

Blending Clinical Practice and Research

Challenges of Clinical Supervision for Empirically Supported Treatments

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Objectives

1. Review primary role of supervision
2. Describe barriers to effective supervisory practice
3. Identify what we know from research about technology transfer
4. Share learning from NIDA Clinical Trials
5. Discuss implications of what we know regarding the adoption of empirically supported treatments in agency settings

Multiple Roles for Clinical Supervisors

- Develop practicing clinicians
- Assure delivery of quality services
- Provide administrative supervision
- Assure fidelity with agency policies and clinical procedures
- Improve agency treatment design and protocol

Current Supervisor Reality

- Oversee direct services
- Juggle administrative and clinical supervision
- Manage daily crises
- Prepare reports
- Carry a caseload
- Maintain payer and referral relationships
- Member of management team
- Link management and consumers

So what's the problem?

- **Issue:** What is happening behind the closed group room or counseling office is too often not known
- **Assumption:** Practice conforms to policy, procedure, and clinical protocol
- **Verification:** Rarely happens
- **Reality:** Clinicians lack performance feedback and mentoring. Observational supervision is rarely practiced.

Insights from research...

- In a MI adoption study, workshop training resulted in short term skill acquisition but rapid erosion of skill during following 4 months
- Coaching and/or performance feedback during months after initial training were needed to maintain beginning skills, advance proficiency and integrate MI into clinical practice

Miller, et al. *A Randomized Trial of Methods to Help Clinicians Learn Motivational Interviewing*, Journal of Consulting and Clinical Psychology, 2004

Insights from research...

- In a CBT adoption study: Training plus supervision was only condition that resulted in counselors reaching criterion levels for adequate fidelity
- “Face to face training...video examples, practice and supervision...may be essential...to learn and effectively implement new approaches”
- Starting with “early adopters” can generate enthusiasm. Recognize some may never get it

Sholomskas, et al. *We Don't Train in Vain: A Dissemination Trial of Three Strategies of Training Clinicians in Cognitive-Behavioral Therapy*. Journal of Consulting and Clinical Psychology, 2005

**What lessons have we
learned about clinical
supervision within the
CTN?**

Supervising Motivational Interviewing: Lessons Learned

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Experiences derived from:

- NIDA CTN MI/MET/MET-S protocols
- NIDA-funded Training Strategies in Motivational Interviewing randomized clinician training trial in Connecticut
- MI training/supervision of community-based clinicians within inpatient, ambulatory, and outpatient addiction and dual diagnosis treatment settings

Making a MI Supervisor

- Clinical Administrative Position
- MI Knowledge and Skill
- Does an elite athlete make a talented coach?

The Recipe

- Select staff members to supervise MI (preferably higher in clinic hierarchy than supervisees, want to supervise MI, administratively supported).
- Place in a MI workshop training bowl.
- Mix for 2-3 days.
- Pour in practice pans. Do not use non-stick pans.
- Bake until MI proficiency forms.
- Apply supervisor icing (more training) before cooling occurs.

Supervisor Training

- Motivational Interviewing Network of Trainers (MINT) managed under the auspices of the Center on Alcoholism, Substance Abuse and Addictions at the University of New Mexico often makes the MI cake.
- What about the icing on the cake?

Key ingredients for training EBP supervisors

- Clear Supervision Model
- Parallel Practice Process
- Minimum Proficiency Standards or Competencies
- Expert Support

Clear Supervision Model

- Direct observation from audiotapes
- Use of adherence and competence tape rating systems
- Performance feedback and coaching
- Repeated practice to hone skills
- Supervision conducted in a manner consistent with targeted EBP approach

Sample Tape Rating Items

MI-Consistent items:

- Open-ended Qs
- Reflections
- Affirmations
- Pros/Cons
- Discrepancies
- MI Style

MI-Inconsistent items:

- Confrontation
- Unsolicited Advice
- Asserting Authority
- Total Abstinence
- Powerlessness/Loss of Control

TWO RATING DIMENSIONS

Adherence – How often a particular intervention or strategy occurs. Items rated from 1 (Not at all), to 7 (Extensively).

Competence - The quality of the intervention or strategy. Items rated from 1 (Very Poor), to 7 (Excellent).

Sample Item: Adherence

OPEN-ENDED QUESTIONS: *To what extent did the therapist use open-ended questions (i.e., questions that elicit more than yes/no responses) to elicit the client's perception of his/her problems, motivation, change efforts, and plans?*

Adherence Rating Guidelines:

Open-ended questions are questions that result in more than yes/no responses and that don't pull for terse answers or very specific pieces of information. Often these questions begin with the following interrogatives: "What," "How," "In what," and "Why (somewhat less preferable)" or lead off with the request, "Tell me..." or "Describe..." The clinician uses open-ended questions to elicit an open conversation about the client's view of his/her problems and commitment to change. In brief, by using open-ended questions, the clinician gives the client a wide range for discussing his or her life circumstances and substance use patterns.

Sample Item: Competence

Higher: High quality open-ended questions are relevant to the therapist-client conversation and pull for greater client exploration and recognition of problem areas and motivation for change, without appearing to be judgmental or leading to the client. They are simple and direct, thereby increasing the chance that the client clearly understands what the therapist is asking. Usually, several open-ended questions do not occur in close succession. Rather, high quality open-ended questions typically are interspersed with reflections and ample client conversation to avoid the creation of a question-answer trap between the therapist and client. The therapist pauses after each question to give the client time to respond to each query.

Lower: Low quality open-ended questions are poorly worded or timed or target an area not immediately relevant to the conversation and client concerns. They often will occur in close succession, giving the conversation a halting or mechanical tone rather than one that flows naturally between the therapist and client. Lower quality open-ended questions also may compound several questions into one query (e.g., “Tell me about how you felt before and after you got high and how that all affects your future risk for using cocaine.”), making them harder to understand and respond to by the client. Further reductions in Skill Level ratings may occur if the therapist seems to be leading or steering the client or uses a judgmental or sarcastic tone when asking open-ended questions.

Supervisor Tape Rating Oath

I solemnly swear
To rate what I hear,
Even if illicit
As long as explicit.
Whatever the clinician
does,
I will indicate what it was
Based upon what had
occurred
Not on what I wished I
heard.
All items are a possibility.

And then with discerning
exclusivity
I'll make my final tally
mark
So reliably, firm and dark,
Taking notes to
substantiate
All the ratings that I
create.
Whenever I begin to
waver
I will use the Rating Guide
as my savior.

Feedback/Coaching

- Supervisor Feedback Forms
- Clinician Session Reports
- Catching what clinicians are doing right.
- Catching what clinicians are doing wrong.
- Practice makes progress toward proficiency.

Catching What's Right

Clinician: What have been the negative effects of using these drugs?

Client: It's been a mind blowing experience of septic proportions.

Clinician: You feel that drugs have fouled up your mind.

Client: Sh--. You know, I can't see college on my horizon right now.

Clinician: Your mind is not working the way it used to, in part due to the drugs, and it's hard to see going back to college right now.

Client: I can't concentrate very well, and its hard to remember things. Will I be convicted when others have not?

Clinician: You wonder why this has happened to you. Others have used drugs, stopped, feel fine later and continue to function.

...continued

The client gets up from his chair, walks to the office door, opens and then shuts it hard and then stands in the middle of the room looking confused.

Clinician: You are not sure if the door has been shut for you to return to college. You want to do what you can to open it, but you are not sure what you can do.

Client: [The client looks at his clinician.] What can I do? [The client sits down.]

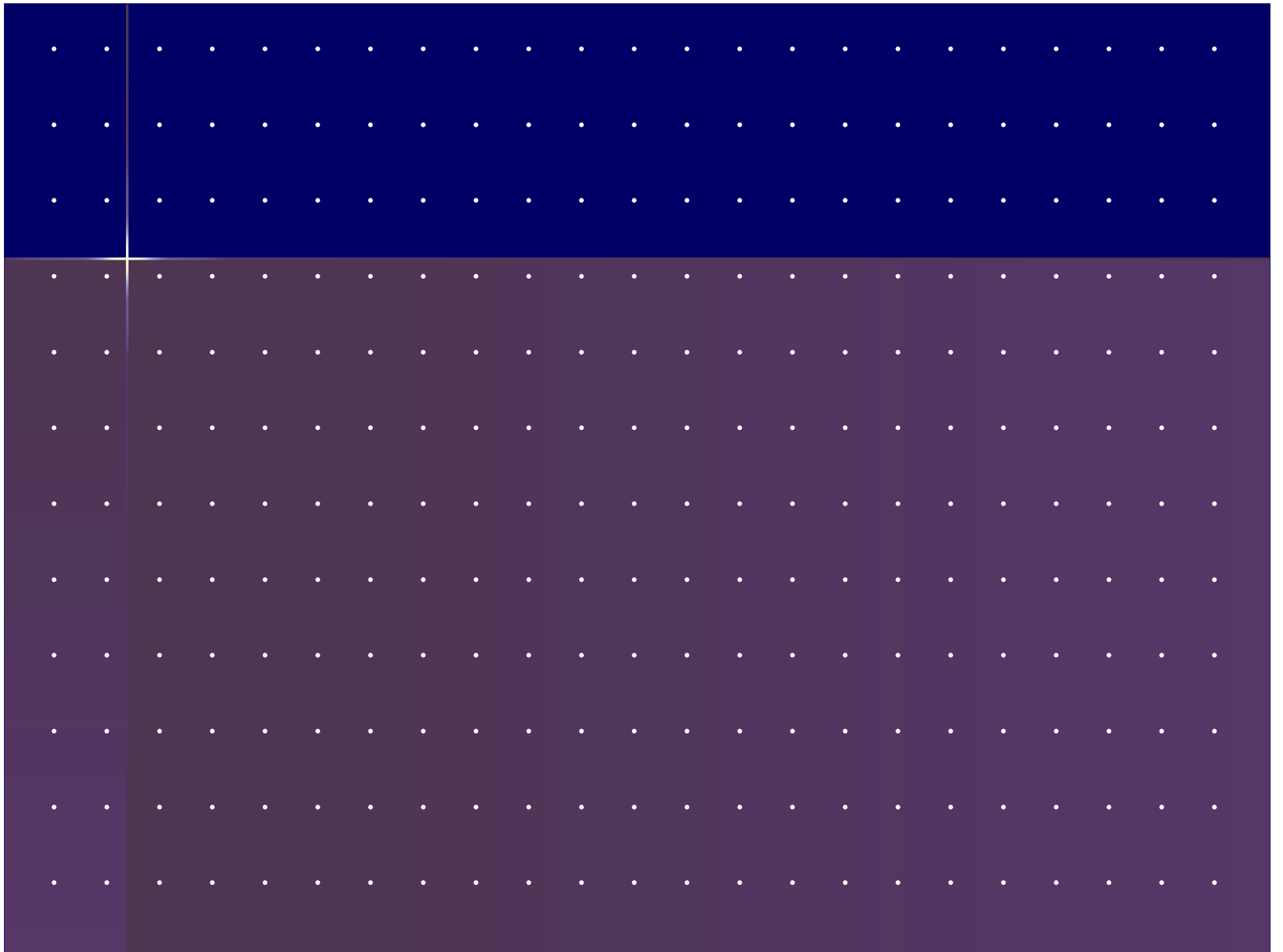
Catching What's Wrong

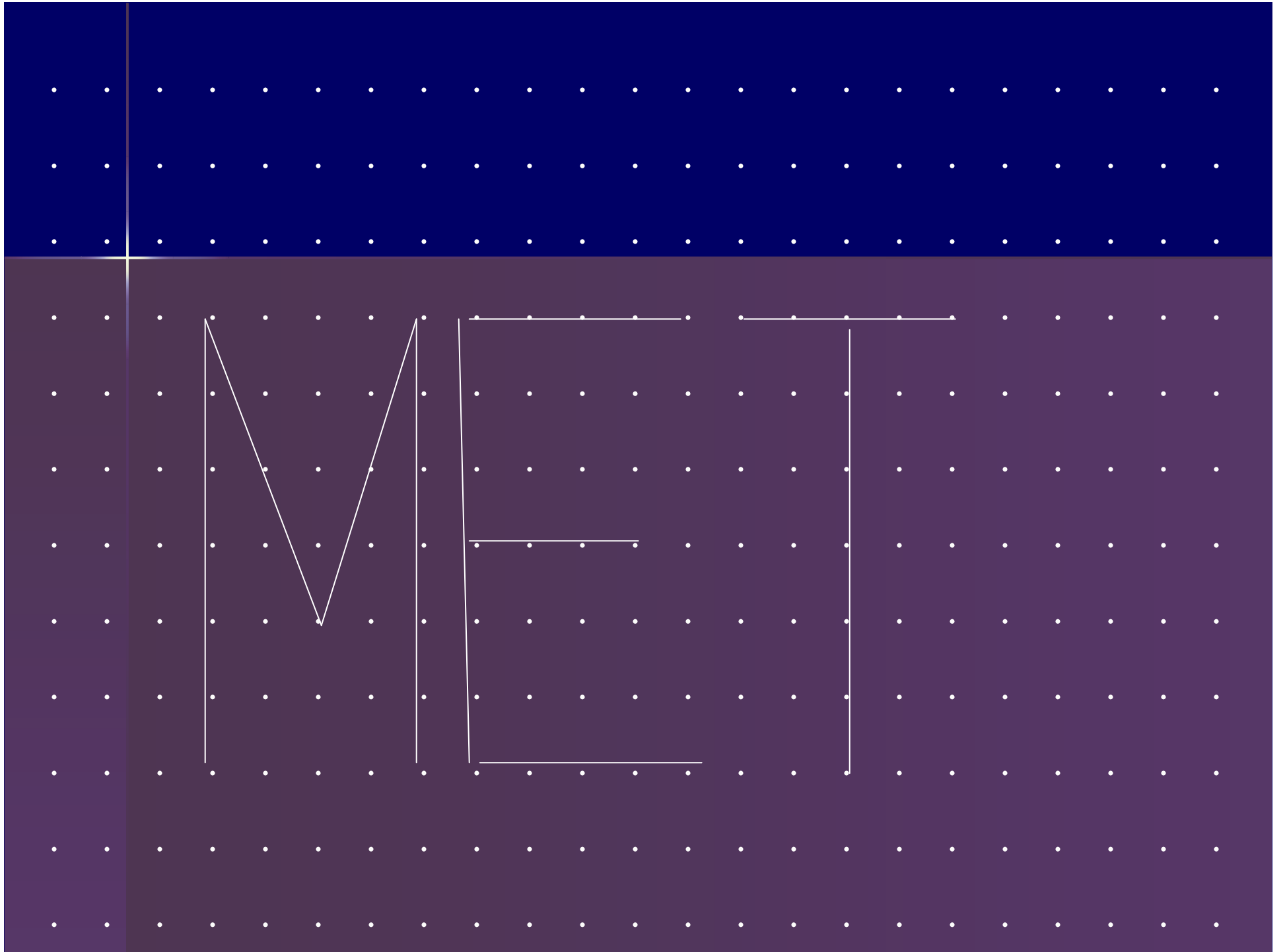
Client: No matter how hard I try, I always seem to relapse. I must be doing something wrong.

Clinician: So you are trying but may be going about it the wrong way.
(reflection) There are other things you haven't tried that may be more helpful to you. Let's talk about them. (Unsolicited Advising)

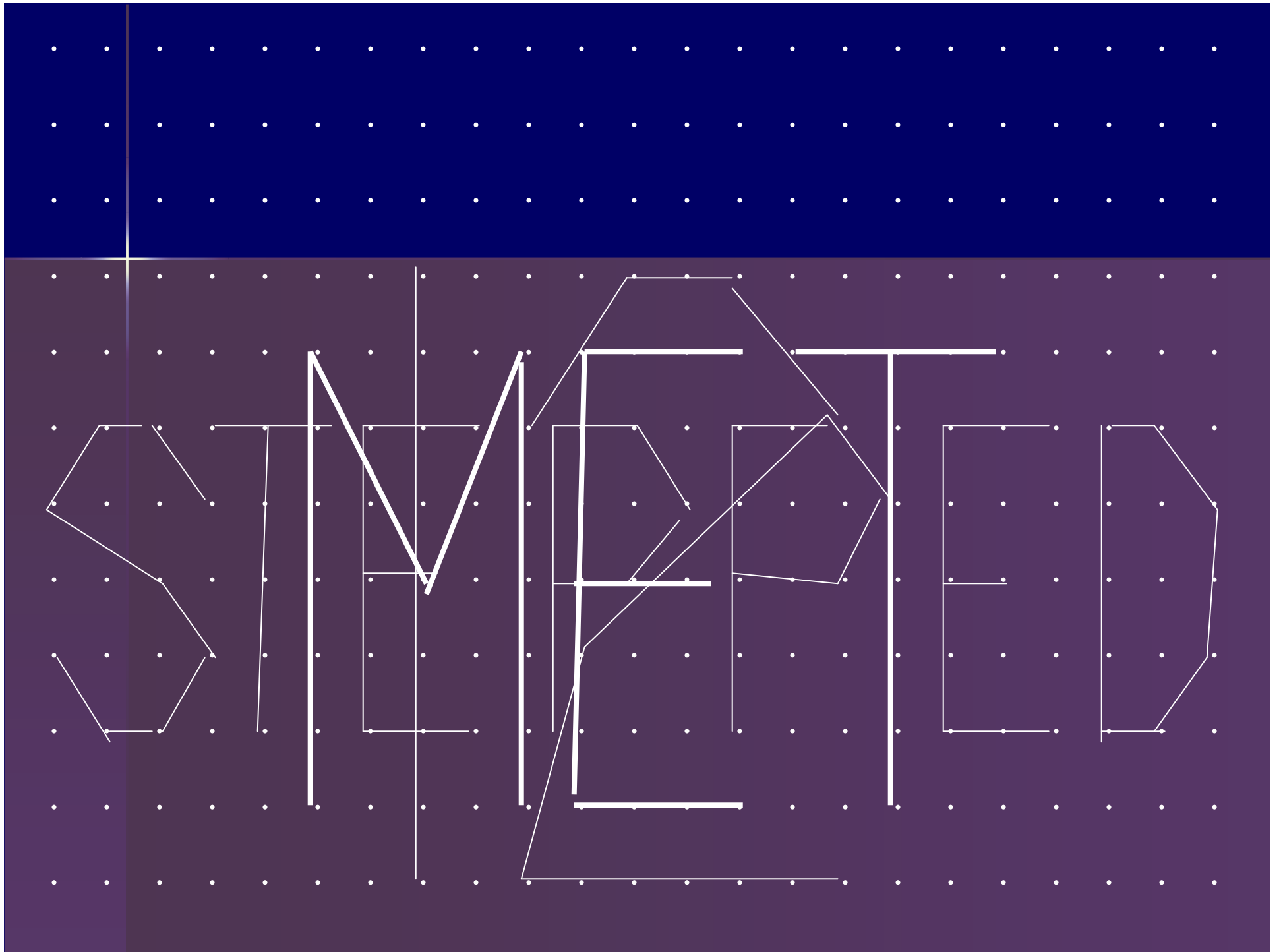
Other Clinician Competency Challenges:

- Grasping the style/spirit
- Meeting clients where they are at and knowing how to proceed strategically
- Reducing the amount of questioning
- Reflecting with depth
- Affirming clients
- Shifting to other treatment approaches

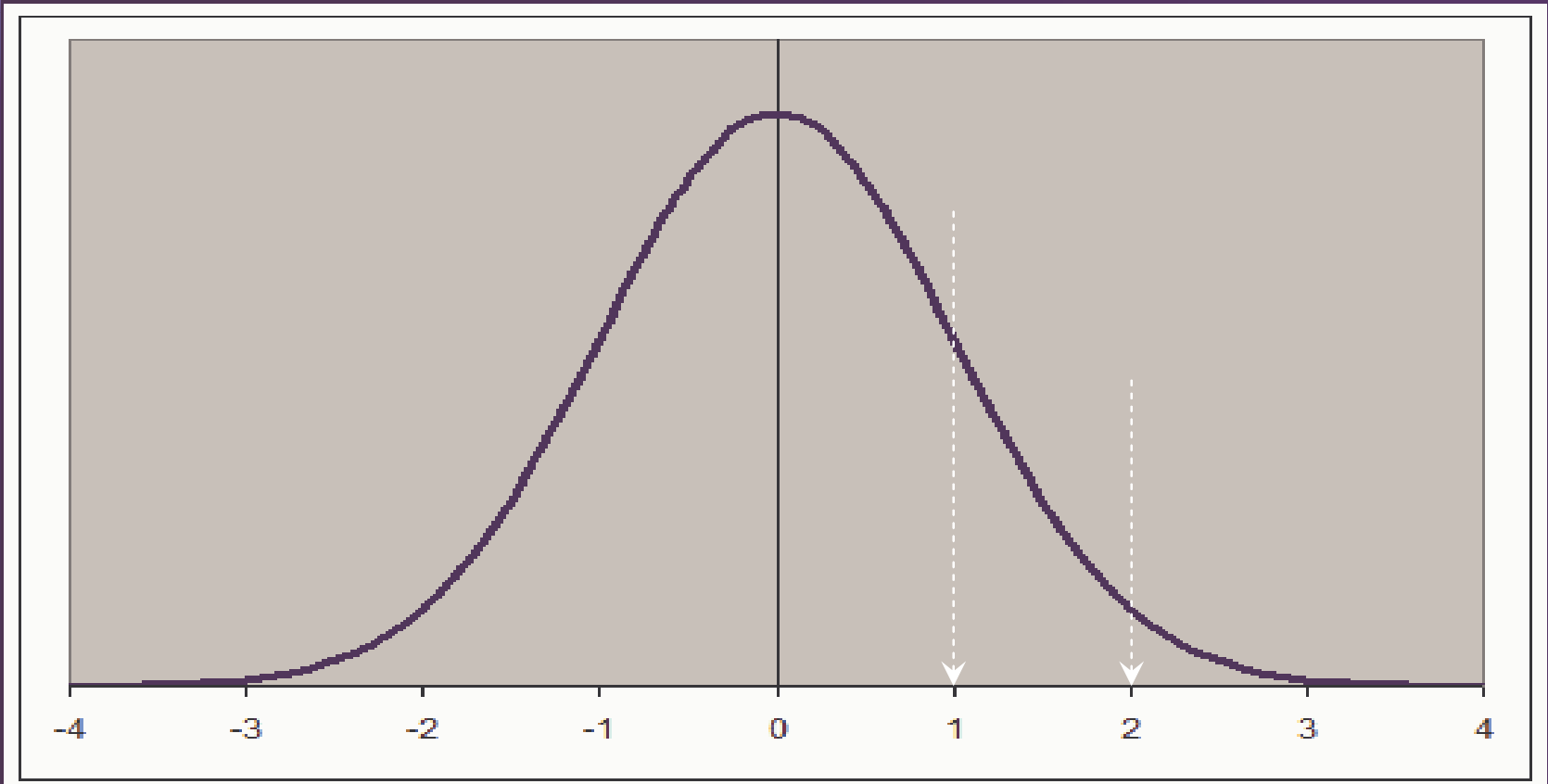








MI Proficiency: Where do we draw the line?



MI Consistent Supervision

- Clinician-centered
- Meet clinicians at their current level of MI skill and interest
- Resistance to learning MI is an opportunity to understand what makes using MI in clinical practice difficult for clinicians.

Challenges to MI Supervision

- Time
- Client Population
- Treatment Modality
- MI Inconsistent Programmatic Practices
- Staff Turnover
- Maintaining Supervisors' Skills
- Developing System for Training MI Supervisors

Get a MI Consultant (supervisor coach)



- Experienced clinician/supervisor who has extensive MI background.
- Provides support to supervisors for set period.
- Assists the supervisor with rating system, construction of feedback/coaching, and supervisory dilemmas.
- "Nobody ever taught me to be a supervisor."

Other System Supports

- Development of competency/certification standards for supervisors
- Development of continuing education requirements for supervisors
- Supervision as a reimbursable practice

Where is the supervisor icing for the MI cake?



NIDA/SAMHSA
MI Protocol
Blending Team

ATTC
MI Supervision
Dissemination Plan

Clinical Supervision

Perspectives from a Community Treatment Provider

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Perspectives from a CTP

The 4 W's of Gateway Community Services

- Who
- Where
- What
- Why

Clinical Trial Protocols

Issues

- Research versus Clinical
- Educating program staff
- Training
- Supervision
- And more Supervision

Women and Trauma Protocol

Comparing 2 interventions added on to TAU

□ Assessments

□ Baseline

□ Weekly

□ Follow-up

□ 1 week post-treatment

□ 3, 6, & 12 months

□ Treatment interventions

□ 1 individual session

□ 2 group session 2 times a week – 1.5 hours for 6 weeks

Brief Strategic Family Therapy - BSFT

- BSFT in adolescent outpatient treatment compared to TAU
- Assessments
 - Baseline
 - TLFB once a month
 - Follow-up at T4, T6, T8, T12 months
- 12 -16 week intervention
 - Up to 6 booster sessions if needed

Staff Requirements

Women & Trauma

- .15 Site PI
- .50 Research Coordinator
- 1.50 Research Assistants
- 2 Supervisors
- 2 Counselors

Staff Requirements

BSFT

- .25 Site PI
- .50 Research Coordinator
- 2.50 Research Assistants
- 6 Counselors

Training Requirements

Women & Trauma

Off site training

- 8 staff travel to New York
- 3.5 days for intervention supervisors and counselors
- 3 days for research staff
- 9 days for site PI

Training Requirements

Women & Trauma

On site training

- Practice interventions
- 4 – 6 video tapes to be certified
- Phone feedback

Supervision

- Review one tape a week
- Adherence rating
- Supervisor supervised by phone 1 hr/wk
- Counselor & supervisor meet 1 hr/wk
 - After 8 sessions in a row at adherence, meet every other week

Training Requirements

BSFT

Off site training

- 9 eight hour days for research staff
- 4 – eight hour days for BSFT counselors

On site training

- 10 – 15 hours for research staff
- 3 – 3 day workshops over 3 months BSFT counselors
- Time for certification
 - BSFT counselor 1 - 5 months
 - BSFT counselor 2 - 8 months
 - TAU – agency training – 2 days

Clinical Supervision Requirements

Women & Trauma

□ Counselors

- Meeting weekly with on site supervisor
- Discuss at least one video tape – adherence rating

□ Supervisors

- One hour of phone supervision
- Match adherence rating with lead node supervisor

Clinical Supervision Requirements

BSFT

□ Counselors

- Meeting weekly with off-site supervisor via teleconferencing – 2 counselors, 1 supervisor
- Discuss at least one video tape – adherence rating
- 3 hours a week

□ Supervisors

- On site clinical supervisor
- Role to assist with agency requirements and on-site crisis intervention

Clinical Supervision Requirements

TAU

□ Counselors

- Contract licensed clinician
 - Address crisis issues as they occur
 - Meets weekly with RC to discuss administrative issues
- On staff AOD clinician/administrator
 - On staff counselor has weekly multidisciplinary staffing
 - Group supervision at least once a month

Clinical Supervision CTP Realities

- ❑ **NO FUNDING FOR SUPERVISION OR TRAINING**
- ❑ **What's Offered**
 - ❑ Group supervision weekly
 - ❑ Weekly staffing with psychiatrist and clinical supervisor
 - ❑ 8 to 20 staff in each meeting
- ❑ **What's Needed**
 - ❑ **Qualified and competent supervisors**
 - ❑ Individual supervision
 - ❑ Smaller group supervision
 - ❑ Observational supervision
 - ❑ Live
 - ❑ Video
 - ❑ Audio

Florida Node Clinical Supervision Strategies

- Meet with State Agency Director
- Educate funding sources
- Educate agency leaders to be change agents
- Increase value of supervision
- Decrease focus on documentation

**So, what have we
learned about the
importance of clinical
supervision?**

Without Observation...

Clinical Supervisors cannot:

- Reinforce the good work of their clinicians
- Correct clinical mistakes or inconsistencies
- Provide training to improve services
- Assure fidelity with clinical protocol

The Critical Roles of the Clinical Supervisor

- Maintain and raise standard of care
- Observe practice
- Provide feedback
- Reinforce good work
- Mentor counselor skill acquisition
- Assure fidelity with agency protocol
- Keep current with best practices
- Make literature and training available
- Facilitate measures of effectiveness

**What other issues
impact our ability to
adopt empirically
supported treatments?**

Successful Adoption of Empirically Supported Tx

Appears to require:

- Strong support of senior management
- Effective leadership of the adoption process
- Credible and persuasive data that documents need and efficacy of service improvement
- More complex changes require more time, more training, management of more resistance
- Planning to sustain the innovation, including observational clinical supervision