Staff Coaching

In their review of operations of ministries of health for the World Health Organization, Unger, Macq, Bredo, & Boelaert (2000) stated that systems reform (such as implementation) depends upon “training of field staff, on-the-spot expert coaching, and promotion of a new organizational structure.” Spouse (2001) noted that formal knowledge (“episteme”) needs to be supplemented with craft knowledge (“phronesis”) so practitioners can learn to see the relevance of what they have learned to the situations at hand. Coaching needs to be work based, opportunistic, readily available, and reflective (e.g., debriefing discussions). Spouse (2001) described four main roles of a coach:

• Supervision
• Teaching while engaged in practice activities
• Assessment and feedback
• Provision of emotional support

After a few decades of research on training teachers, Joyce & Showers (2002) began to think of training and coaching as one continuous set of operations designed to produce actual changes in the classroom behavior of teachers. One without the other is insufficient. Behavior change is difficult for most people (for example, some people hire personal coaches to help them exercise more or change their eating behavior or stop smoking). With newly learned behavior there are several simultaneous problems that must be faced:

Newly-learned behavior is crude compared to performance by a master practitioner. Training usually is designed to introduce the learner to the essential elements of a new set of skills. For example, there are nine components of a “teaching interaction” (Phillips et al., 1974) and these components are taught to and rehearsed by practitioners in a preservice training workshop until they reach mastery criteria (Kirigin et al., 1975). However, there are uncounted nuances of when and how to use the components in various combinations in proactive teaching, reactive teaching, conceptual teaching, effective praise, proactive prompting, and so on given the treatment plans for and immediate behavior of particular children, families, or adults. This functional and adaptable set of skills is developed in practice with the help of a consultant/coach who shares craft knowledge as he or she observes, describes, and tutors the practitioner (Smart et al., 1979). With experience and effective coaching, a practitioner develops a personal style that is comfortable for the practitioner while still incorporating the core intervention components of the evidence-based practice.

Newly-learned behavior is fragile and needs to be supported in the face of reactions from consumers and others in the service setting. Behavior change directly impacts others in the environment. For example, when a teacher makes a significant change in his or her behavior in the classroom, 20 to 30 children and their families react to that change. When Nurse-Family Partners make a significant change in their behavior, 25 families and a variety of stakeholders react to that change. Joyce & Showers (2002) recommend having discussions with students and their parents to prepare them for the new ways of teaching that are about to be implemented. Although we could find no data on the topic, this probably is a good idea.

When practitioners change their behavior the reactions from consumers and stakeholders initially may not be positive, effectively punishing the practitioner for making a change. For fragile, new behavior the negative reaction may be enough to discourage the practitioner from persisting. One role of a coach is to prepare the practitioner for potential reactions and support the practitioner through the early stages of implementation until the new behavior is more skillfully embedded in the clinical environment (Joyce & Showers, 2002). Bierman et al., (2002) describe this as a counter-control function of a coach. That is, to help the practitioner engage in the new behavior even though they are not yet proficient and despite the negative reactions to using the new behavior (sometimes poorly).

Newly-learned behavior is incomplete and will need to be shaped to be most functional in a service setting. When designing workshop training experiences, there is only so much that can be accomplished effectively within the time available. Preservice workshop training can be used to develop entry-level knowledge and skills. Then, coaching can help practitioners put the segmented basic knowledge and skills into the whole clinical context. Coaches can help practitioners see how their personal beliefs and attitudes can be integrated with the skills, knowledge, philosophy, values,
and principles of the program as well as other aspects of the clinical context (Smart et al., 1979).

In addition to helping to establish new behavior in the clinical environment, emotional and personal support is another role for a coach (Spouse, 2001). In human services, practitioners are the intervention. Evidence-based practices and programs inform when and how they interact with consumers and stakeholders but it is the person (the practitioner) who delivers the intervention through his or her words and actions. In the transactional interplay between practitioner and consumer, each affects the other in complex ways (for example, Fixsen & Blase, 1993) pointed out that each dependent variable is also an independent variable in a treatment environment; in this case, the consumer is “treating” the practitioner as well as being treated by the practitioner). In clinical work, practitioners often come face to face with their own issues and sensitivities as they work with consumers and stakeholders. A coach can help support a practitioner during times of stress or discomfort (Spouse, 2001). However, an overemphasis on emotional support may be counterproductive (Schoenwald et al., 2004).

**Factors that Impact Coaching**

The amount of time devoted to coaching often is not reported, but seems to vary widely. Diamond et al., (2002) provided 2 hours of coaching per week for therapists using drug treatment models. Supervision in Australian mental health settings typically occurred monthly for about 2 hours (Kavanagh et al., 2003). Coaching of teachers in special education classrooms occurred twice a week for an hour or so (Marks & Gersten, 1998). In Multisystemic Therapy for children and their families in the delinquency system, group coaching (primarily based on practitioner reports) occurs once or twice a week for about 90 minutes for each group of 3 to 4 therapists and the coaches themselves receive individual consultation once a week for about an hour (Schoenwald et al., 2000). For the Teaching-Family Model, consultation occurs weekly (more often for new practitioners, less often for certified practitioners) with several hours devoted to on-site direct observation of the practitioner while he or she is providing direct services, feedback after the observation, and skill development in keeping with a professional development plan for each practitioner coupled with more frequent telephone consultation and coaching (Smart et al., 1979).

Denton, Vaughn, & Fletcher (2003) reviewed attempts to implement reading programs for students with reading and learning disabilities. While noting that effective coaching was the most critical factor in successful implementation, they cautioned that effective coaching depended upon the availability of coaches who are expert in the content, techniques, and rationales of the program. It is said that good mentors are encouraging, supportive, committed, sensitive, flexible, respectful, enthusiastic, diplomatic, patient, and willing to share information, credit, and recognition (McCormick & Brennan, 2001). In their survey in Kentucky, McCormick & Brennan (2001) found that coaching was impacted by time allotted to do the work, reluctance to seek information from the mentor, role confusion due to the dual role of supervisor and coach, feelings of inadequacy on the part of the mentors, poor match between the coach and practitioner, and lack of availability of coaches in rural areas.

Joyce & Showers (2002) pointed out that leadership, organizational culture, labor-relations, scheduling, interpersonal relationships, and engagement in participatory planning all impact the availability and effectiveness of coaching. In addition, coaches need to be trained and coached to provide specialized coaching functions for teachers, and that requires more organizational leadership and more resources (Marks & Gersten, 1998). Kavanagh et al., (2003) found that high caseloads and inadequately trained supervisors were major impediments to adequate supervision. Bond et al. (2001) noted that coaching sometimes suffered due to lack of information and skills, lack of time, inadequate staff resources, and a focus on paperwork instead of outcomes.

Showers & Joyce (1996) described the evolution of coaching and recommended that coaching relationships should start during training so parts of the training experience (practice new skills, receive feedback, re-practice) can facilitate the development of the coaching relationship (a strategy also recommended by Smart et al., 1979).

**Experimental Research on Coaching**

The value of on-the-job coaching repeatedly appeared in the overall implementation evaluation literature. In Chapter 4 the results of the Joyce & Showers meta-analysis were presented showing that implementation in educational settings occurred primarily when training was combined with coaching in the classroom. A similar result was obtained in a mental health setting.
The use of consultants (for feedback, supervision, and clinical settings without additional help from a coach. Staff training has little impact on staff performance in care for the delivery of interventions. They found that directly addressed the issue of the capacity of direct and acquired brain injury and found 42 papers that reviewed “best practice” for intervention for challenging behavior in persons with intellectual disability. They found significantly greater improvement on several practice dimensions. Joyce & Showers (2002) also recommended the use of peer coaches although they did not have experimental data to support their conclusion.

While these studies point to the importance of coaching in any attempt to implement a practice or program, we did not find any experimental analyses of the functional components of coaching. Thus, at this point, we know that coaching is important but we do not know (experimentally) what a coach should do or say with a practitioner to be most effective.

**Other Evidence for Coaching**

Some non-experimental data do provide some clues to what may be the functional components of coaching. Kavanagh et al. (2003) conducted a telephone survey of nearly 300 mental health practitioners in Australia. They found that constructive feedback and praise were common components of supervision but there was very little direct observation of clinical practice by the supervisors (median = 0; also see Walker, Koroloff, & Schutte (2002) who found a similar result for persons supervising treatment planning teams). Four factors accounted for 62% of the variance of the perceived impact of supervision on practice: supervisor taught new skills, strengthened confidence, offered safety in sessions, and devoted time to discipline-specific skills (as opposed to generic skills).

Ager & O’May (2001) conducted a literature review of “best practice” for intervention for challenging behavior in persons with intellectual disability and acquired brain injury and found 42 papers that directly addressed the issue of the capacity of direct care for the delivery of interventions. They found that staff training has little impact on staff performance in clinical settings without additional help from a coach. The use of consultants (for feedback, supervision, and support) was found to be necessary for changes in staff performance. Schoenwald et al., (2004) evaluated a Consultant Adherence Measure (CAM) developed to measure clinical consultation in the multisystemic treatment (MST) program. They found that items related to perceived consultant competence (knowledgeable, skilled in MST, able to teach MST) were related to higher Therapist Adherence Measures (TAMS) and better youth outcomes. Items related to MST procedures (use of MST-specific assessment, intervention, and analytic techniques) were not related to TAMS scores for therapists and had mixed results for youth outcomes. Although the results are not conclusive, this study represents an important step forward in finding ways to measure the interaction of core implementation components, core intervention components, and outcomes for consumers.

Looking at data from the first 17 years of development and implementation of the Teaching-Family Model, Fixsen & Blase (1993) analyzed the success of implementation attempts before and after systematic consultation and supports were provided to Teaching-Parents in Teaching-Family group homes. Only 24% of the attempted group home implementations lasted 6 years or more before and 84% were sustained for 6 years or more after systematic consultation and supports were provided.

Harchik, Sherman, Sheldon, & Strouse (1992) examined the effects of consultation on staff in a community group home for adults with severe mental retardation. They found that consultation had a positive impact on staff members’ appropriate use of the token reinforcement system, constructive teaching interactions, and engagement and participation in activities. Kelly et al., (2000) compared technical assistance manuals on how to implement HIV prevention interventions with manuals plus staff training plus consultation on how to conduct implementations of the program. The addition of the consultation component produced a significant improvement in the number of implementations of the prevention program (about 60% adoption rate compared to about 35% for the manuals-only group).

**References**

For references included in this document, please see “Implementation Research: A Synthesis of the Literature” monograph located on the NIRN web site at http://nirn.fmhi.usf.edu