Supervision for the delivery of Mental Health Psychosocial Support in Emergency Humanitarian Settings

A Desk Review Report

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Coláiste na Tríonóide, Baile Átha Cliath
Trinity College Dublin
Ollscoil Átha Cliath | The University of Dublin

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Desk Review Team

The Desk Review Team comprised of Kelly McBride, Byron Bitanihirwe, Frédérique Vallières, Camila Perera, Nana Wiedemann, and Pia Tingsted Blum. The report benefitted from the comments and feedback received from fellow staff and team members, and a special thanks to Anouk Boschma, Ea Akasha, and Sarah Harrison for the thoughtful review.

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Acronyms and Abbreviations

CHW – Community Health Worker

CVT – Centre for Victims of Torture

DIME – Design, Implementation, Monitoring and Evaluation

GIZ – Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) GmbH

IASC – Inter-Agency Standing Committee

IASC RG- Inter-Agency Standing Committee Reference Group

IFRC – International Federation of Red Cross and Red Crescent Societies

IMC – International Medical Corps

IOM – International Organization for Migration

LMICs – Low- and Middle-Income Countries

MHPSS – Mental Health and Psychosocial Support

MhGAP – Mental Health Gap Action Programme

MSF – Médecins Sans Frontières

NGO – Non-Governmental Organization

PHC – Primary Health Care

PMT – Post Graduate Medical Trainees

WHO – World Health Organization

Executive Summary

Supervision is an essential component of Mental Health and Psychosocial Support (MHPSS) programming. Harm can come to not only beneficiaries, or recipients of MHPSS, but also to staff and volunteers working in emergency settings as a result of unsustainable, poorly structured and/or inadequate MHPSS supervision. Despite its noted importance, there is currently no general guidance on MHPSS supervision in emergency humanitarian settings.

Against this background, this report examines the available evidence on MHPSS supervision by exploring: existing definitions of supervision, different approaches used to supervise, best practices in supervision and current barriers and challenges to conducting supervision. The findings from this report confirm a lack of consensus regarding a definition of MHPSS supervision in humanitarian settings in conjunction with a dearth of evidence relating as to *when, how* and *for whom* different models of MHPSS work. A number of challenges were identified that need to be overcome in order to improve MHPSS supervision including dealing with: a reliance on recruitment of expatriate personnel to serve in the capacity of a supervisor; a lack of available/allocated funding for MHPSS programming; inadequate availability and accessibility to supervision; a lack of cultural competence by the supervisor; language barriers; a lack of human resources and a lack of role clarity for supervisors. Despite these shortcomings, opportunities do exist to generate international consensus and developing guidelines for MHPSS supervision, with concerted efforts playing a key role in the process.

1. Background and Rationale

Human resources constitute a vital component of any health care system and represent an important asset in the delivery of mental health and psychosocial support (MHPSS) services (1). The success of any MHPSS intervention relies heavily on the capacity, wellbeing, competence and motivation of its workforce to promote mental health and psychosocial wellbeing and provide support for people with mental health, psychosocial and protection needs (2, 3). A well-trained and supervised, culturally sensitive and competent MHPSS workforce, including volunteers, is therefore essential if services are to meet internationally recognised standards of care to safely provide MHPSS in emergency settings. Supervision is considered especially important in the delivery of MHPSS interventions and wellbeing of staff (4) and features as a key recommendation in all major international guidelines on MHPSS in emergency and non-emergency settings.

Notably, the importance of supervision features in the Inter-Agency Standing Committee (IASC) Guidelines, the 2018 edition of the Sphere Handbook, UNICEF (5) and International Organization for Migration (IOM) operational MHPSS manuals and guidelines, Centre for the Victims of Torture (CVT) and International Medical Corps (IMC) manuals and guidelines, the Mental Health Gap Action Programme (mhGAP) and the various scalable interventions developed by the World Health Organization (WHO). This is consistent with decades of research within broader, global health programming, which highlight supervision as a key determinant of successful health programming. Supervision is considered particularly valuable to ensure the performance, motivation, and retention of those offering services through a task-shifting or task sharing approach (6), where responsibilities are transferred from more specialized staff to less-specialized staff or volunteers, as is often the case in MHPSS programming.

Despite its noted importance, there remains a gap in provision of supervision within MHPSS and protection programmes in humanitarian contexts, which has been referred to as one of the most challenging aspects and unmet needs in programme implementation (5). It should also be emphasized that there is often confusion differentiating between managerial supervisory roles and supervision that is focused on the growth and development of the MHPSS worker. In this regard, generic inter-agency supervision tools for use by IASC Reference Group members and the international MHPSS community have yet to be developed.

Against this background, it is perhaps surprising that the promotion of supervision to develop effective MHPSS skills and knowledge within emergency settings currently remains overlooked. This notion is affirmed by the fact that despite a mounting body of literature having focused on MHPSS tools and guidelines (7-9), these publications lack information pertaining to training and supervision processes (e.g., number of sessions, length of training, monitoring and supervisory relationship) and fidelity to the specified intervention. A notable exception is the Child Protection Alliances' Toolkit on Child Protection Case Management Supervision Coaching and Training. While narrow in scope, in terms of the target audience (Case Managers), much of the guidance is applicable in MHPSS and protection contexts. Without additional guidance and studies on the impact of supervision however, it is hard to comprehend and ascertain the impact and significance of supervision on the quality and scalability of MHPSS programming.

In this context, the aim of the present desk review is to report on the current evidence available for MHPSS supervision. First, we review existing definitions of supervision (**Section 3.1**) and summarise the different approaches used to deliver supervision (**Section 3.2**). Best practices in supervision (**Section 3.3**) and current barriers and challenges to conducting supervision (**Section 3.4**) are also discussed. Finally, identified gaps in MHPSS supervision are used to propose future opportunities to strengthen the availability and accessibility of MHPSS supervision going forward (**Section 4**).

2. Methodology

The content of this desk review is based on information collected through a synthesis of extant literature (viz., a rapid literature review) relevant to MHPSS supervision in emergency settings (e.g., armed conflicts, natural disasters) from web research and resources suggested through discussions held with experts in the area of MHPSS. In order to locate relevant publications a search was performed of electronic bases including MEDLINE, PubMed, PsycINFO, Embase and CINAHL in addition to the Google search engine. All databases were searched for the following key terms (using boolean operators): "supervision", "clinical supervision", "emergencies", "disaster", "crisis", "mental health and psychosocial support", "psychosocial support services", "community health workers", "paraprofessionals", "psychosocial workers", "peer-to-peer support", "peer support", "psychosocial first aid", "problem solving therapy", "low intensity psychological interventions", "group based therapy", "apprenticeship model", "non-healthcare professionals", "volunteers", "training", "task-shifting" and "task-sharing". The desk review therefore covers global publications in peer-reviewed journals and grey literature published and internally shared by organizations such as the WHO, IOM and the International Medical Corps (IMC), in addition to reports related to specific countries.

3. Findings Across Specific Objectives

3.1. Definitions of Supervision

The concept of *supervision* takes on a variety of definitions based on the context in which it is performed. For many, particularly in humanitarian contexts, supervision suggests a managerial relationship that oversees tasks, outcomes, and performance (4). Less commonly within MHPSS and protection, it is understood as a *supportive* relationship between supervisor and supervisee(s) with the primary goal of creating a safe and collaborative space to promote the quality of work, technical competencies, and wellbeing (10, 11)

A number of professional bodies focusing on mental health support including the American Psychological Association, the American Counselling Association as well as the British Association for Counselling and Psychotherapy recognize supervision as a process related to constructive teaching and guidance in relation to personal, professional and educational development. Within community-based emergency settings, supervision of MHPSS practitioners focuses on aspects regarding outcome monitoring as well as skill-building (12-14).

Despite a lack of a clear definition the literature suggests supervision should provide a space for continuous reflection on the work with beneficiaries, the MHPSS relationship (viz., safeguarding), methods that may be helpful as well as on inter-collegial cooperation (15). Below we articulate key definitions, or possible ways of describing supervision in relation to MHPSS. Specifically, the literature differentiates between three key elements of supervision within MHPSS: Supportive Supervision, Technical Supervision and Clinical Supervision (Table 1).

Supportive Supervision

The cornerstone of supportive supervision is the supervisor and supervisee relationship that enables joint problem solving and the discussion of challenges, cases, and collaboratively enhances service delivery. It also serves as a platform for supervisors to be able to assist in placing limits and boundaries in how far the supervisee should be extended (11). In addition, it allows the opportunity for structured training, learning, direct observation of a supervisee's performance and provides space for constructive feedback. Supportive supervision is typically referred to in the extant humanitarian literature in terms of a process of improving the ability for community based non-specialized workers to provide MHPSS (16), as well as those taking on

a more specialized role (17). It is recommended by the WHO as the preferred type of supportive supervision for task shifting, and has been found to strengthen health systems and outcomes (18)

Technical Supervision

Technical supervision is most commonly used to describe supervision that is provided by a skilled MHPSS practitioner to enhance the skillset and development of supervisees, and ultimately improve the provision of MHPSS (10). In some cases, it is synonymous with 'clinical supervision' (19). Within technical supervision, individuals or teams are brought together by a supervisor—that possesses a higher level or training—on a regular basis. The structured supervision sessions provide a time for reflection upon their work and their own personal and professional development (10). It is also used to ensure that skills and information that MHPSS practitioners learn in training are applied in the field (20). As with supportive supervision, technical supervision in MHPSS 'reflects a process of building empowered relationships as opposed to cultivating controlling relationships', the latter of which may be more common to technical supervision relationships in other fields (10).

Clinical Supervision

The term clinical supervision is often used within professional mental health contexts, such as psychology (21) and psychiatry (22) to describe the process of ongoing professional development within specific fields. Within these contexts, supervision would typically be conducted by someone within the same discipline to ensure continuous growth and development both personally and professionally. Similar to the primary goal of clinical supervision within other professions, within MHPSS contexts, clinical supervision is described as a structured process that allows for support, education, and monitoring of professional performance and ethical considerations (9, 23). Within MHPSS, clinical supervision is said to be a key facilitator in enabling non-specialists to be able to employ basic, or 'low intensity' psychological interventions (24, 25), and found to be an integral part of working with newly trained MHPSS workers in low income and post-conflict settings (23). Furthermore, clinical supervision is recognized as a primary means to facilitate supervisee professional development and provides a gatekeeping role in the profession for client welfare and the protection of the public (26). As such, clinical supervision represents an important strategy for ensuring intervention are provided according to the treatment in question (i.e., mhGAP Training of Trainers and Supervisors) (27) and also serves as a way to provide emotional support for those being supervised (28). It can also increase supervisees self-awareness and personal and professional growth (23).

Table 1: Definitions of Supervision

	Supportive Supervision	**Clinical Supervision**	**Technical Supervision**
What	Fostering a supportive relationship that enables joint problem solving and the discussion of cases between the supervisor and supervisee	Enhance the skillset and development of supervisees, and ultimately improve the provision of MHPSS	Facilitate supervisee professional development and is key facilitator for non-specialists to provide MHPSS. Way to provide emotional support.
How	Exploring boundaries and limits, structured training and learning, direct observation,	Structured sessions that meet regularly to reflect on work and personal professional development	Structured process that allows for support, education, and monitoring of professional performance and to ensure intervention is in

			accordance with treatment
Who	Supervisor: Supervisee(s)	Skilled MHPSS Practitioner (Supervisor): Supervisee(s)	Supervisor (skilled): Supervisee(s)
Format	Individual or group (not specified in literature)	Individual or group	Individual or group

3.2. Supervision Modalities

The primary approaches or delivery modalities of supervision mentioned in MHPSS literature, guidelines and reports largely reference individual and group supervision. This approach also expands to include peer supervision, face-to-face supervision, remote supervision as other forms of supervision that are widely utilized within MHPSS in emergency contexts. In accordance with the IOM's Community Based MHPSS manual (10) and the Johns Hopkins Design, Implementation, Monitoring and Evaluation (DIME) manual, it is suggested that supervision within MHPSS should be *flexible* in order to meet the needs of the individuals that are implementing MHPSS activities. Deciding which model to use will therefore depend on what works best within the organizations that are providing supervision. There is little evidence to support one supervision model over another, indeed, there are few descriptions of existing models in general, making it difficult to discern appropriateness of supervision models that have only been studied in high-income settings only (29).

Within the discussion of individual and group supervision, there are numerous ways in which supervision sessions can be conducted. Some organizations promote individual supervision as the primary modality, and group supervision as an optional add-on. Others rely more on group supervision, as it typically uses fewer human resource hours compared to one-on-one supervision (i.e., cost-effectiveness), and where individual sessions are conducted on an *ad hoc* basis with supervisees. It is also possible to do a combination of group and individual supervision (30). When considering differences between group and individual supervision several factors are apparent. For instance, in group supervision, supervisees often learn from fellow supervisees as they share their cases. In addition, a group format allows a supervisor to review a component of the intervention just once, rather than repeatedly with each supervisee. However, if there is one supervisee that is struggling in group supervision, it is possible that other supervisees will not receive due attention to their cases.

Individual

Individual supervision largely takes place as a one-on-one meeting between the supervisor and the supervisee. Individual supervision is found to allow for more privacy and more individualized and focused attention on the supervisee (9, 10). The content of individual sessions can focus on a variety of different topics. Within the session, the supervisee and supervisor might review case files together, discuss ways forward if the supervisee has doubts about how to proceed with the case (31). In other words, the individual nature of the session allows for the supervisee to discuss specific issues they might be having in their work, or particularly difficult cases that they might working with. In addition to reviewing cases in session, it is also an opportunity to explore reactions and personal issues of the supervisee that might come up and potentially impact their relationship with beneficiaries and ability to provide services (23) The literature suggests that individual sessions can be scheduled regularly or scheduled as needed (10, 17). It is also noted that individual supervision involves more resources (e.g., financial and in terms of time) to conduct (9).

Group Supervision

Group supervision typically occurs when two or more supervisees attend the session with the supervisor. The makeup of the members of the group can vary, whether it is those working on the same team, within interdisciplinary teams, providers working in the same location, or having similar roles.[1] Group supervision is further characterised by a referent person with more experience than the rest of the group, who leads the session. The facilitation by the supervisor adds power dynamics within the group (31). As such, it is suggested that everyone in the group agree to the model and processes used (17). Within group supervision, confidentiality has limitations, especially compared to individual supervision. van der Veer et al. also state that 'in areas of armed conflict security considerations should be taken into account: groups may attract the attention of the armed groups and evoke suspicion (28).'

Group supervision allows for support from the team but also allows the group to learn about what other supervisees are facing and understand that they are not alone in their experiences at work. Peer learning and support is also often a key component of group supervision (10). According to van der Veer and colleagues, group supervision is preferred for clinical supervision as it allows for different methods to be used within the session (example role plays). One can also use the dynamics within the team as a topic for supervision (9). It is noted that group supervision is seen to be more cost effective and appropriate for use in settings where resources for supervision are limited. In other words, it allows supervision to reach an increased number of supervisees through fewer human resources (i.e. the supervisor), or as Kemp states, for 'increased coverage' for less cost (29). IOM suggests that group supervision should take place every week in the beginning, and then every other week (2).

Peer Supervision or Intervision

Peer supervision is a group or one on one session that is not directed or facilitated by a supervisor. Within peer supervision, participants have the same role and function within their organization(s) and around the same level of expertise and experience (10). This approach allows for collaboration among peers without the hierarchical element (6) present in supervisor/supervisee arrangements. Also called intervision, peer supervision consists of groups or two peers coming together to support one another in mutual training and learning, to discuss and share tools, cases, and other areas of interest (15, 31), thereby learning to provide solutions for difficult situations with colleagues or clients (10). It is considered integral in creating support systems for MHPSS practitioners.

The underlying purpose of peer supervision is to allow participants to learn better or alternative methods of managing professional problems, discuss reactions and feelings, and coping strategies (32). IOM cautions that this approach usually works with 'mature teams that have worked together for a certain period of time' and has been noted in MhGAP training materials as a possible solution for when no supervisor is available (10, 33). IFRC cautions that peer supervision is not to provide counselling or to replace professional help (32). Peer supervision can also be less costly, as it does not rely on a supervisor role (10). Another resource indicates that it is ideal to have a supervisee lead groups after having supervision by an expert (15). Guidance suggests that peer supervision is a key opportunity for supporting MHPSS interventions (16, 32), it is helpful in cases where access is difficult and can be quickly implemented without straining resources (32).

[1] In numerous humanitarian organizations, group supervision is done through multi-disciplinary teams (IOM, CVT, MDM). Cross discipline or multidisciplinary supervision is a group supervision inclusive of more than one professional discipline.

Live supervision

Live supervision, also known as 'direct' supervision or 'in-vivo' supervision is used to inform the supervisor about the supervisees skill level and ability to implement MHPSS (34) through direct observation. Live supervision is considered under 'Clinical Supervision' in MSF guidelines reviewed, and involves the supervisor being physically present with supervisee and client, observing a session, intervention, or interactions. According to MSF, this is needed to ensure the quality of the sessions and of the intervention (31). With beneficiary permission, live supervision allows for a supervisor to directly observe and provide feedback on body language, facial expressions, and verbal cues and conversation content (35). MhGAP ToHP suggests that competency checklists to be completed during a live supervision session to provide feedback on core competencies. Debriefing[2] sessions can take place before and after sessions in order to enhance learning potential and understanding (35) IMC also incorporated this type of live supervision, or observation within their framework created to support mental health integration into the primary healthcare system in Lebanon (17). Within the Centre for Victims of Torture's (CVT) supervision structure(23), psychotherapist/trainers also provide this observation modality form of supervision, in which supervisors sit into group and individual sessions and observe the skills of facilitators and provides coaching and 'therapeutic input' (23)

The literature highlights that this type of supervision can be helpful with complicated cases (31) can be conducted systematically, or on a regular basis (17, 31, 36). Challenges to conducting live supervision include issues of time and confidentiality (34).

Remote Supervision

While the literature indicates a preference for live supervision, and that in-person supervision never be completely replaced (30), being able to physically access the location of supervisees is not often possible in difficult contexts (i.e. in humanitarian emergencies), or because of limited human resources. In such cases, remote supervisory methods have been employed, including through the telephone, text, and the Internet. Recent evidence supports the use of WhatsApp groups as an effective tool for peer-to-peer group-based supervision (6, 29). During remote supervision sessions, a variety of methods can be used, such as case presentation and role play (36). Considerations for employing these methods when using translation as being particularly challenging has been noted (37).These tools can also be used to record sessions with clients for the purpose of receiving supervision around the session, to be shared directly with the supervisor and/ within group sessions (29). Although it should be noted that this should only be done in situations where the service user has given their consent for the session to be recorded (35), and it can be guaranteed that the data can be secured and shared safely, which is a key consideration when using technology (38). Service users should be made aware of the risks of recording and the potential risk that their information could be accessed.

Table 2: Modalities of Supervision

	Individual	**Group**	**Peer (Intervision)**	**Live**
What	One to one meeting between supervisor and supervisee to discuss cases, wellbeing, challenges and opportunities for future practice	Group meeting facilitated by referent person who has more experience than the rest of the group	Peers coming together to support one another, discuss cases, problem solve, and create space for mutual learning and sharing	Direct observation of supervisee by supervisor during intervention

[2] Debriefing in this context is not synonymous with the intervention 'Psychological Debriefing' but rather refers to discussion before or after a session.

Who	Supervisor and supervisee	-Supervisor (experienced referent person) and two or more supervisees -Supervisees can work on the same team or project, or can be part of a multidisciplinary approach	-One or more individuals who are not directed or lead by a supervisor -Roughly the same level of experience and role	Supervisor, supervisee, and beneficiary(ies)
Format	-In person or remotely -Private and confidential space	-In person or remotely -Private and confidential space	-Group or one to one -Remotely - Private and confidential space	-Direct observation of group or individual MHPSS -In person or remotely (recording)
Benefits	-Increased privacy and confidentiality -Individualised attention	- Peer support and group learning -Supervisees can learn from one another -Increased opportunity for role plays and other modalities -More cost effective and can reach higher number of supervisees -Limits supervisor repeating the same teaching over and over	-Collaboration without hierarchal power dynamics -Mutual learning, sharing and support -Stress reduction	- Feedback can be given on verbal and non-verbal skills of supervisee -Can observe and provide feedback on fidelity to intervention -Helpful with complicated cases
Limitations	-More costly to implement	-Power dynamic of having a supervisor in group -Confidentially cannot be ensured the same way as in individual -In areas of armed conflict, may attract the attention of authorities	- Works best with 'mature' teams -More cost effective	-Must have beneficiary consent

3.3. Facilitators of Supervision

A number of elements have been identified that can facilitate effective MHPSS supervision in emergency humanitarian settings. These best practices, explored in more detail below, include: supervision alliance characterised by building rapport, trust, and establishing an open dialogue between the supervisee and supervisor; structured and consistent supervision sessions; setting clear goals or expectations pertaining to the supervision process (i.e. supervisee-driven meeting agendas; incorporating follow-up and ad-hoc supervisory sessions in addition to flexible and responsive supervision on a regular basis).

Organizational Commitment to Supervision

It is essential that organizations place more focus on ongoing supervision as opposed to one-off trainings, particularly those conducted by expatriates who only stay for the duration of the training. All too often, organizations are conducting trainings and implementing MHPSS activities without incorporating sustainable supervisory practices within programming, which can hinder learning and practical application skills (15). According to Murray and colleagues,"implementation science research, most of which has been conducted in the United States and other Western countries, clearly indicates that "one-off" training approaches may lead to initial knowledge change, but will not result in behavioral change in practice or counseling approach, even among mental health specialists" (14). Described as 'train and hope' (39), evidence shows that training alone will not lead to behaviour change (12).

Multiple Layers of Supervision

In a tiered model, or multi-layered approach, all those involved in the MHPSS 'system' have access to the supervision they needed to provide high-quality MHPSS (36). Supervisors who are identified prior to trainings by their organizations or communities, or through trainings as demonstrating a readiness and aptitude for MHPSS, can help increase appropriate coaching and mentorship. Supervisors will likely need ongoing coaching and training on how to be an effective supervisor (34). Lastly, allowing for multi-step or long-term trainings consisting of self-reflection and continuous supervision has also been indicated as best practice (15)

It should not be assumed that because someone is in a supervisory role themselves, that they cannot also benefit from supervision. This is a key component of the apprenticeship model, explored below, in which the continuous support from the trainer allows for the supervisor to learn how to supervise. Literature also suggests that including external supervision when possible can help to ensure that the delineation between managerial supervision and MHPSS supervision is clear. External supervision further reduces the concern that any challenges and mistakes discussed in supervision might have negative repercussions on the supervisee's employment (15). Budgetary and logistical considerations must be taken into account by organizations to adequately resource MHPSS programming with supervision. Beyond employing supervisors, time within supervisee's schedules for preparation and participation should also be accounted for.

Apprenticeship Model

The apprenticeship model of supervision (14), similar to that of other trades, allows for continuous, on the job training. In MHPSS, the apprenticeship model suggests using trainers (often external), supervisors (ideally from the local community), and lay persons as counsellors to construct a system for MHPSS delivery. Within this model, the trainer, who is usually coming from outside of the local context, would help to identify local community members who would be ideal for a more advanced role (supervisor) through training. Within this model, the 'experts' would then continuously mentor and coach those identified as supervisors for local lay persons providing MHPSS. The process of apprenticeship would begin at the stage of training and be an ongoing practice to build the confidence and competencies of the MHPSS practitioner, before being gradually 'handed over' to the local community. This model has demonstrated that supervisees report an increase in confidence, competencies and ability to use skills learned in trainings when participating in the apprenticeship model compared to those who received training alone (35). Utilizing an apprenticeship model has been noted as a key lesson learned in benefiting MHPSS program implementation (35, 40).

Supervision Contract

The supervision contract is a binding document between the supervisor, supervisee and the organisation that provides a map for the entire supervisory journey (28). This document typically formulates the methods, goals, and objectives of supervision; expectations of the supervisor and supervisee; encourages professional collaboration; emphasizes issues not appropriate to discuss during supervision; draws on aspects related to reviewing and concluding the supervisory relationship; makes specific reference to the professional code of ethics or standards for practice; and highlights specific policies and procedures related to supervision that are present within the organisation (41).

Profile of Supervisor

Within the literature, supervisors should be open, honest, self-aware, empathetic, supportive, have higher level of technical or practical skills than supervisee, accountable, maintains confidentiality, ability to provide feedback, encouragement, and guidance (17, 42). As noted in much of the literature, there are often many barriers when using non-local staff for supervision. Local supervisors, who are members of the communities they serve, can speak the same language, and share an understanding of the definitions, stigma and ways of understanding mental health, as well as how a community expresses distress. Using external supervisors, even when technical skill might be high, and previous experience with supervision extensive, often lack an essential understanding and ability to communicate with supervisees, and much can be lost in the supervision process as a result. In situations where an expat is in a supervisory role and does not speak the same language as supervisees, it is essential to train an interpreter so that they can transfer sensitive terms and knowledge to supervisees (31), or when possible, pair with a local supervisor in order to ensure that the cross cultural elements are not lost (30).

Profile of Supervisee

The profile or characteristics of the supervisee influence the supervision process. Indeed, several authors have identified characteristics or traits that are thought to impact supervision. Key among these are a supervisee's motivation, maturity, learning skills or perspicacity, autonomy, self-awareness and preparation (17). It is noted that in order for supervision to be effective, it is important for the supervisee to be an active participant in supervision, to be punctual, come prepared, give respectful and appropriate feedback, and to be reflective (33).

Supervision Alliance and Supervisee Performance

Outcomes connected to supervision alliance include satisfaction and retention in addition to self-efficacy, impact on client outcomes, stress and burnout. Literature also suggests that supervision alliance is associated with job satisfaction, organizational commitment and perceived organizational support. As such, building strong supervisory work alliances and reducing the negative effects of stressful work environments known to exist in humanitarian settings will be of core importance. In this regard, the following techniques may prove effective in terms of improving the supervision alliance: developing supervision contracts (viz., describing the purpose and frequency of supervision), role induction procedures, documenting supervision sessions, establishing qualifications and preparations for supervisors and developing procedures for assessing supervision quality, collaborative goal setting, providing feedback and evaluating the supervisory relationship (26)

Location and Frequency of Supervision

Location of supervision is often a key challenge in emergency and humanitarian settings. Best practice dictates that finding a confidential space, free from interruptions is ideal. When operating in complex settings, finding space to have a private conversation is challenging. In addition, MHPSS service providers often work across numerous locations. Given limited human resources, the supervisor may not be able to visit all sites, making it necessary for supervisees to travel to a central location. In emergency and conflict settings, travel can at times be life threatening and impossible, creating a significant barrier to supervision (28). Recent years have seen an increased use of technology to help overcome the geographical barriers to supervision.

Monitoring and Evaluation

Supervision can be considered part of quality assurance and monitoring and evaluation within MHPSS programming. A strong emphasis, however, should be placed on competency thresholds (e.g., basic knowledge, skills, traits, motives and social role), through the use of checklists (43). Kemp and colleagues suggests that the use of checklists is considered to be a part of more 'traditional' supervision models in which supervisees are not empowered to solve problems on their own (29). The use of checklists and their efficacy in enhancing MHPSS supervision is an area to be further explored.

Remote Supervision

It is widely acknowledged that continuing professional development requires robust support mechanisms so as to maximize opportunities for achieving best practice in clinical settings. This is of particular significance when considering staff or volunteers that are based in rural areas, conflict and other emergency settings where physical meetings are not possible**.** In such cases, there is an increase in the use of remote supervision using telephones, messaging services, and video platforms (29), along with an increase to understand how best to deliver supervision and effective systems (38), and their associated risks. Unfortunately, poor mobile signals and Internet connectivity in remote rural and conflict affected areas and communities may hamper this process. With this in mind, more evidence is needed to determine whether multimedia-based platforms are a useful strategy to support sustainable implementation of supervision in resource poor and difficult to access settings and can effectively protect client data.

Culturally Appropriate Supervision

Recent years have seen an increased focus on the need to tailor interventions to effectively address the mental health needs of those in humanitarian settings in a culturally appropriate way. Cultural adaptations and considerations may reduce the risk of experiencing interventions that intrude or transgress individual cultural values and norms. Contextual factors such as educational backgrounds and literacy levels have also been highlighted as a key consideration in working in LMIC settings (39). With this in mind, empirical evidence suggests that supervision process also vary across cultural contexts (44). Thus, adapting supervision techniques according to cultural context (i.e. cultural competence) is of core importance.

Gender differences have long been known to influence the supervisory relationship within a clinical context (45, 46) and this maybe further exacerbated in humanitarian settings (47) depending on the operating context. It therefore follows that a better understanding of gender-related aspects in relation to MHPSS supervision represents another future opportunity for exploration within the MHPSS domain. Unfortunately, very little of the material reviewed to date probed the important element of gender dynamics in relation to MHPSS supervision. In this regard, it is evident that the MHPSS sector needs to place a sharper focus on

understanding, improving and expanding on the emphasis placed on gender-related components with regards to MHPSS supervision.

3.4. Barriers to Supervision

Some of the barriers known to affect supervision include general attitudes towards supervision, unstructured or under-prepared supervision sessions, lack of time in addition to inadequate availability and accessibility to supervision (48). In recent years, an increasing number of studies have placed focus on awareness of cultural factors in addition to diversity and multicultural competence in terms of counselling and professional psychology as well as psychotherapy (49-51). In particular, an emphasis has been centred on supervisor multicultural competence in relation to aspects of multicultural self-awareness, multicultural skill and knowledge, as means to facilitate conceptual learning with supervisees for their competency development and clinical practice. Unfortunately, research evidence suggests that supervisors do not pay enough close enough attention to cultural aspects related to supervision (e.g. lack of awareness and knowledge of cultural issues) (49). Notably, it has been suggested that aspects purporting to culture may enhance the nature of the supervisory relationship and potentially promote supervisee satisfaction as well as improve supervisee awareness to cultural considerations in therapy (52). In contrast, a lack of culturally sensitive supervision is suggested to have a destructive effect on the supervisory relationship (53) as well as supervisee outcomes (e.g., self-confidence and self-awareness) (54), which, in turn, may have a negative impact on therapy outcomes (52).

In addition to the above mentioned aspects, an over reliance on expatriate supervisors (14, 29) particularly when they do not have an understanding of the history and context that they are working in, issues with language barriers (10), inadequate human and financial resources (15, 55), a lack of awareness and understanding in terms of the importance of MHPSS supervision (15), lack of role clarity (56), insufficient guidance in relation to supervision (15), and interpreters not being trained in mental health or knowing how to adequately explain terms (57), all reflect further barriers in relation to effective MHPSS supervision.

4. Conclusion and Key Future Opportunities in MHPSS Supervision

The findings from the desk review suggest a dearth of literature pertaining to MHPSS supervision models in emergency settings. It follows that inadequate MHPSS supervision in emergency settings is a major hurdle in providing the respective services. The fact that a lack of supervision in MHPSS can potentially result in harm to staff and volunteers working in emergency settings further underscores the necessity of this core component.

A key unexplored opportunity for MHPSS lies in collective and concerted efforts geared towards assessing the efficacy of supervision and its impact on MHPSS in emergency settings. Opportunities lie in conducting studies focusing on the efficacy of supervision, given that RCTs provide the strongest evidence base in health research. Calls for additional studies to evaluate methods to supervise non-specialist MHPSS workers, and mental health interventions in LMIC have been made (12, 13, 35, 39), and it is acknowledged that conducting research or collecting data in emergency humanitarian settings, especially those that are inaccessible, represents a challenging task (58). Even so, one cannot underestimate the significance of conducting research in these settings, especially in relation to generating evidence stemming directly from the humanitarian context (59). As such, the focus here will lie on conducting studies to detect differences in supervisee and client outcomes in humanitarian emergency settings in terms of cohorts receiving supervision as opposed to cohorts that received no supervision or less supervision.

Yet another important area of exploration in the MHPSS domain is the use of technology to improve supervision outcomes. Numerous barriers, such as physical access to supervisees, can potentially be

improved through the use of remote supervision. As such, future work in the sector will need to consider how and what technology (with the relevant cultural adaption) might be combined with task-shifting interventions to optimize their effectiveness for supervision in emergency settings. Employing communication technology such as e-mail, texting, WhatsApp and Skype, as opposed to face-to-face supervision to monitor outcomes of such coaching could help ensure improved quality, reach and effective services are provided for MHPSS in humanitarian settings.

Finally, reaching a place in which consensus is built within the MHPSS community around key definitions, roles, and ways of working will no doubt help enhance advocacy efforts to improve and increase supervision within MHPSS programming globally.

5. Lessons Learned from the Desk Review Process

Despite a growing body of knowledge focusing on concepts and the significance of supervision in relation to MHPSS in humanitarian crises, significant gaps still exist in our understanding as to what effective MHPSS supervision within emergency settings should constitute. For instance, a consensus regarding a clear definition of supervision with regards to MHPSS in humanitarian settings still remains unclear. Similarly, there is a lack of evidence in terms of when, how and for whom different modes and frequencies work. Despite these shortcomings, opportunities do exist to generate better international consensus with regards to developing guidelines in relation to MHPSS supervision via effective dialogue.

6. Limitations

The collated documents described here may be missing key information for a number of reasons based on language restrictions of the documents included (only those available in English considered), inaccessibility to internal organizational documents, in addition to an underreporting of specific details pertaining to supervision. Consequently, the conclusions and recommendations should be considered with caution. Similarly, types of study (i.e., qualitative, narrative review, and scoping review) and differing frameworks of supervision may have further compounded the conclusions of the present review.

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