Questions Asked During Live Webinar Broadcast on 8/05/2020

Increasing Effective Clinical Supervision for SUD Treatment Providers

Presenter: James Campbell, LPC, LAC, MAC, CAC II and Celeste H. Hutchinson, MA, LPC, MAC, SUDP

Is there an agreed upon format of clinical supervision? Previously, I know that the Powell Model of Supervision was the standard for substance use, but doesn't seem to have been updated since his passing.

A: In my opinion, an eclectic blend of models that suits the supervisors style and compliments the staff configuration is best. I have found it helpful to include a Philosophy of supervision where it outlines the definition and role of supervision, expectations of supervisor and what the clinician can expect from the supervisory relationship. It also includes a statement of responsibility / accountability of the clinician receiving supervision. I add the individuals stated professional integrity statement to set the foundation of overarching goals; this way it comes from them and models a mutual contribution to the supervisory process. The ATTC Counselor competencies section of supervision has a self scoring component and a supervisor rating column to ensure we are on the same page and any area of discrepancy can also lead to further goal development or performance improvement plans.

The NAADAC CLINICAL SUPERVISION: AN OVERVIEW OF FUNCTIONS, PROCESSES AND METHODOLOGY By Thomas G. Durham, PhD: emphasizes PSYCHOTHERAPY-BASED MODELS OF CLINICAL SUPERVISION 40 THE DEVELOPMENTAL APPROACH TO CLINICAL SUPERVISION 44 SUPERVISION PROCESS MODELS

The SAMSHA TIP 52: Clinical Supervision and Professional Development of the Substance Abuse Counselor

How does a graduate student find cliinical supervisors who are not burnt out, uses EBP interventions and who are motivated to supervise?

A: In my opinion, word of mouth is still likely one of the best tools for finding effective clinical supervisors. Of course, you want to be certain ther individual has the appropriate credentials to provide the needed supervision. Beyond that, however, individuals who have are currently being supervised can likely provide some wonderful feedback and about individuals who are doing wonderful work and actively helping to build clinical skills as well as individuals they may have found less helpful or engaged.

I graduated in 2017 with a Masters Degree and I have had the worst luck finding supervision. How does NAADAC assist graduate students in finding reputable clinical supervision?

A: In my opinion, contacting NAADAC would be your best avenue to gain direction. However, the NAADAC Clinical supervision manual mentioned in my response to #1 above does outline ways to go about seeking quality clinical supervision and the types you can seek out. I have over the years interviewed several clinical supervisors and read reviews. Local colleges and universities you respect can give word of mouth suggestions for such resources as well especially if you approach the graduate counseling office. Most clinical supervisors that advertise within the academic settings are keen to the needs of newly credential requirements which is an added benefit when seeking a clinical supervisor for the first time or following unpleasant supervisory experiences.

At my job, we were given a CS who did not have a CASAC, or experience in the SUD field. I opened my mouth & gave resources for another choice, and was penalized (Written up). What can I do to HEALTHILY protest this write up?

A: Although I am not an attorney nor a human resource professional, I always encourage individuals to start with what written policies are present. Often there are policies about non-retaliation when even an accusation of unethical behavior, etc. are made. There also should be a corporate compliance officer withn your agency as well,

but that is likelwise usually guided by policy. There is also generally written policies related to disciplinary acion of any kind. Should none of those policies result in an appropriate resolution, an individual could choose to consult an attorney, seek advisement from regulatory bodies, and/or simply decide the organization is a poor fit and choose to consider alternative employment options. One other personal footnote is that for me it would potentially be important to note what experiences the identified clinical supervisor may bring to the table. Some individuals have a wealth of other experiences to draw from that I may not have had and that I can learn a great deal from.

A: I agree with James' response above and also, I am not an attorney nor a human resource professional, I would simply add that with any write up an employee can submit a response to the write up and copy both for your own records therefore, anyone who would review such write up would also have a well written rebuttal. Most signatures on a write up indicate receipt not agreement.

What do you think about "Group Supervision"?

A: Group Supervision is one wonderful tool in a clinical supervisors repertoire to help build clinical capacity within a team. There are some aspects of clinical supervision, such as building skills specific to a particular clinical model or sharing information which can be done very effectively in a group setting. The group setting can likewise provide an opportunity to learn from the unique insights and experiences of peers as well and offer diverse perspectives and feedback. That said, like most things clinical, supervision should be individualized even when it is not always individual. Some individuals may need individual feedback and skill development or may need coaching that they might find embarrassing or shaming in a group format. For that reason, ideally, an individualized supervision plan should be developed for each clinician and followed accordingly.

A: Group supervision is my favorite mode of education and peer accountability. I agree wholeheartedly with James' response to this question.

I entered the field in 1994, and we were known as "paraprofessionals" for substance abuse counselors, and the pay was abismal then. Here we are in 2020, and SUD you report is STILL amongst the lowest paid, despite the increase of need, pandemic of opioids, etc. and EBP. Why do you feel this is still an issue (the pay)?

A: There are many different factors that likely contribute to this problem. They range from historical reimbursement rates being the precedent to likely implicit bias related to substance use disorders and those who have them. Historically, substance use professionals have also not advocated collectively for the field as well as other licenses and credentials have at times. This is one of the reasons that NAADAC's role in advocacy, especially at the state and national level, is so critical. The more we are unified in our voice and in articulating concern related to substance use, the more likely we are to be heard by decision-makers and policy-makers who help guide fiscal decisions.

A: I agree with James' response to this question and would add this: Salary ranges can vary from state to state as well as a noted differential between rural and more urban areas. Researching agencies in a variety of locations would be encouraged here. Looking at the areas cost of living in conjunction with salary ranges in varying areas is advantageous along with keeping an open mind to relocation.

Professionalizing the field of SUD professionals over the years has contributed to being able to raise some agencies ability to increase salaries. Co-occurring education and certifications can also raise your diverse professional profile which could potentially influence your compensation. I encourage individuals to look for agencies that offer workplace incentives such as tuition reimbursement as well as other benefits that can compliment salary ranges.

Is the number of hours of supervision defined as scheduled meetings or also availability of consultations ?

A: Ideally, hours of supervision would be scheduled. This is indicative of a more proactive, strategic approach versus the open-door (often crisis response) model that is less systematic and more haphazard. Availability for consultation is important when needed, but an immediate consultation on a case is not a substitute for having a specific supervision plan that emphasizes building specific skills or a particular evidence-based practice.

How do you go about side supervision work? Do you work in the evenings and weekends? How do you balance?

A: If you are providing clinical supervision in addition to working in a full-time employment environment, there are two main categories of decisions to consider. The first is with regard to your current employer. Most employers have a non-compete policy that you would want to ensure you are following in order not to jeopardize your regular employment. Of course, any work for which you are paid outside of your regular employment would need to happen outside of the hours for which you are paid by your regular employment as well. Secondly, you also need to consider some of the strictly business aspects of providing supervision and being paid directly. If you already have a personal business (sole proprietorship, LLC, etc.) established for clinical services, you can likely easily provide the service underneath its auspices. If not, you will need to consider whether you will be paid and report the income on your individual taxes, whether you will establish a business, etc. Finally, you cannot provide good clinical supervision if you are unhealthy yourself. In the regard it is important to practice good self-care and to have some time that is not focused solely on work. Practicing good self-care means establishing boundaries as well. This sometimes means saying no to opportunities that may arise if they will mean sacrificing your own peace or health.

Besides case management, what should be done during clinical supervision?

A: Case management is only a very small part of what is covered during clinicial supervision. Clinical supervision should follow a clinical supervision plan agreed upon by the clinical supervisor and the clinician that emphasized building the knowledge and clinical skill of the clinician. This could include learning and growing in relation to any evidence-based practice as well as general counseling skills.

A: I take a Psychodynamic /ACT / CBT (EBP) blended style to supervision. Differentiating that while I utilize components of counseling theory, I outline how it differs distinctly from counseling with both directive and indirective approaches to education, professional self-care and structured goal development (All included in the "Supervision Philosophy" they sign). I take an eclectic style as I indicated in #1 question response and the resources I listed can offer direction.

I'm in a private practice, with CEU's, billing, progress notes etc., how do I get time for clinical supervision and what about the costs?

A: The first step, in my opinion, comes down to prioritizing clinical supervision. In private practice, if you do not intentionally plan for, schedule and make arrangements for clinical supervision, it likely will not occur. Fortunately, the advent of virtual platforms can cut down on travel time and travel expense and lost time in the office if the clinicial supervisor is willing to engage in that way. If you are in private practice, the costs associate with obtaining clinical supervision may be deductible for tax purposes, depending on the laws nd regulations for your state. Your CPA or tax preparer could likely guide you with regard to that as well. In the end I consider effective clinical supervision a bit like effective professional liability insurance, if you think that it's expensive to have, you should consider the potential costs of not having it.

A: I agree with James' response here.

Can we get a list of readings/books recommended for clinical supervision?

A: My personal top three recommendations are: Clinical Supervision in Alcohol and Drug Abuse Counseling by David Powell, Clinical Supervision: An Overview of Functions, Processes, and Methodology (available from the NAADAC bookstore), and TIP 52 Clinical Suoervision and Professional Development of the Substance Abise Professional from SAMHSA (available as a free downloadable PDF from their website.

Tools I use in supervision: *Strength Finder 2.0* From Gallup and Tom Rath; *Emotional Intelligence 2.0* by Travis Bradberry and Jean Greaves (for self reflection as it relates to colleague relations and growth as a person who happens to be a clinician); where it applys it can support goal development and awareness around potential areas of blockages towards competency enhancement.

The Addictive Organization by: Anne Wilson Schaef and Diane Fassel

Can a supervisor get into legal problems or lose her or his license if they allow some administration or the secretaries to do individual counseling or SUD evaluations, when the person has only H.S degree and doesn't have the credentials or education required to become a counselor?

A: The short answer to this is yes. As addiction professionals, we are all beneath the auspices of various code of ethics. These codes of ethics generall state that is a person knows of ethical vilations and does not report them that they bear some of the responsibility. Allowing anyone to provide services outside of their scope of practice is an ethics violation. Additionally, if the individual is co-signing or forging any paperwork related to services this would be an ethics violation and could even have legal ramifications.

I'm from the Philippines where clinical supervision in addictions counseling is lacking. How and/or where can we access training?

A: If services and/or training are lacking in your area, virtual options may be best. If you are a member of NAADAC, there are some virtual trainings available through their website. Another option is the Addiction Technology Transfer Center's website. There may also be opportunities through NIDA's and SAMHSA's sites as well.

As a Clinical Supervisor, I find it difficult managing the demands of the company and the demands of supervision. I work in an OTP in MAT. I supervise 1 hour per work for newly certified counselors individually, 1 hour group per week, and 1 per month per certified counselor. What can I do to improve on this? I feel much is very based on immediate needs instead of clinical needs.

A: The first step, in my opinion, comes down to prioritizing clinical supervision. If you do not intentionally plan for, schedule and make arrangements for clinical supervision, it likely will not occur. The second step is equally crucial if working inside an organization. Solicit administrative support. Your plans for effective supervision will fall by the wayside unless the administration also understands how vital the role of clinical supervision is in terms of liability, effective services, and its potential impact on staff satisfaction and retention. In an OTP, in my experience, clinical supervision is often best accomplished by having a set time just after the close of business to meet. After the doors of the facility are locked, distractions decrease to some degree and it is generally easier to focus on the provision of supervision. I have seen this done where it is a requirement for staff to stay and there fore they are paid for the hour(s), where it is provided but the clinician may seek external supervisionelsewhere if they so choose, or where it is provided with the facility covering half of the time the clinicans are required to stay and staff electing to be present for the balance due to it benefitting them professionally as well.

A: I agree with James' response to this question. I would add that I am very familiar with what is often called the MANAGEMENT SQUEEZE and we as clinical supervisors find ourselves being an advocate for the implementation and structuring of supervision. We therefore, must function as such in creative ways at times. I find it helpful to outline the benefits of clinicial supervision as it relates to outcomes and retention of staff. Administration likes to here the bottom line of how it will benefit the agency…Clinical Supervision that is sound can also serve to be enhancement during state credentialing visits / surveys etc. I find it a matter of speak in Administrations language and how it affects the bottom lines.

What entity/who would provide the reimbursement for clinical supervision?

A: There are multiple payor sources that could be considered. Some of these may include the SAMHSA block grants as well as third-party reimbursers such as Medicaid, MCOs and insurance providers. Traditionally, clinical supervision has been treated more like a "cost of doing business". We are encouraging the approach that it be considered as a vital service worthy of consideration for reimbursement on its own merits.

What about having an agenda developed prior or at least ready at the start of supervision session?

A: This is actually preferable. Although there should be some time alloteed for Q&A and discussion nd there ay be times when a critical or issue or need arises, the bulk of clinical supervision should be proactice rather than reactive. Having anagenda for what will be covered during a given clinical supervision session is good practice and helps demonstrate the intentionality we discussed in the webinar.

A: I am an advid believer in PRE-AGENDA items. I give each of my supervisees a nice professional journal at the onset of our supervisory relationship (to model mutual investment) where I ask them to jot down 1. Pre-Agenda

items: daily questions, comments, ideas for program system enhancements along with 2. Free writing any abbreviated internal processing of themes following sessions that come up for them (with no identifying PHI) to identify extraneous contributors to case conceptualization and to also identify potential countertransference themes. I require the pre-agenda portion be given to me within 24 hours in advance to provide me the opportunity to research resources or seek out what will best address the areas of question etc. I, too, will at times utilize this pre-agenda format where I give them areas I hope to address in General business or Education/ Training areas etc.

Do you have any resources for additional supervision trainings that are free or at a nominal cost?

A: If in-person trining opportunities are not available in your area, virtual options may be best. If you are a member of NAADAC, there are some virtual trainings available through their website. Another option is the Addiction Technology Transfer Center's website. In addition, there may also be virtual training opportunities through NIDA's and SAMHSA's sites as well.