BOARD OF COUNSELING
ADHOC TELE-COUNSELING and SUPERVISION COMMITTEE MEETING
Thursday, November 1, 2018 – 1:00 p.m.
Second Floor – Perimeter Center, Board Room 2

1:00 p.m. **Call to Order – Terry Tinsley, Ph.D, LPC, LMFT, CSOTP, Chairperson**

Ordering of the Agenda

Public Comment

New Business

- Discuss Tele-Counseling and Supervision Guidelines
  - Summary of Tele-therapy Guidelines
  - Virginia Board of Counseling Guidance Document 115-1.4: Guidance on Technology-Assisted Counseling and Technology-Assisted Supervision, revised November 13, 2015
  - Virginia Board of Social Work Guidance Document 140-3 Guidance on Technology-Assisted Therapy and the Use of Social Media, reaffirmed September 21, 2018 (PDF)
  - Association of Martial and Family Therapy Regulatory Boards Teletherapy Guidelines
  - National Frontier & Rural ATTC Technology-Based Clinical Supervision Guidelines
  - Ohio Board of Counseling Telehealth Regulations

3:00 p.m. **Adjourn**

* Requires Board Action

Summary of Guidelines

Tele-Therapy
Policies & Procedures

- HIPAA Compliant

- Training:

    - Therapists must be accountable to sates of jurisdiction education requirements for tele therapy prior to initiating tele therapy.
    - Therapists may only advertise and perform those services they are licensed and trained to provide.
        - Operate within their scope of practice

- Therapist & Client Relationship:
    - A therapist who engages in technology-assisted services must provide the client with his/her license number and information on how to contact the board by telephone, e-mail, or USPS and must adhere to all other rules and regulations as outlined by the BOC.

- Informed consent and Emergency Procedures:
    - Agreed upon emergency procedures
    - Procedures for coordination of care and with other professionals
    - The conditions under which tele-therapy services may be terminated and a referral is made to another LMHP.
    - The conditions under which tele-therapy services may be terminated and a referral is made to another LMHP who can provide session in the same physical location.

- Serving minors:
    - Therapist must determine if a client is a minor. If so, this will require parental/legal guardian consent. Before providing tele-therapy service to a minor, therapist must bereft the identity of the parent, guardian, or other person consenting to the minor's treatment.
    - In cases where conservatorship, guardianship or parental rights of the client have been modified by the court, therapist shall obtain and review a written copy of the custody agreement of court order before the onset of treatment.

- Confidentiality of Communication:
    - Therapist utilizing tele-therapy must meet or exceed applicable federal and state legal requirement s of health information privacy including HIPAA/HiTECH.
    - Therapists must understand and inform their clients of the limits to confidentiality and risks to the possible access or disclosure of confidential

data and information that may occur during service delivery, including the risks of access to electronic communications.
    - Recording of the session in any form (audio or video) is Not Permitted without clear written consent of the client.
        - If the client is a minor then consent must be obtained from parent(s) and/or Legal Guardians.

- Professional Boundaries regarding Virtual Counseling:
    - Reasonable expectations about contact between sessions must be discussed and verified with the client. At the start of the treatment, the client and therapist shall discuss whether or not the provider will be available for phone or electronic contact between sessions and the conditions under which such contact is appropriate. The therapist shall provide a specific time frame for expected response between session contacts. This must also include a discussion of emergency management between sessions.

- Documentation/Record Keeping:
    - Written policies and procedures must be maintained at the same standard as face-to-face services for documentation, maintenance, and transmission of the records of the services using tele-therapy technologies.

- Emergency Management:
    - Therapist must have clearly delineated emergency procedures and access to current resources in each of their client's respective locations; simply offering 911 may not be sufficient.
    - If a client recurrently experiences crises/emergencies suggestive that in-person services may be appropriate, therapists shall take reasonable steps to refer a client to a local mental health resource or begin providing in-person services.
    - In the event of a technology breakdown, causing disruption of the session, the therapist must have a backup plan in place. The plan must be communicated to the client prior to commencement of the treatment and may also be included in the general emergency management protocol.

Virginia Board of Counseling Guidance Document

Virginia Board of Counseling

Guidance on Technology-Assisted Counseling and Technology-Assisted Supervision

The Board's regulations for Standards of Practice (18VAC115-20-130) are prefaced by the following:

The protection of the public health, safety, and welfare and the best interest of the public shall be the primary guide in determining the appropriate professional conduct of all persons whose activities are regulated by the board. Regardless of the delivery method, whether in person, by phone or electronically, these standards shall apply to the practice of counseling.

Therefore, the standards of practice set forth in section 130 of the regulations and in the Code of Virginia apply regardless of the method of delivery. The Board of Counseling recommends the following when a licensee uses technology-assisted counseling as the delivery method:

1. Counseling is most commonly offered in a *face-to-face relationship*. *Counseling that from the outset is delivered in a technology-assisted manner may be problematic in that the counseling relationship, client identity and other issues may be compromised.*

2. *The counselor must take steps to protect* client confidentiality and security.

3. The counselor *should seek training or otherwise demonstrate* expertise in the use of technology-assisted devices, especially in the matter of protecting confidentiality and security.

4. *When working with a client who is not in Virginia*, counselors are advised to check the regulations of the state board in which the client is located. It is important to be mindful that certain states prohibit counseling by an individual who is unlicensed by that state.

5. Counselors must follow the same code of ethics for technology-assisted counseling as they do in a traditional counseling setting.

Guidance for Technology-assisted Supervision

The Board of Counseling recommends the following when a licensee uses technology-assisted supervision:

1. Supervision is most commonly offered in a *face-to-face relationship*. *Supervision that from the outset is delivered in a technology-assisted manner may be problematic in that the supervisory relationship, client identity and other issues may be compromised.*

2. *The counselor must take steps to protect supervisee* confidentiality and security.

3. The counselor *should seek training or otherwise demonstrate* expertise in the use of technology-assisted devices, especially in the matter of protecting supervisee confidentiality and security.

4. Counselors must follow the same code of ethics for technology assisted supervision as they do in a traditional counseling/supervision setting.

5. The Board of Counseling governs the practice of counseling in Virginia. Counselors who are working with a client *who is not in Virginia* are advised to check the regulations of the state board in which a *supervisee is located*. It is important to be mindful that certain states *may regulate or prohibit supervision* by an individual who is unlicensed by that state.

Virginia Board of Social Work Guidance Document

VIRGINIA BOARD OF SOCIAL WORK

Guidance on Technology-Assisted Therapy and the Use of Social Media

BACKGROUND

Social workers are currently engaged in a variety of online contact methods with clients. The use of social media, telecommunication therapy and other electronic communication is increasing exponentially with growing numbers of social media outlets, platforms and applications, including blogs, social networking sites, video sites, and online chat rooms and forums. Some social workers often use electronic media both personally and professionally.

Social media and technology-assisted therapy can benefit health care in a variety of ways, including fostering professional connections, promoting timely communication with clients and family members, and educating and informing consumers and health care professionals.

Social workers are increasingly using blogs, forums and social networking sites to share workplace experiences particularly events that have been challenging or emotionally charged. These outlets provide a venue for the practitioner to express his or her feelings, and reflect or seek support from friends, colleagues, peers or virtually anyone on the Internet. Journaling and reflective practice have been identified as effective tools in health care practice. The Internet provides an alternative media for practitioners to engage in these helpful activities. Without a sense of caution, however, these understandable needs and potential benefits may result in the practitioner disclosing too much information and violating client privacy and confidentiality.

This document is intended to provide guidance to practitioners using electronic therapy or media in a manner that maintains client privacy and confidentiality. The protection of the public health, safety, and welfare and the best interest of the public shall be the primary guide in determining the appropriate professional conduct of all persons whose activities are regulated by the board. ***Therefore, the standards of practice set forth in section 18VAC140-20-150 of the regulations and in the Code of Virginia apply regardless of the method of delivery.***

RECOMMENDATIONS BY THE BOARD

The Board of Social Work recommends the following when a licensee uses technology-assisted services as the delivery method:

- *A Social worker providing services to a client located in Virginia through technology-assisted therapy must be licensed by the Virginia Board of Social Work*.
- *The service is deemed to take place where the client is located*. Therefore, the social worker should make every effort to verify the client's geographic location.
- Social workers shall strive to become and remain knowledgeable about the dynamics of online relationships, the advantages and drawbacks of non-face-to-face interactions, and the ways in which technology-assisted social work practice can be safely and

appropriately conducted. Traditional, face-to-face, in-person contact remains the preferred service delivery modality.

- *The social worker must take steps to ensure* client confidentiality and the security of client information in accordance with state and federal law.
- The social worker *should seek training or otherwise demonstrate* expertise in the use of technology-assisted devices, especially in the matter of protecting confidentiality and the security of client information.
- *When working with a client who is not in Virginia*, social workers are advised to check the regulations of the state board in which the client is located. It is important to be mindful that certain states prohibit social work services to a client in the state by an individual who is unlicensed by that state.
- Social workers must follow the same code of ethics for technology-assisted therapy as they do in a traditional social work setting.

ETHICS AND VALUES

Social workers providing technology-assisted therapy shall act ethically, ensure professional competence, protect client confidentiality, and uphold the values of the profession.

TECHNICAL COMPETENCIES

Social workers shall be responsible for becoming proficient in the technological skills and tools required for competent and ethical practice and for seeking appropriate training and consultation to stay current with emerging technologies.

CONFIDENTIALITY AND PRIVACY

Social workers shall protect client privacy when using technology in their practice and document all services, taking special safeguards to protect client information in the electronic record.

During the initial session, social workers should provide clients with information on the use of technology in service delivery. Social workers should assure that the client has received notice of privacy practices and should obtain any authorization for information disclosure and consent for treatment or services, as documented in the client record. Social workers should be aware of privacy risks involved when using wireless devices and other future technological innovations and take proper steps to protect client privacy.

Social workers should adhere to the privacy and security standards of applicable federal and state laws when performing services with the use of technology.

Social workers should give special attention to documenting services performed via the Internet and other technologies. They should be familiar with applicable laws that may dictate documentation standards in addition to licensure boards, third-party payers, and accreditation bodies. All practice activities should be documented and maintained in a safe, secure file with safeguards for electronic records.

BOARD OF SOCIAL WORK IMPLICATIONS

Instances of inappropriate use of social/electronic media or technology-assisted therapy may be reported to the Board, and it may investigate such reports, including reports of inappropriate disclosures on social media by a social worker, on the grounds of:

- Unprofessional conduct;
- Unethical conduct;
- Moral turpitude;
- Mismanagement of client records;
- Revealing a privileged communication; and
- Breach of confidentiality.

If the allegations are found to be true, the social worker may face disciplinary action by the Board, including a reprimand or sanction, assessment of a monetary fine, or temporary or permanent loss of licensure, certification, or registration.

GUIDING PRINCIPLES

Social networks and the Internet provide unparalleled opportunities for rapid knowledge exchange and dissemination among many people, but this exchange does not come without risk. Social workers and students have an obligation to understand the nature, benefits, and consequences of participating in social networking or providing technology-assisted therapy of all types. Online content and behavior has the potential to enhance or undermine not only the individual practitioner's career, but also the profession.

HOW TO AVOID PROBLEMS USING SOCIAL MEDIA

It is important to recognize that instances of inappropriate use of social media can and do occur, but with awareness and caution, social workers can avoid inadvertently disclosing confidential or private information about clients.

The following guidelines are intended to minimize the risks of using social media:

- Recognize the ethical and legal obligations to maintain client privacy and confidentiality at all times.
- Client-identifying information transmitted electronically should be done in accordance with established policies and state and federal law.
- Do not share, post, or otherwise disseminate any information, including images, about a client or information gained in the practitioner-client relationship with anyone unless permitted or required by applicable law.
- Do not identify clients by name or post or publish information that may lead to the identification of a client. Limiting access to postings through privacy settings is not sufficient to ensure privacy.

- Do not refer to clients in a disparaging manner, or otherwise degrade or embarrass the client, even if the client is not identified.
- Do not take photos or videos of clients on personal devices, including cell phones. Follow employer policies for taking photographs or video of clients for treatment or other legitimate purposes using employer-provided devices.
- Maintain professional boundaries in the use of electronic media. Like in-person relationships, the practitioner has the obligation to establish, communicate and enforce professional boundaries with clients in the online environment. Use caution when having online social contact with clients or former clients. Online contact with clients or former clients blurs the distinction between a professional and personal relationship. The fact that a client may initiate contact with the practitioner does not permit the practitioner to engage in a personal relationship with the client.
- Consult employer policies or an appropriate leader within the organization for guidance regarding work related postings.
- Promptly report any identified breach of confidentiality or privacy in accordance with state and federal laws.

CONCLUSION

Social/ electronic media and technology-assisted therapy possess tremendous potential for strengthening professional relationships and providing valuable information to health care consumers. Social workers need to be aware of the potential ramifications of disclosing client-related information via social media or through technology-assisted therapy. Social workers should be mindful of relevant state and federal laws, professional standards regarding confidentiality, and the application of those standards. Social workers should also ensure the standards of practice set forth in 18 VAC 140-20-150 are met when performing technology-assisted therapy.

Association of Martial and Family Therapy Regulatory Boards Teletherapy Guidelines

Association of Marital and Family Therapy Regulatory Boards

Teletherapy Guidelines

September 2016

AMFTRB
Teletherapy Guidelines

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Overview

The AMFTRB Teletherapy Committee was created and tasked with developing a set of guidelines for use by Member Boards when regulating the practice of teletherapy by Licensed Marriage and Family Therapists (LMFTs) across the country. The Committee reviewed current AAMFT Codes of Ethics and other professional codes of ethics, state laws, research articles, and telehealth guidelines of many disciplines in creating the following guidelines for Licensed Marriage and Family Therapists.

Key Assumptions of the Teletherapy Committee

The committee agreed upon the following tenets which informed each of the guidelines herein:

I. Public protection must be the overriding principle behind each guideline.

II. Each guideline shall be written with special consideration of those uniquely systemic challenges.

III. All existing minimum standards for face-to-face client interaction are assumed for teletherapy practice.

IV. A teletherapy standard shall not be unnecessarily more restrictive than the respective face-to-face standard for safe practice.

V. Each guideline must be a recommendation for a minimum standard for safe practice *not* a best practice recommendation.

VI. The regulation of teletherapy practice is intertwined with the challenges of portability of LMFT licensure across state lines.

VII. Each guideline shall be written with consideration for the possibility of a national teletherapy credential.

The Process

The AMFTRB Teletherapy Committee members were identified in fall 2015. The committee began with a review of literature and current telehealth practice publications within the field of marriage and family therapy and across professional disciplines. Topical areas for telemental health guidelines were identified, and each committee member was charged with researching the critical elements to be included in the final draft. The committee met and reviewed each of the elements of the guidelines. Please be advised that the committee did not draft specific regulations regarding the appropriateness of telemental health and working with domestic violence victims, completing child custody evaluations, treating cyber addiction, or using technology for supervised sanctions as the research in each of these areas was limited. We also acknowledge that a method by which cultural competency may be measured is needed and encourage Member Boards to advise therapists to seek training in this area.

Committee members identified stakeholders whose input was desired in reviewing the draft guidelines. Comments were requested from marriage and family therapy graduate programs, continuing education resources, and state licensing boards. The committee reviewed and analyzed the comments from stakeholders, consulted the AAMFT Code of Ethics, and Guidelines, and incorporated this information into the final document. The draft guidelines were then submitted to the 2016 AMFTRB delegate assembly for discussion and adoption.

Introduction to Teletherapy Guidelines

Electronic practice in behavioral health has continued to garner momentum. With the creation of Facebook in 2004, the onset of 140 character messages through Twitter in 2006, and the proliferation of video conferencing platforms, therapists and clients have more options available to interact with each other than ever before. Telemental health is experiencing an "evident boom" for many reasons. Social media has significantly contributed to the growth. For example, as of July 2016, Facebook reports over 950 million users, 500 million of whom log in daily. The Pew Research Center (January 2014) reported 87% of American adults use the internet, up from 14% in 1995 (Pew, 2014). The Internet World Stats estimates 3,611 millions of users of the internet (Zephoria, 2016).

The State of Telemental Health in 2016 identifies five reasons for this growth. First, telemental health does not require physical contact with patients; therefore, technology based services are not that different from face-to-face therapy. While this statement overlooks the nuances of providing telemental health, it does support a burgeoning practice of clients receiving services without needing to step foot in a therapist's office. Second, telemental health has been accepted by a large number of payers, more than other telehealth disciplines. As more and more payers cover services provided through electronic practice, it is anticipated that a growing number of therapists will provide care electronically. Third, telemental health may reduce the stigma of those seeking care. One of the unspoken benefits of telemental health is that clients do not need to be seen entering a therapist's office. Therapists are cognizant of the concern clients have for confidentiality when determining where to house their brick-and-mortar practices. With the opportunity to receive telemental health electronically, the stigma of receiving counseling may be lessened. Not only is the potential for the stigma of mental health diminishing, more and more clients may also have an opportunity to receive care through telemental health. Fourth, the prevalence of mental health services and the shortage of mental health counselors is incentivizing stakeholders to look for alternatives to face-to-face care. For psychiatry, the American Medical Association reported that 60 percent of psychiatrists nationwide are at least 55 years old, with about 48 percent considering retiring in the next five years. "According to Mental Health American's latest report on mental health, there is only one mental health provider for every 566 people in the country." Maine has the highest number of mental health providers with a 1:250 ratio and Texas has the fewest (1:1,100). Finally, the patients who have received telemental health services have perceived their care to be effective (Epstein, Becker, & O'Brien, 2016).

Since the early discussions about telemental health, the technological landscape has changed. Cybercounseling (Hughes, 2000), e-counseling, e-therapy (Epstein, Becker, & O'Brien, 2016) and the current term of telemental health services have evolved as the shifting sands of modalities used in electronic practice have altered the modalities therapists use. Early publications about telemental

health services asked questions such as, “Should emails be encrypted?” (Mitchell, 2000), “What fee structures should be established for online services?” (Hughes, 2000), “Can a client decline to use secure systems?”, and “What if a client emergency is received, and there is no identifying information?” (Mitchell, 2000).

Discussions about online therapy have shifted as technologies available for therapy have shifted. Early discussions involved telephonic counseling and emails which evolved into video counseling, avatars, chats, blogs, and more. Social media and social networking sites have also altered the therapy landscape. Although the technologies have changed, the concerns associated with the provision of telemental health services have not. The assurance of confidentiality continues to be a concern (Hertlein, Blumer, & Mihaloliakos, 2014; Derrig-Palumbo & Eversole, 2011), as does boundary management ((Hertlein, Blumer, & Mihaloliakos, 2014; Hertlein et al, 2014), and management of crises (Hertlein, Blumer, & Mihaloliakos, 2014; Perle et al., 2013; Chester & Glass, 2006). Other concerns identified in research include the impact technology has on the therapeutic relationship, liability and licensing issues, and training and education required to provide effective telemental health services (Hertlein, Blumer, & Mihaloliakos, 2014).

As millennials enter the counseling field, the use of technology is anticipated to continue. Reith (2005) noted millennials are more comfortable with technology and have been dubbed the “digital natives”. Digital natives were “born into” a world of technology, more so than previous generations who have been termed “digital immigrants” (Prensky, 2001). Furthermore, Blumer, Hertlein, Allen, & Smith (2012) reported that millennials also feel technology is private and safe. This perception could impact the decisions made in the care and safekeeping of clinical information which fuels the need for technology specific regulations.

The proliferation of counseling-related websites has also impacted the need for technology-related regulations. In September 2008, Haberstroh (2009) identified 4 million websites when searching “online counseling”. In July 2016, a recent search of the same term netted 94 million results. This growth clearly indicates more and more counselors are turning to the internet to provide services of some type. Blumer, Hertlein, Allen, & Smith (2012) noted in their research that therapists used technology to augment treatment and Twist & Hertlein (2015) noted the use of technology for online professional networking.

While research indicates a growing use of technology in professional communications, Maheu & Gordon (2000) discovered that 78% of counselors acknowledged treating clients from other states online. Furthermore, Shaw & Shaw (2004) and Heinlen et al (2003) “found many online clinicians did not regularly follow ethical guidelines in their practices”. In a study of Swedish physicians, Brynold et al (2013) noted that physicians were tweeting in a manner deemed “unprofessional,” and the tweets were considered violations of patient privacy. Nearly 84% of family therapists were noted, in one study, to have communication with clients via email (Hertlein, Blumer & Smith, 2013).

Therapists may be confused about how to ethically and legally provide telemental health services. Haberstroh, Barney, Foster, & Duffey (2013) noted while no state licensing boards prohibit telemental health services, the language is vague. “Less than half of state boards directly allowed the practice of online clinical work through their local state laws or ethical codes…However, the specificity of the guidance provided by licensure boards varied greatly.” States seem to be grappling with the challenges of writing effective and somewhat timeless technology regulations. Therapists must comply with the

relevant licensing laws in the jurisdiction where the therapist is licensed when providing the care and the relevant licensing laws where the client is located when receiving care. Many states will only process complaints from residents of their state. Note, in the United States, the jurisdictional licensure requirement is usually tied to *where the client is physically located* when he or she is receiving the care, *not* where the client lives; however, therapists must ensure they are also compliant with any and all state and federal laws.

While the technologies and opportunities continue to emerge, few graduate programs provide meaningful guidance in how to establish a telemental health practice. Feedback received from graduate programs indicate the majority of programs, if they are addressing telemental health practice at all, are covering telemental health services typically in one class period. Many noted that the lack of clear regulations impacted their willingness to provide more comprehensive education about telemental health practice.

Therapists currently in the field rely on post-graduate training, typically in the form of continuing education workshops and programs, to expand their professional competence. Hertlein, Blumer & Smith (2013) noted that therapists should be trained in providing telemental health services, and yet, at the 2010 AAMFT conference, they note 1 of 220 workshops/posters focused on telemental health. Williams et al (2013) suggested a "framework that includes e-professionalism" be drafted. All of these events support the need for AMFTRB to establish telemental health guidelines.

Definitions

Asynchronous – Communication is not synchronized or occurring simultaneously (Reimers, 2013)

Competency - Marriage and family therapists ensure that they are well trained and competent in the use of all chosen technology-assisted professional services. Careful choices of audio, video, and other options are made in order to optimize quality and security of services and to adhere to standards of best practices for technology-assisted services. Furthermore, such choices of technology are to be suitably advanced and current so as to best serve the professional needs of clients and supervisees. (AAMFT Code of Ethics, 2015)

Electronic communication - Using Web sites, cell phones, e-mail, texting, online social networking, video, or other digital methods and technology to send and receive messages, or to post information so that it can be retrieved by others or used at a later time. (Technology Standards in Social Work Practice, 2016)

Encryption – A mathematical process that converts text, video, or audio streams into a scrambled, unreadable format when transmitted over the internet. (Trepal, Haberstroh, Duffey, & Evans, 2007)

HIPAA compliant – HIPAA, the Health Insurance Portability and Accountability Act, sets the standard for protecting sensitive patient data. Any company that deals with protected health information (PHI) must ensure that all the required physical, network, and process security measures are in place and followed. This includes covered entities (CE), anyone who provides treatment, payment and operations in healthcare, and business associates (BA)**,** anyone with access to patient information and provides

support in treatment, payment or operations. Subcontractors, or business associates of business associates, must also be in compliance. (What is HIPAA Compliance? 2016)

HITECH - Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009 addresses the privacy and security concerns associated with the electronic transmission of health information, in part, through several provisions that strengthen the civil and criminal enforcement of the HIPAA rules (HITECH Act Enforcement of Interim Final Rule, 2016)

PHI – Protected Health Information (HIPAA, 2016)

Social media/social networking - Social media are web-based communication tools that enable people to interact with each other by both sharing and consuming information (Webtrends, 2016)

Synchronous – Communication which occurs simultaneously in real time (Reimers, 2013)

Telesupervision - refers to the practice of supervision by a licensed (teletherapy) supervisor through synchronous or asynchronous two-way electronic communication including but not limited to telephone, videoconferencing, email, text, instant messaging, and social media for the purposes of developing trainee marital and family therapists, evaluating supervisee performance, ensuring rigorous legal and ethical standards within the bounds of licensure, and as a means for improving the profession of marital and family therapy.

Teletherapy/Technology-assisted services – refers to the scope of marriage and family therapy practice of diagnosis, evaluation, consultation, intervention and treatment of behavioral, social, interpersonal disorders through synchronous or asynchronous two-way electronic communication including but not limited to telephone, videoconferencing, email, text, instant messaging, and social media.

Verification – Measures to verify both counselor and client identities online (Haberstroh, 2009)

Virtual relationship - A relationship where people are not physically present but communicate using online, texting, or other electronic communication devise (Urban Dictionary, 2016)

Guidelines for the Regulation of Teletherapy Practice

1. Adhering to Laws and Rules in Each Jurisdiction

A. Therapists of one state who are providing marriage and family therapy to clients in another state must comply with the laws and rules of both jurisdictions.
B. Treatment, consultation, and supervision utilizing technology-assisted services will be held to the same standards of appropriate practice as those in traditional (in person) settings.

2. Training/Educational Requirements of Professionals

A. Therapists must be accountable to states of jurisdiction education requirements for teletherapy prior to initiating teletherapy.
B. Therapists may only advertise and perform those services they are licensed and trained to provide. The anonymity of electronic communication makes misrepresentation possible for both therapists and clients. Because of the potential misuse by unqualified individuals, it is essential that information be readily verifiable to ensure client protection.
C. Therapists shall review their discipline's definitions of "competence" prior to initiating teletherapy client care to assure that they maintain recommended technical and clinical competence for the delivery of care in this manner. Therapists shall have completed basic education and training in suicide prevention. While the depth of training and the definition of “basic” are solely at the therapist’s discretion, the therapist’s competency may be evaluated by the state board.
D. Therapists shall assume responsibility to continually assess both their professional and technical competence when providing teletherapy services.
E. Minimum 15 hours initial training. Must demonstrate continued competence in a variety of ways (e.g. encryption of data, HIPAA compliant connections). Areas to be covered in the training must include, but not be limited to:
    a. Appropriateness of Teletherapy
    b. Teletherapy Theory and Practice
    c. Modes of Delivery
    d. Legal/Ethical Issues
    e. Handling Online Emergencies
    f. Best Practices & Informed Consent
F. Minimum of 5 continuing education hours every 5 years is required.

3. Identity Verification of Client

A. Therapists must recognize the obligations, responsibilities, and client rights associated with establishing and maintaining a therapeutic relationship.
B. An appropriate therapeutic relationship has not been established when the identity of the therapist may be unknown to the client or the identity of the client(s) may be unknown to the therapist. An initial face-to-face meeting, which may utilize HIPAA compliant video-conferencing, is highly recommended to verify the identity of the client. If such verification

is not possible, the burden is on the therapist to document appropriate verification of the client.

C. A therapist shall take reasonable steps to verify the location and identify the client(s) at the onset of each session before rendering therapy using teletherapy.
D. Therapists shall develop written procedures for verifying the identity of the recipient, his or her current location, and readiness to proceed at the beginning of each contact. Examples of verification means include the use of code words, phrases or inquiries. (For example, "is this a good time to proceed?").

4. Establishing the Therapist-Client Relationship

A. A therapist who engages in technology-assisted services must provide the client with his/her license number and information on how to contact the board by telephone, electronic communication, or mail, and must adhere to all other rules and regulations in the relevant jurisdiction(s).
B. The relationship is clearly established when informed consent documentation is signed.
C. Therapists must communicate any risks and benefits of the teletherapy services to be offered to the client(s) and document such communication.
D. Screening for client technological capabilities is part of the initial intake processes. (Ex. This type of screening could be accomplished by asking clients to complete a brief questionnaire about their technical and cognitive capacities).
E. Teletherapy services must have accurate and transparent information about the website owner/operator, location, and contact information, including a domain name that accurately reflects the identity.
F. The therapist and/or client shall use connection test tools (e.g., bandwidth test) to test the connection before starting their videoconferencing session to ensure the connection has sufficient quality to support the session.

5. Cultural Competency

A. Therapists shall be aware of and sensitive to clients from different cultures and have basic clinical competency skills providing these services.
B. Therapists shall be aware of the limitations of teletherapy and recognize and respect cultural differences (e.g. when therapist is unable to see the client, non-verbal cues). Therapists shall remain aware of their own potential projections, assumptions, and cultural biases.
C. Therapists shall select and develop appropriate online methods, skills, and techniques that are attuned to their clients' cultural, bicultural, or marginalized experiences in their environments.
D. Client perspectives of therapy and service delivery via technology may differ. In addition, culturally competent therapists shall know the strengths and limitations of current electronic modalities, process and practice models, to provide services that are applicable and relevant to the needs of culturally and geographically diverse clients and members of vulnerable populations.

E. Therapists shall consider cultural differences, including clarity of communications.
F. Sensory deficits, especially visual and auditory, can affect the ability to interact over a videoconference connection. Therapists shall consider the use of technologies that can help with visual or auditory deficit. Techniques should be appropriate for a client who may be cognitively impaired, or find it difficult to adapt to the technology.

6. Informed Consent/Client Choice to Engage in Teletherapy

Availability of Professional to Client

A. The therapist must document the provision of consent in the record prior to the onset of therapy. The consent shall include all information contained in the consent process for in-person care including discussion of the structure and timing of services, record keeping, scheduling, privacy, potential risks, confidentiality, mandatory reporting, and billing.
B. This information shall be specific to the identified service delivery type and include considerations for that particular individual.
C. The information must be provided in language that can be easily understood by the client. This is particularly important when discussing technical issues like encryption or the potential for technical failure.
D. Local, regional and national laws regarding verbal or written consent must be followed. If written consent is required, electronic signatures may be used if they are allowed in the relevant jurisdiction.
E. In addition to the usual and customary protocol of informed consent between therapist and client for face-to-face counseling, the following issues, unique to the use of teletherapy, technology, and/or social media, shall be addressed in the informed consent process:
    a. confidentiality and the limits to confidentiality in electronic communication;
    b. teletherapy training and/or credentials, physical location of practice, and contact information;
    c. licensure qualifications and information on reporting complaints to appropriate licensing bodies;
    d. risks and benefits of engaging in the use of teletherapy, technology, and/or social media;
    e. possibility of technology failure and alternate methods of service delivery;
    f. process by which client information will be documented and stored;
    g. anticipated response time and acceptable ways to contact the therapist;
        i. agreed upon emergency procedures;
        ii. procedures for coordination of care with other professionals;
        iii. conditions under which teletherapy services may be terminated and a referral made to in-person care;
    h. time zone differences;
    i. cultural and/or language differences that may affect delivery of services;
    j. possible denial of insurance benefits;
    k. social media policy;
    l. specific services provided;
    m. pertinent legal rights and limitations governing practice across state lines or international boundaries, when appropriate; and
    n. Information collected and any passive tracking mechanisms utilized.

F. Given that therapists may be offering teletherapy to individuals in different states at any one time, the therapists shall document all relevant state regulations in the respective record(s). The therapist is responsible for knowing the correct informed consent forms for each applicable jurisdiction.
G. Therapists must provide clients clear mechanisms to:

    a. access, supplement, and amend client-provided personal health information;
    b. provide feedback regarding the site and the quality of information and services; and
    c. register complaints, including information regarding filing a complaint with the applicable state licensing board(s).

Working with Children

A. Therapists must determine if a client is a minor and, therefore, in need of parental/guardian consent. Before providing teletherapy services to a minor, therapist must verify the identity of the parent, guardian, or other person consenting to the minor's treatment.
B. In cases where conservatorship, guardianship or parental rights of the client have been modified by the court, therapists shall obtain and review a written copy of the custody agreement or court order before the onset of treatment.

7. Acknowledgement of Limitations of Teletherapy

A. Therapists must: (a) determine that teletherapy is appropriate for clients, considering professional, intellectual, emotional, and physical needs; (b) inform clients of the potential risks and benefits associated with teletherapy; (c) ensure the security of their communication medium; and (d) only commence teletherapy after appropriate education, training, or supervised experience using the relevant technology.
B. Clients must be made aware of the risks and responsibilities associated with teletherapy. Therapists are to advise clients in writing of these risks and of both the therapist's and clients' responsibilities for minimizing such risks.
C. Therapists shall consider the differences between face-to-face and electronic communication (nonverbal and verbal cues) and how these may affect the therapy process. Therapists shall educate clients on how to prevent and address potential misunderstandings arising from the lack of visual cues and voice intonations when communicating electronically.
D. Therapists shall be aware of the limitations of teletherapy and recognize and respect cultural differences (e.g. when therapist is unable to see the client, non-verbal cues). Therapists shall remain aware of their own potential projections, assumptions, and cultural biases.
E. Therapists shall recognize the members of the same family system may have different levels of competence and preference using technology. Therapists shall acknowledge power dynamics when there are differing levels of technological competence within a family system.
F. Before therapists engage in providing teletherapy services, they must conduct an initial assessment to determine the appropriateness of the teletherapy service to be provided for the client(s). Such an assessment may include the examination of the potential risks and benefits to provide teletherapy services for the client's particular needs, the multicultural

and ethical issues that may arise, and a review of the most appropriate medium (e.g., video conference, text, email, etc.) or best options available for the service delivery. It may also include considering whether comparable in-person services are available, and why services delivered via teletherapy are equivalent or preferable to such services. In addition, it is incumbent on the therapist to engage in a continual assessment of the appropriateness of providing teletherapy services throughout the duration of the service delivery.

8. Confidentiality of Communication

A. Therapists utilizing teletherapy must meet or exceed applicable federal and state legal requirements of health information privacy including HIPAA/HiTECH.
B. Therapists shall assess carefully the remote environment in which services will be provided, to determine what impact, if any, there might be to the efficacy, privacy and/or safety of the proposed intervention offered via teletherapy.
C. Therapists must understand and inform their clients of the limits to confidentiality and risks to the possible access or disclosure of confidential data and information that may occur during service delivery, including the risks of access to electronic communications.

9. Professional Boundaries Regarding Virtual Presence

A. Reasonable expectations about contact between sessions must be discussed and verified with the client. At the start of the treatment, the client and therapist shall discuss whether or not the provider will be available for phone or electronic contact between sessions and the conditions under which such contact is appropriate. The therapist shall provide a specific time frame for expected response between session contacts. This must also include a discussion of emergency management between sessions.
B. To facilitate the secure provision of information, therapists must provide in writing the appropriate ways to contact them.
C. Therapists are discouraged from knowingly engaging in a personal virtual relationship with clients (e.g., through social and other media). Therapists shall document any known virtual relationships with clients/associated with clients.
D. Therapists shall discuss and document, and must establish, professional boundaries with clients regarding the appropriate use and/or application of technology and the limitations of its use within the counseling relationship (e.g., lack of confidentiality, circumstances when not appropriate to use).
E. Therapists shall be aware that personal information they disclose through electronic means may be broadly accessible in the public domain and may affect the therapeutic relationship.

10. Social Media and Virtual Presence

A. Therapists shall develop written procedures for the use of social media and other related digital technology with clients. These written procedures, at a minimum, provide appropriate protections against the disclosure of confidential information and identify that personal social media accounts are distinct from any used for professional purposes.

B. In cases where therapists wish to maintain a professional and personal presence for social media use, separate professional and personal web pages and profiles shall be created to clearly distinguish between the two kinds of virtual presence.
C. Therapists must respect the privacy of their clients' presence on social media unless given consent to view such information.
D. Therapists must avoid the use of public social media sources (e.g., tweets, blogs, etc.) to provide confidential information.
E. Therapists shall refrain from referring to clients generally or specifically on social media.
F. Therapists who use social networking sites for both professional and personal purposes are encouraged to review and educate themselves about the potential risks to privacy and confidentiality and consider utilizing all available privacy settings to reduce these risks. They are mindful of the possibility that any electronic communication can have a high risk of public discovery.
G. Therapists who engage in online blogging shall be aware that they are revealing personal information about themselves and shall be aware that clients may read the material. Therapists shall consider the effect of a client's knowledge of their blog information on the professional relationship, and when providing marriage and family therapy, place the client's interests as paramount.

11. Sexual Issues in Teletherapy

A. Treatment and/or consultation utilizing technology-assisted services must be held to the same standards of appropriate practice as those in face to face settings.
B. Therapists must be aware of statutes and regulations of relevant jurisdictions regarding sexual interactions with current or former clients or with known members of the client's family system.

12. Documentation/Record Keeping

A. All direct client-related electronic communications, shall be stored and filed in the client's medical record, consistent with traditional record-keeping policies and procedures.
B. Written policies and procedures must be maintained at the same standard as face-to-face services for documentation, maintenance, and transmission of the records of the services using teletherapy technologies.
C. Services must be accurately documented as remote services and include dates, place of both therapist and client(s) location, duration, and type of service(s) provided.
D. Requests for access to records require written authorization from the client with a clear indication of what types of data and which information is to be released. If therapists are storing the audiovisual data from the sessions, these cannot be released unless the client authorization indicates specifically that this is to be released.
E. Therapists must create policies and procedures for the secure destruction of data and information and the technologies used to create, store, and transmit data and information.
F. Therapists must inform clients on how records are maintained electronically. This includes, but is not limited to, the type of encryption and security assigned to the records, and if/for how long archival storage of transaction records is maintained.

G. Clients must be informed in writing of the limitations and protections offered by the therapist's technology.
H. The therapist must obtain written permission prior recording any/or part of the teletherapy session. The therapist shall request that the client(s) obtain written permission from the therapist prior to recording the teletherapy session.

13. Payment and Billing Procedures

A. Prior to the commencement of initial services, the client shall be informed of any and all financial charges that may arise from the services to be provided. Arrangement for payment shall be completed prior to the commencement of services.
B. All billing and administrative data related to the client must be secured to protect confidentiality. Only relevant information may be released for reimbursement purposes as outlined by HIPAA.
C. Therapist shall document who is present and use appropriate billing codes.
D. Therapist must ensure online payment methods by clients are secure.

14. Emergency Management

A. Each jurisdiction has its own involuntary hospitalization and duty-to-notify laws outlining criteria and detainment conditions. Professionals must know and abide by the rules and laws in the jurisdiction where the therapist is located and where the client is receiving services.
B. At the onset of the delivery of teletherapy services, therapists shall make reasonable effort to identify and learn how to access relevant and appropriate emergency resources in the client's local area, such as emergency response contacts (e.g., emergency telephone numbers, hospital admissions, local referral resources, a support person in the client's life when available and appropriate consent has been authorized).
C. Therapists must have clearly delineated emergency procedures and access to current resources in each of their client's respective locations; simply offering 911 may not be sufficient.
D. If a client recurrently experiences crises/emergencies suggestive that in-person services may be appropriate, therapists shall take reasonable steps to refer a client to a local mental health resource or begin providing in-person services.
E. Therapists shall prepare a plan to address any lack of appropriate resources, particularly those necessary in an emergency, and other relevant factors which may impact the efficacy and safety of said service. Therapists shall make reasonable effort to discuss with and provide all clients with clear written instructions as to what to do in an emergency (e.g., where there is a suicide risk). As part of emergency planning, therapists must be knowledgeable of the laws and rules of the jurisdiction in which the client resides and the differences from those in the therapist's jurisdiction, as well as document all their emergency planning efforts.
F. In the event of a technology breakdown, causing disruption of the session, the therapist must have a backup plan in place. The plan must be communicated to the client prior to

commencement of the treatment and may also be included in the general emergency management protocol.

15. Synchronous vs. Asynchronous Contact with Client(s)

A. Communications may be synchronous with multiple parties communicating in real time (e.g., interactive videoconferencing, telephone) or asynchronous (e.g. email, online bulletin boards, storing and forwarding information). Technologies may augment traditional in-person services (e.g., psychoeducational materials online after an in-person therapy session), or be used as stand-alone services (e.g., therapy provided over videoconferencing). Different technologies may be used in various combinations and for different purposes during the provision of teletherapy services. The same medium may be used for direct and non-direct services. For example, videoconferencing and telephone, email, and text may also be utilized for direct service while telephone, email, and text-may be used for non-direct services (e.g. scheduling). Regardless of the purpose, therapists shall be aware of the potential benefits and limitations in their choices of technologies for particular clients in particular situations.

16. HIPAA Security, Web Maintenance, and Encryption Requirements

A. Videoconferencing applications must have appropriate verification, confidentiality, and security parameters necessary to be properly utilized for this purpose.
B. Video software platforms must not be used when they include social media functions that notify users when anyone in contact list logs on (skype, g-chat).
C. Capability to create a video chat room must be disabled so others cannot enter at will.
D. Personal computers used must have up-to-date antivirus software and a personal firewall installed.
E. All efforts must be taken to make audio and video transmission secure by using point-to-point encryption that meets recognized standards.
F. Videoconferencing software shall not allow multiple concurrent sessions to be opened by a single user.
G. Session logs stored by 3rd party locations must be secure.
H. Therapists must conduct analysis of the risks to their practice setting, telecommunication technologies, and administrative staff, to ensure that client data and information is accessible only to appropriate and authorized individuals.
I. Therapists must encrypt confidential client information for storage or transmission, and utilize such other secure methods as safe hardware and software and robust passwords to protect electronically stored or transmitted data and information.
J. When documenting the security measures utilized, therapists shall clearly address what types of telecommunication technologies are used (e.g., email, telephone, videoconferencing, text), how they are used, whether teletherapy services used are the primary method of contact or augments in-person contact.

17. Archiving/Backup Systems

A. Therapists shall retain copies of all written communications with clients. Examples of written communications include email/text messages, instant messages, and histories of chat based discussions even if they are related to housekeeping issues such as change of contact information or scheduling appointments.
B. PHI and other confidential data must be backed up to or stored on secure data storage location.
C. Therapists must have a plan for the professional retention of records and availability to clients in the event of the therapist's incapacitation or death.

18. Electronic Links

A. Therapists shall regularly ensure that electronic links are working and are professionally appropriate.

19. Testing/Assessment

A. When employing assessment procedures in teletherapy, therapists shall familiarize themselves with the tests' psychometric properties, construction, and norms in accordance with current research. Potential limitations of conclusions and recommendations that can be made from online assessment procedures should be clarified with the client prior to administering online assessments.
B. Therapists shall consider the unique issues that may arise with test instruments and assessment approaches designed for in-person implementation when providing services.
C. Therapists shall maintain the integrity of the application of the testing and assessment process and procedures when using telecommunication technologies. When a test is conducted via teletherapy, therapists shall ensure that the integrity of the psychometric properties of the test or assessment procedure (e.g., reliability and validity) and the conditions of administration indicated in the test manual are preserved when adapted for use with such technologies.
D. Therapists shall be cognizant of the specific issues that may arise with diverse populations when providing teletherapy and make appropriate arrangements to address those concerns (e.g., language or cultural issues; cognitive, physical or sensory skills or impairments; or age may impact assessment). In addition, therapists shall consider the use of a trained assistant (e.g., proctor) to be on premise at the remote location in an effort to help verify the identity of the client(s), provide needed on-site support to administer certain tests or subtests, and protect the security of the testing and/or assessment process.
E. Therapists shall use test norms derived from telecommunication technologies administration if such are available. Therapists shall recognize the potential limitations of all assessment processes conducted via teletherapy, and be ready to address the limitations and potential impact of those procedures.

F. Therapists shall be aware of the potential for unsupervised online testing which may compromise the standardization of administration procedures and take steps to minimize the associated risks. When data are collected online, security should be protected by the provision of usernames and passwords. Therapists shall inform their clients of how test data will be stored (e.g., electronic database that is backed up). Regarding data storage, ideally secure test environments use a three-tier server model consisting of an internet server, a test application server, and a database server. Therapists should confirm with the test publisher that the testing site is secure and that it cannot be entered without authorization.
G. Therapists shall be aware of the limitations of "blind" test interpretation, that is, interpretation of tests in isolation without supporting assessment data and the benefit of observing the test taker. These limitations include not having the opportunity to make clinical observations of the test taker (e.g., test anxiety, distractibility, or potentially limiting factors such as language, disability etc.) or to conduct other assessments that may be required to support the test results (e.g., interview).

20. Telesupervision

A. Therapists must hold supervision to the same standards as all other technology-assisted services. Telesupervision shall be held to the same standards of appropriate practice as those in in-person settings.
B. Before using technology in supervision, supervisors shall be competent in the use of those technologies. Supervisors must take the necessary precautions to protect the confidentiality of all information transmitted through any electronic means and maintain competence.
C. The type of communications used for telesupervision shall be appropriate for the types of services being supervised, clients and supervisee needs. Telesupervision is provided in compliance with the supervision requirements of the relevant jurisdiction(s). Therapists must review state board requirements specifically regarding face-to-face contact with supervisee as well as the need for having direct knowledge of all clients served by his or her supervisee.
D. Supervisors shall: (a) determine that telesupervision is appropriate for supervisees, considering professional, intellectual, emotional, and physical needs; (b) inform supervisees of the potential risks and benefits associated with telesupervision, respectively; (c) ensure the security of their communication medium; and (d) only commence telesupervision after appropriate education, training, or supervised experience using the relevant technology.
E. Supervisees shall be made aware of the risks and responsibilities associated with telesupervision. Supervisors are to advise supervisees in writing of these risks, and of both the supervisor's and supervisees' responsibilities for minimizing such risks.
F. Supervisors must be aware of statutes and regulations of relevant jurisdictions regarding sexual interactions with current or former supervisees.
G. Communications may be synchronous or asynchronous. Technologies may augment traditional in-person supervision, or be used as stand-alone supervision. Supervisors shall be aware of the potential benefits and limitations in their choices of technologies for particular supervisees in particular situations.

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AMFTRB wants to acknowledge and thank the following stakeholders who contributed their responses to the surveys and documents that the Teletherapy Committee has developed. In addition, a special appreciation to the three research assistants who worked with the committee: from Alaska, **Ryan Bergerson**, B.S. and **Lauren Mitchell**, M.S. and from Colorado, **Cody Eden**, B.A.

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Resources

Alaska Board of Marital & Family Therapy, Professional Licensing, Division of Commerce, Community, and Economic Development, Corporations, Business, & Professional Licensing, Board of Marital and Family Therapy

www.commerce.alaska.gov/web/cbpl/ProfessionalLicensing/BoardofMaritalFamilyTherapy

American Association for Marriage and Family Therapy (AAMFT)

www.aamft.org

American Counseling Association (ACA)

www.counseling.org

Association of Social Work Boards (ASWB)

www.aswb.org

American Psychological Association (APA)

www.apa.org

American Telemedicine Association (ATA)

www.americantelemed.org

Australian Psychological Society (APS)

www.psychology.org.au

Federation of State Medical Boards

www.fsmb.org

International Society for Mental Health Online

www.ismho.org

National Association of Social Workers (NASW)

www.socialworkers.org

National Board for Certified Counselors (NBCC)

www.nbcc.org

Ohio Psychological Association

www.ohpsych.org

Online Therapy Institute

www.Onlinetherapyinstitute.com

Renewed Vision Counseling Services

www.renewedvisioncounseling.com

Texas State Board of Examiners of Marriage and Family Therapists

www.dshs.texas.gov/mft/mft_rules.shtm

TeleMental Health Institute

www.telehealth.org

U.S. Department of Health and Human Services

www.hhs.gov/hipaa/for-professionals/special-topics/mental-health

Zur Institute

www.zurinstitute.com/telehealthresources.html

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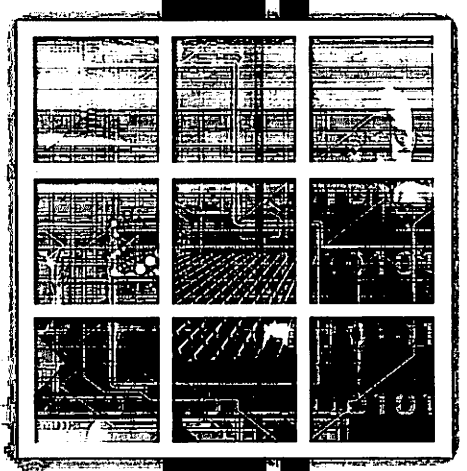
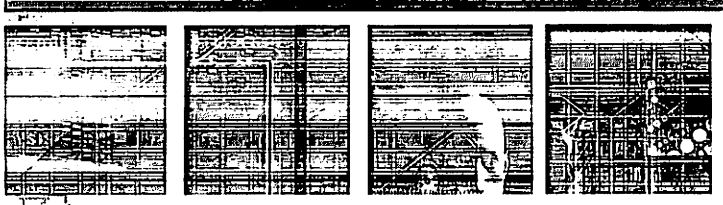
Adopted September 13, 2016 by AMFTRB Annual Meeting Delegates.

National Frontier & Rural ATTC Technology-Based Clinical Supervision Guidelines



Technology-Based Clinical Supervision GUIDELINES



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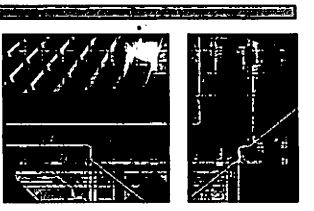

TECHNOLOGY-BASED CLINICAL SUPERVISION:

GUIDELINES FOR LICENSING AND CERTIFICATION BOARDS

Prepared by:

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October 2016

National Frontier & Rural ATTC

ACKNOWLEDGMENTS

Technology-Based Clinical Supervision: Guidelines for Licensing and Certification Boards was developed for the National Frontier and Rural Addiction Technology Transfer Center (NFAR ATTC) by Tobie Barton, MA, Nancy Roget, MS, and Joyce Hartje, PhD., with contributions made by Roy Huggins, LPC, NCC.

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ACKNOWLEDGMENTS/COPYRIGHT

Retna Pullings, DC Addiction Professional Consortium

Roy Kammer, LADC, LPC, NCC, ADCR-MN, CPPR, Minnesota Certification Board; Hazelden Betty Ford Graduate School of Addiction Studies

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The authors would also like to acknowledge the support of the NFAR ATTC staff, including Trisha Dudkowski, Terra Hamblin, Kimberly Prokosch, Mike Wilhelm, and Wendy Woods, as well as the guidance and support of ATTC Project Officer, Humberto M. Carvalho, MPH, of the Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration.

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SUGGESTED CITATION

Barton, T., Roget, N. A., & Hartje, J. (2016). Technology-Based Clinical Supervision: Guidelines for Licensing and Certification Boards. Reno, Nevada: National Frontier and Rural Addiction Technology Transfer Center, University of Nevada, Reno.

This publication was made possible by Grant Number TI024TT9 from SAMHSA. The views and opinions contained in the publication do not necessarily reflect those of SAMHSA, the U.S. Department of Health and Human Services (DHHS), or CSAT and should not be construed as such.

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.

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):

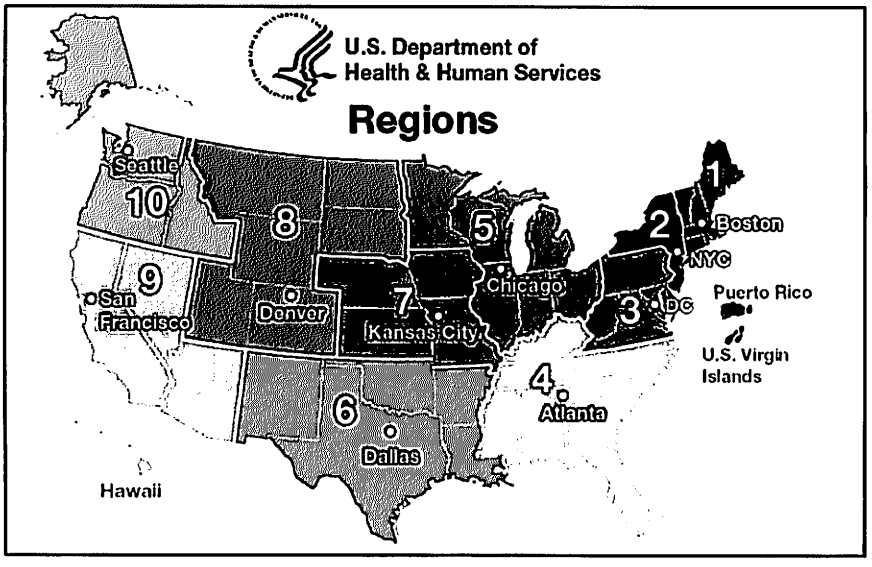
- increases access to qualified supervision by expanding the pool of available Supervisors, particularly those with expertise in a specific population or therapeutic technique;
- promotes better use of resources, is cost-effective, and reduces travel time;
- increases direct observation of clinicians 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:

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.

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.

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.

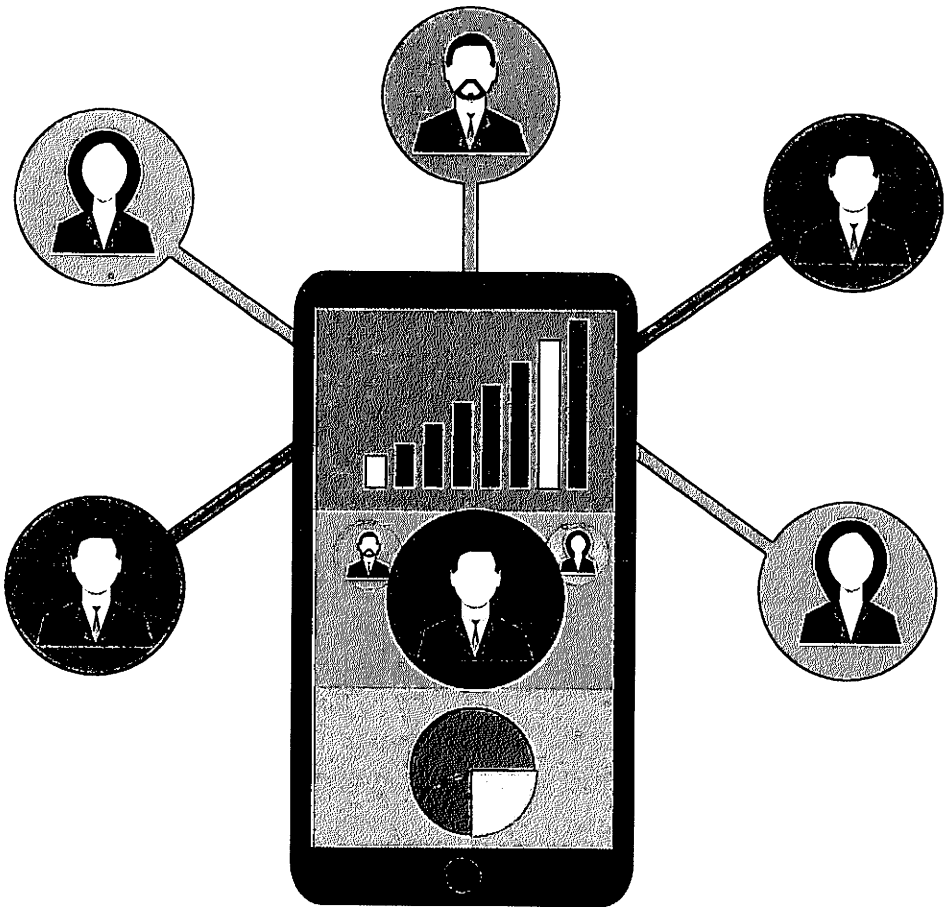
Rationale: Many behavioral health providers, as part of a patient's informed consent process, notify patients about clinical supervision practices and discuss the risks and benefits of clinical supervision and what it entails (e.g., purpose of clinical supervision; audio or video recording of sessions; 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.



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Ohio Board of Counseling Telehealth Regulations

Ohio Telehealth Regulations

4757-5-13 Standards of practice and professional conduct: electronic service delivery (internet, email, teleconference, etc.).

Electronic service delivery is defined in paragraph (EE) of rule 4757-3-01 of the Administrative Code. Licensees are reminded that standards of ethical practice and professional conduct rules 4757-5-01 to 4757-5-12 of the Administrative Code apply to electronic service delivery.

(A) These standards govern the practice of electronic service delivery and address practices that are unique to electronic service delivery and electronic service delivery practitioners.

(1) All practitioners providing counseling, social work or marriage and family therapy via electronic service delivery to persons physically present in Ohio shall be licensed in Ohio.

(2) All licensees of this board providing services to clients outside the state of Ohio shall comply with the laws and rules of that jurisdiction.

(3) Licensees shall provide only electronic services for which they are qualified by education, training, and experience. Licensees shall assume responsibility to continually assess both their professional and technical competence when providing electronic services. This includes ensuring that all methods of delivering services are compliant with commonly accepted standards of technology safety and security at the time at which services are rendered.

(4) Licensees shall screen potential distance service clients for appropriateness to receive services via distance methods, which includes considering their current mental and emotional status. Licensee shall screen the client's technological capabilities as part of the intake process. Therapists shall acknowledge power dynamics when working with a family or group with differing levels of technological competence. These considerations shall be documented in the records.

(5) Licensees shall be aware of cultural differences and how they can affect non-verbal cues. Electronic service delivery methods should be appropriate to the client's cultural experiences and environment, and shall also be sensitive to audio/visual impairment and cognitive impairment.

(6) Licensee shall regularly review whether electronic service delivery is meeting the goals of therapy.

(7) Electronic service delivery shall require an initial face-to-face meeting, which may be via video/audio electronically, to verify the identity of the electronic service delivery client. At that meeting steps shall be taken to address impostor concerns, such as by establishing passwords or phrases to identify the client in future electronic contacts.

(8) Licensees shall identify an appropriately trained professional who can provide local assistance, including crisis intervention, if needed. Licensees shall provide electronic service delivery clients the local crisis hotline telephone number and the local emergency mental health telephone number.

(9) Licensees shall retain copies of all written therapeutically relevant communication with clients, to include emails, texts, instant messages, and chat history. Records. Such records should be maintained for a minimum of seven years.

(10) Licensees must maintain records in accordance with 4757-5-09.

(B) Informed consent shall include information defining electronic service delivery as practiced by the licensee and the potential risks and ethical considerations per paragraph (B) of rule 4757-5-02 of the Administrative Code.

(1) Clients shall be given sufficient opportunity to ask questions and receive answers about electronic service delivery. These discussions should be documented in the client record.

(2) Informed consent should include the risks of entering private information when using a public access computer, or one that is on a shared network, and caution against using auto-fill user names and passwords. Clients should be advised to consider employer policies related to use of work computers for personal communication.

(3) Informed consent shall include the associated needs of delivery method, for example owning a computer with the correct capabilities or internet access, possibility of technology failure and what the procedure is in the event that services are disrupted, anticipated response time to electronic communication, alternative service deliveries, and electronic communication between scheduled appointments and after normal working hours.

(4) Informed consent should include a discussion of how electronic service delivery may affect billing and access to insurance benefits.

(5) Licensees shall obtain written permission prior to recording any part of the electronic service delivery session. If licensees are storing audiovisual data from sessions, these cannot be released to clients unless the client authorization specifically states they are to be released.

(6) Licensees shall obtain client consent when using electronic search engines to gather information about the client, except in emergency circumstances when such searches may provide information to help protect the client or other parties who may be at risk. The licensee must document the rationale for conducting any electronic search and why it is not harmful to the client.

(7) Licensees shall provide links to websites for all of their certification bodies and licensure boards to facilitate consumer protection. Licensees shall provide a link to the board online license verification site on their web page.

(8) Licensees shall obtain written informed consent.

(9) Licensees shall not provide services without client signed informed consent.

(C) Confidentiality in electronic service delivery and records maintainence shall be maintained by the licensee.

(1) Licensees shall use encryption methods that are Health Insurance Portability and Accountability Act of 1996 compliant for electronic service delivery, except for treatment reminders, scheduling contacts or other information provided outside of a therapeutic context .

(a) Clients may waive encryption via informed consent. Licensees must ensure clients understand the risk of non-encrypted communications.

(2) Licensees shall develop and disclose policies for notifying clients as soon as possible of any breach of confidential information.

(3) Licensees shall create a policy for the secure storage, recovery, and destruction of data, as well as the technologies used to store, maintain, and transmit data.