# A study to evaluate the provision of psychosocial supervision within an Early Intervention team

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**Abstract.** Psychosocial Interventions (PSIs) and PSI supervision underpin the delivery of early interventions for people experiencing psychosis. Early Intervention (EI) teams are relatively new in the NHS and there is currently a lack of empirical research into PSI supervision in this area. This study aimed to elicit staff views of PSI supervision and to identify any unmet supervision needs within a newly developed EI team in the UK. Semi-structured interviews were conducted with 16 multidisciplinary team members. Descriptive statistics and a thematic analysis were used to analyse the responses. The different types of supervision available to team members, gaps in the provision of PSI supervision and aspects that supervisees found helpful and unhelpful about PSI supervision are discussed as are ideas for improving the provision of PSI supervision in EI teams. The limitations of the study and ideas for further research are also outlined.

**Key words:** Clinical supervision, early intervention (EI), psychosis, supervision.

## Introduction

In order to review the current literature on supervision and more specifically of Psychosocial Intervention (PSI) supervision in Early Intervention (EI) services a literature search was conducted using a variety of databases, e.g. PubMed, Medline and PsycINFO, using permutations of the search terms: 'PSI', 'cognitive and behavioural', 'clinical supervision' and 'early intervention in psychosis'.

EI teams are highly specialized services (Marshall *et al.* 2004) working with service users experiencing a first episode of psychosis. EI teams adopt a recovery-focused approach in line with the Policy Implementation Guide [Department of Health (DoH), 2001] and interventions tend to be PSI in orientation (McGorry *et al.* 1996). PSI is a universal term that covers a range of interventions for people with psychosis and associated difficulties. Psychological approaches include cognitive and behavioural-oriented therapies for individuals and families, while social interventions might focus on supporting people to access meaningful employment, activities and social networks.

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Skills in PSIs are essential for practitioners working with those experiencing psychosis (Craig 2003), therefore it follows that supervision structures need to be in place to support PSIs for all staff working in EI.

Recent developments in the NHS such as the Knowledge and Skills Framework, and Agenda for Change (DoH, 2004*a*, *b*) have also emphasized the need for services to support supervision structures, suggesting that they provide environments where staff can develop themselves and contribute to the development of others. It is also important that mental-health workers recognize the requirement for ongoing clinical supervision (DoH, 2004*c*).

Studies into clinical supervision suggest that it is seen as fundamental to: developing skills in PSIs (Sin & Scully, 2008), safe and accountable practice (DOH, 1994*a*; Faugier & Butterworth, 1994; Carroll, 1996; Bishop, 2007), the development of professional expertise, and the delivery of quality care (DoH, 1994*b*; Hallberg, 1994; Scaife, 2001; Gilbert & Evans, 2000; Bishop, 2007).

Various types and definitions of clinical supervision have been described (Heron, 1989; Proctor; 1991; Butterworth *et al.* 1996; Bradshaw, 2002; Townend *et al.* 2002) and models include individual, peer, informal peer support or *ad hoc* consultancy (Durham *et al.* 2000). Sloan *et al.* (2000) proposed that there is confusion around models of clinical supervision. However, others suggest that key components of cognitive behavioural supervision include: structure, focus, education, use of review and reflection, and supervisor training (Liese & Beck, 1997; Townend *et al.* 2002).

The literature suggests that individual and peer PSI supervision is helpful to staff supervisees to adjust techniques to the realities of everyday clinical practice, and to clients experiencing various difficulties (e.g. Flemming *et al.* 2008). Supervisors can model therapy skills within supervision to support supervisee training in delivering PSIs. In addition, supervision allows supervisees space to reflect on their practice, find solutions to problems, increase their understanding of professional issues, improve standards of care, further develop their skills and knowledge, and enhance understanding of their own practice. Supervision can also complement PSI training that practitioners are undertaking.

In a recent survey among students training in PSI, respondents rated PSI supervision highly in terms of helping them to develop their practice (Sin & Scully, 2008). Another study found that PSI supervision delivered in the workplace by more experienced PSI practitioners, provided in addition to PSI training, enhanced knowledge of PSIs when compared to education alone, while also improving outcomes for service users (Bradshaw *et al.* 2007). Thus, receiving regular PSI supervision is imperative to the continuing development of those delivering PSIs in improving outcomes.

Factors related to the effective delivery of PSI supervision include: management commitment at every level, protected resources in terms of budget, time, manpower and training, and supervision for supervisors (Townend *et al.* 2002; Bishop, 2007).

Bradshaw (2002) has also proposed that effective PSI supervision should be driven by a contract agreed between the supervisor and supervisee clarifying the purpose of supervision and the model to be used, the structure of sessions, supervisee goals and theoretical orientation, boundaries, confidentiality issues, and arrangements for documenting supervision.

Despite the importance and value of supervision highlighted here, studies have reported that access to and use of clinical supervision in practice is variable (e.g. Townend *et al.* 2002). Barriers to the implementation of successful supervision might include lack of resources and qualified supervisors, individual resistance, workload, high caseloads, time constraints

or other practice development changes, and high levels of training needs (Brennan & Gamble, 1997; Fadden, 1997; Hughes & Pengelly, 1997; Bennett *et al.* 2001).

Worryingly, several studies have highlighted that those working in EI do not always have the appropriate skills to deliver PSIs or to provide PSI supervision (Singh *et al.* 2003; Craig, 2003; Fadden *et al.* 2004). This could be due to either a lack of appropriate training in PSIs and/or access to regular PSI supervision (Brennan & Gamble, 1997; Brabban & Kelly, 2008). Mairs & Arkle (2007) found that only half of specialist PSI courses in the UK included supervision as part of their training and recommend that it should be a core component of all PSI training programmes.

Evidence suggests that practitioners with training in PSIs might experience problems delivering PSIs in the workplace (Mairs & Bradshaw, 2005), possibly due, in part, to difficulties in accessing supervision following training (Devane *et al.* 1998; Rolls *et al.* 2002; Carpenter *et al.* 2003; Brennan & Gamble, 1997; Flemming *et al.* 2008). Furthermore, students evaluate PSI supervision during training highly, whereas following training a significant percentage of staff suggested Trust-based supervision was not meeting their needs (Milne *et al.* 2003).

In summary, access to specialized PSI supervisors appears to be a key factor in implementing PSIs (Brooker & Brabban, 2004; Flemming *et al.* 2008) and supervision has been identified as essential in determining whether or not PSIs are successful (Fadden, 1997). Brabban & Kelly (2008) suggest that clinical supervision in EI must be prioritized and that skilled PSI practitioners should be employed to provide supervision to other team members if EI teams are to deliver all that they promised. Flemming *et al.* (2008) highlighted that PSI supervision should be prioritized and elevated in status. There is also an ongoing need for the development of supervision and measurement of its quality (Kingdon & Pelton, 2002; Pretorius, 2006; Flemming *et al.* 2008).

EI teams are a relatively new development in the NHS and there is currently a paucity of empirical research into the provision of PSI supervision in this area. The studies reviewed highlight the need and importance of PSI supervision in EI and suggest that supervision needs are not being met as well as they might be. However, these studies are limited in that their primary focus was not on the provision of PSI supervision in EI, but on general issues around the delivery of PSIs and training and they tended to use quantitative designs, therefore they might not have captured important information about practitioners' experiences of PSI supervision in EI. There are no studies, which have used a qualitative approach to explore EI practitioners' views of the process of successful PSI supervision in EI and/or the potential barriers to this.

The main aims of this study were to elicit multidisciplinary practitioners' views and experiences of PSI supervision, evaluate the provision of PSI supervision and identify any unmet supervision needs within an EI team. The study was primarily conducted to develop supervision practice within the team and to disseminate the findings in order to inform other EI teams locally and nationally.

## Method

### *Design*

This study used a semi-structured interview/questionnaire design. The interview schedule comprised of open-ended questions aimed to elicit information on team members'

conceptualizations of supervision, what people found helpful/unhelpful about supervision, how much supervision individuals were currently receiving and how much they wished to receive, how much supervision informs people's work, how the provision of supervision could be improved, which professionals they wanted as supervisors, how many people in the team provided PSI supervision to others currently, and whether people wanted the opportunity to become supervisors themselves in the future.

### Sample and service setting

Participants were recruited from one EI team, which had been established for 1 year. The Service Operational Policy stated that all staff would have regular supervision or consultation with a relevant professional with appropriate skills, and have access to a range of different clinical supervision options. Peer supervision was also taking place in the team occasionally. All EI team members were invited to participate in the interviews.

### Ethical considerations

In line with the conditions of the central ethics research committee, participants were provided with information regarding the study, advised of the confidentiality and anonymity of their responses and of the availability of support should the study cause any distress. Participants gave their informed consent to participate and were informed of their right to withdraw their participation or data at any time.

### Procedure

Two clinical psychologists conducted the semi-structured interviews and recorded participants' responses on paper. Each interview lasted between 20 and 60 minutes.

### Data analysis

Descriptive statistics were used to analyse quantifiable data. Open-ended questions were analysed using an empirical thematic analysis (Braun & Clarke, 2006). This involved reading and re-reading the data, so that the first author (S.T.N.) could become familiar with the content of the answers given and begin to identify regular re-occurring views described by participants. These re-occurring patterns were then used to form themes or categories that described people's supervision experiences, views, needs, and suggestions for improving PSI supervision in EI.

There is no agreed criterion for demonstrating validity, robustness or rigour in qualitative research. The criteria proposed by Pawson *et al*. (2003) identifying transparency, accuracy, purposivity, utility, propriety, accessibility, and specificity was used in this study. A further criterion often cited for assessing qualitative research is the notion of credibility (Lincoln & Guba, 1985), which relates to whether the results of the participants reflect their experiences in a believable way. To assess the credibility of the findings, the themes identified were discussed with fellow researchers and shared with participants and staff from other EI teams via presentations and a draft supervision policy document (developed from the findings of this

study). Feedback was requested and used to refine the findings. The feedback suggested that the interpretation of data was valid and plausible.

## Results

A total of 16 practitioners took part in the study ($n = 16$, 100% response rate). These consisted of one team leader (6.3%), seven care coordinators (43.7%) (including social workers and community psychiatric nurses), three psychiatrists (18.7%), three psychological therapists/clinical psychologists (18.7%), one occupational therapist (6.3%) and one support time and recovery (STR) worker (6.3%).

Participants' responses to the question areas are presented below.

### *How staff conceptualize supervision*

Team members identified that there are different types of supervision. Most people said that they saw supervision as being either clinical or managerial, although overlaps were mentioned between the two. Different types of clinical supervision were identified, e.g. peer, individual, and triad approaches. Within managerial supervision two types were identified, e.g. EI and own speciality. Two people (12.5%) were not clear about what supervision means in EI and three people (18.7%) said that they were unsure in this team, as to what supervision was, as it differed from their experiences of supervision in previous roles.

The themes that emerged from the open-ended question responses are illustrated in Table 1. Several themes were identified in the responses given to each question. An example of a supporting quote for the first theme derived from the answers to each question is also provided.

### *Types of supervision and the amount of supervision staff receive*

When asked about the different types of supervision received, in addition to the types of supervision described above several people also identified consultancy and informal advice from peers. Table 2 illustrates the different types of supervision that people currently receive, how often, and the supervisors' backgrounds.

### *How much PSI informs the work of individual staff*

The amount that PSI-informed practitioners' work ranged between 0% and 100%. Mode = 100%, mean = 85% (s.d. = 2.34).

### *The amount of supervision staff wished to receive and where they wanted this to take place*

All people currently receiving PSI supervision from someone in the team said that they were happy with the current amount of supervision provided and with the venue. Although one person (6.6%) said they would prefer this to be outside the team base. For those not currently receiving PSI supervision from within the team the frequency of supervision they wished to receive, ranged from between 1 hour every 2 weeks and 1 hour every 6 weeks (average 1 hour every $3\frac{1}{2}$ weeks).

**Table 1.** *The themes derived from the open-ended question responses and examples of supporting quotes*

| Question | The main themes derived from the responses given | Example of a supporting quote (from the first theme, derived from each question) |
|---|---|---|
| Understanding of clinical supervision | 1. Learning from other perspectives<br>2. A place for reflection<br>3. A place for support<br>4. Maintaining clinical governance<br>5. An equal relationship<br>6. Feedback on own performance | 1. 'An opportunity to examine work from a different perspective' |
| Understanding of managerial supervision | 1. Personal/professional development<br>2. Organizational issues<br>3. Clinical issues, maintaining clinical governance<br>4. Maintaining professional identity | 1. 'A place to assess professional performance' |
| Helpful aspects of (individual) clinical supervision | 1. Developing and consolidating skills and knowledge<br>2. Support<br>3. Supervisor attributes<br>4. Having dedicated time and space | 1. 'It facilitates the setting of new objectives, acquisition of new knowledge, learning, personal and professional development' |
| Unhelpful aspects (individual) clinical supervision | 1. Lack of clarity about supervisor roles<br>2. Lack of consistency/structure<br>3. Meeting organizational rather than personal objectives<br>4. Working with people from different professional backgrounds<br>5. Unsatisfactory outcomes<br>6. Too much supervision | 1. 'Need clarification as to the roles and function of clinical supervision' |
| Unhelpful aspects of (peer) clinical supervision? | 1. Lack of structure<br>2. Lack of frequency<br>3. Lack of professional development | 1. 'Unstructured . . . it's not always focused' |
| How individual PSI/clinical supervision could be improved | 1. A better understanding of PSI<br>2. Development of different PSI skills, strategies and models<br>3. A choice of different types of supervision to meet different needs<br>4. A choice of supervisors | 1. 'Would like an overarching model that informs supervision . . . a better understanding of PSI' |

**Table 1.** (*cont.*)

| Question | The main themes derived from the responses given | Example of a supporting quote (from the first theme, derived from each question) |
|---|---|---|
| Who participants wanted to deliver individual clinical PSI supervision | 1. A choice of supervisors<br>2. Range of professional backgrounds<br>3. Supervisor attributes and experience | 1. 'Potentially someone from outside the team' |
| How peer supervision could be improved | 1. More structure/focus<br>2. Prioritizing<br>3. Change in format<br>4. Flexibility<br>5. A better understanding of peer supervision<br>6. More commitment from team members<br>7. Ways to derive more commitment<br>8. Focus on clinical issues<br>9. Keeping records | 1. 'Needs a chair and direction . . . a set agenda' |

PSI, Psychosocial interventions.

### Staff experience of supervisors and interest in supervising other staff

Three people (18.8%) in the team currently identified themselves as having experience and currently providing PSI supervision. However, 15 people (93.8%) have experience and skills in supervising others. Seven people (43.8%) also said that they would be interested in providing PSI supervision although most felt they would need more time or training.

### Discussion

The response rate of our sample was 100% and although it was a small sample it was representative of the general multidisciplinary mix of EI teams. Therefore, the study offers some useful insights into the experience and supervision needs of staff working in EI. The implications of these findings, suggestions for improving the provision of supervision, and limitations of the study are outlined in detail below.

The findings suggest that about 70% of staff have a good understanding of what PSI supervision means and the aspects they identified as helpful are consistent with the key components and functions of clinical supervision identified by others (DoH, 1994*a*; Faugier & Butterworth, 1994; Carroll, 1996; Bishop, 2007). However, for almost one third (31.3%) there was a lack of understanding or clarity about what supervision means, which was identified as unhelpful to staff. Similarly, Flemming *et al.* (2008) has highlighted that supervision needs to be clearly defined within Trusts.

Several other aspects were also identified as being unhelpful. It is therefore a recommendation that these need to be addressed in order to promote successful PSI

**Table 2.** *What types of supervision and how much supervision do Early Intervention (EI) team members currently receive*

| Types of supervision identified | Delivered/facilitated by | No. of people receiving this | How often (minutes per month) | |
| --- | --- | --- | --- | --- |
| | | | Range | Mean (S.D.) of supervision |
| Managerial | EI team leader | 81% | 45–120 | 40.38 (17.38) |
| Individual clinical PSI | Psychological therapist or clinical psychologist (EI) | 62% | 60–240 | 102.00 (56.92) |
| Own professional background | Same professional | 18% | 40–60 | 53.33 (11.55) |
| Peer EI | EI clinical lead (clinical psychologist/ psychological therapist) | 62% | 60–120 | 93.00 (35.95) |
| Peer within own professional forum | Same professional background | 31% | 15–90 | 58.00 (32.71) |
| Consultancy expert advice | Same professional background | 6.25% | 120–180 | 180 (00) |
| Informal advice | Other EI team members | 37% | As needed–400 | 230.00 (240) |

PSI, Psychosocial interventions.

supervision practice in EI, given that supervision is crucial to safe practice and developing skills in PSIs (Bishop, 2007; Sin & Scully, 2008).

Based on these findings, to address the unhelpful aspects of individual PSI supervision, it would be good practice to offer staff separate clinical and managerial supervision. This would help clarify supervision and ensure that PSI supervision is focused primarily on clinical rather than organizational issues in line with staff suggestions for improving supervision. Furthermore, a supervisory contract agreed at the start of PSI supervision, as recommended by others (Scaife, 2001; Bradshaw, 2002; Townend *et al.* 2002; Townend, 2004) would help provide clarification of the roles and functions of supervision/supervisors and ensure that effective PSI supervision is provided consistently. It is anticipated that the use of a contract would also help to address 'unsatisfactory outcomes' (e.g. where agreed actions are not met), which staff also identified as being unhelpful in individual PSI supervision.

Other unhelpful aspects of individual PSI supervision included working with supervisors from professionally different backgrounds, and receiving too much supervision. Given that people's professional backgrounds, experience, skills and knowledge of PSIs vary in EI it follows that individual supervision needs/preferences within teams will differ.

It is therefore proposed that individual staff needs and preferences might be best assessed prior to a supervisor being allocated. The findings suggest that staff prefer to have a choice of supervisors and support Bradshaw *et al.*'s (2007) proposal that someone more experienced than the supervisee delivers the supervision, so as to guide the supervisee through new learning, ideas and concepts. Staff might benefit from having a choice of PSI supervisors and although supervision should be provided within the EI teams to optimize limited resources some team members might need to access external supervisors for specialist supervision. In terms of addressing the problem of too much supervision, contracting individual needs should help to address this. It is also possible that staff feel they receive too much supervision because they do not have enough time to attend, it is therefore imperative that practitioners are guaranteed time to attend (Flemming *et al.* 2008).

In terms of peer PSI supervision these findings suggest that staff value peer supervision. However, the findings indicated that peer supervision was not being facilitated as well as it could be. Flemming *et al.* (2008) point out that PSI supervision requires good facilitation skills as well as knowledge of PSIs and PSI. In line with Flemming *et al.* (2008) it is recommended that peer supervision is delivered by PSI clinical leads and, based on these findings, it is recommended that peer supervision takes place regularly and consistently. As in individual PSI supervision, the role and function of peer supervision should be clarified, so that individual team members are clear about the aims of supervision and their role. There should also be a set agenda, and staff should prepare points/clients for discussion. Implementing these changes might also increase lack of commitment/investment and attendance, which some staff identified as unhelpful.

Although not evaluated in the current study, another model that might be useful for delivering PSI supervision in EI teams where there is a lack of supervisors is the triad model (Bradshaw, 2002). Preliminary research suggests that this approach is effective (Bradshaw *et al.* 2007); however, further research into the model and its effectiveness in EI is needed.

How much PSI informed people's work and people's individual knowledge of PSIs was high and variable. This is consistent with the idea that some staff in EI might not have a clear understanding of PSI, and that individual knowledge and skills in PSI are variable (Craig, 2003; Singh *et al.* 2003; Fadden *et al.* 2004). This has implications for the successful

implementation of EI given that PSIs are essential in working with people experiencing first-episode psychosis (Craig, 2003). To redress this, individual EI team members might benefit from a clearer understanding of the meaning and definition of PSI and the role of PSIs within their own and other team member's roles. It is proposed that regular PSI supervision will help to improve this. In addition, EI teams might benefit from an overarching model of PSI to develop a shared understanding of PSIs that could also be used to inform supervision.

Consistent with previous research (e.g. Townend *et al.* 2002) it was found that the amount of PSI supervision currently received within the team was variable with several people not receiving any individual PSI supervision (although it is acknowledged that this might have changed since the study). There are likely to be a number of different reasons for this including: the gradual expansion of the team, a lack of available supervisors, lack of time (e.g. Hughes & Pengelly, 1997; Bennett *et al.* 2001), different supervisee needs, different levels of experience, lack of clarity around supervision (Sloan *et al.* 2000), and that different professional groups in EI have different ways of working. However, given that PSI is crucial in EI (Craig, 2003), it follows that all team members should receive regular PSI supervision. Based on these findings it is recommended that as a minimum all team members should have access to individual PSI supervision for 1 hour every 3–4 weeks. More supervision could be negotiated, contracted and reviewed with supervisors as required, based on ongoing need and availability.

Three people (18.8%) in this sample were experienced PSI supervisors and were providing supervision to other team members. However, it was also found that 15 people (93.8%) have experience and skills in supervising others and seven of these were interested in providing PSI supervision (if they were given time and training to do so). This suggests that EI teams potentially have valuable resources that are unused. Therefore it is recommended that team members who are interested in supervising others could identify this as part of their continuing professional development. Given the lack of supervisor training in PSIs (Mairs & Arkle, 2007) training for new supervisors could be facilitated within EI teams by experienced PSI supervisors. Flemming *et al.* (2008) identified that organizations need to be creative in how they use their existing resources.

Participants in this study identified that they valued supervisors who are creative, flexible and facilitate the learning of different PSI approaches and skills needed for working with different clients (e.g. cognitive and behavioural, motivational interviewing, and family interventions). Supervisors should work collaboratively, be non-judgemental and not too expert.

In EI the main factor likely to influence the continuation and development of PSI supervision is an ongoing management commitment to its implementation. The National Service Framework (DoH, 2004*c*) recommended that evidence should be obtained regarding cost-effectiveness in mental-health settings with regard to resources and performance management, and when reviewed made it clear that any new investment must produce improved outcomes for service users. Although there is a growing body of literature about clinical supervision, there is a paucity of research into PSI supervision and evidence for its effectiveness.

There were several limitations to this study. First the sample size was small, participants were recruited from only one EI team and the qualitative findings were based on subjective interpretation. Data gathered using a pre-designed questionnaire could be considered problematic in terms of gathering qualitative data; however, it was felt that staff would benefit

from some prompts. These limitations might constrain generalization of our findings to other EI teams. However, the aim was to derive in-depth information regarding people's experiences and needs of PSI supervision in EI. This is an under-researched area and the design utilized provided some rich insights. Moreover, these findings were consistent with previous research into clinical supervision outside EI teams and added some empirical support to theoretical suggestions made about PSI supervision in EI by others. It is anticipated that these findings could be useful to EI and other teams delivering PSIs, in developing their provision of PSI supervision. More rigorous research could follow once these standard PSI structures are in place across EI teams. Future studies might use a grounded theory approach, which would allow for an iterative approach and help to develop theoretical models of PSI supervision in EI. Studies into the effectiveness of PSI supervision in EI and how this links to client outcomes are also needed.

## Declaration of Interest

None.

## Acknowledgements

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### Learning objectives

This study outlines the evaluation of supervision for practitioners delivering psychosocial interventions (PSI) within an Early Intervention (EI) team.