

Utilizing Quality Clinical Supervision as a Workforce Retention Strategy in Rural Community Mental Health

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ABSTRACT

An analysis of the availability of mental health services indicated that 85% of mental health shortage areas are located in rural America (Bird, Dempsey, & Hartley, 2001). The Council's 2002 Survey of Behavioral Healthcare Providers further indicated that as the demand for services increases, so does the annual turnover rates of direct service mental healthcare professionals. Rural community mental agencies are especially vulnerable to this workforce issue. Challenges that face community mental health staff can be addressed using clinical supervision as a tactic to alleviate weary clinicians and promote accountability and best-practices. A myriad of strategies are suggested for streamlining supervisory practices.

INTRODUCTION

An analysis of the availability of mental health services indicated that 85% of mental health shortage areas are located in rural America (Bird, Dempsey, & Hartley, 2001). The National Council for Community Behavioral Health Care reports a consistent increase in demand for mental health services nationwide (2002). The Council's 2002 Survey of Behavioral Healthcare Providers further indicated that as the demand for services increases, so does the annual turnover rates of direct service mental healthcare professionals. Rural community mental health, with a de-centralized pattern of mental health care, is especially vulnerable to this workforce issue. The Bureau of the Census (2001) reported that the rural United States encompasses 90% of the total landmass, and accounts for approximately 25% of the entire population. The President's New Freedom Commission on mental health (2003) indicated that rural issues in mental health are often minimized or misunderstood; this has resulted in a lack of consideration by mental health policy makers.

In many rural areas, the recruitment and retention of qualified mental health professionals is a daunting task (Merwin, Hinton, Dembling, & Stern, 2003). In a study of 853 rural mental health workers (Destefano, Petersen, Zweig, & Potter, 2003), the majority of workers had been with a specific agency for 3 years or less. Only 10% of those workers were employed with an agency for 8 years or more. Destefano, Clark, & Potter (2004) suggested that while the demand for services in community mental health appears to be on the rise, resources and treatment services have even less availability in rural regions than their urban counterparts. This can cause a significant amount of stress for a clinician who is seeking needed community resources and treatment options for their clients. Destefano, Clark, & Potter (2004) noted that other contributing factors may include the problem severity of rural clients, isolation from other professionals and supervisors, and higher caseloads, thus resulting in subsequent burnout.

Maslach, Jackson, and Leiter (1996) reported that the burnout of community mental health clinicians can lead to their subsequent absenteeism, attrition, poor morale, and deterioration of client care, which can become a financial burden, and can also be very costly to the clients that are served, thus affecting this challenging population of clients exponentially. In rural areas in the United States with limited resources, this phenomenon can be especially restrictive to both the clientele and the counseling professionals that serve them. Kee, Johnson, and Hunt (2002) found in a study of 513 rural mental health counselors that 65% of these participants experiences moderate to high levels of burnout. Wilcoxon (1989) examined 177 mental health professionals in 27 rural areas; results from this study also indicated that participants experienced a moderate to high rate of burnout. However, Wilcoxon also suggested that participants who received a high amount of structure and support from their supervisors endorsed the lowest levels of burnout. Additionally, participants who had administrators who rated high on “consideration for employees” reported less burnout due to depersonalization. These results point to a negative correlation between supervision and burnout. As support increases, the strain of the job decreases. DeStefano and Horn (2008) suggest that emotional exhaustion should be anticipated, addressed, and monitored regularly in supervision and may aid in the retention of clinical staff.

Job satisfaction is a variable that may be associated with lower levels of employee burnout and turnover. While it is reported by the National Council of Community Behavioral Healthcare (2002) the high attrition rate of mental health clinicians is found in all geographic areas, job satisfaction may prevent employee burnout and attrition (Tett & Meyer, 1993). Since job satisfaction may contribute to higher employee retention rates and lower levels of burnout, it should be a primary goal of administrators in the field of mental health to increase employee job satisfaction. Change should begin with administrators and supervisors.

Within the fields of counseling, social work, and other related fields in community mental health, a considerable amount of attention has been focused on the perceived competencies of mental health professionals (Fernando & Hulse-Killacky, 2005; Larson & Daniels, 1998). It is supported that counselor supervision is related to the perceived competencies of mental health professionals (Larson & Daniels). Destefano, Clark,

Potter, and Gavin (2005) investigated the degree of influence of work environment factors on job satisfaction for 742 paraprofessional and professional clinical staff at mental health agencies in rural Arizona. Clinical supervisor support was found to be the single best predictor of job satisfaction. Similar variables that are related to clinical supervision have also been found to affect job satisfaction; social support (Tyler & Cushaway, 1995) and receiving praise by supervisors (Martin & Schinke, 1998) were found to influence job satisfaction. In similar fields, supervision is also being linked to job satisfaction. A study by Hyrkas (2005) found that efficient clinical supervision among mental health and psychiatric nurses was related to lower levels of burnout and higher levels of job satisfaction.

Bernard and Goodyear (2004) point out that there is little evidence that experience by itself will lead to the development of a clinician. But how confident are supervisors in providing clinical supervision? Barnes (2005) indicates that “supervision is critical to the development of competent counselors and, in turn, client growth” (p. 26). Given that clinicians with fewer years of experience may be especially vulnerable to problems such as burnout (Mackie, 2008); this makes supervision a first line of defense during the early stages of clinician development. However, the presence of clinical supervision alone may not improve an employee’s chance of staying with an agency. In a study by Mitchell (2008), there was a negative correlation between the frequency of supervision and counselor self-efficacy. While this correlation did not reach significance, it does pose a poignant question: What happens if an employee receives a high amount of poor-quality supervision? This raises the concern of adequate training for clinical supervisors. In light of these concerns, a myriad of clinical supervision strategies are offered for the purpose of promoting workforce retention in rural community mental health.

Aspects of Supervision

Often times, those professionals who undertake the task of supervision have more education and experience. Because of this, they will often have the highest caseloads and some of the more difficult and complicated clinical cases. This immense workload leaves little time to put in the amount of effort needed to tenaciously support and supervise their staff. In order to effectively oversee staff, a supervisor’s workload should be decreased to allow for an increase in their availability to their supervisees. The result of an increase of supervisory support will lead to the positive growth and development in staff. In turn, staff members will be better prepared for higher caseloads and more complicated cases. Given that few community mental health agencies typically service very large geographic areas and a high number of clientele, this dynamic can maximize the capacity for the ever-increasing needs in rural community mental health.

Given the recent effort to serve large geographic areas, many community mental health agencies have been using various strategies to reach this under-served population including: telemedicine and web-cam technology, satellite offices, school-based services, home-based services. While these efforts are certainly a step in the right direction, this poses a new challenge. Clinicians are becoming increasingly “mobile” in rural regions. This reduces the availability for supervision in moments of immediate need (e.g., a crisis

situation). Utilizing some of these same strategies that reach out to clients could be used to reach out to supervisees that are “in the trenches” (i.e., telemedicine, web-based technology, etc.) to increase opportunities for supervision, especially in remote settings (Sampson, Kolodinsky, & Greeno, 1997).

While these opportunities for supervisory activities may increase the availability for on-the-spot supervision, this should not be considered as a viable substitute for in-person supervision. A variety of modes of supervision is available for use and includes: individual, group and peer supervision. Both individual and group supervision have their benefits. While group supervision can offer such benefits as group dynamics and feedback from the combined experiences of many as opposed to one clinician, individual supervision can offer more of an opportunity for the supervisee to openly discuss personal and professional issues that they would be less likely to discuss in a group setting (Bernard & Goodyear, 2004).

The literature suggests that there are no significant differences in the benefits (e.g., counselor self-efficacy or counselor development) of one or the other or a combination of these two modes of supervision (Dee & Altekruze, 2000; Mitchell, 2008). However, to reap the potential aforementioned benefits of both group and individual supervision, a combination of both modes of supervision is suggested. Furthermore, peer supervision, which is a one-on-one or group supervision approach in the absence of an administrator or more senior staff member, has received modest coverage in the professional literature and is a growing phenomenon in the counseling profession (Bernard & Goodyear, 2004). While peer supervision can offer some of the same activities (i.e., discussing ethical issues, case consultation, and discussing counter-transference issues), peer supervision can also serve to neutralize isolation and burnout (Lewis, Greenburg, & Hatch, 1988). Peer supervision can be considered as a practical option, especially in situations where clinicians might be isolated in satellite offices or school-based practices.

It is also important that supervision be provided on a regular basis and in a consistent fashion. However, opinions vary regarding the recommended frequency and duration of supervision (Bernard & Goodyear, 2004). Munson (2002) suggests that the frequency and length of supervisory sessions and the duration of the supervision experience should be made clear from the outset. While there are no strict recommendations on these variables, the supervisee should know what to expect at the outset of the supervisory relationship. It is the responsibility of both parties to maintain consistency. In rural community mental health, it can be very easy to hold supervision at a lower level of priority, especially when staff members become overwhelmed. Supervision tends to be the first to be left by the wayside when a crisis or an overflow of clients in need comes to the forefront. It is important to remember that those who have the consistent support and guidance of a strong supervisor are less likely to make mistakes in clinical judgment or experience burnout. The regularity of supervision enhances the learning and supportive opportunities for the clinician, as well as increasing counselor self-efficacy (Cashwell & Dooley, 2001; Shanklin, 2003).

During the supervisory process, using a variety of supervisory activities (i.e., case consultation, technical supervision, specific training modules, paperwork training, etc.) is

essential; getting “tunnel vision” by only providing one of these activities can hinder the development of the supervisee. Additionally, it is important supervisors branch out from the traditional one-on-one discussion style to more experiential methods of supervision. Live or recorded observation of the supervisee’s performance not only gives the supervisor a better understanding of the conceptualization of the case (that reading the chart or hearing second-hand from the supervisee may not), but it is also an opportunity to understand other aspects of the therapeutic process (i.e., the clinician’s style, their skill-base, transference and counter-transference issues, etc.). Co-therapy is another useful supervisory method in understanding this process, and it is also beneficial in using modeling as a training tool. While these supervisory methods may be both useful and practical, some methods may pose potential challenges and impracticalities in rural settings.

Training Supervisors

First and foremost, it is important to understand that a competent counselor doesn’t necessarily make a competent supervisor (Bernard & Goodyear, 2004). While there are similar constructs at work in both the therapeutic and supervision processes that certainly doesn’t mean that therapy and supervision are synonymous. Anecdotally, it appears commonplace for the most experienced and effective clinicians to be chosen to provide clinical supervision to more junior clinical staff members in community mental health. However, many of these clinicians lack the training needed to make the most of clinical supervision.

Supervision should be theoretically grounded and developmentally oriented. It is critical that supervisors receive continuing education, professional seminars, and peer review to stay sharp in the areas of supervision that include: a strong theoretical base in supervision and counselor development (Bernard & Goodyear, 2004); ethical principals such as due process, informed consent, and confidentiality (Martinez, 2008); knowledge of empirically-based practice in supervision (Martinez); the supervisory relationship (Kaiser, 1997); and the formative and summative evaluation process in supervision (Bernard & Goodyear, 2004). However, it is suggested in the literature that workshops and seminars alone do not provide adequate experiential training (Holloway, 1992) and supervisors may be best served through advanced graduate training programs (Martinez, 2008). Unfortunately, this continues to be a challenge in community mental health, especially in rural areas that are a far distance from these graduate training programs.

Documentation in Supervision

Documenting the supervisory experience can be used as a means of increasing accountability, tracking the development of the clinician, and can be used for the purposes of licensure requirements. It is recommended that a “supervision contract” be the first step in documentation. However, it is never too late to sit down and draft a contract if the supervisory process has already begun. While the term “contract” is used in the literature most frequently (Bernard & Goodyear, 2004; Munson, 2002; Osborn & Davis, 1996), a more congruent term for this document might be a “Professional

Development Plan”. Osborn and Davis (1996) suggest that a professional development plan should include: clear, measurable, attainable goals and objectives for supervision; a context for services (e.g., frequency, location and duration of supervisory sessions); methods by which the supervisee is evaluated; the responsibilities and expectations of both the supervisor and supervisee; procedural considerations (e.g., due process); and the supervisor’s scope of practice. This plan should be considered as a “living document” – a document that can and should change over time to meet the changing developmental needs of the supervisee.

Supervisory activities should be continually documented. A supervision “progress note” is recommended during each and every activity. This note should have the following components: 1) names of the supervisor and supervisee; 2) date and time of the activity; 3) a review of the last session (e.g., supervisee ‘homework’); 4) content of the session (e.g., case review); and 5) goals to be accomplished by the next session. These components of the note can be used to organizing the format of the supervision session, which is also of great importance. It is important to remember that this document should not have any client identifying information on it. Bernard & Goodyear (2004) recommend using only first names or initials.

Documentation can be especially useful in rural community mental health agencies. Not only does this process emphasize the development of the clinician, but also it allows for an organized experience that provides accountability for all parties involved. In a setting where caseloads are high, clinical staff are few, and time is scarce, using documentation to enhance the supervisory experience can result an increase in an organized and efficient process.

Conclusions

Workforce retention in rural community mental health agencies poses many challenges. Clinicians who are “in the trenches” and experience the many burdens of the job (e.g., high caseloads) may experience low job satisfaction and are potentially at risk for burnout. While this can be difficult for staff, there is also a risk for a trickle-down effect to those receiving clinical services in these agencies. Use of clinical supervision may be a rewarding tactic to alleviate these burdens and, in turn, promote a higher quality of provision of clinical services. Suggested strategies for streamlining supervisory practices include: increasing opportunities for supervision in remote areas, increasing training opportunities for novice and seasoned supervisors, and improving accountability and efficiency in supervision through documentation.

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