Competency-Based Clinical Supervision

Dr. Laurel Johnson
Clinical Director, Child and Youth Mental Health

Teresa Scheckel
Program Director, Child and Youth Mental Health, East

CMHO 2018

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Agenda

• Kinark and redevelopment of our CYMH program service
• What is clinical supervision?
• What the literature says about clinical supervision
• What is ‘competency-based clinical supervision?’
• Process and resources for competency-based clinical supervision
• Implementation efforts
MISSION
Helping children and youth with complex needs achieve better life outcomes.

Kinark by the Numbers: 2016/17 – 2017/18

1. Autism Services
   - Children and Youth Served: 1400
   - Children and Youth Served: 1311

2. Child & Youth Mental Health
   - Total Children & Youth Served: 3798
   - Total Children & Youth Served: 4187

3. Forensic Mental Health/Youth Justice
   - Total Children & Youth Served: 283
   - Total Children & Youth Served: 238

Kinark Outdoor Centre: 3810
Supervised Access - Children: 2899
Supervised Access - Families: 2137

Staff: 849
Volunteers: 109
Drivers for Change

<table>
<thead>
<tr>
<th>Internal</th>
<th>External</th>
</tr>
</thead>
<tbody>
<tr>
<td>• A need to strengthen our service and improve outcomes for children, youth, and families</td>
<td>• Moving on Mental Health - 2012</td>
</tr>
<tr>
<td>• Shifting mandate in CYMH to align with other service streams</td>
<td>Board approval of Kinark shift in mandate – February 2014</td>
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</tbody>
</table>

**Level 1**
- All children, youth and their families/caregivers

**Level 2**
- Children and youth identified as being at risk for, or who are experiencing, mental health problems that affect their functioning in some areas, such as at home, school and/or in the community

**Level 3**
- Children and youth who are experiencing significant mental health problems that affect their functioning in some areas, such as at home, school and/or in the community

**Level 4**
- Children and youth experiencing the most severe, complex, rare or persistent diagnosable mental illnesses that significantly impair functioning in most areas such as at home, school and in the community

Least Intensive → Most Intensive

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BETTER OUTCOMES. TOGETHER.
# Drivers for Change

## Transformed Child and Youth Mental Health Services

<table>
<thead>
<tr>
<th>Current State</th>
<th>Future State</th>
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<tbody>
<tr>
<td>Fragmented, inefficient, hard to access, provider-centric</td>
<td>Child and youth centred, responsive, flexible, seamless, equitable, evidence-informed and matched to needs</td>
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<tr>
<td>Services not consistently matched to needs</td>
<td>Valid tools, evidence-informed practice</td>
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<td>Many providers; uneven access to equitable service</td>
<td>Defined communities, lead agencies, and core services</td>
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<td>Lengthy wait times</td>
<td>Pathways/needs and timeliness at centre of service delivery</td>
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<td>Duplication and silos</td>
<td>Coordination between providers and across sectors</td>
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<td>Cannot demonstrate results</td>
<td>Linked standards contracting, performance and results</td>
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<td>Historical funding distribution</td>
<td>Funding tied to population, needs, and performance</td>
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## What it will look like:

- Parents, children and youth know how to access services, what is available to them, and what to expect at each point along transparent service pathways.
- Regardless of where they live, families have access to a consistent set of easy to identify supports and services through an identifiable lead agency that is accountable to government.
- Parents, children and youth have confidence in the people and agencies providing services.
- Wait times for service are timely, predictable, and matched to severity of need.
- Parents and funders know whether the services received have made a difference.

[kinark.on.ca BETTER OUTCOMES. TOGETHER.]
Model Principles

Efficient client flow
Data-driven treatment planning and clinical decision-making
Matching service response to treatment need
Client-centred care
Continuity of service
Clear and easy service pathways for families
Timely service response
High quality service with inter-professional expertise
Supports complex clients

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Redevelopment Journey

• Reorganize staff into pods
  o Case Managers, Clinical Therapists

• Complex and Brief/Diversion

• Implementation of interRAI assessment tool
  o Case formulation, treatment planning, clinical documentation

• Adjunct Services
  o ICSS, Psychology, Psychiatry, Nursing

• Milieu Services
  o Day Treatment, Residential

• Interventions
  o MI, Behaviourism, CBT, UP, (DBT)
Connecting the Dots

Case Management
- Differentiate roles - who is responsible for what
- Set the therapy up for success - collect collateral, problem solve barriers

Assessment
- Interventions
- IBLA
- BCA
- Case conceptualization
- Integrate assessment information to understand the problem behavior

Intervention
- Treatment Plan
- Motivational Interviewing
- Modular CBT
- Session-by-Session Outcome Monitoring
- Targets what is maintaining the behaviour
- Keeps treatment focused
- Tells you when there is progress on target

Formation of pods
CM intake Process
Final Phase

Supervision and Sustainability

- **Sustainability**: Ensure new, quality practices and processes are upheld and do not drift
- **Supervision**:  
  - One aspect of sustainability
What is Clinical Supervision?

• Quality clinical supervision is founded on a positive supervisor-supervisee relationship that promotes client welfare and the professional development of the supervisee

• Supervisors act as a teacher, coach, consultant, mentor, evaluator, and administrator
  • They provide support, encouragement, and education to staff while addressing an array of psychological, interpersonal, physical, and spiritual issues of clients

(TIP 52-Clinical Supervision, SAMHSA)
Assumptions About Supervision

• Therapists need supervision to perform better
• Supervision protects the agency
• Supervision protects the clients
• Experience makes supervisors perform better
• Supervision improves therapist adherence
• Supervision improves client outcomes
What We Know About Supervision

• We need it to change therapist behaviour - didactics and workshops alone do NOT (Fixsen, 2005)

• Supervisors adherent to a model are more likely to produce therapists who adhere to the model (Shoenwald et al., 2009)

• Supervisors who address the immediate concerns of a supervisee are associated with clients who have superior outcomes (Shoenwald et al., 2009)

• Supervision enhances clinical outcomes (Bambling, 2006)

• Clinical supervision is a primary means of improving workforce retention and job satisfaction (Roche, Todd, & O’Connor, 2007)

• 84% of supervisees commit nondisclosure (Mehr, Ladany, & Caskie, 2010)
Non-Disclosure in Supervision

• There is a positive correlation between positive supervisory alliance and supervisee disclosure

• 84% of supervisees commit nondisclosure (Mehr, Ladany, & Caskie, 2010)

• **Nondisclosure** occurs in supervision for various reasons
  • Amongst those supervisees who failed to disclose, reasons included:
    • Negative reactions to supervisor (90%)
    • Personal issues (60%)
    • Clinical mistakes (44%)
    • Evaluation concerns (44%)
    • Negative (critical, disapproving, unpleasant) reactions to client (36%)

  (Ladany, Hill et al., 1996)

• Negative supervision erodes supervisee professional self-confidence, increases self-doubt, and invites negative countertransference reactions to clients, increases performance anxiety and exacerbates supervisee self-criticism

  (Orlinsky & Ronnestad, 2005)
Best Practices Optimizing Supervision

- Use of **differing training modes** in a targeted and conceptually driven way (didactic, observational, experiential)
- **Structuring supervision** in a manner that mirrors CBT practice
  - Agenda setting
  - Problem definition
  - Use of feedback and homework
- **Developing a good supervisory alliance that involves collaborative empiricism**
- Providing **corrective feedback** to supervisees and eliciting and responding to trainee feedback regarding supervision
- **Use of self-practice and self-reflection** to foster learning
- **Focus on the supervisory process**
- **Ensuring supervisors have ongoing supervision and training to fine-tune their supervisory skills**

(Milne, 2009; Milne & James, 2000)
Best Practices of Supervision

• The supervisor examines his or her own clinical and supervision expertise and competency;

• The supervisor delineates supervisory expectations, including standards, rules, and general practice;

• The supervisor identifies setting-specific competencies the trainee must attain;

• The supervisor collaborates with the trainee in developing a supervisory agreement or contract for informed consent, ensuring clear communication in establishing competencies and goals, tasks to achieve them, and logistics; and

• The supervisor models and engages the trainee in self-assessment and development of metacompetence (i.e., self-awareness of competencies) from the onset of supervision and throughout.

(Falender & Shafranske, 2007, p. 238)
Metacompetence

• Ability to assess what one knows and what one doesn’t know
  • Introspection about one’s personal cognitive processes and products
• Dependent on self-awareness, self-reflection, and self-assessment
  
• Supervision guides development of metacompetence through encouraging and reinforcing supervisee’s development of skills in self-assessment

Weinert, 2001

Falender & Shafranske, 2007
Most Effective Supervision Elements

• Joint review of videotapes of sessions; live supervision/feedback
• Supervisees participate on a treatment team behind one-way mirror
• Group supervision
• Supervisor demonstrates specific therapy skills (modeling)
• Individual case consultation

(Goodyear & Nelson, 1997)
Effective Supervisors

- Form a supportive alliance with the supervisee
- Integrate supervision with didactic and clinical training
- Plan supervision sessions
- Have defined and measurable goals for teaching encounters
- Do more than just listening and commenting on a case
- Expect expertise (not just competency) to be the ultimate goal of supervision

(Cabaniss & Arbuckle, 2011)
Negative Factors in Supervision: Supervisor

- Negative supervision erodes supervisee professional self-confidence, increases self-doubt, and invites negative countertransference reactions to clients, increases performance anxiety and exacerbates supervisee self-criticism

- **Rigid** - Over structuring the therapy/supervision
- **Uncertain** - Failure to structure the therapy/supervision
- **Exploitive** - Inappropriate self-disclosure/supervision
- **Critical** – Managing
- **Distant** - Unyielding transference interpretation
- **Tense** - Inappropriate use of silence
- **Aloof** - Belittling
- **Distracted** - Superficial interventions

(Orlinsky & Ronnestad, 2005)
Negative Factors in Supervision: Supervisee

- Unwilling to grow and change
- Fearful of change
- Psychological limitations
- Unwilling/unable to examine self
- Social limitations
- Lack of sensitivity/respect
- Distrustful/defensive

- Unwilling/unable to accept feedback
- Defiant/avoidant in supervision
- Limited skills and knowledge base
- Limited motivation for learning
- Inadequate understanding of counseling process

Wilcoxon, Norem, & Magnuson, 2005
Current Supervision Model: Parallel Process

• History of Current Supervision Model
  • Supporting Evidence Based Practice

• Key Components of Current Supervision Model:
  • Stages and Structure of Supervision (Lawrence Shulman)
  • Process of Supervision (Peter Hawkins and Robin Shohet)
  • Skill Development and Competencies (Carol Falendar)
We learned from current supervision model that a focus on skill development is key in supporting quality delivery of evidenced based practice.

Key learnings:
• Establish a culture of learning
• Create a strong sustainability Plan
What is Competency-Based Clinical Supervision?

• Places emphasis on the identification of the knowledge, skills, attitudes and values that are assembled to form specific clinical competencies and systematically describes supervision processes to facilitate the development of professional competence.

(Falender & Shafranske, 2016)
Competency-Based Supervision is Distinguished From:

• Case Management
• Consultation
• Psychotherapy
• Mentoring

Competency-Based Clinical Supervision aims to transform the training approach from reliance on assumptions of competence to demonstrations of competence.

Falender & Shafranske, 2017
Why is Competency-Based Supervision Important?

- The articulation of competencies allows for greater clarity in formulating training objectives and leads to more precise observation and evaluation of supervisee performance. This in turn enables the supervisor to provide clear feedback and to formulate learning objectives and strategies to enhance supervisee competence.

  (Falender & Shafranske, 2016)

- To improve clinical quality and outcomes for kids and families!
Benefits for Staff

- Clinical Expertise
- Comfort
- Efficiency
- Independent Practice
- Positive Outcomes
- Client and Staff Satisfaction
Getting Started

1. Orientation to the competency-based approach
2. Collaborative identification of individual areas of strength and areas for enhancing knowledge and skills
3. Development of supervision contract

Note: Developmental levels should not be assumed (Self-assessment, self-report, and observation should be used)
Getting Started

Supervisor Examines Own Clinical Expertise
  • Rating Scale
  • Develop Plan with own Supervisor

Supervisor Examines Own Supervision Expertise
  • This is new for everyone!

Supervisee Examines Own Clinical Expertise
  • Rating Scale
  • Needs Assessment preparation

Collaborative Supervision Agreement
  • Needs Assessment
  • Set Goals
  • Template

Supervisor Determines Plan
  • Conceptualization:
    • Early
    • Intermediate
    • Advanced

First Meeting

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Competency Rating Scales

• Roth and Pilling (2007) Competency Framework for CBT knowledge
• Cognitive Therapy Rating Scale (CTRS) for CBT application
• DBT Adherence Rating Scale for DBT
• CAMAT for Unified Protocol
• MITI for Motivational Interviewing
• Others….
Needs Assessment

• Why?
  • Increases intrinsic motivation for learning
  • Increases supervisee responsibility for learning
  • Makes a public commitment to learning a new skills
  • Models self-practice and self-observation

• How?
  • Gather information about the supervisee that helps define level of ability
  • Link past experiences to current learning issue
  • Activate prior knowledge to formulate new learning goals
  • Use Socratic questions whenever possible

• What are your goals for supervision this year?
• Are there particular learning issues you have identified that you wish to address?
• What have you learned about this type of client that can help you here? (didactic, past learning)
• What have you tried to do with this type of client in the past? (application)
• What is your level of comfort with “X”? What has worked less well for you about “Y”?
Supervisee Goals

- Incorporated into Supervision Agreement
- Without learning goals, supervision is often ‘case management’
- Progress toward goals should be monitored

SMART Goals
- **Specific**
- **Measurable**
- **Achievable**
- **Relevant**
- **Timely**
Supervisor Goals

- Teach supervisees the skills of intervention
- Help supervisee deliver competent intervention
- Increase capacity for independence
- Ensure client care is adequate and safe (case management)
- Be a mentor/role model
- Provide supervisee and program with evaluation and feedback
Supervisory Contract/Agreement

- Development of the supervision contract is an essential component of the supervisory process and serves as the basis for the supervisory alliance, enhanced articulation of expectations, informed consent, and definition of parameters of the relationship and the process.

- Includes:
  - Content and Context of Supervision
    - Scope of practice under supervision
    - Length of contract period
  - Roles and Expectations of Supervisee and Supervisor
    - Learning activities, processes, supervisor and supervisee responsibilities, feedback, mutually defined goals and tasks
  - Legal/Ethical Parameters
    - Informed consent; Confidentiality
    - Adherence to agency/practice requirements and rules
    - Include specific reference to ethical codes, licensing statutes, and laws
    - Reference to agency/site personnel practices
  - Performance Expectations
    - Specific knowledge, skills, values (from Competency Framework)
    - Modes of formative and summative evaluation
Supervisees are Not All Created Equal

• **Conceptualize** the supervisee on a developmental continuum
  • Psychological makeup
  • Learning style
  • Sociocultural background
  • Educational background
  • Knowledge
  • Prior experience
  • Beliefs about clinical work
Ongoing Supervision

• **Supervisee Prepares**
  
  • Review
    • Material/resources/reports
    • Cases and case formulations
  
  • Develop supervision question

• **Supervisor Prepares**
  
  • Review *Individual Development Plan for Clinical Supervision Goals*
  
  • Review past supervision note/assigned homework/treatment plan reports
  
  • Prepare required materials
Structure of Supervision

- Like a CBT session!

Check In  Bridge

Agenda  Homework  Work on problems  Summary  Bi-directional feedback  Assign (and review) new homework

- Keep Supervision Notes
Process at a Glance – Getting Started

Competency Assessments
- Supervisor
- Supervisee

Initial Supervision Meeting
- Needs Assessment
- Review Agreement

Supervisee Conceptualization
- Early, Intermediate, Advanced
- Goals for Clinical Supervision Worksheet

Supervision Agreement
Process at a Glance – Ongoing Supervision

Supervisee Prepares
- Supervision Preparation Form
- Case Formulation Worksheet
- Plan for Supervision Meeting
- Comprehensive/Assessment Treatment Plan Report
- Treatment Plan Progress Report

Supervisor Prepares
- Review records
- Review reports/Quality Audit
- Plan for Supervision Meeting
- Prepare materials

Supervision Meeting
- Supervision Summary Report
- Record of Supervision Meetings
Next Steps
Implementation

• Supervision Model Task Group
  • To make recommendations for successful implementation
  • What are the quick wins?
  • What are the barriers?
### Time and Scheduling

<table>
<thead>
<tr>
<th>Type</th>
<th>Time</th>
<th>Frequency</th>
<th>Time/Month</th>
<th>Attendees</th>
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</thead>
<tbody>
<tr>
<td>Individual Supervision*</td>
<td>1 hour</td>
<td>Monthly</td>
<td>1 hour</td>
<td>Supervisor, Supervisee</td>
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<td>Prep/Notes for Individual Supervision*</td>
<td>1 hour</td>
<td>Monthly</td>
<td>1 hour</td>
<td>Supervisor, Supervisee</td>
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<td>Assessment Tape Review*</td>
<td>3 hours</td>
<td>Bi-Monthly</td>
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<td>Pod Meeting – Group/Peer Clinical Supervision*</td>
<td>2 hours</td>
<td>Bi-Weekly</td>
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<td>Supervisor Direct Client Service (2 clients)</td>
<td>2 hours</td>
<td>Weekly</td>
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Total Hours Available per month: 140

Total Hours for Supervisor: 32 hours per month
- If supervising 6 staff, add 7 x 4 hours per month = 28 hours per month
- Grand total for 6 staff = 60 hours per month

Total Hours for Supervisee: 129 hours per month

Does NOT include: report writing (case notes included)
### SUPERVISOR SCHEDULE – Monthly (8 Staff/2 Pods)

<table>
<thead>
<tr>
<th>Time</th>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
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**79 hours per month (140 total hours)**

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BEETTER OUTCOMES. TOGETHER.
### SUPERVISEE SCHEDULE - Monthly - Early

<table>
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<tr>
<th>Time</th>
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Ind Tx = 48  
Prep/Notes = 48
# SUPERVISEE SCHEDULE - Monthly - Advanced

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New Client Ax = 2.5
Group = 8
Ind. Tx = 50
Prep = 18.5
Other Barriers

• Change fatigue
• Fear
Other Barriers?

• What would you anticipate to be barriers to implementing this model if you were to adopt in your agency?
Questions?

Laurel.Johnson@kinark.on.ca
Teresa.Scheckel@kinark.on.ca