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Equity in the Agency Experience: Supporting Supervisors in Community Mental Health Centers

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Editor's Note: This transcript was recorded on August 17, 2022 as part of NEAFAST's year-long series Equity in the Agency Experience. Porsche Lockett, MA, was the facilitator for this conversation.

Jeremiah Gibson: I'm Jeremiah Gibson. I'm the Executive Director for the New England Association for Family & Systemic Therapy (NEAFAST). Thanks so much for joining our monthly conversation about how we, as a group of mental health practitioners can influence, impact, and hopefully improve the practice of mental health currently being practiced by those in a multitude of settings. This is a workshop that focuses specifically on agency clinicians.

Many of our agency clinicians are new therapists, recent graduates with Masters degrees, so these are folks who have unique needs around training, getting used to the ins-and-outs of the work, maintaining a professional caseload, and working with a diversity of clientele. And that's before we get to the standards and requirements put on them by MassHealth, documentation standards, the productivity model, and other topics that we have discussed and will discuss in Equity in the Agency Experience.

Central to and overseeing all of this are clinical supervisors. Supervisors play such an important role in the functioning of agencies. I want to introduce you all to our panelists: Rachael Gay, Jalesa Frye, Amelia Hasbun. I'm going to join this panel too because I have a few years of experience in supervision at South Bay. And our facilitator for today is Porsche Lockett.

Porsche Lockett: Thank you so much, Jeremiah, and thank you so much for everyone attending today. I am Porsche Lockett. I am a Clinical Supervisor at The Home for Little Wanderers. I'm a Licensed Mental Health Counselor and I'm also in private practice as well.Today we are going to consider several questions from the lens of the clinical supervisor. And so, the first question that I have for our panelists is: What are some of the trainings you have received to become a supervisor?

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Jalesa Frye: Hi, everybody. My name is Jalesa Frye. I am a Supervisor at The Home for Little Wanderers in Boston. I've been a Supervisor there for four years now. I will have to say when I first started, I actually did not receive any training at all. I transitioned from my previous role as an IHT Clinician, In-Home Family Clinician, and I was put into a supervisor position. It was kind of sink-or-swim at that point. When I began I was given a supervisors' training which was more like how to be a manager, how to support staff and company policy, with the goal of ultimately finding one's management style. So, it was more about finding who you are as a manager, what your style is, and how you can be respectful of everybody's style that you're managing and be able to identify those styles. And so, that training was provided by The Home for Little Wanderers I would say about two years into my position. And that was my training.

Rachael Gay: I can jump in. My name is Rachael, I'm also at The Home for Little Wanderers and have only been a Clinician Coordinator for one year. I think that interestingly my experience feels pretty similar to Jalesa's and it was four years later. I will say that my training did come right when I started. I think that training was built out by our training program and, again, echoing what Jalesa's shared, a lot of the training was how to be a manager, and I had to seek additional trainings elsewhere for how to engage in clinical supervision. I had good clinical supervision and good models for that but no training on how to develop that style on my own. We do have one online training that's offered on reflective supervision practices which is a practice we embody at The Home. That was just one online training that I took.

Amelia Hasbun: I'm Amelia. I was in community mental health at Behavioral Health Network for a few years. And then I actually left from there and I'm now in a group practice that had independent contractors but we moved to a system where now it's a bit different, and people now have salaries and things like that. I was given the opportunity to do supervision, something I had never done before. I'm brand new and I did not receive any training and I have been figuring it out along the way. But, thankfully, because of CANS, I would get emails alerting me to CANS training, and I have been doing them. And so, one of these training sessions included the Assessment in Clinical Understanding, which was very helpful, as it connected me with other clinical supervisors, so we were able to collaborate, and support each other. And so, I went through that training to review my own ways of assessing and then also to help supervisees with their assessments.

Other than that, I have been on my own. I do seek supervision from other supervisors that I've had in the past, which has been immensely helpful; I stay in touch with an LMFT Supervisor who retired from Behavioral Health Network. We regularly meet, and she kind of gives me a lot of guidance. And then, in relation to paperwork and figuring out how to get guidance around that, I do have somebody else that I work with within the practice where we're trying to figure out ways to make the paperwork more efficient. Ultimately getting the necessary guidance has been very challenging.

Jeremiah Gibson: Hi everyone, my name is Jeremiah Gibson. I worked at South Bay for seven years, three years as a therapist, In-Home Therapist, and then four years at the Dorchester office as a Supervisor. My role was a little bit different: South Bay had a distinction between Administrative Supervisor and Clinical Supervisor. So, I was technically on the books but not really paid staff or anything like that. I got 1099s, not W-2s, and was seen as a consultant. So, one of the things that I think will be important for us to talk about as we go along is the distinction between clinical supervision and administrative supervision. I strictly did clinical supervision; I didn't oversee the paperwork or any of the documentation standards that agency workers have to oversee. Thank goodness, because that is not my gift.

Regarding the training, I did not receive any training from the organization, but I did five years ago the American Association for Marriage & Family Therapy (AAMFT)'s approved supervisor training which I took at a weeklong conference at the AAMFT Conference in Atlanta. And that was a 30 CE program, 15 face-to-face, 15 internet. It was a really good training program but I had to pay for it out-of-pocket since I wasn't a W-2 employee at South Bay. The supervision training at AAMFT tends to focus a little bit more on the administrative supervision stuff: how to oversee documentation and the like, and less so around how to help clinicians conceptualize cases, how to address transference, countertransference, self-of-therapist issues, things like that. Like the other three panelists, I was much on my own for that.

Porsche Lockett: Thank you for that. So, the next question I want to ask is: how did the training you received, or lack of training you received impacted how you function as a supervisor today?

Rachael Gay: A lot of how I show up as a clinical supervisor comes from an eclectic approach, because it's being pulled from different areas of learning. I had multiple supervisors, as is often the case in community-based work, the result of high turnover. And I'm wondering, "What did I appreciate about this person as a supervisor, and how do I want to bring that into my own practice?" So, I think the modeling I received from other skilled supervisors and how I want to show up in that is the most helpful.

I also think it invites our staff to give us the feedback about what is, and is not working for them; I think that has been more the primary model, on-the-ground learning exploring what didn't go well this week, and then focus on following up in our next meeting," versus, being equipped with a toolbox of things that I bring every week. It feels more like I'm adapting my style as I go.

Amelia Hasbun: I would add that not having consistent supervision training meant that I was essentially changing what I'm trying week to week. In some ways it reminds me a little bit of graduate training where you're learning about different models and you're trying something different depending on that week's teaching. And, depending on the feedback that I get from my former supervisor—and, again, I see her about once a month—I kind of head into the next month

trying different things. So, I suppose it's like trial-and-error; definitely not that efficient of a way of doing things.

Organizing clinical tools for clinicians has also been very challenging. I guess I feel like I'm going in a lot of different directions at once because the paperwork aspect gets mixed in, and trying to help clinicians with their paperwork and meet standards with their paperwork—that's a huge chunk. And then, of course, dealing with clients and everything that comes up with them, and fielding client calls that come in when they're not comfortable talking with their clinicians. And then, helping clinicians in accessing trainings that they want to pursue that I may not know about, and also, when they're expressing interest to me that they want more supervision in a particular model that I'm not too familiar with, and trying to find resources for them or refer to somebody else that I may know that they can consult with.

So, again, all of this to say, I guess I just find myself being pulled in a lot of different directions and trying to figure out: "How can I best balance this? How can I build a relationship with these clinicians? How can I build trust with them? How can they come to me and know that I support them and I care about them genuinely? Also, how can we get your paperwork done? And for it to be correct? And how can I hold you accountable for that? And how can we help your clients?" So, it's just being pulled in so many different places.

Jeremiah Gibson: Yeah, that's a lot of different roles. Hats off to you, Amelia, and Rachael and Jalesa and Porsche for navigating all of the components of supervision that you do. I got lucky that my role was strictly limited to clinical work. And even then, my experience was that the agency kind of cut me loose and didn't give me very much oversight, which I think is both confident-building, and I look back at the Jeremiah of five years ago and I'm like, "Y'all are crazy for trusting me as much as you did." Because there's a lot of wisdom and skills that I've picked up in the last five years that I would do a lot differently: everything from thinking and conceptualizing casework differently, to including conversations about race and class and gender into conversations. I did receive supervision of supervision as part of AAMFT's process through my boss. That was helpful. I recorded a couple of my supervision sessions. Those were painful to watch, as all recorded evaluative work should be. So, those were helpful. And then also I was in supervision as a Certified Sex Therapist towards the second half of my time at South Bay. So, I really paid attention to the way that that supervisor connected with me, built supervision structures, and then toward the end of my time at South Bay, I tried to model that. But I didn't really have any sort of checks and balances or too much oversight of that.

Porsche Lockett: So, the next question I have for you all: When there's a crisis within communities of color, how do you respond to the clientele and to your employees that have been impacted to support them in that time?

Jeremiah Gibson: Can I share a story of what not to do? So, five or six years ago, there was a big opioid crisis and attention to the opioid crisis that was happening on the Cape. And the Cape is primarily in working class white communities. And so we watched a documentary in one of my groups. And I'm thinking, "Oh, I'm doing really good. I am talking about a really important topic and bringing film into it." And one of the members of my group, as an African American woman, raised her hand and pretty angrily, understandably, said, "Uh, Jeremiah, the opioid epidemic, heroin epidemic, has been impacting my Black communities for years and years and years. And you're only showing this video because this is something that's impacted white communities and now it's finally getting attention." And I'm like, "Guilty." And at that particular time, I had very few resources and people in my life to talk about the intersectionality of issues, in this particular instance, substance use within different sectors, different types of community. And then I also failed to consider media coverage and the way that our professional communities talk more about things that happen in white communities and not much about things that happen in non-white communities. So, I wanted to out myself to begin that conversation.

Jalesa Frye: So, I think as a supervisor of color who mostly supervises clinicians not of color, I see where the clinicians and clients are, what perspective and lenses they're bringing so that when they go into the homes they're not doing more harm. So, that might be checking their biases or sometimes being the person that they have to ask questions to—things that they might not know. And while I do not own the Black experience for everybody, I do try to give perspective that they might not have so that they're not using their families as a knowledge-base. I try to give them whatever context I can and just supervise them the best way that I can so that they're not going into Black and Brown homes doing more harm or feeling that white savior complex and bringing that into homes of people of color.

Rachael Gay: It's interesting we're at the same agency and just the opposite where as a white supervisor, all of the people I supervise are people of color. And so, I have found, doing a lot of checking on myself of when I'm showing up in white saviorism, asking myself: "When am I not naming things that need to be named?" I think for a while, my team and I were processing and naming a new thing that is showing up. And my team and I got to this moment of like, "We appreciate you naming it, and trust us when we bring it to you and share when we want this centered in our experience". I think that was a really helpful learning moment for me. I know a couple of months ago around where there were a few mass shootings, I was continuing to name it and advocating to the higher-ups: "How are we giving productivity reductions? Like we are expecting people to show up at work when communities of color are being harmed everyday?" I think it was an interesting learning moment to learn my staff didn't ask for that, they will let me know what they're asking for.

And so, it's this balance of: "How are we making agency-wide decisions and also making those decisions informed by our staff too and not centering voices that are like mine?" And I think, too, when my staff are working with white families that is a unique position to be in for myself of

naming, "How can I show up in support for those white families? And how can I step in to, you know, do some of that labor that might not be yours to hold and shouldn't be yours to hold?"

Amelia Hasbun: I think there are so many different things that come to my mind with this. It's really important to me that we have some kind of a space to talk about things if we want to. Ideally, I was hoping people where I'm working right now would want to meet as a group to be able to talk about difficult things. People didn't really seem to jump onto that idea, but we do have an online thread for tragedies. I put on this thread things that are happening in hopes that people will respond. Out of all of the threads, I am the only one, except maybe two other emails. So, what I'm noticing is a lot of people aren't feeling comfortable to talk about difficult topics, especially when it comes to tragedies within communities of color. And I think that within individual supervision, I'm noticing people are a little bit more comfortable to talk about challenging things if I bring it up. I wish that this could be a bigger conversation that would include all of us, but there seems to be some kind of tip-toeing.

I've also been struggling some with the goodness of fit for clients and clinicians and wanting to be respectful that: "Ok, yes, we can all push ourselves, and technically a clinician can address some of this stuff with clients if they're being triggered in a way that might be appropriate. But do they have to and do they need to and do we need to be putting clinicians through that? Not really, I don't think. So, what else can we do to support the clinician and make sure that as a whole we have their back too and knowing that, no, you are not going to be assigned someone different because you're not happy with them for this reason, you know? That's really not okay.

What I'm noticing is a lot of clinicians just questioning what's ok and not ok to bring up with their clients. I don't think that there are too many rights or wrongs, but I think that people deserve to not be traumatized by their clients and to have some space to do what's right for them and to protect themselves in some way. And I don't think that a lot of the time clinicians do protect themselves; we're usually kind of thinking about the clients first. But there's also a line with that I feel.

Porsche Lockett: Thank you so much for sharing all of those wonderful perspectives. I think those are so awesome. I would like to add to what Jalesa and Rachael have shared because we are clinical supervisors at the same location. I am a clinical supervisor with a whole team of people of color. Although we are all of color, we're all different backgrounds; we come from all different experiences and different impacts in society—which one, is something to account for. The second piece is as a therapist of color, as a woman of color, and as a clinical supervisor of color, there are moments that are large and big for people.

So, when we have tragedy, I can say that myself—and I can speak for the folks on my team—that sometimes we have just been so overexposed and oversaturated with these experiences and

with these moments in our communities where we have learned how to move through space and time and keep going. We may look up: "Is there anything I can do? Nope, okay, keep moving forward." And sometimes there's space where that's not healthy because then there's a portion of hurt trauma that is not being worked through. And then there's a time when it's like, "This is normal. This happens often." And sometimes the response from others is shock:, "Oh wait, this is an experience that you feel often? This is a pain that you feel often? And you still have to move through the world in a way that does not allow you to take space and time?"

And so, for me as a clinical supervisor, it's helping my team first, check in, "How are you feeling about this? Where are you? Do you need to put it on the shelf, leave it on the shelf? Do you need to look at it? And also, then what do you do for your families? Are they wanting to talk about it? No? Ok, was it someone that they knee? Did it happen in their neighborhood? Is it scaring them from going out into the world?" And so, those are the questions that I ask my team. As a supervisor of a team of color I am always taking their pulse: "Ok, where on the scale or on the spectrum are you with this?" So, I just wanted to add that third component with having the other two perspectives of my colleagues as well.

So, we have a few minutes before we wind down. So, I would love it if you all could add a tip or snippet that you would pay forward to a clinical supervisor—someone who was in a position of training others—that you feel like, "If I had had this little nugget beforehand this would've really been great."

Jalesa Frye: I think if I had been trained more to manage conflict. Let me explain what I mean by that. When you have a team of people, people might witness something and think one thing. Then, rumors and perception starts to come in, and people hold a perception that is not accurate, and then that inaccurate perception causes conflict. And as much as you would like to tell your team like, "What is happening is being managed between that person," you can't give details, as much as they want, because it's private amongst that employee. And I think at times that causes a lot of conflict because people don't see what's going on behind the scenes; all they think is, "Well, this person is doing this," and then that creates conflict within trying to manage all of these different people and the perceptions that they have. And so, I wish that I knew three years ago how to do that. I wish that there was training or something around managing conflict.

Amelia Hasbun: I think that this is going to sound very basic, but for me it's true. I think just looking back, I wish that I had been meeting clinicians just as a person-to-person and joining with them just like I do with my clients more. I'm so new to this and I think that speaks to how much training I need. Just thinking of models of supervision and joining with your clinicians and getting to know them a little bit and building a relationship first before anything else so that when there are experiencing a crisis of some kind, we have something to pull on, and that we know a little bit about what helps us get through the day and coping strategies within their family or whatever that might be. There are people that can help them, and it's important to know a little bit about the

support system that's available.

I think I gave in a lot to the pressure that is built into the system, "Figure this out and get their paperwork done and have it meet this criteria now," that I skipped over thinking, "Oh yeah, I can build these relationships. It'll happen over time." But really, it won't because then I'm going backwards and am often left wondering, "Well, what are you going to do to take care of yourself tonight?" But had that all been built in from the start, and I had given myself permission to slow things down, then we could think about balancing the needs of the individual, and the system a little bit more gracefully.

Jeremiah Gibson: I definitely second, Amelia, your comment about community: find community, build relationships. One of the things NEAFAST has invested in for the coming year or two is building more peer consultation groups, and I'm highly invested in having one of those consultation groups being for supervisors. To add to that, I would encourage folks to say that the needs of your clients and then also the needs of the therapist supersede the needs of the agency. I'm told this is why I was never hired as an administrative supervisor, because that's not a particularly popular opinion within the agencies; I think my organization knew that I had that perspective but kind of still wanted me to be a part of their team. Figuring out how to navigate that the needs of the client, the needs of the family system, the needs of the therapist are going to clash with what the agency needs and encouraging folks to lean into what's best for the family system and the therapeutic relationship.

Rachael Gay: I would probably say that learning that feedback and evaluation is a two-way street. Maybe evaluations are on the mind because it's staff evaluation time at our organization, but I think agency structure creates so many opportunities for supervisors and managers to give our staff feedback and very little opportunity for staff to give feedback to supervisors and managers. And I think creating multiple avenues to do that can reduce the power dynamic of the fear of, "Do you have any feedback for me?" That's a scary environment to give your supervisor feedback, so I've been looking to really lean into supervision reflection forms and utilizing reverse evaluations, which can be another task in a busy week. I think I supervise a team of experts in what they do as well and so, I'm no expert and I just value their feedback. And it's not just that we're supporting them; it's that they're supporting us as well.

Jeremiah Gibson: Can I ask a question to the group? And, Porsche, I'm curious about your feedback on this, too. If there is one element of support that you wish that your agency gave you in being a more effective supervisor, what do you wish that element would be?

Porsche Lockett: One, I will say that this is my first official position as a Clinical Supervisor and so honestly I feel very lucky. Rachael, Jalesa, and two of our other colleagues and myself: I think that we're a wonderful team. I went into this work wanting to give back to clinicians so that more clinicians would become licensed so that we would then have more licensed clinicians to provide more help and care for people. So, for me it has been a really good experience as far as community

work. And I know that that's not necessarily always the case, and I know working for organizations can be hard. I support what Jeremiah says about clients and supervisors being priorities and I find that to be very important.

However, the other piece that I find difficult is being in community is in private practice. That solo part and having a clinician who might be contracting for me, I have found that kind of clinical supervision work a little more difficult because I am the agency and I also care about your wellbeing and I also care about the client. And so, that feels a little bit more stressful for me as opposed to working in an agency.

Rachael Gay: I believe Jalesa spoke a bit to this but I would definitely value and benefit… So, in In-Home Therapy it's a dyadic model so it's often two people working together, and I really could use support in how to mitigate conflict, support compromise, support collaboration. I think particularly when we step into family systems, we become a part of their family system and often that shows up with both clinicians. And I really struggle to figure out how to support that work. And it can be hard I think in particular when you supervise one person and another supervisor supervises another person because we're both supporting our team members and they are having challenges within a family system that is having challenges. And so, that systemic support I think would be so helpful because I think that conflict comes up all the time.

Amelia Hasbun: I think it was Rachael that mentioned something about this. Feeling supported in allowing clinicians to have flexibility in reduced productivity if they're going through something or, again, if there's something that's happening that's so big that people can't really show up and be present with people, that that would be okay. And, again, having moments to allow for productivity to take a backseat when it comes to things that are just so much more important. And I just feel that there's such an emphasis on that that it gets in the way so I suppose a support in prioritizing clinician care.

Porsche Lockett: Thank you for that. I wanted to ask: How do clinical supervisors take care of themselves in order to continue doing this work? Because working with clinicians and also being a clinician who works with other folks, where does the time and space come in for yourself?

Jeremiah Gibson: Can I ask another version of that, Porsche? I want to be careful about asking in this process. How can we create a system within agency work that allows for that question to happen? That allows for self-care to happen? With supervisors being people who are leading the charge in advocating for that; advocating for, Amelia, what you're talking about. Because my direct answer to your question… I haven't seen it practiced, unfortunately.

Jalesa Frye: I would have to say for our agency for The Home for Little Wanderers, because we are productivity based, I think supervisors could be better at self-care when our staff is better at self-care. And I think what hinders them is these increase-in-productivity numbers continuously

going up and up and up. And we're requiring more and more from them. And while as supervisors we don't have to meet productivity, we have to support our staff who are scrambling to meet productivity. So, finding ways to help them be creative. And I think the productivity model in itself is not conducive to self-care, because even when they go on vacation they're still technically responsible for productivity so now we're asking them to make up their time and work harder in these other weeks to manage taking a week off. And that is not fair and our staff has been complaining and asking and advocating for it, and we've been doing the same, and there's been no budge. And it really starts with CBHI, the whole CBHI model. We're not mad at upper management for imposing it on us; it's a CBHI problem. And Massachusetts needs to address that model and how that, you know, trickles down to your bottom line workers.

Amelia Hasbun: Yeah, I think that's a beautiful answer. I really support everything that you said there.

Porsche Lockett: I think continuing to advocate is really important. And I know that that can also feel like running up against a brick wall sometimes. And so, I wonder if, as we are in our different agencies and different organizations, we continue to make a splash and more noise, if at some point it will be seen, then it'll be something that is seen across the board. Because I'm sure the folks who run these agencies at some point are talking to each other, just like we have a space to hold for each other, that hopefully these ripples will be seen at the same time. That's a desire that I have.

So, if we don't have any more questions, we're going to begin to wind down. We're going to pass it over to Jeremiah so he can tie it up. Thank you so much for coming and holding space for everyone today.

Jeremiah Gibson: Yeah, and I want to echo what Amelia said. Jalesa, thank you so much for the way that you summarized what you did. One of the reasons that we're recording this session is that we can have this on file so that as NEAFAST grows, as we get more numbers, more influence, we can refer to this document and refer to this in a professional journal context and hopefully use this as a way to influence some of the decisions that get made about where money goes, where money stays, things like that. So, you're absolutely correct that it's definitely an upper level issue. Thank you all so much for being a part of this conversation.