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Mind Care Matters

Transcript – Clinical Supervision

Summary:
Clinical supervision is the type of supervision that helps a mental health practitioner (e.g. counselor, social worker, psychologist) to do their job in a better way. This conversation with Dr. Tom Bartholomew highlights the importance of clinical supervision for practitioners working with people with severe mental health conditions.

Michelle:
Hello, my name is Michelle Zechner. I'm faculty at Rutgers School of Health Professions, at the Department of Psychiatric, Rehabilitation and Counseling Professions. I've been helping people living with mental health conditions and their families for over 20 years, and one of my passions is learning about new services to help people recover from mental health issues. Welcome to Mind Care Matters, a podcast series dedicated to exploring new and innovative strategies to improve mental health. Today, I'm talking to my longtime colleague, Dr. Tom Bartholomew.

Dr. Bartholomew has been working in the field of psychiatric rehabilitation since 1988. He has worked in residential and clubhouse programs and was the director of a partial care program. For the last 19 years, he's been on the faculty of Rutgers University and a consultant to New Jersey State psychiatric hospitals. Doctor Bartholomew's current research interests include implementation theory and restorative clinical supervision. And he is an avid ultra runner and metal fabricator and lives in rural New Jersey with his wife and two kids. Welcome, Tom.

Tom:
Thank you so much. That guy sounds great, by the way.

Michelle:

He's here with me.

Tom:

Yeah. Thank you so much for the invite. And yeah, I'm excited to talk about clinical supervision. It's one of my areas of interest.

Michelle:

And that's why we wanted you to come talk to us. We're actually going to be talking about clinical supervision with Dr. Bartholomew in mental health settings and the importance of restorative supervision for mental health staff. So, I always ask my visitors and guests to come and talk about the first question: what do mental health providers need to know about clinical supervision?

Tom:

It's a great question. So, one of the most common misunderstandings about supervision in general is the distinction between administrative supervision and clinical supervision. Administrative supervision can be thought of as like maintaining a smooth-running office. So, it's time keeping, it's documentation, it's a patient or client flow, so, you know that kind of thing. Whereas clinical supervision has to do with the interface of the practitioner with the client and what goes on there and that kind of thing. So, that's a really important distinction because some people think they're getting clinical supervision or doing it and they're actually doing administrative.

Michelle:

That's a great first point. And so administrative is like, "my vacation form", right, or "did I come into work on time" or "my mileage reimbursement" whereas clinical might be "what am I doing to engage my client?".

Tom:

That's exactly right. Yeah, it is. I have a wonky definition of clinical which I like very much. I'm going to read it. *Clinical is applying objective and standardized methods to the description, evaluation and modification of human behavior.* So that's really helpful for me because when you're talking clinically you want to talk about what is the standard method to address this problem. You know what's the evidence and we'll get into some of that. But so that's a big difference then your time off request, you know.

Michelle:

Well, that's very helpful to kind of operationalize it in that kind of way. So, it's that relationship between the person and the people that they're helping or the service recipients. So, can you talk about some of the more common models that are out there of clinical supervision?

Tom:

Sure. There's, there's really you might call them families of models, right? So, there are developmental models which are for folks entering the field to develop a mastery within the field and learn the ropes you know you might say. So, those are very common and that in fact many people think that that's what it is, really to orient new people. And then there are, there are some issues, a big word, but some isomorphic models.

Michelle:

I think you win the prize for the fanciest word. Tom.

Tom:

So, an isomorphic model is a parallel model. Meaning if you're trying to apply cognitive behavioral therapy, you use the principles of cognitive behavioral therapy as the supervision, as the model of supervision. And you can, you know, you can do that with almost any therapeutic model can become the model for supervision. So, that's really common in psychology, more so than psychiatric rehab or counseling. So, to answer your question, those are the broad classes of models. One of the big issues and problems in this study of clinical supervision is there's too many models and too little science. In other words, there's just hundreds and hundreds of models. In fact, in the mid 80s, a researcher called for a moratorium on new models of clinical supervision until anybody tested any of them. Right.

Michelle:

So, wait, they said. Stop, stop the madness. Do not have any more of these models of supervision until we test them.

Tom:

Exactly. And, you know, I think what we'll get into in a little bit is they really haven't. We haven't come down on you know some basic models that have been well tested and it's a big problem in the field of clinical supervision.

Michelle:

I know you've looked at this for years and I respect your work a lot. What are the models that you're sort of heading towards or leaning towards that you feel are most helpful for people in psychiatric rehabilitation or in the mental health field in general?

Tom:

Yeah, yeah, that's a really, really good question. And what helped me the most was I came across an article by Bridget Proctor and she called her model the Alliance model. But what I liked about it was not the model per se., it was the three functions that she identified, in other words, what are the functions of a clinical supervisor and what are the functions of clinical supervision. She said that the three functions are restorative as a restorative function, a normative function, and a formative function. And those three functions, so, restorative, for example has to do with taking care of the person engaging in self-care and reflective practice, you know, are they thinking about what they're doing and why they're doing it? How do they feel about various clients, issues of transference, that kind of thing? And that's a really critical aspect of clinical supervision where the practitioner is, engaged in a therapeutic use of self. In other words, they are part of the curative engine of this process and so we have to think about how are they doing. And this is the restorative function.

Michelle:

So, the restorative function of supervision, can you talk about some more and that I think is an important place to just drill a little bit deeper because that is really important for mental health

providers and now many of us have gotten really burned out, we're really struggling things are really hard post COVID. Can you talk about some of the interventions, the outcome of restorative supervision that you've seen or read about?

Tom:

Yeah, it's a really good question. So, when we look at the science of the study of clinical supervision, the one area that is the most maybe understood, well documented are the benefits to the supervisee of clinical supervision, meaning that you can help people reduce or prevent burnout, and compassion fatigue and the way you do that is to give people a place to be vulnerable and to talk about their experiences. I heard recently something so interesting, the guy said if you hit yourself with a hammer on the thumb you can't be present for someone else, right? If you're in that kind of pain, you're all about yourself. And so, imagine a therapist who's really in pain and not doing well. They need support around the kind of the difficult work that we do. So, that was really helpful. So. There are two large studies on burnout in mental health. And, surprisingly, at least to me, what I took away from those two large meta-analysis studies is that most things help. In other words, just addressing staff support and, you know, concerns about how our staff is doing seems really helpful. So, there's no magic pill. It's not that it's any one thing, but it's just going there, talking about it, allowing the person to be vulnerable.

Michelle:

Wow. So, just kind of showing up for the mental health staff is helpful from a supervisory perspective. So, the models are helpful and giving us some direction, but really, you're saying that almost anything where the organization or the supervisor is like, I care, I'm here for you.

Tom:

Exactly right. Yeah. I think in these, very often, mental health settings are really time pressured, and you know you have people that don't go to the bathroom much less, you know reflect on how they're doing.

Michelle:
Right. Well, they don't eat lunch. They don't take breaks. Yeah. Yeah.

Tom:
The restorative function of clinical supervision is really critical. So as, as I mentioned, there's restorative, formative and normative. We'll talk, we can talk more about what those other two functions are. But the restorative function I would say is the most important function and without that you're unlikely to see benefits from clinical supervision.

Michelle:
And I think you know that is so interesting because you're saying I'm just going to kind of highlight what you just said, is that restorative supervision is the most important thing in terms of preventing burnout or addressing burnout and compassion fatigue. And yet often when you know, I, I don't know, a lot of the supervisors might be like, no, what's really important is that people follow the rules. What's really important is billing. I'm not saying that all supervisors are like that, but it may be that we are much more in this administrative mindset at times rather than restorative.

Tom:

Yeah, I would take it even a step further that what I've seen and I've not seen evidence of this other than my own experience is that the restorative function, if a person feels safe in the supervisory relationship, they're much more likely to accept critical feedback, risk making, trying things different, you know, and that's really important. So, if you don't have that, that sense of psychological safety, the person, you know, even if they're supposed to follow the rules, maybe they'll go through the motions, but it's really not going to be a healthy process.

Michelle:

That's very helpful.

I know we kind of took a deep dive in restorative supervision, but it is so important as you're saying. Can you mention briefly the other two types of supervision?

Tom:

Yeah. So, restorative, formative and normative. And I love them because they kind of rhyme and otherwise I'd have no way to remember. So, formative if you think of forming new skills and abilities, right? Supervision also has this function of helping people learn new things and get better, you know, and become master clinicians. And the science of the formative function is largely about audit and feedback. Like that's the real sweet spot. And what that means is if you have a valid intervention like cognitive behavioral therapy and you watch the person that you're supervising do the therapy and you audit them based on the critical ingredients of that therapy and then give them feedback, supportive feedback, and you know you're not wagging your finger at them. That's the number one way to improve clinical skills so the formative function, there's others of course you can do trainings, you can do many trainings. That's all part of, you know, getting better. But audit and feedback is where the evidence is.

Michelle:

Yeah, yeah, I've heard that term a lot, audit and feedback, particularly in nursing literature. But it's exciting that it's starting to come into mental health as well. I realize there's a third element to the Proctor model, which is normative. Can you tell us a little bit more about that?

Tom:

Sure, so the normative is the accountability function, the norms, right? And if there is an overlap here with administrative supervision and what I mean by that is if a clinician isn't showing up on time or isn't showing up at all, that obviously not going to have good clinical outcomes and so the normative function. Now Judith Proctor, when she coined those terms, she wasn't as expansive as I now think of the normative function. But you can also think of norms as what is the evidence for a given condition. Right? And so, if somebody has obsessive compulsive disorder, for example. What should you be doing, right? And the norm of that practice is part of the accountability. Like if you're doing Primal Scream, that's probably inappropriate for that condition. So that's the normative function.

Michelle:

Yeah. Yeah. Well, that's, you know, that's so helpful. I appreciate how you've broken that down and I do, you know, I worked alongside with you for many years and you've done a lot of work thinking about

clinical supervision and inpatient settings. I'm wondering could you give us some kind of example of how you've used restorative supervision or some of these models that you've just described.

Tom:

Yeah, so, we have been implementing evidence based practices within the state psychiatric hospital system of New Jersey and so we it took us a while to learn these things. I didn't learn the Proctor model until maybe eight or nine years ago. So, what we've done is we've used a valid measure of the provision of Illness Management and Recovery is one example. And used audit and feedback and invited people to a restorative focused supervision. And we really got feedback. In fact, we did a National Institute of Health study on that topic, seeing if the supervision resulted in better clinical outcomes. So that was very exciting and the other thing that occurred to us kind of as we began looking into clinical supervision was the need for the supervisors to receive support. And so, we developed what we call meta supervision, which is a similar process for supervisors where the focus is best practices in clinical supervision instead of a clinical intervention, and that's been really, really interesting and some of the feedback has been that it's been one of the best professional experiences of the people in those groups. So, very interesting and exciting.

Michelle:

Yeah. Yeah. So that that sort of meta supervision model really is targeted for improving the skills of clinical supervisors themselves.

Tom:

It's true, but it's also restorative, right? It turns out that middle supervisors or the supervisors in many agencies get squished between leadership and their subordinates. In other words, sometimes they're told to do stuff that they don't really believe in. But this is your job. What are you going to do? And so it was, it was uniquely helpful for that group of people to have a place where they could go and be honest. I just want to take one step back, that in the literature on clinical supervision, it says one of the big problems is the tension between psychological safety and accountability, between the restorative function and the normative function. I'm going to hold you accountable, but I want you to be safe, feel safe. And so, one way to address that is, is to have the supervisor not be the administrative supervisor for the person. In other words, you're just the clinical supervisor, right? And what that could do is allow an element of psychological safety because it's not the person who's going to be disciplining you or doing your evaluation, it's a clinical focus.

Michelle:

Right, right now that makes perfect sense that you would have sort of a separate person be, you know, offer the kind of normative or the administrative aspect of the supervisor versus the clinical aspect which really requires good self-reflection and dialogue. Yeah, no, this is really, cool. I'm wondering, I know you've had years of experience doing this. Have you seen any limitations to these kinds of models like offering restorative supervision or like anything? Can you speak to that a little bit?

Tom:

Yeah. So there's interesting research about the dangers of clinical supervision and they seem to occur when there's a mismatch either with the theoretical approach like I don't believe in cognitive behavioral

therapy and yet I'm being forced to do it, or one of the keys of effective supervision is the relationship between the supervisee and the supervisor, and so if that relationship is not good, if it's sour for example, it can really harm the supervisee because of the imbalance of power, right. So, I think that is one limitation, the other limitation as it as it relates to burnout is that sometimes the job design, in other words, what the person's expected to do is so out of out of balance. In other words, it's too much. There's no amount of restorative supervision, that's going to change that and the person needs to leave that job or or, you know, advocate to have the job changed or whatever, but so you don't want to, you've got to be careful about blaming the victim; it's not always about self-care. Sometimes it's about your job sucks, right?

Michelle:

Right, or that you have, you know that you're so short staffed that you're taking on and you're taking on the job of three people because there is no one else doing the job.

Tom:

I've received that feedback actually now after COVID retention issues.

Michelle:

And yeah, it's really tough. Yeah. Well, thank you. I'm wondering, can you speak to any new and emerging areas of this topic of supervision and clinical supervision?

Tom:

Yeah. So, in preparation for this interview, I reread an article by Watkins, who reviews 25 years of reviews of clinical supervision, he reviews the reviews. And he makes the point that what we're seeing now is, is a much larger focus on evidence-based practices, right, and the supervision of evidence-based practices and in fact part of my work is now focused on intervention specific, clinical supervision. In other words, this supervision is just for this program. It's not a general thing, it's a real focus on the critical ingredients of this, you know, cognitive behavioral therapy for example. So that's by far the biggest change in the world of clinical supervision.

Michelle:

That's very cool. And the other area that I've seen is I've done some work with the Academy of Peer services in New York and they're talking about clinical supervision of peers and offering clinical supervision of peers from non-peers. And I think that's also kind of an emerging area that we keep our eye on as well. But you know again that kind of goes back to what you were just saying which is it should be really focused on the intervention itself and targeted to what the intervention outcomes are if you're going to do CBT or if you're going to have peer support, peer supporters or if you're going to have a skills training program you want to or employment or you know health and wellness whatever you're going to do it should really be targeted to the supervision should be targeted to that area. That's exciting.

Tom:

That's exactly right and that long winded definition I gave of clinical of applying objective and standardized methods is exactly what you're talking about. In other words, the days of going in and just winging it and doing whatever you want in a clinical setting are gone, right? Or they should be gone

because we now know that certain things work better than other things. And, that's true for whether you have a PhD, an MA or if you're a peer, it doesn't matter. There are things that can be really helpful and we should be using that. We owe it to the people we work with to use those objective and standardized methods when they work.

Michelle:

Well, Thomas it has been so fun to talk to you in this realm. I'm wondering how can people learn more about this topic? If someone wants to know more about clinical supervision, where could they turn?

Tom:

So, I'm currently the director of the Institute for Inpatient Psychiatric Rehabilitation at Rutgers University and we have a website with about 40 free trainings across a variety of topics, but some of those topics are clinical supervision. And you can check out our website and I think you're - how can they find their website meeting? We are on a podcast. You're going to send it out?

Michelle:

No, it's so I have a companion blog and in the show notes for today, I will have the link to that website where you can access those free trainings and we'll also have some additional resources. So the references that you're citing, like Proctor and some of the different articles we'll make sure that we have those listed. Anywhere else that you would recommend that people turn to learn more about clinical supervision?

Tom:

Yeah, it's, it's a good question. As I mentioned, one of the big problems in this area is that there's hundreds and hundreds of models and so it's overwhelming. If you were to type in clinical supervision and get a Google search, you'll get 5000 hits. So, one other is called competency-based supervision or fidelity supervision. So, the American Psychological Association is promoting a version of competency-based supervision because they've become aware that even if somebody hangs a shingle and says I do this type of treatment there's a chance that they're not doing that type of treatment because, you know, doing whatever they want. And so that would be another way; to look at your professional organization and see if they have a model.

Michelle:

Yeah.

Thank you, Tom. You know, that's very helpful. I know that many of us have to have a license. I have a license in social work so I could go to the social work board. Counselors and marriage and family therapists could go to their boards. And so, if you have that kind of certification or license, there may be additional information there as well. Great suggestion. Well, anything, any last words you'd like to offer about clinical supervision, Tom?

Tom:

You know, I have been excited about this area for a long time and the one thing we didn't talk about is, is clinical supervision used in implementation, right, the implementation of programming and that kind

of thing. So maybe if we have another opportunity to talk we can get more into that because there's a lot there.

Michelle:

Yeah. And that is I would say, would you agree that's a new and emerging area of clinical supervision? Is it using clinical supervision and partnering with implementation science.

And that's a great suggestion. Well, thank you, Tom. It's been so lovely to talk to you in this way. I really appreciate your time and I think, hopefully we've given our, our listeners some food for thought about clinical supervision.

Tom:

Great. Well, thanks for having me. Yeah, this was fun. Good talking to you.

Michelle:

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Resources for This Podcast:

Rutgers Institute for Inpatient Psychiatric Rehabilitation (2023). https://sites.rutgers.edu/shp-shpri/

SAMHSA. *TIP 52: Clinical Supervision and Professional Development of the Substance Abuse Counselor*. Retrieved from: https://store.samhsa.gov/product/TIP-52-Clinical-Supervision-and-Professional-Development-of-the-Substance-Abuse-Counselor/SMA14-4435

SAMHSA. *Quick Guide For Clinical Supervisors Based on TIP 52 Clinical Supervision and*

Professional Development of the Substance Abuse Counselor.

Retrieved from: https://store.samhsa.gov/sites/default/files/d7/priv/sma13-4770.pdf

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