Professional leadership in mental health social work

An examination of a professional leadership role in the mental health division of a New Zealand district health board

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Abstract

Recent decades have seen significant changes in the political context and the management and supervisory framework in which social work is practised, particularly in public health and statutory agencies. In this context new roles which can be broadly identified as professional leadership, as distinct from management, have developed. This article examines one professional leadership role, in mental health within a New Zealand district health board. A qualitative study of the experiences and perceptions of incumbents of this role was conducted. Participants experienced significant ambiguity in the role, however this could be experienced as opportunity for initiative and creativity in identifying and addressing professional needs. Although formal power is limited by not being in line management, there is opportunity for the exercise of expert power and informal strategic influence.

Introduction

The past two decades have seen substantial change in the political context and the managerial and supervisory framework in which social work is practised (Hughes and Pengelly, 1997; Cooper, 2000). Social work literature has generally identified functions of supervision as administration or management of service delivery, education and support for the worker (Hughes and Pengelly, 1997; Cooper, 2000). Some recent authors add another role of mediation between senior management in organisations and workers (Cooper, 2000). Traditionally these functions of supervision have been provided by one professional supervisor, who also had line management responsibility for the practitioner's work.

However the rise of managerialism has led to the emergence of situations where the immediate line managers of social workers, responsible for the management of service delivery, no longer necessarily have a social work background, but are generic managers employed for management rather than practice supervision skills. Accordingly those managers may have limited understanding of, or identification with, the nature of social work, including its values, ethics, knowledge base and practice skills. Social workers may not feel valued or supported in their work.

In this context a number of different models and structures for supervision have developed (Cooper, 2000) which share in common the division of responsibility for the different functions of supervision between various managers, and recognise peer professional or clinical supervisors either within the organisation or externally contracted. Typically the administrative or management function remains the responsibility of line management, while professional and/or clinical supervision is provided by peer professionals or external consultants.

Further, recent years have seen the emergence of positions and roles that could be broadly defined as professional leadership, distinct from both immediate professional supervision and line management. What is the role of these positions in the overall supervisory framework? This article examines the developing role of professional practice leadership especially in mental health social work, through a review of relevant literature and a small scale research project into the perceptions and experiences of the role of current and recent incumbents of one professional leadership position.

In the practice context of this study social workers work in multi-disciplinary teams in specialist mental health services including adult general psychiatry, child, adolescent and family, forensic and intellectual disability, comprising both inpatient and outpatient services. Team line managers generally have a clinical background, commonly nursing or social work, nevertheless in many team situations, social workers come under the immediate line management of a manager from a different discipline. The model for professional supervision that has been implemented is probably best described as a formalised version of what Cooper (2000) identifies as *Efficiency Supervision with Peer Support*. Professional supervision is provided on a formally contracted basis by peers who are formally trained and identified as professional/clinical supervisors, and undertake this role in addition to their clinical work. In most services the professional supervisor is from a different team to the practitioner so supervision takes on some aspects of an externalised supervision model.

The role of the professional leadership position includes ensuring robust clinical support for social workers, and providing social work consultation to services. Recognised senior practitioners are appointed to the role, with an allowance of four hours per week allocated to the leadership role in addition to ongoing clinical work. Each professional leader is responsible for leadership for a group of six to 10 social workers within a specified service, for example adult general or child, adolescent and family. Most professional leaders also undertake direct clinical supervision for some social workers.

Relevant literature

Cooper and Anglem (2003) and Cooper (2006) examined the practice of supervision in mental health services in a New Zealand district health board. They also explore the concept of clinical governance, and the relationship of clinical supervision to this. Clinical governance is defined as:

> …a strategy for improving quality of patient care by creating an environment in which excellence will flourish. It encompasses clinical audit, risk management, clinical effectiveness, quality assurance, and professional and staff development (Cooper and Anglem, 2003: 40).

However Cooper and Anglem express the concern that despite the key role of clinical supervision in enhancing the quality of practice, the relationship between clinical supervision and clinical governance has not been adequately addressed. They observe that:

> There is less emphasis on administrative supervision and professional monitoring of practice, less involvement of line management with practice supervision and an increased use of supervisors from outside the supervisee's work unit. Clinical supervisors' accountability and responsibility for practice is uncertain (Cooper and Anglem, 2003: 42).

While recognising the importance of clearly defined confidentiality in the professional supervision relationship, they express concern at the risk of poor performance being contained within supervision when it should be addressed more broadly, with the potential of harm to clients. Ultimately, they argue that 'clinical supervision needs to be a more open and transparent process, linked formally to clinical governance' (2003: 49).

The concept of professional leadership in social work, as distinct from either management or clinical/professional supervision, has received little attention in the literature. In the Aotearoa New Zealand context, Muir, Schluter and Findley (1998 a and b) examine the role of practice consultants in the Department of Child, Youth and Family Services (CYFS). Like the position that is the subject of this study, the practice consultant position was located outside the line management structure, with an emphasis on professional development. Difficulties that were experienced with the position included a lack of clarity about the role, staff perceiving consultants as being aligned with management, especially when consultants were required to act in management positions for periods of time, limited resources, and too many tasks, not all of which may be appropriate. Schluter, Muir and Findley note that what consultants saw themselves as needing from CYFS included a clear mandate, role clarity, and supervision and support to help them perform the role successfully (Shluter, Muir and Findley, 1998b: 43).

In a situation which seems to have remarkable similarity to the context of current study, Globerman, White, Blacker and Davies (2005) explore the development of the role of professional practice leaders in health services in Ontario, Canada. From the mid-1990s restructuring of health services had led to the dis-establishment of specific social work departments with their own management structure, and the relocation of social workers in multi-disciplinary teams, with managers from other disciplines, especially nursing, in a flattened management structure. It was found that generic managers were not equipped to understand, evaluate and meet the needs of allied health professionals they were responsible for. This has led to the development of roles identified as Professional Practice Leaders (PPLs). Globerman et al conducted a study of social workers identified as PPLs in a number of different health services in the province of Ontario. In some cases PPL roles were full time positions, in others the role was undertaken by practitioners in addition to a clinical workload. Responsibilities included:

- scope of professional practice, which includes standards development, promoting best practices, and spokesperson for the profession;
- professional resource person for front line and administrative staff with responsibilities for professional development and performance appraisals;
- communicator and translator between management and front line, workload statistics and in some cases budgeting; and
- collaboration with senior management in strategic planning.

Globerman et al found that PPLs experienced a significant sense of role ambiguity and 'blurriness', of being 'caught in the middle' of systems, and consequently experienced difficulty in meeting their own and their social work peers' expectations of the role. 'When asked about the challenges of the role, many PPLs felt that juggling time, competing demands between clinical and administrative roles, continuous change, and having their voices heard topped the list' (Globerman, et al. 2005: 119). They felt that their power and influence was limited as the role does not carry formal authority; 'the consultative nature of the position and insufficient time and budgetary allocation limited opportunities to be clinically and administratively effective' (ibid: 118). In relation to front-line social work peers, PPLs felt a sense of alienation from front-line workers, despite most continuing to carry a clinical caseload. They 'perceived that their social work peers expected them to have a level of influence and authority that is outside their direct control' (ibid: 121). Nevertheless:

> Most PPLs enjoyed the challenges. They carved out leadership roles, are recognised as experts, have identified areas that have the potential for successful outcomes and seized opportunities to influence decision makers.

Globerman, et al. conclude by encouraging professional leaders to actively assert their role to promote professional development in organisations, to:

> …acknowledge the expert power of their specialised knowledge and skill. In seizing these beliefs social work PPLs can be empowered, effective leaders through their ability to influence formal and informal organisational change (ibid: 121-122).

The experience of a sense of role ambiguity, and lack of clarity of expectations, is common to both the CYFS practice consultant role, and the professional practice leadership roles examined by Globerman et al. In a handbook provided to participants in a workshop for staff in a health service transitioning into management and leadership roles, Brooks (2006) quotes Kahn and Quinn in observing that roles new to an organisation, and roles concerned with process, are among those identified as most likely to experience role ambiguity. Brooks also observed that job descriptions are often of limited value in providing clarity. In one exercise workshop participants were invited to divide management and leadership tasks into categories of definite line management roles, definite professional leadership roles, 'turf wars' and 'hot potatoes'. Significant overlap between the categories emerged. Roles clearly identified as belonging to professional leadership included professional development, supervision, teaching and mentoring, taking responsibility for students and advocating for respective professions. Roles identified as 'turf wars' included service development, performance appraisals, staff recruitment and retention, and staff training. Tasks identified as 'hot potatoes' included troubleshooting, conflict management, dealing with poor performance and disciplinary issues.

Social work professional leaders' experience and perception of their role

The current study is a brief, qualitative exploration of a group of social workers' experiences and perceptions of the role of one professional leadership position in a specialist mental health service. Six current, and one recent, incumbents of the position were interviewed by the author. Participants varied in their time in the role, with a range from four months to four years.

Participants were provided with a written information sheet about the project, including assurance of confidentiality and anonymity, and signed a written consent form. Management approval for the study was sought through the social work professional advisor. Interviews were taped. Questions followed an interview guide, however this functioned as a stimulus to conversation about the role rather than being rigidly followed (Patton, 1990; Whyte, 1982). Participants were asked about their perception and evaluation of the model of supervision and professional leadership currently employed in the mental health service, and their perceptions and experiences of the specific professional leader role, including definition and expectations of the role, scope for initiative and creativity, power and influence, and what was enjoyable and satisfying, and what was stressful about the role.

In regard to the service's model of supervision, the fact that clinical supervision is specific to the social work profession was considered important in the context of a service dominated by the 'medical model'. Participants were unanimous that the model has the advantage of removing from the supervision arena tensions and conflicts with line management over caseload and workload pressures and day-to-day workplace issues. Practitioners feel safer and more confident to explore difficulties and problems in the context of a relationship with a supervisor who does not have line management responsibility for performance appraisal.

However the most commonly cited disadvantage of the service's current supervision model was that the supervisor only gets the information that the supervisee chooses to bring to supervision; they may choose not to bring issues that really need to be addressed to supervision, so that the supervisor does not have sufficient information to be truly effective. In the words of one participant:

> It's *their* reality that we get, how close that [is to] true reality is variable.

The supervisor's lack of objective information can compound difficulties in addressing issues of poor performance. Other difficulties in managing performance issues included a lack of communication between different people undertaking different supervision and management functions, uncertainty about the extent and limits of confidentiality in the supervision relationship and uncertainty about who was, or should be, doing what in regard to addressing the issues. It seems that much depends on the individual worker's willingness to face and address issues.

In addition to directly providing some professional supervision, the professional leader role in the supervision model was described as having an overview of supervision arrangements for social workers in the group one is responsible for, ensuring that social workers have a supervision arrangement that is appropriate for them and is functioning effectively. Professional leaders have a role in bringing together the different functions of supervision; in the words of one participant:

> I think sometimes we're like the thread of a patchwork quilt, pulling together the patches to make the quilt. So we're kind of putting everything together really to create a picture of where that social worker is at professionally, as an wholistic person, not just in terms of their clinical practice, but supervision, where they're at in their work, and issues they face.

One participant, however, clearly asserted that it is not a professional leadership role to assess the supervisor or the supervision. If there is one function of supervision that the professional leader carries a particular mandate for it is professional development, assessing development needs, promoting educational opportunities and advocating for staff to be enabled to access relevant training.

In discussing other aspects of the professional leadership role, participants identified the following as important functions:

- maintaining quality supportive relationships with social workers in the group one is responsible for, especially those who are isolated, being the only social worker in their multi-disciplinary team or work area;
- providing clinical expertise and advice for social workers;
- advocacy for the needs of social workers within the mental health service;
- ensuring professional standards and ethical practice;
- maintaining a high profile for social work within one's own multi-disciplinary team;
- active promotion and advocacy for social work within the context of a multi-disciplinary service dominated by the 'medical model';
- having input into policy development from a social work perspective;
- having professional input into management decisions, including staff recruitment;
- providing information to social workers about policy direction, generally being a conduit for information;
- supporting the professional advisor in decision making and advocacy for the profession, including advocacy that social work positions are retained rather than being lost to other more dominant professions.

One participant summarised the overall goal of the position as being:

> …to make social work positions function for the social worker and for their clients.

However, several of the participants did describe the overall role as vague, with one commenting 'I'm still trying to work it out'. Participants did not receive much guidance from the job description, with most acknowledging that they had read it in preparation for their interview for the position but referred to it little since. Participants generally described a process of having to find their own way in the role, and indeed to develop and shape it to suit their own perspectives and the needs of their particular service areas. In the words of one participant:

> I'm the kind of person who will put my own stamp on something. What I do and how I do it is self-determined, unless someone pulls me aside and corrects me I assume what I'm doing is useful and contributing.

Another commented:

> …the role has been vague, people have had to find their way. The role grows as you grow into it, it is about responding to need.

Another elaborated further on response to need, that:

> …when you're needed, it's really clear what you're needed for.

Others commented on a dynamic process of exploring the role in the context of the leadership group, and especially discussion with and feedback from the professional advisor, as being invaluable in clarifying the role on an ongoing basis.

Perceptions of the expectations of the role held by various stakeholders varied. In particular some social workers wanted a lot of meetings and interaction, and needed more support, others less, partly as a factor of their individual stages of professional development and workload pressures. Some social workers were perceived as questioning the role, the reason for it, and where it fits with professional supervisors, managers and the professional advisor. Generally social workers were perceived as seeing the role as 'someone they can go to about issues and be supported'. One participant commented that:

> …some social workers ring constantly, others seem to avoid you, see you as part of management.

Managers likewise were experienced as varying in their expectations of the role. Some managers seemed to promote the role quite strongly, valuing professional input into management forums, but that carried the expectation of professional leaders being active members of executive committees and 'being at every meeting'. Others seemed to expect professional leaders to 'get stuff sorted', particularly in regard to performance issues, 'when that needs to be a team approach'. One respondent also commented that as a result of being appointed to the role, he was also more definitively identified as a senior clinician in his own team, and expected to take more of a leadership responsibility within the multi-disciplinary team. Generally participants were confident that they were meeting expectations appropriately.

Participants generally identified considerable scope for autonomy, initiative and creativity in the role. Accordingly several participants saw some level of vagueness and ambiguity in the role in a positive light, as it gave scope to define the role for one's self. In responding to a question on how the role could be improved, one participant commented:

> …you could say 'a clearer idea of the role', but that's restricting as well . . . if we make the role too restrictive we stop creativity.

Creativity was limited, however, by the need to 'cover the basics', especially availability for performance appraisals and interview panels, in the time available.

Regarding power and influence in the role, participants generally felt that formal power and decision making authority is minimal. However, several participants felt that the role can and does exercise considerably more informal influence. One participant commented on being readily accepted to meet with senior management and advocate at that level, observing that:

> …we have more power at that level than we think we do, perhaps limited by not being in line management, however they don't have much power.

Another commented on actively using her own personal power to achieve change, through being strong-minded, outspoken and an active advocate for the profession.

Significant satisfaction in the role included:

- relationships with social workers in different settings;
- supporting good social workers struggling in difficult settings to achieve the best for their clients;
- empowering social workers, seeing professional development occurring, especially 'taking on new graduates and watching them blossom';
- the mutual support of the social work leadership group; and
- receiving feedback from management acknowledging the skills individual social workers and the social work profession have to offer to the service.

Stresses included:

- lack of clarity and feeling 'all things to all people';
- inadequate orientation to the role and supervision specifically for it;
- trying to keep up with the progress of all the social workers in the area one is responsible for;
- not feeling fully familiar with all the 'political' issues in services;
- attending executive meetings and being uncertain about what to contribute, especially as many of the other participants in the meeting also attended other meetings together that the professional leader was not a part of;
- lack of clarity over who has ultimate responsibility for the performance appraisal process, difficulties in getting performance appraisals done, and managers being insufficiently prepared for appraisal sessions;
- dealing with 'hot potato' situations, where professional standards are not being met;
- the constant tension between the demands of the role and one's ongoing clinical work. This included finding that one's own professional supervision was being entirely consumed by issues arising from the professional leader role, with inadequate attention in supervision to one's own clinical work.

A major theme was that participants experience the four hours per week allocated to the role as inadequate to fulfil it effectively. Participants also expressed significant dissatisfaction that the role is paid significantly less than equivalent leadership roles in other disciplines, especially nursing.

Conclusion

Overall the findings of this study generally confirm and exemplify issues arising from the literature reviewed. These include the ambiguity of leadership roles, the tension between the demands of the role and clinical work, the lack of formal power but the potential to exercise more informal expertise-based influence (Globerman, et al. 2005), and the need to link clinical supervision more closely into clinical governance to ensure the maintenance of professional standards (Cooper and Anglem, 2003).

In particular this study has found a level of vagueness and lack of clarity about the role. However this is not necessarily a bad thing, as it allows scope for initiative and creativity. It could be suggested that the nature of a leadership role is to be proactive in identifying and assessing needs, and taking action to address them, rather than needing to be told what to do either by personal instruction or a prescriptive formal job description. The role can then continue to develop through ongoing application of the processes of reflective learning described by Ellis (2000).

This study has been limited to exploring the nature of one professional leadership role in one district health board. It is further limited by only considering the experiences and perceptions of current and recent incumbents of the role. More comprehensive research would include the perceptions of other stakeholders, including front-line social workers, managers and consumer advisors, and could also explore a comparison with similar roles in other services, both nationally and internationally.

Nevertheless both the literature reviewed, and the findings of this study, suggest that professional leadership roles can have a significant strategic impact in services in the current managerial climate. This can include bringing together the different functions of supervision, holding responsibility for seeing that all three functions are being implemented (Hughes and Pengelly, 1997), with a particular focus on professional development and mediation and advocacy with senior management. Professional leaders have an essential role in setting the strategic direction, and advocating, for the profession as a whole in a multi-disciplinary, medically dominated service, in a culture of managerialism and resource constraints. The role may be especially significant in defining the relationship between professional supervision and clinical governance (Cooper and Anglem, 2003), including both ensuring that professional standards of practice are maintained, and that social work's voice is heard in the overall direction of the agency. Possibly the major challenge for social workers in professional leadership roles is to accept the inherent ambiguity of leadership roles, maintain a firm belief in themselves and the importance of what they are doing (Bevilacqua, 1995), and seize the opportunity to make an impact.

Finally, it is imperative to recognise that supervision and leadership structures can consume and divert substantial resources away from direct client contact. As Davys (2004:21) challenges:

> We must also be mindful of the ultimate purpose of supervision which, succinctly stated, is to ensure the best service to clients or patients.

The major mandate for social workers in leadership roles in public services must be to advocate for and ensure continuing effective service for the most vulnerable and needy members of our communities (Bevilacqua, 1995).

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