NAADAC - How to Structure Clinical Supervision

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>> Hello everyone, and welcome to Part 5 of 6 for this specialty online training series on clinical supervision the addiction profession. Today's topic is how to structure clinical supervision, presented

by Samson Teklemariam and Cynthia Moreno Tuohy. It's great that you could join us for this training. My name is Tom Durham and I am a proud member of NAADAC and the former director of training at NAADAC. I'll be introducing this specialty online training. This online training is produced by NAADAC, the association for addiction professionals. Closed captioning is provided by CaptionAccess. Please check your most recent confirmation e-mail or our Q and A and chatbox for the link to use the closed captioning. If you have not done so already, make sure to visit NAADAC's online bookstore and get your most up-to-date copy (inaudible). Since the foundational work of the late David Powell, there really has been a gap on clinical supervision (inaudible) bringing together a collection of research, theory, and best practices for the clinical supervisor and aspiring supervisor.

You can find more information about this specialty online training series by bookmarking the web address that you see at the top of the screen. Every NAADAC online training series has its own web page that houses everything you need to know about that particular series. If you missed a previous live training from the series, you can find it on this web page and take the course at your own pace. You must be registered for any NAADAC training, live or recorded, in order to receive a certificate. GoToWebinar also provides us with a time tracking tool that verifies that those who pass the CE quiz not only were registered, but they also watched the entire training.

Reviewing the slides alone does not qualify one to receive a certificate. This training is approved for one continuing education hour and our website contains a full list of accepting boards and organizations. As you know, you have already paid the registration fee of $25, and this includes your access to the CE quiz, receiving the CE certificate upon successful completion of your quiz, and eligibility to apply for the certificate of achievement for clinical supervision in the addiction profession. Please remember the following steps.

Watch the entire training, pass the online quiz, which is posted at the website you see on this slide, maintain records of your invoice receipt of payment for registration, and any CE you have received from this series. These records will be required to apply for the certificate of achievement for clinical supervision in the addiction profession. And finally, e-mail ce@naadac.org if you experience any difficulty with this process. Also, please note, you will have to listen closely for this entire training to capture the password for access to the CE quiz. It will be one word all lower case but will be revealed in three separate moments throughout the webinar.

If you happen to miss one part of the password, no worries, you will have access to this recording and be able to capture it by viewing the archived recording. We are using GoToWebinar for this slide event. Here are some important instructions. You have entered into what's called listen-only mode. That means your mic is automatically muted. If you havetrouble hearing the presenter for any reason, I recommend switching to a telephone line as some Internet connections are not strong enough to handle webinars. If you have any questions for the presenters, just type them into the questions box of the GoToWebinar panel. It looks like the one on my slide here. We'll gather the questions and any questions can be posed to the presenters during the live QA at the end of the webinar. Any questions we do not get to will be collected directly from presenters and posted -- and they will be posted on our website.

So let me tell you about today's very skilled presenters. Samson Teklemariam is the director of training and professional development for NAADAC. As a licensed professional counselor, Samson has worked in a variety of treatment settings, including school-based, inpatient, adolescent academies, outpatient, prison-based, family practice, and family counseling settings. As a certified professional training manager, Samson worked for Phoenix House Foundation (inaudible). In this role he (inaudible)

and led the successful implementation of a clinical supervision model in all programs using some of the tools he will discuss today.

Cynthia Moreno Tuohy is the executive director of NAADAC, the association of addiction professionals. She previously served as the executive director of the (inaudible). Prior to that, she was the program director for Volunteers of America, Western Washington, serving as the administrator of alcohol drug centers, providing a broad range of services and a trainer in domestic violence, anger management, and conflict resolution. She has written on a variety of professional issues, including addiction evaluation, counseling methods, co-occurring disorders, treatment, and recovery. She has served as president of NAADAC, (inaudible), international chair, treasurer, and legislative chair for NAADAC. NAADAC is delighted to provide this webinar presented by these two wonderful professionals. So, Samson and Cynthia, if you are ready, I will hand this over to you.

>> Thank you so much, Tom.

>> Thank you, Tom.

>> And during this training, we hope to provide a practical understanding of what occurs during clinical supervision method (inaudible). There are successful methods and unsuccessful methods. And I think we can all agree that a lot can change from what we've learned in the classroom to actual practice. Before we talk about learning objectives and get into this material, Cynthia and I just want to share a personal note of what this topic means to us. I can tell you as both a person in recovery and as an educator and counselor, there's no way that I would be in this field for more than 12 minutes without the protection and the oversight of good supervisors, supervisors that have attention to detail, that have passion about what they do, that even though they're just as burdened as we are and they're just as overwhelmed, they still took that time to invest. And we all have different ways, different styles of how to do it, but my situation was unique in that I had three supervisors in my first year as a clinician. That continued during my first three years, and I had three different settings that I was working in at the same time. And, you know, I got three different styles. So those styles sort of mixed within me into my paradigm and how I practice, how I think, act, and believe, and I know we've done surveys in this series, and we've identified that some of you are aspiring supervisors, meaning you may currently be under someone else's supervision as you practice, and some of you are current clinical supervisors. I'm going to turn this over to Cynthia and share her reason why this is important to her.

>> Thank you, Samson. You know, this topic became important to me as I started out after college, starting out as an intern and a college intern at my first place of practice and getting that field experience and really understanding the basic nature of supervision and why supervision is so important. I had a supervisor who was master level, and then when I started in the addiction world, there were very few people with master level credentials or that kind of experience to share. And this particular -- I'll never forget him, Don Linky, this particular supervisor, was really concentrating not only on my skills as a counselor but that professional development. How do we help this person get to the next stage of their own development? And I was pretty bashful. Hard to believe. I was pretty bashful and I was very quiet, and he said, well, I want you to go to teach a class at this school district. They want a community education class. And I said, Please don't make me do that. I don't want to do that. I hate talking in front of people.

And he said, No, I think this is part of your professional development, and you need to do it. And I just begged him, please, don't make me do it. Well, he said, look, you are educated in this field, you understand the information, you have a passion for it, so they're going to feel that. And by the way, Cyn, these are third graders. You can't make too many mistakes. It was like, oh, okay, I guess I'd better get with it. And I did. And what happened from there is I began learning how to speak to other

people about the disease. And now today, I still get nervous, I still get those butterflies in my stomach, that little girl inside still sometimes says, well, if it's good enough. But you know what? I always remember what he said and always remember my first supervisor and clinical supervisor, is that he said I'm here to help you to develop, I'm your coach, I'm your mentor. Allow me to do that. Trust what I'm going to say. Do the behavior before you believe the behavior, and it's going to work out just perfectly. And, in fact, that's true. That's my story, Samson.

>> Thank you so much, Cynthia. That's awesome. And so, everyone, we're going to go into the learning objectives. I'll talk a little bit about the first two. I'll let Cynthia explain what her plan is for the last two, 3 and 4. So our first objective is to understand why it's vital to maintain consistency and structure in clinical supervision. In other words, we're going to really talk about the true value of effective clinical supervision, ECS. You'll learn a little bit later about that. And then we'll define structure versus unstructured supervision. And for the third and fourth objectives, Cynthia.

>> Thank you, Samson. So we're also going to explore how to use the individualized development plan. Some of you may not be familiar with that, so this will be an opportunity to learn about that. Some of you use it already. So we'll talk about the plan and why it's important to track progress through supervision. And then we'll analyze effective tools to maintain that structure in clinical supervision, not only so that you know where you've been, but if you're working on certification or recertification, you also can use that tool to help you and assist you in that as well.

>> And to truly understand why maintaining consistency and structure in clinical supervision is so critical, we really need to clarify the primary objectives of supervision. And in no way is this meant to be an exhaustive list, but it gives us a foundation for understanding our goals as partners and leaders in trying to develop a competent clinician with the ability to carry out effective work with their clients. Many of these goals overlap, but overall, as a supervisor, you're looking to train your clinicians who are able to assume responsibility for their part in the unfolding of the session and maybe the treatment experience as a whole.

You're looking to foster the supervisee's ability to be curious about the client and empathize with the client's current state of mind. When it comes to discord or a clinical impasse, as a supervisor, we coach our counselors to build self-awareness of both intentional and unintentional participation in that conflict. So, one of the other objectives of supervision is also to enhance the supervisee's receptivity to feedback, not only from you as his or her supervisor, but, you know, sometimes from the clients as well. You know, sometimes in supervision, this is accomplished very simply by asking your supervisee something like, Share more about what your thought process was when you said that to the client. Or, what do you think the client was thinking when they heard you say that? You know, facilitating that feedback culture almost. You know, essentially, it's almost better to release a professional helper into the addiction treatment profession, who's pliable, moldable, and capable of containing the learning process and growing professional.

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>> However, this supervisor is accessible during regular business hours, and for the most part, you may be able to run into their office, call, text anytime to seek immediate supervision and guidance. Now, I know these were two extremes. Sometimes that may not fit into reality, but here is our first polling question. What do you think? Let's say you only have one choice and you've got to make your choice now. Two different supervisors. Which would you prefer? The poll is going to launch on your screen now and you'll see two options. The first is a

schedule-only supervisor, and the second option, an open door policy supervisor. We'll give you about ten more seconds to respond. And if you can multitask with us for a minute, if you remember Tom's instructions earlier, as a reminder, in order to access the CE quiz, please view the entire training and listen for the password. The first part of your password is [redacted] (for the hearing impaired please email ce@naadac.org for CE Quiz password assistance).

Again, [redacted] And, of course, if you have any questions, make sure to send it to us in the questions box and we'll answer them in the order in which they are received. It looks like almost everyone has answered the poll. I'm going to go ahead and close the poll and share the results. And I'll let both Cynthia and myself speak to the results. Cynthia, I don't know if you have anything to say first. So it looks like our results show that the large majority prefer the open door policy supervisor, the one who's always accessible, over the schedule-only supervisor. What do you think, Cynthia?

>> Well, what that tells me is that people want to be able to have access when they feel like there's a crisis or there's a concern. And so they want to be able to feel that way that I'm not going to be left out there hanging. And I think that's pretty typical. So in a way, that doesn't surprise me. Although I would think we would have a more 50-50 here, because at the other end of the spectrum is that knowing that you're going to have an appointment. What do you think, Samson?

>> Yeah, so it's so funny because an open-door policy supervisor, I mean, who wouldn't want that? You know? It's kind of like you're on that million dollar show and you have an unlimited amount of ask for help. That's nice. Sounds pretty comfortable, especially in a field that's really tough to navigate. And, you know, with the addiction disease, it doesn't fit in a structured model. Anything can happen anytime, anywhere, especially if you're in an inpatient or residential setting or full day program where patients are there all the time, not just for their session. So, yeah, an open-door policy supervisor, wow, who wouldn't want that? Well, first, thanks for participating in that poll. So I know it's extreme to have to choose one over the other because it's in life, it's not always that simple. Right? Sometimes we do experience those random drive-by supervision moments that were unplanned, unstructured, and somehow illuminated an intuitive revelation. We have all experienced those in our life and in our career, right? So let's say it now.

This training is not to dismiss those moments but rather to leverage a structured process where you can lay a foundation in your professional relationship with your supervisee so that moments like those can occur. So we really can spend a full day training on why structure in clinical supervision is supervision vital. But here's some of the most universal reasons regardless of what clinical supervision model you use or what type of program you work in, structure and consistency in clinical supervision provides a sense of predictability, meaning as a supervisee, I know clearly what's expected of me and what I can expect from my supervisor. Thus, what I can expect in my supervisory relationship and the overall development as a counselor. I also can predict this safe space for professional development and growth. Second, there's consistency and then there's consistency that also in a way models responsibility. You know, in that parallel development process of the supervisory alliance to the therapeutic alliance. If you haven't learned this yet in our series, parallel process

occurs a lot in the supervisory relationship. and that parallel process is really what happens when what is happening in the supervisor relationship mimics what happens in the clinical or treatment relationship. For our open-door fans, is that what we want for our clients? We want them to see us with an open-door policy? Maybe. But what are the pros and cons of that. Hm. So let's dig deeper. Remember that the perception the supervisees have of the supervisor Lyons impacts the overall perception of care. For example if a supervisor has difficulty setting clear boundaries and maintaining them with their supervisees it is likely that the supervisee as a

professional counselor will have that same difficulty having boundaries with their clients. Lastly the most important factor in the case for supervision and clinical supervision is the structure promotes overall autonomy.

From day one we have to ask ourselves as leaders in the profession do I want my supervisees to learn that they need me or do I want them to learn that they need the concept of continual development in consultation? A well- rounded counselor does not want their patients to just value them as a counselor. I am your champion, I'm your counselor, I will solve all your problems.

But rather value of the overall treatment experience and recovery process regardless of who the professional helper is. That promotes autonomy. And we promote autonomy because we know this disease requires you to own your journey to the fullest. And that transcends the supervisor relationship. Every decision you make and promote an unhealthy and unrealistic dependence, as if you are really always available, which is really not the reality for any of us. Or it can promote a balanced view of autonomy that says, I am not alone in this field. I do have support and do have help in this field.

But most of the time I have to make a decision on my own and I need to learn how to navigate those tough choices.

So in wrapping up our two possible dream supervisors, consider this. An open-door policy can feel good to have as a cushion. But for someone who is working in the helping profession and no longer learning about it theoretically in the classroom, that type of accessibility can be damaging to their growth. Yes I know that may sound crazy but your open-door accessibility may actually hinder the professional development of your supervisee.

We all need a little bit of space to figure things out on our own. We need room to ask ourselves the right questions. What should I do here? What have I learned that would help me in this situation or even sometimes we have to ask what would my supervisor, my mentor, my sponsor say in this exact moment?

We need a chance to have a dialogue internally so we can resolve certain conclusions of what we know and begin formulating our understanding of the therapeutic process. Doctor Tanya examined ECS and it helped prepare counselors for patient interactions and how it impacted overall job performance beachy assessed 392 groups of supervisors and counselors and asked them to provide reports. Challenging assignments, excepting and acknowledging counselor, proficiency of supervisor and counselor, role modeling, mentoring and general task performance. They defined effective clinical profession as building consistent structure and clearly defined relationship with scheduled interactions between a senior licensed/certified professional and a newly licensed/certified professional. EC has had a positive effect and Doctor Laschober had a higher value between the disparities between counselors. At the most surprising result was that counselors did not rate their supervisors proficiency as the most influential factor affecting their job performance but rather their supervisors mentorship.

Having a strong supervisor alliance between supervisors and counselors is just as important or even more so is having a therapeutic alliance between the counselor and patient. In a time

where evidence-based practices are emphasized and clinical cohorts in the populations are so needed, effective clinical supervision can feel like a daunting task especially when we throw a word like structure on top of it. It feels trapping, difficult to attain and maybe even a little bit of a perfectionist type of thing. But it is important to remember as a leader, you do not have to be an expert. Every treatment approach or program offers to be an effective supervisor.

You just need to build a relationship and maintain consistency in your supervision schedule. Structure is not about perfection. It is about laying the path before you.

As we have reviewed the definition and purpose of supervision, just a quick recap. Our general goals for clinical supervision. Promote professional growth and development, protect the welfare of patients, monitor counselors performance and empower the counselor to self-supervise. Whether you have already bought into the why or not, we can all agree that there has to be a "what". What does clinical supervision look like when we talk about structure? And developing on your preferred clinical supervision model. You will notice that each model has to address what occurs when it comes to training the supervisee, how notes are handled and what no preparation looks like. And how the section is structured. So when training discussed things like evidence-based practices, what practices we use in this program. What my model or paradigm or supervision model is or what the program model is. The good beyond style preferences and models make sure to review that maintaining compliance as an ethical professional does not mean adhering to federal guidelines for ethics but that there are tiers of ethics. You could do at all times the professional helper must be aware of ethical guidelines at the state level, type of program or level of care level, agency and brand level and even personal level.

Adhering to the tiers of ethics and making sure you and your supervisee are on the same pages clinical. Lastly make sure to clarify your supervision style or preferences, making mention of things like phone is off, we are going to record our session. That we are being clear about this.

In the EHR on the actual treatment plan, so for about three months counselors were implemented a treatment plan that was not even signed off on it. It still had edit notes but because they did not know where it was and they were not trained on where to find it, that piece was just missing. So when we talk about supervision and structure we are also talking about the training so they understand what is expected.

We will talk later on more about the checklist leading to supervision and we will share with the checklist you can give to supervisee as they prepare themselves for that supervision. But last but not least, we must have some form of structure and how it is executed. So for the most part supervision tends to look the same each time each week, every session but how we go about executing and maintaining the structure can produce safety and predictability for the counselor to grow and develop at the reverse can also happen when supervision tends to be unpredictable or inconsistent. We have to ask how we train them to present cases, is that maintained or reinforced in the session, did I teach them and then let them present? Did we provide clarity on how the supervisee should resent difficult scenarios with difficult scenarios? Do we have a place for things like administrative supervision? The amount of time the person took off last week versus this week we creating a safe space for that is critical and feedback and follow-up. So I'll ask Cynthia to speak about feedback later on when we go into the IDP. It is more of

establishing a norm and using a method to make feedback a part of the overall development process. But how do we deal with feedback? And is it consistent? Is there a model? Is there a system? How do we structure the actual session? While there are many ways to do that but here is a simple example. We want to structure the session may be in the same way we would structure the therapeutic session. First identifying the problem. It is not he said/she said but describe what happened in session and make sure to continuously train on case presentation skills.

There is a lot of science behind doing that. Training on case presentation skills also trains the new counselors mind on case conceptualization or how to wrap their mind around the unique case that is presented on this individual person.

To not review the documentation so not just what you were saying occurred as a counselor but also what are we seeing, what was written? We say if it is not documented it did not happen. That is sort of the same role when it comes to supervision. So we have to ask how is supervision documented? Do you have a supervision documentation protocol? Is it established the same way that we have a particle for treatment? Make sure to explore the counselors interpretation of how the session went. How they were feeling, what type of intervention was expressed. And you are constantly trying to build a safe space the same way you want your supervisees to build trust, that is the same way you are building that same trust so creating a non-judgmental space where they can openly explore their thoughts and perspectives and the reactions to the patient empty patient interventions that worked and did not work.

Fourth, you are constantly trying to make sure that it is not just about growth in developing, sometimes it is about confirmation and validation. Giving attention to the vulnerability in the room. In the same way that a client is revealing the darkest intimates to the counselor. But it's not the same. And in the supervisory relationship there's a shift or balance of power where the counselor, counselee is seeking supervision and guidance from the supervisor who is probably not doing the same to the supervisee. So acknowledging the imbalance of power and acknowledging the experience and maybe even some timesharing your challenges and positives from your supervisory experience, but altogether giving attention to that vulnerability. And then where are the measurable outcomes and follow-up? We will go more into that later. As I prepared to hand this off you may have noticed a mention training your supervisee a number of times. So how do we train for optimal success? Use a weekly case management form. If it is not documented it did not happen. Case management or supervision management, having a document for that in the process for that is necessary to guide a new professional helper on managing their week two week cases but also their week two week development. And unpacking of treatment and what treatment looks like to them. Without a weekly form or some type of document in place that tracks and monitors your supervision, then the supervision is really unstructured. Imagine if treatment was like that. It is like walking into a meeting without an agenda. You lose the first 15 minutes to small talk. Hey how is it going everyone? What did you do this weekend, how about you? That is weird. Entering treatment is occurring as expected by the many stakeholders involved. Without an agenda, we have no structure without a case management form. Unusual train your supervisor to use their time with you wisely. This is what clinical supervision in the addiction profession is about. Fourth, supervision is just as much what happens outside of supervision as what happens inside. Coach them on a really practical filter, sometimes as a supervisor it can feel like they are always in supervision, I don't

know if you've ever felt like that. I am always in supervision with this guy-- sometimes we think and open-door policy is the best way to provide feedback and growth but it often leads to poor use of actual clinical supervision and undermining the growth and autonomy, it leads to inefficient use of time for everyone involved. So if your supervisee seems to always knocking on your door, encourage them to go through the thought process first.

Before approaching her supervisor with a question outside of supervision ask yourself this. One, is a patient in imminent danger. If the answer is yes then get help. Find someone in a higher ranking of authority in the program. If the answer is no establish clear boundaries that not everything is an emergency. We want our clients to believe that? Probably not. So how are we training our supervisees?

Number two, can this wait until my next supervision session? Three, how should I handle this now, give them a chance to try out what they have learned and the number four, is there a peer that I can run through my thought process if I am still unsure.

Then you give adequate space to these supervisee to start practicing what they learned from you but you are also modeling responsible, healthy boundaries. And giving them a model they can use with their clients who may also wrestle with boundaries. I will turn this over to Cynthia but if you have additional questions or thoughts do not hesitate to send them in the questions box. We'll ask one more poll. The question is, to maintain structure in the clinical supervision session, what should a supervisor ask first when the supervisee enters? You will see four answer options there and feel free to interact with the poll and select the one you believe is best to maintain structure in the clinical supervision session, what should a supervisor ask first when the supervisee enters? I will give you 10 seconds to answer that poll.

As a second reminder in order to access the CE please view the entire training and listen for the password. This password is related in three separate sessions. I will show the second part of your password. When you enter the online CE quiz the password you will be all one word, lowercase and the second part is [redacted](for the hearing impaired please email ce@naadac.org for CE Quiz password assistance).To cut if you missed the first part of the first part of the password and the webinar was sent and automated email that says thank you for attending with the word attached.

Cynthia if you see those results on your screen, what you think?

>> CYNTHIA TUONY: This teaches and we want to teach from the beginning that people have an expectation or the supervisor and the supervisee has an expectation that people are prepared before they enter into the clinical supervision session. Thinking about my clients doing well is a great response because you are seeking clients that entered and maybe I need to be preparation centered when I come into supervision. Sampson, what do you think?

>> SAMSON TEKLEMARIAM: if we want our supervisees to create an environment of promoting autonomy with our clients we have to ask how are we helping them promote that same autonomy in our supervision sessions? And sometimes --

>> CYNTHIA TUOHY: this talks about how it is after the supervisor and counselor have agreed on their goals and they formulate an individual development plan or IDP or they can call it a professional development plan, does it address the expectations for supervision? The counselor experience, the readiness for the position the procedures to be used to observe and assess the clients competencies and the counselor's professional development goals.

All these are part of the IDP. Some IDP formats follow the core functions taking into account the development of the counselor. Others use what are the competencies that need to be addressed in that person's development. What is important is something is used beyond just general conversation. What format is adopted, the IDP should provide the counselor with a roadmap for learning goals. As Sampson was talking about the clinical supervision process, one of the things that came to my mind is that the contractor supervision needs to be clear between the supervisee and supervisor. And it needs to denote the written expectations that include the amount of time for clinical supervision. The frequency, how often are they going to meet? And what is the expectation if in fact there is an interruption in the clinical supervision time. As you set these goals, as you are working through this process you are also using the smart process or smart planning so that the goals are measurable. You are thinking about, are they specific? Are they measurable? Are you measuring the progress of the person? Are they obtainable? Are you working through a situation, teaching at the level this person is ready. Are they a level I counselor? So you are doing things in teaching and working to detect 21 in the areas that are specific to level I.

Do they have a little more education and training so are they a level II supervisee and so are you teaching and coaching and giving direction at the level II? Or are they level III where they are more of a master level counselor and that relationship is more of a parallel relationship or collegial relationship with that person?

Are they realistic for that person? Again, similar to what we talked about. And are they time sensitive to that person? Taking the time to create the moments of practical collaboration and building the plan and reevaluating the plan -- it's a lot of those types of things we want to go back, just like in a treatment plan that you do with a client and you reevaluate.

Do not be tentative about recommending training or development areas that you assess are important to the supervisee. If it is important in their development, it is important to put on the plan. And share some of your own experiences. If you feel it would be helpful to the supervisee. However it is important not to just sit and talk about your own development and experiences. It really has to relate to their development. Practice by strategizing the obstacles or challenges this person is having read write down the strategies and weigh them along the supervisee to lead the process. And to learn from this, the skills that the supervisee has to work through.

Here's an example of an IDP. This can be used in the very beginning of the supervision experience. It is actually part of the orientation to the agency. I like to make it part of what they should expect and what we are going to do along with other personal paperwork so your supervision of roles or practices are specific to your expectations for that supervision and supervisee professional development role.

Will talk about other tools on the webinar, this tool can be used in conjunction with the TAP 21 As you talk about each dimension with the supervisee and as you concentrate on specific competencies within each dimension. Allow the supervisee to do the same and explain their own perspective.

Be clear on the goals for each competency and areas of knowledge in those specific competencies. And it is also about attitude, not just skill. And be clear as to your expectations on the behaviors you expect on the performance and goals and activities the counselor will complete an order to achieve the goals or behaviors. How will you evaluate if the goals or behaviors are achieved? Will it be through direct observation? Will it be through peers or colleagues? Will it be through the clients themselves? Review at each supervision session and add to it what else you would like to see.

We have to teach people how we expect them to present the case. We want them to be thinking about the clients have set? Counselors often need to be taught to be thinking about those goals from the client and the counselor needs to think, what is it and what will it take for that client to achieve that? Is it possible to use case presentation format for a variety of purposes? Yes, to explore the clients clinical needs, to aid in case conceptualization, to process relationship issues and counseling. Issues like transference and countertransference. To identify and plan how to use specific clinical strategies, and to promote self-awareness for the counselor.

In the beginning, the supervisor should structure the case presentation procedures to ensure consistency and conformance two agency guidelines. It can be adapted to the theoretical model of the agency or model and to the supervisee and supervisor.

All these tools we share with you manual referred to earlier, you will find a lot of these tools. I want to move forward in talking about the issue of how it is we look at and teach to our supervisees the issues around what is important in a situation versus how we are spending our time. What is important, what is urgent and so sometimes in our industry we overlook this. We are so busy serving the client that we are not thinking through these quadrants and we forget the needs of basic professional competencies, business practices that can make the workflow more efficient and time management principles from the private sector that may be necessary or helpful in the work that we do.

I've been lucky enough in my work to go to some of Stephen Covey's training and read Seven Habits of Highly Effective People. That help me understand time management. Because sometimes I would see something as urgent, it was important and seemed like a crisis and important. However, it was not as important as a crisis or pressing problem or a deadline that was important for the agency or the projects we were working on.

So that is the first quadrant. The second question talks about nonurgent and yet important. And so really understanding, yes, some things may not be urgent, but they are still important and still need to be on the planning process. We still need to be paying attention to those things. And then you can see that quadrant three is not important and yet we see it as urgent. So are all these things urgent issues or are they things pushing us instead of us pushing them?

It is something to think about. And of course quadrant four talks about busywork or trivia and sometimes we get caught up in that in the things we are doing. And we need to move forward.

We have a sample case consultation form. This gives you the information on the age and marital status, the occupation, the number of children and illegal issues. Sometimes those specific demographic pieces of information help us to remember more of the dynamics that are affecting the client that we are serving. And so this slide evidences that. It is important to train your supervisees in one form or another, and that you consistently use these four case reviews. This will lead to your understanding of the supervisee skills and competencies as well as teach the supervisees how to articulate treatment and recovery. It gives you a heads up regarding what other competencies they may need to be learning. This is a case management form sample. As we talked about before it is important that the supervisee is coming to the session with their case management form. And they are able to discuss that with the supervisor. And so you can see here at sample information as well as some questions the supervisor could ask. This is another tool that you will find in the clinical supervision manual that Samuel had been talking about earlier.

Now we will talk about how the supervisee can judge or can look at the skills that the supervisor has. This is an adapted version of the Manchester scale for clinical supervision. Many of our friends and colleagues have used this and are familiar with it. This is an adapted version that only shows 17 of possibly 36 questions. For the complete version you can see that on the webpage for this course. It is a great way to get feedback to the supervisor and give them thoughts about how they are developing. Sampson would you like to add anything here?

>> SAMPSON TEKLEMARIAM: each of these tools is designed to help you build that clinical supervision relationship. And you can collect feedback from supervisees and find out how it is going. In the same way we try to get feedback from patients on the perception of care, how about collecting feedback on their supervisees, it can shape your next years, if you are closing out a year. We will have a version of the Manchester scale on the website but it is also one of the tools that is recommended in nurse researcher and other research articles, we mention it on our supervision workbook which you can purchase online. But there are a few more tools coming up.

>> CYNTHIA TUOHY: The SAMHSA TAP 21 -- this looks very much like a treatment plan and many of us are familiar with this. What is important, not so much the type of individual development plan that you use, it is the consistency in which you use it and keep it updated that is of prime importance to the clinical supervision process.

What are the favorable conditions or atmosphere when you're doing clinical supervision. It is maintaining that awareness as the supervisor that this is an unequal relationship. And it is seen that way by the supervisee. So being cognizant of that being thoughtful about that.

Thoughtful about clarifying the roles. I am the supervisor, you are the supervisee. This is what that means in terms of my role and responsibilities. And your role and responsibilities. Address any defensiveness of the supervisee openly. Do not be taken hostage by not talking about the things you need to talk about. Address culture openly. In short evaluation is mutual and continuous. Evaluation must be meaningful, it must be a part of the agency structure. So it is

not just, hey, I think you're doing great, it is very specific to the actual skills you hope that person will develop. Avoid premature evaluations so give the person time to develop, give them time to feel comfortable with you. And feel comfortable in your space. Supervisors must model their own development so you need to walk the talk and not just talk it. And that is true. Are you as a supervisor also getting clinical supervision? Who do you go to when you need to look over something or have a conversation about something you are not quite sure about? You need to maintain awareness of that supervisor relationship and be passionate about being a supervisor. This is awesome work and it is cool. something you can keep on doing. Sampson would you like to say something about the supervisor checklist?

>> SAMPSON TEKLEMARIAM: Earlier we spoke about giving the supervisee something in her hand, something that you say, I want you to use this before you come into a supervision session with me. That is training. And so by putting that in their hand and even letting them make it their own, that is what option nine and 10 is. Before you start using your checklist, what are two things you think would make supervision the most valuable to you? And help them take ownership of the checklist the same way you would manage groups. That is as technique, is leading the group take ownership of the group experience by letting them shape half the group norms and putting it in her hand. Also on the checklist, this will be on our webpage within about 24-48 hours, it will be on the same webpage as this course.

>> CYNTHIA TUOHY: -- that reason you want to continuously be assessing the diagnosis of the patient and this checklist helps you and in a constant conversation about how is the client doing? Do we need to do a reassessment for that client?

Moving forward to talk a little bit about the references and to show those references to you so that you can see that these are some of the pieces of information that were pulled for this particular webinar. These are great references for you to use in your clinical supervision development as a clinical supervisor. And also to give you ideas as you move forward with the supervisee, giving them some ideas about how to become a clinical supervisor. Because in my day, the person that was left standing was the person who became the clinical supervisor.

We want to take a moment to maybe answer a question or two if we have any time left, that you may have written in for yourself regarding this webinar. Sampson, do we have anything that -- to have a couple minutes to share a question-and-answer?

>> SAMPSON TEKLEMARIAM: We have questions that claim in any of your question does not get answered it will be posted on our website also. You may be wondering what is the third and final part of your password for the CE quiz. The third and final part of your password for the CE quiz is the [redacted](for the hearing impaired please email ce@naadac.org for CE Quiz password assistance). Again, the [redacted]

If you missed the first or second part you will get a watch recording link in your thank you for attending, GoTo Webinar email and within that email you can view the webinar recording and fast-forward and rewind throughout the recording and identify the first parts of your password.

Two quick questions. The question is, is it okay to promote autonomy during the IDP? Can we make it their journey and what are some techniques to achieve that? Cynthia?

>> CYNTHIA TUOHY: Good question. Is it okay to promote autonomy within the IDP? It depends on the level the Council. If you are a level I counselor you will have less time developing those competencies. You always want to keep in mind the ethics. And want to make sure they have developed enough and are mature enough to hold that autonomy in an ethical way. So I would say, yes, there are however contingencies to it. What ways you can do that, examples of how you can do that. One of the things you will find in the clinical supervision manual is we will talk about expectations for level I, level II, and level III. So you can really look at those areas and use them as a guiding rule two when you are moving forward to the next level with a person. It's not always time when you are two a or three years, it is the professional development and maturity and if you see that in the work they are doing it and the way they express themselves in the case reviews and case consultation and the case management form.

>> SAMPSON TEKLEMARIAM: I'm going to try to squeeze into more. One that we may both answer, how do I nurture the feedback receptivity needed to be an effective supervisor?

I love that word, or that phrase, feedback receptivity. I can give you the short and simple answer. It is about trust. You know? I receive feedback from people who I trust a lot more than I do from people I do not trust. Trust is pretty cool because it can come from a variety of methods. You trust some people because they are an expert. And because of their experience, their years of experience, their knowledge and wisdom or publicity or the reputation, maybe you have automatic trust in you walk in just ready to receive whatever feedback they have.

Sometimes it is not quite that way. And it takes time; and so it is really or about how do you build rapport with your supervisor? What does it look like to build that trust? And how it is that built? There are other techniques and I will let Cynthia respond. How do I nurture the feedback receptivity needed to be an effective supervisor?

>> CYNTHIA TUOHY: You are right on about that but also make it safe. Make it a safe place to talk about and share. And none of us started out as the perfect counselor and done everything perfectly. We have made mistakes and so make it safe, share something that maybe you did not do so well. And then also share how you developed as a result of that. And that it was not the world crashing because you made this mistake where the client was heard because of this mistake. And how you grew and did a better job in the future.

>> SAMPSON TEKLEMARIAM: We have run out of time. Congratulations you completed part 5/6 specialty training series and you are that much closer to completing eligibility for certificate of achievement which can be an excellent resource to add to your career portfolio and resume. It validates your education, your interests and studies in the area of clinical supervision. So make sure to register for part six Motivation and in Clinical Supervision at 12 Noon. A certified trainer talks about strategy enhancing your clinical supervision register. It is only $25 for training in this series and it includes her eligibility for the certificate of achievement and access to the quiz and certificate upon successful completion of that quiz. You could do for those who missed earlier instructions, to obtain your one CE hour, if you have any questions about receiving the CE, please make sure to email us anytime.

Since the foundational work of the late David Powell, there's been a gap when it comes to targeted education and professional development on clinical supervision in the addiction profession. And the newest booklet was just released on this topic, Perry and best practices for both the clinical supervisor and aspiring clinical supervisor. With NAADAC you will receive our quarterly Advances in Addiction and Recovery. And Other Resources. You Can Email NAADAC on getting support on joining NAADAC. And thank you for joining us on this webinar. And thank you to Cynthia and Tom. You can stay connected with us on LinkedIn, Facebook and Twitter.