Mental Health & Addiction
Certification Board of Oregon
(formerly ACCBO)

Behavioral Health Supervision

Oregon Behavioral Health Workforce Survey

(n=1,302)

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Brent Labhart, MSW student-intern
Eric Martin, MAC, CADC III, PRC, CPS

Data Analysis Consultants
Christi Hildebran, LMSW, CADC III
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Section 3: Behavioral Health Supervision

Summary by Aja Stoner, M.S., CADC III, Chief Clinical Offifficer, Addiction Recovery Center

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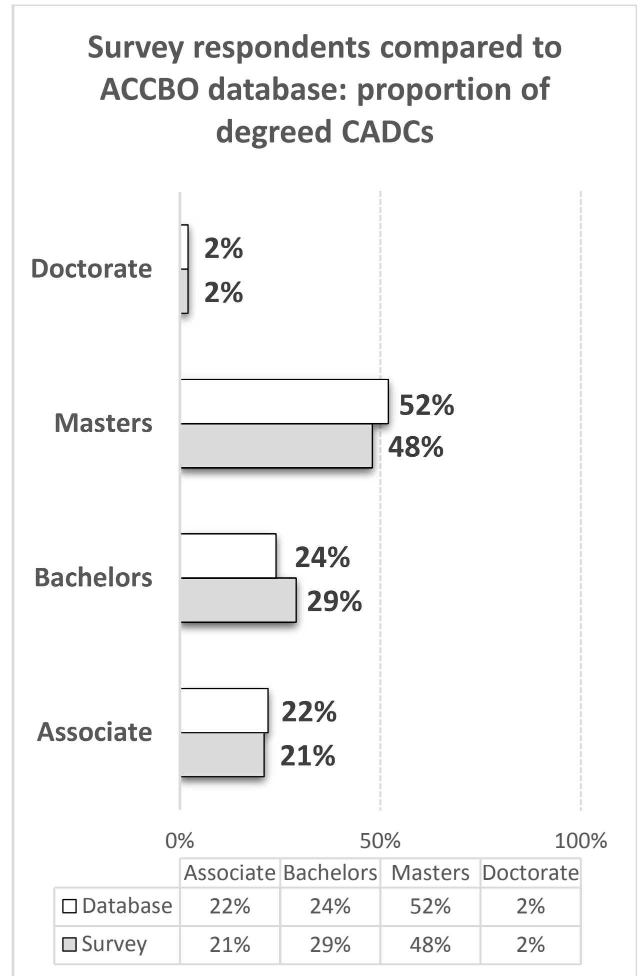
Survey Methodology

Collaborative Survey Development: This 2018 survey was developed and analyzed by 98 participants, representing statewide behavioral health organizations: ACCBO, AOCMHP, OPERA Portland State University, Oregon Health Authority, the MetroPlus Association of Addiction Peer Professionals, HealthInsights, the NW Instituto Latino, the African American Behavioral Health and Addiction Treatment Coalition, and the University of Colorado Farley Health Policy Center. Participants worked in core groups and with contributors to design survey questions to elicit information regarding disparity, wages, benefits, contemporary healthcare initiatives, caseloads, etc. The draft survey was emailed to over 100 program directors for their review, generating feedback regarding clarity and readability of questions. Flesch-Kincaid analysis ranks this survey at grade aptitude level 12.9.

Implementation: Survey was implemented through Survey Monkey. Survey was emailed to 4,400 CADC's/applicants (QMHA's/P's), CRM's, CGAC's, CPS, state approved addiction treatment program directors, and state approved mental health program directors. The survey was also distributed through AOCMHP, the Association of Oregon Community Mental Health Programs, and OPERA the Oregon Prevention Education and Recovery Association. Announcements through Constant Contact bulk email, and SMS text messaging encouraging participation were disseminated statewide.

Response: Survey data was collected from 1,306 respondents. 86% completed the entire general survey (questions #1 through #105), and 82.0% completed the additional role related questions.

Cross-Database Validation: Of 1,306 respondents, there were 776 degreed CADCs. These 776 CADCs were assessed proportionally by level of education and compared to proportions of nearly 3,000 degreed CADCs from ACCBO's database.



	Associate	Bachelors	Masters	Doctorate
Database	22%	24%	52%	2%
Survey	21%	29%	48%	2%

This cross-database comparison suggests baccalaureate CADCs are slightly over-represented in the survey. Overall, the proportion of CADC respondents closely approximates that of Oregon's entire CADC pool. It is important to note that ACCBO updates educational attainment of CADCs every two years upon recertification, and it is possible some individuals have completed a bachelor's degree since their last renewal of certification.

Survey Development Question Writing & Contribution:

- Michael Razavi, M.P.H., CADC I, PRC, CPS, *Addiction Counselor Certification Board of Oregon*
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- Jesus Navarro, CADC II, *NW Instituto Latino & Volunteers of America*
- Anthony Jordan, M.P.A., CADC III, *Multnomah County*
- Heather Jeffries, M.A., ATR, *OPERA*
- Cherryl Ramirez, M.P.H., M.P.A., *AOCMHP*
- Mark Davis, CADC II, *Addiction Counselor Certification Board of Oregon & Polk County Mental Health*
- Van Burnham IV, B.A., CRM, *Addiction Counselor Certification Board of Oregon & Treasurer, 4th Dimension Recovery Center*
- Julia Mines, M.S.W., CADC III, *Addiction Counselor Certification Board of Oregon*
- Aja Stoner, M.S., CADC III, *Addiction Counselor Certification Board of Oregon & Jackson County Health and Human Services*
- Christi Hildebran, LMSW, CADC III, *HealthInsight Oregon*
- MetroPlus Association of Addiction Peer Professionals, *review of survey questions and question writing at membership meeting of 58 peer participants*

Survey Reviewers/Editors:

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- Cheryl Cohen, LPC, CADC I, *Healthshare, Behavioral Health Program Manager*
- Jackie Fabrick, M.A., *Oregon Health Authority*
- Reed McClintock, M.S., QMHP *Cascadia Behavioral Health Care*
- Chris Mason, *CEO Addiction Recovery Center*
- Rick Trelevan, LCSW, *Executive Director, BestCare*
- Kim Shay, M.S., LPC, *Center for Addiction and Counseling Services*
- Michelle Brandsma, M.S., CADC III, MAC
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- Eric Martin, MAC, CADC III, PRC, CPS, *Addiction Counselor Certification Board of Oregon*
- Christi Hildebran, LMSW, CADC III, *HealthInsight Oregon*
- Anthony Jordan, MPA, CADC II, CRM *Multnomah County*
- John Fitzgerald, PhD, LPC, CAS *Oregon Criminal Justice Commission*
- Jeff Marotta, Ph.D., CADC III, CGAC II, *Problem Gambling Solutions & Voices of Problem Gambling Recovery*
- David Course, M.A., LPC, CADC III, CGAC II, NCGC II, *Program Manager, Lincoln County Health & Human Services*

Section III: Behavioral Health Supervision

We analyzed responses from Addiction program supervisors (*n=105*), Mental Health program supervisors (*n=50*), addiction staff (*n=710*), and mental health staff (*n=508*).

Overall, the majority of both addiction and mental health supervisors reported that they also perform direct care in addition to their supervision activities (*fig.1*). Inpatient/Residential supervisors were more likely to report performing direct client care (*fig.2*).

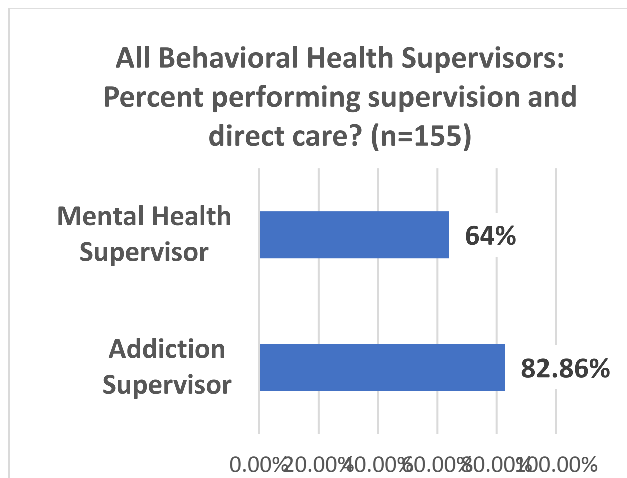


Figure 1: Supervisors who report they also perform direct care

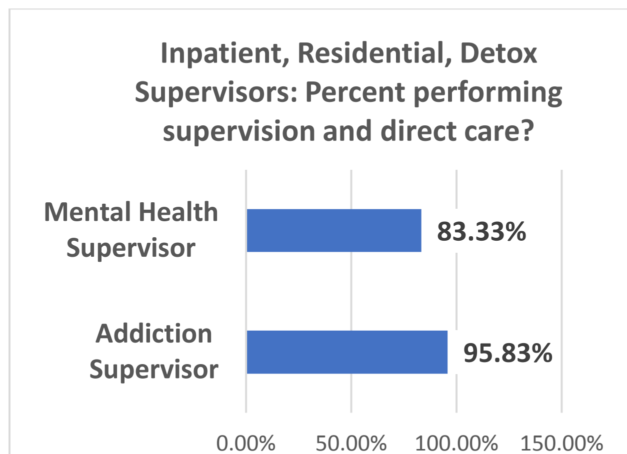


Figure 2: Percent of Inpatient/Residential Supervisors performing direct care

Addiction and mental health supervisors report wide ranging numbers of individuals they supervise.

Mental health supervisors, largely perform supervision for mental health peers (PSS) and peer wellness specialists (PWS), qualified mental health associates (QMHAs), and qualified mental health professionals (QMHPs).

Addiction supervisors, largely perform supervision for certified alcohol and drug counselors (CADCs), addiction peers (CRMs/PRCs, CGRMs), and certified gambling addiction counselors (CGACs).

Behavioral health supervisors report an average of 16.5 years of experience working in behavioral health.

Both addiction and mental health supervisors, perform supervision duties for approximately 10 staff, while often simultaneously providing direct care (*fig.3*).

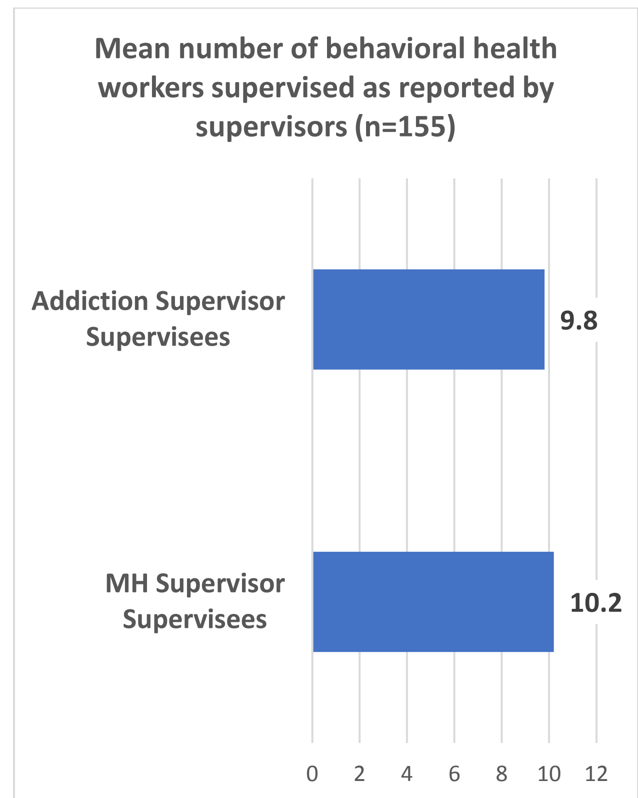


Figure 3: Average number of supervisees for both addiction and mental health supervisors

We asked both supervisors and staff if they provide or receive two hours of supervision per month consistent with Oregon Administrative Rules.

92.15% of Addiction supervisors reported that they provide two hours of supervision per month (*fig.4*), while only 76.65% of addiction staff report receiving two hours of supervision per month (*fig.5*).

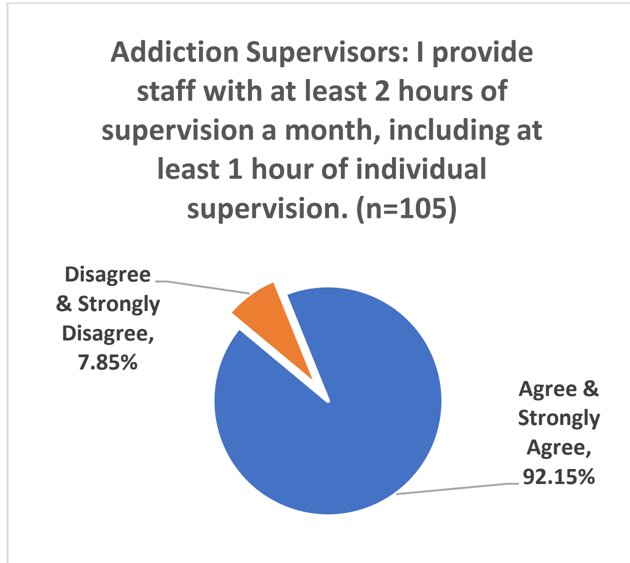


Figure 4: Percentage of Addiction Supervisors reporting they provide 2 hours of supervision per month

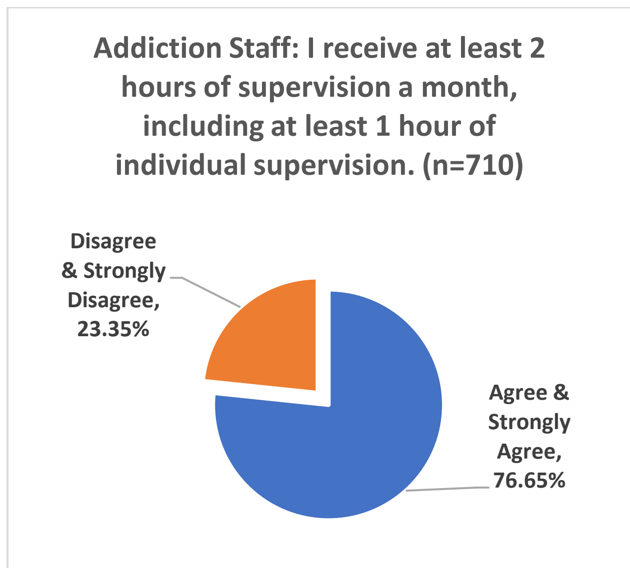


Figure 5: Percent of Addiction Staff who report receiving 2 hours of supervision per month

94.20% of Mental health supervisors reported that they provide two hours of supervision per month (*fig.6*), while only 78.22% of mental health staff report receiving two hours of supervision per month (*fig.7*).

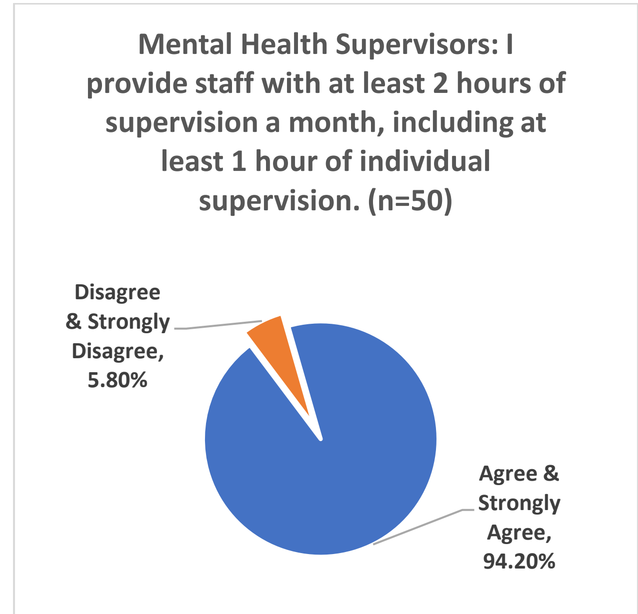


Figure 6: Percentage of Mental Health Supervisors reporting they provide 2 hours of supervision per month

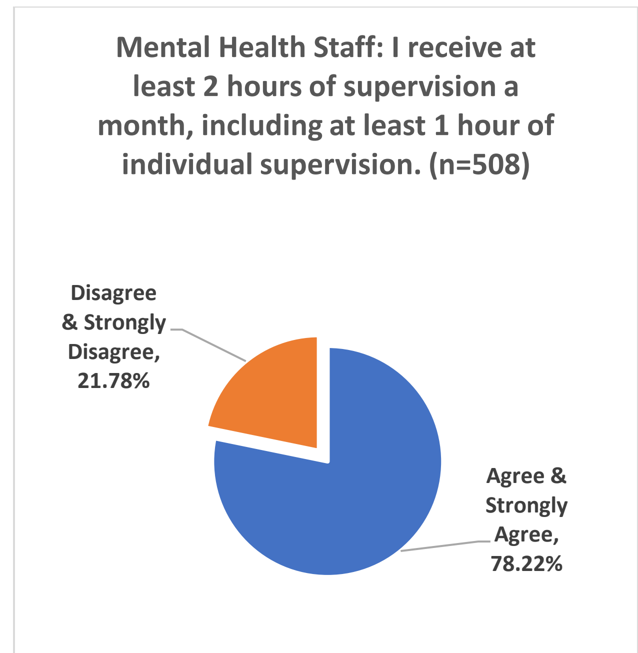


Figure 7: Percentage of Mental Health Staff who report receiving 2 hours of supervision per month

97.09% of addiction supervisors reported that they are available most of the time and discuss issues that arise within 24 hours (*fig.8*), while only 87.71% of addiction staff report their supervisors are available most of the time and are able to discuss issues within 24 hours (*fig.9*).

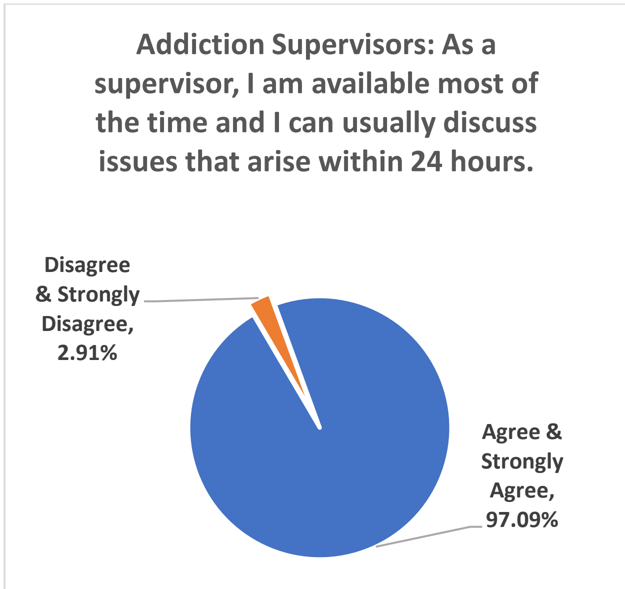


Figure 8: Percent of Addiction Supervisors reporting they are available most times, and respond to issues within 24 hours

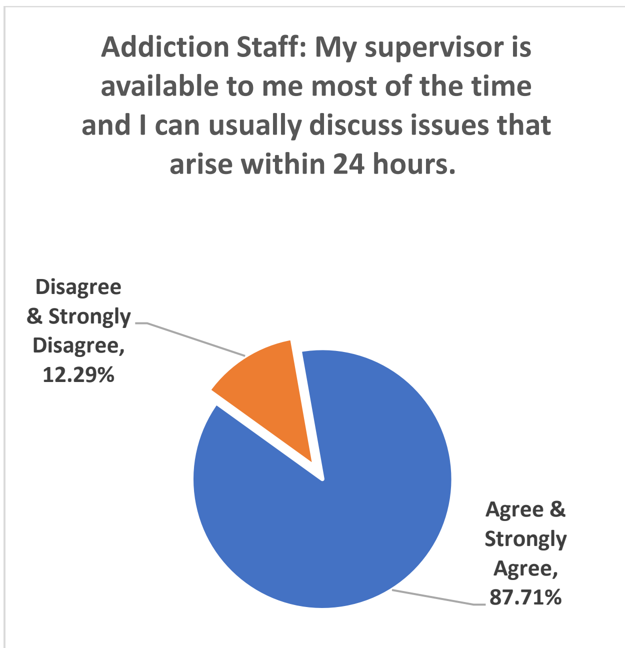


Figure 9: Percent of Addiction Staff reporting supervisors are available most times, and respond to issues within 24 hours

100.00% of mental health supervisors reported that they are available most of the time and discuss issues that arise within 24 hours (*fig.10*), while only 85.77% of mental health staff report their supervisors are available most of the time and are able to discuss issues within 24 hours. (*fig.11*).

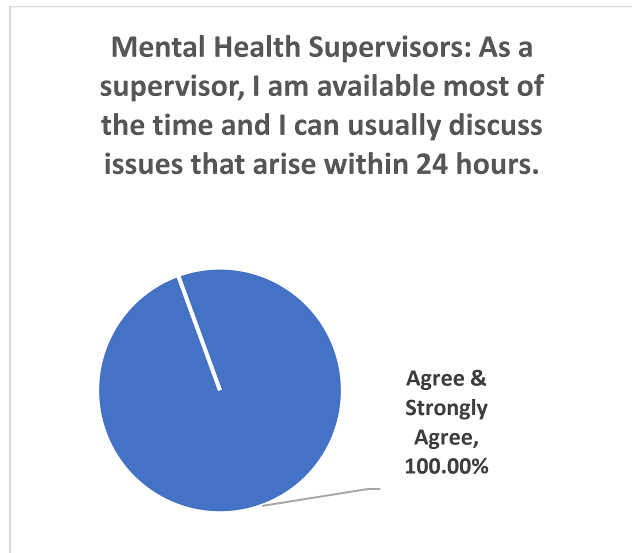


Figure 10: Percent of Mental Health Supervisors reporting they are available most times, and respond to issues within 24 hours

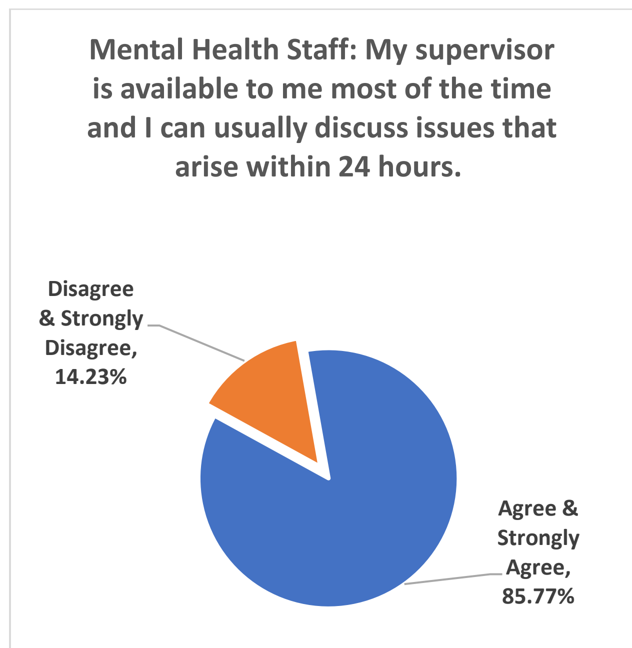


Figure 11: Percent of Mental Health staff reporting supervisors are available most times, and respond to issues within 24 hours

95.10% of addiction supervisors reported that they create professional development plans with those they supervise (*fig.12*), while only 72.57% of addiction staff report they have a professional development plan (*fig.13*).

94.00% of mental health supervisors reported that they create professional development plans with those they supervise (*fig.14*), while only 70.47% of mental health staff report they have a professional development plan (*fig.15*).

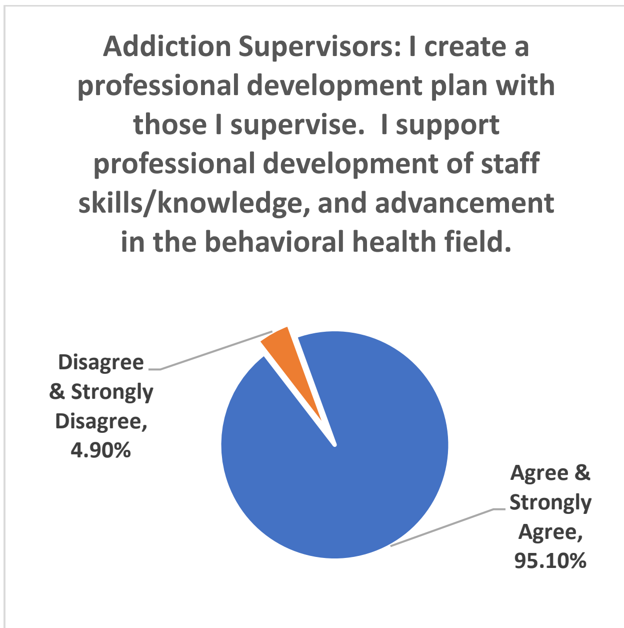


Figure 12: Percent of Addiction Supervisors reporting they create professional development plans for their staff

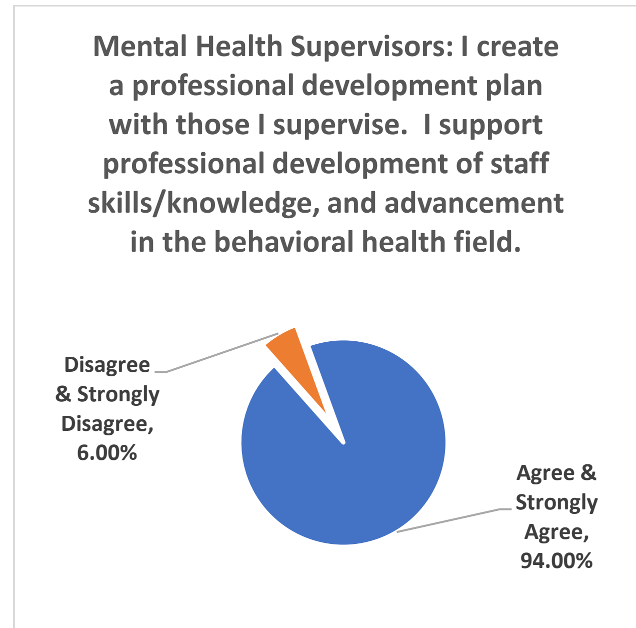


Figure 14: Percent of Mental Health Supervisors reporting they create professional development plans for their staff

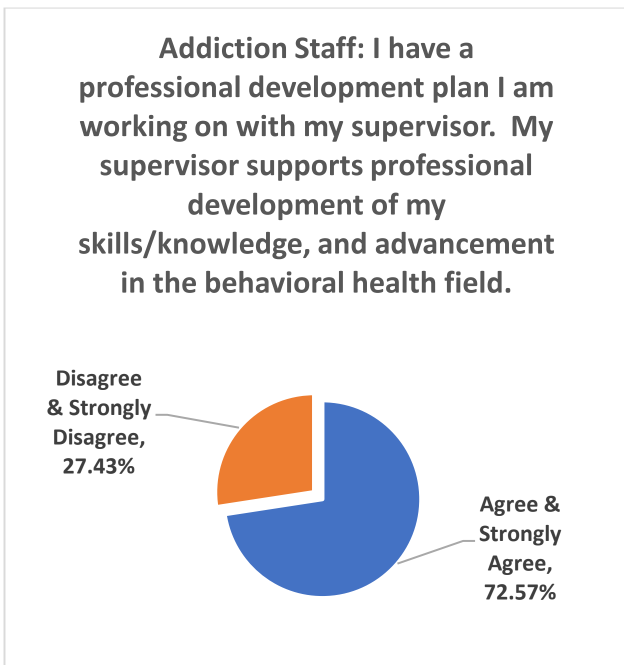


Figure 13: Percent of Addiction Staff who report they have a professional development plan

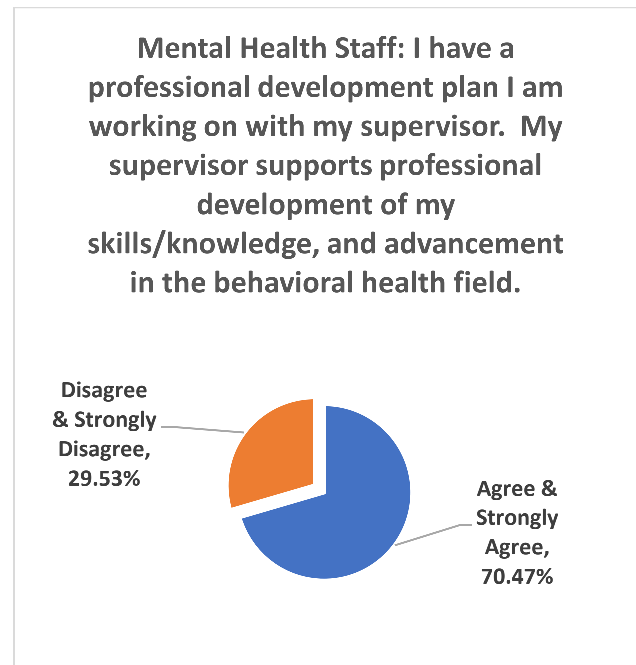


Figure 15: Percent of Mental Health Staff who report they have a professional development plan

Behavioral Health Supervisors Assessment of Workforce Training Needs

51.46% of addiction supervisors reported that think most CADCs have an adequate understanding of co-occurring disorders (*fig.16*), while only 24% of mental health supervisors report that QMHAs and QMHPs have an adequate understanding of co-occurring disorders (*fig.17*).

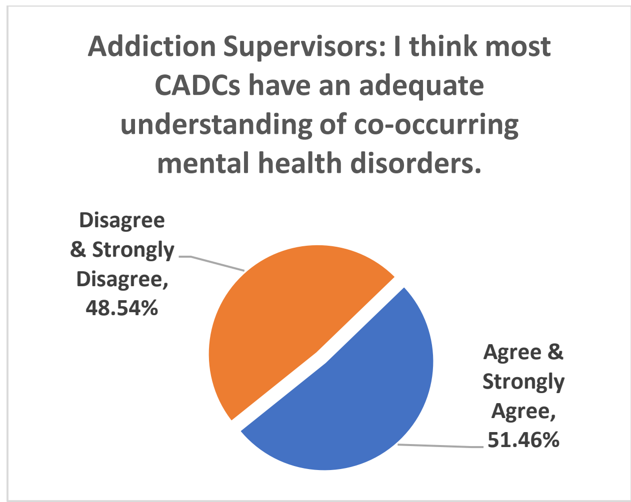


Figure 16: Percent of Addiction Supervisors who think their staff have an adequate understanding of co-occurring mental health disorders

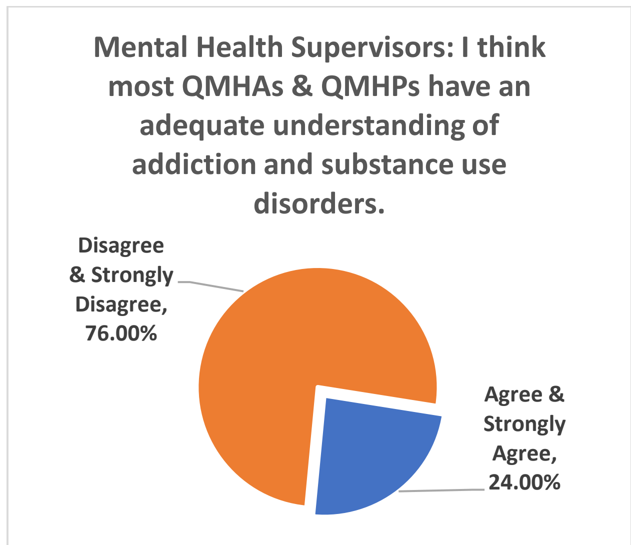
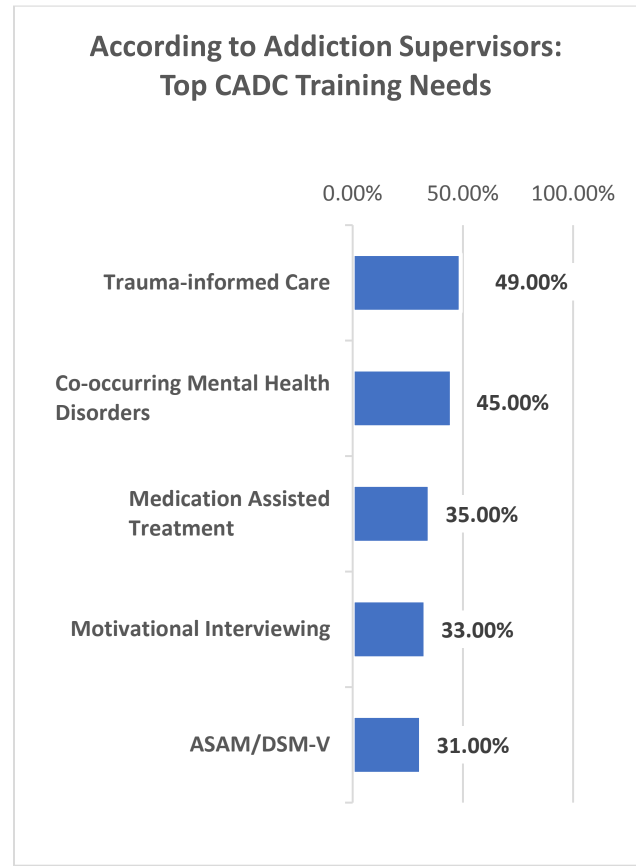
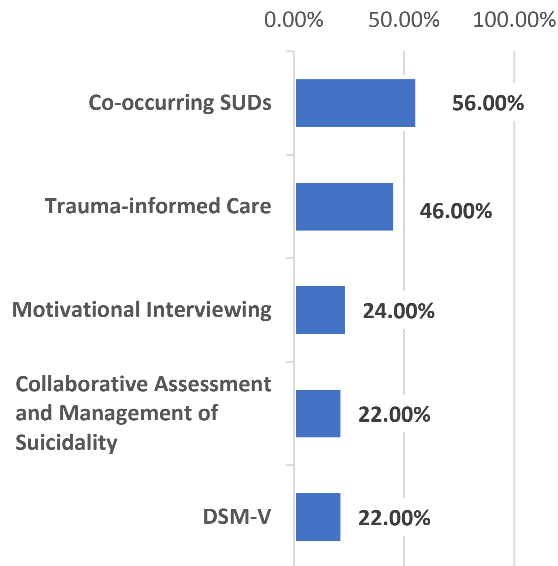
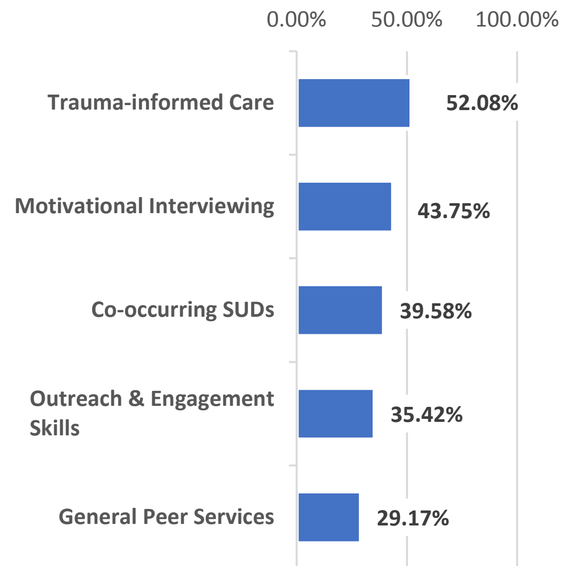


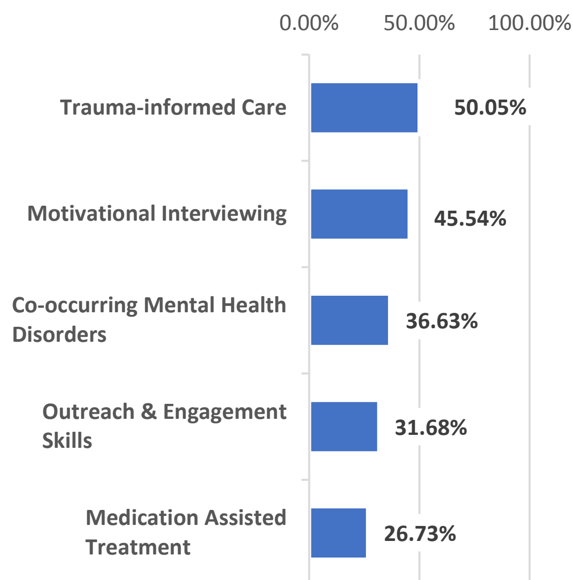
Figure 17: Percent of Mental Health Supervisors who think their staff have an adequate understanding of addiction and SUDs

Approximately half of addiction and mental health supervisors report the top three training needs for Oregon behavioral health workers are: Trauma-informed Care, Co-occurring Disorders, Medication Assisted Treatment, Collaborative Assessment and Management of Suicidality (CAMS), and Motivational Interviewing. 44.68% of mental health supervisors report "*working with substance use disorders*" as the greatest competency deficit of QMHPs. Likewise, 39.39% of addiction supervisors report that "*working with mental health disorders*" is the greatest competency deficit of CADCs.




According to Mental Health Supervisors: Top QMHA/QMHP Training Needs
0.00%
50.00%
100.00%
Co-occurring SUDs
56.00%
Trauma-informed Care
46.00%
Motivational Interviewing
24.00%
Collaborative Assessment and Management of Suicidality
22.00%
DSM-V
22.00%


According to Mental Health Supervisors: Top Mental Health Peer Training Needs
0.00%
50.00%
100.00%
Trauma-informed Care
52.08%
Motivational Interviewing
43.75%
Co-occurring SUDs
39.58%
Outreach & Engagement Skills
35.42%
General Peer Services
29.17%


According to Addiction Supervisors: Top Addiction Peer Training Needs
0.00%
50.00%
100.00%
Trauma-informed Care
50.05%
Motivational Interviewing
45.54%
Co-occurring Mental Health Disorders
36.63%
Outreach & Engagement Skills
31.68%
Medication Assisted Treatment
26.73%

Administrative Supervision

The majority, 83.97% of Oregon's behavioral health workforce (*n=1,106*) reports that their supervisors are effective (*fig.18*). While, 35.6% of Oregon's behavioral health workers report that their supervision sessions are primarily focused on paperwork and administrative compliance (*fig.19*).

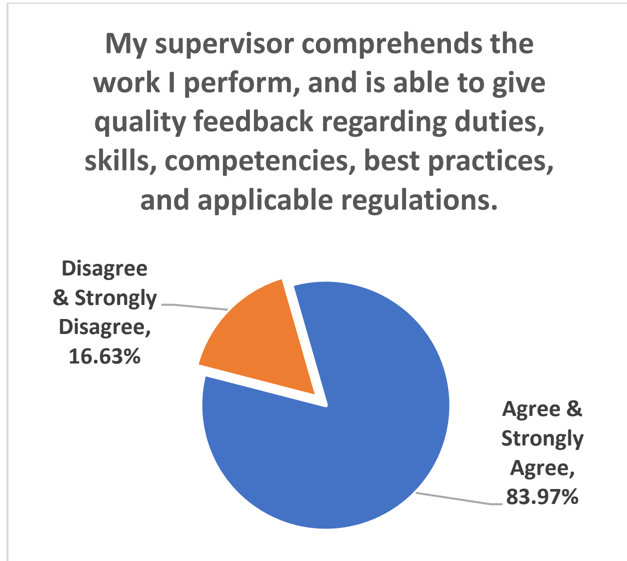


Figure 18: Percent of workforce reporting that their supervisor is effective

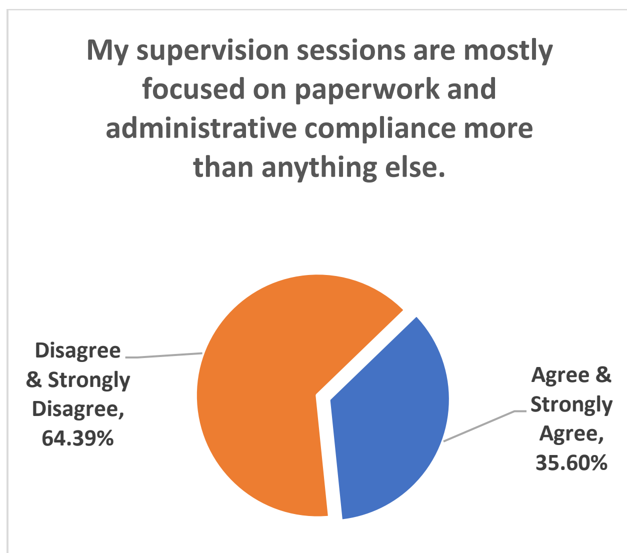


Figure 19: Percent of workforce reporting that their supervision session are focused on paperwork and adminstrative compliance

The majority, approximately 80% of Oregon's behavioral health workforce reports their agency has clear policies regarding texting with clients (*fig.20*), and clear policies regarding social media contact with clients (*fig.21*).

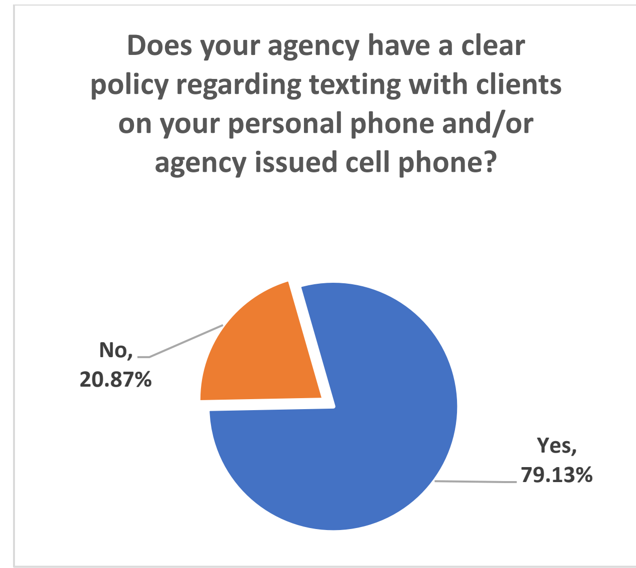


Figure 20: Percent of Workforce reporting that their agency has policies regarding texting with clients

Figure 21: Percent of Workforce reporting that their agency has policies regarding social media contact with clients

On average, approximately 92% of behavioral health supervisors report their agency has a Drug Free Workplace Policy that includes marijuana (*fig.22*).

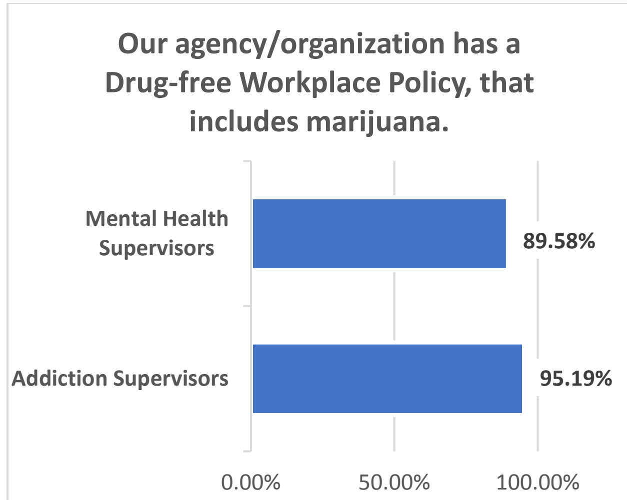


Figure 22: Percent of Supervisors reporting their agency has a drug free workplace policy that includes marijuana

Nearly 60% of Oregon's behavioral health workers have seen little to no outcome data for their agency/organization (*fig.23*).

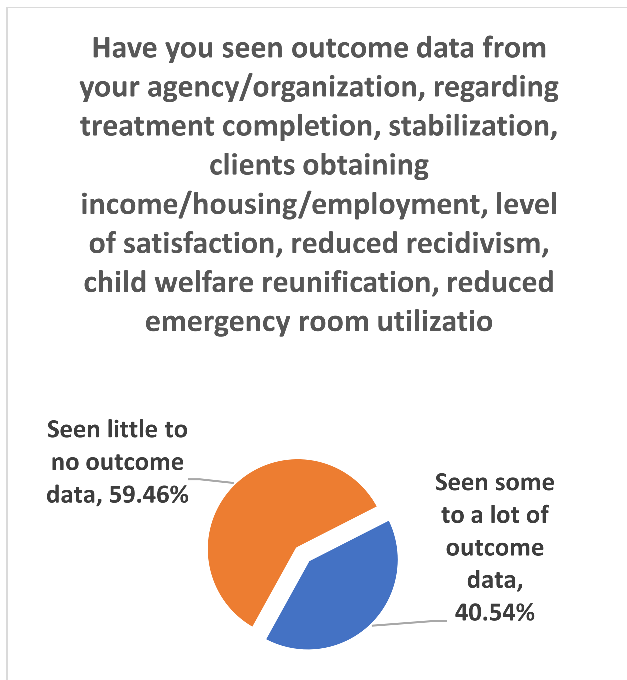


Figure 23: Percentages of Behavioral Health Workers reporting awareness of outcome data for their agency

Supervisor Turnover Intention

70.48% of behavioral health supervisors report their plans to remain at their current agency/organization (*fig.24*). 88% of supervisors report they are satisfied with current position (*fig.25*).

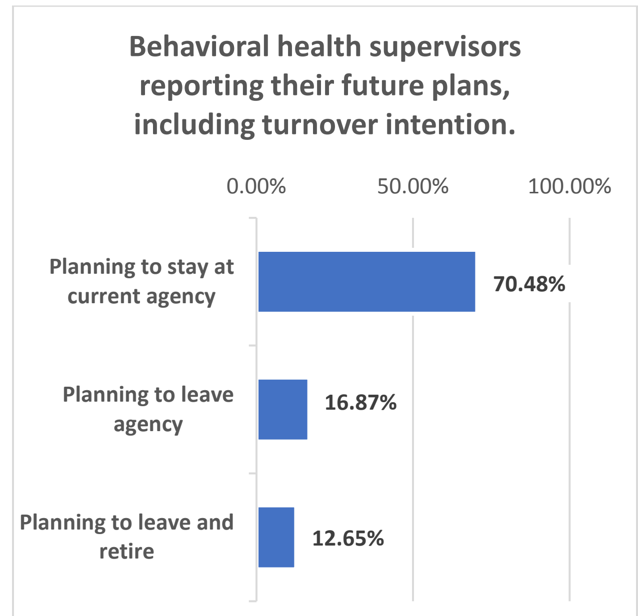


Figure 24: Percent of Behavioral Health Supervisors reporting future plans, including turnover intention

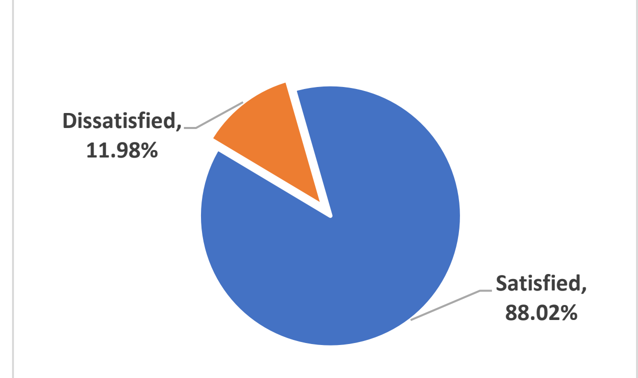


Figure 14: Percentages of Behavioral Health Supervisors reporting varying levels of satisfaction

Summary

by Aja Stoner, Chief Clinical Officer, Addictions Recovery Center

The majority of Oregon's behavioral health workforce (84%) report that their supervisors are effective. They comprehend the work being performed, and can give quality feedback regarding duties, skills, competencies, best practices, and applicable regulations. Most supervisors (88%) report high levels of satisfaction with their current employment.

On average supervisors manage 10 staff, while often carrying a client caseload themselves. It can be assumed that this split between direct care and supervision duties may create challenges for supervisors in creating and maintaining structured clinical supervision time. About 93% of supervisors report that they provide two hours of supervision per month, while only 77% of staff report receiving 2 hours of supervision per month. With this discrepancy it is likely that supervisors are including more informal supervision time in their personal assessment of total supervision hours being delivered. It may also be likely that supervisee's feel as though they need more, or do not get enough supervision each month reflecting a lower assessment of actual supervision time.

Moreover, about 98% of supervisors report that they are available for urgent issues and typically respond within 24 hours, while 87% of staff report that the supervisor is routinely available. About 95% of supervisors report having professional development plans with staff, while only 72% of staff report having a professional development plan with their supervisor. This discrepancy is likely created due to informal professional development plans that are verbal in nature and not clearly documented or defined for the supervisee.

It is relatively concerning that 36% of staff report that most of their supervision time is dedicated to "paperwork and administrative compliance." This type of supervision may be problematic when not properly balanced with direct care professional development and a consistent overview of clinical care provided. This number may also be reflective of continued industry pressures related to increased regulatory compliance and cumbersome documentation constraints. It can be assumed that EHR requirements and pressures to modernize documentation formats causes constraints for supervisors, and that on-boarding staff into the electronic world causes disproportionate time spent in paperwork, compliance and administrative tasks. It can also be assumed that program staff do not recognize these administrative tasks and pressures as an aspect of their on-going professional development.

Only 40% of behavioral health workers report having seen any significant amount of outcome data on their agency. As payment models move forward to value-based/outcome-based funding structures, more than ever behavioral health staff will need to have knowledge of performance metrics and defined outcomes. Having shared knowledge of these outcome measures can inform the quality of services and assist providers and administrators to have a shared direction and vision related to the efficacy of the services they provide.

Seventy percent of supervisors report their intention to stay at their current agency of employment, while 30% are planning a separation. This is consistent with national separation rates in Health Care & Social Assistance. The Bureau of Labor Statistics reports the annual separation rate (2013-2017) for Health Care & Social Assistance is approximately 30%. 30% of supervisors plan to leave their current employer, nearly half of those are planning to retire. As we experience the exodus of Boomer Generation supervisors, our field may want to create part-time work options for supervisors reaching retirement age.

Ninety two percent of supervisor's report that their agency has Drug Free Workplace Policies that

include marijuana, and approximately 80% of supervisors report that their agencies have policies on texting and social media contact with clients. As electronic communications and social media platforms expand, programs must insure they have articulated policies in place regarding electronic contact with clients that establish professional boundaries, discourage dual relationships and reinforce HIPAA compliance.

Supervisors assessed co-occurring disorders as the most significant competency deficits of both addiction and mental health workers. 49% of addiction supervisors indicate that addiction workers need more knowledge regarding comorbid mental health disorders, and even more striking, 76% of mental health supervisors report that mental health workers need more information regarding comorbid substance use disorders. Significantly, more mental health supervisors assessed this co-occurring disorder competency deficit compared to addiction supervisors. With the high prevalence of co-occurring disorders, it is essential that supervisors in both mental health and addictions create cross training opportunities to develop the competencies of their staff in recognizing, assessing and treating co-occurring disorders. This increased level of competency will allow for a more comprehensive and effective approach in Oregon behavioral health care.

Top training needs selected by supervisors

All behavioral health workers	Trauma-informed Care
All Addiction workers combined	Motivational Interviewing Medication Assisted Treatment Co-occurring Mental Health
All Mental health workers combined	Co-occurring SUDs Motivational Interviewing CAMS

In conclusion, this survey illustrates the overall strengths and deficits of the current behavioral health supervision system across the state. This survey identifies targeted areas for improvement and serves as a framework for supervision needs and competencies. Despite the highlighted area's for improvement, this survey clearly shows that behavioral health supervisors remain a consistent source of expertise, offer invaluable insight, and are leaders in the competency and skills development needed for the continued enhancement of Oregon's behavioral health workforce.