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NAADAC WEBINAR
CLINICAL SUPERVISION:
INCREASING EFFECTIVE CLINICAL SUPERVISION
FOR SUD TREATMENT PROVIDERS

WEDNESDAY, AUGUST 5, 2020
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>> The broadcast is starting, all attendees are in listen mode.

>> JESSIE O'BRIEN: Welcome to today's webinar on clinical supervision, increasing effective clinical supervision for substance use disorder providers. Presents by Celeste Hutchinson and James Campbell.

I'm happy you can join us today. I'm Jessie O'Brien, and I'm the training and professional development contact for NAADAC, the associate for addiction professionals and I will be the organizer for today's training experience.

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We are using go to webinar for today's live event. You will

notice the control panel. You can use that orange arrow right there to minimize or maximize the control panel. If you have any questions for the presenter, just take them into -- type them into the questions box. We'll gather the questions and give them to our presenter during the live Q and A. Any questions that we do not get to, we will collect directly from the presenter and post the questions and answers on our website.

Lastly, under the questions tab, you will see another tab that says handouts. You can download the Power Point slides from that handout tab and there's also a user friendly instructional guide on how to access our CE quiz and earn your certificate. So use the instructions in the handout tab when you're ready to take the quiz.

Without further ado, let me introduce you to today's presenters.

First, James Campbell has been working professionally in the human services field for over 25 years. His passion is helping individuals, families, and relationships to heal through leveraging their strengths, and supporting other helping professionals as they cultivate their skills and expertise to assist others more effectively.

James is a Licensed Professional Counselor, a Licensed Addiction Counselor, Master Addictions Counselor, and a Certified Addictions Counselor II. And he is a member of both NAADAC and the ACA.

James is the current president of SCAADAC, NAADAC's South Carolina state affiliate, and has worked in a wide range of clinical settings over the years. Currently he serves as the training manager for the Southeast Addictions Technology Transfer Center, and works privately as a nationally recognized author, consultant, professor, and speaker.

Also with us today, Celeste Hutchinson has 27 years of experience delivering treatment services, cultivating clinical staff and programs as a leader. She is certified as a John Maxwell international speaker and trainer and as a Licensed Professional Counselor, a National Certified Psychologist, Master Addiction Counselor, Board Certified Clinical Psychotherapist and Co-Occurring Disorders Professional Diplomate. Celeste serves on numerous state and national committees and has presented both nationally and internationally. Some of her recent presentations include introduction to acceptance and commitment therapy for clinical and support staff, steps to recovery that took place in Levittown, Pennsylvania, in 2017 and one step consultancy, safeguarding children conference at the Jamaica conference center in Jamaica in 2018 and 2019.

NAADAC is delighted to present to you this webinar.

Celeste, if you're ready, I'm going to hand this over to you.

>> CELESTE HUTCHINSON: Thank you so much. And good day to everyone.

We're going to first start out talking about what the webinar learning objectives are today. And we want to welcome you to this webinar. First because we want to define clinical supervision and

evidence-based practices. We want to identify barriers and articulate principles and suggestions to enhance the delivery of clinical supervision in diverse settings.

Our goal is to familiarize each of you with this information so you can apply it to improve supervision and the practices in which you do in your everyday practices and agencies.

Since our time together is brief, let's get under way.

So what is clinical supervision? Supervision is generally defined as the application of principles that facilitate professional development and skills relevant to providing quality service.

Supervision that is guided by the concept of evidence-based practice is the foremost necessity in process in implementing evidence-based practices as a standard treatment throughout the addiction treatment profession.

Supervision often involves a senior or more experienced individual -- sorry, my screen is -- mentoring a junior or less experienced practitioner in order to ensure quality of clinical care.

I think it's really important for us to remember that some of the functions of a supervisor include many different things. Evaluating practitioners, performance, teaching skills through demonstration and discussion, and encouraging clinicians to consistently administer evidence-based practice.

So when we're looking at clinical supervision, it's important to look at history all the time, because one of the main pieces is that we learn from the past, right? So one of the things we want to make sure is that we're all on the same page as to why is this important, right?

So historically in the substance use profession was disproportionately staffed by people whose primary credential was established from their personal recovery, and while this is a plethora of information that is very useful to us, many of these early professionals brought a wealth of information to the profession based upon their personal experiences and despite the strengths, the professionals often lack formal education and professional training in substance use disorder treatment, as well as in clinical supervision.

So it's really important for us to remember these things historically as we move forward to enhance and build upon the great foundation that many people before us have put forth into ensuring that clinical supervision is sound.

So the times are definitely changing in many different ways as we all have experienced. When it comes to clinical supervision, it's important to remember that over the past decade, the rate of bachelor's and master's level clinicians within the substance use disorder profession has steadily increased. It's estimated 60 to 80 percent of substance abuse professionals hold at least a bachelor's degree, whereas 50 percent have obtained a master's

degree and this comes directly in the substance abuse and mental health services administration.

So along with the addition of formal credentialing within the profession, there is also a progressive movement towards utilizing evidence based intervention.

As the profession is guided more by science, it's important to remember that clinical supervision will be an important intervention to help assure implementation and the fidelity of evidence-based practices. In other words, can we trust what we are doing? And I think that it's important that while we're educating our supervisees to show fidelity in the work we're doing with them, where we go from here is to say that the implementation of evidence-based practices, to be able to show that fidelity. The barriers that impact the frequency of regular clinical supervision, there's many of them, and it's important to look at them. And the recommendations we're also going to be looking at to help assure that clinical supervision occurs more frequently in substance use disorder treatment.

So why is it important? There's two good reasons. Reason one, supervision increases the fidelity to evidence-based practices, which we've already kind of touched on.

Reason number two, supervision decreases burnout and increases the quality of care.

Why is clinical supervision important? There's a thing called standards of care, which is the best practice in both medical and behavioral health practices. Evidence-based practices has now been established as the only acceptable standard of care in the modern age of addiction treatment.

So the literature that has been established that evidence-based practices is oriented supervision is the key to successful evidence-based practice implementation and maintenance.

So to look at some of the other reasons for why clinical supervision is important, we're going to talk with James Campbell. And I'm going to turn it over to you, James.

>> JAMES CAMPBELL: Thank you, Celeste.

The second reason that we listed in terms of the importance of clinical supervision is that supervision decreases burnout and increases quality of care. Both of those are incredibly important to those doing the work in the field day in and day out. We know that burnout takes an incredible toll on programs. It takes an incredible toll on the remaining clinicians when someone does leave or transitions to a different place. And one of the things that we know is that the more competent a clinician feels, regarding the work that they are doing or the practice that we're -- they are using, the more competent they feel, the more likely they are to remain with it. It decreases the stress day in and day out so they're more likely to maintain services in the same location. The decrease in burnout also helps increase quality of care.

Those of us who have been doing supervisory work for some time,

have probably had the experience of what feels like a revolving door in training. You have someone who comes in, you begin working with them and begin building their skills, you begin giving them some information and education around evidence-based practice and after an investment of a month or six months or a year, that individual may move on to another place and we have to start again with someone beginning to educate them and restarting that process.

So as we decrease burnout, we really increase the quality of care, and for that reason clinical supervision is really important to helping to build that competency that decreases the burnout that we mentioned.

We shared a little bit about some of the reasons that we feel clinical supervision is important, but I also wanted us to take a brief moment just to touch base with those of you who are on the session today to get your feedback on what you feel might be the most compelling reason that the clinical supervisor is needed or clinical supervision is important. Here we have four of those listed, and I'm going to step back and let Jessie take the reins for a bit to lead us through our polling question.

>> JESSIE O'BRIEN: Wonderful. Thank you, James.

I'm going to go ahead and launch this first poll.

Wonderful, I see some people responding already. Great.

As a reminder, if you guys have any questions, put them into the questions box in the control panel for go to webinar. We're going to have a live Q and A towards the end of the webinar, and ask your questions in the order they're received.

If you're having trouble seeing the poll, consider switching your view and go to -- in go to webinar from the full screen to a different view, but it looks like for most of you it's showing up, because I'm getting a lot of responses here. Awesome.

All right. I'm going to give you about five more seconds, so if you're hemming and hawing, choose your answer, and we'll get to see the results.

Great. I'm going to go ahead and close the poll. And share the results for you, James, and you can see them and everyone should be able to see them.

>> JAMES CAMPBELL: Excellent. Excellent.

Thank you so much for responding to that. I always love to see how your own values and your own motivations play into some of the things that you believe are most compelling in terms of clinical supervision.

So the heads and shoulder winner for this group was to improve the standard of care. That was the one that was clearly the strongest or the highest of them.

The key point here though is that it's not just a matter of which of these is more important. The truth is there isn't a best answer. All of these are really good reasons and compelling reasons why clinical supervision is needed. And why clinical supervision is so important.

There's not a bad answer to that question. And this also isn't an exhaustive list. In other words, I'm sure that there are things that you could come up with in terms of reasons clinical supervision is needed that aren't encapsulated in those four things. It's certainly much broader than that.

So you would assume with us agreeing that clinical supervision is important, us talking a bit about some of the reasons that it's so important, that it is happening consistently and uniformly across all treatment programs and systems. The reality is, however, we know that simply is not the case. In fact a survey that was done by Newby back in 2018 identified that approximately 30 percent of substance use counselors are not receiving any type of clinical supervision. Let me read that again. They are not receiving any type of clinical supervision. So here we're not talking about efficacy. We're talking about existence. And again that's about one in three of people who are doing clinical work in the field around substance use don't have a clinical supervisor and aren't getting clinical supervision hours. That for me is a really frightening hour. That means that these folks are in some ways flying solo. Hopefully they have the benefit of good peers and a good treatment team and a staffing around them. Hopefully they have that benefit. But one of the things I know after having done this work for a great many years, is that with regards to ethics violations, people don't generally lose credentials or licensure based on decisions that are made in clinical supervision. They don't usually lose them based on decisions made in a treatment team. It's often with an individual or a clinician decides to fly solo, if you will, when they make a decision on their own. And that decision may be more punitive, reactive in that way, or it may be more ostensibly compassionate. It may be that the individual is trying to help the client that they're working with, but they crossed some boundaries in that regard.

In both cases, clinical supervision can be an important safeguard for that. So for that one almost one in three who aren't getting that clinical supervision, they're certainly at much greater risk from an ethics standpoint in terms of potentially crossing some boundaries and making ethical violations.

Additionally in a study by Eby and others, supervisors in the field in the profession spend only 2.6 hours per week providing clinical supervision services. Again these are people whose job title is clinical supervisor, and yet when we look functionally at the amount of time they spend providing clinical supervision, it's 2.6 hours per week. So if we take the imaginary 40-hour work week, which most of us are familiar with, you're talking about a very, very small percentage of time actually being spent in the provision of clinical supervision of people who are -- by people who are clinical supervisors. The reasons for that are not because of a lack of interest on the part of the clinical supervisor.

It isn't happening for a great many reasons, but it's not a lack

of interest. Clearly if you are a clinical supervisor you see the value in what you do. Hopefully you know you have the ability to convey some skills to benefit the clinicians that you supervise, to help them grow as clinicians, to help them in their clinical fields and clinical practice. So if it's not happening so consistently, why is that?

So I'd like for us to take a moment to look at some of the common barriers to the provision of effective clinical supervision.

Now, if you've been doing this work for a time, I don't think you'll be shocked by anything you're about to hear. Part of my hope for this is it's a matter of affirmation of us understanding that you're not the lone ranger in this dilemma. Because these are common barriers, meaning they're ones that many of us have faced to varying degrees.

The first barrier I'd like for us to take a moment to look at is competing demands for time. Oftentimes a person who is the clinical supervisor carries their own caseload. Now, there's a variety of reasons for that. Some people really love clinical work, and want to keep their clinical skills sharp and so they choose to carry a clinical caseload in order to basically keep their finger on the pulse of the clinical services that are being provided within the agency.

Sometimes, however, it is a matter of demand. There are so many individuals coming through the door that they just can't manage to do the clinical supervision because they're so busy providing services, and that can be certainly a challenge as well for them.

For clinical supervisors, the truth is that unfortunately they're often in a system that spreads them far too thin. So in addition to carrying their own caseload, they're often providing clinical services. Sometimes that's on a consistent service, they're doing X number of assessments or providing X number of groups. But often it's on a crisis base, someone is out sick. But if you're in a larger agency, people are out sick or on vacation frequently. So that cuts into the time that's available to do clinical supervision.

In addition to that, clinical supervisors are often part of the leadership team of the agency world as well. They sort of walk in multiple worlds, if you will. They're doing clinical services but they're part of administrative meetings. So they get pulled for those sorts of meetings as well, whether it's a leadership or management meeting, something of that nature.

And there are also often multiple sites being served by the same clinical supervisor. Those may be in different buildings but they may be across town or in different towns, where a clinical supervisor is going from place to place. I know we've mitigated that a little bit by virtue of technology and Zoom and various other platforms, but oftentimes that is still a matter of particularly if that clinical supervisor is doing direct observation, going from place to place, traveling from point A to

point about takes time.

And last but not least, are billing related duties. I like to think of that as the wonderful world of co-signature that many of us walk in, whether that's for LPHA or whether that's co-signing people who are in process, that sort of thing but they're often duties related to billing or to quality assurance and things of that nature that again take up a good portion of time.

When you add all of those things together, what you see is a person who is trying to juggle more balls than a person can typically juggle, and unfortunately whether that happens, some of them are bound to hit the ground.

That also leads to a situation in which clinical supervision can become more reactive. And that really leads us to the second barrier that we often face. A lack of intentionality. That doesn't mean that we don't have good intentions. That doesn't mean that as clinical supervisors we're not trying to provide excellent clinical supervision. What that means is because we are spread thin and we have more demand on our time than supply of it, what we sometimes do is use phrases like, well, we have an open door clinical supervision policy. In other words when a clinician has a question they know I'm available. The problem with that, the problem with an open door approach, it puts the onus of the responsibility on the least experienced clinician in the pairing. In many cases, if they're newer to the field, they don't know what they don't know. And we're telling them to seek out help when you need it, but they may think what they're doing is perfectly fine. They may not know that what they're doing isn't in line with evidence-based practice or maybe isn't trauma informed or isn't something else along those lines.

So in that regard, the question of intentionality is whose responsibility is it? And what we would like to say is the clinical supervisor should be the one who is trying to be a little bit more systematic. That lack of intentionality and the structure in terms of meeting almost always is going to result in catch as catch can clinical supervision, and that's going to be a significant issue as well.

Next up is lack of training. When we're referencing a lack of training, what we're really talking about is for someone who is just coming into the clinical supervision role. When someone becomes a clinical supervisor, in many states it's not a question of any specific training having happened. In many states a lack of training really just references the fact that it's just a matter of hours in the field. If you have X number of hours in the field doing clinical work, then you suddenly become eligible to be a clinical supervisor. What we know about that is that there are times when absolutely that is a tremendous help. If someone has done clinical work as a counselor or as a clinician, absolutely there's incredible benefit in lived experience. That's something that we talk about a lot in terms of peer support, but that's true

in terms of clinical supervisor as well. It can provide a wealth of information.

The problem is that there seems to be an assumption that an excellent clinician by definition will make an excellent clinical supervisor. And although at times that can be true, it isn't necessarily. The skill set of providing clinical supervision is not identical to the skill set of providing clinical services. And so in that regard, we really do advocate and suggest making sure that there is some structured training on the front end for how to supervise. What are the ways that you can provide effective clinical supervision? What does the documentation for that look like? Those aspects of things are really important to the work that we do as well.

Fourth on our list is continuing education. Some of you may say didn't we just talk about that? The difference is we're talking about ongoing. The reality is is that we're in a very changing field. Our profession is changing more rapidly perhaps now than at any time in my memory with the advent of telehealth and many things that we're doing right now at this point in time. But the reality is is that if we do not continue to sharpen our clinical skills and stay abreast of developing models, developing practices in our profession, we're going to get left behind.

What can even happen is you may have someone who is coming right out of a program academically who is being supervised by someone who has tremendous experience in the field, but that individual coming straight out of an academic program may know more about evidence-based practices than that person who has been doing clinical supervision for a long time. So in that regard, we're trying to make sure that we don't run into the barrier of becoming the clinical lid on our program. It's going to be a challenge for us to really coach and help clinicians to grow if we're trying to help them grow beyond where we already are. We can't give them skills that we don't possess in many cases.

So in that regard, we need to make sure that we're continuing to seek out educational opportunities and trying to overcome that barrier to the extent that we can.

And to a large degree the four that came previously often tie in to the fifth. Sometimes there's a lack of administrative support for clinical supervision. Now, most CEOs and program directors are way too savvy to say it that way. They won't articulate in most cases in that way. But the reality is is that oftentimes administrative people may not have an understanding of the importance of clinical supervision. Just because someone is directing or being a CEO of a behavioral health service of some sort, it doesn't mean that they necessarily have a background in behavioral health. Their background may be public health, business, public relations or science, it may be any number of things. But the reality is they truly may not understand why clinical supervision is important.

Another aspect of that is that sometimes there are short term fiscal demands versus being able to put on our long term lens in terms of growth. In other words what's -- what is urgent sometimes trumps what is important. We may know that clinical supervision is important, but right now we just have five people who we don't have a clinician to see walk through the door, so I know you've had this hour reserved for clinical supervision, but we need to pull you to do X, whatever that may be. That lack of administrative support often creates that competition for time that sometimes contributes to that reactionary approach. It can also contribute to whether or not there's ongoing education or training on the front end of becoming a clinical supervisor, so again that one is one of the places that there's sort of a hinge, if you will.

Let's continue to look at a few more barriers before we shift gears for a bit.

An additional barrier is clinician perception. That can mean a few different things. For one, if a clinician is new to the field, if the clinician is new to the profession and they're starting out, the likelihood is they probably have never had clinical supervision, and the truth is that although we as clinicians are very good typically at telling people, hey, there's a need to change and we need to embrace the change, we're typically very bad at actually embracing the change ourselves. That can be a significant issue.

And so that change into being supervised can change for some people. It's anxiety producing and not surprisingly we tend to avoid things that produce anxiety for us. That can be a significant issue as well.

Additionally some people who have had clinical supervision have not necessarily had clinical supervision that was most effective. They may have had clinical supervision that was much more critically oriented, much more of a critique than an encouragement and a fostering and a skill development, or it may be that they have had clinical supervision that was much more punitive in nature. Not surprisingly when we do something and it is critiqued and looked heavily at and may even have consequences that are adverse tied to it, we're not usually eager to embrace that quite so much, so in some cases, past experiences for that clinician can be something that gives us pause. Something that makes us either avoid clinical supervision as much as we can, or may be something that we only engage in on a surface level. We don't go in depth into that.

Additionally one more step in that is cultural differences. The reality is is that individuals who work in any particular program or service become -- come from a wide variety of backgrounds. That may be differences in terms of gender, sexual orientation, differences in terms of race, differences in terms of lived experience. All of those things can potentially be a barrier based on the clinician's perception in terms of how they proceed, how

will they move forward, how much they're willing to share, what the comfort level is with that. Again those are all barriers that we may well run into.

Turnover and stress. We already alluded to this one a bit earlier. But the sad fact is that substance use counselors are among the lowest paid professionals in human services. To pretend that that does not impact turnover is just disingenuous. The reality is that unfortunately that increase in turnover, an increase in stress leads to that revolving door that we spoke about a little bit earlier. That tendency or that struggle within trying to provide good clinical supervision to build a strong cohesive clinical team, and then feeling like there's a hole in the bucket that keeps draining as we're trying to fill it in many cases.

That turnover in turn creates stress for the people who are left behind. As we all are well acquainted with, when we have a clinician to leave, the clinical workload does not change. Typically it redistributes. That means everyone is now carrying a heavier weight than they were before. The problem is is that it can become a vicious cycle. As stress levels go up, people become a little more disenchanted or a little more burned out, if you will, or have compassion fatigue, and when you see those things, that can be a significant struggle as well for folks.

So that can be a barrier in terms of this turnover stress. The irony is that good clinical supervision can actually, as we mentioned earlier, help mitigate that a bit. It can help people to feel more competent and confident in their clinical work, which at least helps alleviate some of that pressure.

The last on the slide is other. The bottom line here is we are under no delusion that this is a comprehensive list either. Depending on the type of program you're working in, whether that happens to be outpatient or intensive outpatient or residential or family based or in home services or opioid treatment services, whatever those things may be, there are unique barriers to each and every one of those different scenarios, to each and every one of those programs and services. So as we take a look at those and consider those, I would love it if just in the chat box, you just listed some of the ones that we missed. Again I'm sure there are many. But by all means, feel free to put those in there, and again if you're thinking it, someone else on here is probably too. So just take a minute and type that one in the chat box and we'll see at the end if we have some time, we'll circle back around to those as well.

At heart, I am a pragmatic person and so I do enjoy the theory, I enjoy the research, but I'm always at the end of any training or presentation, the question I always have is so what? What can we do about it? Like what do we do with this information? It's not enough just to know what the barriers are. Let's take a moment to look at some practical application, so practical considerations for what we can do or where we can go in terms of our service

provision.

Here we're going to talk about six of those. Here are six things that we can do to really help elevate our clinical supervision skills and really help build on those.

First, learn as much as we possibly can about clinical supervision and evidence-based practices. Now, I know that may seem almost too obvious, but the reality is that we're all busy. One thing I can guarantee you is that if you are a clinical supervisor, you are not sitting around trying to figure out what to do with your free time. The idea of going and looking up a recent study in a journal may be a fond treatment or a nightmare if you're not so much a research person. But the reality is, it's no one else's responsibility to help you be a good clinical supervisor more so than it is yours. You are the CEO of you. In other words, if you need to build a skill set, it's incumbent first and foremost on you to take the necessary steps to build that.

Certainly we hope you're in an environment that is rich and nurturing and healthy and helpful, but whatever that situation or scenario may be, certainly we hope that you are continuing to scout information and build your own skill set.

It's not enough just to have information. Information without relationship seldom gets us very far and so from a clinical standpoint, one of the things that we want to do with our supervises is really to build a relationship and our rapport with them, to really assess the supervisee's counseling or clinical skill set, to really begin to build what their supervisee learning or development plan is going to look like. Just as for a clinical service provider, sitting in an office by yourself, writing a treatment plan for a person who is not there is a terrible practice. Likewise I would suggest that there's the parallel process there. For an effective clinical supervisor, you wouldn't want to be in your office coming up with a plan of things to do to this clinician or to this supervisee. The goal is what you do with them, things that you come alongside with them to help them grow in, to know something about what their interests are and what motivates them and what they want to develop. It's not always going to be that everything on that plan is something they're in love with. It is mutualistic. There will be times when you may need to challenge them or stretch them to grow in a particular way. But that goes over much better when you have the rapport and the relationship to actually build on that that they know that they have been heard, that they know that they have been seen, all of those things. So making sure we take the time to really assess and relate with those that we supervise is incredibly important.

Next it goes back to that idea of intentionality, the schedule. Now, some of you saw this and you laughed. You laughed, I tell you. Set up a weekly meeting schedule for supervision to occur. Weekly. Now, we've already put out there that one in three aren't getting any at all, and I dare say there is a tiny minority that is

getting weekly supervision.

I will say to that that one of the things that we know about adult learning is that for anything to stick for most adults means they have to be exposed to it six times. So if you're doing once a month clinical supervision, it's going to take six months for a piece of information to stick if that's the only place they're getting it. So there needs to be something more consistent. Even if it's shorter in duration, but is more frequent, it's going to have a greater impact. So try to set those up as frequently as they can. And it may be that there's a longer once a month session followed with some briefer times where you touch base with a clinician or the supervisee. That's certainly fine. It's certainly okay, but again the goal for that is that it is targeted. That you are actually building skills and it may not just be a conversation, with oh, did you see that clients the other way or oh, did you see that person, that sort of thing as well.

Fourth is evaluation. The key here is agreeing upon how clinical skills are going to be assessed. And there are a wide range of ways that can be done. But the truth is is that the anxiety level of everyone isn't the same for each one of these different modalities. Some people are perfectly fine with a senior clinician sitting in their group and they're facilitating that group and just being observed directly. For some people their anxiety level would be through the roof. The direct observation would potentially render them clinically inert. They wouldn't necessarily be able to just jump in and lead.

Some people would be much more comfortable with a co-facilitation or co-leadership of the group, but the reality is is that is also an individual skill set. Co-facilitation has unique challenges with that.

We also referenced video recordings can be a huge help. Again there's some considerations around waivers and HIPAA and things of that nature, so you do want to be mindful of those, and so if a client shows up to a group and suddenly there's a camera there and there's never been one there before, there's going to need to be some conversation around that or you're not going to get a real assessment of that clinician's skills anyway in many cases. The key point is there needs to be a conversation, that there does need to be discussion around what's going to be the means of assessing clinical skill and giving feedback related to that and that's a good segue to the fifth.

Providing clear and consistent feedback, and knowing how the individual prefers to receive that can be significant. Some people are fine just give it to me straight, doc, you know, they want to just hear, how did I do, what was the good, the bad, the ugly, they're open to this. Some people may be internal processors. These are the folks you're going to get much further with if you provide them with a brief write-up ahead of time, here's some strengths, some things you may want to consider. If you provide

that to them ahead of time, it can really go a long way towards them not being on the defensive when you do get to this type of clinical supervision. It also can provide sort of a framework for that conversation to follow, if they're not necessarily all the way comfortable with clinical supervision just yet. Or if you're newer to clinical supervision, it's good to have that framework and that structure to really work off of as well.

Now, if you notice I said that there were six, and there are only five on here. I'm no mathematician, but I do know the difference between five and six, which really leads us to the last step of something that we really hope that each of you will consider in terms of clinical supervision.

These are suggestions related to advocacy for addictions professionals related to clinical supervision. The first and foremost in this is get involved. That sounds like a good catch phrase or bumper sticker or meme, but what it means is if you're on this session, odds are that you're already probably a NAADAC member. If you're not, you should definitely look into that, starting today. But getting involved with NAADAC at the national level and with your state an affiliate at the state level and your service providers and other individuals who are doing similar work in the field, is so important. The reality is that we tend to take on attributes of any population that we consistently work with. And unfortunately for substance use disorders, they are incredibly isolating in terms of the disease of addiction. So if we're not careful, we will find ourselves self-isolating. We will be in little fortresses or little fiefdoms out in the community and we have no idea what's going on in the broader recovery community, what's going on in the treatment field. The more involved and collaborative you are in working with others, it's going to be to your benefit and it's going to help us not repeat the same mistakes that somebody else already made and gain some of the benefits that some of the people who have gone before us have done.

Additionally advocating at the state and national level for reimbursement for clinical supervision is incredibly important. Part of advocacy is involvement in the legislative process. If you are a clinician and if you are a counselor, advocacy is part of what we do, and it's not because we're trying to be self-serving. It's because we need to make sure that it's possible for us to retain good people in the field, that it's possible for us to make a livable wage or to earn a living doing the work that we do so that we can continue to provide the service to those who are in need. Reimbursement is a significant part of that.

We also hope to really promote reimbursement that focuses on evidence-based practice. For those two-thirds who are receiving clinical supervision, my hope is that a sizable portion of that is also focused on building skills and specific evidence-based practice, whether that's motivational interviewing, whether that's cognitive behavioral therapy, contingency management. Again we

could go down a long list of those. But we want to be doing the things that evidence and research has demonstrated work. And part of that is building skills that are very tangible, very specific measurable things. They're not just things that are always soft skills. These are things that we really want to be able to see build over time and know that growth is happening in.

As we alluded to earlier, requiring training in clinical supervision prior to becoming a clinical supervisor is a great step. Again some of you are in positions where you can really encourage that. For some of you at some point, assuming you don't retire from wherever you're working right now, at some point you are likely to step into a different role or a different position. When that happens, you can advocate amidst your departure for going, hey, this is a wonderful clinician or this is a wonderful person who I think would do a good job, but they will need some training around how to provide clinical supervision and what that looks like. Again if you have that kind of influence to be able to exert that, it's a great thing.

Also encouraging certification and licensure boards to require training hours in clinical supervision in order to obtain and to maintain that certification or that license. The reason for that is if the administrative powers that be in your organization don't necessarily see the value, they usually do see the value in adhering to the rules and regulations that are put forth, so if these are part of licensure, if these are part of what's required, it's more likely to occur. Just as what is billable is more likely to happen, so is what is required by regulation as well.

We really hope that also you'll use your multiple platforms to spread the word about the need for and the how to of quality supervision. That can be of course in house, advocating and talking about protecting the supervision hour, that sort of thing. But it also can be external, that can be webinars, that can be journals, that can be local and national conferences. Again there are a wide range of ways that you really can step up and do that. An op ed piece in the paper or an online journal or an online page can be a great way to come alongside and support the work that you do.

Last on that list is promoting are or to promote developing national standards for clinical supervision. Really emphasizing fidelity to evidence-based practices related there too.

We always are heard better when we speak with a unified voice. That's one of the things I appreciate about NAADAC. It gives us a unified voice to be able to speak to Washington and the powers that be. That is a wonderful asset. What we really think that having those national standards gives some consistency and some cohesion to clinical supervision from state to state. Right now things vary really widely in terms of what is required between states, what is reimbursable or not, what the criteria and credentials are -- or prerequisites are for being a clinical supervisor. Knowing those

things are more consistent to being able to speak with a more unified voice. So our hope is that these are things you will really consider, how you can step in and get involved and advocate for.

We're about to switch over and go into some questions and answers, and before we do that, I want to take money moment to pause and say this: Thank you. Clinical supervision is difficult work. In many ways you are the sergeant of the clinical world. You have upper management on the one hand, and you have your supervises and clinicians on the others, and so oftentimes what happens is you're caught in the middle. You're sometimes translating between the administrative ease to clinical ease and vice versa. You are so needed in this profession. You are so needed in this field, and in many ways you are the key to sustaining effective provision of clinical services across the board.

So I'm so grateful to you for what you do, and I'm so grateful to NAADAC for hosting this.

With that said, I do want to save a little bit of time at the end to move on and to do some question and answer. And so with that, I'm going to invite Celeste back to the stage and Jessie and we'll facilitate a little bit of conversation if there were any questions that came in.

>> JESSIE O'BRIEN: Oh, my gosh, do we have questions. So I see that they're both back here. I'm going to just kick it off. Thank you guys. That was an awesome presentation, full of a lot of really good content, and obviously people are excited, 'cause we have a lot to share here.

So I will start with the first one from Antoinette, how does a graduate student find clinical supervisors who are not burnt out, who use EBP interventions, evidence-based practices, and who are motivated to supervise?

>> CELESTE HUTCHINSON: Well, I can start on that one. I think it's important to know your network. There's clinical supervision, supervisors that advertise a lot of times through APA or you can even call your governmental offices, such as SAMHSA and other places and they can make recommendations for professionals who do supervision. Oftentimes clinical supervisors and directors in agencies on the side do clinical supervision. So much like James and myself, we've done private supervision, clinical supervision. So it's a matter of I think just putting yourself out there and asking.

>> JESSIE O'BRIEN: Great. Thank you.

So I guess along those lines in terms of resources, and, sorry, James, I didn't mean, if you were going to add something, feel free to jump in and say it on this next question. But another question in terms of resources is what is your best recommendation for a text or handbook for supervision?

>> CELESTE HUTCHINSON: Well, I definitely think that SAMHSA

tips and taps, I think it's the tip 52 and tap 21, I believe. I could have the wrong number.

>> JESSIE O'BRIEN: I think that's right.

>> CELESTE HUTCHINSON: But they are really great resources and they break it down into a lot of great applicable categories, and you can get these resources for free from SAMHSA.

>> JAMES CAMPBELL: Absolutely. I would also add in that mix, even though it's been around for some time, I would say that David Powell's work is a wonderful place to start, and I know one of his protégés does great work around that in regards to training on that as well.

>> JESSIE O'BRIEN: That's great. Thank you.

And yes, I was going to mention NAADAC actually partnered with Tom Durham who is one of David Powell's protégé to produce a new manual on clinical supervision that includes the latest research and also best practices from Powell's model of supervision, which you can find in the NAADAC bookstore. So that's another resource.

Question three from Ann from Michigan: Any suggestions on starting a practice as a clinical supervisor. She has some colleagues doing this. Do you think there is a need for independent practitioners for people who don't have supervision by employers?

>> CELESTE HUTCHINSON: I definitely think that there is a need, because there's a growing individuals going back to school and there's -- you're right, there's not a lot of individuals who take a vested interest in the development of skills, as well as well-rounded helping you to be able to develop your own style. So there's a difference between just doing flat clinical supervision, but I really love what James talked about, in personalizing that, making time and being able to have someone who's focused on you and your work. But you also have to talk to your agency as to what their views are in obtaining outside clinical supervision, because they may have some policies and procedures that they specify to their agency that you have to follow as well. But there's a definitely a need for it.

>> JAMES CAMPBELL: I think that's excellent and you raise an excellent point as well. The need is certainly there in most places. I find that there are more people who are seeking good clinical supervision than there is good clinical supervision and effective clinical supervision to be found in many cases.

You do want to be mindful though about conflict of interest, if you do work for an agency and you provide clinical supervision as a part of that. You just want to be mindful that you do a disclosure or whatever the process or protocols are with human resources there.

>> CELESTE HUTCHINSON: Uh-huh.

>> JESSIE O'BRIEN: Awesome.

Okay. So I'm trying to pick. There's so many questions, guys. So we will -- for those, just a reminder, for the questions we

don't get to, we'll send them to our presenters and we will post them on the website for this webinar.

For our last one, this is from Jonathan, as a clinical supervisor, I find it difficult managing the demands of the company and the demands of supervision. I work in OTP, and medication assisted treatment. I supervise a one hour per work for newly certified counselors, individually one hour of group per week and one hour per month. What can I do to improve on this? I think much is based on immediate needs rather than clinical needs.

>> CELESTE HUTCHINSON: I definitely want to normalize the management squeeze because in my circle that's what we call it. You're an administrator but you're also in the frontline that needs to be engaged and oftentimes you're advocating for the needs for the direct service and yet at the same time it may not be meeting those administrative expectations and how do you find the balance, and you feel squeezed in between. I definitely think it's important to self-care, number one, and a lot of times self-care isn't involved in supervision, which I add it all the time, to make sure that they're aware of what is self-care, so just for that side note of that experience of what you're feeling, I definitely think modeling self-care to everyone that you work with is a key component to balancing it for yourself.

As far as the time that you use for supervising the groups and individuals, I mean I think the big thing again is just engaging that self-care and modeling that to your clinician as well. Time management and all of those things.

I'm hoping I answered your question. I'm kind of -- I kind of lost the question.

>> JESSIE O'BRIEN: I know, and it's such a big question. I'm sorry, I kind of threw that out there and I'm going to have to cut you off. But we'll send that question to you both as well so you can write a more elaborate answer to that question and post it. So James if you have stuff you want to say on it too, we will definitely include your thoughts on that, but it is getting close to wrap-up and I want to be mindful of everyone's time, so thank you guys again. This was fabulous. Obviously we have a lot of interest on this topic.

As I mentioned, you guys, every NAADAC webinar has its own web page that has everything you need to know about that webinar. Here is the one for today's at the top of the screen. The online CE quiz will be posted there as soon as this is done. You can go and take it. So check that out.

Check out the schedule for our upcoming webinars. Tune in if you can. There's some really interesting topics with great presenters just like today. This coming Friday, August 7, (indiscernible) advocacy executive director will continue our advocacy series which is right there.

Bookmark this web page on our cultural humility training series. All of our trainings are open. We're fortunate to have with us

Dr. Pierluigi Mancini (indiscernible) here is the website to look those up on your slide right in front of you.

Also of course this is continuing to be relevant. Please visit our COVID-19 resources page. The website is right here on my slide. NAADAC the association for addition professionals, have provided to you six excellent free webinars covering top concerns in the addiction profession and presented by leading experts in the field.

Here relevant to today, here's the manual that I referenced over here on the right. You can get that in the NAADAC bookstore. We offer two specialty online training series. This is the first one on clinical supervision. You can find all of these courses on this website right here at the bottom of your screen. Please check it out. There's a lot of really good information there.

Additionally we have the second series, addiction treatment in military and veteran culture, which you can find at this website down at the bottom here.

As a NAADAC member, reminder there's a lot of benefits. If you joined, you will have immediate access to over 145 CEs, which are included as a specific NAADAC benefit. You are also going to be able to register for our conference which is coming up in September, guys. 24th through 26th. It will be offered through a virtual platform, early bird registration is opening soon, so we really hope that you will join us.

Please note at the end of this, a short survey will pop up at the end. They always do. We love your feedback. We need your feedback. What you have to say is really important to us, and shapes how we offer our future learning experiences.

Thank you, thank you, thank you again for participating in this webinar. Thank you, Celeste, thank you, James, for your valuable expertise, leadership and support in the field. I encourage you to take some time to browse our website. To learn how NAADAC helps others, stay connected with us on LinkedIn, Facebook and Twitter.

Have an awesome day, everybody. Take care.

(End of webinar.)

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