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Clinical Supervision of Peer Navigators for HIV Prevention among Black Men who Have Sex with Men: Lessons Learned

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Abstract

Black men who have sex with men (MSM) are the group most heavily burdened by HIV/AIDS in the United States. Peer navigation has been utilized to improved access to health care and promote treatment adherence among those affected by HIV/AIDS. This article will explore lessons learned from clinical supervision for peer navigators in the context of the HIV Prevention Trials Network, 061 Study. A semi-structured questionnaire asked supervisors to identify challenges addressed during the supervisory process. Dilemmas addressed in clinical supervision included managing multiple roles with participant-navigator relationships, interpersonal boundaries and coping with emotions associated with exposure to participant challenges. Clinical supervisors fulfilled multiple roles in support to navigators; with focus on teaching, coaching, consultation and counseling.

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Introduction

Sexual contact between men is a major route of HIV transmission in the United States, accounting for 64% of estimated new infections in 2012.(1) For the period of 2006 – 2009, Black men represented an estimated 38.2% of infections in men who have sex with men (MSM),(2) reflecting HIV incidence and prevalence rates among Black MSM several times that of other racial groups.(3-6)

There is new hope for controlling the spread of HIV with the 2012 FDA approval of oral pre-exposure prophylaxis (PrEP) to prevent HIV infection.(7) However, PrEP can only fulfill this hope if groups most heavily impacted by HIV, notably Black MSM in the U.S., are engaged in the spectrum of prevention services.(8, 9) National and international guidelines call for PrEP to be used in combination with other prevention methods, including behavioral strategies to reduce the risk of HIV infection.(10-12) Innovative strategies to increase testing and other HIV services among Black MSM are urgently needed,(13-15) and the mobilization of culturally-specific resources within communities impacted by HIV may strengthen such strategies.(16-18) Recent reviews identify several efficacious behavioral interventions to reduce the risk of HIV infection in Black MSM.(19, 20) However, researchers caution that wide access to and uptake of these interventions is needed to impact the trajectory of the epidemic among Black MSM.(19, 21, 22).

The HIV Prevention Trials Network (HPTN) 061 Study (BROTHERS Study) assessed the feasibility and acceptability of a multi-component HIV prevention intervention among Black MSM in six US cities.(14) In addition to risk-reduction counseling and testing for HIV and other

sexually transmitted infections, the study offered 12 months of individualized peer navigation to increase access to health and other services related to HIV prevention.(5, 23)

Peer Navigation: An Extension of the Patient Navigation Model

A patient navigator works individually with patients to ensure timely access to services for a specific medical issue.(24) While navigation is focused on a specific health goal, it is also patient-centered and intended to resolve individual barriers to accessing needed healthcare.(25-28) The foundational patient navigation model, created in the 1990's to increase screening and follow-up care for breast cancer among women in Harlem, New York, involved building trusting relationships, framing medical practices within a system of values that are meaningful to the patient and addressing barriers to care.(24) This model was expanded to support assessment, screening, education and coordination of care for a wide range of medical conditions, especially for low-income and minority populations in urban and rural settings.(24, 26, 29-31). Navigators are not universally drawn directly from the patient population they serve. In some interventions health care professionals serve as navigators.(32) In other interventions peer navigators who share health conditions and other characteristics with their patients are considered essential to the meeting individual patient goals and building acceptance of health services in the specific communities(30)A peer-based patient navigation model has also been used to engage persons with HIV infection in care,(33, 34). Such navigation has focused on building on diverse mechanisms of peer support for health behavior,(35) including retention in care,(36) strengthening HIV knowledge and attitudes and reducing sexual risk behaviors,(35, 37).

Challenges to Peer Navigation

What makes peer navigation work is yet to be clearly understood. There has been a call for more attention to moderators and contextual factors that affect peer interventions and a closer examination of contextual factors that color peer interventions.(38-40) In addition, the potential for multiple-role relationships in peer-based interventions and research are ethical challenges that require close attention.(41) Additionally, lessons learned from peer-led HIV prevention studies underscore the importance of in-depth research training and routine support to the peers.(42) Clinical supervision is an important aspect of such support.(43)

Clinical Supervision

Clinical supervision is a contractual relationship, in which the supervisor guides the supervisee in skills training and reflection about work with clients.(44) This approach was originally developed to ensure that counseling professionals in-training maintain standards of the profession and are held accountable for the provision of ethical care.(45) More advanced mental health professionals utilize clinical supervision to ensure ongoing improvement of competence,(46) prevent burnout and to support provider well-being.(45) Clinical supervision has also focused on mentoring and professional development.(46)

The clinical approach to supervision is different from traditional operational models of supervision because there is less emphasis on evaluation, oversight and monitoring. Recent approaches to supervision involve a combination of systematic feedback and guided reflection about professional activities.(47) Clinical supervision is also driven by the needs of a particular supervisee. While there is an evaluative component, consultation is also provided in which weaknesses are viewed an opportunity for the supervisee to receive support to work more effectively professionally.(48)

Despite the emphasis on utilization of clinical supervision among mental health providers, there is limited data to support positive outcomes for client care and no studies identify the components that are most useful for providers. However, there is evidence to suggest that the quality of the supervisory relationship from the perspective of the supervisee has an impact on one's ability to cope with client work.(49) Clinical supervision has been found to be problematic when described as confrontational, critical, blaming and instructive.(50) Thus, exploration of the process of clinical supervision is critical.

Clinical Supervision for Peer Navigation

As peer-based initiatives for HIV prevention grow, clinical supervision will play a critical role in the personal and professional development of peers. However, published documentation and analysis of institutional and human resource support for peer navigation is lacking.(40, 51) Although conceptual models for clinical supervision are well-developed for traditional mental health settings, these models may not be directly applicable to peer navigation for HIV prevention. Furthermore, guidelines for the integration of clinical supervision in peer programs are greatly needed. These guidelines should reflect the anticipated challenges to peer navigation HIV prevention.(52)

This article will focus on clinical supervision for peer navigators in the context of the HPTN 061. Clinical dilemmas that emerged in clinical supervision of the peer navigators will be explored. Lessons learned during the process of clinical supervision will be described from the perspectives of the clinical supervisors and applied to an adapted theoretical approach to supervision. Recommendations for integration of clinical supervision into future peer navigation programs will be provided.

MethodsHPTN 061 was conducted from July 2009-October 2010, enrolling 1553 Black MSM in six US cities (Atlanta, Boston, Los Angeles, New York, San Francisco and Washington D.C.).(5, 23) Interventions included screening for HIV, testing for other sexually transmitted infections and risk reduction counseling. Peer navigation served as the behavioral intervention, which was utilized to engage men at risk for HIV in healthcare and/or social support services as needed. Peer navigators were expected to engage men at the point of initial study enrollment and to provide support for a period of 12 months. Research staff at each study site included two to three peer navigators and one clinical supervisor. Clinical supervision was a key aspect of the HPTN 061 protocol; with focus on support to peer navigators to address stress associated with their roles, maintain supportive relationships with participants and to ensure compliance to research ethics.

A semi-structured questionnaire was developed to collect data from clinical supervisors about each research site. The questionnaire addressed in clinical supervision and provided a description of the supervisory process (Appendix 2). Open-ended questions were identified by the primary author. The questionnaire asked supervisors to describe the educational background of peers supervised. Supervisors were asked to describe the training and preparation provided prior to beginning peer supervision. The questionnaire asked supervisors to identify challenges associated with interpersonal boundaries and confidentiality. Supervisors were also asked to describe how peers coped with the emotional challenges to their work and the type of assistance that was provided. Additionally, supervisors were asked to identify skills that were gained by peers during the course of supervision.

The questionnaire was administered to clinical supervisors across seven research sites. All supervisors responded to the questionnaire. Responses were analyzed to develop a conceptual

framework of common themes. Theme development was based on cross analysis of core ideas among the responses.

Results

Peer and Supervisor Characteristics

There were sixteen peer navigators across study sites, with education levels ranging from high school to a masters-level education in the social sciences. Clinical supervisors were licensed mental health clinicians, with backgrounds in clinical social work or clinical psychology. All clinical supervisors had prior experience in clinical work and research with HIV- infected and MSM populations. Clinical supervisors across sites were encouraged to develop individualized protocols for the supervision process, based on local navigator needs and study challenges. There was some support from research site investigators to provide feedback regarding the supervisory process and ongoing challenges to peer navigation. Clinical supervisors met quarterly via a telephone conference to discuss the challenges associated with the supervisory process.

Dilemmas in Clinical Supervision

While some dilemmas addressed in clinical supervision could have been easily predicted by prior research on peer navigation, other challenges that emerged during the course of HPTN 061 were unexpected and without straightforward solutions. When asked to describe the peer navigation experience during a clinical supervision session, a peer navigator reported “I am this study. I am just like the participants”. In this case, the navigator referred to similarity in ethnicity, socio-economic status, psychosocial stressors experience and sexual identity. This observation highlights how peer navigators may have identified with challenges faced by

research participants; a reoccurring theme that was experienced as both facilitator and barrier to the engagement process.

Multiple-Role Relationships. Peer navigators were expected to balance relationship building with maintenance of professional boundaries in work with participants. It is commonly understood that multiple-role boundary violations can be harmful to vulnerable persons in the context of a helping relationship.(53) Such conduct is also considered a violation of ethics in research. Thus, peer navigators were expected to avoid multiple-role relationships with participants, in which there would be a personal relationship outside of the research setting.

However, establishing professional boundaries was particularly challenging to peer navigators, who lived and worked in the same community as participants. At times, the social communities were so contained that it was difficult to avoid encounters outside of the study setting. The primary concern among navigators was the risk of violating confidentiality of HIV status during interaction with mutual friends. In other cases, participants assumed that encounters in social settings were indication of an opportunity to establish an unprofessional relationship. For example, there were several incidences reported in which participants openly expressed attraction to navigators and/or made sexual advances in social settings. This became particularly difficult for navigators who did not want participants to feel rejected, but wanted to avoid acknowledging the context of their relationship in public spaces. Most navigators considered personal relationships with participants to be harmful and requested that clinical supervision focus on techniques for establishing professional boundaries.

However, some navigators used clinical supervision to express the perception that it was appropriate to develop personal relationships with participants who are in their peer group. These

navigators expressed disagreement with study investigators regarding regulations that prohibited dating relationships with participants. For example, “if I was hired to use my experience in the MSM community to recruit and retain, why can’t I use those relationships to date the men and encourage them to participate in the study activities”. Such boundary violations existed in the form of excessive self-disclosure, with participants or the development of friendships.

The issue of self-disclosure proved to be an additional challenge to establishing professional boundaries. In many cases, participants asked navigators about their HIV status or sexual orientation. Navigators were unsure of how self-disclosure of sexual identity or HIV status would impact rapport with participants. Some navigators expected that disclosure would be useful for motivating participants to engage in treatment (i.e. “I am HIV positive and living well”). However, self-disclosure was more complicated if the navigator identified as a gay male and the participant openly expressed homophobic ideas despite having enrolled in the study as a self-identified MSM. At times, navigator refusal to respond to questions about their sexual identity or HIV status created tension between peers and participants.

Shared Experiences. Peer navigators were expected to establish an empathetic stance toward participants, while maintaining an objective and non-judgmental understanding of needs. This expectation is based on humanistic models of unconditional positive regard, which have been effective in helping people to change behavior in counseling relationships.(54)

In many cases, the navigators reported having faced similar experiences with the participants, which made it difficult for navigators to maintain a non-judgmental perception of participants. For example, a navigator with a history being a victim of f sexual abuse found it difficult to empathize with a participant who was a sex offender. As a former victim, the navigator found it

difficult to cope with hearing stories from the perspective of a sexual offender, who was a participant. Another navigator who was well connected to the Black MSM community acknowledged an overwhelming desire to help participants that reminded him of himself, with intense anger and disappointment when participants failed to meet educational goals. In many cases, navigators reported resilience when faced with psychosocial stressors similar to those experienced by participants and hoped that participants would respond to their sources of stress with a similar resilience. Such expectations impacted capacity to understand why it was difficult for participants to complete goals for further education, economic advancement or improved health-related behaviors.

Emotional Consequences. Emotional consequences associated with the peer navigation process also emerged as a dilemma in clinical supervision. Navigators reported feeling overwhelmed by study responsibilities, while managing familial and personal responsibilities within their respective communities. Several navigators reported being primary caretakers for partners and families at home. When this was the case, navigators reported feeling overwhelmed by care for others, which made it particularly difficult for them to engage in self-care.

As participants presented with multiple psychosocial stressors, participation in navigation activities tended to be inconsistent and unpredictable. At times, navigators expressed frustration with unpredictability; which elicited feelings of helplessness and disempowerment when unable to meet goals with participants. For example, frustrations were high when participants failed to follow through with agreed upon tasks, were incarcerated or presented with changes in mental status. Navigators also reported frustration when participants focused on more immediate needs vs. long-term solutions. This was further complicated by limited social services for unmet needs; such as housing instability, food insecurity, difficulty navigating the criminal justice system or

undocumented immigration status. Some participants were victims of relationship violence and those suffering from substance abuse. In many cases, social service providers demonstrated limited cultural competence for work with Black MSM, which represented an additional point of frustration.

Peer navigators presented with mental health conditions that impacted capacity to cope with multiple roles. Personal experiences of depression and mood disturbance colored their experiences while engaging with study participants. For example, navigators with a history of major depression and substance abuse reported that difficulty sleeping made it difficult for them to maintain motivation in the research setting. There were navigator absences due to psychiatric hospitalization and outpatient mental health appointments. Navigators who lived with depression also reported that participants reminded them of themselves, which made it difficult for them to avoid self-focus during sessions with participants. For example, navigators also reported that hearing participant descriptions of mental illness was stressful; particularly when navigators were reminded of their own struggles with depression or anxiety. Navigators were also overwhelmed by emotional needs of participants who received positive HIV test results, lost social support or were separated from primary partners during the course of the study.

Feeling Ineffective. Feelings of burn-out and ineffectiveness emerged as a common dilemma in clinical supervision. For participants that tested positive for HIV, peer navigators were responsible for goal setting with participants who faced multiple barriers to engagement in HIV treatment. However, there was limited uniformity of client-level prevention goals. For example, for some participants the goal was engagement in substance abuse treatment, while housing or condom negotiation skills were goals for other participants.

Navigators also reported uncertainty about how to measure participant success. Lack of uniform indicators made it difficult for navigators to measure their performance independent of client outcomes. This uncertainty led some navigators to report feeling ineffective in goal setting with participants. For example, a navigator described his role as "someone they can talk to and have support while they are still on the streets, which makes me an enabler." Navigators who felt more effective when goal setting was conceptualized in the a public health and harm reduction contexts. Effective navigators tended to resist setting their own definitions for success and allowing participants to define success.

Learning as We Go: The Approach to Clinical Supervision. Clinical supervisors fulfilled multiple roles in support to navigators; with focus on teaching, coaching, consultation and counseling. All supervisory activities were embedded in the foundation of a strong working relationship. For navigators who were new to the concept of clinical supervision, the initial expectation was that supervision would consist of checks and balances, in which their performance would be stringently evaluated. The perception of the clinical supervisor as a disciplinarian was found to disrupt the engagement process and led navigators to feel restricted during supervisory sessions. In order to establish a healthy supervisory relationship, it was made clear to peer navigators that study coordinators on-site were tasked with performance evaluation, while clinical supervision was conceptualized as a supportive and confidential relationship. Navigators were encouraged to share successes, as well as challenges and mistakes during clinical supervision sessions.

Navigators expressed a need for in-service training to support ability to translate life experience into counseling skills to use with participants. There was concern that conversations with participants were preachy or unauthentic. Peers indicated low self-efficacy for work with

mental health issues related to Black MSM. This included mood disorders, substance abuse and cognitive problems. Based on the existence of these conditions, navigators sought support with identifying the appropriate level of mental health care for participants. Navigators also expressed a desire to learn counseling techniques, such as motivational interviewing for use with participants that were resistant to engaging in care or changing risky sexual behaviors.

As teachers, clinical supervisors provided assistance with skill building for core capacities required for successful and culturally-appropriate peer navigation. Skill building was provided in the form of didactic training and group supervision. Skills taught included motivational interviewing techniques, recognition of mental health issues among Black MSM, suicide risk assessment, safety in relationship violence and knowledge of psychosocial challenges faced by PLWHA. Didactic training was provided to help navigators set goals with participants, create action plans and monitor progress. Skill building also involved recognition of limits in skills to ensure that peer navigation activities were not beyond the scope of the study (i.e. providing counseling for mental health issues). Didactic training also explored barriers to engagement in medical care for HIV positive MSM. The use of labels and derogatory terms about mental illness, substance abuse and LGTBQ communities were discouraged during group supervision.

Group supervision was also used to guide navigators in establishment of professional boundaries with participants. Legal and ethical implications for relationships with research participants were reviewed. Navigators were encouraged to differentiate between a navigator, counselor and friend. The typical exchange that occurs among friends was highlighted, with emphasis on how friendship can be harmful to participants in the context of research. Navigators were encouraged to recognize how a navigation relationship should encourage eventual independence for participants, with effective use of resources by the end of participation in the

study. Group supervision was utilized to obtain group consensus on policies for use of personal cell phones and social media to contact participants. The group supervision process was also used to explore potential harm caused by personal relationships with participants. Navigators were encouraged to provide case presentations for group supervision sessions, in which individualized dilemmas were explored.

As consultants, clinical supervisors assisted with identification of community resources, crisis intervention and assessment of participant needs. Case histories were reviewed in detail, with guidance on follow-up questions to ask participants to determine current needs. Assistance was provided to assess barriers to engagement in HIV treatment. Clinical supervisor familiarity with social services in respective regions allowed for support with referrals and coordination of care to ensure services are accessible to participants. Navigators were also provided with assistance in advocating for services, while avoiding alienation of participants from critical support systems.

As a coach, individual supervision was utilized to encourage navigators to self-reflect and build awareness regarding relationships with participants. Navigator self-disclosure in individual supervision was instrumental in helping to set professional boundaries. Navigators were encouraged to explore how their personal history impacts professional relationships; with specific focus on how boundary violations have been harmful to them. They were encouraged to explore if a desire to self-disclose to a participant is beneficial for participants. For example, a navigator needed to share his own history of sexual abuse to work through challenges associated with care for sex offender. Additionally, navigators were encouraged to identify how their behaviors send messages to participants regarding expectations for the navigation relationship. Navigators were encouraged to acknowledge participants' feelings and respond professionally,

while establishing clear boundaries and allow participants to maintain some sense of dignity. In preparation for home visits, the purpose of the visit and risks for harm were reviewed.

In the role of counselor, clinical supervisors provided support for navigators in coping with the nature of the work, developing self-awareness regarding capacity and providing assistance for self-care. Individual supervision focused on how to cope with lack of predictability among participants, with particular frustration when working with patients with complex needs (i.e. substance abuse). Navigators were encouraged to think about the role of the navigator position for their broader life goals (establishing meaning for the work). Mental health issues that impacted engagement in navigation were explored. However, this became increasingly difficult as the line between clinical supervisor and therapeutic provider was blurred. In this case, challenges were discussed with administrative and operational managers when systems changes could be made to reduce stress (i.e. negotiating time off to attend mental health appointments). A list of therapists in the area was maintained and peer navigators were referred for treatment as needed.

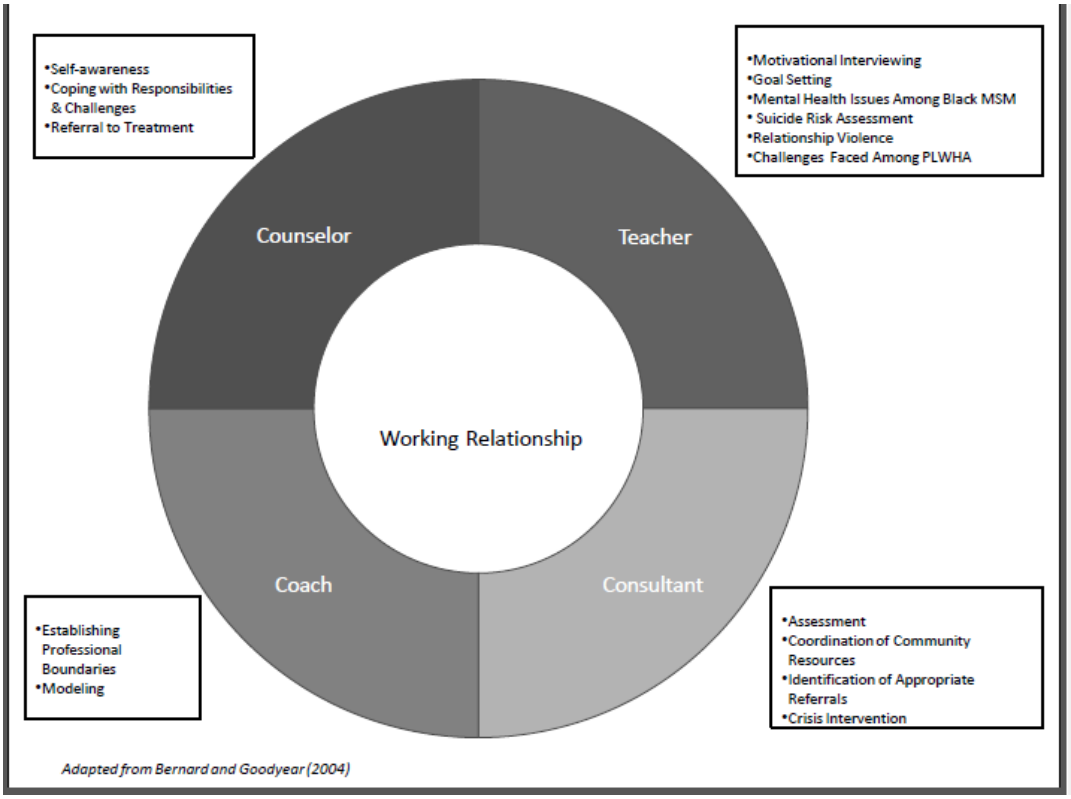
Lessons Learned

Clinical supervision was a critical component of the 061 protocol. T he supervisory experiences allowed navigators to feel competent in handling the demands of their work, while balancing personal issues. Navigators demonstrated improved skills in presentation, organization and professionalism. Clinical supervisors also found that supervision allowed navigators to fulfill altruistic goals of making a contribution to their own community, while maintaining ethical boundaries. Navigators gained knowledge of helping processes such as motivational interviewing and developing realistic expectations of the change process. Structure

provided by clinical supervision allowed peer navigators exposure to the practice of research in a community setting. Supervision also supported established partnerships between researchers and community-based organizations that meet the needs of Black MSM. The expected outcome is that navigators will continue their commitment to work in HIV prevention among Black MSM.

Clinical supervision provided for the HPTN 061 protocol was consistent with current models of clinical supervision. Bernard's Discrimination Model(48) indicates that clinical supervisors play dual roles in interactions with supervisees; such as the role of a teacher, a counselor or a consultant. The teacher provides instruction, modeling and direct feedback. Counselors encourage self-reflection and consultants challenge surpasses to think critically about actions. In the current study, consultation was provided for the process of assessment, coordination of community resources and crisis intervention. Teaching involved building competency in methods of counseling and issues affecting Black MSM. Counseling assisted navigators in coping emotionally with the challenges of navigation.

However, Figure 1 is a proposed model of clinical supervision for peer navigation, which should be explored further in future HIV prevention research. While core components of the model were demonstrated by supervision for the HPTN 061 STUDY, this experience indicated that such models should be modified to meet the needs of Black MSM who are vulnerable to HIV acquisition. For example, an additional "coaching" component is a modification of existing models, in which supervisors provided emotional support to build navigator confidence when establishing professional boundaries.



In retrospect, assumptions about the benefits of clinical supervision of peer navigators are limited by the absence of objective guidelines and indicators to measure outcome. The following lessons learned from the clinical supervision experience should be applied to future studies that seek to clearly define indicators of successful implementation.

Clinical supervisors in HIV prevention for MSM require competency for work with this vulnerable population. Although most clinical supervisors had extensive experience in populations affected by HIV/AIDS, several acknowledged limited experience in work with Black MSM and "learned along the way". In general, studies indicate that less than half of clinical supervisors have had a sexual minority client themselves or report competence in work with gay or bisexual clients.(55) It is recommended that core competencies are identified for future study protocols to ensure that clinical supervision is appropriate.

Clinical supervisors require training and consultation to prepare for the nature of the work. A training-the-trainer approach to preparation would allow more consistency in clinical supervision methods, which would allow for operationalization of methods and measurable outcome indicators.

Traditional clinical supervision models do not fit the work. Traditional models of clinical supervision for counselors can be applied to models of supervision for peer navigation. However, these models should be adapted to meet the needs specific to peer work and training. Training should be individualized and flexible, while integrating evidence based practices for behavioral change.

Peers know best. Objective outcome indicators should involve feedback from peer navigators to determine aspects of clinical supervision that are most helpful. Pre- and post-supervision measures should focus on changes in self-efficacy, knowledge of core skills and coping for peer navigators.

Set clear expectations. As peer navigators are embedded in the communities served by HIV prevention research, models of clinical supervision should focus on training on research ethics to ensure the confidentiality of participants. It is also recommended that clear protocols regarding duel relationships are established across study sites. The lessons learned also underscore the importance of training and development of core competencies for peer navigators. These competencies should be more clearly identified in follow-up studies.

Conclusion

The HPTN 061 Study sought to increase access to preventions services through a community based intervention. The clinical supervision process speaks to the power of relationship building and calls one to recognize the strengths that exist within communities commonly thought to be vulnerable populations within the world of research. Although critical aspects of relationships can be difficult to operationalize, it is important to utilize clinical supervision to maintain professional boundaries, support focus on protocol goals and to guide peers who are coping with stress. It is recommended that future studies continue to evaluate the process by which clinical supervision builds, maintains and improves competence for peer navigators.

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