NAADAC

ADVANCES IN TECHNOLOGY IN THE ADDICTION PROFESSION, PART VIII: LEVERAGING TECHNOLOGY TO ENABLE AND ENHANCE CLINICAL SUPERVISION

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>> JESSICA O'BRIEN: Hello everyone and welcome to today's webinar Advances in Technology in the Addiction Profession: Leveraging Technology to Enable and Enhance Clinical Supervision. Presented by Dr. Malcolm Horn. My name is Jesse O'Brien and I am the Training and Professional Development Content Manager here at NAADAC the Association for Addiction Professionals. I'll be the facilitator of the string experience.

A reminder the current homepage for NAADAC is listed on the slide. Make sure to bookmark that page to stay up to date on the latest in addiction education. Closed captioning is providing by CaptionAccess today and posted a link to StreamText in the chat box and you can find it there. Everyone is very quiet today. If you want to tell us where you are from and coming from today, feel free to put it in chat.

It is Friday the end of the week. We are using Zoom webinar for today's live event. I invite you to use the chat box and Q&A chat box and the Zoom features we will utilize. You can send chat messages to the host and panelists and hosted today's presentation and second is the Q&A box when you have a question for presenter. If you would like when you like you can put a thumbs up and if you have a question at NAADAC that's unrelated, it like it in and we will do our best to answer them if we can.

We also put a link to the handouts in the chat that you can find. A reminder every NAADAC webinar has its own webpage that has everything you need to know about that particular event. The same place you register for this webinar you can go back after it is over and you will find a link that we will activate as soon as this is done. You cannot access it yet.

There is a handy dandy instructional guide that guides you through the getting your certificate. If you have not done before, please follow it and it makes the process easier. If you need your certificate to say live on it and some people do, complete that CE credits within the next 24 hours.

Without further ado, let me introduce you to today's presenter Malcolm Horn who received her master's degree in social work from Walla Walla College. She served as president of the Montana chapter of the NASW as well as NAADAC affiliate. She was vice president of NAADAC for the Northwest region.

Malcolm is certified as MAC and SAP and currently works at Rimrock, a CARF-accredited treatment facility that treats the entire ASAM spectrum as Director of Special Services. She coordinates internship programs and provides educational outreach to the region and adjunct family and individual therapy. She teaches two courses at Montana State University-Billings in the addiction specific program and recently got her a doctorate degree in psychology. Hello, Malcolm.

>> DR. MALCOLM HORN: I will start sharing my screen. Thank you, Jessica, for the introduction. I am super excited to be here and hope everything is showing. I am glad to be here. Clinical supervision is something near and dear to my heart. I have been a state approved clinical supervisor since 2011. Almost 11 years now.

In Montana where I live, in order to sign off on LCSW or LCPS licensure you have to take state approved course and I had to do that and then in this a while an acute try to go to more courses because it is ongoing learning. I think that is important as being someone in the profession. I love talking about clinical supervision and it is something as a counselor I cannot fix everybody. I cannot save everybody but if I could teach other counselors and grow other counselors they can help save everybody.

In some ways for me is providing good clinical supervision and growing counselors is how I try to help patients in general. Try to help all the people we serve because there are so many hurt and wounded people and the more people we have to help them, the better it will be.

As we go through, do not hesitate to use the chat box. I will front this by saying there is a ton of information on the slides. There are 79 slides and I will not cover 79 slides in less than an hour and a half. I can talk really fast but not that fast. One of the reasons I put so much in the slides is this is I pulled information from a session that Cynthia, who is the Executive Director of NAADAC, her and I did a three-day session in Alaska three years ago. I pulled information from that and part is because to talk about technology and clinical supervision, first we have to have a little information about what are the fundamental components of clinical supervision?

I will translate them to technology. I have to know what I am translating. There are a ton of slides that I will not talk about and we will gloss over and skip a bunch of them. I put them in deliberately so you have access because it is important information. If you are new to clinical supervisor and the slide you want to know where about, I strongly recommend find another clinical supervision course. There are several on-demand webinars through NAADAC that talk about that and I recommend you do that.

>> JESSICA O'BRIEN: Hold on. You are showing the notes version of your slides. You may want to switch screens.

>> DR. MALCOLM HORN: You may want to see what is coming up. You never know. Is that better?

>> JESSICA O'BRIEN: Stop sharing and then restart and selected again.

>> DR. MALCOLM HORN: That is why I need people like Jesse to keep me in line.

>> JESSICA O'BRIEN: It is still the notes. Now we are good.

>> DR. MALCOLM HORN: It is Friday and it was not going to work. A little bit about me. Director of Mental Health Services and I work in a CARF accredited facility. We do everything from individual detoxing and medication assisted therapy and coordination and all things. It is shocking when I talk to people who do not work in a facility where I can shuffle patients around to meet their needs.

This morning I had a patient that I do individual therapy with who joined the group and said I think I need peer support and I said great and no problem and connected her with a peer supporter she will meet with later today. Sometimes I forget that is not the case for everybody. I feel blessed I work in a facility we can jive and pivot to be individualized for our patients. That is a facility I work at.

I have been doing telehealth about eight years. When Covid-19 happened, it was not that big of a stretch for us to say we will start using webcams and doing telehealth. Me and a couple of my staff have been doing it for a while and it was not that big of a deal. It was but it was not. We knew how to do it and we had to implement it on a bigger scope.

That included clinical supervision. I am the only state approved clinical supervisor at the organization. I have seven people working on licensure to do clinical supervision and an additional six in their internship for the master's degree and I do their clinical supervision. I have a lot of people I do clinical supervision for.

In Covid, we had to translate that to telehealth. How do we do that? I had done it before and was not a huge stretch. We had to broaden what we were doing. Let's talk about what I want to cover.

We will do a definition of what is clinical supervision and the elements of effective clinical supervision? Touch base on counselor competencies and relationship issues and how do I take the four things and do over tech? This comic picture is funny but it

reminds us that one of the things we talk about how do we do tele whether it is supervision or therapy? If you would not do it in your office, do not do it in tele.

You would not click your fingernails during a therapy or clinical session, do not do it over tele. Telehealth you see like you see my shoulders and you do not see all of me. Who knows what is happening in the background. It is important to keep at the forefront of our head. Not just in terms of being focused on the session we are in but what is happening in the room? What else is happening?

I was doing clinical supervision this morning over web can with a supervisee who was home and we were talk about nothing patient specific or confidential but talking general things. Her husband handed her a cup of coffee. Not a big deal. We were not doing anything confidential.

Being aware she was not in a place she could have talked about confidential things. Nobody else is in the room. This picture is funny but it reminds us you need to stay present.

That is one thing I noted during Covid-19 in 2020 and going into 2021 and it is not getting better in Montana. We still have to be present and because it is over a camera does not mean it is more casual or we loosen some of the standards.

I saw lacking standards and that's okay but we want to keep that in mind.

The state of clinical supervision and let's talk about why it is clinical supervision so incredibly important? There are inconsistencies and substance use disorders. Inconsistencies in models of care, how we do things and your state may have rules who provide services and it is important to have supervision to guide it for the new counselors and sometimes not new counselors.

How do we make sure or doing ethical evidence-based care we need to do know the actual model of substance use disorder treatment is not stagnant? It is flexible and moves and changes. We can make an argument there is not solid standards of care across all 50 states. We can say different states have different standards of practice.

It is important to keep it in front of our head. And how is clinical supervision defined? Different states may define it different. In Montana -- the three licenses I am authorized to do clinical supervision for -- each one of the licenses has different requirements. Knowing in Montana the definition of clinical supervision is the same for all of them.

That may not be the case. Each of the licenses I supervise, I look up how many hours have I tracked and how many hours of this? Each license has a different standard as to what they need for clinical supervision. It is important you are aware of that.

Something else I see all the time that clinical supervision is not a priority. I have been just as guilty of that. I have told my supervisees if I have a patient that needs to be seen and they only time they're available is your supervision slot, I will dump you and put in the patient because I have to do patient care first. We will have to reschedule your supervision time and that can be frustrating.

I have gotten a better handle of it in the last six months. I made difficult changes in my caseload so I can put clinical supervision back into the forefront of what I do. We have to take that into account.

If you think from a business organizational perspective, there is no money attached to that. If I spend an hour of my time doing clinical supervision, that is one hour my time I am not dealing for patient services. In this day and age where it should not be about the money but it is because you have to make payroll. Sometimes for an organization, supervision is not a priority.

That can be good and bad. You have to be aware if you do this at organization, do you have buy-in from administration and leadership that says yes, it is important to grow our staff and important to provide the clinical supervision? It is okay there is not a dollar amount attached to the hour.

You want available resources for self-care of treatments that. During Covid-19 because we recognize our staff was overwhelmed and then burning out not just because of work but because of their home life because the things our patients were struggling with so is our staff. We started and once a week there is a compassion fatigue support group for

staff. Any staff member can attend and it is a timed event, process, cry or whatever you need to do. Is important that is an option.

Sometimes clinical supervision is self-care. I have had supervision sessions where counselors need to vent or process and cry or do whatever. That is good. It is not a bad thing. Be careful that clinical supervision does not become therapy because it should not be therapy. If you are counselor by trade, you will use a lot of the skills you use as a therapist. You will use them as a clinical supervisor. It is important you are not doing therapy.

It is important to look at appropriate diagnosis and treatment of patients. Doing differential diagnoses is one of the biggest things we do. If a counselor says I'm not sure what diagnosis to put in, let's get out that DSM and talk through one of the criteria. Why is that relevant?

You cannot really implement appropriate treatment unless you have a proper diagnosis. Often diagnosis set the stage for what the treatment is going to look like. If a patient has co-occurring alcohol use disorder and Posttraumatic Stress Disorder their treatment plan will look one way versus if they have only Posttraumatic Stress Disorder.

Diagnosis is important because it affects the stage for what the treatment plan will look like but how we are reimbursed. Diagnosis is important and that should be part of clinical supervision.

General training needs of staff whether it is things staff say. A month ago, some of the staff at one of our female residential houses said we have patients who have disorder eating stuff. Can we get in-service stuff going? I said yes, absolutely. We implemented ongoing in-service trainings to help staff understand what disorder eating is and what do we do know when it may not be the primary diagnosis we are treating in that setting. How do the staff handle it?

We want to jive and say these are the ongoing needs of staff. And balancing that with what are their licensure requirements? In Montana, you have to have two CEs year of suicide and education prevention because Montana ranks one or two in terms of suicide throughout the United States. Our board of behavioral health says it is important that

license clinicians have two CE's per year of that type of education and we have to add that in. Having someone who can do the clinical supervision or training is important.

Telehealth can make all that happen it can make it easier or make it more convenient or more efficient. We want to make sure we do it right. Just like doing therapy over camera, there is a right way to do it and a not right way to do it. We have to keep that in mind.

Some issues that affect clinical supervision is lack of time. I have a critical patient that needs to be seen and they get priority over my clinical supervisees. Then we have to reschedule and sometimes it means we do it on the weekend. That may be when we have to do it. Sometimes there is lack of time and it is hard. Some of my supervisees in a residential houses, their day is packed. They are full and busy. To take an hour to do clinical supervision is they say really?

I have 4 treatment plans to write and three patients to see and they do not have time. Administration or leadership has to say it is a priority to do clinical supervision and try to figure out how to do that.

Lack of trained clinical supervisors is another issue. I am the only one at my facility who can sign off on LCSW and others. Others can sign off on licensed addiction counselors supervision but on the one who can do master level licenses. That is a problem. It is stressful for me and overwhelming. We used to have two others who couldn't but they are no longer with the organization and we have not gotten anyone else train. It is overwhelming to me sometimes to have so many supervisees. That can be a barrier.

Not only at organization but in your region. Depending on where you are, in Montana, I live in the biggest city. There are 120,000 people in my city. It is the biggest town in Montana but in terms of size of the city, 120,000 people is not that big. There are cities that are much bigger.

Who in the City of Billings is approved to do clinical supervision? In Billings there are several. If somebody needed to, if they could find someone besides me to do clinical supervision but we are lucky.

You go into some of the rural communities in Montana, there may be no one else who can do clinical supervision. I have done supervision for people who live in a city or town where there is not anybody else who can do the clinical supervision. That can be a huge barrier for licensure which goes to our workforce shortage.

If I live someplace where there is nobody to do my clinical supervision, that is a barrier for me to get a license. Telehealth can help because I can turn on my webcam and do clinical supervision and that's a huge advantage for them.

And the lack of funds. How do you pay for? If I do one hour of supervision, that is one hour I cannot deal and the counselor is not able to bill. There is a financial deficit happen. Can you get funding for clinical supervision to other resources and often the answer is no which is what has to be a priority and a decision that organization or leadership team says this is an important enough not only for organization but for the patients we serve.

Lack of consistency is another thing that happens. I have done that were I say we have to reschedule this week for whatever week and that is a problem. Like I mentioned in the last several months I have made difficult decisions with my own schedule to try to make sure clinical supervision comes back to the top one priority list so it is consistent.

And the lack of state regulations and each state has a different set of rules which makes it hard. If you love somewhere and in a town in the East or state are smaller, the closest clinical supervisor for you may be in a different state.

Can someone in another state to my clinical supervision? What are my state rules and regulations? Is it possible and feasible? Those are things to look at within your own state of what are the licensure requirements for your governing board? Can you be supervised by someone outside of your state? Those are things to look at. If we had national regulations and set of standards, that would be one less barrier for people to deal with.

We have to think about what is your definition of clinical supervision? If we were in a conference room or live, you would have a big discussion of what is it? What does clinical supervision look like? What was clinical supervision like for you? When I got

clinical supervision, the counselor who signed off on my license who did my 3000 hours of supervision was basically a gripe session every week. A group gripe session.

I thought that was what clinical supervision was. After I got my license, my CEO sent me to a training course to do clinical supervision because I was the one at our organization to do it. I went to the course two days and said oh my gosh. I did not have any clinical supervision. I had weekly group griping sessions.

There are specific components of clinical supervision. A lot of the PowerPoint I am not talking about goes through what some of these are. I strongly recommend you look at them even if you have been doing clinical supervision a while. Look and get to know what they are. If it is not something you have done much of, I recommend you take additional courses on clinical supervision so you have a better understanding of what it is.

How would you define clinical supervision? After I went to the training course, I said okay. Clinical supervision is a way we model responsible counseling, model ethical quality care, the way we teach and mentor and grow. To some degree it is a sense of gatekeeping and there are times I do not sign off on people's hours. I say I'm not comfortable signing off on that right now and you have to be able to do that. I hate saying that but to some degree, we have to function as gatekeepers.

I do not think you're ready for full licensure. We need to learn more about XYZ. That should be reflected on a learning plan and I will talk about that in a little bit. Thinking about what is your definition of clinical supervision? What did you experience as a supervisee?

What did you feel was missing and what would have been more important or relevant for you to know? It depends on where you are adding your counseling trajectory. Are you brand new or experienced and what do you want to know? If you are a clinical supervisor, what does it look like and mean? This is a definition I will read to you.

[Reading slide]

The senior member of a profession is an important thing to think about. When I became state approved clinical supervisor, I had only been licensed as LCSW about three years. I was still pretty new. I consider myself pretty new.

It was daunting that I was considered senior level therapist at my organization at that time. We have a turnover problem, don't we? Yes, we do.

At the time I became a clinical supervisor, I would not say I was senior member of the profession. I felt I was brand-new and green. Now I feel I more the senior-ish level. I am still learning and growing. Be aware that.

The relationship with the clinical supervisor and supervisee is evaluative and I evaluate their progress. I identify problems or concerns. It should extend over a period of time. I feel blessed some of my supervisees I have now, I have been his clinical supervisor in one form or another for about six years. I have a good relationship with him.

I did his internship when he was getting his bachelor's degree and did his internship when getting his master's degree and I do clinical supervision for the license and on his clinical supervisor. We have a good relationship and we can have frank, honest conversations about that. Where parallels being a therapist when you have a good relationship with the patient and have safety in the relationship, you can confront difficult issues.

We know when our patients identify and address difficult issues they grow as people. It is the same with the supervisee. When you have a good relationship of trust and safety, you can discuss the uncomfortable things and the counselor has the same to grow.

It is important to recognize that. There is a simultaneous process that enhances professional functioning and monitoring quality professional services and serving as a gatekeeper to those who should not enter that profession. That is a good definition.

This is a picture of Mr. Powell. He is one of the formative people that talks about clinical supervision and he talked about being disciplined tutorial process wherein principles are transformed into practical skills with four overlapping foci. We are valuing the process

and evaluating their competence and supportive and you support them in going through difficult issues. You support them in learning and growing.

There is administrative supervision where you do time sheets, disciplinary actions and things like that. Then there is clinical supervision where it is focused on clinical skills and ability to make diagnoses and identify and implement clinical interventions and things like that.

If you're going to do clinical supervision, think of how you would translate any of this. How would you translate this to using a webcam or other type of technology. It should be interpersonal. Just like therapy, it is easier to have the solid interpersonal relationship when I spent time with you face to face and not just over the camera.

Thinking how do I build that rapport over the camera? It is harder to do that over a camera. It takes longer to build up rapport over a camera. I have patients I only ever worked with over camera because of Covid-19 and it felt it took me longer to build that rapport.

I had to put more work into it versus if they been live in face to face and my office. There's a tutorial relationship and we help tutor them and grow them and whether it means they learn how to do differential diagnoses or a specific skill set like cognitive behavioral therapy or whatever. There is a tutorial educational relationship.

What do they need to learn more about? Professional growth and things they want to grow and learn. I have a learning plan where I want them to identify their own professional goals. What do they want long-term or short-term? How do they get there? How do I help them do that?

There should be learning and practicing which is where technology makes it different. It is one thing to do individual supervision over camera where we talk about cases and how it is in group or whatever. It is different when it comes to observing them provide the service. You cannot do effective clinical supervision unless you have the opportunity to watch them conduct the group. To watch them conduct the service delivery.

You have to be able to do that. I am shocked in Montana for one of the licenses there is 10 hours of direct observation. 10 hours is it? That seems really small. It feels anyone can say these are my cases and this is what I do and how amazing it is without knowing what does it really look like? How did they do the skill? You want to be able to watch it. There should be observation involved in clinical supervision.

Thinking about how you use technology to do that. Evaluation feedback and how do I evaluate service delivery, diagnosis, treatment planning documentation? Acquisition of competence. How do I identify you are developing those competent skills? If I never observed you do this, how do I know you have achieved that competence?

If I do not use technology at all, theoretically, I walked down the hall and sit in your office and watch you do the individual sitting or write the treatment plan. But if I do not do that and I'm not on site or in your building or in your town, how do I do that? If I'm going to sign off, that is my license on the line, and sign off your company able to do that, I need to be able to observe that.

How do I know that was effective? Effective patient care means sometimes this goes along with professional responsibilities is how people know and maybe this is not a good fit? When do I say maybe this patient's best needs are not best served through me? I had to do this two weeks ago.

She worked with the patient maybe three weeks of not very long. He was triggering a lot of her own past trauma and she came and said I don't know if I can work with him. I am nervous before every session and I feel my own trauma coming back. I don't know what to do.

I said okay. You are probably not able to effectively meet his needs. If you're trying to manage her own internal regulation and trauma during the session and she had not had a lot of sessions with him. We had a session on how to transfer him to a different counselor. You have to make sure that counselors can come to and say I'm struggling with this patient. Kind of like a counselor, I build a relationship of safety so my staff or supervisee can come and say I do not know I can do this.

That has to be saved. If they do not feel they can come to you and say they are struggling, they will keep trying to do it and may inadvertently hurt the patient or themself. Making sure we are able to help them learn that. How do I effectively take care of my patients, balance my ethical responsibilities and model good care?

Four primary goals of clinical supervision. Think of how you would do this over a camera. The first one promoting professional growth and development. Gate keeping and how do I promote that growth?

Clinical supervision should not be weekly meeting where we go through your cases and you tell me what you are working on. I need to see and hear what you are doing. Depending on where you are, sometimes it means you get feedback directly from the patient. If I have a supervisee that is doing residential or inpatient program, all of the patients do give feedback about how staff is doing.

Not in a punitive way but significant events where they fill out feedback to staff. That is a fabulous tool. I love it when I get it because the counselor says yes, things are going great. I get it from the patient and I say your patient is not thinking it is great. Let's talk about this.

Making sure you have the ability to observe their growth, observe their development and help point out to them things they may not do well. Things they may need to work on or are there things this is a population that they don't know if they can effectively work with. That is good to know.

I am not one of the counselors or supervisors that said you should be able to work with every population and if you cannot, there is something wrong with you. There may be populations you do not work well with and if you force that, you may hurt the patient. If you recognize there may be some populations or groups that for whatever reason you are not able to provide good care to, you should not do it. Bottom line.

I have a lot of initials after my name and probably make argument I could work with every population. There are certain populations that are not my jam. My kids, not my jam. Could I work with kids? My LCSW says I can work with kids. Can I? I have in the past but I do not like to. I should not do that.

I should be able to know it within myself and say who else can do this work? If I cannot see this kid, who can I refer them to? Who can I send them to and who will give them time and attention they really deserve? That goes to protecting the welfare of clients. How do I make sure? That is the bottom line and why we do what we do. It is to take care of our patients.

How am I taking care of that? We teach ethical decision-making and scope of practice. These are things you need to be aware for what you do. Whether it is there license or skill set or whatever it may be.

There should be monitoring of counselors' performance. There are two types of supervisor. Administrator and clinical supervisor. They both may have different performance objectives. Depending on if you are not both of those roles, heavy work with the other one? Several of the people I do clinical supervision with, I am not the administrative supervisor.

They have a different boss. A different person signs off their time sheets, etc. Because of where I work, we are an integrated program. I have no problem going to another supervisor and saying one of the supervisees I do license supervision for I'm concerned about some of these issues. Because you are the administrative supervisor I'd like to have a conversation on what we can do. I have to do that later this afternoon with another supervisor.

It can be difficult if you do not share the organization. I have done in the past where I do that licensure supervision for someone but they worked with but they work a different organization. I do not like it. I can do it but I do not like it. If there is an issue, how do I protect the confidentiality of that supervisee and the confidentiality of the patients while being able to communicate to the administrative supervisor? It is sticky and I prefer not to do it.

How do you monitor their performance? Do you have a set standard of these are the reasonable objections for licensure? That state lines out these are minimal competencies. Things they have to be able to demonstrate in order to get this license.

How do you monitor that and communicated to the supervisee? These are the expectations?

I have had supervisees I tell them and I had one that we do not a good outcome. He was so far behind on his notes. It would make me nuts. I would get notes dated three months ago. That messes up the business office and it is impacted are financial bottom line. Are you tell me you remember things that happened three months ago in the session?

Trying to say this is the expectation. The expectation is your documentation is done at the end of that week. All of my supervisees, that is my expectation and I am clear on that. Your notes should be done by the end of the week and if you come in on Saturday to do your notes, you come in on Saturday to do your notes. If your notes are behind, I will get twitchy and write you up. I tell them that.

This is the expectation and if you're struggling let me know. And when you are new and learning the electronic health record is a pain in the butt. If I need to help you, I am happy to help. This is the expectation. Let me know if you are struggling because I am happy to help you and happy to show you how to do it and happy to support you.

We want to empower counselors to self-supervise. Counselors come to me and say I had this difficult case. What do I do? I say what do you think you should do? They look at me. You tell me. You know this patient best. What do you think you should do?

I had two supervisees and she had a difficult issue. I said okay. I asked the other supervisee, what do you think we should do? He had an answer and I had an answer and we all three talk about the best option.

I want to empower people to make decisions. They need to learn critical thinking. What is critical thinking? How do they do that and navigate ethical issue? Maybe look at the actual ethical standards and look at it to remind themselves this is what my next step should be.

We want to empower to self-supervise. I want to empower them to take care of themselves. The last thing I want is a patient who feels they need to hold my hand the

rest of their life. That is not good patient care. Eventually they need to manage themselves and that's the same type of goal we have at the supervisor.

There are different roles you may play as a supervisor. The first is a teacher. For the brand-new baby counselors, it is a learning experience. This is therapy 101. This is how you do a session and treatment plan. You may be a sounding board for struggles they have. Not just professionally but sometimes personally.

It can be a challenge when personal struggles impact their professional goals. Sometimes we have to be able to let them know there is a boundary between personal and professional life but we would be silly if we said your personal life should never affect your professional life. There is stuff happening in your personal life that probably does impact you to some degree professionally. How do you manage that and teacher supervisees to manage that?

If you're not on site working with them on a daily basis and you're only doing remote supervision, it may be hard. You do not see them on a daily basis. It is one thing if you in the same building and you see them walking down the hall. You hear how they interacted with other people but if there at a different location and you do not see them, it can be hard to navigate.

You are a mentor, role model and coach and provide direction and guidance. I am up front with my supervisees. I in not perfect and I will make mistakes. I encourage them to call me out. If I make a mistake, tell me. I want them to learn mistakes happen and it is not just a mistake but what do we do about it? How do we fix it to make amends and avoid it from happening again?

You may be an evaluator. A skill set of how well they do diagnoses and build treatment plans and how well they make licensure. Do they jump through the hoops to get the license? You may be a consultant and problem solving ethical legal issues and empowering them to have independence is important.

There are parallel roles. If you are a counselor by trade and there are skills you have learned as a counselor, you can use as a clinical supervisor. Building rapport, building safety, having empathy, encouraging independence, encouraging internal motivation.

Those are skills you probably learned as a counselor and you can use as a clinical supervisor.

Be careful. Be careful supervision does not become therapy. On the learning plan I have for my supervisees says you are engaged with another personal counselor for your own stuff. They can check yes or no. I do not care what they see the counselor for. I want to know are they insightful and willing and able enough to do their own personal growth and work? That can be important.

Be aware some of the skills you use as a counselor are translatable to clinical supervisor. Making sure you do that. The same when it comes to tele. As a counselor doing tele-therapy with I have to work harder in those sessions.

I work harder to build the rapport and understand emotionally what they are going through. I may have to reach out to them more often and not just in our session and maybe we should email back and forth or whatever and I work harder to engage them and the same goes for when I'm doing supervision over camera.

I may have to work harder to build up the relationship.

I will skip through some of the slides because this is in-depth. It is what you would use and the next 40 slides we will skip through quickly. I recommend you pull up the PowerPoint from the NAADAC website and look at it. If you want to know more, sign up for another seminar or workshop or conference. I encourage you to learn more.

Overreach of supervisory responsibilities. Establish goals. I have a learning plan for all my supervisees. Is not just get your license. What are the specific skills they want to learn? It's a Word document and we can change things. Be prepared. All my supervision session start with do you have any difficult ethical issues you want to talk about? You have any difficult cases? If they say no I say okay. Here you go. I need to have things.

Here is an ethical situation and you tell me what you are going to do.

Here is a case and I want to look at it and tell me what your diagnosis would be. I need to be prepared. I need ongoing education. I tried to go to supervision courses when I can because I feel is important for me to continue to grow and learn.

Adopt a learning style. I am casual and relaxed and funny. I am not super serious. I am an engaging and it is a learning style based on how I do therapy where it is safe. It is open and I expect them to be engaged. If they make it mistake it's okay because we will learn and grow from it.

Different techniques can be difficult. I have several supervisees who said they wanted to learn to do EMDR. That which of trainings and a class and they do EM DR. I do not do EMDR and I have never been to one of the classes. I know what is and I know what that might know a little bit about it. I have to know enough about what is there doing so if they have a problem I can say what should we do and what can we do? And knowing that each have EMDR coach person and they can be EMDR certified.

I need to know what it is they are doing so though typeset things and techniques are out they're not just therapy wise but supervision wise and you have triadic supervision and group supervision and observe the work. A needs assessment and what do they need to learn about?

One of my learning plans thing with substance use abuse is a thing that goes through substance use. What is ASAM and how comfortable are you doing ASAM? They rate how competent they are. We can look at and say you identify things you need to learn more about and let's make sure it's on your learning land to learn more about and in three months we will look at again and see if we made progress.

Giving accurate feedback. I cannot emphasize enough how important it is if there is a problem and you identify it right away. You do not let it go.

The gentleman with the paperwork was an ongoing issue of help me understand why your notes are three months late. This is an issue. I do not understand this problem. We had the same conversations over and over again. We had to make sure it was documented and it need be accurate. You have to give that accurate feedback.

As a supervisor we say they will figure it out. What if they do not? Now you are stuck with someone you have been working with six months, a year and they have not made progress. They expect you to sign off on the hours and when you say I cannot and if they do not know why, that is not good. They should know why you are not comfortable signing off on the hours. It should be documented and it should not be a surprise.

We want to encourage them and motivate them and model what being a good ethical counselor it looks like. We want to expect much. I want to expect a lot from them. When I say I have high expectations, I was talking to a new work supervisee. She said that is it? Be on time. Show up for your patient sessions.

Make sure your documentation is done on time. These core things I have minimal expectation on. To me, those are do not pass go and do not collect $100 and she said that seems reasonable. To me, it seems this is the expectation make sure you have it.

I need to care. I need to care about what happens with my supervisees. If you have a patient after a while you say I do not care anymore and find yourself doing that with a supervisee, you should probably take a check on whether you should still be doing this.

If we get to the point we do not care, that is a problem.

Some of these I will skip because it is important and relevant and you should know it, however, we will focus on technology. Administrative versus clinical supervision. This can be sticky and may come up when it comes to technology and how you use technology.

There is administrative supervision and clinical supervision. It is important to note administrative supervision is the person that signs off the time sheet, signs off vacation time and maybe do schedule and disciplinary action type of thing. They are the boss. The work boss.

Then you have clinical supervisor who does more like licensure stuff, therapy stuff type of thing. In my organization, there are seven people I do clinical supervision. My name is on their LCSW and it is my name on their temporary practice license. It is me.

However, I am not their boss. I do not supervise the program they work in or sign off their time card or approve their vacation. I do not do any of that.

Where I work it does not really matter. If I have an issue, I go to their actual administrator and say I am worried about this and let's talk through. I am lucky I can do that. I have done supervision before but that is not the case. The administrative supervisor does not work my organization and it is a problem. It is hairy and I do not like it.

It is important you're able to make that differentiation. Thankfully, most of my supervisees I am not only their clinical supervisor but also their administrative supervisor. One-stop shopping is great. That is not the case everywhere. You may find if you work in organization, you may be someone's clinical supervisor and responsible for signing off on their licensure hours, you are not their boss. Making sure you have not only an agreement or plan with your supervisee or whoever there boss is. If there is a problem, this is what we're going to do. If there is a concern, this is what we're going to do.

Make sure you have that down and you talk to the supervisee so the supervisee knows if there are concerns, I will have open dialogue with your administrative supervisor. For a new supervisee who is doing her internship and she's not working on licensure and she is working on her school objectives.

I said I want to be clear if that all of these great things for your school learning plan are amazing and fabulous. I cannot wait to see you work through this. However, if stuff is happening with your job, those take priority. You never get to say Malcolm says I get to do this and this was school so I'm not do the patient transport.

No. Being clear with them that if it's in that type of situation that there work duties do not supersede the other things and less as organization you decide that is what you're going to do.

Tele can make it easier like the conversation I had yesterday. With one organization we have 10 different locations in Billings. If I had to drive around all 10, that would be exhausting. It would be a lot. I can turn on my webcam and we use GoToMeeting or

Microsoft Teams or pick up my phone and talk to them. That is great. Technology allows us to do that and allows us to have multiple roles in multiple locations and as long as we are transparent with these are my responsibilities and obligations and these are your other supervisor's response those obligations, these are have a mesh and great.

There are different levels of supervisor competency. Are they a brand-new counselor or more experienced? That should be stuff that comes out on a learning plan I recommend you have some type of learning plan that identifies where they are at in their growth. They're brand-new or they are not.

Modalities of supervision and this is important when it comes to technology. Individual supervision. It can be time-consuming. They come into your office and you sit there an hour. You go through whatever. It may be a problem in that it may increase miscommunication among staff. I go to my other supervisor and she tells me this and the other supervisor tells me that and there can be conflict.

There is not always opportunity for people to learn from others or build a team. Distant supervision by telephone or email has been used and you can use it in individual or group or technology for individual and group supervision. Telephone and email can be used that will talk through in a minute. Distance is simple and post session debriefing.

A video or phone call. Confidentiality can be better preserved in individual counseling if you add in technology. You have to put in safeguards for confidentiality. If a counselor because my office and we go through a caseload and now let's do it over technology. Am I protecting patient confidentiality the same way I would if it was a patient on the other side of the webcam or phone? How are you doing that?

Do not use patient full names. A lot of us probably use texting. We use texting and not just personal phone texting but never ever put a patient name in a text. Use initials. I had it happen where there's an issue with the patient and I can text a supervisee use patient initials. Your patient at the house and put in the initials had a problem with XYZ. That counselor just based on the little bit should do exactly what I'm talking about. If

they do not and I need to be more in depth is not be over a text. I should call them and tell them.

If it cannot be understood and clear and brief in a text, you should not be using technology to do that. You should call them and talk to them. Do not put the patient name in and that is never a good idea. Texts are not secure. If you use text, it should be patient initials and very short blurb.

If the counselor does not know what you're talking about, call them. Is this a good time to talk? Yes. Let me step in the hallway so I can have a private conversation with you.

I was talking to a supervisee and I was at my house and talking on my cell phone. I was in my living room. We were not talk about a patient issue. I suddenly realized my husband got in the car with my kids to take them to taekwondo. My Bluetooth clicked on and my husband and kids heard the entire conversation. Thankfully, we were not talking about anything confidential. But what a good learning experience for me.

If I'm going to talk about anything confidential over my phone, make sure no one gets in my car and turn on in my Bluetooth kicks in. Good things to think about. That's a great example of how technology can be used to conduct clinical supervision and making sure I use technology appropriately. I am aware of how I might be inadvertently violating patient confidentiality using technology.

Counselors may feel safer and more comfortable individually and certainly when the supervisor came to me in a patient treated her own problem, individual that was the way to go. She would not want to say those things in a group supervision session. Individual supervision and what I prefer with my supervisees is I have group supervision session I hold on Monday. I want them to all come to that.

We have an individual session throughout the week. I like them to do both and I want them to have both. Sometimes it does not work but that is the goal. They should have individual time with me and have group time where they learn from other counselors.

Triadic supervision and there's group dyadic. There are three of use and that is great because if I'm trying to build a team and I need two counselors to work together,

sometimes is great to put them in there. Or maybe two counselors never met each other or work in the same programs, it might be helpful to put them in a triadic supervision together so they learn from each other and know who the other person is.

That is great when you have brand-new staff to put them in a triadic supervision with more seasoned supervisee who could be part of the learning and growing for that new counselor. That is a great method to use. Dyadic is more of where I am teaching kind of like this. I'm telling you what to do versus -- I hope we get to dialogue and stuff in the Q&A box instead of more like where we are discussing like this. Group is standby. When I went to the training back in 2011 where I learned how to do clinical supervision, I realized I never had any individual supervision.

It was a group griping session. Group supervision is great in terms of counselors and more time effective. You can do several supervisees at one time. You can learn different things from each other and they learn and grow and have a chance to mentor and teach others and great group process.

States limit can limit how much group session they had. It may say ask number of hours and a certain amount the group and certainly must be individual. Individual triadic is accepted as well as individual and you need to look at regulations to see what it says.

It can be efficient and effective and role playing. I love doing role playing even though when I was our brand-new baby counselor I hated it. Role playing is a great rate to learn. I want you to practice have the difficult conversation with a patient. Your peer will pretend to be the patient and you will pretend to be the counselor and let's practice this.

Group can happen over camera as well. Be aware if you do that, if you do group session over the camera, do you know they are sitting there paying attention? I can almost guarantee that some of you are checking your email. Some of your probably looking at Facebook. We know that happens. If you are doing group supervision, be aware they may be doing other things as well.

Hopefully, you are not. That goes back to the first slide I had making sure that you are present and attending to that session. You are not also checking your email or playing

Candy Crush or whatever on your phone and you are present and attending that session.

When it comes to technology as great as it is, I am a fan of using technology for supervision. There is the wiggle room to they will not know I am checking my email. They will not know I'm typing while we are talking and some of us are good at multitasking. If it is important enough to do it, make sure you are fully present and doing it.

Supervisory styles and levels of counselors. Level one counselors our brand-new baby counselors. They have more of a task-oriented way. They need to learn how do I connect a group or confront difficult things in a group? How do I write the treatment plan? People at level one in my head is harder to use technology.

I feel to some degree I should be there. It is easier to walk down the hall and sit in the office and say let's look at doing a treatment plan versus share your webcam. You are sharing the wrong screen. And you build a rapport better. Think of a brand-new patient. You build rapport easier live face-to-face versus a camera. Not that a camera is bad but being aware of what they need given the level they are at in terms of growth as a counselor.

Level 2 and 3 counselors may be dealing with more complex countertransference issues. They may need more broadening of skills. They may need looking at how do I build on a foundational cognitive behavioral skills and I want to learn more about that in the different styles. They may benefit from being more interpersonal.

They also might be more independent and do better with technology. They maybe do better with quick check-in on the webcam. Knowing where they're at determines like what you're going to do for them.

Cross cultural supervision. One of the things technology has meant for using technology for supervision, we can access more culturally diverse supervisees and supervisors. We had a leadership session this week on diversity. It is shocking but it is not. Montana is predominantly white.

There is not a lot of diversity here. It is hard to find diversity. How do we bring that in? On technology if I say I need to do better in terms of being diverse with whatever the population in and there's a great supervisee in a different location or a supervisor in a different location who knows about a certain population, how cool would be if I did supervision with them?

What if I could call them and say I can benefit from supervision with your expertise on whatever the issue is or the race or ethnicity? How cool would it be if they can provide that supervision? They can provide me guidance, consultation.

Technology allows us to do that. When it comes to clinical supervision and diversity, technology allows us to access those more diverse areas which may be important.

I will skip a few of these. Getting information. When you build the learning plan, try to do it pretty soon in the process. That should be foundational this is what we're going to learn. But you should feel free to modify that because what if you set a learning plan and go and observe them doing group and say we need to add to your learning plan because you need help doing XYZ.

You want it to be flexible and I need to watch them work and do what they do and maybe modify the learning plan is appropriate. Want to involve the supervisee in doing that. Case presentations are great way to look at how they work. Every clinician should know how to do a case presentation. Malcolm is a 43-year-old Caucasian married female and so on. She itself referred for help and they should know what that looks like. That is a basic foundational things counselor should know how to do.

How do they present the case and present progress is? We do a lot of case presentations in supervision. I ask it almost every supervision session. I will tell a counselor I want you to present this in group supervision next week and have a case ready to talk to the group about. It should have these things. Progress, struggles, what the client is working on what has been tried in the past and the goals. The counselor's perception of what the problem is.

I have brought my own cases to group supervision. When I have a difficult patient, I take it to group supervision. If no one has a case I say I will give you one of my cases.

I give it to them and I have learned from my supervisees. But if you try this? Yes, that is amazing. Thank you. It is good feedback.

Supervisor actions. Demonstrations. Demonstrating how we do this. This is how we do intervention with XYZ. We practice it and do role playing and role model how we do things. Videotape and recording. I see this more with people getting their degree and doing internship. They may have to record or tape a client session. At my organization we do not allow that. We do not allow to tape a patient session. We role-play with other staff. If you need to do that, I recommend on the record the counselor.

You do not need the counselor and the patient. Record the counselor. We are observing what is the counselor doing? If I'm observing a session, what if it's hard to observe that session whether because it is geography or whatever? How do I do that? If you have a webcam, you can observe the web session.

I prefer observing sessions over the camera and this is why. I am less obtrusive. If I need to observe supervisee doing a session and make arrangements the patient knows on sitting there, it is still awkward. I go to the session. I am observing as part of the licensure process and thank you for letting me sit here and I sit here and watch. It is awkward and I feel weird.

It feels you are the third wheel on a date. Versus a webcam. They turn on the webcam and I introduced myself to the camera and I'm observing in terms of licensure and I can only see the counselor and I appreciate you letting me observe. I sit there on the camera. I am not in the room.

Much easier. Patients often feel less awkward you're not just sitting there watching. You are on camera and they do not see you. And if you only do tele and during Covid-19 where we were all doing just tele, it was easy to join a session. I would join the web session and like we are right now there would be three of us on the session and I would say thank you for letting me observe and I appreciate it. I will turn off my webcam and I appreciate you letting me observe your session.

I turn off the webcam in the patient and counselor see each other. I am not there. In my mind, that is the best way to use technology in terms of clinical supervision. I can

unobtrusively observe the session. I love it. Group as well. I do not like group as much because there are 15 people and it is weird. You can still do it that way.

For me, that was one the best ways to use technology for clinical supervision. One-way mirror and bug in the ear or models we can do to use clinical supervision. It is harder to do in technology. Probably good.

Content of supervisory sessions are things of their experience and their strengths and what do they need what are they struggling with? Do you identify those and make sure the reflected on the learning plan. The learning plan should be flexible living document. You should be able to write on it, date it and sign it.

You may say that is well and good but what if I never with my supervisee [indiscernible]? I need to make sure do we send the document back and forth? Do we have file share or Dropbox? You can use technology to share your learning plan back and forth and you should do that.

I will skip through some of these. A couple of high points on documentation. This is incredibly important. Supervision does you no good if you are not properly documenting. Just like doing therapy. It is not documented, it did not happen and the same thing when it comes to clinical supervision. If you are not documenting what the problems are and the concerns are in the progress being made, it does not do you any good. Have the documentation.

There should be a learning plan or document and the state may tell you these are the things that need to be documented. They may have a template for you. If not, write your own. They're competent in making sure you document that and cultural issues that may come up and their scope of practice and things you should be documented.

Boundaries is another thing when it comes to clinical supervision. There are people you should never do clinical supervision with.

[Reading slide]

I tell all my supervisees that if I am their Facebook friend, I'm going to unfriend you. It is not appropriate. I need to make sure there is that boundary there. This can be hard in

a rural community because there are overlapping documents and try to make sure you keep the boundaries in place and verbally tell them that at the beginning.

Boundary issues and making sure as a clinical supervisor you are not their therapist. You may use some of the skills it might look similar but you are not their therapist. Be clear on that. Do not hesitate to say this issue seems big. My supervisee who said her own traumas being triggered said she talked to her own therapist about the issue. I said great. I am glad you are doing that.

Go back to your counselor and keep talking to your counselor. I document that. She was triggered by this and working with her own therapist on that.

I will skip through some of this. Evaluation can be a whole session on how you evaluate. This is recapping the challenges of supervision.

[Reading slide]

Even though I live in a relatively small town, for me to drive to one of the other locations to do clinical supervision is probably going to eat at least 30 minutes of my day. It does not sound like a lot but as up. If I did it several times a day were talking three hours just in travel time by the end of the week. That is not efficient or effective.

Making sure we use technology to be more efficient and effective but if there's an issue and I have to go see this, I need to take time to do that. The issue I need to address with the supervisee this afternoon I will talk with her and may decide next week I will take time and sit with her at the residential house.

If it is appropriate, I will do that. Making sure you build it in and document it. Workforce challenges is not enough counselors and high turnover affect our ability to do quality supervision. Technology makes it easier and more effective. How many of you would have done the technology series if you had to travel to go to each one? Probably not. That is time and money and money is time.

It is not effective. Using technology can be a great way to enhance our workforce, improve our education and team building. We want to use it effectively. E-Supervision

does not replace face-to-face. I make over to the residential house next week and spend time.

It may appeal to the younger generation. I say younger but I do not feel that young. Our younger set is totally comfort with web cans. Some of our older clinicians may be less comfortable. You can you Skype, GoToMeeting, email text and tell had units. These can be used and your smart phone can be used to do supervision.

Make sure you're predicting confidentiality of not just patient but the supervisee. Make sure you're in a confidential space and the supervisee is in a confidential space and if you have a difficult conversation where you address a difficult issue it might be to your advantage to talk to them face to face and in person.

Telephone and email and videoconferencing web chats can be used technology to do supervision but use the tool appropriately. There is evidence that supports using technology for supervision and it is important we know it is not just Malcolm spouting off. There is evidence and research and data that says it is effective and useful.

[Reading slide]

It helps us utilizing technology moving forward and in 10 years the way we deliver services may look completely different and I bet we have more technology involved. We have talked to my organization every new patient was admitted gets a tablet and their task work is on their and web links to different groups are preloaded on there.

[Reading slide]

If I do not get my car, I'm not risking getting in a car accident and it can be safer. Other benefits. If use email to document how you are adjusting your treatment plan, you have a record. It can be useful for non-urgent issues. You want to know if you use technology and especially texting, if a supervisee has a critical issue and they text you I need help, make sure they have a backup if you are not available.

Who else do they go to? They have to have a backup to go to.

[Reading slide]

Email is part of the medical record. Be aware that if you are emailing a patient, it is part of the medical record. Do not use Facebook or social networking sights to post things or communicate. Be aware public Wi-Fi May not be confidential. If you are discussion confidential issues, I recommend using a secure Wi-Fi or use a VPN. If you are discussing general things, I would not worry so much but make sure what is the Wi-Fi and Internet connection you are using?

Look at what is HIPAA and making sure you are protecting that. If you're going to be using technology, have the confidentiality agreement and technology agreement and place so the client is aware that using technology, if they join you via webcam and you are observing session, the client should sign the consent same we are using technology so they are aware. Look at the privacy rules.

[Reading slide]

Supervision is not a guarantee of licensure.

[Reading slide]

There we go. Jesse, I will turn it back over to you. I apologize we had to go fast. This could easily be a full day. I hope you got some good nuggets and tidbits. I will turn it back over to Jesse. Thank you, Jesse.

>> JESSICA O'BRIEN: I will jump into questions. How do you differentiate between a good learning case versus a case that is out of someone's scope of practice?

>> DR. MALCOLM HORN: Do they have a foundational skill to do it? If they bring in I have a kid who is cutting themselves and I have never dealt with that before, what do you think you should do? Do they have a good response? We could try XYZ. Do they have an idea where to go and do they feel comfortable doing it?

If they feel uncomfortable doing it, it may be a good indicator they are not ready. If possible, I sit in with them. If it is a delicate issue, would you like me to sit in while you have the conversation? I would be happy to do that. Do they know what they should do or are they completely off of I don't know?

I ask what do you think you should do? If they have a good answer I say do you feel you can do that and it is reasonable? Great. Try it and let me know how it works. If not, maybe try a different strategy.

>> JESSICA O'BRIEN: And your experience, is there any distance that is too far to supervise someone remotely?

>> DR. MALCOLM HORN: No. I would have talk more about this but if I have someone and a few times I have done distant supervision. I want to make sure someone is on site so if I'm not available they have someone to go to. We need to be clear in lining out in our learning plan and agreement that I'm not just a walk down the hall or drive across town. I am not easily accessible physically.

If there is a physical issue this is a backup and I need permission to talk to the backup person. I had this happen where on-site administrative supervisor was simply not licensed to do clinical supervision. The supervisee signed an agreement and agreed we could talk and it worked okay. I did not really like it but it worked okay because someone was on site they could go to.

The question would be if it is so far away and I am never going to see them on site, it does not matter how many hours away it is, who cares? I think you have to have a type of clause that says if this is not working, we make an agreement I am free to terminate this information if I feel it is not effective.

The thing that bothers me about significant distance is I like to know where they are at. All of my supervisees here, I can go to the residential house and see where they are at. That would get me because I like the big picture and they went to group and we discussed that. I have an image of what it looks like what the setting in verses I have never seen that.

Maybe you say we agree to do this and they have a webcam or use their phone and show you this is my group room. This is where I work. That might be helpful and that might be okay and the distance would not bother me as much if I can see where they're at. It is in times of emergency you care about being on sight and as long as you have a safe plan and the ability to terminate if you need to, okay.

>> JESSICA O'BRIEN: Good answer. I will do one more. What release needs to be done for clinical supervisor to observe counseling sessions over webcam? A consent?

>> DR. MALCOLM HORN: In our organization and our general consent to treat, we added in a technology piece that says we have the ability to use webcams, etc. I would build it into your consent to treat. If it is not something you use for every patient, you can write a simple Word document that says we are going to be using webcams to do XYZ.

Patient has been informed our technology we have firewalls and virus protection and we will confirm who was in the room and not and follow those best practices and make sure if you have a lawyer that they look at it and that seems copacetic and have the patient sign it and you have it on file.

Make sure it has release of liability so the patient complains you can say we gave you fair warning and we reviewed the practices with you and you are well informed. That is the steps I would take.

>> JESSICA O'BRIEN: Thank you very much. That is all the time we have for questions. That was a lot of information. It is in the PowerPoints and you have access to it. In a little plug for our clinical supervision specialty series if you want to learn more and dive into fundamentals of clinical supervision. You can take that.

And we will send Malcolm any questions we did not get too so she can write up the answers and we will post that on the webpage where everyone registered. Thank you, Malcolm. I will wrap up with my last announcements and a reminder that as soon as this is over, the CE quiz should be activated and you can complete it and get your certificate.

If you've not done the certificate process before, use the instructional guide available. It will guide you through and be a seamless process. If you need your certificate to say live, complete the CE quiz within the next 24 hours.

Some upcoming webinars.

[Reading slide]

There is a bit of a hiatus seemingly between September 29 and November 17 but that is because we have our conference at the end of October. We also have three days of pre-conferences. It seems there is nothing there, there is a lot going on and I hope you join us for the conference and some pre-conference days. Those have six CEs each and two you can choose from each day. They will be available on demand and you can do it if you want to.

We hope you will join us at the conference and it is a fun time and a lot of work and I love seeing it come to fruition. A reminder if you've not seen any of our Advancing Awareness In LGBTQ Care Series, they wrapped up September 17 last Friday. It is one of the best series we have ever put together and phenomenal presenters throughout the whole course of the series.

It was a corporate serious and I highly recommend those if you take my recommendations with any grain of salt. I recommend you take that and we had wellness specialty series that wrapped up in June early this year on ethics if you want to take that.

Check that out. Website at the bottom and the benefits of the member and please become a member if you are not already. It is Friday. Thank you, Malcolm. We love having you here. I will not see many of you for a little while but I hope I get to see you all at the conference. At least virtually because it is virtually.

Take care and enjoy your weekend and complete your certificate that pops up after this. Goodbye everyone.

[END]