Effective Supervision for Mental Health First Aiders (MHFA): A Literature Review

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"When you learn a little, you feel you know a lot. But when you learn a lot, you realize you know very little" (anon)

" Tell me and I forget. Teach me and I remember. Involve me and I will learn.

Introduction

The Mental health First Aid programme was developed in Australia by Betty Kitchener and Anthony Jorm in 2000. In 2003 it was introduced in the UK. From what the author can ascertain, a 2 day programme gives a full certificate for an employee to become a MHFA employee. A number of studies have been carried out showing that people who are trained in mental health first aid showed improved knowledge, confidence, attitude and helping behaviour (compassion). Searching various training suppliers including MHFA England the aims and objectives of the two-day course are general about the following:

a) Spot early signs of a possible mental health issue
b) Feel confident in how to offer initial help
c) Preserve life where a person may be at risk of harm to themselves or others.
d) Hope to stop the issues from getting worse and promote hope
e) Guide someone towards appropriate treatment
f) Understand the stigma surrounding mental health
g) Provide help on a first aid basis

MHFA is no doubt a valiant attempt to promote mental well-being and reduce the cost both emotionally, socially and psychologically to individuals who are in distress and this must be congratulated. The authors concerns are around the process of applying this model in the organisation in a transparent, healthy and safe manner to ensure it obtains the most positive impact within the organisation. Any individual who works in the field of mental

health should receive some form or preceptorship (learning and coaching) or supervision (case or emotional supervision) and as with most new developments it will only be through trial and error that this will become more and more apparent. If we look at social media and facebook….. governments knew there were risks but can only apply law after they are identified through experience. The same will no doubt apply with artificial intelligence (AI). Well, we have enough literature and experience in the mental health field to inform the support processes that need to be in place and do not have to wait to "learn from mistakes" and can use this evidence to ensure processes are in place at the beginning. West Midlands Fire Service often pioneer many developments and this is a great opportunity to ensure we are at the leading edge in applying this proven model but in a safe and health manner.

In brief, every individual working in the field of mental health even on the periphery should have avenues for support due to the nature of working alongside emotional distress and some of the issues this can bring up in our own psychological functioning.

Eg I am often affected when clients lose children as I have a daughter and grandson and I cannot stop brief intrusive thoughts imagining what that would be like for me. This triggers of emotional reactions that I manage due to insight and practice but also supervision should I need to talk it through.

Social learning theory also supports the notion that we only really learn through experience and as such we can attend a course to give us a framework but only learn the content of such course through experience when we process that learning fully both cognitive and emotionally. Therefore, no matter how ""good" the course is " learning through experience has to occur" just as firefighters learn their role.

Whatever we call the process (preceptorship , supervision etc) , something needs to be put in place as well as learning updates (podcasts, bibliography, TE talks, seminars etc) to ensure knowledge is maintained. To apply MHFA process in the workplace without this is waiting for something to go wrong rather than attempting to prevent it especially within emergency services. I have written a brief literature on supervision to support the action plan and highlighted specific learning notes for the reader.

This literature review serves to explore the role of supervision in occupational health/workplace (OH) paradigms. The article determines the relative outcomes of undertaking supervision; particularly noting the consequences of working with psychopathology and general psychological disorder. The potential challenges in defining

and operationalising supervision will be explored; establishing the levels of support that are available, and the necessary steps moving forward to implement supervision with MHFA employees

WHAT IS SUPERVISION?

Supervision is a procedure of specialized support and education that aims to enhance the continued professional development of an individual's character (Milne, 2007). The most typical supervision model is comprised of an employee sitting down with a mental health professional at bi-weekly intervals to discuss thoughts, feelings and experiences of certain clients or scenarios (Hawkins & Shohet, 2012). Supervision serves to address an individual's progressive needs and aims to provide insight to a range of challenges within an healthcare setting; serving to increase an individual's competence and self-efficacy through exchanges with skilled professionals in a conducive environment (Milne et al., 2008).

The notion of supervision has been a part of health and social care professions for a long period of time, however the concept has become particularly synonymous with psychologists and nurses. Within occupations such as midwifery and psychotherapy, evidence-based supervision systems exist to monitor, enhance and develop practice. Recently however the role of supervision has been **applied to occupations regarding any individual who may be exposed to psychopathology (Wahesh, 2016).**

Supervision is now firmly established as a key element of professional practice and is recommended or required for registration with a range of regularity organizations operating within the context of health and social care (BACP, 2019; BABCP, 2019; NMC, 2019; RCOT, 2015; HCPC, 2019). The important role of supervision in improving care and support and as a means to value and support professional practice has also been a feature of UK health policy (DoH 1998;1999). **Furthermore, the absence of a culture that supports supervision has been cited as a factor contributing to recent catastrophic failings in health care provision (Tomlinson, 2015; Francis, 2013; Berwick, 2013).**

Operationalizing Supervision

Given that supervision is widely accepted as an essential feature of effective professional practice, it should stand that efforts to support and develop supervision within practice are a priority. However, this goal presents a number of challenges. Firstly,

definitions and models of supervision are numerous and diverse within the literature prompting some to suggest there are '*as many definitions of clinical supervision as there are books and papers published on the subject'* (Bond & Holland, 1998 pg.13).

The range of views across disciplines with regards to the core and defining features of supervision can create confusion (Franklin, 2013). Of particular note is the tendency for 'clinical' supervision and 'managerial' supervision to be mistakenly viewed as synonymous (Pack, 2009; Franklin 2013). This may lead to a reluctance on the part of practitioners to engage with supervision due to expectations of an emphasis on performance monitoring (McBride, 2007). Furthermore, activities and skills within supervision may overlap with those often associated with mentoring, coaching or counselling further adding to difficulty in achieving conceptual clarity (Lennox et al., 2008; Yegdich, 1999).

Secondly, supervision can be challenging to implement in the context of busy health and social care environments with demands of time, competing priorities and budgetary restriction creating potential barriers to implementation (Martin et al., 2015). Finally, uni-professional based models of supervision involving practitioners from the same discipline have been challenged for failing to reflect the multi-disciplinary nature of modern health and social care. This has led some commentators to espouse multi-professional supervision as more appropriate (Mullarkey et al., 2001)

The plethora of definitions, models and debate in relation to supervision whilst potentially confusing has also proved a positive force in facilitating the evolution of supervision and offering a variety of approaches that can be tailored to a specific context of care. Supervision can be delivered on a one to one or group basis (Bifarin & Stonehouse, 2017), between peers or with a trained experienced supervisor, and on a uni or multi-professional basis (CQC, 2013; Mullarkey et al., 2001).

The frequency of supervision is context dependent and subject to needs of the participants and requirements of local policy, however some regulations and guidelines suggest between bi- weekly and monthly supervision (BABCP, 2019; IAPT, 2011; RCOT, 2015). Each of these approaches and modes of delivery have strengths and limitations depending on the practitioners involved, their scope of practice and the organizational context.

Despite the aforementioned challenges in defining and operationalizing supervision, it can be argued that there is broad agreement in the literature on some of the core functions of and conditions necessary for effective supervision. Supervision typically addresses normative, formative and restorative dimensions of practice with a clear emphasis

on client care (Inskip & Proctor, 1993; Milne & Martin, 2019) whilst being distinct from managerial supervision or counselling (Bifarin and Stonehouse, 2017; Pack, 2009).

Having a choice of supervisor and choice in the mode of delivery is often advocated as is the use of a supervision contract or agreement to identify the aims and format of supervision (Bifarin & Stonehouse). Contracts also typically establish how models of supervision might be applied, the roles of participants and other details regarding the supervisory process (Bifarin and Stonehouse)

Reflection and reflective practice are often afforded a central role as is an emphasis on the growth and development of the practitioner/profession (Pack, 2009; Milne & Martin, 2019; NHS 2000). This can facilitate a more comprehensive understanding of one's occupation; simultaneously improving services provided and continuing professional development. Supervision is best integrated when workers aim to expand their knowledge and skills and should fundamentally incorporate supervision to meet the complex demands of modern healthcare/working enviornment.

SUPERVISION LITERATURE REVIEW

The evidence-base for supervision is widely saturated; however, within occupations that have exposure with psychopathology (distress), it appears the clinical supervision form lies between person centred, cognitive behavioural and acceptance based therapies (Milne, 2007; Livingston et al., 2014). **Exposure to psychopathology in such jobs as psychologists, nurses, occupational therapists and emergency services personnel can often lead to high prevalence's of mental illness due to the consistent impact of managing others emotions (Little, Gooty & Williams, 2016; Guy, Newman & Ganapati, 2013). A recent occupational review conducted by Wulsin et al. (2014) served to identify mental health disorders by industry. The research suggested that industries with the highest prevalence of clinical depression were those who had frequent or difficult interactions with the public or clients in addition to high levels of stress; a demographic synonymous with health care workers.**

The clear necessity for supervision is apparent. Supervision provides a safe environment for workers to actively engage and reflect upon their practice and improve their overall level of care. This key piece of time allows for the compilation of knowledge and competence whilst being a key link between effective theory and research practice.

OUTCOMES OF CLINICAL SUPERVISION

The benefits of supervision are clearly outlined in the literature. The care quality commission (CQC) sufficiently identify the benefits of supervision for members of staff within an organisation. The CQC (2008) states that supervision can help staff manage the personal and professional demands that are elicited by their specific occupational roles. The research suggests that supervision is particularly important for those who have multifaceted and challenging occupational roles; noting that supervision provides a tailored confidential and supportive environment in which an individual can explore their personal and emotional reactions to their daily work activities. Furthermore, the benefits of supervision are not insular; such that the process ensures that people who utilize services with stated practitioners receive a higher quality of care at all times. It is posited that this is due to the ability for individuals to develop and sustain the personal and emotional impact of their practices for service users (CQC; SCIE, 2013).

Although the CQC mentions the improvement of patient outcomes. One of the most recent studies assessing the practical efficacy of supervision was conducted by Snowdon, Leggat and Taylor (2017). The researchers conducted a systematic review investigating nearly 40,000 episodes of care. The research concluded that the supervision of health professionals was directly connected with efficacy of care. The review found an improvement in the procedure of care that may improve compliance with processes that are associated with enhanced patient psychological and physical outcomes. This therefore identifies how supervision not only benefits practitioners at a personal; but systemic level, therefore permitting the improvement of treatment for collective organizations.

In addition to systemic benefits, previous research has identified the direct benefit of supervision in health-care professional's roles. Koivu, Saarinen and Hyrkas (2012) reported that caring professionals who attended regular supervision showed drastically fewer negative physical symptoms of stress and were less likely to experience symptoms of anxiety in control to their colleagues who did not attend supervision. This evidence has **direct links with further research including Edwards et al. (2006) found that greater involvement with supervision was associated with lower levels of emotional exhaustion, burnout and depersonalization. Potentially one of the most important pieces of research was conducted by Hyrkäs *et al.* (2006). These researchers observed that health care professionals who perceived supervision as efficient were almost two times more likely to not experience symptoms of burnout and exhaustion in addition to**

having a more positive outlook of their performance. This subsequently shows the strong theoretical and practical implications of having suitable supervision in place.

PSYCHOPATHOLOGY AND EMOTIONAL BURNOUT

MHFA employees could potentially be at the frontline of supporting individuals in the workplace cope with physical and psychological issues. An increasingly concerning issue within health care settings and particularly healthcare professonals is 'emotional burnout'. Burnout is defined as an emotional response to work-related events that manifest in psychological disorder (Moss et al., 2016). Burnout often develops gradually and is categorized into three categories: emotional exhaustion, depersonalization and reduced personal accomplishment. **Several research studies have identified the detrimental effect that working with psychopathology can have on increasing the risk of burnout**; given the increased exposure to such symptoms in the occupational health arena, this has dramatic implications for such practitioners (Fernandez-Sanchez et al., 2018; Parola et al., 2017). Its also important to note that burn-out has just been recognized as a disease by the World Health Organisation.

Mental health First Aid (England) suggest that MHFA employees will be trained to provide compassionate care with every interaction; utilizing evidence based practice and resilience to adequately facilitate well-being. Shapiro & Carlson, 2009 discuss this with the role of occupational health advisors. **It further suggested that the process of supervision serves to improve resources such as wellness, resilience, patience and development. Therefore, supervision acts as a buffer to the negative impact of working with psychopathology; leading to an improved sense of emotional well-being and reduction in overall staff turnover and sickness absence that is essential for maintaining the integrity and operations of an organisation (Schwerman and Stellmacher, 2012).**

‘BUT WHAT IF SUPERVISION IS NOT AVAILABLE?’

A review of the supervision protocol for MHFA advisors draws on very little, if any information so this is a new area. We should not have to wait for problems to occur have enough grounded theory to postulate that supervision/coaching or preceptorship is paramount. I hope this paper justifies the rational for the action plan that does not have to be costly but does requirement commitment from management and MHFA advisors and an understanding of the “WHY”.

The literature suggests a clear relationship between psychopathology and the levels of emotional burnout in healthcare professionals and these are individuals who are often trained to a high degree and are very resileint. As the current research mentions, the adherence to consistent supervision within occupational settings does not reflect the necessary level for support. Given the currently high prevalence of mental health disorders and psychopathology in the work-place, it is paramount that First Aiders have the necessary professional support to clarify their emotions and improve their personal development and resilience. **Although the literature review pertains to healthcare settings the theoretical underpinning relates to every human being having regular contact with emotional distress.**

Finally, given the increase in awareness and severity of mental health problems in the workplace this should be looked upon as a priority. The author of this paper is a senior mental health clinician and University Lecturer who has worked in the occupational health setting for nearly 20 years. He has noted a significant increase in psychopathology of the clients being referred.

REFERENCES

Ahola, K., Hakanen, J., Perhoniemi, R., & Mutanen, P. (2014). Relationship between burnout and depressive symptoms: A study using the person-centred approach. *Burnout Research*, *1*(1), 29-37. doi: 10.1016/j.burn.2014.03.003

AMA. (2018). AMA adopts policy to improve physician access to mental health care. Retrieved from https://www.ama-assn.org/press-center/press-releases/ama-adopts-policy-improve-physician-access-mental-health-care-0

Berwick, D (2013) A promise to learn–a commitment to act: improving the safety of patients in England. Department of Health, London

Bifarin, O & Stonehouse, D (2017) Clinical supervision: an important part of every nurse's practice British Journal of Nursing 26(6) pp. 331-335.

Bond, M & Holland, S (1998) *Skills of Clinical Supervision for Nurses*. OU Press, London

British Association for Behavioural and Cognitive Psychotherapies (2019) Professional Accreditation https://www.babcp.com/Accreditation/CBP/CBP-Provisional-Accreditation.aspx

British Association for Counselling Psychotherapy (2019) BACP Accreditation https://www.bacp.co.uk/membership/accredited-membership/ (accessed 23.5.19)

Care Quality Commission (2013) Supporting Effective Clinical Supervision https://cqc.org.uk/sites/default/files/documents/20130625_800734_v1_00_supporting_information-effective_clinical_supervision_for_publication.pdf (Accessed 23.5.19)

Colthart I, Duffy K, Blair V (2018) Keeping support and clinical supervision on your agenda. *Nursing Management*. RCN Publishing Company

CQC. (2008). Supporting Information Effective Clinical Supervision. Retrieved from https://www.cqc.org.uk/sites/default/files/documents/20130625_800734_v1_00_supporting_informationeffective_clinical_supervision_for_publication.pdf

Delos Reyes, R. (2018). Burnout Among Filipino Occupational Therapists: A Mixed Methods Analysis. *The Open Journal Of Occupational Therapy*, *6*(4). doi: 10.15453/2168-6408.1469

Department of Health (1998). A first class service: Quality in the new NHS https://webarchive.nationalarchives.gov.uk/+/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4006902 (accessed 23.5.19)

Department of Health (1999) Making a Difference: strengthening the nursing, midwifery and health visiting contribution to health and healthcare https://webarchive.nationalarchives.gov.uk/+/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4007977 (Accessed 23.5.19)

Edwards, D., Burnard, P., Hannigan, B., Cooper, L., Adams, J., & Juggessur, T. et al. (2006). Clinical supervision and burnout: the influence of clinical supervision

for community mental health nurses. *Journal Of Clinical Nursing*, *15*(8), 1007-1015. doi: 10.1111/j.1365-2702.2006.01370.x

Fernández-Sánchez, J., Pérez-Mármol, J., Blásquez, A., Santos-Ruiz, A., & Peralta-Ramírez, M. (2017). Association between burnout and cortisol secretion, perceived stress, and psychopathology in palliative care unit health professionals. *Palliative And Supportive Care*, *16*(3), 286-297. doi: 10.1017/s1478951517000244

Francis R (2013) Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry. Volume 2013. The Stationery Office. 2013 pp.11–4.

Franklin, N (2013) Clinical supervision in undergraduate nursing students: A review of the literature. *Journal of Business Education & Scholarship of Teaching* 7 (1) pp: 34-42

Gupta, S., Paterson, M., Lysaght, R., & von Zweck, C. (2012). Experiences of Burnout and Coping Strategies Utilized by Occupational Therapists. *Canadian Journal Of Occupational Therapy*, *79*(2), 86-95. doi: 10.2182/cjot.2012.79.2.4

Guy, M., Newman, M., & Emel Ganapati, N. (2013). Managing emotions while managing crises. *International Journal Of Emergency Services*, *2*(1), 6-20. doi: 10.1108/ijes-07-2012-0033

Hawkins, P., & Shohet, R. (2007). *Supervision in the helping professions* (2nd ed.). Enskede: TPB.

Health and Care Professions Council (2019) Standards https://www.hcpc-uk.org/cpd/your-cpd/cpd-activities/ Accessed 23.5.19)

Hunter, E., & Blair, S. (1999). Staff Supervision for Occupational Therapists. *British Journal Of Occupational Therapy*, *62*(8), 344-350. doi: 10.1177/030802269906200802

Hyrkäs, K., Appelqvist-Schmidlechner, K., & Haataja, R. (2006). Efficacy of clinical supervision: influence on job satisfaction, burnout and quality of care. *Journal Of Advanced Nursing*, *55*(4), 521-535. doi: 10.1111/j.1365-2648.2006.03936.x

Increasing Access to Psychological Therapies (2011) Supervision Guidance https://www.uea.ac.uk/documents/246046/11919343/IAPT+Supervision+Guidance+2011.pdf/3a8f6c76-cea0-4f76-af78-e2f0a1f64c5e (Accessed 23.5.19)

Inskipp, F., & Proctor, b. (1993) *The Art, Craft and Tasks of Counselling Supervision, Part 1: Making the most of Supervision* (1st ed.). Twickenham: Cascade Publications.

Koivu, A., Saarinen, P., & Hyrkas, K. (2012). Who benefits from clinical supervision and how? The association between clinical supervision and the work-related well-being of female hospital nurses. *Journal Of Clinical Nursing*, *21*(17-18), 2567-2578. doi: 10.1111/j.1365-2702.2011.04041.x

Lennox S, Skinner J, Foureur M (2008) Mentorship, preceptorship, and clinical supervision: three key processes for supporting midwives. *New Zealand College of Midwives Journal.* 8 (39) pp. 7-12.

Little, L., Gooty, J., & Williams, M. (2016). The role of leader emotion management in leader–member exchange and follower outcomes. *The Leadership Quarterly*, *27*(1), 85-97. doi: 10.1016/j.leaqua.2015.08.007

Livingston, G., Kelly, L., Lewis-Holmes, E., Baio, G., Morris, S., & Patel, N. et al. (2014). A systematic review of the clinical effectiveness and cost-effectiveness of sensory, psychological and behavioural interventions for managing agitation in older adults with dementia. *Health Technology Assessment*, *18*(39). doi: 10.3310/hta18390

Martin P, Copley J, Tyack Z (2014) Twelve tips for effective clinical supervision based on a narrative literature review and expert opinion. *Medical Teacher*. 36 (3) pp. 201-207

McBride, P. (2007). Clinical supervision and the use of structured homework. Mental Health

McBride, P. (2007). Clinical supervision and the use of structured homework. Mental Health

McBride,P (2007) Clinical supervision and the use of structured homework. *Mental Health Practic*e 10 (6) pp29-30

Milne, D & Martin,P (2019) Supportive clinical supervision: Supported at last. *Journal of Advanced Nursing* 75 (2)

Milne, D. (2007). An empirical definition of clinical supervision. *British Journal Of Clinical Psychology*, *46*(4), 437-447. doi: 10.1348/014466507x197415

Milne, D., Aylott, H., Fitzpatrick, H., & Ellis, M. (2008). How Does Clinical Supervision Work? Using a "Best Evidence Synthesis" Approach to Construct a Basic Model of Supervision. *The Clinical Supervisor*, *27*(2), 170-190. doi: 10.1080/07325220802487915

Moss, M., Good, V., Gozal, D., Kleinpell, R., & Sessler, C. (2016). An Official Critical Care Societies Collaborative Statement—Burnout Syndrome in Critical Care Health-care Professionals. *Chest*, *150*(1), 17-26. doi: 10.1016/j.chest.2016.02.649

Mullarkey, K. Keeley, P & Playle, JF (2001) Multiprofessional clinical supervision: challenges for mental health nurses. *Journal of Psychiatric and Mental Health Nursing* 8(3) pp. 205-11.

NHS. (2000). Implementing clinical supervision. Retrieved from https://www.nursingtimes.net/roles/nurse-managers/implementing-clinical-supervision/200410.article

Nugent, A., Hancock, N., & Honey, A. (2017). Developing and Sustaining Recovery-Orientation in Mental Health Practice: Experiences of Occupational Therapists. *Occupational Therapy International*, *2017*, 1-9. doi: 10.1155/2017/5190901

Nursing and Midwifery Council (2019) Guidance for Employers. https://www.nmc.org.uk/registration/guidance-for-employers/responsibilities/ (accessed 17.5.19)

Pack, M (2009) Clinical supervision: an interdisciplinary review of literature with implications for reflective practice in social work. *Reflective Practice* 10 (5) pp. 657-668

Parola, V., Coelho, A., Cardoso, D., Sandgren, A., & Apóstolo, J. (2017). Prevalence of burnout in health professionals working in palliative care. *JBI Database Of Systematic Reviews And Implementation Reports*, *15*(7), 1905-1933. doi: 10.11124/jbisrir-2016-003309

Practice, 10(6), 29–30.
Practice, 10(6), 29–30.

Rcot. (2015). Guidance for occupational therapistsand their managers. Retrieved from https://www.rcot.co.uk/sites/default/files/Supervision.pdf

Royal College of Occupational Therapists (2019) Supervision: Guidelines for Occupational Therapists and their Managers https://www.rcot.co.uk/sites/default/files/Supervision.pdf Accessed 23.5.19)

Schwerman, N., & Stellmacher, J. (2012). A Holistic Approach to Supporting Staff in a Pediatric Hospital Setting. *Workplace Health & Safety*, *60*(9), 385-390. doi: 10.1177/216507991206000903

SCIE. (2013). Effective supervision in a variety of settings - Guide home. Retrieved from http://www.scie.org.uk/publications/guides/guide50/

Shapiro, S., & Carlson, B. (2009). Mindfulness-based stress reduction effects on moral reasoning and decision making. *The Journal Of Positive Psychology*, *1*(6), 504-515. doi: 10.1080/17439760.2012.723732

Snowdon, D., Leggat, S., & Taylor, N. (2017). Does clinical supervision of healthcare professionals improve effectiveness of care and patient experience? A systematic review. *BMC Health Services Research*, *17*(1). doi: 10.1186/s12913-017-2739-5

Tomlinson, J (2015) Using clinical supervision to improve the quality and safety of patient care: a response to Berwick and Francis *BMC Medical Education* 15 p.103

Wahesh, E. (2016). Utilizing Motivational Interviewing to Address Resistant Behaviors in Clinical Supervision. *Counselor Education And Supervision*, *55*(1), 46-59. doi: 10.1002/ceas.12032

Wilberforce, M., Hughes, J., Bowns, I., Fillingham, J., Pryce, F., & Symonds, E. et al. (2016). Occupational therapy roles and responsibilities: Evidence from a pilot study of time use in an integrated health and social care trust. *British Journal Of Occupational Therapy*, *79*(7), 409-416. doi: 10.1177/0308022616630329

Wulsin, L., Alterman, T., Timothy Bushnell, P., Li, J., & Shen, R. (2014). Prevalence rates for depression by industry: a claims database analysis. *Social Psychiatry And Psychiatric Epidemiology*, *49*(11), 1805-1821. doi: 10.1007/s00127-014-0891-3

Yegdich, T (1999) Clinical supervision and managerial supervision: some historical and conceptual considerations. *Journal of Advanced Nursing* 30 (5) pp.1195-1204

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