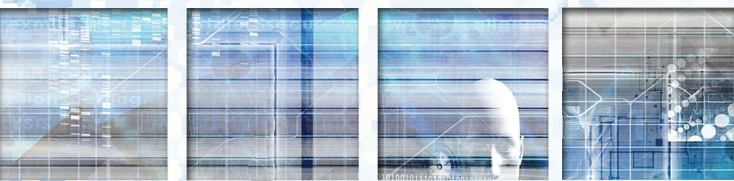




Technology-Based Clinical Supervision

GUIDELINES



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TECHNOLOGY-BASED CLINICAL SUPERVISION: GUIDELINES FOR LICENSING AND CERTIFICATION BOARDS

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The purpose of this document is to provide substance use disorder (SUD) and other behavioral health professional licensing and certification boards with guidelines and associated rationale for policies regarding the implementation of technology-based clinical supervision (TBCS).

Clinical supervision has been shown to decrease staff turnover, improve morale, and lead to better patient outcomes by improving delivery of evidence-based care (Watkins, 2014; Knudsen et al., 2008; Ryan et al., 2012). However, Clinical Supervisors struggle to find the time to review audio or video recordings or observe clinical sessions and provide feedback, particularly in rural or frontier areas. TBCS may be a way to overcome barriers to conducting supervision and enhance the clinical skills of the SUD treatment workforce (Reese et al., 2009; Ryan et al., 2012).

This document was developed with input from members of state licensing and certification boards and other national organizations with expertise in clinical supervision and TBCS. *Part One: Background* details how technology can improve access to and effectiveness of clinical supervision. *Part Two: Guidelines for Technology-Based Clinical Supervision* recommends that all licensing and certification boards adopt the following to support using technology to deliver clinical supervision:

- Develop Clinical Supervisor's TBCS knowledge and skills through evidence-informed training.
- Integrate training on TBCS into clinical supervision training curricula.
- Develop processes through which Clinical Supervisors can determine the appropriateness of TBCS for supervisees and their patients.
- Demonstrate competency with the technologies selected for conducting clinical supervision.
- Demonstrate knowledge and practices that adhere to privacy/security and confidentiality protections related to conducting clinical supervision using technologies.
- Ensure adherence to ethical guidelines and relevant laws and codes specific to supervision of clinical services using technologies.
- Develop written agreements with supervisees that include parameters and structure for TBCS.
- Implement clinical practices that include informing patients verbally and in writing about clinical supervision services being delivered through technology platforms.

PART ONE: BACKGROUND

In August 2014, NFAR ATTC conducted a literature review on the role of technology in advancing clinical supervision of SUD treatment professionals. Clinical supervision, as defined by Bernard and Goodyear (2014, p. 9), is a relationship that is “evaluative and hierarchical, extends over time, and has the simultaneous purposes of enhancing the professional functioning of the junior person(s), monitoring the quality of professional services... and serving as a gatekeeper” for behavioral health professions. A more nuanced perspective is offered by Perry (2012, p. 54), which underscores the ways in which technology-based supervision will play an important role in the evolution of the field:

Today the training and supervision subsystem has become vital ... because it transmits the field’s values, body of knowledge, professional roles, and skills to the new clinician. Training and supervision are also primary vehicles through which a field evolves. They prepare future generations to be the representatives and developers of the field’s viewpoint, with the hope that they will move beyond their mentors in conceptual, therapeutic, and professional development.

With these definitions in mind, two overarching themes appeared frequently in the literature: The use of technology in the provision of behavioral health care is widespread, increasing, and offers many possibilities for improving access to care; and 2) Technology-based clinical supervision is comparable to in-person supervision. Efforts that support using technology to provide clinical supervision will be a necessary asset to advancing the reach and accessibility of behavioral health care.

Technology is a means of overcoming the barriers to effective clinical supervision posed by long distances and limited resources in rural and frontier areas. TBCS is often the only type of supervision accessible to clinicians in rural or frontier areas. However, limited time and resources are barriers to clinical supervision in urban areas as well. TBCS opens up possibilities for conducting one-on-one supervision, group supervision, and web-based training/ continuing education using a variety of technology (e.g., telephone, email, audio and video conferencing, apps, texting, chat or instant messaging, webinars). TBCS responds to the ways in which technology is becoming an integral feature of health care, thereby making comfort with technology an essential skill for clinicians. Questioning whether technology approximates in-person clinical supervision overlooks the fact that technology may be a superior delivery method:

The traditional methods of supervision are in wide use because they were the only methods available, not because research determined them to be the most effective. Making the assumption that the “old methods are best” may do the field a disservice by blinding us to new opportunities and alienating a younger generation of supervisees who identify with technology being integrated into every part of their lives (Rousmaniere, Abbass, & Frederickson, 2014, p. 1092).

Using technology to deliver remote clinical supervision offers the following benefits (Byrne & Hartley, 2010; Conn et al., 2009; Dudding & Justice, 2004; Rousmaniere, Abbass, & Frederickson, 2014, p. 1092, 2014; Panos, 2005; Reese et al., 2009; Barnett, 2011; Ryan et al., 2012):

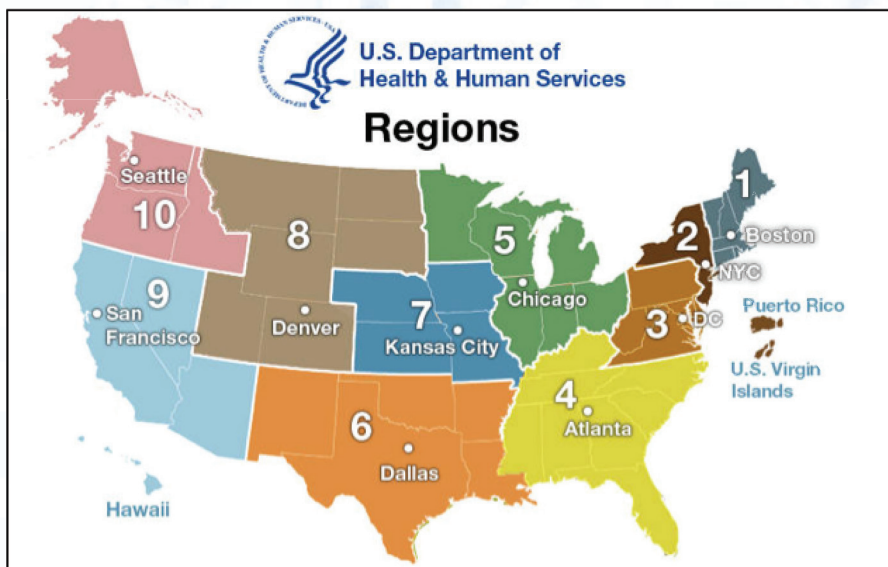
- increases access to qualified supervision by expanding the pool of available Supervisors, particularly those with expertise in a specific population or therapeutic technique;
- promotes better use of resources, is cost-effective, and reduces travel time;
- increases direct observation of clinicians in the communities in which they work, which has positive implications for building cultural competency;
- increases comfort with using technology, which is important as technology becomes more infused in the delivery of care;
- increases comfort with practicing in rural and frontier areas, thereby addressing severe workforce shortages in those areas;
- increases job satisfaction, which can slow the rapid turnover rate seen in the SUD treatment field;
- improves dissemination and fidelity to evidence-based practices; and
- improves patient outcomes.

Despite these benefits, implementing TBCS is not without challenges, including:

- variations in technology proficiency between digital natives and digital immigrants (Perry, 2012);
- security and confidentiality concerns; and
- prohibitions by state boards against using technology to provide clinical supervision.

These challenges can be overcome by adopting policies and guidelines that support responsible implementation of TBCS.

WORKGROUP ANALYSIS



From December 2014 through September 2016, NFAR ATTC hosted five meetings with members of licensing and certification boards from each of the 10 HHS regions (see map to the left). The first meeting was held December 2, 2014 in Denver, Colorado with representatives from regions 6-10, and the second was held April 23-24, 2015 in Alexandria, Virginia with representatives from regions 1-5. Three follow-up meetings were held:

PART ONE: BACKGROUND

August 20, 2015 in Kansas City, Missouri; January 27, 2016 in Portland, Oregon; and September 8, 2016 in Alexandria, Virginia. Each meeting was facilitated by NFAR ATTC staff and included participants from the Substance Abuse and Mental Health Services Administration (SAMHSA), the International Certification and Reciprocity Consortium (IC&RC), the Association for Addiction Professionals (NAADAC), the American Academy of Health Care Providers in the Addictive Disorders, and representatives of licensing and certification boards from the following states and territories: California, Colorado, Iowa, Illinois, Indiana, Kansas, Massachusetts, Michigan, Minnesota, Missouri, North Carolina, Nebraska, New Jersey, Nevada, New York, Oregon, Rhode Island, South Carolina, Texas, Utah, Virginia, Vermont, Wyoming, Puerto Rico, and the US Virgin Islands. The goal of the meetings was to gather information about current practice and policy related to TBCS. Throughout these meetings, participants provided assessments of their state/organizational readiness for implementing TBCS and provided insight into the guidelines, skills, and training support needed to build capacity to use technology to extend the reach of Clinical Supervisors.

The overall consensus among participants was that there is a strong need for rural counselors to receive quality clinical supervision and that technology can be useful in meeting this need. One participant remarked that the use of technology to increase access to supervision can be viewed through a social justice lens as a way of improving the capacity of the rural workforce to better meet the needs of individuals who are struggling with addiction. As a result of these meetings, NFAR ATTC developed guidelines that are closely aligned with what state licensing and certification boards are already doing to support TBCS.

This document was informed by the knowledge that the addiction counseling field must do more to keep up with other medical and behavioral health professional organizations that have already adopted guidelines for the delivery of technology-based care and supervision. The development of technology-assisted care is moving quickly and as gatekeepers, licensing and certification boards have a duty to stay informed about and be responsive to changes in the field. This requires attention to the role that technology can play in improving access to quality services by ensuring that clinicians have appropriate supervision.

The following guidelines are not intended to be mandatory or exhaustive, or to take precedence over a Supervisor's judgment about what is best for supervisees and patients. Likewise, the aim is not to promote TBCS to the exclusion of in-person supervision, suggest an optimal amount of supervision to be conducted remotely, or endorse specific technologies to be used. Rather, these guidelines are intended as a broad overview of how licensing and certification boards can encourage and support TBCS. More detailed training and evaluation will be necessary, along with efforts to promote access to technology in areas where it may not be available, in order to see positive outcomes. Broad guidelines encourage individual programs to be responsive to both rapid changes in technology and changes in patient needs and expectations as the role of technology-based care evolves.

Policies and regulations for Clinical Supervisors who wish to provide services via technology platforms should include the following:

1. DEVELOP CLINICAL SUPERVISOR'S TBCS KNOWLEDGE AND SKILLS THROUGH EVIDENCE-INFORMED TRAINING.

Rationale: It is essential that licensing and certification boards recommend an evidence-informed training program for Clinical Supervisors to establish essential clinical supervision knowledge and skills before using technology platforms to conduct supervision. Clinical supervision is a specialized skill set and technology is just one delivery method for providing effective teaching, training, observation/feedback, skill building, and consultative services. Many behavioral health professional associations and licensing and certification boards have specific training requirements for Clinical Supervisors, such as a specified number of training hours, required curricula, mandatory periodic recertification, and, in some cases, supervision of the Supervisor. All Clinical Supervisors providing TBCS should meet their state and professional standards for required training to provide clinical supervision services, and licensing and certification boards should ensure that recommended clinical supervision training uses evidence-informed curricula. The Addiction Technology Transfer Center (ATTC) Network offers an online introductory course on clinical supervision and many ATTC Regional Centers provide in-person advanced clinical supervision workshops. Information about these training opportunities can be found at www.nattc.org. In addition, the SAMHSA Technical Assistance Publication, TAP 21-A: Competencies for Substance Abuse Treatment Clinical Supervisors is available online (<http://store.samhsa.gov/product/TAP-21-A-Competencies-for-Substance-Abuse-Treatment-Clinical-Supervisors/SMA13-4243>) and provides step-by-step guidelines for implementing a comprehensive supervisory training program.

2. INTEGRATE TRAINING ON TBCS INTO CLINICAL SUPERVISION TRAINING CURRICULA.

Rationale: The adoption and eventual use of TBCS will increase within the addiction counseling profession as counselors and Clinical Supervisors become more familiar with both the concept and practice. The ultimate goal is to have TBCS be a natural part of clinical supervision training. This integrated training approach will help promote TBCS as a best practice rather than an optional approach to supervision done in mostly rural/frontier areas as an accommodation when in-person supervision is unavailable. The pace and growth of technology and use of technology in behavioral health is rapidly increasing. New behavioral health professionals are interested in using technology-based interventions with patients, as well as using technology platforms to advance their clinical knowledge and training (i.e., the demand for TBCS is increasing). TBCS training to increase knowledge and skills should be available upon demand to expand access to quality supervision and improve treatment services.

PART TWO: GUIDELINES

3.

DEVELOP PROCESSES THROUGH WHICH CLINICAL SUPERVISORS CAN DETERMINE THE APPROPRIATENESS OF TBCS FOR SUPERVISEES AND THEIR PATIENTS.

Rationale: Not all supervisees or patients are suitable for TBCS, so Clinical Supervisors should assess the practice setting, individual supervisees, and patients for their appropriateness and suitability for using TBCS. For example, some agencies do not have appropriate or adequate office space to use specific technology platforms, thereby increasing privacy/security and confidentiality risks. Some supervisees and patients may be uncomfortable with video or audio recording of their sessions or with using the telephone. Recent research demonstrates that patients with various behavioral health conditions benefited from treatment services delivered using videoconferencing (ATA, 2013). However, it is important that supervisees or patients who express discomfort with their sessions being recorded or viewed electronically have their concerns addressed as part of the assessment process. In some cases, Clinical Supervisors may let supervisees choose the type of technology platform they are most comfortable with to start, but then encourage them to expand their familiarity and comfort with other platforms. Patients should never be pressured to consent to have their sessions recorded/observed, whether or not technology is used.

4.

DEMONSTRATE COMPETENCY WITH THE TECHNOLOGIES SELECTED FOR CONDUCTING CLINICAL SUPERVISION.

Rationale: Professional competence is a measurable capability required for effective performance that involves judicious use of communication, knowledge, skill or ability, clinical reasoning, and/or emotions and values for the benefit of the individual and community being served (Marrelli et al., 2004, in CSAT's TAP 21-A, 2007; Epstein & Hundert, 2002). Increasing TBCS training (see guideline #2) will ensure development of competence through training, and states or professional boards may adopt assessment measures or recurring training requirements to ensure that Clinical Supervisors maintain and build competency in the technologies being used. Clinical Supervisors who use technology to extend the reach, efficacy, and availability of their services should choose technologies that best meet the needs of their supervisees, taking into consideration availability, affordability, reliability, and privacy and security issues. Requiring the purchase of expensive equipment may place undue burden on the supervisee. Currently, technologies used to deliver clinical supervision include: telephone; videoconferencing; digital video and audio recordings; text/chat/instant messaging; email; apps for smartphones and tablets; and avatars (for detailed comparisons of technologies, see: www.telementalhealthcomparisons.com).

Clinical Supervisors should be able to assess when new supervision delivery technologies require development of new competencies, especially given the proliferation of new technologies that can be applied in TBCS. Clinical Supervisors should be able to demonstrate competency in their selected technologies, and should be aware that developing competency may require training and/

or supervised experiences in using the particular technology platforms. This competency includes the capacity to use the technology with basic skills and troubleshooting ability. For example, the Clinical Supervisor should be able to advise and help supervisees with their use of the selected technology platform. Next, the Clinical Supervisor should be able to explain the reasons for their choice of technology platform (e.g., ease of use, affordability, functionality, privacy and security, etc.). Finally, the Clinical Supervisor must be able to demonstrate an ability to translate best practices in clinical supervision to the technology-based format. As an example, the Clinical Supervisor may use a videoconferencing platform when providing specific observational feedback to a supervisee so they can see and hear responses to determine how the supervisee is receiving feedback on their skills, but may use the telephone when reviewing questions about a new case. Translating best practices in clinical supervision to a technology-based format is a higher level task for Clinical Supervisors and may require additional training. However, this should be seen as part of the competency development process and not a barrier to implementing TBCS.

5. DEMONSTRATE KNOWLEDGE AND PRACTICES THAT ADHERE TO PRIVACY/SECURITY AND CONFIDENTIALITY PROTECTIONS RELATED TO CONDUCTING CLINICAL SUPERVISION USING TECHNOLOGIES.

Rationale: Responsibility for maintaining privacy and security rests with both the Supervisor and supervisee. However, the Clinical Supervisor should serve as the lead and provide guidance to supervisees regarding privacy/security and confidentiality issues when using technology to provide clinical supervision services. Privacy and security protection does not rest solely on features of the technology itself. While some technologies adhere to security best practices via encryption and other tools, compliance with applicable laws, codes, and rules regarding security and privacy requires that all persons involved in transferring and storing information be mindful of necessary precautions needed to ensure that those security features can do their work, and that Supervisors and supervisees do not inadvertently create security or privacy breaches of their own through overdependence on those features. All Supervisors using technology to provide clinical supervision must know how to minimize risk associated with transferring and storing sensitive information.

When Supervisors or supervisees choose technology tools or platforms that include creation, receipt, maintenance, or transmission of data by the vendor of the tool or platform (e.g., “cloud” services), Clinical Supervisors should ensure compliance with all applicable security and privacy laws and regulations regarding written agreements or contracts between the vendor and the Supervisor or supervisee, as appropriate. Clinical Supervisors need to take reasonable steps to ensure that the product vendor has appropriate safeguards in place to protect the security and confidentiality of the Supervisor’s and/or supervisee’s data. Clinical Supervisors should be aware of the special privacy protections afforded to information regarding SUD treatment and ensure that all vendors comply with applicable laws and regulations regarding SUD treatment information.

6. ENSURE ADHERENCE TO ETHICAL GUIDELINES AND RELEVANT LAWS AND CODES SPECIFIC TO SUPERVISION OF CLINICAL SERVICES USING TECHNOLOGIES.

Rationale: Existing regulations that address clinical supervision ethics and codes of conduct apply equally to TBCS. As such, it is essential that Clinical Supervisors review their specific state and professional licensing and certification requirements to ensure their practice of TBCS is aligned with existing guidelines:

- NAADAC: www.naadac.org/code-of-ethics
- NASW: www.socialworkers.org/pubs/code/code.asp
- AAMFT: www.aamft.org/iMIS15/AAMFT/Content/Legal_Ethics/Code_of_Ethics.aspx
- ACA: www.counseling.org/resources/aca-code-of-ethics.pdf
- NBCC: www.nbcc.org/assets/ethics/nbcc-codeofethics.pdf
- APA: <http://www.apa.org/about/policy/guidelines-supervision.pdf>

Clinical Supervisors should provide supervision to supervisees that practice within the jurisdiction that oversees the practice of the Clinical Supervisor. Clinical Supervisors should have written verification of the supervisee's practice site or setting and should ensure that their supervisee's practice meets the jurisdictional, regulatory, licensing, credentialing, and privilege, malpractice, and insurance laws and rules for their profession. Finally, Clinical Supervisors should advise supervisees that in most states, patients may only be seen by clinicians who are licensed or certified in the state where the patient resides. Licensed professionals are usually allowed to provide consultation outside the jurisdiction of their licensure. However, Clinical Supervisors should check with the state regarding the definition of consultation and its terms. Certainly, ongoing clinical supervision that has been approved by a licensing and certification board to assist a supervisee in accruing experiential hours towards licensure or certification differs from short-term case consultation. In many states or jurisdictions, it would be considered a regulatory violation for a Clinical Supervisor to provide clinical supervision services for a supervisee regarding a patient that resides in a state where the supervisee or Clinical Supervisor is not authorized to practice. Clinical Supervisors should check with their supervisees to ensure all patients live within the supervisee and Clinical Supervisor's jurisdiction. For more information on the laws, regulations, and regulatory policies in each of the 50 states and the District of Columbia, please see: www.ebglaw.com/telemental-telebehavioral-survey/.

Clinical Supervisors may encounter new ethical dilemmas when using technologies for clinical supervision. For example, what procedures do Clinical Supervisors and supervisees follow if there is a disruption in clinical supervision services due to a technology interruption/failure, or what is the best method for the supervisee to reach the Clinical Supervisor should an emergency situation arise? Therefore, it is important that Clinical Supervisors and their supervisees develop and adhere to a clinical supervision agreement (see guideline #7). The use of technology for supervision does not change the ethical guidelines that reinforce the appropriate boundaries between Supervisor and supervisee, including the prohibition against sexual relationships with supervisees.

7. DEVELOP WRITTEN AGREEMENTS WITH SUPERVISEES THAT INCLUDE PARAMETERS AND STRUCTURE FOR TBCS.

Rationale: Typically, most Clinical Supervisors have a written agreement with their supervisees that covers such topics as: scope of the supervisee's practice; how the supervisory relationship will be initiated and evaluated; how and when supervision will be delivered; the Supervisor's training, licensure, and jurisdiction; and other pertinent practice issues. TBCS-specific items can be added to an existing clinical supervision agreement or a specific agreement for TBCS can be created. Some suggested items to include in an agreement are:

- use of secure electronic methods that allow for interaction between the Supervisor and supervisee;
- the technologies that both parties agree to use and protocol for accessing technology and initiating communication;
- a plan to ensure accessibility of the Supervisor to the supervisee despite physical distance between their offices;
- a backup communication plan in cases when technology is interrupted or fails, and a plan for establishing contact in an emergency;
- the identified risks and benefits of technology-based clinical supervision;
- how clinical supervision sessions will be documented and stored; and
- action steps for addressing conflicts between Clinical Supervisor and supervisee or Clinical Supervisor and agency.

8. IMPLEMENT CLINICAL PRACTICES THAT INCLUDE INFORMING PATIENTS VERBALLY AND IN WRITING ABOUT CLINICAL SUPERVISION SERVICES BEING DELIVERED THROUGH TECHNOLOGY PLATFORMS.

Rationale: Many behavioral health providers, as part of a patient's informed consent process, notify patients about clinical supervision practices and discuss the risks and benefits of clinical supervision and what it entails (e.g., purpose of clinical supervision; audio or video recording of sessions; how the recording will be stored or destroyed; name and qualifications of the Clinical Supervisor; etc.). If the supervisee plans to receive TBCS that includes live supervision or audio-visual recording of sessions, additional information should be disclosed to the patient regarding the technology platform(s) to be used, privacy/security issues relevant to the technology, and storage/destruction practices if different than non-distance supervision. Clinical Supervisors may request a copy of the patient's informed consent form that denotes their agreement to have their clinical services digitally recorded or observed for their records as long as they adhere to all privacy, security, and confidentiality regulations regarding storing forms with patient identifying information.

NEXT STEPS

To support incorporation of these guidelines, NFAR ATTC will initiate and implement the following training and technical assistance activities:

1. Consult with licensing and certification boards to address state-specific concerns and challenges in implementing TBCS guidelines;
2. Conduct skills-building trainings to ensure that Clinical Supervisors develop the required skills to use technology to provide effective clinical supervision;
3. Offer technical assistance by TBCS experts to provide lessons learned from their experiences using technology to provide clinical supervision; and
4. Hold ongoing webinars.

Finally, the NFAR ATTC has the resources to fund trainers/speakers to conduct workshops that are associated with conferences or stand-alone trainings. For more information about these services and products, please contact NFAR ATTC at (877) 978-7346 or nfar@attcnetwork.org.



- American Association for Marriage and Family Therapy. (2015). Board Approved Revised Code of Ethics. Retrieved from: www.aamft.org/iMIS15/AAMFT/Content/Legal_Ethics/Code_of_Ethics.aspx
- American Counseling Association. (2014). ACA Code of Ethics. Alexandria, VA: Author. Retrieved from: www.counseling.org/resources/aca-code-of-ethics.pdf
- American Psychological Association. (2014). Guidelines for Clinical Supervision in Health Service Psychology. Retrieved from: <http://www.apa.org/about/policy/guidelines-supervision.pdf>
- American Telemedicine Association, (2013). Practice Guidelines for Video-Based Online Mental Health Services. Retrieved from: <http://thesource.americantelemed.org/resources/telemedicine-practice-guidelines>
- Barnett, J. E. (2011). Utilizing technological innovations to enhance psychotherapy supervision, training, and outcomes. *Psychotherapy*, 48(2), 103-108.
- Bernard, J. M., & Goodyear, R. K. (2014). *Fundamentals of clinical supervision* (5th ed.). Boston: Pearson.
- Byrne, A. M., & Hartley, M. T. (2010). Digital technology in the 21st century: Considerations for clinical supervision in rehabilitation education. *Rehabilitation Education*, 24(1-2), 57-68.
- Conn, S. R., Roberts, R. L., & Powell, B. M. (2009). Attitudes and satisfaction with a hybrid model of counseling supervision. *Educational Technology & Society*, 12(2), 298-306.
- Dudding C. C., & Justice, L. M. (2004). An e-supervision model: Videoconferencing as a clinical training tool. *Communication Disorders Quarterly*, 25(3), 145-151.
- Epstein, R. M., & Hundert, E. M. (2002). Defining and assessing professional competence. *Journal of the American Medical Association*, 287(2), 226-235.
- Knudsen, H. K., Ducharme, L. J., & Roman, P. M. (2008). Clinical supervision, emotional exhaustion, and turnover intention: A study of substance abuse treatment counselors in the Clinical Trials Network of the National Institute on Drug Abuse. *Journal of Substance Abuse Treatment*, 35(4), 387-395.
- National Association for Alcoholism and Drug Abuse Counselors. Code of Ethics. Retrieved from: <http://www.naadac.org/code-of-ethics#vii>
- National Association of Social Workers. (2005). NASW & ASWB Standards for Technology and Social Work Practice. Retrieved from: <http://www.socialworkers.org/pubs/code/code.asp>
- National Board of Certified Counselors. Code of Ethics. Retrieved from: <http://www.nbcc.org/InteractiveCodeOfEthics/>
- Panos, P. T. (2005). A model for using videoconferencing technology to support international social work field practicum students. *International Social Work*, 48(6), 834-841.
- Perry, C. W. (2012). Constructing professional identity in an online graduate clinical training program: Possibilities for online supervision. *Journal of Systemic Therapies*, 31(3), 53-67.

