TEAM UP Memo: Training and Consultations: Clinical Supervision

2-18-2022

I. Context and Opportunity Statement

Reviews of mental health provider training in evidence-based treatments (EBT) indicate that clinical supervision following training is required to positively impact provider behavior; "there does not seem to be a substitute for expert consultation, supervision, and feedback for improving skills and increasing adoption". Studies suggest that clinical supervision may be even more important than the type of training for adherence and competency. (Dorsey 2018)

The primary reasons for clinical supervision are to ensure (1) quality client care, and (2) continued professional development of clinical staff in a systematic and planned manner. Supervisors ensure that EBTs are successfully integrated into ongoing programmatic activities by training, encouraging, and monitoring (SAMHSA TIP 2014*)*. Contextual factors, culture, race, end ethnicity all affect the nature of the supervisory relationship.

There are many different models that provide a framework for supervision. Two approaches to consider relative to the work in TEAM UP are described below.

> **Developmental Models of Supervision** define progressive stages of supervisee development from novice to expert, with each stage consisting of discrete characteristics and skills (Smith 2009). <u>The key is to accurately identify the supervisee's current stage and provide feedback and support appropriate to that developmental stage, while at the same time facilitating the supervisee's progression to the next stage</u>. The model stresses the need for the supervisor to utilize skills and approaches that correspond to the level of the supervisee. Supervision addresses skill and competency development as well as affective issues, based on the unique needs of the supervisee and supervisor. The supervision starts with a more rigid, shallow, imitative way with growth toward more competence, self-assurance and self-reliance. Three key parts of the development of the supervisee are: 1) self and other awareness, 2) motivation, and 3) autonomy. Moving from more rigid to more competent allows the supervision to incorporate skills competence, assessment techniques, client conceptualization, theoretical orientation, treatment goals and plans and ethics.
>
> **Treatment Based Models of Supervision** train to a particular theoretical approach to therapy, <u>incorporating EBTs into supervision and seeking fidelity and adaptation to the theoretical model</u>. Motivational interviewing, cognitive behavioral therapy, and psychodynamic psychotherapy are three examples. These models emphasize the therapist's strengths, seek the supervisee's understanding of the theory and model, and incorporate the approaches and techniques of the model. Many of these models begin with articulating their treatment approach and describing their supervision model based on their approach.

In all models of supervision, it is helpful to identify culturally or contextually centered models or approaches and find ways of tailoring the models to specific cultural and diversity factors. <u>Cultural adaptation</u> is "the systematic modification of an evidence-based treatment or intention protocol to consider language, culture, and context in such a way that it is compatible with the client's cultural patterns, meanings, and values" (Bernal et al., 2009).

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The **Hays Model** can help to ensure the intersectionality of all families are being considered, providing a structure through which to address complex domains of individual identity.

ADDRESSING (Hays Model 2008)
Age/generational
Developmental disabilities
Disabilities acquire later in life
Religion and spiritual orientation
Ethnic and racial identity
Socioeconomic Status
Sexual orientation
Indigenous heritage
National origin
Gender

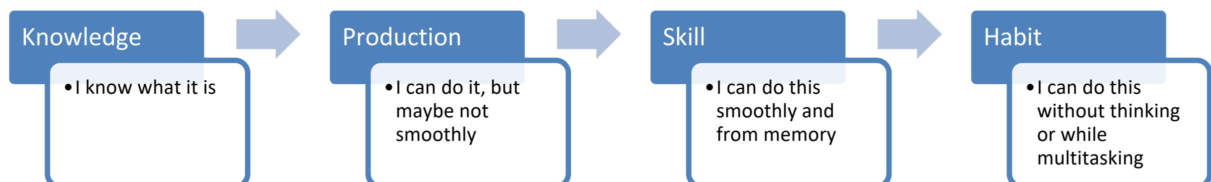
Lastly, but as important, is the supervisee and supervisor relationship when the supervisee's identity does not match the identity of the supervisor and/or the client. Things to consider:

- Explicitly addressing diversity of supervisees (i.e., race, ethnicity, gender, age, sexual orientation) and factors associated with these types of diversity
- Explicitly eliciting supervisees' concerns related to particular client diversity (i.e., those whose culture, gender, sexual orientation, and other attributes differ from those of the supervisee) and addressing specific factors with these types of diversity
- Explicitly addressing supervisees' issues related to effectively navigating services and intercultural communities as well as effectively collaborating with agencies and institutions

II. Goal of memo

This memo is intended to achieve the following goals:

a. To provide guidance and structure to clinical case supervision
b. To encourage clinicians to move along this continuum of learning and competence:



c. To outline TEAM UP's rationale and expectations for clinical supervision within each health center and the mechanisms within the Learning Community designed to support health centers in implementing a robust and sustainable clinical supervision capacity.

As part of its participation in the TEAM UP Learning Community, each health center will develop and/or mature a sustainable model for clinical supervision that aligns with the core structure outlined below, which has been developed with an eye towards feasible implementation and long-term sustainability. Health centers will work directly with the clinical training team to plan the specifics of the approach to clinical supervision based on their local context and environment.

III. Guiding Principles

The TEAM UP initiative seeks to ensure access to quality, evidence informed care that promotes child health and well-being by building capacity within primary care to address the behavioral issues of children and families. Enhancing supervision aligns with our goal to build knowledge and skills within the community health center team to improve clinical outcomes and ensure sustainability of the model after the implementation phase. Finally, supervision allows the team to create a process to systematically monitor treatment progress and

provide the appropriate level of care based on symptom presentation within a stepped care model. As such, the TEAM UP Learning Community provides support to health centers to develop internal capacity in clinical supervision.

IV. Structuring Supervision

While using one of the models of supervision as outlined above, it is important to guide clinicians in utilizing tools to help with assessment, diagnosis, and case conceptualization.

Case conceptualization is a method and clinical strategy for obtaining and organizing information about a client, understanding and explaining the client's situation and maladaptive patterns, guiding and focusing treatment, anticipating challenges and roadblocks, and preparing for successful termination (Sperry 2012). This includes:

- Diagnostic Formulation: presenting problem, symptom, and criteria for diagnosis – *What happened?*
- Clinical Formulation: theoretical explanation of the client's presenting issues – *Why did it happen?*
- Cultural Formulation: social and cultural factors – *What role does culture play?*
- Treatment Formulation: goals, strategies, and intervention – *How can it be changed?*

> ***"A clinician without a case conceptualization is like the captain of a ship without radar, a compass and a rudder...aimlessly floating about with little or no direction." ~Sperry 2012***

In reflective supervision, attention is given to all relationships, including that between supervisor and practitioner, between practitioner and parent, and between parent and child. It is critical to understand how each of these relationships affects the others. Thus, reflective consultation/supervision incorporates a process of consciously connecting the lived experience of individuals and their relationships with the lived experience and relationships of others.

> ***"When it's going well, supervision is a holding environment, a place to feel secure enough to expose insecurities, mistakes, questions and differences." ~Shahmoon-Shanok, 1992 on reflective supervision***

Managing and Adapting Practices (MAP) (Chorpita 2014) is an online platform that offers tools to help clinicians improve the quality of care for children and adolescents. The platform is organized by a set of core concepts and decision models and uses specialized knowledge resources to inform key decisions and service delivery. The goal is to integrate clinician and family expertise (local knowledge) with findings from the evidence-base (general knowledge) to guide and organize treatment. MAP recognizes that youth in the community often have more than one clinical problem and EBTs are usually packaged for one problem. MAP provides the clinician with a resource to identify common components of evidence-based treatments for a particular diagnosis. Furthermore, MAP provides a variety of coordination resources called process guides to help with providing a framework for decision making and planning regarding certain aspects of care using the best evidence. Treatment planners, session planners, and a diversity guide all support conceptualization of the case, planning and decision making.

Based on the above concepts and tools, we suggest the following table which outlines Group Supervision with different goals for each session type:

Session Type 1: Present Case Conceptualization: Goal to home in on skills in presenting history, diagnosis, and treatment

• Include screeners used and why • Discuss differential diagnosis and ongoing diagnostic considerations • Utilize MAP resource Evidence Based Service Systems Model (attachment 1) – What decision did you come to about how to proceed with an intervention or interventions? What evidence do you have for focusing on certain aspects of the case? • End with reflection on case and your experience • *Group asks clarifying questions, diagnosis clarification questions, and offers ways they have used a particular skill in similar cases*
Session Type 2: Present Treatment Plan Utilizing MAP Planner: (attachment 2 – Treatment Planner) • Focus – What behaviors/symptoms are the target? Crisis should not divert us from this focus • Connect, Cultivate, Consolidate (attachment 3) • Interference – What may be interfering with treatment? • *Group asks clarifying questions, diagnosis clarification questions, and discuss other practice elements that could potentially be used (the cultivate)*

Session Type 3: Present focused on Cultural Consideration and how the content/process can be modified (attachment 4 provides examples of adaptation)
• Important and appropriate to adapt when engagement strategy is ineffective, family has unique risk and/or resiliency factors, unique symptoms of a common disorders
• Present the conceptual structure of what you are adapting or describe the approach used (ex of adaptation is Culturally Responsive CBT Hays 2009)
    ○ What approach was used
    ○ How was it altered and why
    ○ Was the theory behind a specific modality completely changed or altered in any way?
• *Group asks clarifying questions, diagnosis clarification questions, and understand the adaptation presented, provides feedback on adaptation model and other examples of ways they have adapted an EBT*

V. Next Steps

Support for building internal capacity within each health center to provide clinical supervision is incorporated into the TEAM UP Learning Community. The structure outlined in this memo will form the basis for TEAM UP - wide BHC case consultations throughout the end of Implementation Year 2 and all of Implementation Year 3. In addition, members of the clinical training team are available to join each health center's internal group supervision sessions to provide customized facilitation and support. Supervisors are encouraged to reach out to the clinical training team directly to coordinate schedules and confirm plans around how the clinical training team can best support your supervision work.

VI. Supporting Documents

a. **MAP Attachment 1 Evidence Based Services System Model**
b. **MAP Attachment 2 The Treatment Planner**
c. **MAP Attachment 3 Connect Cultivate Consolidate**
d. **MAP Attachment 4 Embracing Diversity**
e. **MAP Attachment 5 THE MAP**

VII. References

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