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Primary-care mental-health workers' views of clinical supervision

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Abstract. Clinical supervision is an essential component of psychological work with clients. This article presents views of a group of primary-care mental-health workers on the introduction of clinical supervision. A focus group interview was analysed. The key themes extracted were: the supervisor's approach that provided an educative, safe, boundaried space that allowed exploration, support and validation; the advantages and disadvantages of group supervision; helpful and unhelpful ingredients of supervision; the governance and facilitative functions of supervision; and the dangers inherent in not having supervision for both client and worker. Key recommendations are made encompassing: training in supervision and a psychological approach; encouraging theory–practice consolidation; balancing competency with curiosity; and reviewing supervision regularly. Limitations of the study are also discussed.

Key words Clinical psychology, clinical supervision, primary care, supervision.

Introduction

There is an evolving and diverse array of individuals delivering psychological interventions within a primary-care setting, with varying degrees of previous experience and training. Consequently, clinical supervision must be a crucial factor in assuring the quality and the safety of interventions carried out (Lee, 2008). While among Health Professions Council-registered practitioner psychologists, supervision is commonly known as an essential component when working with clients, many primary-care mental-health workers (PCMHWs) are currently in the process of establishing supervisory systems that complement their own needs and roles.

The definition of clinical supervision is not necessarily agreed. For example, in an effort to refine and clarify an empirical definition, Milne (2007) carried out a logical analysis where definitions were subjected to four 'tests of good definition': precision, specification,

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operationalization, and corroboration. It was reported that widely used definitions failed these tests and Milne suggested a robust alternative:

> The formal provision by senior/qualified health practitioners of an intense relationship-based education and training that is focused and which supports, directs and guides the work of colleagues (Milne, 2007, p. 440).

Within primary care, there is currently a move to ensure that an Improving Access to Psychological Therapies (IAPT) approach to mental health services is followed. Guidance on supervision produced by IAPT (2008) differentiates between caseload and clinical supervision, dependent upon the intensity of the intervention that the worker delivers. Both these approaches to supervision share the common goals to 'safeguard the wellbeing of the client and assist the development of the supervisee' (p. 6). This ethos within IAPT services is professionally supported by BABCP who have given guidance on supervision frequency and focus (BABCP, 2010).

Types and functions of supervision

According to Hawkins & Shohet (2006), types of supervision can be placed into four distinct categories: training, tutorial, managerial, and consultancy. Within the current service, the main focus of supervision was consultancy following case presentation and discussion; and training and tutorial by way of demonstration and role play. Managerial supervision was in the process of being established by a different member of the team.

Inskipp & Proctor (1993) refer to the generally agreed functions of supervision as being normative; quality assurance encompassing ethical and professional considerations; formative, referring to the competence of the supervisee, their learning and development; and restorative, encouraging emotional processing and supporting wellbeing. Using these as a basis, Hawkins & Shohet (2006) assert that their supervision model also encompasses developmental, resourcing and qualitative functions. Although multiple models of supervision have been postulated over the years (see Beinart, 2004 for a review of many of these), the model of supervision used within the current primary-care mental-health setting reported here is the 'seven-eyed' model (Hawkins & Shohet, 2006). This model is used because it covers aspects of context and organization, often absent in other models. In addition, there is allowance within the model that takes into account the developmental nature of the supervisee and gives clear guidelines related to what the supervisor will be monitoring; thus, reducing anxiety and confusion related to what will be covered within supervision sessions. Hawkins & Shohet (2006) report the readiness of individual supervisees to receive supervision at certain modes is in keeping with their level of clinical experience. They suggest new supervisees attend to modes 1 and 2 in the earlier stages of their career, while more experienced supervisees can utilize modes 1-7; the latter moving fluidly and flexibly across the different levels as appropriate.

Methods of supervision

Differences in how supervision is carried out also exist, although most modes are loosely along the following lines: closely monitoring the supervisee, modelling competence, providing specific instructions, goal-setting and providing contingent feedback on performance (Milne & James, 2000). IAPT recommendations also suggest that supervision

should be informed by monitoring formal outcomes (IAPT, 2008). Although not broadly researched, there is some suggestion that the timing of when supervision occurs in relation to seeing a patient may change the content of the supervision session (Couchon & Bernard, 1984). Additionally, although acknowledged that the format of supervision is usually one-to-one, there are a variety of other formats that are perfectly valid, such as peer, group or co-supervision (Milne & Oliver, 2000).

Impact of supervision

A meta-review carried out by Wheeler & Richards (2007), identified many enhancing characteristics of supervision for the supervisee. These included: self-awareness (especially awareness of supervisee's impact on a client), application of skills, self-efficacy, timing and frequency of supervision, theoretical orientation, support and outcome for client. Of particular note, parallel processes and thematic transference from supervision sessions to client sessions and vice versa were commented on. The reviewers conclude that supervisees improve practice and gain in confidence through supervision and this raises the likelihood of better outcomes for clients.

Background to service

At the time of writing there were five PCMHWs from a variety of backgrounds, for example, community mental health nursing, life coaching, and a psychology graduate. The team had grown relatively quickly from its inception in 2007; however, there were no formal arrangements made for clinical supervision. Two workers had been on an in-house cognitive behavioural therapy (CBT) course that occurred one day per week for one year; and three others had been trained in basic counselling skills, as well as basic CBT models to understand anxiety and depression. The service is not part of the formal IAPT programme but is considered to be IAPT equivalent. The service receives referrals for the more common mental health problems including anxiety, stress and depression; both self-referrals and GP referrals. It is run as a primary-care direct access service (from within a secondary-care mental health trust on behalf of the PCT). This provides the opportunity for a seamless service with clients being moved up or down the stepped-care continuum as needed. As such, the notion of either low intensity or high intensity did not quite fit the team structure at that time although workers adhere to a stepped-care approach model. All PCMHWs began to receive weekly group supervision from October 2009 from a Band 8 a clinical psychologist whose main therapeutic orientation is CBT. It was envisaged that all would also receive monthly caseload supervision, thus adapting the IAPT clinical/caseload distinction to the development of the service (IAPT, 2008).

A literature search (22 August 2011) combining the terms 'PCMH' (primary care mental health) and 'clinical supervision' yielded only one result which was a discussion paper on the issue of professional regulation (Lee, 2008). Using the workers' full title generated more results; some of which were of relevance. Nevertheless, there are few papers specifically examining the issue of clinical supervision for such workers. For example, Shepherd & Rosairo (2008) considered the many challenges of supervision in this area from the supervisors' viewpoints. They outline responsibilities encompassed by the roles as well as the

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conflicting expectations in the light of workers' training, backgrounds, level of competence, the pressures workers may be under including the complexity of presenting clients and organizational issues. They described adaptations made to their supervision style and focus.

Hickey *et al.* (2010) also noted the lack of studies from the workers' viewpoint. They surveyed PCMHWs examining the perception of their role, and reported that while many were satisfied with the supervision received, a training-needs deficit was noted by 51% (212/415) of their sample.

Although it has been suggested that clinical supervision is crucial for this staff group (Lee, 2008; Richards, 2010) there is a paucity of literature on this topic. Little is known of the types and formats of supervision undertaken, the different functions and impact of such supervision. Information gained from the workers' themselves would add to the literature and lend support to the stated case for supervision.

Research question

What is the experience of PCMHWs now receiving clinical supervision?

Method

Design

A qualitative approach was chosen because the aim of the evaluation was to gather rich data that comprehensively reflect the workers' views yet requiring relatively little outlay of time. A group method was selected because it was considered that the participants would be more likely to speak openly to each other, than in a formal one-to-one setting. It was also thought that this would help to reduce anxieties in the presence of the lesser-known facilitators. The focus group was facilitated by two consultant clinical psychologists, skilled in group facilitation; neither of whom had been in much direct contact with the PCMHWs.

Participants

The focus group consisted of five PCMHWs; one male and four females. Two of the workers were relatively new to the team and had only attended the group supervision sessions once or twice; the other three had been regular attendees, being present at approximately 20 supervision sessions.

Procedure

PCMHWs were invited to participate and informed consent was obtained in writing. Although this was not a formal research project (rather an evaluation of the ongoing supervision service for audit purposes), a formal consent form was still used as part of good practice. We were particularly mindful of the potential influence of various dynamics, such as power issues, and therefore tried to compensate for this by reiterating the right to withdraw consent at any time.

In view of the fact that facilitators and participants worked in the same service, it was recognized that the evaluation was not completely external. However, one of the focus group facilitators had recently started working in the trust but in a tertiary-care service and the other

had worked in secondary-care services. Although covering the same geographical area, this was only for one day per week and at that point there had been little contact between staff members from primary care and secondary care.

As the facilitators had not formally met the PCMHWs, the first few minutes of the meeting was used for introductions. Ninety minutes was set aside; the meeting lasted 65 minutes. Group facilitators had prepared questions to ask participants, but used minimal encouragers, clarifiers, summarizing, and reflection, to elicit participants' views†.

The qualitative data analysis computer program, NVivo (QSR Ltd, Australia) was used to code the data and relevant themes emerged using principles of thematic analysis. One facilitator grouped the statements into themes followed by a discussion with another colleague to check for 'reasonableness' and to discuss any that did not fall obviously into only one of the categories. PCMHWs understood that any quotes in the final report would be anonymized. Additionally, workers were informed that the clinical supervisor would receive anonymized feedback and that the digital recording and transcript made would be secured in accordance with good practice guidelines.

Results

Information from the transcribed interview was coded into the categories listed in Table 1.

Analysis

The supervisor's approach

Within the educative subtheme, several emergent themes were identified. It appeared that the supervisor's approach helped workers in enhancing their clinical focus in order to prioritize clinical issues. One worker said that 'it was helpful to get a focus on what to prioritize with the clients' and 'help the client prioritize what their goals are and not to get sidetracked'. An additional educative theme included learning new tools; having more tools available. It was commented that it was useful that the clinical supervisor pinpoints 'a specific tool' that can be used in client work, rather than just encouraging a general therapeutic model. This was jokingly illustrated by one participant stating 'Gosh there is more to depression than looking at thoughts'. Group members also thought that the approach of the supervisor was helpful in enhancing practice as it was judged that the introduction of clinical supervision had 'improved our working practice immensely over the last few months'. Learning from the supervisor was also deemed important, as it was useful to 'actually see somebody go through . . . rather than just having to read about it'. Further, the benefit of picking the supervisor's brain was preferred over 'big, long training days'. It was felt that what was needed was 'regular bite-size training now and again'. Finally, the supervisor's approach allowed the opportunity for increasing reflection with an emphasis on 'improving on most of the work we carry out'.

† For example, 'That's pressure for you?', 'So just to understand a bit more about what you're saying, so you're saying that if you, especially when you're starting off just having the kind of emotional support isn't enough' and 'so we've talked about kind of a bit about the pros and cons of clinical supervision generally and, and kind of the clinical supervision you're currently having. Anything else on those two topics before we move'.

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Table 1. *Thematic themes and subthemes of PCMHW focus group*

Theme	Subtheme	Emergent themes
The supervisor's approach	Educative	Enhancing clinical focus
		Learning new tools, having more tools available
		Enhancing practice
		Learning from the supervisor
		Picking the supervisor's brain
		Increasing reflection
	Enabler and safety figure; setting boundaries	Valuing skills
		Safe space to explore ideas
		Grounding
	Exploring issues of responsibility and blame for clients' progress	Helping to let go
		Where my responsibilities end and clients' begin
	Supporting and validating staff	Encouraging individuals' work
		Encouraging the team
		Nurturing and caring for the human resources
		A healing function
		Showing workers their potential
		Increasing positive feelings
		Open door policy
The format of supervision	Advantages of a group	Learning through others' experiences
		Group cohesion
		Sharing personal emotions
	Disadvantages of a group	Time constraints of being in a group
		Self-deprecation through comparison
Ingredients of supervision	Helpful	Rapport
		Agenda setting
		Collaboration
		Encouraging openness
		Consistency
		Flexible yet safe
	Unhelpful	Information overload
Functions of supervision	Governance function of supervision	Accountability
		Quality assurance
		Education
	Safety	Trying new things
Dangers of not having supervision	Fear for clients	Making people worse
		Digging too deep
		Time wasting
	Fear for self	Overloaded caseload
		Overwhelming clients
		Personal emotional toll
	Compromising professionalism	Unprofessional staff
		Unprofessional employers

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The subtheme of the supervisor being an enabler and a safety figure and also setting appropriate boundaries emerged from comments about valuing skills. One person stated that the clinical supervisor 'values the skills you have and doesn't sort of put them in a box and say … beyond your remit … but realistic'. In addition, it was suggested that supervision provided a safe space to explore ideas, or 'throw some ideas around'; however, there was also an acknowledgement that the supervision process also 'keeps you in check as well, a lot of the time' and 'grounds you'.

It was seen that the supervisor's approach was helpful in exploring issues of responsibility and blame for clients' progress. Helping workers to 'let go' of clients who had been helped as much as was possible went a long way to helping with feelings on discharging a client where progress had not been as hoped. It also helped workers reflect on where their responsibilities end and clients' begin and they described the supervisor checking on 'how responsible do we feel [supervisor] … doesn't pander to … draws a very clear line.'

In line with the supervisor's approach was a subtheme of supporting and validating staff, individually and for the team. There was a sense of high levels of encouraging individuals' work in a very person specific way. It was thought that this encouraged the team to be 'quite open and honest with each other' which aided in understanding each others' limitations and strengths. This led to building a 'kind of team ethos', instilling confidence in the team and 'the people looking after the team'. The idea was further developed when one worker remarked that the 'more successes you have within the team, the more the team's confidence grows'. There was a sense that the clinical supervisor could 'look after', or nurture and care for the human 'resources' and this could be seen as a healing function. For example, if someone had previously had a negative clinical experience, using the rapport that had been established with the supervisor, the clinical supervision process could be, in one worker's opinion 'quite a healing thing'. It was thought that the supervisor's approach helped in showing workers their potential although they acknowledged that there is a huge potential to expand and develop the service. One worker commented: 'If that's the difference that clinical supervision can make within six months … then you think gosh! … what would two years of it do'. Increasing positive feelings about their work resulted in increased confidence and hope. It 'builds your confidence and then you actually, you learn more on the job'. One worker's interest was sparked, it 'reignited my fire'. It was described as helpful that the supervisor had an 'open door policy' so that workers, when they are feeling stuck, could 'walk in and ask'.

The format of supervision

The workers undertook group supervision and this had its advantages and disadvantages. Learning through the experience of others was strongly discussed, making comments such as they could 'draw off each other then when we … start talking, talking through in supervision' or 'bounce ideas off' each other including when they have had similar experiences or through learning when other people have had a success through trying a particular technique. There was also a realization that the format provided a sense of group cohesion by 'going through people together' as well as recognizing that colleagues are seen as being 'on the same level as yourself'.

Several disadvantages of the group format were noted. For example, sharing personal emotions was found to be risky and one worker was aware that he/she might 'hold back

(in a group) . . . that would be the downfall of that and maybe not too helpful' because when speaking of things that are personally difficult 'you don't really want to share that with, with others'. The main disadvantage that emerged seemed to be related to the time constraints of being in a group, both in terms of the limit to how much you say in a session and the implications of taking time out for supervision. One worker noted this in the statement 'whip through five or six', the recently changed format allows time to discuss 'two or three clients'; 'that's worked well'. Time pressure in their busy work schedule meant that staff felt personally 'pressured' and so the main problem with clinical supervision was it 'eats up' time. Although people thought it was 'essential', it 'takes time away from us sort of doing either admin or having contacts with clients'. So, logically people understood the need for clinical supervision but emotionally there was a feeling of 'oh for God's sake I've got things to do'. Of some concern, workers thought that there was some self-deprecation through comparison, illustrated by the comment 'at the . . . end of supervision, you can feel worse about what you do, instead of better'. When they hear other people talk of their work, the evaluative voice, 'the human bit', kicks in within their own head, and they say to themselves 'I would never have thought of doing that, I wouldn't know how to do that'.

Ingredients of supervision

Several key components of what constituted helpful supervision were established. Rapport with the supervisor was identified as being important 'that's the secret to success' as was setting out an agenda of what people expected from supervision, from the supervisor, and describing what supervision is. Building a collaborative approach immediately was considered helpful as well as encouraging openness. This was encapsulated in the comments 'encouraged a team ethos'; 'you know we can go and be open. Not just . . . within supervision'. The team also appreciated the idea of consistency because they had gone from none to weekly clinical supervision; they said 'having the consistency now has been a huge, huge benefit'. An additional helpful ingredient to clinical supervision was the concept of being able to be flexible yet safe, as illustrated in the following statements: 'adaptable to change', 'making it a safe place for us to explore'; creating a safe atmosphere so that people are more willing to bring difficult things to supervision 'to start pushing yourself that little bit . . . well actually I will reveal that'.

Only one unhelpful ingredient of clinical supervision was mentioned in the form of information overload and this was highlighted by one worker's growing realization of the different therapeutic approaches in use which invoked the statement 'Gosh there's so much more out there . . . and we all work in different ways . . . it's scary isn't it'.

Functions of supervision

From the interview, a governance function of supervision was identified. Workers recognized that along with the opportunity to have supervision comes an amount of accountability for their practice. They realized that knowing that there is someone to ask and then choosing not to, increased their accountability. One worker said that supervision was a necessary part of 'doing the job well because of the increased accountability'. They also recognized that there was a quality assurance element to clinical supervision and stated: 'open to going in and

saying actually I've got this problem . . . I'm not sure I'm going the right direction'; 'been checked when you are not sure of what you should be doing'; 'keeps you in check as well a lot of the time'. Implicit from other themes is the governance strand of education.

Safety featured relatively strongly as a function of supervision because it seemed that the workers felt that they were able to try new things with clients because they had discussed these in clinical supervision sessions. One worker said that it gave her the freedom to adopt the approach 'well let's try'.

Dangers of not having supervision

Within this theme there was a definite subtheme of fear for clients. The workers were acutely aware of the possibility of making people worse. It would appear that the workers were initially told that they could not do anyone harm by just talking to them. This statement was vehemently rebuked and one worker said 'you could just be doing anything, . . . could be saying anything to people, . . . we could be promoting the madness of theories and therapies' and that unsupervised clinical practice 'could just be making them so much worse'. They were also attuned to the possibility that, at times, they could be digging too deep (when unnecessary) and that clinical supervision was a way to help them to monitor this. Additionally, there was recognition that unsupervised clinical practice may mean a lot of wasted time for clients. One worker said 'if you don't have it [supervision], the time that you do have, isn't going to be as constructive anyway'. Emergent was also a fear for self in that it could be easy to become overloaded, having a caseload with overwhelming clients and that this would carry a personal emotional toll. One worker who had been employed by another service, where clinical supervision was not carried out, summarized this with the description: 'everyone [staff] was down, everyone was exhausted, . . . taking time off sick . . . no one to offload to . . . discussing your caseload with other people . . . who are just feeling as bad about their own caseload'. The focus group expressed concern that not having clinical supervision would compromise their sense of professionalism; that they would be unprofessional staff and working for unprofessional employers. This was captured in the comments: 'I would feel that I was being unprofessional . . . and the [employer] was being unprofessional'; 'I wouldn't want to do the job without supervision'.

Discussion

Some limitations of this study included the lack of triangulation to check on robustness of the themes extracted. A draft of the in-house report was provided to the workers themselves prior to circulation asking for comments, whether it was felt that anything was incorrect; no such comments were received.

Using another method may have elicited more negative views; perhaps it was difficult to challenge each other in the focus group situation, i.e. someone with a minority view may not have found it easy to express a different opinion to that held by the majority of the group. Asking individuals to complete self-report questionnaires could have been another alternative or complementary option.

In summarizing the results obtained, the introduction of clinical supervision appears to have been found to be indispensable by the PCMHWs with many supporting emergent themes.

The general themes lend support to the notion that the provision of supervision both improves the quality, efficiency and safety of these individuals in providing psychological therapies in a primary-care setting and supports the findings of the IAPT supervision guidance (IAPT, 2008) as well as those from Lee (2008), who suggested that 'the requirement for clinical supervision for PCMH workers is a crucial element in promoting safe and effective care', p. 263). Moreover, other findings also support the idea of Hickey *et al.* (2010) who found that levels of job satisfaction were linked to good opportunities for supervision.

However, there were also a few negative emergent themes about clinical supervision which we consider below. For instance, time pressure is keenly felt. One worker said they had not managed to do certain administration tasks for the last three weeks and needed time for 'paperwork' and time on the computer. The worker reflected that perhaps they needed more 'time management'. The worker went on to joke 'do we, can we have supervision for that?' Joking aside, clinical supervision must continue to be accepted as a priority and essential for any such work.

Supervision is about obtaining treatment fidelity for better outcomes, as well as supporting staff. When transferring evidence-based therapies from a research trial setting to a clinical context, Roth *et al.* (2010) point out the potential danger of failing to incorporate the supervision aspects received by the research trial therapists themselves (and thus adversely affecting the therapy delivered). They found that therapists are often 'supervised intensively' in trials and such supervision 'may not be routinely provided' in everyday practice. They focused on the outcome of therapy potentially being affected. Here, the importance of supervision for the workers themselves has been clearly demonstrated. Roth *et al.* (2010) suggest that the training and supervision that forms part of the therapies evidenced in research trials should be routinely offered.

The learning that occurs in such supervision can take many forms 'from problem solving to transformational' (Carroll, 2008) and via a number of different modes (e.g. case discussion, role play demonstration) within the different foci (e.g. the therapeutic relationship, therapists' reactions) (Padesky, 1986). This is particularly valuable for those workers new to this sphere of work. Familiarity with a specific psychological model was also believed to be helpful, workers expressed that this 'kind of grounds you'. These results show that tailoring the supervision to the individuals' needs is part of good practice.

Other disadvantages of supervision were linked to how it made the supervisee feel during and/or after the supervision; for example, the workers' frustration with themselves that they had not presented a patient as well as they could (to enable helpful advice to be gained), or the comparison they were making with other workers. Another example was that one worker placed too high expectations on themself after supervision because of the realization that there was much they did not know.

One person thought clinical supervision and emotional personal supervision needed to be kept separate. This worker had a background of working in more traditional mental health services (nursing-dominated background). Previously that person had gone to one person for emotional personal support and another for managerial support. This worker was applying that same model to the supervision and support issues in psychological therapies.

The pros and cons of group supervision noted by the workers should be borne in mind by any supervisor and in this way the supervision offered differs from IAPT recommendation; however, it could be argued that in the face of economic constraints that group supervision will be increasingly used. Ways to minimize the disadvantages of the group format were

still considered, e.g. clearly negotiating issues such as safety, openness, willingness to explore personal issues raised by the work. One group member suggested the idea of an individual supervision session every 3 or even 6 months by way of 'finding out where they are up to' and certainly this might provide an opportunity to resolve some of the negative aspects, particularly associated with group supervision. Such a forum would also provide opportunity for feeding back 'formative' as well as 'summative' evaluation (Division of Clinical Psychology, 2003) and may more openly allow the worker a space in which to perform the restorative function of emotional processing reported by Inskipp & Proctor (1993).

The present findings also mirror to some degree those of Radcliffe & Milne (2010). In their pilot study of satisfaction with supervision, themes which emerged from interviews included: 'the supervisor addressing the subjective needs of the supervisee in an alliance in which the supervisor is available and empathic' with supervisor/s 'demonstrating adequate expertise . . ., create a secure space, and contribute to clinical solutions' (p. 18). Here, group clinical supervision (with its pros and cons) was also seen as a training activity, helping with personal feelings of responsibility as well as governance functions of a professional service. Hence, the educative function of supervision was highlighted by a worker who stated that 'supervision has effectively been a mini training sessions, each week. So it's more "yeh, it feels a bit of a lifeline" when you're new to the project.' The idea of not having adequate clinical supervision was, appropriately, abhorrent to these workers.

However, there is the danger that wanting clinical supervision to cover all these functions may be representing an idealization of supervision (perhaps reflecting the stage of development of the service); there is the possibility that each function becomes too diluted to perform adequately enough. Once the workers are more skilled in using clinical supervision at the higher levels as suggested by Hawkins (1985) then the time available will need to be used for such discussions. Other functions of clinical supervision described here should become subsumed under caseload/managerial supervision; which, like clinical supervision, should be available to workers to help enhance the governance and staff support functions of the service.

Conclusion

In summary, the experience of the supervisees would suggest the following recommendations:

- The clinical supervision offered to the PCMHWs should continue and needs to be viewed as essential for a number of functions including clinical governance, training, monitoring adherence to treatment protocols, and for support and career development.
- PCMHWs be offered a training session on a major theory of clinical supervision and its use in practice to understand how it may be different in the context of a psychological therapy service and that in fact emotional personal responses may be used as part of the psychological therapy. This may also encourage and facilitate fluid movement between modes 1-7 as proposed by the 'seven-eyed' model (Hawkins & Shohet, 2006) and provide what Shepherd & Rosairo (2008) called socialization to the supervision process.
- Clinical supervision should be seen as an appropriate forum for some personal support. Despite finding the clinical supervision forum to be appropriately containing in some ways, the workers felt that they would seek emotional support from someone 'obviously who I know and respect and I have known for a long time'. Another worker had no other forum for emotional support beyond the clinical supervision provided but raised the issue that they

used peer supervision also for emotional support. Another was concerned that there would not be enough time in the present clinical supervision to deal with emotional issues as well due to the pressure inherent in the need to talk about the 'huge [later changed to lots] of cases'.

- PCMHWs should be encouraged to attend *bona fide* training so that they are (and feel) competent in at least one psychological therapy approach.
- PCMHWs can continue to use supervision to apply theory to practice, to consolidate skills learnt elsewhere and to learn about other approaches/techniques which may be of benefit to particular patients, discussed in supervision.
- Supervisor/s should continue to achieve a delicate balance between making sure that the PCMHW is not working outside their limits of competence while nurturing the current culture of lively curiosity and the desire to help patients to the best of their ability.
- The high standards of clinical supervision that PCMHWs find valuable should be maintained. Regular reviews of clinical supervision, the group itself and the individual's use of clinical supervision should be performed.
- To clarify to the workers themselves the distinction between (*a*) clinical supervision, (*b*) managerial supervision and (*c*) caseload management including supervision about system issues.

This study reports PCMHWs' views of experiencing clinical supervision. In line with the few published studies (mainly from a supervisor's viewpoint) they concur that clinical supervision is essential, and outlined for them what is helpful from a group format, and from a supervisor's approach. Clinical supervision with this group of workers could cover a range of functions; the purpose of clinical supervision should be made clear. Workers were clear about the dangers in not receiving clinical supervision for their work and the possible detrimental effects that would have on their clients.

Declaration of Interest

None.

Recommended follow-up reading

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Learning objectives

By the end of this article, a reader will have obtained knowledge on:

(1) The importance of supervision in primary care mental health.
(2) Understanding clinical supervision. from the perspective of a primary care mental health worker.
(3) Gaining ideas of recommendation for implementing clinical supervision.