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STRUCTURED SUPERVISION SUPPORT: THE ASSOCIATION WITH TIME BETWEEN SUPERVISION AND TREATMENT EVENTS

By

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Submitted in Partial Fulfillment
of the Requirements for
Graduation with Honors from the
South Carolina Honors College

May, 2020

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Structured Supervision Support: The Association with Time Between Supervision and Treatment Events

Anna Hukill

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Honors College Senior Thesis

May 6, 2020

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Acknowledgements

I would like to thank everyone in the Becker Lab for their support, guidance, and friendship. Dr. Becker has allowed me the opportunity to explore psychological research and gain valuable skills that will translate into my future endeavors as an aspiring psychologist. She has served as a role model and mentor for 2.5 years and I am forever grateful for the experience and knowledge I have gained from her.

I would also like to thank the lab's postdoctoral fellow, Dr. Davi Lakind, for her mentorship and encouragement throughout the thesis process and during my day-to-day time in the lab. Josh Bradley, one of the graduate assistants, has served as an incredible role model and knowledge source throughout my time in the lab and during the thesis process as well. I am grateful for his supportive guidance and ability to help me grow as a researcher in the most supportive manner. All of the other research assistants in the lab have served as wonderful colleagues turned friends and I am thankful for the time we shared.

I would also like to thank my family and friends for their unwavering support and love throughout my four years as a Gamecock. They have inspired me to accomplish my goals and develop my passion for learning and communication, and for that I am forever grateful.

Abstract

Supervision is an important resource for assisting mental health providers in providing quality care to clients but not much is known about how its timing unfolds. Data for this study were drawn from the Reaching Families study, which examined the efficacy of a coordinated intervention framework for addressing engagement problems in children's mental health. Providers from Los Angeles, California and across South Carolina were divided into two groups – one received training in a coordinated framework for addressing low engagement (Coordinated Knowledge System) and the other was a control condition (Delayed Training). The current study examined time between notification of a client being at risk for engagement problems and supervision to discuss the case, and then between that supervision session and the next treatment session, and whether there were differences between the two conditions and the two sites. It was hypothesized that CKS participants would demonstrate less time between events because they would have a framework to identify and implement interventions for engagement concerns. It was also hypothesized that Los Angeles practitioners would report less time between events because of their smaller caseloads and higher level of resources. Independent t-tests were run to compare time between events by condition and by site. Results showed that there was not a significant difference in time between events between the conditions but there was a significant difference between the two sites. Findings indicate a potential for a coordinated framework to improve clinical supervision but it needs to be tailored to each site.

Supervision in Mental Health Services: The Association with Time Between Supervision

and Treatment Events

Supervision in mental health services supports developing professionals to identify and address client issues and ensure that clients receive effective and ethical services (Duncan, 2016). Supervision is a critical part of treatment and is defined by Milne as a professional relationship between an experienced practitioner and a more novice practitioner to develop and support the services being provided given the client's background, symptoms, and strengths (2007). Clinical supervision, when implemented well, has been demonstrated to help providers more effectively and efficiently learn and apply skills and strategies (Walsh-Rock 2018; Dorsey, 2017). Supervision covers an array of topics, sets the course of treatment, and can provide a sense of urgency for providers in particularly vulnerable cases. A lack of supervision or ineffective supervision has been shown to lead to higher stress and burnout rates for providers, leading to high turnover rates and decreases in quality of service (Connolly Gibbons, 2015; Beidas et al, 2016). This study focuses on whether a coordinated framework helps guide supervision to address client needs in a more timely manner than is seen in standard practice.

Proctor's supervision model is widely accepted in mental health services (1986). This model is comprised of three components and provides a framework to characterize the function, format, and process of supervision. The normative component targets administrative tasks such as session productivity and required paperwork. The formative component centers around expanding the provider's skills and knowledge and includes supporting and developing plans for implementing evidence-based practices and building a therapeutic alliance. The restorative component emphasizes provider wellbeing and involves check-ins to prevent burnout and turnover. Structure such as this allows supervisors and providers to effectively ensure job

compliance, assist their clients, and maintain their own health. This cumulative approach is crucial because without any of the three components, clients, providers, or the general system would suffer.

A recent study found that providing structured support for supervision was related to increased attention to identifying a problem to work on in treatment and making a plan for intervention (Becker, Park, Boustani, & Chorpita, 2019). This suggests it is possible to structure the interactions between supervisors and providers in a way that makes it more likely that goal-oriented, client-focused formative activities occur.

This study was designed to investigate whether a structured framework for supervision might affect not only supervision focus and behaviors, but also timing. Within the context of a study of clinical decision-making related to client treatment engagement, we wanted to see if a structured supervision framework would be associated with the time from notification of a client's at-risk status for low engagement to the ensuing supervision session and from the first supervision session to the first treatment session. We hypothesized that having a structured supervision framework would be associated with reduced time between events because the framework would help supervisors and providers feel a sense of urgency and make them more likely to rapidly schedule supervision and treatment because they have a plan of action. In contrast, those without a structured supervision framework might have increased time between events due to the absence of clear prompts for action.

Within this study, we also had the opportunity to consider the effects of site differences on event timing. Given the significant caseloads that occur in mental health services, (Ducharme et al., 2008) it can be difficult to address each case during supervision (Dawson, 2013). Additionally, it was hypothesized that there would be site differences. Specifically, practitioners

with smaller caseloads and more resources would report less time between events because these factors would allow them to proactively intervene and keep cases moving.

This research could help us understand whether a structured supervision model is associated with reduced time between supervision and treatment events and, independent of the supervision model, whether organizational differences across sites might be related to time between events. This study is crucial in the expansion of clinical supervision research and ensuring adequate mental health services for clients.

Methods

Overview

This study utilized data from a randomized controlled trial examining the efficacy of a coordinated intervention framework for addressing engagement problems in children's mental health. This study, entitled Reaching Families, provides a coordinated framework to identify engagement concerns and use resources to develop a coordinated intervention. Reaching Families uses the five domains outlined in the acronym REACH (Relationship, Expectancy, Attendance, Clarity, and Homework) to characterize concerns and direct providers to appropriate interventions (Becker & Chorpita, 2016). Supervision was a large part of this study as it also looked at how supervision can improve treatment outcomes.

Participants

This study worked with the Los Angeles Unified School District (LAUSD) and two community mental health centers in South Carolina (SC): Pee Dee and Santee-Wateree. Pee Dee Mental Health Center encompasses their main center as well as satellite clinics in Florence, Lake City, Marion, and Hartsville. Santee-Wateree oversees satellite clinics in Sumter, Lee,

Clarendon, and Kershaw. The current study used existing provider-supervisor dyads with many supervisors supporting multiple providers.

This sample includes 19 supervisors and 59 providers from across LAUSD and 9 supervisors and 42 providers from SC. LAUSD supervisors and providers were directly employed by LAUSD and SC supervisors and providers were employed by the South Carolina Department of Mental Health.

Of the supervisors, 100% identified as female. Supervisors identified themselves as White, Caucasian, or European-American (21.4%), Spanish/Hispanic/Latino (21.4%), Black/African-American (39.3%), Asian/Asian-American (10.7%), or Other (7.2%). On average, supervisors had 16 years of full-time clinical experience.

Of the providers, 93.2% identified as female. Providers identified themselves as White, Caucasian, or European-American (12.6%), Spanish/Hispanic/Latino (47.6%), Black/African-American (36.9%), or Asian/Asian-American (2.9%). On average, providers had 6.4 years of full-time clinical experience.

Supervision Conditions

All supervisors were randomly assigned to one of two study conditions and their supervisees were assigned to the same condition. The Coordinated Knowledge System (CKS) condition included 14 supervisors and their 58 providers while the Delayed Training (DT) condition included 14 supervisors and their 45 providers. Each supervisor and supervisee were alerted to youth cases that were determined to be at risk for low engagement according to a 35-item survey (i.e., My Thoughts about Therapy questionnaire) administered to youth and caregivers. Supervision conditions differed according to the resources they used to discuss these at-risk cases.

Coordinated Knowledge System (CKS)

Providers and supervisors in this condition received an Engagement Report that detailed client and caregiver perceptions of the five REACH domains in order to help them identify engagement problems. Providers and supervisors were also given the Reaching Families Worksheet (RFW) in training. The RFW suggested ways for providers and supervisors to work together to identify the problem, select a practice, and then implement and evaluate that practice. This, in combination with the Engagement Report, was offered as a resource for providers and supervisors to more accurately identify and address issues specific to each client. This incorporated the "coordination" aspect of CKS by helping providers and supervisors identify a specific problem and then select and implement an appropriate intervention. Participants were also given twelve two-page practice guides that guided the implementation of practices mentioned in the RFW through step-by-step procedures within each practice along with how and why to implement them.

All of these materials were distributed during training and were accompanied by detailed instructions about proper use and evaluation. After training, participants in the CKS condition received ongoing consultation with Reaching Families researchers to support the implementation of these materials.

Delayed Training (DT)

Participants in the DT condition were alerted to cases that were at risk for low engagement but did not receive an Engagement Report with more detailed information, nor was the nature of the problem specified. They had access to a one-page set of practice guidelines but that did not include the REACH domains or step-by-step instructions for implementation.

Procedure

University Institutional Review Board approval was received before study procedures began.

Providers and supervisors provided informed consent to participate in the study after being given a clear overview of the study goals and procedures. After provider and supervisor consent, researchers first collected demographic information, including age, gender, race, etc. and which site they were based at. Consented supervisors were then randomly assigned to either the coordinated knowledge system (CKS) condition or the delayed training (DT) condition. The providers and clients they served were nested within these supervisors and assigned to the same condition.

Participants learned how to obtain informed consent from clients, process My Thoughts About Therapy (MTT) surveys, record treatment and supervision sessions, and return resources and data to researchers. All participants were given a general overview of engagement practice guidelines and then DT participants were dismissed from training. CKS participants then attended the training session outlined in the study conditions. Providers and supervisors in the CKS condition participated in screening simulations for REACH scoring, role plays with RFWs, and practice activities using the two-page handouts to implement engagement practices.

Clients and caregivers completed the MTT survey early in treatment to assess engagement. Clients were deemed "at-risk" of poor engagement and premature dropout if they received a low score (i.e., 13 or below) in one or more of the domains. Providers with at-risk clients were then notified that their client was at risk of poor engagement. Those in the CKS condition were provided an Engagement Report detailing which domains the client or caregiver reported problems in. Providers in both conditions then proceeded to engage in conversation with the client and caregiver (in their preferred language) to obtain consent to participate in the study.

After client consent, providers, supervisors, and clients were given non-identifying IDs to protect their privacy. Each provider consented either one or two cases.

After receiving consent, providers attended a supervision session before meeting with their client again. Such meetings are regular proceedings for providers and involve working together to make a plan for their first treatment session post-consent. Researchers collected the date of consent, the date of the first supervision session, and the date of the subsequent treatment session.

Data Analysis

To prepare the data for analysis, the time between notification and the ensuing supervision and treatment sessions was calculated to see what differences in timing took place between the two conditions and sites. Independent t-tests were run to compare the two conditions (CKS and DT) for time between consent and the first supervision, first supervision and first treatment, and consent and first treatment. Independent t-tests were also run to compare the two sites (LAUSD and SC) for time between consent and first supervision and first supervision and first treatment. A two-way ANOVA was also conducted to understand the interaction between condition and site in terms of time between the first supervision session and the first treatment session.

<div align="center">

Results

</div>

Table 1 shows descriptive statistics for demographic descriptors such as gender, race/ethnicity, language(s) of fluency, and years of clinical experience of providers and supervisors. Demographics are also reported by condition.

Condition Differences

Figure 1 displays the mean number of days between notification and supervision and between supervision and treatment by condition. Independent t-test were conducted to determine whether there was a difference between the CKS and DT conditions when it came to time between notification of at-risk status, supervision, and treatment. Results showed that the number of days between at-risk notification and the next supervision session did not differ significantly between CKS participants ($M = 12.25$, $SD = 12.89$) and DT participants ($M = 12.89$, $SD = 14.71$), t(184) = -.301, $p = .764$. Results also showed that the number of days between supervision and the next treatment session did not differ significantly between CKS participants ($M = 9.56$, $SD = 11.70$) and DT participants ($M = 9.91$, $SD = 12.61$), t(184) = -.197, $p = .844$. This shows that there was no significant difference in time between notification of at-risk status, supervision, and treatment for either condition, CKS or DT, as shown in Figure 1.

Site Differences

Figure 2 displays the mean number of days between notification and supervision and between supervision and treatment by site. Independent t-tests were conducted to determine whether there was a significant difference in time between notification of at-risk status, supervision, and treatment between LAUSD and SC practitioners. Results showed that the number of days between at-risk notification and the next supervision session differed significantly between LAUSD practitioners ($M = 7.18$, $SD = 7.981$) and SC practitioners ($M = 20.05$, $SD = 17.816$), t(184) = -5.927, $p < .05$. Results also showed that the number of days between supervision and the next treatment session differed significantly between LAUSD practitioners ($M = 6.67$, $SD = 7.012$) and SC practitioners ($M = 13.99$, $SD = 15.933$), t(184) = -3.774, $p < .05$. This shows that LAUSD was significantly faster in completing supervision

sessions after notification of at-risk status and also faster at completing the ensuing treatment session, as shown in Figure 2.

Interaction

A two-way ANOVA was conducted that examined the effect of condition and site on time between the first supervision session and the first treatment session. There was not a statistically significant interaction between condition and site on time between supervision and treatment, $F (1, 180) = .002$, $p = .964$.

Discussion

Seeing as clinical supervision is a vital aspect of mental health treatment, it is important to understand what makes it most effective. In this study, we investigated the effects of a coordinated framework on time between treatment events.

Results showed that there was no significant difference between conditions when it came to time from notification of at-risk status to first supervision session to first treatment session. This indicates that the intervention did not appear to affect time between sessions. More research would be required to determine whether the intervention has a long-term effect, but from these results the coordination framework does not appear to have an effect on time between sessions.

Results showed that there was a significant difference between sites when it came to time from notification of at-risk status to first supervision session to first treatment session. This indicates that LAUSD practitioners had less time between sessions, likely because of their smaller caseloads and increased resources.

ANOVA tests showed that there was no significant interaction between site and condition when it came to time between supervision and treatment. This shows that even though SC practitioners reported more time between treatment and LAUSD practitioners reported less, even

within these sites the coordinated framework did not appear to have an effect on time between sessions.

Conditions were evenly split between sites and showed no results, but differences between events at the two sites was significant. LAUSD had shorter time between all sessions, indicating that they were more timely between sessions. Although this is not what the research originally intended to study, it leads to more questions about differences between the sites that could have led to this result and whether it could happen in different locations as well.

Despite this large disparity between LAUSD and SC, practitioners from both sites averaged over a week between each event. Given that the first event notified them that their client was at high risk of poor engagement, it is surprising that they waited so long to meet.

In terms of time between sessions when looking at conditions, it is likely that providers, supervisors, and clients had established appointments before notification and it would have been difficult to rearrange. Although it is surprising that they appeared to wait over a week between events, this is likely due to the fact that it would have been difficult to rearrange other meetings as well on short notice. These results would be better analyzed over a longer period of time to see whether providers and supervisors managed to decrease that time between events or even added in events such as phone check-ins. Both sites likely averaged over a week between events because of pre-existing commitments as well. Over time, it is possible that the coordinated knowledge system could have a larger effect because they could implement new systems and schedules to respond faster.

Implications

More research is needed to fully understand supervision and the efficacy of a coordinated framework despite these limited results that possibly indicate efficacy. In addition to looking

more long-term at time between events, it would be important to look at other possibilities to allow for faster responses to engagement concerns. Options include supervision or treatment sessions through alternative means such as Skype or over the phone. This would allow for providers and supervisors to quickly discuss and address concerns. This would also help clients express their concerns and learn more about the process before they make a decision about termination.

Another potential future direction would be to look at what is happening during supervision sessions and whether they are being implemented effectively. Frequent supervision sessions do not necessarily indicate more help to providers, so it would be important to look at what is going on during such sessions.

In general, the main future direction for supervision research lies in providing supervisors and supervisees with effective structures and frameworks to address client concerns. In this case, it has to do with engagement and how providers can detect and address lack of client engagement. Supervisors are a key resource to help providers properly address concerns and it is important to make the most of supervision sessions.

Limitations

It would be important to look at practitioners' previous records of service and how much time they left between events to see if they did decrease the time, relatively. It would also be prudent to survey providers' previous perceptions of supervision as well as engagement to see if they viewed engagement as a serious concern and supervision as a useful way to address it.

Conclusion

This research indicates the possibility of a coordinated framework for clinical supervision sessions as a means to improve timeliness in responding to engagement concerns. More research

needs to be done into how to adapt it based on site because of the clear site differences, but these findings are promising and indicate a future area of research. Clinical supervision is a crucial aspect of mental health treatment and needs to be fully understood and implemented effectively.

Tables and Figures

Table 1

Characteristics of 131 Participating Practitioners

Characteristics	Total (N = 131)	CKS (N = 72)	DT (N = 59)
	N (%)	N (%)	N (%)
Race/Ethnicity			
White, Caucasian, or European-American	19 (14.5)	9 (12.5)	10 (16.9)
Spanish/Hispanic/Latino	55 (42)	32 (44.4)	23 (39)
Black/African-American	49 (37.4)	27 (37.5)	22 (37.3)
Asian/Asian-American	6 (4.6)	3 (4.2)	3 (5.1)
Middle Eastern/North African	0 (0)	0 (0)	0 (0)
Native American/Alaska Native	0 (0)	0 (0)	0 (0)
Native Hawaiian/Pacific Islander	0 (0)	0 (0)	0 (0)
Other	2 (1.5)	1 (1.4%)	1 (1.7)
Gender			
Male	7 (5.3)	4 (5.6)	3 (5.1)
Female	124 (94.7)	68 (94.4)	56 (94.9)
Site			
LAUSD	78 (59.5)	46 (63.9)	32 (54.2)
SC	53 (40.5)	26 (36.1)	27 (45.8)
Role			
Supervisor	28 (21.4)	14 (19.4)	14 (23.7)
Provider	103 (78.6)	58 (80.6)	45 (76.3)

Figure 1

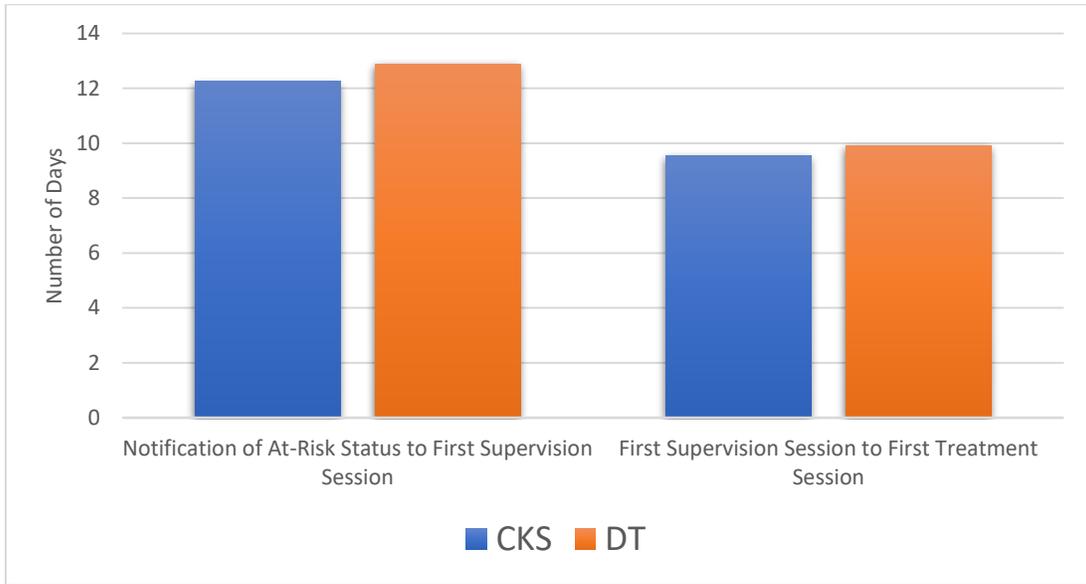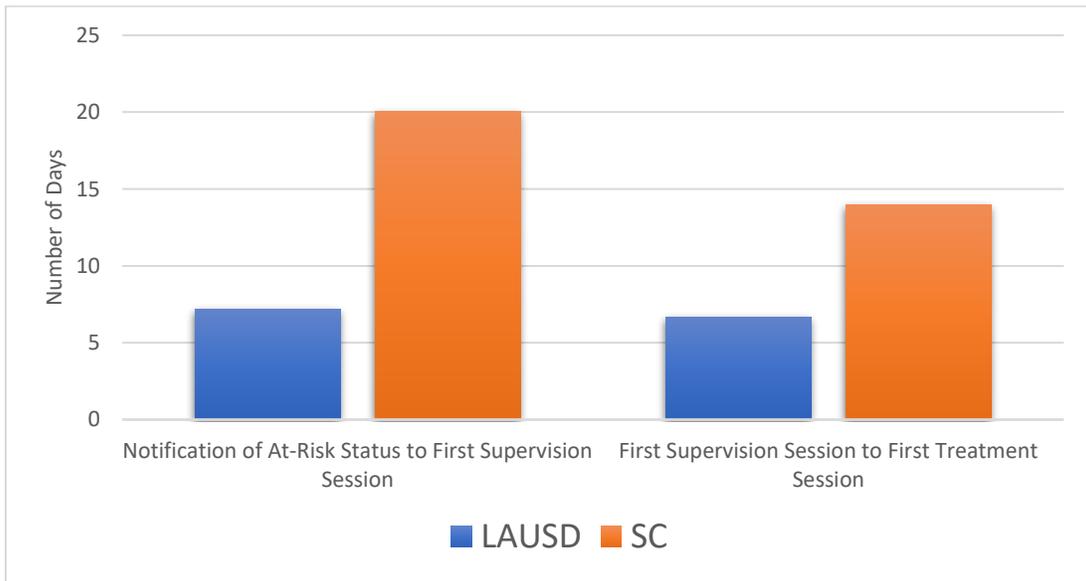*Time Between Sessions by Condition*

Figure 2

Time Between Sessions by Site

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