Published in final edited form as:

Adm Policy Ment Health. 2016 July ; 43(4): 546–554. doi:10.1007/s10488-015-0665-6.

Unpacking clinical supervision in transitional and permanent supportive housing: Scrutiny or support?

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Abstract

Behavioral health organizations use clinical supervision to ensure professional development and practice quality. This qualitative study examined 35 service coordinators' perspectives on supervision in two distinct supportive housing program types (permanent and transitional). Thematic analysis of in-depth interviews yielded three contrast themes: support versus scrutiny, planned versus impromptu time, and Housing First versus Treatment First. Supervisory content and format resulted in differential perceptions of supervision, thereby influencing opportunities for learning. These findings suggest that unpacking discrete elements of supervision enactment in usual care settings can inform implementation of recovery-oriented practice.

Keywords

Mental health recovery; qualitative; supervision; supportive housing

Introduction

Housing programs with supportive services have been a growing health intervention (Henwood, Cabassa, Craig, & Padgett, 2013) with upwards of 289,000 units nationally (HUD, 2013). These programs have coupled permanent housing with ongoing coordinated health care and case management services (Rog, Marshall, Dougherty, George, Daniels, et al., 2014). A recovery orientation is particularly critical for the provider-service user relationship (Borg & Kristiansen, 2004) given the intensity of provider contact with service users living in housing combined with service programs. In addition, organizational contextual factors play a key role in influencing service provision and provider-service user relationships (Beidas, Wolk, Walsh, Evans, Hurford, et al., 2014).

Provision of housing plus support services has been found to be a cost-effective solution for a vulnerable subset of people who are homeless and have been diagnosed with serious mental illness and co-occurring substance use (Culhane, Metraux, & Hadley, 2002). Among

supportive housing programs, a distinct difference in programmatic philosophy has resulted in differential service user experiences and outcomes (Padgett, 2007; Collins, Malone, Clifasefi, Ginzler, Garner, et al., 2012; Tsai, Mares, & Rosenheck, 2010; Pearson, Montgomery, & Locke, 2009). The traditional approach (called Treatment First here) has followed a “staircase” or continuum model with service users moving from emergency shelter to transitional to permanent housing, earning higher levels of independence with demonstrated treatment compliance and sobriety (Kertesz, Crouch, Milby, Cusimano, & Schumacher, 2009; Wong & Stanhope, 2009). Another supportive housing approach, originating with Pathways to Housing, Inc. in New York City, took a rights-based approach and bypassed this traditional staircase. Instead, this program has offered permanent “Housing First” and services wrapped around individuals after they attain independent housing (Tsemberis, Gulcur, & Nakae, 2004).

The differing models have been found to impact the focus of service provision in the programs (Henwood, Stanhope & Padgett, 2011). In the traditional Treatment First model, service coordinators evaluate “housing readiness” which is typically mental health stability, sobriety and mastery of daily living activities (e.g. cleanliness and appointment attendance). Once achieved, service users are assisted in moving toward the final “step” of permanent housing (Allen, 2003; Robbins, Petrila, LeMelle, & Monahan, 2006). Because permanent housing needs were met at the outset, Housing First providers were able to focus on the clinical needs of service users. Paradoxically, for Treatment First providers, securing permanent housing dominated their work, limiting the opportunity to focus on clinical or “treatment” needs of service users (Henwood, et al., 2011).

Recovery-oriented services are a U.S. policy and ethical mandate for behavioral health care systems (New Freedom Commission on Mental Health, 2003; Drake & Deegan, 2009; Atterbury, 2014). The recovery approach stresses enhanced agency rather than traditional goals of treatment compliance. Organizations have been required to safeguard the resources of time, process and training to support the “sensitive work” necessary to truly proffer choice and the “dignity of risk” (Hopper, 2007, p.12). Team managers and supervisors play a key role in the daily operationalization of organizational goals and in supporting quality practice by their subordinate staff colleagues, i.e., service coordinators (Kadushin & Harkness, 2002). Supervisory oversight now requires urging service coordinators to shift from the traditional medical model approach to a service user driven, strengths-based, recovery approach (Solomon & Stanhope, 2004; Davidson, Rowe, Tondora, O’Connell, & Lawless, 2008).

In behavioral health service organizations, service coordinators ideally have access to regular, ongoing clinical supervision with a trained supervisor. This supervisory time is theorized to help them to develop professionally and to deliver quality services (Kadushin & Harkness, 2002; Bogo & Knight, 2006). In community-based behavioral health service models, both Assertive Community Treatment (used in many Housing First programs) and individual case management (used in virtually all Treatment First programs) have a built-in expectation that service coordinators receive weekly individual supervision sessions and group supervision/team meetings (Rapp, Hardcastle, Rosenzweig, & Poertner, 1998; Goodyear, 2014; Bogo & Knight, 2006). However, busy practice settings set in a context of

fiscal austerity have been found to create competing priorities for supervisors' time (Bowers, Esmond, & Canales, 1999; Goscha & Rapp, 2003).

How behavioral health service coordinators' perspectives and practice behavior is influenced by clinical supervision is under-investigated (Bogo & Knight, 2006). Additional knowledge of the supports service coordinators need to carry out a recovery-oriented approach would contribute critical insights for implementation of recovery-oriented practices (Institute of Medicine, 2001; Drake, Goldman, Leff, Lehman, Dixon, Mueser, & Torrey, 2001; Glisson & Schoenwald, 2005). Limited understanding of the interaction between clinical supervision and recovery-oriented practice indicates use of qualitative methods to explore the service coordinators' perspectives. Given the strong association between individual's perceptions and their behavior (Jaccard, Dodge, & Dittus, 2002), service coordinator perceptions are particularly germane to understanding the role of supervision in practice.

Building on empirical inquiry into factors critical to provider-service user relationships and service provision in housing programs (Stanhope, Henwood, & Padgett, 2009; Henwood et al, 2011; Tiderington, Stanhope, & Henwood, 2013), this inquiry examined clinical supervision in the context of organizational supports and barriers to the integration of recovery-oriented practices. Less attention has been focused on understanding the organizational supports necessary to help service coordinators deliver effective case management services that integrate choice and hope (Fakhoury, Murray, Shepherd, & Priebe, 2002). To this end, qualitative methods were employed to explore service coordinator perspectives and experiences of clinical supervision and the role it played in their practice with service users in two distinct types of housing programs. The research questions were:

1. What were service coordinator perspectives and experiences of clinical supervision within supportive housing programs? Did these differ by program type (Housing First or Treatment First)?
2. How did the clinical supervision they received help or hinder recovery-oriented practice with service users?

Method

Sampling

A purposive sample of service coordinators (e.g. case managers, social workers, peer providers) (N=35) were recruited through the associated service users' participation in the larger study examining mental health recovery with service users in two housing programs. The two program agencies were selected to compare divergent approaches to housing service provision for adults diagnosed with serious mental illness with histories of substance use and homelessness: one traditional Treatment First (TF) and one Housing First (HF). In the TF program, service users received transitional housing in scatter-site apartments (often shared occupancy) and individual case management services. In the HF program, service users received permanent housing in scatter-site apartments (single occupancy) and Assertive Community Treatment (ACT) services. New enrollees of these programs were invited to participate (inclusion criteria required individuals to have an Axis I diagnosis of serious mental illness and a history of substance use). Service coordinator participants'

inclusion criteria were providing direct services and the service user's consent for their inclusion. The majority of service user participants gave consent to have their service coordinator interviewed (49 of 54). Only 2 of 37 service coordinators refused to participate constituting an overall 93% consent rate.

Data Collection

Study protocols included semi-structured interviews with service coordinator participants throughout the service user's participation in the study. The baseline interviews occurred within a month of the service user's enrollment in the study and follow-up interviews conducted after 6-months or at the service user's discharge, whichever came first. In total, 35 service providers participated in 84 interviews (45 at baseline and 39 at follow-up).

All study protocols were approved by the authors' university human subjects committee. All participants gave written informed consent prior to participation. Researchers emphasized the voluntary nature of participation and that they could decline to answer any particular question or stop their participation at any time.

Four trained interviewers with experience working in the mental health service system conducted the semi-structured interviews lasting approximately 45 minutes. Interviews were scheduled at the service providers' convenience and completed in a private office space at their program. Interviewers asked general questions about their work experience and questions specific to the paired service user. Interviewers also asked additional probing questions of provider perspectives. Some of the questions include the following: What is working here like for you? What are you working on with [service user's name] right now? What is supervision like here? How does service planning work?

Data Analysis

Boyatzis' (1998) thematic analysis was utilized to 1) generate and assign codes for similar quotes and ideas, 2) revise codes to fit ideas across transcripts related to supervision and develop themes, and 3) determine consistency across all transcripts to ensure "trustworthiness" of themes through seeking confirming and non-confirming data. Two authors independently reviewed and co-coded 20 transcripts to develop an initial code book. After all 84 transcripts were reviewed, initial template codes were revised to fit similar ideas across transcripts related to clinical supervision and leadership. Authors used consensus to resolve any inconsistencies. Atlas.ti software was used to sort and analyze coded data.

Subsequent to initial thematic analysis, the supervision template code was extracted. A secondary inductive thematic analysis was then conducted and combined with a case-study matrix method (Miles, Huberman & Saldana, 2014) to review themes across cases in both programs. The participant-by-theme case study matrix ensured further reliability and consistency of findings across providers. To aid in development of ideas and ensure analytic rigor, several "strategies for rigor" were employed including peer-debriefing, independent and co-coding, memo-writing and prolonged engagement with study participants (Padgett, 2008).

Findings

Sample Characteristics

Table 1 shows the demographic characteristics of the sample of 35 service provider participants. The majority had less than three years tenure at the organization (74%); most had prior work experience with this population (77%). Differences in racial composition of the sample included Housing First (HF), with 46% African-American versus 83% in the Treatment First (TF) program. Additionally, the percentage of staff with a graduate degree was much higher in the HF (64%) than in the TF program (4%).

Themes

The analysis yielded three themes: planned vs. impromptu, support vs. scrutiny, and housing first vs. treatment first programs.

Planned vs. Impromptu

Scarce available time was understood as an obstacle to accessing supervision. Service coordinators acknowledged the expectation of one-hour individual supervision sessions weekly and the workload reality that limited supervision time. “We are supposed to have supervision once a week, but in my situation that rarely happens. Um, most of the times it is as needed.” To accommodate this time scarcity, supervision time was of two different types: proactive and reactive. *Proactive* supervision was planned, scheduled individual sessions and *reactive* supervision was either with a supervisor in response to an immediate crisis or informal discussions in the field or at the office.

Paperwork and job management tasks dominated proactive supervision time in many cases. One coordinator said, “supervision is paperwork” and another shared, “the whole thing is about the chart.” Conversely, service user-related or clinical discussion happened more in reactive or ad hoc supervision time. “When we’re in the car riding together, that’s another meeting. We’re always talking.” This flexible and impromptu time was described as an ‘open door policy’ where supervisors were available to the service coordinators if anything arose requiring supervisory input.

This ‘reactive time’ was spent relaying service user-related details for supervisors to make ‘higher level’ decisions. “The only time like I’ll go to my supervisor is really when I need a decision made because I feel that I am not—my job is not to decide; my job is to report” and when asked about those decisions, service coordinators reported, “that’s not in my pay grade.” Service coordinators understood their role to “check-up” on service users and in an emergency when someone had to be “911ed” or had not met a program expectation. Additionally, in anticipation of potential service user noncompliance, service coordinators would share service user information to demonstrate their fulfillment of their job responsibilities. “I’m not really telling on the client to get them in trouble, I’m just telling you what they’re doing so you know I’m doing my half.”

Unscheduled supervision received mixed endorsements from service coordinators. In some cases, service coordinators reported unlimited access to their supervisors, which was experienced as positive,

We have, like, an open-door policy. I can see her whenever I want, for anything. ... We text after hours, there's, like, a lot. She's very supportive in many ways. But there isn't, there's a complete lack of a structured supervision session with documentation and formal supervision—there's no formal supervision. None.

For others, this absence of structured meetings increased frustration and made integrating useful learning, support and feedback difficult. One service coordinator shared, “it's just not enough support. I mean it's too far, few and in between, the, the, the—our staff is not really trained well.”

Service coordinators expressed the need for protected space for reflection in order to make better choices as a program. Supervisors had limited service user information to inform policy decisions given this nature of information sharing. “It's just like we're policy building around crisis. So we just go from one crisis and another policy. It's like, can we stop?”

Scrutiny vs. Support

This focus on documentation and outcomes in planned supervision is described negatively as scrutiny. One service coordinator shared this experience, “Sometimes I just feel it's almost like you're hanging me on the wall and you're throwing darts at me, telling me, ‘Oh, this is what you need, this is what you need, this is what you need’”. Service coordinators attributed this emphasis on paperwork to the program's need to pass funder audits. This service coordinator described the organizational climate during a program audit and the general feeling of fear,

It's just like, everyone was on edge. And I understand, like, if you get a bad audit people lose their jobs. ... but it's just like this culture of, like, ... doomsday. Today, today could be your last day, type of a feeling, and God, it's like so nerve-wracking, I hate it to hell. Yes. ... So it's like, it's like a constant, like, it's a constant like, measure, like, it's like intense. Like, it's emotionally, it's like intense. And you can feel, and you can cut it with a knife. Like, you can feel the tension in the office, I guarantee you. You feel it, because it's quiet, and there's running around, especially the day of the audit.

In order to avoid this uncomfortable supervisory scrutiny, service coordinators focused their energy on vigilance with documentation. This documentation safeguarded them and allowed them to avoid supervision time, “Everything is documented. Everything that occurred, I can explain it. So it [supervision] doesn't affect me.”

In contrast, this intensity of supervisory attention was not extended to the service delivery process with service users. One service coordinator shared, “I don't have anyone supervising that part [the service user interactions] of my job. I have people supervising the other part of my job, like down my throat! And everyone does.” Service coordinators experienced less guidance and reflection on the process of service delivery, resulting in more discretion and autonomy in their service user interactions. In describing supervision, one service

coordinator noted that “[supervision is] like what you didn't do or what needs to be done, not so much your insight on how things are and what can change for you, or the client's needs.” Another service coordinator described how this discretion plays out from supervision to the field. “My supervisor or whoever, will point it out to me, oh, you have to get substance abuses in. So, I'll take opportunities where maybe um, you're [the service user] not talking about it [substance abuse], I'll put it in” to the service user interaction.

From the service coordinators' perspectives, this focus on outcome rather than process overshadowed clinical practice and resulted in perceived skill gaps. One service coordinator shared her interest in developing her skills and problem-solving with a clinically trained supervisor,

Since people here have the degrees and are more clinically um, have the degrees, I think they should be a little bit, give more insight into what I should do with clients and how to solve problems. Instead of just auditing, what wasn't right, what wasn't right, that's what I believe, I wish could happen. Like I wish I could be able to talk to a supervisor, like how do you think we should approach this client? And what ways can we deal with...can we have an intervention? Or what's not working?

Missing this clinical discussion was perceived as lacking support and took a toll on service coordinators. One shared, “you have to be up to date, you have to. And it's like they're constantly just putting more and more weight on the counselors, so it's like, it's like, it's tiring.” Service coordinators also shared being left alone to reason through gray areas of “flexible” practice and to make sense of their own emotional responses. One service coordinator talks about this experience of providing flexible services and a desire to abandon the practice,

We straddle the fence a lot, because we really don't have a real definition in terms of what we're supposed to be like. And we don't have many occasions to kind of be consoled when we get wounded, because we, we, for the most part believe in our clients. ... But when we see the reality that this person needs some more time—not that that's not their goal, but they need some time, we need to come up with another strategy, that can be kind of hard, because there's times you want to throw up your hands after you've had a client that goes to rehab every week.

This service coordinator was expressing support needs in order to stay focused with service users as they work in what was often a non-linear recovery process.

When acknowledged, supervisory support focused on job management (e.g. paperwork reminders or schedule flexibility), interpersonal support (e.g. saying good morning or listening), or ‘backing them up’ in enforcing program rules with service users. One service coordinator interprets this supervisor's interaction with a service user as supportive,

She's like, “You need to make yourself available to your counselor because, if you don't, X, Y and Z is gonna happen.” ... Because if you sugarcoat things, they're just gonna continue to do what they're gonna do. And she's not one of those people, so I really like that.

For others, in a job that is difficult at times, the emotional support from supervisors was important. “She is a support system, a supervisor but a support too. ... some days you just need a smile and nobody's smiling, but they [supervisors] do that.”

Additionally, these interpersonal communication skills were highlighted as useful in supervision, in particular for supporting the learning of new skills. “Um, she's *very* caring. ... any time I feel I'm stuck or there's a block I can't get something done, I can always go to her and we get it done together.” Service coordinators explained that a supervisor's ability to present corrective feedback influenced their ability to integrate it. “[The Supervisor] tells you what you're doing good and then she tells you what needs to be improved on. And she puts it in such a way that you can't take it personally.” Another service coordinator shared, “[The Supervisor] motivates you...by working *with* your personality.” When present, this context facilitated learning. “Well in supervision what you know, I'm not ashamed to learn. Um, I wasn't good just recently on uh, a service plan and we reviewed that service plan to uh, see how we could come up with better way of tweaking that service plan. That was fine with me. And I ... didn't put it in the person's word. ... I want housing. Now, opposed to the client wants stable housing.”

Housing First vs. Treatment First

Differences between the organizational settings were identified in the service coordinators' discussions of their experiences in supervision. Table 2 demonstrates broad thematic differences between the Housing First (HF) and Treatment First (TF) programs. While the perspectives and experiences of the TF providers were fairly uniform, HF respondents had more diverse experiences with supervision, describing it as happening in daily group meetings, in the field or impromptu. Documentation and audit requirements along with clinical discussion were encompassed in those meetings. HF service coordinators were not consistent in their description of the clinical-administrative balance. At times, supervision was collaborative, flexible and unstructured. Unstructured time was interpreted as having both positive and negative influences on practice as described earlier.

In contrast, TF supervision was described as supervisor-led and dominated by contract compliance. “I just felt like it would be a lot more like client need first-based. Instead of like make sure that...like if OMH (Office of Mental Health) came tomorrow, we would pass with flying colors.” Service coordinators in TF expressed limited supervisory support and feeling scrutinized. Thus, service coordinators had considerable discretion in their service user interactions and the process of service delivery, discretion that was described as feeling ‘alone’ and like a ‘weight’ was on them. In this absence of supervisory clinical support, service coordinators in the TF program emphasized the value of peer support, “Support-wise, one thing that's amazing is the counselors really do support each other.” Service coordinators made time weekly to eat lunch together outside the office and talk about work, family and life. They also reached out to each other to problem-solve, “Like if I have a question about a resident, 9 out of 10 times I just go to someone who does my job, who's been here longer. They're very helpful. Like, try this, try that.” While some did express supervisory support in other aspects of their work (e.g. schedule flexibility), service

coordinators were generally consistent in expressing the limited clinical support in supervision.

Discussion

This study sought to explore service coordinator perspectives of clinical supervision in supportive housing programs to better understand prospects for recovery-oriented practice integration. Findings suggest that supervisory process factors (e.g. format and content of supervision) communicate priorities and work expectations. When documentation and billable interventions dominated planned supervision, staff members understood expectations to be focused on outcomes over service delivery processes. The resultant autonomy in service delivery was experienced as taxing more than empowering as service coordinators struggled to find the best approaches with service users. Understanding supervisory influence on norms and expectations for direct care staff could aid in the integration of new practice changes as influential individuals, such as leaders, are theorized to influence others' behavior (Rogers, 1995).

These supervision factors had implications for service coordinator learning opportunities as well. Organizational demands constrained opportunities generally. Supervision experienced as supportive included a warm, interpersonal focus and facilitated learning. Notable in these findings were the conflicts for service coordinators navigating clinical process with service users combined with 'audit fear' as sources of stress. This confirmed previous findings regarding the utility of supervisory support for important staff and organizational factors (Leiter & Maslach, 2006; Hemmelgarn, Glisson, & James, 2006) and underscored the importance of strong communication skills and emotional support. These 'soft' skills facilitated a learning environment, helped staff to negotiate emotionally taxing work environments, and promoted nuanced work with service users. Such skills facilitate recovery-oriented practice and require attention to both the process and outcome of service delivery to be successful (Tondora, Miller, Slade, & Davidson, 2014).

When comparing the Housing First to the Treatment First programs, service coordinator reports of supervision practices differed. These findings further supported the 'treatment paradox' that HF programs were free to focus on clinical interventions more than TF programs because service users' need for housing had been met (Henwood, et al., 2011). In the HF program, service coordinators described more supportive supervisory relationships focused on service users and service delivery compared to the TF program. At the same time, HF supervision was more variable and unstructured in format. The variability across service coordinators may be a function of supervisory adaptation to the needs of the individual service coordinator. In the TF program, service coordinators consistently agreed that organizational demands drove supervision content, resulting in limited clinical discussion. Education requirements in hiring or other program foci (e.g. ACT versus ICM) may also drive some program differences with HF holding team meetings daily and favoring staff with master's degrees. We acknowledge that the greater intensity and team approach of ACT may underlie program differences found in this study.

Findings also suggest that service coordinators are actively seeking to fulfill unmet needs and adapt to new practice strategies. Ad hoc or impromptu supervision practices in the field, in the hallway or just using an ‘open door policy’ serve to keep supervisors abreast of crises and to access their decision-making abilities. These informal interactions have the potential to build relationships and access support. Such nuanced use of supervision time suggests the need for further investigation to separate the innovative supervisory practices from the neglectful.

A limitation of this study is that it considered service coordinator perspectives only. Supervisors' experiences of the process and content of supervision could offer further insights. Unstructured supervision also has been experienced negatively with limited opportunities for thoughtful reflection and feedback. Unknown are the best ways to use these different variations of supervision time to leverage supervisors' capacity to translate knowledge. What seems clear here is individual, structured supervision focused on clinical discussion is a challenge in most supportive housing programs. What remains unclear is whether an ‘open door policy’ and unstructured supervision signal the dominance of organizational oversight or new adaptive supervisory models.

Implications

Unpacking supervision practices in real world community health settings aids in the translation of recovery-oriented best practices. Clinical supervision models have demonstrated effectiveness in translating interventions to practice (Fraser & Galinsky, 2010). However, translation processes must contend with organizational constraints shifting real world supervisory practice away from traditional supervision models. Scarce resources often diminish staffing supports and necessitate strategies with more efficient supervision models in mind. Further knowledge of strategies to leverage supervision practices efficiently will aid in realizing community mental health services that actively partner with people to create meaningful change in their lives.

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Table 1
Provider Participant Demographic Characteristics

	Housing First N (%)	Treatment First N (%)	Total N (%)
Gender	11	24	35
Male	3 (27)	13 (54)	13 (37)
Female	8 (73)	11 (46)	22 (63)
Race/Ethnicity			
White	4 (36)	1 (4)	5 (14)
Black/African American	5 (46)	20 (84)	25 (71)
Other	2 (18)	2 (8)	4 (11)
N/A		1 (4)	1 (3)
Employment Tenure			
<1 year	6 (55)	8 (33)	14 (40)
1-3 years	2 (18)	10 (42)	12 (34)
>3 years	3 (27)	5 (21)	8 (23)
N/A	0	1 (4)	1 (3)
Highest Degree Completed			
Graduate	7 (64)	1 (4)	8 (23)
Bachelors	2 (18)	13 (54)	15 (43)
Associates or less	1 (9)	8 (34)	12 (33)
N/A	1 (9)	2 (8)	
Prior Experience in the Field			
Yes	8 (73)	19 (79)	27 (77)
No	3 (27)	4 (17)	7 (20)
N/A	0	1 (4)	1 (3)

Table 2
Clinical Supervision in Housing First versus Treatment First Programs

Themes		
Program	Impromptu vs. Planned	Support vs. Scrutiny
Housing First (HF)	<ul style="list-style-type: none"> • “When we're in the car riding together, that's another meeting. We're always talking” • “The only time I go to my supervisor is really when I need a decision made because I feel that I am not – my job is not to decide; my job is to report” 	<ul style="list-style-type: none"> • “She is a support system, a supervisor, but a support too.... Some days you just need a smile and nobody's smiling, but they [supervisors] do” • “She's very caring... any time I feel I'm stuck or there's a block I can't get something done, I can always go to her and we get it done together” • “[The supervisor] tells you what you're doing good and then she tells you what needs to be improved on. And she puts it in such a way that you can't take it personally”
Treatment First (TF)	<ul style="list-style-type: none"> • “Supervision is paperwork” • Supervision is “like what you didn't do or what needs to be done, not so much your insight on how things are and what can change for you or the client's needs” 	<ul style="list-style-type: none"> • “if you get a bad audit people lose their jobs... but it's just like this culture of doomsday” • “The culture that's implied, like, you have to be up to date, you have to. And it's like they're constantly just putting more and more weight on the counselors” • “Like I wish I could be able to talk with a supervisor, like how do you think we should approach this client? And what ways can we deal with [service user]?”