generally accepted as a core competency within the field of mental health.6 7 Therefore, it is unsurprising that a number of governing bodies within mental health assume this position and have regular CS as a requirement of accreditation8–11 despite the absence of research trials proving its worth.

Surveys among clinicians have found that CS is highly valued in relieving isolation and providing greater confidence,12 as well as improving working relationships and clinical insight.13 It is proposed that this in turn may lead to improved staff recruitment, retention and efficiency, meaning that the costs to organisations in supporting and providing CS are likely to be recovered.14 One Cognitive Behavioural Therapy (CBT) training programme showed that when clinicians were supported with regular CS they were more likely to use evidence based approaches in their practice.15

Many occupational mental health services provide short term psychotherapy as a mechanism of returning those suffering with what are termed ‘common mental health disorders’, including depression, social anxiety and generalised anxiety disorders, or post-traumatic stress disorder back to work in a timely and effective manner.

The UK Armed Forces operate an in-house mental health service. It aims to provide high quality mental healthcare to military personnel.16 The Defence Mental Health Services (DMHS) makes use of various National Institute for Health and Clinical Excellence (NICE)-approved
psychological treatments. The DCMH in question here operates a ‘stepped care’ approach that makes much of its talking treatment service in line with the Improving Access to Psychological Therapies (IAPT) initiative which provides National Health Service (NHS) NICE recommended talking therapies for common mental health disorders. This DCMH is fortunate enough to have a skill mix similar to an IAPT team, with numerous clinicians accredited in CBT and/or Eye Movement Desensitisation and Reprocessing (EMDR) and most other clinicians with basic CBT and/or EMDR training. Therefore, anecdotal evidence would suggest patients under the care of this department with a depressive or anxiety disorder are much more likely to receive psychological therapy such as they would in an IAPT and far more than the 12.9% found in recent research of military personnel seeking treatment.

A key principle underpinning IAPT is that all therapists should receive weekly outcome-informed supervision examining their whole caseload. In contrast, Joint Services Publication 950, which relates to personnel working in the Defence Nursing Service, requires a minimum across the board 1 h per month of protected time for this activity. However, it is worth noting IAPT teams generally undertake markedly more intense (both in time with patient and caseload) patient interventions than a typical DCMH which may account for the higher ratio of CS being mandated.

Due to the additional emphasis being placed on CS within the NHS and by professional bodies, in 2009 a CS working group was established as a subgroup of the Royal Navy Mental Health Services (RNMHS) clinical governance committee. Following a review of the literature and consultation with subject matter experts, additional RNMHS CS guidelines were developed and introduced across three DCMHs (Portsmouth, Plymouth and Faslane). These guidelines applied to all professional groups working within DCMH (nursing, psychiatry, social work and psychology). Although the guidelines encouraged the use of ‘live’ supervision and that the supervisor was outside the line management structure of the supervisee, only three areas were benchmarked:

- Every DCMH was to use a departmental CS database which clinicians complete retrospectively each month. This would record details of their clinical supervisor(s), contract renewal details and dates of their supervision sessions. This would allow a departmental manager to keep a realistic overview on supervision activity.
- All clinicians to complete a minimum of 1 h of CS per month for each of the clinical specialties (e.g., CBT, EMDR) that they regularly practice.
- All clinicians to hold an up-to-date CS contract for each treatment modality they practice which specifically identifies target areas for supervision. The contract should detail the aims of supervision, frequency and the responsibility of the supervisor and supervisee.

**METHODS**

An audit was completed to identify one DCMH’s adherence to the inhouse CS recommendations outlined by interrogation of the departmental CS electronic database. This database listed all the arrangements for all the mental health nurses, clinical psychologists and GP trainees delivering some form of talking therapy as part of their clinical practice. As clinicians were instructed to keep their supervision records up-to-date, any out of date records were assumed to indicate non-compliance.

This audit required 100% compliance against three standards:

- All ‘talking therapies’ clinicians had the details of themselves and their clinical supervisors registered on the database.
- Supervision contracts recorded and up-to-date according to the database.
- Monthly supervision recorded in each of the specialties they practice in (unless they are away on leave/operations or not currently practicing in that specialty).

The audit targets were chosen to match the modest benchmarks set by the CS guidelines details. Data were drawn from an investigation of the 3 months records held within the database. There were two phases of auditing first in 2009 and then in 2011. Individual supervision records or contracts were not examined as part of this audit as the audit was purely to measure whether CS occurred.

**RESULTS**

The 2009 audit included information on 23 clinicians including 39 separate records, whereas the 2011 audit included information on 20 clinicians with 40 records (Table 1).

**DISCUSSION**

This study had a number of key findings; first, compliance with the database remained consistent and second utilisation of supervision contracts improved significantly over the period. Finally, when looking at the adherence to monthly CS, there was no sign of significant improvement across the time frames. This last finding is concerning as this is only being measured against the modest recommendations within both the Surgeon General’s Department’s policy on CS for nurses and the RNMHS guidelines, even though both are considerably less stringent than the CS recommendations within IAPT. It is hypothesised that this may include the high levels of staff rotation often seen in a DCMH due to staff often being away on military courses and operations. It is also worth noting that although there was no consistent pattern of compliance or non-compliance among professional groups, there was a greater adherence to monthly supervision among those who were accredited with the CBT and/or EMDR national bodies. This could be due to a combination of monthly supervision being part of reaccreditation requirements with these organisations and that the value of CS is heavily weighted during these accreditation processes.

It has been suggested that if CS is to be fully implemented the key is the promotion and importance of it being championed throughout management levels. It is the authors’ view that supervision networks in specialist psychotherapies such as CBT and EMDR are still in their development stages in the DMHS. The findings from this audit suggest that although this is improving, there still is required a further cultural shift within DCMHs to ensure the military recommendations for CS are met. This is a delicate and complex process demanding staff

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<th>Table 1 Clinical supervision audit results</th>
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<td><strong>Standard</strong></td>
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time, organisational resource and commitment by all stakeholders to achieve it.  

It is also worth noting that IAPT also faces challenges with its supervision model. There is currently no published evidence on the uptake of CS within IAPT although there are reports that it can get missed altogether due to the pressures to achieve services outcomes.

A challenge for the DMHS is that small units such as a DCMH CS will often be facilitated by senior therapists who may also be within the management chains of individuals. This may then generate a conflict and resistance to CS as supervisers view it as a mechanism where they may be exposed and it can lead to a reduced uptake of regular CS. This may partially explain the findings of this audit.

Whether the policy directions on the frequency of CS within the DMHS are appropriate and if they require more championing at a strategic and departmental level will require further audits to see the pattern of CS compliance across other DCMHs. The pattern of accreditation leading to increased compliance with monthly CS seems to suggest that accreditation has an additionally important factor worthy of note. Auditing CS for field mental health teams is also warranted because there have already been recommendations written on the need for enhanced levels of supervision for talking therapies when delivered in operational areas. Any further audits should examine individual supervision records instead of relying solely on the database, which would allow a fuller picture of compliance rates along with details on the quality and content of supervision. These audits could also investigate whether the CS being provided is role appropriate and survey reasons for non-compliance.

To increase individual clinician’s commitment to CS, further organisational initiatives are required to promote it as an integral part of effective mental healthcare. The clinical executives might need to consider introducing additional measures to further their support of CS, for example, including it within key performance indicators.

Research that identifies whether CS leads to improved clinical outcomes would assist in prioritising CS among stakeholders. Such research could begin with a controlled trial that matches cases by clinical severity and then comparing outcomes of those actively discussed in CS with those which are not. Investigations into how other occupational mental health providers manage CS may help to generate best practice solutions that recognise the challenges in the delivery of talking therapies in a non-IAPT setting.

LIMITATIONS

A clear weakness of the audit is that it relied entirely on the central departmental database. There is a strong possibility that in reality more clinicians were compliant with the guidelines, but were merely forgetting to keep the database updated. As the audit was only measuring whether CS occurs, it misses some potentially rich data around the content and format of CS and how these impact on its uptake. Auditing individual supervision records could have potentially supplied this information. The reasons for non-compliance were only speculated instead of being formally investigated through the audit process. Exclusively auditing one DCMH limits the ability to see trends across the whole of the DMHS.

CONCLUSIONS

This audit demonstrates that the uptake of CS may not be meeting the service guidelines and this warrants further investigation. Although additional research linking CS with improved clinical outcomes would be beneficial, there is a general acceptance of its importance within the governance processes of a DCMH. Therefore, to improve adherence at an individual and department level, CS may need further prioritising throughout the management structure of the DMHS.

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Contributors

MIW and MG carried out the audits. All authors were involved in preparing the manuscript.

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