Board of Behavioral Sciences

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SUPERVISION COMMITTEE MEETING NOTICE
April 29, 2016
10:00 a.m.

Department of Consumer Affairs
Hearing Room
1625 North Market Blvd., 1st Floor
Sacramento, CA 95834

While the Board intends to webcast this meeting, it may not be possible to webcast the entire open meeting due to technical difficulties or limitations on resources. If you wish to participate or to have a guaranteed opportunity to observe, please plan to attend at the physical location.

1. Call to Order and Establishment of Quorum

2. Introductions*

3. Update on Prior Committee Decisions and Remaining List of Topics to Discuss

4. Discussion and Possible Recommendation Regarding Allowing Smaller Increments of Supervision to be Credited Toward Supervised Experience Hours

5. Discussion and Possible Recommendation Regarding Supervision Via Videoconference in a Private Practice

6. Discussion and Possible Recommendation Regarding Methods of Monitoring/Evaluating Supervisees
   a. Addressing Issues Related to Supervisee Performance
   b. Written Plan for Remediation
   c. Supervisory Plan

7. Discussion and Possible Recommendation Regarding a Supervisor's Availability while a Supervisee is Providing Clinical Services

8. Discussion and Possible Recommendation Regarding the Supervisor Self-Assessment Form

9. Discussion and Possible Recommendation Regarding Allowing Time Spent Supervising Social Worker and Clinical Counselor Students/Trainees to Satisfy the Two-Year Requirement to Become a Supervisor of Candidates for Licensure

Governor
Edmund G. Brown Jr.
State of California
Business, Consumer Services and Housing Agency
Department of Consumer Affairs

10. Discussion and Possible Recommendation Regarding Proposed Supervision Language Amendments for Licensed Marriage and Family Therapists

11. Suggestions for Future Agenda Items

12. Public Comment for Items not on the Agenda

13. Adjournment

**Introductions are voluntary for members of the public*

Public Comment on items of discussion will be taken during each item. Time limitations will be determined by the Chairperson. Times and order of items are approximate and subject to change. Action may be taken on any item listed on the Agenda.

This agenda as well as Board meeting minutes can be found on the Board of Behavioral Sciences website at www.bbs.ca.gov.

NOTICE: The meeting is accessible to persons with disabilities. A person who needs a disability-related accommodation or modification in order to participate in the meeting may make a request by contacting Christina Kitamura at (916) 574-7835 or send a written request to Board of Behavioral Sciences, 1625 N. Market Blvd., Suite S-200, Sacramento, CA 95834. Providing your request at least five (5) business days before the meeting will help ensure availability of the requested accommodation.

Board of Behavioral Sciences

1625 North Market Blvd., Suite S-200
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Memo

To: Supervision Committee Members

Date: April 19, 2016

From: Christy Berger
Regulatory Analyst

Telephone: (916) 574-7817

Subject: **Update on Prior Committee Decisions and Remaining Topics to Discuss**

All prior decisions made by the Supervision Committee have been incorporated into the proposed language in agenda item 10. Due to time constraints, we have had to narrow down the subjects remaining to be addressed by the Supervision Committee. Some of the topics that are not strictly supervision-related will be addressed by other committees as indicated on the following page.

Topics Remaining for Consideration

- Non-clinical hours (i.e., workshops, training) for LMFT Trainees not yet in practicum
- Decrease LCSW experience hours requirement to 3,000 hours
- Revise Supervisor Responsibility Statement
- Supervisor not signing for hours/one-week notice requirement
- Review BBS Unprofessional Conduct code sections pertaining to supervision
- More thorough requirements to become a supervisor of individuals on probation
- Offsite or Contract Supervisors:
    - Do the current requirements pertaining to offsite supervision adequately protect the supervisor, supervisee and client?
    - Should offsite supervision requirements be made consistent between license types, keeping in mind possible differences needed for MFT Trainees since they are still in school?

Employment/Employers - To be addressed by Exempt Setting Committee

- Temp agency employers
- Should an intern who is not gaining experience hours be permitted to work as an independent contractor?
- Maximum number of supervisees per supervisor in exempt settings
- Supervisors employed by or under administrative supervision of the person he or she is supervising (i.e., cases where the registrant is also the executive director of a nonprofit employing the supervisor)

Other Issues - To be addressed by the Policy and Advocacy Committee

- 6-year limit on age of experience hours
- 6-year limit on working in a private practice

Future Meeting Dates

June 29, 2016

Board of Behavioral Sciences

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Sacramento, CA 95834
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www.bbs.ca.gov

Memo

To:	Supervision Committee Members	**Date:**	April 22, 2016
From:	Christy Berger Regulatory Analyst	**Telephone:**	(916) 574-7817
Subject:	**Allowing Smaller Increments of Supervision to be Credited Toward Supervised Experience Hours**		

Staff will present this item at the meeting.

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Memo

To:	Supervision Committee Members	**Date:**	April 19, 2016
From:	Christy Berger Regulatory Analyst	**Telephone:**	(916) 574-7817
Subject:	**Supervision via Videoconference in Private Practice**		

Background

The use of technology, in both the provision of supervision and psychotherapy, is quickly increasing worldwide, and not only in rural areas. The use of videoconferencing and related technology will continue to increase as the next generation of professionals, many of whom will be "digital natives," will have a high level of comfort with providing and receiving all types of services online.

In 2009, after receiving a request from the California Association of Marriage and Family Therapists (CAMFT), the California Mental Health Directors Association and other community mental health entities, the Board pursued a law change to allow supervision in exempt settings to be provided via videoconference. The reasons for the request at the time were as follows:

- Rural areas were facing "extreme difficulties" in "growing" their own local licensed mental health professionals due to a shortage of supervisors
- Placements for registrants and trainees were becoming more difficult to find, as many agencies were reluctant to provide the required quantity of supervision
- Due to geographical limitations, most supervisees do not have access to a choice of supervision types, theoretical orientations, or experiences

California law began allowing the use of two-way, real-time videoconferencing for supervision of experience hours on January 1, 2010[1], but only in exempt settings (government entities, nonprofit and charitable entities, and a school, college or university). The number of supervision hours allowed to be provided via this method is unlimited.

Because this was a newly allowed medium that requires specific efforts be made in order to use it in an effective, secure and ethical manner, the Board contracted with California State

[1] SB 821 (Chapter 307, Statutes of 2009)

University at Chico to produce the *Best Practices Guide to the Use of Videoconferencing in Supervision*, provided in Attachment A.

Stakeholders have now requested that the Committee consider allowing clinical supervision to be provided via videoconferencing in private practice and other non-exempt settings.

Supervision Survey Results

The Committee conducted a survey of supervisors and supervisees in 2015. The results indicate that videoconference supervision is currently used minimally. However as previously mentioned, the usage is expected to increase greatly over time.

Where did the supervision take place? Select all that apply.				
	IMF	**ASW**	**PCI**	**TOTAL**
Onsite	375 (90%)	158 (85%)	37 (80%)	570 (88%)
Offsite	69 (17%)	36 (19%)	13 (28%)	118 (18%)
Videoconferencing	*7 (2%)*	*10 (5%)*	*2 (4%)*	*19 (3%)*
			Response Count	**647**

In a private practice setting, any supervision received via videoconference cannot be counted toward the supervised experience requirements. However, videoconference supervision is otherwise allowable and therefore being used in private practice settings as indicated below:

Where do you conduct your supervision for the following settings?						
Videoconferencing						
	N/A	**0-25 %**	**25-50 %**	**50-75 %**	**75-100 %**	**Response Count**
Private Practice	*18*	*4*	*1*	*2*	*1*	*26*
Governmental Entity	14	14	0	0	0	28
Public Non-Profit Agency	28	17	3	2	0	50
Other Community Agency	13	5	0	0	1	19
Medical Facility	12	2	0	1	0	15
School, Colleges and Universities	15	4	0	1	2	22
Other	10	1	0	0	1	12

Benefits of Videoconference Supervision

The provision of clinical supervision through videoconferencing offers a number of benefits, which include:

- Increasing the availability of supervision, leading to a higher population of licensed professionals in rural and other underserved areas
- Increases access to supervision expertise or specialties that might otherwise be unavailable
- Can be used to provide live “one-way mirror” supervision
- Increased flexibility for both supervisor and supervisee
- Decreases time spent traveling to supervision
- May decrease the cost of supervision

Drawbacks of Videoconference Supervision

Potential drawbacks include:

- Confidentiality, ethics and security concerns
- Lack of training and support for the use of technology
- Issues with connection quality, such as transmission delays, audio echo, poor picture quality, etc., impact the ability to clearly communicate
- Increases the amount of time necessary to fully develop the supervisory relationship

Research on Videoconference Supervision

There is now a significant body of clinical research on technology-assisted supervision. Three studies are included in the attachments. A summary of the pertinent findings are as follows:

- Satisfaction with videoconference supervision (both individual and group) was rated similarly to in-person supervision. However, less experienced supervisees rated their satisfaction slightly lower.
- The supervisory relationship did not appear to be negatively affected by the use of videoconferencing. However, establishing an in-person relationship may facilitate the development of, and strengthen the supervisory relationship.
- Supervisee perception of self-efficacy as a counselor increased similarly under both types of supervision.
- Videoconference supervision may have some unexpected advantages over in-person supervision. For example, participants tend to be more prepared.
- When technology is unreliable or inadequate, it disrupts the ability to communicate, both verbally and non-verbally.

Use in Private Practice and Other Non-Exempt Settings

The drawbacks of providing videoconference supervision may be amplified in a private practice setting, where the licensee has sole responsibility for the technology and for ensuring ethical and security issues are addressed, as opposed to an agency setting where there is more likely to be technical support for the supervisor. For information about private practice settings and basic employment/work site requirements for registrants and supervisors, see Attachment E.

These risks can be minimized by providing additional guidance to these supervisors, by efforts such as updating the Board's *Best Practices Guide to Videoconference Supervision (2010),* which is now somewhat outdated. The Committee may also want to develop a list of the supervisor's specific responsibilities when providing videoconference supervision, and consider incorporating that list into law. Some examples of supervisor responsibilities for your consideration are below.

A supervisor providing videoconference supervision shall:

- Meet with the supervisee at least once in person initially
- Assess the supervisor and supervisee's technology proficiency and obtain training or consultation if necessary
- Develop procedures for maintaining confidentiality and security and discuss these procedures with the supervisee
- Have a backup plan in place to address technical difficulties before supervision occurs

Attachment A: *Best Practices Guide to the Use of Videoconferencing in Supervision,* Board of Behavioral Sciences *(2010)*

Attachment B: *New Developments in Technology-Assisted Supervision and Training: A Practical Overview,* Journal of Clinical Psychology (2014)

Attachment C: *Attitudes and Satisfaction with a Hybrid Model of Counseling Supervision,* Educational Technology and Society (2009)

Attachment D: *Telehealth in Supervision: A Comparison of Supervision Formats,* Journal of Telemedicine and Telecare (2009)

Attachment E: Chart - Private Practice Employment and Site Requirements

THE USE OF VIDEOCONFERENCING

IN SUPERVISION OF

ASSOCIATE CLINICAL SOCIAL WORKERS,

MARRIAGE AND FAMILY THERAPIST INTERNS, AND

PROFESSIONAL CLINICAL COUNSELOR INTERNS:

A BEST PRACTICES GUIDE

This guide is designed to provide INFORMATION ONLY, and should NOT be interpreted as “standards” set by the Board of Behavioral Sciences. The sole purpose of this guide is to provide support to supervisors considering using videoconferencing to conduct supervision of future mental health professionals.

California Board of Behavioral Sciences, 2010

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This project was funded by the Mental Health Services Act (MHSA) in partnership with the California Department of Mental Health and the Board of Behavioral Sciences

CALIFORNIA BOARD OF BEHAVIORAL SCIENCES

TABLE OF CONTENTS

Introduction 2
Background and Supervision-Related Laws 2
Recommended Best Practices in Supervision with Videoconferencing 4
Establishing a Supervisory Alliance 4
Contracting for Supervision 5
Assessing the Learning Needs of the Supervisee 6
Developing a Learning Plan 8
Facilitating Learning 9
Monitoring the Supervisee's Progress Toward Goals 10
Evaluating the Supervisory Process 11
Advantages and Disadvantages of Using Videoconferencing for Supervision 11
Selecting a Videoconferencing Medium 12
Best Practices for Computer-Based Videoconferencing 14
Computer-based Two-Way Videoconferencing Security 16
Best Practices for Room-Based Videoconferencing 16
Best Practices for Computer and Room-Based Videoconferencing 18
Potential Ethical Concerns 18
Group Supervision Best Practices 20
References 23
Addendum 1: Matrix for Computer-Based Videoconference Systems 26
Addendum 2: Additional Resources 27

This guide was funded by the Mental Health Services Act (MHSA) in partnership with the California Department of Mental Health and the Board of Behavioral Sciences.

INTRODUCTION

Drawing from the literature on clinical supervision, as well as interviews with seasoned clinical supervisors in the fields of social work and marriage and family therapy, this report seeks to identify the key components of effective supervisory practice. An emphasis is placed on factors that should be considered when conducting supervision via videoconferencing. It is anticipated that the use of various video technologies for providing supervision to novice clinicians will increase over the next decade and beyond. While this practice may offer expanded opportunities for Associate Clinical Social Workers (ASW), Marriage and Family Therapist (MFT) interns, and Licensed Professional Clinical Counselor (LPCC) interns to meet the California Board of Behavioral Sciences' requirements for supervision, it also presents new difficulties and challenges. This guide is intended to support the application of the critical elements of high-quality clinical supervision to this emerging practice involving distance education and training.

BACKGROUND AND SUPERVISION-RELATED LAWS

Legislation to permit Marriage and Family Therapist (MFT) interns and Associate Clinical Social Workers (ASWs) to gain supervision via videoconferencing was signed by Governor Arnold Schwarzenegger in 2009 and took effect January 1, 2010. Supervision via videoconferencing had not been permitted in the past. However, the legislation was introduced in response to requests from stakeholders, especially those who work in public mental health or in rural areas where supervision can be difficult to obtain. Under these new provisions, videoconferencing is considered the same as face-to-face, direct supervisor contact. It is permitted only for MFT interns or ASWs working in a government entity, a school, a college, a university, or an institution that is both nonprofit and charitable. It is not permitted for students who have not yet completed their degree or those who have not yet registered with the Board of Behavioral Sciences as an MFT intern or an ASW. Additionally, it is not allowed in a private practice setting or other setting not explicitly permitted in the code.

The following sections of the Business and Professions Code (BPC) address supervision as well as videoconferencing:

- **MFT INTERNS:** BPC §4980.43(c) states that, effective January 1, 2010, supervision shall include at least one hour of direct supervisor contact in each week for which experience is credited in each work setting. According to Paragraph 2 of the same section, "an individual supervised after being granted a qualifying degree shall receive at least one additional hour of direct supervisor contact for every week in which more than 10 hours of client contact is gained in each setting. No more than five hours of supervision, whether individual or group, shall be credited during any single week."
BPC §4980.43(c)(6) addresses the issue of videoconferencing: "An intern working in a governmental entity, a school, a college, or a university, or an institution that is both nonprofit and charitable may obtain the required weekly direct supervisor contact via two-way, real-time videoconferencing. The supervisor shall be responsible for ensuring that client confidentiality is upheld."

- **ASWS:** BPC §4996.23(c)(3) states that "an associate shall receive an average of at least one hour of direct supervisor contact for every week in which more than 10 hours of face-to-face psychotherapy is performed in each setting in which experience is gained." BPC §4996.23(c)(7) allows for "an associate clinical social worker working for a governmental entity, school, college, or university, or an institution that is both a nonprofit and charitable institution, may obtain the required weekly direct supervisor contact via live two-way videoconferencing. The supervisor shall be responsible for ensuring that client confidentiality is preserved." [1]

- **LPCC INTERNS:** BPC §4999.46(f)(1) and (2) state that supervision "shall include at least one hour of direct supervisor contact in each week for which experience is credited in each work setting...an intern shall receive an average of at least one hour of direct supervisor contact for every 10 hours of client contact in each setting[2]." Additionally, BPC §4999.46(f)(4) states:
"An intern working in a governmental entity, a school, a college, or a university, or an institution that is both nonprofit and charitable, may obtain up to 30 hours of the required weekly direct supervisor contact via two-way, real-time videoconferencing. The supervisor shall be responsible for ensuring that client confidentiality is upheld."[3]

As videoconferencing is a new mode for providing supervision, a number of special considerations must be taken by supervisors. This guide is intended to assist supervisors in determining those considerations and to provide resources for further inquiry.

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[1] BPC §4996.23(c)(5) contradicts this code by limiting direct supervisor contact via videoconferencing to up to 30 hours only. However, the Board is sponsoring a bill (SB 1489) that would delete this provision.

[2] The Board-sponsored omnibus bill (SB 1489), proposes to amend this as follows: "An intern shall receive at least one additional hour of direct supervisor contact for every week in which more than 10 hours of face-to-face psychotherapy is performed in each setting in which experience is gained."

[3] The Board has sponsored legislation (SB 1489) that would change this section and allow LPCC interns to obtain all the required weekly direct supervisor contact via videoconferencing.

RECOMMENDED BEST PRACTICES IN SUPERVISION WITH VIDEOCONFERENCING

ESTABLISHING A SUPERVISORY ALLIANCE

Clinical supervision can be considered a form of "relationship-based education and training" (Milne, 2007, p.439). Thus, it is of paramount importance that clinical supervisors establish a climate of trust with their supervisees. They need to provide a safe place for novice clinicians to "share and struggle with concerns, weaknesses, failures, and gaps in skill" (Munson, 2002, p.12). Further, they need to create a level of emotional safety that will allow interns to acknowledge issues of counter-transference, vicarious trauma, and other forms of workplace stress. By building a trusting relationship and a strong supervisory alliance with their practicing clinicians, supervisors set the foundation for the development of clinical competencies (Falender & Shafranske, 2004; Kadushin & Harkness, 2002).

ALLIANCE ISSUES AND VIDEOCONFERENCING

Supervision via videoconferencing, by its very nature, involves a more distant relationship between the supervisor and supervisees than face-to-face supervision. Clinical supervisors who are new to this practice may find it difficult to "tune in" to the challenges faced by supervisees, when meeting on a remote basis. However, supervisors experienced in the use of this technology claim that over time they are able to tune in to more subtle communication and non-verbal behaviors of the supervisee, and a supervisory alliance is formed.

It is recommended as a best practice that one or more initial in-person meetings between the supervisor and supervisee be held to jump-start the relationship-building

process, develop the learning/supervision contract, and establish protocol for use of the technology. It is also recommended that face-to-face supervisory sessions occur periodically throughout the supervisory relationship in addition to the supervision meetings held through videoconferencing. Additional forms of technology may also be used to supplement videoconferencing and mitigate limitations that the distance may impose, including e-mail, WebEx meetings, online discussions, and phone conferences.

Another factor that impacts the development of supervisory alliance through videoconferencing is the quality of the audiovisual equipment used. When lower quality equipment is used, video movement appears jerky, and there may be several seconds of delay between the time when one person speaks and the other person hears what is said. This reduces the emotional bandwidth of the supervisory process, or the "amount of emotional understanding, contact, and support that can be transmitted" (Panos, Panos, Cox, Roby, & Matheson, 2002, p.429). Technology-related challenges could result in loss of non-verbal information, limited bonding between supervisor and supervisee, and the supervisory relationship taking longer to form (Hara, Bonk, & Angeli, 2000). With higher-end technological systems, such difficulties are much less likely to interfere with verbal or non-verbal communication in supervisory sessions. The recommended best practice is for the technology picture size to be large enough and clear enough to provide for eye contact and a maximum amount of observable emotional and physical nuance.

CONTRACTING FOR SUPERVISION

Formality and structure are also key elements of effective clinical supervision (Coleman, 2003), as are clearly articulated expectations (Munson, 2002). Thus, best practice as it relates to supervision involves the use of a written contract between the supervisor and supervisee that outlines how and when supervision will occur, what is expected of each person in preparation for the supervisory sessions, and how supervision time will be utilized, tracked, documented, and evaluated. Additional components that may be added to this contract include clarification regarding the parameters of confidentiality and the nature of the supervisor-supervisee relationship. Additionally, Milne (2009) emphasizes the importance of supervisees being informed of the values-base that the supervisor will bring to the supervisory process (such as respect, empowerment, commitment to lifelong learning, valuing of social work ethics, and cultural competency).

CONTRACTING FOR SUPERVISION VIA VIDEOCONFERENCING

The recommended best practice when contracting for supervision is to review the supervisory contract in a face-to-face initial meeting between the supervisor and supervisee. If this is not possible, the process of contracting for supervision could be accomplished through the use of telephone, teleconferencing, or videoconferencing along with the faxing or mailing of signed documents. Either way, it is critical that supervisees have the opportunity to ask questions and receive needed clarification prior to committing to a supervisory agreement. When videoconferencing is newly initiated, it is particularly important that procedures be identified for maintaining privacy during supervisory sessions and obtaining technical support, as needed. Finally, the availability of the clinical supervisor for consultation outside of the regularly scheduled supervisory sessions should be clearly documented, with contact information provided.

Assessing the Learning Needs of the Supervisee

An assessment of the learning needs of supervisees at the start of supervision contributes to an empirical approach in which needs inform goals, and progress toward these goals is closely monitored. The format for this needs assessment ranges from an informal discussion of desired competencies to a formal assessment using one or more structured inventories or rating scales. Falender and Shafranske (2004) advance a competency-based approach to supervision that provides some guidance for supervisors in conducting this assessment. First, broadly defined competencies are identified based on the clinical service requirements of the setting and contemporary clinical practice. Next, the measurable units of the competency are defined, which form the basis of performance requirements. For example, if the intake interview is identified as a required area of competence, the specific abilities required include “listening skills, knowledge of diagnostic formulation, risk assessment, diversity awareness, and interpersonal skills” (p.23).

An assessment of the learning style of the supervisee also contributes to high quality supervision. Neil Fleming (2001) defines learning style as an individual's characteristic and preferred ways of taking in and giving out information. He proposes the use of the VARK Inventory (www.vark-learn.com) for assessing the extent to which the learner has an instructional preference that is visual (V), aural (A), read/write (R), or kinesthetic (K). Visual learners are said to prefer charts, diagrams, and other spatial configurations, while aural learners prefer lectures and discussion. Read/write learners prefer lists, books, and articles, while kinesthetic learners like hands-on approaches. As applied to clinical supervision, knowledge of learning styles can guide the use of tools and activities that are tailored to the preferences of the supervisee.

For example, the use of genograms and flow charts may benefit a supervisee who leans toward visual learning, while brief didactic presentations and verbal processing of clinical issues may be more useful for an aural learner. When group supervision is provided, it may be important to utilize a blend of methods in recognition of the varied learning style preferences of group members. Additionally, a best practice recommendation includes an assessment of both the supervisor and supervisee's technology proficiency and participation in training that will facilitate successful use of videoconferencing.

ASSESSMENT OF LEARNING NEEDS AND SUPERVISION VIA VIDEOCONFERENCING

Discussion of the supervisees' learning needs and styles can take place in an initial face-to-face meeting with the supervisor or during a videoconferencing session. When written inventories or rating scales are used for this assessment, they will ideally be provided to the supervisee in advance of this meeting. This will allow the novice clinician time to review and complete the documents and formulate questions and ideas about how this assessment might inform the process of supervision. During this discussion, the supervisor should consider ways to adapt the supervisory process to the learning style and needs of the supervisee(s). This might entail the incorporation of visual and kinesthetic learning activities, in addition to auditory processes. It is important that both supervisor and supervisees recognize that foresight is necessary when using written material, visual charts, or pictorial representations to enhance verbal discussion (e.g. genograms, ecograms, written vignettes), as they will need to be e-mailed or faxed prior to each supervisory session.

Developing a Learning Plan

Following the assessment of learning needs, the supervisor and supervisee should collaborate to develop a learning plan. Best practice would recommend that this collaboration occur in a face-to-face meeting. This plan will ideally include goals and objectives for the clinician, as well as activities that will be performed to meet those objectives. According to Milne (2009), the best supervisory goals are SMARTER (specific, measurable, achievable, realistic, time-phased, evaluated, and recorded). Learning activities that should be documented on the plan may be those performed inside or outside of the supervision sessions. Activities that take place during supervisory sessions might include: ongoing case review; case presentations; role plays; review of process recordings, audiotaped or videotaped sessions; and/or online video vignettes, etc. Those that take place outside of the meeting include shadowing experienced or licensed clinicians, co-facilitating therapeutic sessions, and/or performing solo clinical activities that are observed or recorded.

THE LEARNING PLAN AND SUPERVISION VIA VIDEOCONFERENCING

Along with contracting for supervision, the development of the supervisee's learning plan will ideally occur in an initial face-to-face meeting with the supervisor prior to the onset of videoconferencing sessions. If this is not possible, the learning plan may be created via video communication. Either way, it is vitally important that the supervisor create an atmosphere that is conducive to a collaborative goal-setting process. This is key in empowering supervisees to engage in self-directed learning. Secondly, it is helpful for the supervisor who is utilizing videoconferencing as a primary medium for supervision to have a clear understanding of the clinically oriented learning opportunities available to the intern within the remote service setting. For example, if a supervisee is expected to become competent in conducting suicide risk assessments, shadowing others in the process of carrying out this function will be critical to skill development in this area. If such opportunities are not available at the site where the supervisee is employed, they may need to be created at other locations within or outside of the employing organization.

Facilitating Learning

The facilitation of learning through supervision is a complex process. A variety of teaching methods are available to the supervisor that Milne (2009) suggests fall into three main categories. Behavioral methods, referred to as "enactive" include the opportunity to observe and rehearse strategies to be used with clients. Cognitive methods are often called "symbolic" and involve discussion, verbal prompting, questioning, feedback, and instruction. Finally, visual methods, sometimes called "iconic," include the use of live supervision and video modeling of clinically appropriate behavior and interactions.

Effective clinical supervisors also recognize the importance of modeling professional ethics throughout the process of supervision. By exemplifying appropriate and ethical behaviors, they utilize the supervisory relationship as an important teaching tool (American Board of Examiners in Clinical Social Work, 2004). Supervisors must be aware of the impact of their authority on the supervisee and maintain appropriate boundaries within the context of their supervisory relationship. In this way, they promote a parallel process that furthers clear boundaries between the supervisees and their own clients.

FACILITATING LEARNING THROUGH VIDEOCONFERENCING

Cognitive methods for facilitating learning are well suited to the use of videoconferencing for supervision (such as discussion of cases and questioning regarding alternative strategies for assessment or intervention). Enactive methods may also be easily incorporated, through role-plays of clinical interactions and interventions (behavioral rehearsal). Some iconic methods may be used outside of the supervisory session, including the assignment to observe online video vignettes. Methods that may be less available to supervisors utilizing computer-based videoconferencing include live supervision and feedback based on direct observation of the intern's practice. In lieu of these learning activities, it may be especially important to utilize role-play in supervisory sessions as well as the review of audio or video recordings of live clinical sessions performed by the supervisee. In doing so, the supervisor provides a well-rounded process for the advancement of supervisee learning and clinical competence.

Monitoring the Supervisee's Progress Toward Goals

Clinical supervisors and their supervisees share responsibility for the quality of services provided to clients. Furthermore, supervisors can be held liable in certain circumstances in which the supervisee is negligent, causing harm to the client served. More specifically, direct liability can be charged against the supervisor who assigns a task to the supervisee who is ill-prepared to perform it. Thus, it is vitally important that supervisors monitor the professional functioning of the clinicians they supervise. It is expected that any practice of the supervisee that presents a threat to the health and welfare of the client will be identified and remedied (Coleman, 2003).

Methods for monitoring clinician performance include direct observation of practice and review of documented assessments and case notes written by the supervisee.

MONITORING WITHIN THE CONTEXT OF SUPERVISION VIA VIDEOCONFERENCING

The clinical supervisor utilizing video conferencing as the primary modality for supervision may have limited options for monitoring the practice of supervisees. It is important that some form of in vivo supervision arrangements be made to monitor the supervisee's performance, such as the supervisor reviewing videotaped sessions of the supervisee working with a client, or onsite managers or other licensed clinicians performing ongoing documentation review and/or direct observation of the supervisee's performance. It is important that lines of communication be established between the clinical supervisor and any other professionals who are managing the supervisee or monitoring their practice. Toward this end, it is common for clinical supervisors who work from external or remote sites to be asked to submit regular reports to the manager of the supervisee regarding their progress toward learning goals. Also important is the routine monitoring of clinical hours performed by the ASW, MFT, or LPCC intern, as well as the supervisory hours received. This information is documented on the Weekly Summary of Hours of Experience (MFT interns only) and the Experience Verification forms (ASWs, MFT and LPCC interns) that are submitted to the Board of Behavioral Sciences.

Evaluating the Supervisory Process

It is important that clinical supervisors routinely evaluate the effectiveness of their supervisory practice, as well as the supervisee's growth in utilizing supervision (American Board of Examiners in Clinical Social Work, 2004). This evaluation might begin with a review of the documentation pertaining to supervision provided. This documentation should ideally note the date and duration of supervisory sessions and outline the content, including "questions and concerns, progress toward learning goals, recommendations and resources" (Coleman, 2003). Evaluation of the supervisory process should proceed with discussion with the supervisee(s) about the ways in which they have benefited from supervision and/or challenges they have encountered in utilizing it successfully. Additionally, this evaluation might incorporate the use of a measurement tool, completed by supervisee(s), aimed at assessing the effectiveness of clinical supervision. In his Handbook of Clinical Social Work Supervision, Munson (2002) offers the Supervision Analysis Questionnaire (SAQ) – a tool that could be utilized or adapted for this purpose.

EVALUATING SUPERVISION CONDUCTED THROUGH VIDEOCONFERENCING

When clinical supervision is conducted via videoconferencing, it is important that an evaluation of its effectiveness focus not only on the content of sessions and interpersonal processes but also on the adequacy of technology used. If technical difficulties are repeatedly encountered it can severely disrupt the learning experience for supervisees. If this is found to be a concern, additional technical support or an upgrade to higher quality audiovisual equipment may be needed.

ADVANTAGES AND DISADVANTAGES OF USING VIDEOCONFERENCING FOR SUPERVISION

ADVANTAGES

- Reduces stress and time involved in traveling to supervision.
- Provides access to supervision expertise that might otherwise be unavailable.
- Access to supervision empowers professionals and ensures good standards of care are maintained.
- Cognitive and enactive methods for facilitating learning in supervision are well suited for videoconferencing.
- The use of videoconferencing for supervision may enhance supervisees' confidence with technology and encourage the use of technology to enhance their practice outside of supervision.

- The distance relationship often encourages supervisors to provide supervisees with more options for consultation and feedback outside of the scheduled super vision time which can result in the supervisee being able to receive feedback more often with practice situations requiring consultation.
- The lack of ability to view written documents using videoconferencing means that documents are shared ahead of time and both the supervisee and supervisor are then able to prepare questions and items for discussion regarding these documents ahead of time.

DISADVANTAGES

- Start-up costs for a room-based videoconferencing system that provides a better quality of bandwidth can be prohibitive for small agencies.
- There may be lack of access to training and ongoing support for the use of technology.
- Remote relationship may require a longer period of time for the supervisory relationship to develop.
- The use of videoconferencing may limit the learning methods used during supervisory sessions due to lack of ability to view written materials.
- Remote distance from supervisee may prohibit opportunities for live supervision and limited options for monitoring the practice of supervisees.
- The use of inadequate audiovisual equipment can pose increased security risks and potential breach of confidentiality.

SELECTING A VIDEOCONFERENCING MEDIUM

Today, videoconferencing can be defined as connecting two or more locations at the same time utilizing cameras, microphones, monitors and a network. Videoconferencing can be computer-based or involve more expensive room-based systems. Computer-based videoconferencing solutions are inexpensive and easy to set up if a high bandwidth connection and a computer are already available. Examples of computer-based videoconference software include: Skype, Oovoo, SightSpeed, Adobe Connect Now, WebEx, and many others. The features available vary by product but many allow multiple participant connections, file sharing, whiteboard sharing, and 128-bit security encryption.

Creating a room-based videoconference experience is more expensive to set up, with each room requiring an investment of $20,000 to $100,000. If the investment in technology has already been made, this high-end technology can be a good videoconference solution. It is important to note computer-based systems and room-based systems cannot interconnect.

Videoconferencing has evolved as an Internet tool for home and business use. Today there are many options available for two-way videoconference communication. Selecting the appropriate videoconference system or software depends on many factors, including: number of simultaneous users, budget, end user knowledge, security requirements, and available bandwidth. When considering a videoconference solution from a vendor it is important to consider a vendor's product security, user interface, customer service, long-term company viability, and pricing models.

Selecting or recommending a videoconferencing solution will always be a moving target. Vendors are constantly updating software features, changing privacy policies, modifying pricing, considering mergers and listening to end users with ever changing needs. In this section we will review a few computer-based videoconference solutions currently available and provide a matrix in Addendum 1 with additional product details.

ADOBE CONNECT NOW

Adobe Connect Now is free videoconferencing software that allows three users to connect. Users can share files, desktops and a whiteboard[4]. The interface is simple and intuitive. It is limited to three simultaneous users.

ADOBE CONNECT PRO

Adobe Connect Pro is very similar to Adobe Connect Now. There is a monthly fee. In addition to the features included in Adobe Connect Now, Pro allows up to 100 simultaneous users. According to the Adobe Web site, the United States military is utilizing the software.

[4] A "whiteboard" is a collaborative space on the Internet in which participants can write and draw on a shared space resembling an actual dry-erase board. Allows sharing of a variety of data (pictures, sketches, spreadsheets etc.) in an information window as part of videoconferencing system. Also called a smartboard or electronic whiteboard.

MEGAMEETING

MegaMeeting is a user-friendly Web-based videoconference application. The product offers many of the same features as the Adobe Connect videoconference software. It doesn't run on the Windows 7 operating system. Pricing is based on individual seats and it is more expensive than Adobe Connect Pro.

OOVOO

The reviews for this videoconferencing application were not very good. Most reviews focused on a poorly designed user interface and pop-up ads. Based on these reviews, this product is not recommended.

SIGHTSPEED

SightSpeed offers many of the same features as the Adobe Connect videoconference software. The author tested this software and found the computer response time to be very slow, and the program does not offer file sharing.

SKYPE

Skype is free software that allows two users to videoconference. The software does not provide an option for multiple users in the same meeting. It does allow screen and file sharing. The literature suggests that security is an issue and that the software is more vulnerable to hacking.

BEST PRACTICES FOR COMPUTER-BASED VIDEOCONFERENCING

The following recommendations are considered best practices for the use of computer based videoconferencing:

MEETING ETIQUETTE

Establish meeting norms to create an environment where efficient and effective discussion can occur. Agree to protect the supervision time by not taking phone calls, sending e-mails or allowing co-workers to disrupt the supervision time. Establish an agenda prior to the meeting, arrive prepared and on time.

CONNECT WITH PARTICIPANTS

The videoconferencing window, where one can see the other participants, should be placed near the camera to ensure that as participants look into the camera they appear to be making direct eye contact with the other participant. It can be distracting for participants to look at a videoconference window located near the base of their computer monitor when the camera is located on the top of his or her monitor.

LIGHTING AND BACKGROUND

Most videoconference software allows for the user to preview the image on screen. Use the preview image to adjust lighting so that your image is clearly visible to other participants. In order not to disrupt other co-workers with lighting adjustments and to ensure confidentiality, it is important to conduct the supervisory sessions in a solitary room. It is important to continue to make adjustments until your image is not too bright or dark. If window lighting cannot be adjusted, strategically adding a desk lamp may improve the lighting. The background of the video image can be very distracting. Anything that is continuously moving, like a novelty clock, should be relocated to an area out of camera range.

AUDIO QUALITY

The quality of the audio coming from each participant can make or break a videoconference. A headset with a microphone will reduce the possibility of audio being retransmitted and creating a continuous echo or annoying feedback. It may be necessary to change audio settings in the Control Panel - Sounds and Audio Devices Properties – Voice Tab to allow the microphone to work the first time. Most videoconferencing software will use a setup wizard to test the headset and microphone. It is important to find a headset that will fit comfortably with an adjustable, flexible band. Read online product reviews and purchase the right setup for you.

Computer-based videoconferencing for group supervision may require a supervisor to transmit to a small group at a single site. The supervisees may use individual audio speakers and a microphone instead of headphones. Testing the audio setup prior to the first meeting is recommended. The supervisor may experience audio echo. If this occurs the group may need to mute their microphone when the supervisor is speaking. This will eliminate the audio echo received by the supervisor.

COMPUTER-BASED TWO-WAY VIDEOCONFERENCING SECURITY

Securing client information is extremely important. HIPAA and the Sarbanes-Oxley Act of 2002 require that medical providers secure all electronic data associated with customers. This includes videoconferences. Participants should limit the client identity information shared, using only initials or codes instead of client names, and changing identifying details of cases discussed during a videoconference. Identifying information should be kept to a minimum when utilizing videoconferencing for supervision in order to protect client confidentiality. When the need arises to discuss sensitive cases or those where identifying information needs to be shared, the supervisor and supervisee should ideally arrange to meet face to face or by phone. Participants may also reduce security risks by using secure or closed networks, encryption programs, and consistently updating virus scan programs (Wood, Miller, & Hargrove, 2005). Individual videoconference vendors may be able to recommend additional security measures.

Some computer-based videoconferencing products are more secure than other products. Products such as MegaMeeting and Adobe Connect use hosted videoconference servers and 128-bit encryption to make connections between participants secure. SightSpeed, Skype and Oovoo utilize less secure peer-to-peer computing to transmit videoconference signals across the Internet. Currently, no computer-based videoconferencing is completely hacker proof. The likelihood of a hacker accessing a useable portion of a hosted 128-bit encrypted videoconference is unlikely. However, it is important for videoconference users to maintain an up-to-date virus checker to verify their computer remains uncompromised. Consulting with a local specialist to ensure security measures are in place on participant computers is recommended.

BEST PRACTICES FOR ROOM-BASED VIDEOCONFERENCING

Room-based videoconferencing systems can be expensive to install, maintain, and operate and may be cost prohibitive for supervisors and/or supervisees. Modifying and equipping a room for videoconferencing can range from $20,000 to $100,000 per room. Supervisors and supervisees may want to research

local agencies or companies to determine if any pre- existing systems exist in their locale. If participants have free access to previously installed videoconference rooms, this may make this form of videoconferencing supervision accessible. The following recommendations are considered best practice for the use of room-based videoconferencing:

MEETING ETIQUETTE

Establish meeting norms to create an environment where efficient and effective discussion can occur. Agree to protect the supervision time by not taking phone calls, sending e-mails or allowing co-workers to disrupt the supervision time. Establish an agenda prior to the meeting and arrive on time. Look at the camera when speaking. Looking away from the camera can make participants wonder what is distracting the speaker.

AUDIO

Mute your microphone when you are not speaking. This will minimize the possibility of audio echoing and creating feedback. Also remember there will be a one-second delay in the audio as it is being transmitted; therefore it is common for participants from two sites to “speak-over” each other making it difficult for either participant to be understood.

NON-VERBAL COMMUNICATION

Keep in mind participants may be more focused on nonverbal communication than they are in a face-to-face meeting. Many first-time participants consider a two-way videoconference meeting as a passive activity just like watching television. Every meeting should be considered an active experience. Be aware of non-verbal behavior.

CANCELING MEETINGS

The use of two-way videoconference rooms can be labor intensive for the videoconference administrator and the technical staff. If a meeting is canceled, notify the videoconference administrator so the room can be used for other meetings.

ROOM-BASED TWO-WAY VIDEOCONFERENCING SECURITY

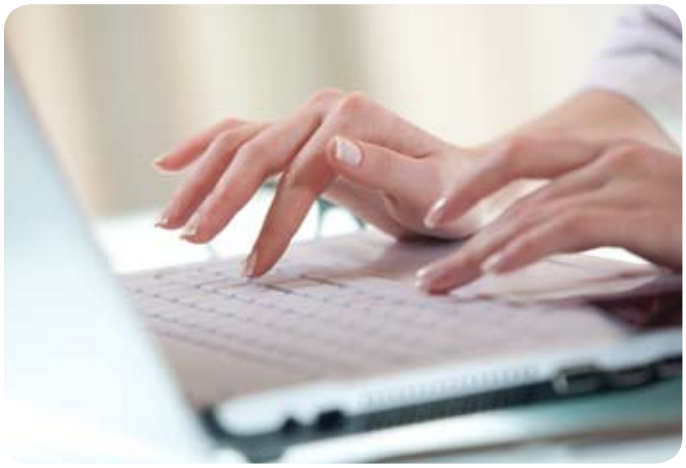
There are fewer security risks involved in utilizing a room-based two-way videoconference system. If the video signal is transmitted via IP (Internet Protocol), it will travel over the Internet. It is possible the signal could be intercepted, but highly unlikely. If the videoconference signal is monitored in another room or location by a technician, measures should be taken to train the technician about the importance of confidentiality and the location should be secured to limit the exposure of the content of the supervisory sessions.

Participants should be aware of the audio volume in the room. The audio should be adjusted to ensure someone in the hallway or a nearby office cannot overhear the conversation.

BEST PRACTICES FOR COMPUTER AND ROOM-BASED VIDEOCONFERENCING

- Accessible technology support at both sites.
- Agreed upon plan/follow-up actions should technology fail.
- Periodically scheduled in-person meetings.
- Established agreed-upon method for review of clinical documentation.
- Instruction/introduction to use of technology to include basic troubleshooting and procedures for technical assistance.
- Frequent and ongoing assessment of the technology as well as the supervisory process.

POTENTIAL ETHICAL CONCERNS



QUALITY

The success of videoconferencing supervision can be dependent on the sophistication of the videoconferencing system selected. While bandwidth is defined as the amount of information that can be communicated via a fiber optic network, emotional bandwidth refers to the amount of emotional understanding, contact and support that can be transmitted (Panos, Panos, Cox, Roby, & Matheson, 2000). High-end systems for videoconferencing may require an investment of several thousand dollars, but ensure sufficient emotional, visual and auditory content is transmitted. According to Mahue, Whitten, and Allen (2001), most telehealth programs have a common transmission rate of 384-786 kbps.

Computer-based, two-way videoconferencing is a low-cost videoconferencing option, typically operating at 128 kbps. However the quality can be much poorer due to less clear audio and the small delay that occurs after one person speaks and before the other one hears what is said. Movement can also appear jerky, and the speakers appear in a relatively small screen on the monitor compared to a full screen with a room based system. The ethical concern lies in whether or not the videoconferencing equipment provides for adequate communication to occur between the supervisor and supervisee to ensure quality supervision. It is the supervisor's responsibility to ensure that the videoconferencing equipment is fully functional and that the supervisee has received adequate training in how to use the equipment.

QUANTITY

Current videoconferencing technology does allow for increased accessibility to supervision. Supervisees who live in diverse geographical regions will have access to supervision that logistics may have previously prevented. Access to discussions that allow reflection on issues or factors that impact the supervisee's practice can lead to decreased feelings of isolation and can enhance the supervision experience. The ethical issue in question is whether or not supervision provided solely through the use of technology is adequate for the demands of a particular supervisee and his or her clinical responsibilities. It is important to evaluate whether additional local or onsite supervision should be provided.

CULTURAL COMPETENCE

Preparing supervisees to be culturally competent is an important ethical practice concern for supervisors. If the supervisee is practicing with a population that the supervisor has limited expertise working with, it is important to consider supplementing the supervision with additional onsite supervision that would provide the necessary local expertise. While the supervisee may not have a licensed professional in his or her agency to provide the necessary licensure supervision, there may be a local professional who does have expertise working with the population served by a particular agency. Access to this expertise could greatly enhance the supervisee's cultural competence. As needed and at prearranged times, the supervisor, supervisee, and onsite local expert could be concurrently on screen during a videoconference session to discuss the supervisee's progress in this area.

SECURITY AND CONFIDENTIALITY

Security and confidentiality are additional ethical concerns to consider when using videoconferencing for supervision. Protocols need to be established to ensure client confidentiality. Specifically:

- Supervisors and supervisees need to monitor the location of the supervisory sessions and the auditory privacy of the sessions.
- Client identifying information should be kept to a minimum, with initials or codes used to describe the client whenever possible (Panos, Panos, Cox, Roby, & Matheson, 2000).
- When the need arises to discuss sensitive cases or when specific identifying information needs to be shared, the supervisor and supervisee should ideally ar range to meet face to face or by phone.

Additionally, as part of informed consent and as regulated by HIPAA, supervisees will need to notify clients of their intent to discuss the client's health-related information with their supervisor via the use of videoconferencing and explain the specific measures that will be taken to ensure their privacy (U.S. Department of Health and Human Services, Office of the Secretary, 2000).

Supervisors and supervisees should make every effort to reduce security risks by using secure or closed networks and encryption programs (minimum 128 bit), as well as checking to see that system managers are updating virus scan programs (Wood, Miller, & Hargrove, 2005). Supervisors and supervisees will need to continuously monitor both the risks that result from people and the risks that result from technology to ensure ethically sound practice while using videoconferencing for supervision.

LIABILITY AND INSURANCE COVERAGE

Supervisors should ensure that their supervisees have professional liability coverage. Supervisors have an ethical responsibility to ensure that clients served by the supervisee have access to resources should problems occur as the result of inappropriate actions by the supervisee. The licensure process allows for monitoring of professional conduct and has processes in place to hold licensees accountable for professional behavior. However, clients may also seek compensation in civil court for perceived harm, and it is important for supervisees to be protected by malpractice policies. When considering using videoconferencing to provide supervision to a supervisee located in another state, it is important for the supervisor and supervisee to first research that state's laws pertaining to supervision and practice. If consultation will occur across state lines it is important to check the licensure requirements for each state. The supervisor may also want to confirm with their liability insurance carrier that they will be covered while providing supervision via videoconferencing.

GROUP SUPERVISION BEST PRACTICES

Group supervision is defined as the regular meeting of a group of supervisees with a designated supervisor or supervisors, with the purpose of monitoring the quality of work and to further the supervisee's understanding of themselves, of the clients with whom they work and of service delivery in general. Supervisees are aided in achieving these goals by their supervisor(s) and by their feedback from and interactions with each other (Bernard & Goodyear, 2004). The literature on the use of group supervision with computer-based videoconferencing and room-based videoconferencing is scant. However, the advantages and disadvantages may include the following:

ADVANTAGES

- Provides a supportive atmosphere for peers to share anxieties and normalize.
- Supervisee benefits from feedback and input from peers in addition to supervisor.
- Group supervision can promote communication between supervisees working in fields of practice and providing services in remote locations reducing isolation of providers of services.
- Group supervision provides exposure to a broader range of clients and life experiences that other supervisees bring to the group.
- Provides more opportunity to use role-playing and other action techniques for supervision.
- Reduces stress and time involved in traveling to supervision and conserves resources.

DISADVANTAGES

- Group supervision is less likely to mirror the dynamics of the supervisee's work with clients as is individual supervision.
- Group dynamics can consume valuable supervision time.
- Subtle non-verbal behavior and eye contact can be challenging to observe, con sequently the accuracy of communication can be compromised.
- Disruptions in the flow of communication due to delay in transmission or losing connections can cause confusion if participants are at multiple sites.

BEST PRACTICE RECOMMENDATIONS

- Establish group rules that encourage trust and safety.
- Containment – equal sharing time for supervisees.
- Confidentiality – parameters, security issues with audiovisual technology.
- Meeting time, attendance, expectations.
- Identify adjunctive communication methods; e-mail, online discussions.
- Establish a structure for each meeting.

ISSUES TO KEEP IN MIND WITH GROUP SUPERVISION

(Bogo & Globerman, 2004)

Supervisee anxiety related to exposing their practice to their peers can work for them and can work against them. This needs to be mitigated by peer feedback that is helpful rather than critical. Group supervision can provide more socio-emotional support and enriched learning about group process while individual supervision is more conducive to revealing vulnerabilities, learning how to relate to clients and developing self-awareness (Walter & Young, 1999). Additionally, it is important to consider all of the following potential pre-existing factors in group supervision:

- Previous experience with each other.
- Pre-existing relationships.
- The supervisee's level of competence and skill as a group member.
- The supervisor's ability as a group facilitator.

The group facilitator can be most effective by:

- Modeling expected group behavior (risk-taking and providing well-framed feed back are particularly important to the model).
- Promoting group norms – intervening when necessary to support group norms, clarifying expectations, ensure safety of members who take risks, etc.
- Facilitating group interaction – containing members who monopolize the discussion, helping to establish respectful alliances with all group members, encouraging open communication about issues between group, not playing favorites, addressing conflict openly.
- Considering how evaluation will be handled for supervisees who are participating in the group; they may be less likely to express conflict due to a fear of being judged negatively by their supervisor.
- Setting clear expectations how the group will operate – the process for deciding who will present, how much time will be allotted for each student, how feedback will be given, group norms and behavior expectations.

In addition to the best practices mentioned above, group supervision through the use of videoconferencing should include a technology system that best meets the needs of a group model of supervision.

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ADDENDUM 1: MATRIX FOR COMPUTER-BASED VIDEOCONFERENCE SYSTERMS

VIDEOCONFERENCE SOFTWARE APPLICATIONS REVIEWED

PRODUCT	COST	NUMBER OF CONCURRENT USERS	SECURITY	WEBSITE	NOTES
Adobe Connect Pro	$45-55 per month for one host and 100 participants	100	Videoconferences hosted on Adobe's secure servers	http://www.adobe.com/products/acrobatconnectpro	More participant functionality than Connect Now
Adobe Connect Now	Free	3	Videoconferences hosted on Adobe's secure servers	http://www.adobe.com/acom/connectnow/	Limited to three seats simple user interface
MegaMeeting	$15 per seat, per month	100	Videoconferences hosted on MegaMeeting's server	http://www.megameeting.com	Any number of seats can be purchased
SightSpeed	$20 per seat, per month	9	Uses a Peer-to-Peer connection across the Internet and therfore does not provide high-level security	http://www.sightspeed.com/	Software seemed to slow down computer operations
ooVoo	$14.95 per month	4	Uses a Peer-to-Peer connection across the Internet and therefore does not provide high-level security.	http://www.oovoo.com/	Poor reviews and pop-up ads
Skype	Free	2	Uses a Peer-to-Peer connection across the Internet and therefore does not provide high-level security.	http://www.skype.com/	Limited to two seats

ADDENDUM 2: ADDITIONAL RESOURCES

American Telemedicine Association
www.americantelemed.org

California Telemedicine and eHealth Center (CTEC)
www.cteconline.org

Center for Connected Health
www.connected-health.org

Center for Telehealth and E-Health Law
www.telehealthlawcenter.org

Mobile Health Watch
www.mobilehealthwatch.com

Telehealth: A Model for Clinical Supervision in Allied Health
Miller, T.W., et. al. (2003)
Internet Journal of Allied Health Sciences and Practice
http://ijahsp.nova.edu/articles/1vol2/miller.pdf

New Developments in Technology-Assisted Supervision and Training: A Practical Overview

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Clinical supervision and training are now widely available online. In this article, three of the most accessible and widely adopted new developments in clinical supervision and training technology are described: Videoconference supervision, cloud-based file sharing software, and clinical outcome tracking software. Partial transcripts from two online supervision sessions are provided as examples of videoconference-based supervision. The benefits and limitations of technology in supervision and training are discussed, with an emphasis on supervision process, ethics, privacy, and security. Recommendations for supervision practice are made, including methods to enhance experiential learning, the supervisory working alliance, and online security. © 2014 Wiley Periodicals, Inc. J. Clin. Psychol.: In Session 70:1082–1093, 2014.

Keywords: distance supervision; Internet supervision; online training; psychotherapy training

Psychotherapy supervision and training are rapidly moving online. A Google search reveals psychotherapy training via Internet-based videoconference in virtually all major psychotherapeutic modalities, including acceptance and commitment therapy (ACT), cognitive-behavioral therapy (CBT), dialectical-behavioral therapy (DBT), emotion-focused therapy (EFT), eye-movement desensitization and reprocessing (EMDR), intensive short-term dynamic psychotherapy (ISTDP), and psychoanalysis, among others. Clinical supervisors are quickly integrating numerous new technologies into their practice, including webcams, tablet computers (e.g., the iPad), the Internet "cloud," web-based software for tracking clinical outcomes, and smartphone applications, or "apps" (e.g., www.isupelive.com).

As the development and integration of technology into supervision proceed, research on its effectiveness is attempting to keep pace. Over 25 clinical research studies on technology-assisted supervision and training (TAST) have been conducted since 2000 in training sites around the world, including Australia, Canada, England, Norway, and the United States (e.g., Reese et al., 2009). The potential benefits of TAST are clear, including greatly increased flexibility, reduced travel costs, and the opportunity to address the limited availability of clinical training in rural, remote, and underserved areas. However, many supervisors have questions about TAST that remain unanswered, including concerns about security, confidentiality, ethics, regulations, supervision process, and technological competence (Rousmaniere, 2014).

The goal of this article is to provide clinical supervisors with a practical and accessible overview of three of the most widely adopted, newest Internet-based developments in TAST: videoconference supervision, cloud-based file sharing software, and clinical outcome tracking software. These technologies will be discussed in the context of their potential benefits and risks for supervisees, supervisors, and clinical treatment.

Videoconference Technology

Of all the new technologies being applied to supervision and training, videoconferencing has quickly become the most widely used medium in practice. Originally, videoconference was

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JOURNAL OF CLINICAL PSYCHOLOGY: IN SESSION, Vol. 70(11), 1082–1093 (2014) © 2014 Wiley Periodicals, Inc.
Published online in Wiley Online Library (wileyonlinelibrary.com/journal/jclp). DOI: 10.1002/jclp.22129

largely used to provide individual supervision to trainees in rural or remote areas (e.g., Stamm, 1998), or in international settings (e.g., Panos, Panos, Cox, Roby, & Matheson, 2002). However, videoconference is increasingly being used by urban clinicians for a wider range of purposes, such as seeking training in advanced psychotherapy from geographically distant experts (Abbass et al., 2011) and providing live one-way-mirror supervision (Rousmaniere & Frederickson, 2013; www.isupelive.com).

Recent advances in videoconference software permit group videoconferencing from multiple locations simultaneously and the option for digital recordings to be shown within videoconference software, permitting supervisors to provide video recording-based group psychotherapy training for an international pool of trainees. Recently, some large supervision and training organizations have adopted videoconference as a primary means of providing international supervision to large cohorts of supervisees (e.g., Fishkin, Fishkin, Leli, Katz, & Snyder, 2011).

Research on Videoconference Supervision and Training

Recent empirical research suggests that videoconference may be effective for individual supervision and group supervision (e.g., Rees, Krabbe, & Monaghan, 2009) as well as for didactic trainings (e.g., Weingardt, Cucciare, Bellotti, & Lai, 2009). Research also suggests that videoconference may benefit supervision in unexpected ways. For example, in one study (Sørlie, Gammon, Bergvik, & Sexton, 1999), both trainees and supervisors reported preparing more thoroughly for videoconference supervision, perhaps because of uncertainty about the new supervision format. The same study found that some supervisees reported increased self-disclosure, which they attributed to a feeling of safety due to the increased experienced distance from their supervisor (e.g., Sørlie et al., 1999). Anecdotal experience and case reports suggest that videoconference can be effective for international and cross-cultural supervision (e.g., Panos et al., 2002), and live one-way-mirror supervision (Rousmaniere & Frederickson, 2013).

On the other hand, research has also indicated some potential concerns about videoconference training. The most frequently cited concern about videoconference supervision is the potential for reduced accuracy or depth of communication between the supervisor and supervisee because of the visual constraints and inconsistent audio quality inherent in videoconference (e.g., Kanz, 2001). However, the effect of this factor is unclear; although some research has found the limited visual range to be potentially problematic (e.g., Sørlie et al., 1999), multiple studies have found the videoconference supervision format to maintain the supervisory working alliance at an equivalent level to in-person supervision (e.g., Reese et al., 2009).

Other concerns about videoconference supervision include heightened anxiety in some supervisees (e.g., Sørlie et al., 1999), the impaired ability of supervisors to provide help from a distance because of unfamiliarity with local laws and regulations (e.g., Abbass et al., 2011) and possible reduced effectiveness when compared to in-person training (e.g., Sholomskas et al., 2005). Given these concerns and challenges, it is recommended that supervisors using videoconference emphasize a collaborative approach to supervision, especially in light of recent data that highlight the importance of collaboration for maintaining a positive supervisory working alliance (Rousmaniere & Ellis, 2014).

One of the promising benefits of videoconference is facilitating international supervision (e.g., Fishkin et al., 2011). However, there is a chance that the geographic distance between the supervisory dyad could increase the risk of cultural misunderstandings (Powell & Migdole, 2012). Panos et al. (2002) proposed the "triad model" of supervision, in which supervisees have two supervisors: one onsite who is well versed in local culture, and one online who possesses the needed competence in clinical supervision.

It is worth noting that most of the research on the use of technology in supervision and training has been done by "early adopters" of those same technologies, who may be subject to a pro-technology bias (Rousmaniere, 2014). As the field moves forward, it is increasingly important for additional research to be completed by neutral parties.

Required Equipment

Until the turn of the century, videoconference was available only through dedicated hardware systems (e.g., Stamm, 1998), whose prohibitively high cost made it largely impracticable for use by individual clinicians. However, the recent decrease in computer costs and increase in Internet connectivity speeds have made the accessibility of videoconference nearly ubiquitous. The new generation of supervisors entering the field "grew up" with Internet technology, and thus they are more likely to be comfortable integrating videoconference into their supervision practice. Many large technology companies now provide free software for individual or group videoconferencing (e.g., Skype, Google, Apple). Virtually all new personal computers, smartphones, and tablet computers come with videoconference software preinstalled: The website www.telementalhealthcomparisons.com has a free list of videoconference software that is searchable by feature (e.g., HIPAA-compliant security).

Videoconference for Individual and Group Supervision

Although the medium is different, the format for individual and group videoconference supervision can be essentially the same as in-person supervision. Supervisees can present cases using notes, audiotapes, or videotapes, have group discussions, and engage in clinical role-plays or skill-building exercises. For supervisors who want to watch video recordings of supervisees' sessions, multiple options exist. The technologically simplest option is to have the supervisee mail a copy of the video to the supervisor before their meeting time, in any format usable by both parties. Both parties can then watch the video simultaneously while discussing it via videoconferencing. The video can be played on the computer that is used for the videoconference, or a separate device (e.g., a television).

The advantages of this option are very high-quality video and avoiding the use the Internet, thus reducing security concerns; however, it is still possible that patients' protected health information may be discussed via videoconferencing. The disadvantages are cost and the hassle of mailing videos (especially for group supervision).

Another option for watching videos during videoconference supervision is for the supervisee to play the video on his or her computer while using the "share screen" option available in most videoconference software (e.g., Vsee). An advantage of this option is that it is technologically simple, especially for group supervision. However, screen sharing may use more Internet bandwidth, which can reduce the quality of the videoconference.

A third option is for the supervisee to send a copy of the video electronically, over the Internet. For this method, it is recommended to use a file-transfer service that is compliant with the standards of the Health Information Portability and Accountability Act (HIPAA, see below for a list) and/or encryption software (e.g., www.truecrypt.com or www.boxcryptor.com). This method is a very fast and economical way of sharing videos, especially for group supervision, but is technologically more challenging. (See below for further discussion on file-transfer programs). While watching videos, supervisors may use a text-chat window or "whiteboard"–a software feature that lets users draw or write on a blank screen during a videoconference–to comment on the video while it is playing.

Following is a partial transcript of a videoconference-based supervision group. The supervisor specializes in intensive short-term dynamic psychotherapy. In this transcript, the psychotherapist and supervisor are discussing a psychotherapy session video, via text chat while the video is playing. In the video, the client had visualized hitting her husband, with whom she was angry. The psychotherapist was unsure if this was therapeutic for the client, because she seemed detached during the visualization. The supervisor watched the client's physical signals on the videotape (e.g., body tension, movement) and dialogued with the psychotherapist via text chat. The other members of the group watched the video and text chat in real-time. This transcript demonstrates how subtle and nuanced aspects of psychotherapy can be effectively addressed via videoconference supervision.

[10:06:59] Therapist: she's talking about her husband here
[10:07:23] Therapist: she has very short portrait then guilt [a "portrait" is the client's visualization of hitting her husband]

[10:09:00] Supervisor: she is a bit of an actor [suggesting she is not connected to emotions]
[10:09:06] Therapist: compliance?
[10:09:08] Supervisor: not sure how attached she is to the feelings here
[10:09:27] Therapist: what tells you that in her presentation?
[10:09:46] Supervisor: it seems superficial. lack of [verbal and visual] signals throughout
[10:09:55] Therapist: what would you do here?
[10:10:09] Supervisor: what problems inside does she have?
[10:10:18] Therapist: anxiety re conflict with husband and others
[10:10:19] Supervisor: is she hitting a projection?
[10:10:34] Therapist: husband repeatedly says things that bother her
[10:10:44] Supervisor: I'm not certain here about what psychic structure we are seeing here
[10:10:58] Therapist: I don't understand
[10:11:30] Supervisor: no signals of unconscious anxiety so either no neurosis or she is splitting and using projection
[10:11:39] Supervisor: so is this compliance?
[10:11:47] Therapist: that was my guess. her father was extremely physically violent throughout her childhood
[10:12:06] Supervisor: need an intrapsychic focus: this seems external
[10:12:36] Therapist: this felt real to me - the guilt. What do you think here?
[10:13:56] Supervisor: not certain yet

Later in the same supervision session, the group watched a video of the same psychotherapist working with a different client. The supervisor described the difference in behavioral signals between the two clients, via text chat.

[10:23:08] Supervisor: look at the differences here vs the last person
[10:23:18] Therapist: yes I see that
[10:23:22] Supervisor: tense, smiling, inhibiting, sighing, laughing, hands tense
[10:23:37] Supervisor: hesitation in speech
[10:23:46] Supervisor: this is a neurotic person for sure
[10:24:35] Supervisor: she has unconscious anxiety and unconscious defenses = neurosis or character neurosis

Videoconference for Live One-Way-Mirror Supervision

Live "one-way-mirror" supervision was originally developed for training in family therapy, but is now used widely, across a range of training programs (Bernard & Goodyear, 2014). The use of videoconference for live one-way-mirror supervision has been termed Remote Live Supervision (RLS; Rousmaniere & Frederickson, 2013). RLS requires the same equipment as regular videoconference supervision. The client and supervisee sit across from each other, similar to a traditional therapy room. A webcam transmits live video of the client during the therapy session to the supervisor in another location, via videoconferencing.

There are two formats for RLS: visual and audio. In visual format RLS, the supervisor types text interventions into a chat window in the videoconference software. A laptop computer sitting next to the client displays the supervisor's interventions in large type, like a teleprompter for the supervisee. Alternately, in audio format RLS, the supervisor speaks interventions into the computer's microphone, which are heard by the supervisee via an earpiece. The supervisee decides which interventions to integrate into psychotherapy. If the supervisor wishes to save a video of the session, a separate device may be used for this purpose (Rousmaniere & Frederickson, 2013). Although RLS was developed to provide distance training, it may also be used as an alternative to a one-way-mirror to provide live supervision to supervisees in the same location as the supervisor. Similarly, Angela Yu recently developed ISup, an innovative app for live one-way-mirror supervision (www.isupelive.com), in which the supervisor's interventions appear on an iPad sitting on the psychotherapist's lap.

Most supervision occurs some time after a psychotherapy session, with the use of aids to help recall what occurred during the session (e.g., process notes, video recordings). This kind of

supervision engages a cognitive method of learning, which helps the supervisee better understand psychotherapy processes and models. In contrast, live supervision occurs during a psychotherapy session, so it also engages an experiential method of learning. Because the supervision is in real-time, the supervisee can experience the supervisor's ability to make moment-to-moment clinical assessments and interventions. Because the supervisee receives the supervisor's guidance at the exact moment it is needed, live supervision facilitates state-dependent learning, which can help build procedural psychotherapy skills while simultaneously advancing cognitive learning.

Likewise, in live supervision the supervisee can "walk in the supervisor's shoes" and feel the psychotherapy model in action. For these same reasons, however, live supervision is a very challenging training method. The supervisee must simultaneously track communication from both the client and the supervisor. New clinicians may risk feeling confused or lost during the session, or may passively obey the supervisor's instructions (Bernard & Goodyear, 2014).

Furthermore, the distance component of RLS may heighten the potential challenges or risks inherent in live supervision. For example, if beginning clinicians do not have the skill (technical or interpersonal) to apply the supervisor's interventions, a clinical problem could be created in a future psychotherapy session when the supervisor is not online for assistance. For example, if a supervisor helps a psychotherapist focus on a client's previously avoided trauma, then it is critical that the psychotherapist have the skills necessary to assess the client's emotional stability and safety in future sessions when the supervisor is not present. (It is worth noting, however, that all supervision formats are subject to the risk of supervisees incorrectly implementing the supervisor's instructions.) Thus, although research has suggested that in-person live supervision may be effective for beginning trainees (Bartle-Haring, Silverthorn, Meyer, & Toviessi, 2009), RLS may not be suitable for prelicensure trainees located in a distant location or different jurisdiction than the supervisor (Rousmaniere & Frederickson, 2013).

A Clinical Example

Below is a partial transcript from a RLS session. The psychotherapist had sought supervision because progress in this case had stalled. In this RLS session, the supervisor hypothesized that the psychotherapy had stalled because the therapeutic dyad had fallen into an unhelpful cycle of passive dependency, in which the psychotherapist would give advice and the client would passively listen, without true engagement. The partial transcript shows the supervisor helping the psychotherapist break out of the passive dependency cycle and reground the psychotherapy in the client's will to change (Frederickson, 2013).

The session began with the psychotherapist asking the client what he wanted to work on. As had happened in previous sessions, the client appeared bored and began flipping back and forth between wanting to address his problems and wanting to avoid them. To help the psychotherapist remain neutral, the supervisor typed two lines to say to the client, at 2 and 3 minutes into the session. (The text appeared on a laptop sitting next to the client, like a teleprompter for the psychotherapist.)

[11:02:08] Supervisor: notice even now you offer two versions and sit on the fence
[11:03:08] Supervisor: If you don't know why you're here, I sure don't.

After the psychotherapist said these lines, the client became more focused. The client looked at the psychotherapist expectantly, waiting for the psychotherapist to provide an answer to the psychotherapist's own question ("What do you want to work on today?"). The supervisor anticipated that the psychotherapist would have difficultly not rescuing the client from his own passivity (by jumping in to answer the psychotherapist's own question), so the supervisor repeatedly typed instructions for the therapist to wait. Note that these instructions are only 8 to 28 seconds apart.

[11:03:43] Supervisor: [Just keep waiting for him]
[11:04:00] Supervisor: [At this point just say, "go ahead"]
[11:04:25] Supervisor: [wait while he is passive to let feeling build]
[11:04:52] Supervisor: [wait]

[11:05:24] Supervisor: [wait]
[11:05:32] Supervisor: [wait]

The pressure in the session grew. The client tested the psychotherapist's will by saying, "I'm not sure if I can answer your question." To help the psychotherapist emphasize his stance of patience, the supervisor typed lines for the psychotherapist to say to the client, and instructed him to wait.

[11:05:48] Supervisor: take your time
[11:05:52] Supervisor: take your time
[11:06:55] Supervisor: sounds like you feel stuck
[11:07:52] Supervisor: [wait]

As the pressure in the session grew, the client began to grow frustrated with feeling stuck. The client described the mental dialogue that kept him stuck. When the client had done this in previous sessions, the psychotherapist had argued with the reasoning of the client's internal dialogue, trying to convince the client that his thoughts were illogical. This strategy had failed, as the client would simply take the opposing side of the argument and refuse to change. Anticipating this, the supervisor typed a paradoxical approach for the psychotherapist to use–to become a "devil's advocate" and argue for the client to remain stuck. This helped shift the conflict from interpersonal (between the psychotherapist and client) to intrapsychic (within the client himself). Most of the supervisor's comments are about 30 seconds apart.

[11:08:22] Supervisor: may be important to stay stuck until you are certain about what to do
[11:08:59] Supervisor: may be important to respect how the stuckness may be helping you
[11:10:28] Supervisor: You're a smart guy. Must be a good reason to believe those stories.
[11:10:49] Supervisor: [excellent]
[11:11:23] Supervisor: it may be important not to know what you want
[11:12:55] Supervisor: no decisions = no negative consequences

This partial transcript demonstrates how RLS can facilitate experiential learning for challenging psychotherapy cases. Anecdotal experience suggests that this aspect of RLS is particularly effective for helping supervisees become aware of blocks in treatment that have occurred outside the supervisee's awareness (for example, due to counter-transference). Because the supervisor is able to give moment-to-moment guidance, he or she can "hold" the supervisee, providing cognitive and emotional support at the exact moment it is needed. All of the supervisor's comments are, in effect, interventions for both the client and the trainee.

Videoconference Reliability

Videoconference generally requires an Internet connection speed of .5 Mbps or greater. (Readers can test their personal Internet connection speed at www.speedtest.net.) Anecdotal experiences suggest that the reliability of videoconference software and Internet connections are mixed, so users should expect occasional problems with dropped calls or poor connectivity. For example, in the first author's experience using videoconference over 3 years, about 20% of the sessions had some degree of connectivity problems, at both private practice and university sites. For this reason, videoconference should only be used if both the supervisor and the supervisee are comfortable with this limitation, and backup methods for communication should be identified and agreed to in the informed consent process (e.g., phone).

The reliability of videoconference is vulnerable at two points: the Internet connection and the software. Even if the user has a high-speed Internet connection, connectivity problems may occur at any point in the videoconference connection, including international Internet nodes outside of the user's country. Likewise, no videoconference software provider has been demonstrated to be more reliable than others, unless one is willing to purchase a dedicated videoconference line, which generally costs over $10,000. Thus, the reliability of videoconference technology is unfortunately mostly outside users' control. However, the following steps may help improve videoconferencing quality: (a) get the fastest Internet connection available in the area; (b) close

Table 1
Five Simple Steps to Enhance Online Security

1. The most important security procedure is to use "strong" passwords: do not use birthdays, names, or words in the dictionary; use at least eight characters; and use a combination of numbers, special characters (e.g., *&@), and upper/lower-case letters.
2. Do not use the same passwords for multiple accounts.
3. Turn on Two-Factor Identification for your email accounts.
4. Be extremely careful when downloading attachments in e-mails or clicking on links in e-mails. This is possibly the most common way to get a virus and have your e-mail account hacked.
5. Use antivirus and antispyware software, and keep the software updated.

Internet-intensive programs running in background while using videoconference (e.g., Internet-based file-sharing software); (c) limit the use of "screen sharing" features; and (d) turn off the video camera when Internet connectivity is poor.

Security and Confidentiality

Videoconference supervision usually involves the transmission of patient protected health information (PHI), and thus may fall under Health Insurance Portability and Accountability Act (HIPAA) regulations, which set minimum standards requiring the protection of the confidentiality of all electronic health information. The American Recovery and Reinvestment Act of 2009 included The Health Information Technology for Economic and Clinical Health Act (HITECH), which significantly expanded the scope of HIPAA to further cover health providers' "business associates" and increased penalties for noncompliance, in addition to other changes. Although enforcement of HIPAA was generally limited, HITECH mandates the department of Health and Human Services to perform regular audits of health providers and business associates.

Videoconferencing software that permits compliance with HIPAA is also now available at affordable pricing. However, most videoconference software (including Skype) runs through a central server, and thus is not considered "secure" by HIPAA. One risk is that an employee of the videoconference company could listen in on a session. For this reason, it is important to fully inform supervisees about the limits of confidentiality, and patient consent should be obtained if PHI is transmitted over videoconference. However, it is worth noting that this risk is theoretically no greater than the risk of a telephone company employee listening in on a supervision or psychotherapy session done via telephone. (See Table 1 for a list of five simple steps to enhance online security.)

A thorough discussion of HIPAA/HITECH is beyond the scope of this article. However, clinicians who use videoconference or any other electronic communication of PHI are advised to consult with the HIPAA compliance officer in their institution's information technology department or local professional association (Rousmaniere, 2014). For a thorough discussion of videoconference security, confidentiality, and HIPAA, see http://www.zurinstitute.com/skype_telehealth.html#debate.

Regulatory Issues

The regulation of Internet-based supervision is varied and rapidly changing. In their comprehensive survey of 46 state counseling regulatory boards, McAdams and Wyatt (2010) found that regulations on Internet-based supervision had been established in six states and were in development or discussion in 18 states, and that Internet-based supervision was prohibited in 19 states. Sixty percent of boards limited the hours of Internet supervision that could be applied to licensure, with the limits ranging from 10% to 50% of total hours (McAdams & Wyatt, 2010).

Likewise, a number of professional associations in the United States have developed guidelines for the practice of Internet-based supervision, but these tend to be vague and do not provide supervisors with specific guidance. Note, for example, the following paragraph from the recently

released "Guidelines for the Practice of Telepsychology" (American Psychological Association [APA], 2013):

> Psychologists using telepsychology to provide supervision or consultation remotely to individuals or organizations are encouraged to consult others who are knowledgeable about the unique issues telecommunication technologies pose for supervision or consultation. Psychologists providing telepsychology services strive to be familiar with professional literature regarding the delivery of services via telecommunication technologies, as well as competent with the use of the technological modality itself. In providing supervision and/or consultation via telepsychology, psychologists make reasonable efforts to be proficient in the professional services being offered, the telecommunication modality via which the services are being offered by the supervisee/consultee, and the technology medium being used to provide the supervision or consultation. In addition, since the development of basic professional competencies for supervisees is often conducted in-person, psychologists who use telepsychology for supervision are encouraged to consider and ensure that a sufficient amount of in-person supervision time is included so that the supervisees can attain the required competencies or supervised experiences. (para. 1)

These guidelines emphasize that supervisors should become proficient and competent in technologies being used. However, assessing the exact extent of technological competency required for ethical supervision practice may be unclear to supervisors. Indeed, assessing competency in technology can be quite tricky, because many technologies update themselves frequently, so someone who is competent in a program one day may be mystified by it the next. Likewise, it is unclear what constitutes a "sufficient amount of in-person supervision time" because there is only preliminary research comparing in-person to online supervision (Rousmaniere, 2014).

Supervisees using videoconference for distance supervision or training are advised to form good relationships with local mentors and consultants in case clinical issues arise that may not be addressed well by distance supervision, such as compliance with local laws, regulations, and professional guidelines (e.g., Abbass et al., 2011). Supervisors are encouraged to contact their local regulatory agencies or professional associations for answers to questions, including:

- Are there limits on the number of hours of Internet-based supervision that can count towards licensure, continuing education credits, etc.?
- Which jurisdiction has legal accountability when supervision or training is conducted across state lines or international borders?
- Are there informed consent requirements specific to videoconference supervision?
- Do any of the jurisdictions have confidentiality or privacy rules beyond HIPAA/HITECH?
- Do the supervisor or agency's professional liability insurance policies cover Internet-based supervision or supervision in multiple jurisdictions? (Kanz, 2001; McAdams & Wyatt, 2010; Rousmaniere, 2014; Vaccaro & Lambie, 2007).

Internet-Based "Cloud" File Transfer Software

The rapid increase in Internet connectivity speeds and decrease in data storage costs have created a recent flood of new low-cost, user-friendly Internet-based file transfer programs. These programs are often called "cloud-based" software. Visualize the Internet cloud as hundreds of thousands of computers, called servers, located in warehouses around the world. These servers are all connected to each other via the Internet. Technology companies rent servers for many purposes, ranging from data storage, running complex software, and performing research to military or security operations. Server companies often contract with backup server companies, also located internationally, to keep copies of the data in case of emergencies.

Cloud-based software is used by many new devices (e.g., the iPhone) and widely used Internet services (see Table 2). All new smartphones for sale today come with cloud-based software

Table 2
Software That Uses Cloud Computing

- Most backup software programs for computers and smartphones
- Internet-based photo and video organizing software (e.g., Apple iCloud)
- Internet-based file sharing programs (e.g., Dropbox)
- Internet-based e-mail programs (e.g., Gmail, Yahoo)
- Internet-based applications (e.g., Google Docs)

Table 3
HIPAA-Compatible Cloud File-Storage and Transfer Services

1. www.mydocsonline.com
2. www.egnyte.com
3. www.onramp.com
4. www.braveriver.com
5. www.box.com

preinstalled, and in the not-too-distant future many household appliances and automobiles will be connected to the cloud as well. The value offered by cloud computing is efficiency; large technology companies (e.g., Apple, Amazon, and Google) can provide high-quality services at very low prices, or even for free.

However, concerns have been raised about the use of cloud computing in the context of clinical supervision (e.g., Devereaux & Gottlieb, 2012). The foremost concern is that supervisors lose control of their data when they upload it to the Internet cloud. This is particularly a concern for confidential clinical information. Although server and backup server companies may promise to keep data secure, it is impossible for supervisors to assess their compliance, especially because the data are often stored in multiple locations. It is also possible that the staff who manage cloud-based services may not fully understand the scope and limits of clinical confidentiality.

Second, for supervisors who are unfamiliar with new technology, it can be challenging to ensure that the privacy settings on cloud computing software are set to "private." (Even technology consultants report having a hard time understanding the ever-changing and highly complex privacy settings in programs like Facebook.) Furthermore, many software programs have "public" as the default privacy setting. This means that any information uploaded by that program can be accessed by anyone on the Internet, or even possibly found through Google searches (i.e., "google hacking").

For these reasons, the current, safest option for the storage or transfer of confidential information (e.g., clinical notes or video recordings) is to not use cloud computing software (E. Rodolfa, personal communication, October 3, 2012). However, avoiding cloud-based software is not a guarantee of security, because any Internet connection by any program or device can be a route for malicious data theft or inadvertent data loss. Indeed, avoiding cloud-based software may soon be impossible; it is likely that in the near future all records will be cloud-based. Thus, instead of adopting a fear-based avoidance strategy to the cloud, supervisors should instead learn how to take appropriate precautions to use the cloud safely.

First, supervisors can use a HIPAA-compatible cloud-based service (see Table 3). Second, supervisors should ensure that client consent is obtained whenever confidential information is stored or transferred using cloud-based services (Devereaux & Gottlieb, 2012). Third, for an added degree of security, supervisors can utilize encryption software (e.g., www.boxcryptor.com or www.truecrypt.com). The use of encryption software provides a very strong degree of protection for confidential data (arguably much stronger than a locked file cabinet), even if the cloud-based program is compromised. Encryption software also protects against the threat of confidentiality breaches by inside personnel, such as information technology staff at an agency, government, or university setting.

Table 4
Web-Based Software for Continuous Assessment

- OQ-Analyst (www.oqmeasures.com)
- CCAPS (ccmh.squarespace.com/ccaps/)
- Carepaths (www.carepaths.com.)
- ASIST (www.clientvoiceinnovations.com)
- Wellness Check (www.wellnesscheck.net)
- MyOutcomes (www.myoutcomes.com)
- FIT-Outcomes (www.FIT-Outcomes.com)
- CORE (www.coreims.co.uk)
- Celest Health (www.celesthealth.com)

Technology to Facilitate Continuous Assessment of Clinical Outcomes

A third new technological development becoming widely adopted in clinical supervision and training is the use of computer software to facilitate session-by-session clinical outcome assessment (e.g., Lambert, 2010; see Table 4 for more software options). With continuous assessment (CA) software, clients can complete outcome measures on a desktop computer, laptop, tablet, or their smartphone while still in the clinician's waiting room. Most CA programs take just a few minutes for a client to complete. The software automatically graphs the client's progress and highlights risk factors, such as projected clinical deterioration or suicidality.

Research has demonstrated that many clinicians have a positive bias regarding their own clinical skills, and a blind spot that prevents them from correctly assessing their own clients' risk for clinical deterioration (Lambert, 2010). CA programs provide an empirical perspective that may help improve clinical outcomes by addressing this blind spot. Because the blind spot is common to pre- and postlicensure clinicians (Lambert, 2010), CA programs are useful for both training of prelicensure clinicians and aiding licensed clinicians in self- or peer-supervision. Compared to paper measures, the new generation of CA software greatly reduces the time burden of outcome assessment.

One of the first examples of CA software was the "clinical support tools," a program that provides session-by-session feedback to clinicians on clients that are at risk for deterioration, via the Internet-based OQ Analyst software package (Whipple et al., 2003). Another popular CA program is the Partners for Change Outcome Management System (PCOMS), developed by Miller, Duncan, Sorrell, and Brown (2005), which utilizes the Outcome Rating Scale (ORS) and Session Rating Scale (SRS), ultra-brief measures of clinical outcome, and the therapeutic working alliance. Controlled studies (e.g., Anker, Duncan, & Sparks, 2009) have demonstrated that the use of PCOMS can help clinicians achieve significantly better clinical outcomes. Another CA program, the *Counseling Center Assessment of Psychological Symptoms* (*CCAPS*), was developed specifically for use at university counseling centers, is integrated into popular electronic records management programs, and is currently in use by over 200 university counseling centers (Locke, Bieschke, Castonguay, & Hayes, 2012).

Two additional examples of CA technology are the Evidence-Based Assessment System for Clinicians, a collection of more than 30 web-based assessment measures covering a wide range of issues, such as gambling, attention deficit hyperactivity disorder, sports anxiety, and alcohol use, all of which can be completed by clients via the Internet or their smartphone (Smith et al., 2011), and the Contextualized Feedback System, a collection of web-based measures designed for couples and family therapy (Bickman, Kelley, & Athay, 2012)

CA can be used in a variety of ways in supervision. The most common method is for the supervisory dyad to review the CA data, in every supervision session, for each case discussed. This helps supervisees to learn to monitor their clinical progress and assess risk of deterioration, on a session-by-session basis. When used in this manner (as part of regular supervision), CA programs have repeatedly been demonstrated in controlled studies to decrease dropout rates, achieve better clinical outcomes, and reduce the likelihood of client deterioration (e.g., Anker et al., 2009).

Regular use of CA tools teaches an empirical approach to clinical practice and helps supervisees gain an empirical perspective on their own clinical effectiveness. At the end of every training year, one of the authors asks his supervisees to make a list of all of their clinical cases in a spreadsheet, with the presenting problems and outcome data for every case. Reviewing this list can help identify the trainees' clinical strengths and challenges. Reviews like this can also help counter the tendency of some trainees to devalue or glorify their own work.

Conclusion

The pace of development of clinical supervision and training technology is growing rapidly. As new generations of supervisors who are comfortable with technology begin their careers, it is likely that new technologies will increasingly become integrated into supervision as routine practice. Although the development of new technologies has outpaced research on their effectiveness, a growing body of data that suggests that TAST can be effective and safe, if used conscientiously, in the context of the limits posed by the technology (e.g., using strong passwords, disclosing potential confidentiality concerns and obtaining client consent, balancing online and face-to-face supervision).

We would like to conclude with a note on perspective. Most of the research and theorizing on technological developments in supervision and training have focused on evaluating whether the new technologies can approximate the experience of "traditional" in-person supervision and training. Although this approach makes sense, it rests on the assumption of superiority in traditional supervision methods. This assumption has questionable validity and may be arbitrarily limiting. 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 (e.g., Ellis & Ladany, 1997). 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.

Rather than questioning whether TAST is "as good" as traditional supervision, supervisors and researchers may consider asking instead, "What is now possible and how can it serve my supervisees and their clients?" Supervisors serve multifaceted roles; in addition to their gatekeeper role, supervisors, by necessity, must also be clinical explorers and inventors. We propose that the same skills that enable supervisors to be flexible and adaptable in an always-changing clinical environment can serve them well in the new technological frontier.

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Conn, S. R., Roberts, R. L., & Powell, B. M. (2009). Attitudes and Satisfaction with a Hybrid Model of Counseling Supervision. *Educational Technology & Society*, *12* (2), 298–306.

Attitudes and Satisfaction with a Hybrid Model of Counseling Supervision

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ABSTRACT

The authors investigated the relationship between type of group supervision (hybrid model vs. face-to-face) and attitudes toward technology, toward use of technology in professional practice, and toward quality of supervision among a sample of school counseling interns. Participants (N = 76) experienced one of two types of internship supervision: a hybrid model (N= 41) or face-to-face (N= 35). Data analyses indicated that the hybrid model of group supervision was positively related to attitudes toward technology in counselor education, future professional practice, and the overall supervisory experience. Further, differences between the approaches in delivery of supervision showed no effect on perceptions of quality of supervision. Implications for extending the use of technology-mediated supervision to practicing professionals are presented.

Keywords

Hybrid model, Technology, Counseling supervision, School counselors

The study of distance learning is a major focus in higher education (Anakwe, 1999; Benigno & Trentin, 2000; Davies & Mendenhall, 1998; DeBourgh, 1999) and an emerging concern among counseling related programs (Alterkruse & Brew, 2000; Bobby & Capone, 2000; Kjosness, 2002). The body of research examining the general satisfaction with distance learning, although mixed (Salas, Kosarzychi, Burke, Fiore, & Stone, 2002; Smith, 1999), does reflect a consensus about characteristics associated with student satisfaction (DeBourgh, 1999). These include clear course expectations, prompt response to student questions, encouragement of student participation, use of varied instructional techniques, access to the instructor, and timely feedback to students about their work. However, due to limited research, there is less agreement about what characteristics are associated with satisfaction among counselors-in-training concerning technology-mediated supervision (Janoff & Schoenholtz-Read, 1999).

In spite of the limited research, there is growing support for the use of technology in training and supervision (Alpert, 1986; Casey, Bloom, & Moan, 1994; Christie, 1998; Lambert, Hedlund, & Vieweg, 1990; Myrick & Sabella, 1995). Olson, Russell, and White (2001) suggested using technology in supervision to meet the need for outreach to rural areas, for faculty who have limited time to supervise face-to-face, for increasing students' access to qualified supervisors, and to manage the cost of supervision. Other advantages include removal of time and space restrictions, more time to reflect on information, and a permanent record for later reflection (Hara, Bonk, & Angeli, 2000).

Although there is research on various aspects of technology and supervision (Gamon, Sorlie, Bergvik, & Hoifodt, 1998), much of the investigation has focused on the efficacy of email. In an early study of its use, Myrick and Sabella (1995) suggested that email has a place in supervision by providing students with multiple opportunities for feedback and enhanced reflection. Other researchers found that email is a useful supplement to traditional modes of supervision (Olson, Russell, & White, 2001), increases personal reflection (Clingerman & Bernard, 2004), and "offers a way to know students' thought processing and development at a level not before practically feasible" (Graf & Stebnicki, 2002, p. 48).

Researchers have also identified several limitations to using technology in supervision. These include concerns over variations in levels of computer skills among users, loss of non-verbal information, limited bonding between supervisor and student, slow response time, lack of confidentiality, and slow band-width speed, to name a few (Hara, Bonk, & Angeli, 2000; Janoff & Schoenholtz-Read, 1999; Myrick & Sabella, 1995; Olson, Russell, & White, 2001). However, Gamon, et al. (1998) found that, paradoxically, the forced limitations of technology-mediated supervision increased the development of insights and communication and enhanced the quality of supervision.

The nature of technology mediated communication is evolving from Web 1.0 tools such as basic email, chat room, threaded discussion, instant messaging and interactive video to Web 2.0 tools such as Skype, blogs, social networking, Wikis, podcasts and Folksonomy (collaborative tagging). However, faculty who are adopting technology into their instruction prefer the hybrid model, defined as a combination of face-to-face meetings and

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technology delivered instruction (Young, 2002). In a review of the research on computer-mediated communication, Janoff and Schoenholtz-Read (1999) suggested that a hybrid model of supervision offers benefits such as 1) access to peer and expert supervision when not meeting face-to-face, 2) access to information supplied by the supervisor when not meeting face-to-face, 3) opportunity for equal and evolving participation among all members, and 4) opportunity for other members to observe interactions between supervisor and supervisee.

Although there are various models of supervision that guide the process, most of the research has focused on practice in a clinical setting (Bernard & Goodyear, 2004). Nelson and Johnson suggested that supervision of school counselors should focus primarily on skill building. Others have suggested that supervision should also include consultation (Kahn, 1999) and be organized around several primary functions: clinical, developmental, administrative, and peer supervision (Barret & Schmidt, 1986; Henderson, 1994). We have chosen the combination of these recommendations to guide our research.

Like technology-mediated supervision, there is limited research concerning the use of supervision among school counselors (Kahn, 1999) due to 1) the multiple roles school counselors play compared to counselors in clinical settings, 2) the lack of formal training among school supervisors (Nelson & Johnson, 1999), and 3) uncertainty in terms of focus. Therefore, more investigation is needed to guide the growing support of supervision with Web 1.0 and 2.0 tools that include the use of a hybrid model. Our investigation compared two groups of school counseling interns. One group experienced a hybrid model of supervision which included face-to-face, email, and live chat room organized around the ideas proffered by Henderson (1994), Barret and Schmidt (1986), and Kahn (1999); the other group experienced only face-to-face supervision. We investigated three research questions. The first question focused on the degree to which use of the hybrid model of supervision was positively associated with attitudes toward the use of technology in counselor education. Students who classify themselves as "high computer users" have been shown to have more positive attitudes toward technology (Hayes & Robinson, 2000). Thus, our first research hypothesis was: the group experiencing the hybrid model of supervision will report more positive attitudes toward use of technology in counselor education than the face-to-face group.

The second research question focused on the degree to which use of the hybrid model of supervision was positively associated with attitudes about the use of technology in future professional practice. Prior research has suggested that technology is not a neutral influence on the user and may have an impact on future practice (Barnard, 1997). Thus, our second research hypothesis was: interns who participate in the hybrid model of supervision will report more positive attitudes toward use of technology in future professional practice than the face-to-face group.

The third research question focused on the degree to which the two groups differed in their perceptions of the quality of supervision. Although the positive working relationship important to quality supervision is typically established face-to-face (Ladany, Ellis, & Friedlander, 1999), much of the research indicates students are equally satisfied with distance learning as they are with face-to-face learning (DeBourgh, 1999). Thus, our third research hypothesis was: the group experiencing the hybrid model of supervision will report no difference in satisfaction with quality of supervision than the face-to-face group.

Method

Participants

Participants were 76 graduate students enrolled in the School Counseling program at a mid-sized Midwestern University accredited by the Council for Accreditation of Counseling and Related Educational Programs (CACREP). The study was conducted during their first semester of a two-semester internship. All participants completed the survey at the end of the first semester of their school counseling internship. During the 3 years that data were collected, participants were unaware of the different models used in the research and were assigned to one of two groups based on their enrollment in either the on-campus section of internship which received face-to-face supervision or the off-campus section which received a hybrid model combining technology-mediated supervision with face-to-face meetings. Although a convenience sample was used, because of the method of assignment to experimental groups, there is no reason to believe there were prior differences in attitude toward technology among group members.

The technology-mediated groups, with 41 participants, received group supervision by means of a combination of online supervision using WebCT (10 meetings) and face-to-face meetings (5 meetings). The other groups, made up of 35 participants, received all of their supervision face-to-face. Surveys were given to participants at the end of their first semester of internship. In order to insure complete anonymity of participants, the surveys contained no identifying information.

Demographic data, such as gender, ethnic background, and professional status were collected from participants. The majority of the participants were female (N=63), 12 were male, and one participant did not respond. Seventy-one participants were white (not of Hispanic origin), two were black (not of Hispanic origin); and three did not respond. Due to the homogenous sample, the demographics were not factored in the statistical analyses.

Instruments

The Supervisory Working Alliance Inventory: Trainee Form was developed to measure the relationship between supervisor and trainee on two subscales, Rapport and Client Focus (Efstation, Patton, & Kardash, 1990), and supported in research on supervision (Chen and Bernstein, 2000; Patton and Kivlighan, 1997). There were 19 items on this inventory using a 7-point Likert scale ranging from 1 = "almost never" to 7 = "almost always." The Rapport subscale consists of 12 items and the Client Focus subscale is made up of 7 items. Trainees were asked to indicate the frequency of specific characteristics (for example "I feel comfortable working with my supervisor") within the supervisory relationship and to rate accordingly. Confirmatory factor analytic techniques supported the three-factor and two-factor structures for the supervisor and trainee version of the SWAI (Gold, 1993). Further, convergent and discriminant validity for the supervisee form of the SWAI was supported in statistically significant correlations with scales of the Supervisory Styles Inventory (Friedlander & Ward, 1984) and the Personal Reactions Scale – Revised (Holloway & Wampold, 1983). Cronbach's alpha indicating internal consistency was calculated for the Trainee scales with alpha coefficients of .90 for Rapport and .77 for Client Focus (Efstation, Patton, & Kardash, 1990).

The Supervision Questionnaire was developed to measure the trainee's satisfaction with their supervisory experience (Ladany, Hill, & Nutt, 2004; Larsen, Attkisson, Hargreaves, & Nyguyen, 1979). The questionnaire consisted of eight items using a 4-point Likert scale ranging from 1 = "excellent" to 4 = "poor." This survey includes items such as "How would you rate the quality of the supervision you have received?", and "Did you get the kind of supervision you wanted?" Originally derived from the Client Satisfaction Questionnaire (Larsen et al., 1979), this questionnaire was found to be related to supervisee nondisclosure with previous research reporting the SSQ to be alpha = .96 (Ladany et al., 2004). In a study by Ladany, Lehrman-Waterman, Molinaro, and Wolgast (1999), internal consistency was reported as alpha = .97.

The Web-Based Distance Group Satisfaction Survey (Roberts, Powell, & Fraker, 2002) used a 5-point Likert scale ranging from 1 = "strongly agree" to 5 = "strongly disagree." The survey is made up of 3 subscales: 1) Perceptions of the Usefulness of Technology in Professional Practice (8 items), 2) Perceptions of the Usefulness of Technology in Counselor Education (6 items), and 3) Perceptions of the Effectiveness of On-line Supervision (16 items). Participants were asked to indicate the answer that most likely fit their current thoughts or feelings on the topic. This unpublished 33 question survey (Roberts et al., 2002) was designed using a pilot group (N= 43) to measure students' perceptions of the effectiveness of online supervision (Cronbach's alpha = .91), students' perception of the usefulness of technology in professional practice (Cronbach's alpha = .63), and student's perceptions of the usefulness of technology in counselor education (Cronbach's alpha =.82).

Procedure

All participants were enrolled in a semester long internship (15 meetings) in school counseling in which they received group supervision. Data were collected over a three year period. Two of the researchers using identical syllabi taught both the technology-mediated and face-to-face sections over the course of data collection. Students were required to email "cases" to the faculty member and classmates one week prior to discussion to allow for advanced reflection. Students in the technology-mediated group used either WebCT "live chat" or met face-to-face to discuss the cases. In the hybrid model section, the class began with a face-to-face meeting followed by

approximately 2 technology-mediated classes for every face-to-face class. In total, there were 5 face-to-face meetings and 10 technology-mediated meetings.

Data Analyses

To test the three working hypotheses, scores were compared between the online and face-to-face supervision groups. ANOVAs were performed to analyze the relationship between the hybrid model of supervision and attitudes toward current and future practice using technology. In addition, ANOVAs were also performed to analyze the relationship between the hybrid model of supervision and attitudes toward the quality of supervision. Following the ANOVAs, power analyses were conducted.

Results

Table 1 contains the descriptive statistics for the present study. All instruments administered in the present study were found to have moderate-to-high reliability estimates**,** ranging from .66 to .93 for alpha coefficient estimates and ranging from .71 to .90 for split-half reliability estimates. Substantially higher correlations among the respective subscales of the Working Alliance measure and the Satisfaction Survey over the correlations with other measures, including the Supervision Questionnaire, suggested that the three constructs under investigation (i.e., satisfaction with the quality of supervision, working alliance, and satisfaction with the use of technology) were relatively independent of one another.

Table 1. Descriptive Statistics (N = 76)

Scale	*Mean*	*sd*	*α*	*Split Half*[1]	*Correlations*				
					1	2	3	4	5
1. Supervision Quest.	27.2	2.32	.85	.88	1.00				
Working Alliance									
2. Rapport	6.4	0.64	.93	.88	.26	1.00			
3. Client Focus	7.2	0.93	.89	.90	.39*	.80**	1.00		
Satisfaction Survey									
4. Subscale 1	54.7	11.73	.90	.90	-.26	-.08	-.01	1.00	
5.Subscale 2	10.9	3.60	.77	.82	-.20	-.21	-.22	.57**	1.00
6. Subscale 3	11.0	3.14	.66	.71	-.16	-.15	-.08	.74**	.72**

[1] = split half reliability estimates were corrected for length using the Spearman-Brown formula.
*p < .05 (2-tailed); ** p < .01 (2-tailed).

Analysis of Variance results are presented in Table 2 addressing each of the three research questions under investigation. Our first research question focused on the degree to which use of the hybrid model of supervision was positively associated with attitudes toward use of technology in counselor education. Subscale 3 of The Web-Based, Distance Group Satisfaction Survey (Roberts, et al., 2002) was used to determine perceptions of usefulness of technology in counselor education. A one-way ANOVA was computed comparing the means of the hybrid model of supervision group (M = 9.46, SD = 2.76) and the face-to-face supervision group (M = 12.71, SD = 2.90). The analysis indicated that there was a significant difference between the means of the two groups ($F(1,74) = 25.06$, $p < .001$, $\eta = .50$). Thus, our hypothesis was supported, indicating that use of the hybrid model of supervision was in fact positively related to attitudes toward use of technology in counselor education.

Our second research question focused on the degree to which use of the hybrid model of supervision was positively associated with attitudes toward use of technology in future professional practice. Subscale 2 of The Web-Based, Distance Group Satisfaction Survey (Roberts, et al., 2002) was used to determine perceptions of usefulness of technology in future professional practice. The one-way ANOVA computed indicated a significant difference between the hybrid model of supervision group (M = 9.56, SD = 2.72) and face-to-face supervision group (M = 12.71, SD = 3.16) ($F(1,74) = 21.87$, $p <.001$, $\eta = .48$). Thus, our hypothesis was supported, indicating that use of the

hybrid model of supervision was positively associated with attitudes toward use of technology in future professional practice.

Table 2. Analysis of variance results, including Cohen's effect size (ES) f-values

Source	*df*	*F*	η (η^2)	*p*	*ES(f)*
Web-Based, Distance Group					
Satisfaction Survey: Subscale 1	1/74	28.94	.53 (.28)	.001	.61
Satisfaction Survey: Subscale 2	1/74	21.87	.48 (.23)	.001	.55
Satisfaction Survey: Subscale 3	1/74	25.06	.50 (.25)	.001	.58
Supervisory Working Alliance					
Subscale 1: Rapport	1/65	1.08	.14 (.02)	.30	.15
Subscale 2: Client Focus	1/65	2.48	.20 (.04)	.12	.20
Supervision Questionnaire	1/74	.08	.03 (<.01)	.78	.03

Our third research question focused on the degree to which the two groups differed in their perceptions of the quality of supervision. We predicted that use of the hybrid model of supervision would result in no significant difference between groups on perceptions of quality of supervision. Subscales 1 and 2 of the Supervisory Working Alliance Inventory: Trainee Form (Efstation, Patton, & Kardash, 1990), the Supervision Questionnaire (Ladany, et al., 2004), and Subscale 1 of The Web-Based Distance Group Satisfaction Survey (Roberts, et al., 2002) were used to determine attitudes toward quality of supervision.

The one-way ANOVA computed on the Rapport subscale of the Supervisory Working Alliance Inventory: Trainee Form indicated no significant difference between the hybrid model of supervision group (M = 6.53, SD = 0.58) and face-to-face group (M = 6.37, SD = 0.69) groups ($F(1,65) = 1.08$, ns, $\eta = .14$). Thus, our hypothesis was supported, indicating that participants in the hybrid model of supervision group did not significantly differ from the face-to-face group in their perceptions of supervisory rapport.

The one-way ANOVA computed on the Client Focus subscale of the Supervisory Working Alliance Inventory: Trainee Form indicated no significant difference between the hybrid model of supervision group (M = 6.39, SD = 0.66) and face-to-face group (M = 6.09, SD = 0.90) groups ($F(1,65) = 2.48$, ns, $\eta = .20$). Thus, our hypothesis was supported, indicating that participants in the hybrid model of supervision group did not significantly differ from the face-to-face group in their perceptions of supervisory client focus.

The one-way ANOVA computed on the data collected from the Supervision Questionnaire indicated no significant difference between the hybrid model of supervision group (M = 29.44, SD = 3.52) and face-to-face group (M = 29.20, SD = 3.87) groups ($F(1,74) = .08$, ns, $\eta = .03$). Thus, our hypothesis was supported, indicating that students experiencing the hybrid model of supervision did not significantly differ from students experiencing face-to-face supervision in terms of satisfaction with supervisory experience.

The one-way ANOVA computed on the data collected from the Web-based, Distance Group Supervision survey indicated a significant difference between the hybrid model of supervision group (M = 54.39, SD = 11.55) and face-to-face group (M = 68.94, SD = 11.99) ($F(1,74) = 28.94$, $p < .001$, $\eta = .53$). Thus, our hypothesis was rejected using this subscale since results indicated that use of the hybrid model of supervision was in fact positively associated with attitudes toward the quality of supervision.

Effect Size and Power Analyses

Traditionally, statistical analyses of empirical findings test the proposition that the phenomenon under investigation is either present or not in the population (Cohen, 1988). This is accomplished by testing the null hypothesis positing that the phenomenon does not exist in the population, after which it is rejected or not. However, such results say little about the actual results found in the study. For instance, if the null hypothesis is rejected, are the "significant" findings small, medium, or large? Moreover, what is the likelihood that the results found in one sample would subsequently be found in other samples from the same population? These questions can be addressed by the investigation of a nonzero effect size and power analyses.

In the present study, Cohen's (1988, pp. 274-288) *f*-value was used as the effect size index; *f*-values were determined using Cohen's tables. An effect size was evaluated as follows: $f < .10$ as no effect, $.10 <= f < .25$ as a small effect, $.25 <= f < .40$ as a medium effect, and $f > = .40$ as a large effect size. Each of the three Satisfaction Survey subscales yielded large effect size values (i.e., .61, .55, and .58, respectively). Both Supervisory Working Alliance subscales (i.e., Rapport and Client Focus) produced small effect size values (i.e. .15 and .20, respectively), and the Supervision Questionnaire yielded no effect size (i.e., .03).

Power analyses were conducted only for large effect-size findings (i.e., Satisfaction Survey subscales 1, 2, and 3). To minimize the capitalization on chance due to the multiple statistical tests, power analyses were conducted at the Type I error rate of $\alpha = .01$. Results of the power analyses showed a very high power for all three subscales (i.e., power exceeding .995). Thus, for each Satisfaction Survey subscale, one would expect to reject the null hypothesis in 99 out of 100 random samples from the present population studied.

Discussion

Results of the study indicated that the technology-mediated group had more positive attitudes about the use of technology in counselor education than the face-to-face group (hypothesis 1). These results support earlier research (Hayes & Robinson, 2000) which found that "high computer users" were shown to have more positive attitudes toward technology than those not classified that way. As mentioned in the procedure section, the hybrid model consisted of a 2:1 ratio between technology-mediated and face-to-face supervision giving students consistent experience over time with technology. The fact that there was consistency may have alleviated some of the limitations of the use of technology in supervision identified by Olson, Russell and White (2001). For instance, slowness in responding to supervisees' consultation questions becomes a moot point when groups meet weekly. Moreover, another limitation, that computer-mediated communication can overwhelm the student and instructor with endless opportunities to interact (Hara, Bonk, & Angeli, 2000), was not experienced by the technology-mediated group. This may have been a result of specific time frames used for both face-to-face and technology-mediated chat room discussions.

Similarly, hypothesis 2 was supported; that is, the hybrid model of supervision was positively associated with attitudes toward use of technology in future professional practice. The benefits of the hybrid model, which includes opportunity for equal and evolving participation among all members (Janoff & Schoenholtz-Read, 1999) may have influenced the technology-mediated group to envision themselves as users of technology in the future. Although the face-to-face group also experienced equal and evolving participation, they did not use technology to do so; thus any attitude toward technology in future professional practice would not be substantiated by actual experience. Also, the technology-mediated group had the opportunity to experience the development of insights and communication as a result of the hybrid model of supervision (Gamon, Sorlie, Bergvik, & Hoifodt, 1998), and most likely assumed that this type of communication would be possible in the future.

Hypothesis 3 was also supported. With the exception of one subscale, there was no significant difference between groups on perceptions of quality of supervision. This finding supports DeBourgh's (1999) research which indicated that the satisfaction of students experiencing distance learning was not significantly different from students receiving face-to-face learning. Moreover, it appears that the results found in the Roberts et al. (2004) subscale substantiates earlier research (Gamon, Sorlile, Bergvik, & Hoifodt, 1998) which found that the hybrid model of supervision actually may enhance the quality of supervision.

Given these findings, the hybrid model of supervision may be the answer to the need for outreach to rural areas and for increasing students' access to qualified supervisors (Olson, Russell, & White, 2001). Likewise, adopting a hybrid model of supervision appears to address one the limitations, namely, that technology-mediated relationships can take longer to form than face-to-face relationships (Hara, Bonk, & Angeli, 2000; Myrick & Sabella 1995). In acknowledging that a positive working relationship is critical (Ladany, Ellis, & Friedlander, 1999), we suggest that the initial meeting be held face-to-face, which will enable the students to meet and interact with the supervisor. At the same time, students will be able to begin their own bonding process with each other. The initial meeting can also address other identified limitations such as confidentiality and ethics, particularly as they relate to supervision via the internet. Moreover, these topics can be discussed not only during face-to-face meetings, but also in the weekly chat–room discussions.

Our research indicates that the hybrid model of supervision is a positive experience for students. But it will likely become a negative experience if students are not trained adequately or if the supervisors lack access to computer support (Janoff & Schoenholtz-Read, 1999). We found that after students receive information about the chat-room process (during the first meeting), it is important to hold a "practice" session, where students and supervisor meet informally. This allows both supervisor and students to confirm that the process is working and allows them to address any technical difficulties before supervision occurs. Also, it is necessary for the supervisor to have computer support in case any problems arise during the live chat-room time. All of these necessary arrangements must be made before the first face-to-face meeting so that the technology aspect of the chat runs as smoothly as possible and the focus can remain on supervision.

As with any study, ours has limitations. The Midwestern location and homogeneity of participants may limit the applicability of the research to other areas. Two of the surveys are unpublished and although pilot studies were initially done on the Web-Based Distance Group Supervision Survey (Roberts, et al., 2002) more work is needed to ensure its validity and reliability. Future studies of the hybrid model of supervision might include measures of satisfaction among practicing school counselors. It may be that school counselors in rural areas will feel less alienated from colleagues if they participate in a weekly chat.

Conclusion

One of the important findings of this study is that school counseling interns who experienced technology-mediated supervision were more satisfied with their experience than were the interns who met face-to-face with their supervisor. Additionally, interns in the technology-mediated group were more likely than the face-to-face group to have a positive attitude toward the use of technology in professional practice. Counselor Educators can use the hybrid model of supervision to show students how they can seek supervision or consultation about the varied kinds of issues they will be facing when they are working as school counselors. For example, our hybrid model of supervision includes discussion of cases and situations similar to the primary functions suggested in previous research: clinical, developmental, and administrative tasks (Barret & Schmidt, 1986; Henderson, 1994) as well as case conceptualization skills (Butler & Constantine, 2006).

These findings have implications for school counseling interns as well as practicing professionals. This not only includes school counselors, but also other fields such as health (e.g., nursing, medical and psychology training) and education (e.g., student teaching). The importance for supervision has been recognized by school counselors and other professionals. It is particularly important that these professionals utilize emerging technologies including Web 2.0 tools for supervision, especially for those who live in rural areas and have little access to colleagues. However, communication in a cyber environment is not without problems. The hybrid model used in this study addresses the concerns of some researchers about the difficulty of establishing the interpersonal connectedness required for effective communication absent face-to-face communication (Wilczenski & Coomey, 2006). Thus, if practicing professionals who utilize supervision make use of technology for establishing connections, they might be better served if they also included occasional face-to-face meetings.

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Telehealth in clinical supervision: a comparison of supervision formats

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Summary

Nine counselling psychology students were enrolled in a 12-week pilot practicum (i.e. a work placement) for either one hour of course credit (six students) or three hours (three students). Group supervision was provided both in-person and by videoconferencing. Each trainee completed a measure evaluating their satisfaction with supervision (Supervisory Satisfaction Questionnaire, SSQ) and the supervisory relationship (Supervisory Working Alliance Inventory – Trainee Version, SWAI-T). The student's self-efficacy was also tracked during the semester (Counselling Self-Estimate Inventory, COSE). Trainees rated their satisfaction with videoconferencing similarly to the in-person format. The supervisory relationship also did not appear to be affected by the videoconferencing format. The COSE scores indicated that the students increased in counsellor self-efficacy by the end of the semester. Trainees reported that their supervisory needs were met and believed that videoconferencing was a viable format for supervision, although such a format still needed to be augmented by in-person contact. Providing better access to supervision and professional support using technology is one step towards improving health care in rural areas.

Introduction

There is a shortage of mental health professionals in rural areas.[1] One-third of America's most rural counties lack any psychologists and an even larger proportion lack any kind of specialist mental health service.[2] Due to the scarcity of psychologists in rural areas, the opportunities for collaboration, referrals and support between therapists is limited.[3] Without good supervision and a professional support system, rural mental health professionals often feel overwhelmed,[4] report lower job satisfaction, become susceptible to burnout and provide lower quality services.[5] However, travelling long distances for supervision takes time and money, and leaves less time to provide services for a population that is already dramatically underserved.

The use of telehealth to provide clinical supervision, sometimes called telesupervision, has been suggested as an efficient and affordable way to address the problems of training and professional support. Telesupervision offers the opportunity to maximize the use of direct supervision time while simultaneously ensuring proper credentialing and professional education and training in specific areas of supervision.[6]

Accepted 30 May 2009
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Telesupervision programmes have been developed both domestically[7–9] and internationally.[10] Miller *et al.* described an internship programme located in a rural setting that had difficulty finding qualified supervisors.[7] To maintain supervisory accreditation standards, a telehealth-based model of supervision was developed that used videoconferencing, email and other techniques to provide clinical supervision. The response to this programme was rated favourably by interns who used it, which is consistent with other telesupervision research. For example, those in remote areas who were supervised by videoconferencing reported high levels of satisfaction[10] and feelings of reduced isolation.[11]

Telesupervision has been implemented internationally as a successful means of increasing retention rates of psychologists, training interns in rural areas such as northern Canada[12] and outlying regions of Norway,[13] as well as helping to train residents at academic institutions in Norway.[14] Despite concerns about reduced non-verbal cues, all participants in the latter study were satisfied with, and would recommend videoconferencing as an acceptable adjunct to face-to-face supervision for some supervision sessions.[14] Many of those supervised reported that paradoxically, the limited visual cues imposed by videoconferencing improved the quality of their experiences due to the increased emphasis on the verbal aspects of communication. Respondents stated that videoconferencing increased their insight, their ability to

Journal of Telemedicine and Telecare 2009; **15**: 356–361 DOI: 10.1258/jtt.2009.090401

perceive cues embedded in verbalizations and their dexterity in comprehending chaotic feelings and thoughts.

Research in telesupervision has provided generally positive results. However, much of the literature is theoretical, descriptive or lacks controlled studies that have utilized reliable measures. The purpose of the present study was to answer the questions:

(1) Are those supervised via videoconferencing as satisfied as those supervised face-to-face?
(2) Does the supervisory relationship differ between supervision formats?
(3) Is counsellor self-efficacy affected by supervision format?
(4) Does the level of clinical training influence trainee perceptions of the supervision modalities?

Methods

The study participants were nine graduate students (eight females). There were two African-American and seven White participants. The mean age of the participants was 29 years (SD = 6). The students were enrolled in a 12-week pilot practicum (i.e. a work placement) during summer 2008 for either one ($n = 6$) or three ($n = 3$) hours of course credit. Students were graduate masters ($n = 2$) and doctoral students ($n = 7$) in a counselling psychology programme at a large southeastern university. The students completed the practicum in a variety of field settings, including a university counselling centre, a summer programme for at-risk youths and a community mental health centre. The supervisor for the practicum was a Latino male and an adjunct faculty member. He was a licensed psychologist with 10 years of experience as a supervisor.

Measures

There were three main measures:

(1) Supervisory Satisfaction Questionnaire (SSQ). The SSQ is an 8-item scale, using a four-point scale (1 = low to 4 = high) to measure satisfaction with various components of supervision.[15] Ladany *et al.* reported that the SSQ had high internal consistency (Cronbach's alpha = 0.96) and found that satisfaction was positively related to supervisee disclosure in the supervision process.[15] For the present study, the coefficients for the first and last administrations were 0.97 and 0.94, respectively;
(2) Supervisory Working Alliance Inventory – Trainee Version (SWAI-T). The SWAI-T is a 19-item measure of the supervisees' perspectives of the supervisory relationship.[16] The measure consists of two subscales: Rapport (e.g. 'I feel comfortable with my supervisor') and Client Focus (e.g. 'My supervisor helps me work within a specific treatment plan with my clients'). Each subscale is rated on a 7-point Likert-type scale (1 = almost never to 7 = almost always). Confirmatory and discriminatory evidence was also presented in the Efstation *et al.* study, finding significant correlations with the Supervisory Styles Inventory and lower correlations with a supervisor version of the same measure.[16] The internal consistency coefficients for the Rapport and Client Focus scales were 0.90 and 0.77, respectively. Patton and Kivlighan[17] found the scales to correlate highly, and therefore used the scales as a composite in their study. As in their study, we combined both scales. The coefficients for the present sample were 0.97 (first administration) and 0.99 (last administration);
(3) Counselling Self-Estimate Inventory (COSE). The COSE is a 37-item scale using a 6-point Likert scale (1 = strongly disagree to 6 = strongly agree).[18] The COSE is designed to measure a counsellor's self-efficacy across five counselling areas: Microskills, Process, Dealing with Difficult Client Behaviours, Cultural Competence and Awareness of One's Values. Larson *et al.* reported that the five factors accounted for 36% of the variance and demonstrated moderate correlations with a measure of self-concept (convergent validity) and weak correlations with measures of personality and social desirability (discriminant validity).[18] Internal consistency estimates in the same study ranged from 0.88 (Microskills) to 0.62 (Values) and demonstrated an overall coefficient of consistency of 0.93. Based on the recommendations of the scale's author, only the composite score was used in the present study. The coefficient for the total scale scores for the first and last administrations of the COSE in the present study were 0.93 and 0.98, respectively.

Procedure

The students enrolled in the pilot practicum met over a 12-week period with the same faculty supervisor. The course rotated every three weeks between using in-person supervision and distance supervision via videoconferencing. We decided to start with the in-person format to facilitate the supervisory alliance. Trainees enrolled for one hour of course credit were required to attend one supervisory session per rotation for a total of four supervisory sessions. The students enrolled for three hours of course credit were required to attend all 12 classes.

In both the in-person and videoconference formats, class time comprised a didactic component, case presentations by the students and discussion/observation of their work with clients. Trainees videotaped their work (i.e. psychotherapy sessions) in their respective practicum sites. The recorded video was brought to class and observed over the videoconferencing network, enabling all participants to see and discuss the recorded video simultaneously. The majority of class time was focused on case presentations and discussion of the trainees' work with clients. All supervisory meetings were in a group format and lasted 2.5 hours.

Videoconferencing was conducted at a bandwidth of 384 kbit/s using the Kentucky Tele-Linking Network. The supervisor was in a distance learning technology classroom that had two 69-cm monitors side-by-side, one monitor to view students and the other for self-view of the supervisor. The students were in a distance technology classroom at a local community and technical college elsewhere in the same city as the supervisor. The distance technology room for the students had two 132-cm monitors side-by-side (one to view the supervisor and one that allowed trainees to view themselves) with push-to-talk microphones. The student room had a camera that automatically tracked the student who activated a microphone.

During the last rotation (videoconferencing format), six of the trainees (3 one-hour and 3 three-hour enrollees) agreed to participate in a supervisory session using PC-based conferencing (Skype). The session was conducted via the group chat format, where only audio was available. Trainees participated on separate computers. The measures provided did not evaluate this session, only the in-person and videoconferencing formats. However, students were asked about this experience qualitatively.

All students completed a package of measures at the end of each rotation (or the class that was attended for each rotation for the one hour enrollees). Each trainee completed a measure evaluating their satisfaction with supervision (SSQ) and the supervisory relationship (SWAI-T). The student's self-efficacy was also tracked across the semester (COSE). Data from the initial rotation (in-person format) was not included because the trainees enrolled for one hour only had to attend the initial class. Most of the first class was an introduction and overview of the course, with little actual clinical supervision being provided. Therefore, measuring satisfaction and the supervisory alliance was not appropriate. At the end of the semester both the supervisor and student completed a structured qualitative interview as used in the Gammon *et al.* study that evaluated supervision via videoconferencing.[14]

Results

Satisfaction with supervision

Trainees rated their satisfaction with videoconferencing similarly to the in-person format. When comparing the two videoconferencing rotations to the in-person formats, the means were almost identical (see Table 1). There were no differences between the in-person format and the first distance learning rotation, $t = 1.9$, $P = 0.10$ (95% CI −1.2 to 0.1) or second distance learning rotation, $t = 0.9$, $P = 0.40$ (95% CI −0.7 to 1.6). The confidence intervals for both analyses lend support for the null hypothesis. The trainees reported a high level of satisfaction with supervision in both formats.

Supervisory relationship

The supervisory relationship also did not appear to be affected by the videoconferencing format (see Table 1). There were no significant differences between the in-person format and either the first videoconferencing rotation, $t = 0.8$, $P = 0.46$ (95% CI −8.0 to 4.0) or the second videoconferencing rotation, $t = -0.2$, $P = 0.86$ (95% CI −9.0 to 7.7). The composite scores indicate that trainees felt that they had a good supervisory relationship with their supervisor and were consistent with, if not a little higher than other studies assessing the supervisory relationship.[19]

Counsellor self-efficacy

Previous research has demonstrated that counsellor self-efficacy tends to increase with clinical supervision.[20] The same trend was observed in the present study (see Table 1) where utilizing the videoconferencing format did not seem to reduce counsellor self-efficacy. The counselling self-efficacy scores for both beginning trainees (four students with no previous practicum experience) versus more advanced trainees (five students with at least two practicums completed) indicated that both groups increased in counsellor self-efficacy by the end of the semester (see Figure 1).

Perceptions of supervision

Counsellor trainees have different supervisory needs depending upon their level of development.[21] The more advanced students rated their supervision experience a little higher than the beginning trainees (see Figures 2 and 3). However, there were no significant differences when comparing the beginning and advanced trainees' satisfaction, $t = -0.6$, $P = 0.60$ (95% CI −6.9 to 4.3) and the supervisory relationship, $t = -0.9$, $P = 0.39$ (95% CI −47 to 21) for the second distance learning rotation.

Table 1 Mean values for the COSE, SSQ and SWAI-T by supervision format

	Time 0: In-person		Time 1: Videoconferencing		Time 2: In-person		Time 3: Videoconferencing	
Measure*←	Mean	SD	Mean	SD	Mean	SD	Mean	SD
COSE	174.1	18.0	177.1	23.8	174.1	22.0	182.4	28.1
SSQ			29.1	2.7	29.7	2.6	29.2	3.4
SWAI-T			113.6	13.6	115.6	15.9	116.2	21.0

*COSE, Counseling Self-Estimate Inventory; SSQ, Supervisory Satisfaction; SWAI-T, Supervisory Working Alliance Inventory – Trainee

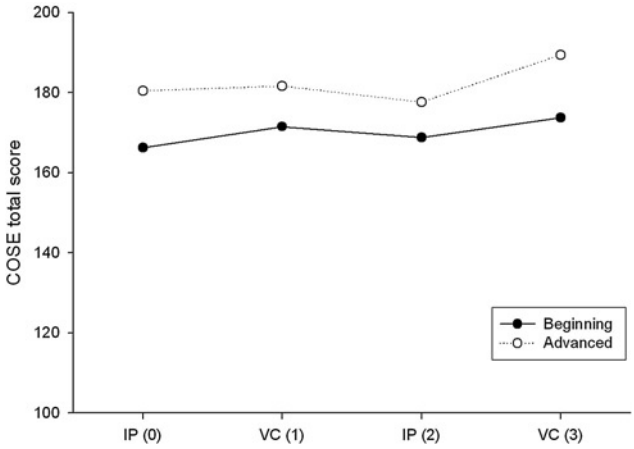

Figure 1 Counsellor self-efficacy scores for in-person and videoconferencing formats. IP, in-person format; VC, videoconferencing format

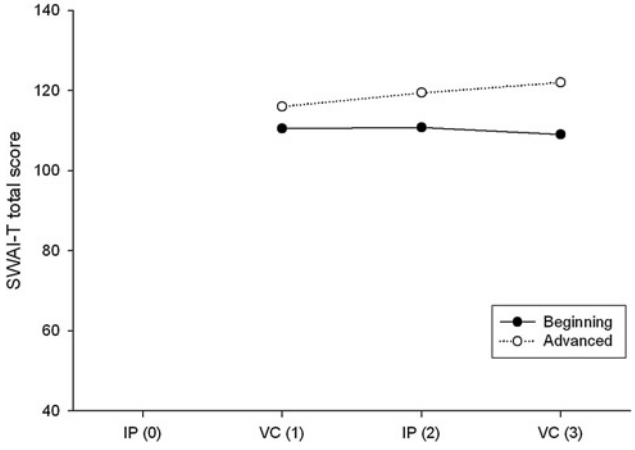

Figure 2 Supervision satisfaction scores for in-person and videoconferencing formats. IP, in-person format; VC, videoconferencing format

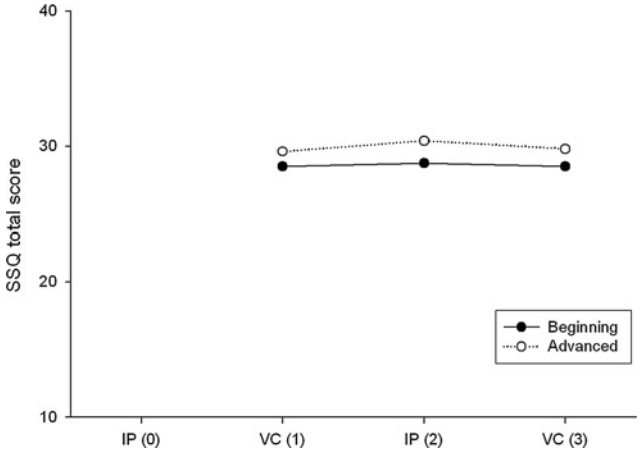

Figure 3 Supervisor relationship scores for in-person and videoconferencing formats. IP, in-person format; VC, videoconferencing format

These confidence intervals were larger due to more variability in the scores of the beginning trainee group.

Qualitative data

The follow-up structured interview was consistent with the satisfaction and supervisory relationship measures and provides additional evidence that trainees found videoconferencing to be a viable alternative to in-person supervision. A summary of the themes expressed based on the content areas of the interview is presented below:

(1) Recommendation to someone who does not want to travel to receive in-person supervision. Trainees unanimously recommended that videoconferencing was a viable format for supervision and would be adequate for meeting supervisory needs. Examples of comments included: 'I would say that videoconferencing supervision could be adequate and effective as long as the technology works correctly' and 'I received the same amount of support and guidance in both formats.' The feedback from the supervisor reiterated that videoconferencing supervision was useful, providing the videoconferencing equipment was reliable.

(2) Differences between in-person and videoconferencing formats. Trainees felt that the videoconferencing format was more structured and more rigid. Several commented that there was more emphasis on staying on task and being clear verbally. However, trainees generally thought this was acceptable and a few believed that supervision was more efficient and goal-directed because of the format. This is consistent with the results of the Gammon *et al.* study that found some of the limitations of videoconferencing supervision to have paradoxical benefit.[14] Examples of comments included: 'I think more time in videoconferencing went toward more intellectual and less personal content; taking care of business so to speak' and '...it did not make me feel uncomfortable that we got right down to the supervision and neglected to chit-chat. I felt we actually accomplished more during the videoconferencing supervision.' Trainees stated that the videoconferencing condition was generally less personal, but did not believe that quality or the goals of supervision were compromised. The interview with the supervisor revealed his belief that this format promoted more of a reporting type of interaction rather than discussion.

(3) Supervisory relationship. In general, trainees said that they felt comfortable with their supervisor via videoconferencing but also commented that it might be important to have an established relationship in person before engaging in a videoconferencing supervisory relationship. Most trainees, although stating that videoconferencing led to supervision that met their needs, were not comfortable with having a supervisory relationship that was strictly in the videoconferencing format. It was the supervisor's opinion that some of the emotional elements were lost in videoconferencing supervision, but he attributed this difference to technology limitations. He listed decreased self-disclosure, less

emotional expression and subtleties that made role-play less effective as negatively affecting emotional content and intimacy. He added that the loss of emotion could have been a combined effect of the group supervision format and videoconferencing, both of which could make displays of vulnerability in supervision more intimidating.

(4) Videoconferencing concerns and recommendations. Most of the positive comments were tempered with concerns about the technology, saying videoconferencing was viable and useful 'if the technology is reliable.' Some of the students expressed mild frustration with the quality of the picture and having to repeat things due to transmission delays. Technology concerns listed by the supervisor included an echo on the audio; occasional freezing of the picture; loss of subtle nonverbal cues due to poor picture quality; and excessive delays in making the video link connection.

One suggestion was that videoconferencing should only be used for more advanced trainees, and that videoconferencing may not be appropriate as the sole form of supervision for beginning trainees. Other concerns/suggestions centred on keeping the group small and other behavioural setting matters (e.g. having a circular table to sit around), having the format structured to facilitate trainees not talking over one another, and making sure the trainees and supervisor were familiar and comfortable with the technology. The audio group chat format (i.e. Skype) was also well-received and participants believed that it was a viable alternative and that the convenience and low cost were the most attractive features. However, they felt this format would only be acceptable as an adjunct to forms of supervision that have visual images.

Discussion

Rural areas are typically underserved for mental health services. The reasons include the increased likelihood of living in poverty and the paucity of services available. This puts enormous pressure on those who do provide services in remote, rural areas. They often have little support or supervision. New professionals not only face these concerns, but also the need for supervision for licensure. Telehealth offers the possibility of addressing such matters and perhaps assisting with attracting new professionals and retaining existing mental health professionals.

Our exploratory study investigated a pilot clinical supervision course that alternated between an in-person and videoconferencing format over a 12-week period. Although the sample size was small, the trainees clearly felt that supervision via videoconferencing was a viable alternative to in-person supervision. Satisfaction with supervision and the supervisory relationship were similar in both formats. Evidence was further strengthened by qualitative data that trainees felt they were able to have their supervisory needs met in the videoconferencing format. This is consistent with other studies comparing the same formats. One difference, however, is that the present study was conducted using a group supervision format. Many students in the present study indicated that they would have liked to have experienced individual supervision using videoconferencing.

Although the feedback was favourable for videoconferencing, trainees did not feel that it should be the only format, especially for trainees with less experience. Trainees expressed having less intimacy with their supervisor, but this was not captured by a measure of the supervisory relationship nor was it clarified how less intimacy affected their supervisory experience. Less intimacy may have led to a reluctance of trainees to disclose perceived concerns or weaknesses regarding performance or to share other information that may have increased vulnerability. Openness to feedback and a willingness to discuss perceived weaknesses in supervision are typically valued trainee attributes in the supervisory process. In addition to experience, these attributes should be considered for supervision via videoconferencing. Students who commented on liking the formality of videoconferencing may have been those who were more avoidant of intimacy and disclosure. Videoconferencing was considered a viable but not equal substitute to in-person supervision. Some of the trainees indicated that they had to work harder in the videoconferencing format, and perhaps felt that meeting in-person simply required less energy to communicate.

The present study had limitations because of the small sample size and there being only one supervisor. In addition, it was not ideal that some students only attended four sessions (those enrolled for one hour of course credit). However, their data did not differ from the students who attended every session. Another limitation of the present study that may have influenced the results was the problems that occurred with the technology. The equipment used was obsolescent and if picture and sound quality had been better, trainees might have perceived even fewer differences. Larger studies need to be conducted that have more statistical power and allow for random assignment to one condition or the other. A confounding factor in the study was that trainees were able to establish a relationship in person with the supervisor and also knew that they would see him in person. Therefore, it is hard to generalize how trainees or new professionals would feel about having a relationship that was predominately or entirely conducted via videoconferencing.

In this study there were several logistical glitches that could have affected the results. Because it was not possible to use the distance education room when not using the distance education equipment, a different location had to be used for the in-person meetings. Therefore, the results may have been influenced by the suitability of each location for supervision. This shifting back and forth of rooms also led to at least one absence due to confusion about location. On two occasions, the distance education link was delayed significantly (once for over 30 minutes). This delay

sometimes led to the supervisor being preoccupied during the actual supervision which may have reduced the quality of supervision. The delays may also have interfered with building the supervisory relationship. The quantitative results for both aspects in this case, however, did not appear to be affected.

On one occasion a student made a case presentation over the video link using an accompanying PowerPoint presentation. During the presentation there was a malfunction and her slides stayed frozen at the receiving end, despite no apparent problems at the transmitting end. She therefore described 10 slides to the audience without knowing that they were still viewing an earlier slide. Other problems that occurred were temporary freezing of the picture at the supervisor's end and a sound delay that contributed to people talking over each other.

In the Skype trial, the sound quality was good but the connection continually dropped out every 5–7 minutes. Although these technical problems caused little confusion, they could have had deleterious effects on the willingness of students to self-disclose or talk about more sensitive matters. For more rigorous investigation into telesupervision to take place, these types of problems need to be solved. Additional variables should also be measured. One way to look at quality of supervision would be to gather outcome data on the trainees' work with their clients. Outside raters who are blind to the experimental conditions could also be employed. Lastly, focus should be placed on measuring the quality of discussion in the supervision, examining variables such as trainee self-disclosure, risk-taking, and development of the students' ability to present meaningful case material. Such studies are difficult to conduct, given the logistics and requirements. Further research also needs to be conducted on the question of trainee experience. In the present study, there appeared to be some evidence that trainees with less experience were less satisfied with the videoconferencing format.

It is hoped that our study will stimulate interest in larger, random assignment studies to investigate the potential advantages that technology can offer to rural practitioners. Technological advances offer many exciting possibilities and have made a 'virtual supervisory' relationship more plausible. Providing better access to supervision and professional support using technology is one step towards improving health care in rural areas.

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Attachment E

REGISTRANT AND SUPERVISOR

PRIVATE PRACTICE EMPLOYMENT AND SITE REQUIREMENTS

MFT or PCC INTERN

- Must be employed by or volunteer at the private practice
- Services must be performed where the employer regularly conducts business BUT
- May provide services at other locations if under the direction and control of the supervisor and employer

Private Practice Employer

SOLE PROPRIETOR

SUPERVISOR

- Must be the owner

OR

- Must be employed by the intern's employer

AND

- Practice at the same site as the intern's employer

Private Practice Employer

CORPORATION

SUPERVISOR

- Must be a shareholder

OR

- Must be employed full-time by the corporation

AND

- Practice at the same site as the intern's employer

AND

- Be actively engaged in performing professional services at and for the corporation

ASWs must be employed by or volunteer at the private practice. However, the LCSW profession does not have the other requirements shown above for LMFT and LPCC. Also, supervision can be provided by a person not employed by the ASW's employer by signing a written agreement with the employer to take supervisory responsibility for the ASW's services. Not allowed in private practice for the other professions.

References: Business and Professions Code (BPC) and Title 16, California Code of Regulations (16CCR)

LMFT: BPC sections 4980.43(f)(4), 4980.43(j), 4980.45(b) and 16CCR section 1833(d)(1)

LPCC: BPC sections 4999.455(b) and 4999.47(f); 16CCR section 1820(f) *LCSW: BPC section 4996.23*

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Memo

To: Supervision Committee Members **Date:** April 12, 2016

From: Christy Berger, Regulatory Analyst **Telephone:** (916) 574-7817

Subject: **Methods of Monitoring/Evaluating Supervisees**

I. Background

A supervisor's requirements for monitoring supervisee performance and providing feedback, as defined in law, currently differ between the professions. The Committee has been working toward consistency when appropriate, and this is an area which could be improved. Additionally, staff have identified areas where the language regarding supervisee performance and feedback could be strengthened, based on the Board's supervision survey, Committee discussion and a review of requirements set forth by other entities (California Board of Psychology and other states).

II. Current California Requirements and Differences Between Professions

See Attachment A for excerpts from California law pertaining to monitoring and evaluating supervisee performance.

A. Requirements Common to LCSW, LMFT and LPCC

The LMFT and LPCC professions have exactly the same definition of "supervision," with the LCSW profession having several differences *(as indicated throughout)*:

Supervision includes:

- Ensuring that the extent, kind, and quality of counseling performed is consistent with the education, training, and experience of the person being supervised; *(LCSW: missing "education")*
- Reviewing client/patient records;
- Monitoring and evaluating assessment, diagnosis, and treatment decisions of the intern or trainee; *(LCSW: missing "diagnosis")*

- Monitoring and evaluating the ability of the intern or trainee to provide services at the site(s) where he or she will be practicing and to the particular clientele being served; and
- Ensuring compliance with laws and regulations governing the practice of (profession).

Supervision shall include that amount of direct observation, or review of audio or video tapes of therapy, as deemed appropriate by the supervisor. *(LCSW: missing this sentence)*

Recommendation: *The Committee should consider making the above language consistent between the professions.*

B. Requirements Common to LMFT and LPCC

LMFT and LPCC law require supervisors to "monitor and evaluate the extent, kind, and quality of counseling performed by the intern" by using any of the following methods:

- Direct observation;
- Review of audio or video tapes of therapy;
- Review of progress and process notes and other treatment records; OR
- By any other means deemed appropriate by the supervisor.

Recommendation: *The Committee should consider adding the above language to LCSW law, and may want to discuss whether "or any other means deemed appropriate" adequately protects clients and supervisees.*

C. Requirements Common to LCSW and LPCC

LCSW and LPCC law require the supervisor and the supervisee to develop a "supervisory plan" that describes the goals and objectives of supervision, on a form required by the Board. The registrant is required to submit the initial original supervisory plan to the board upon application for licensure. See Section III.C of this memo for additional discussion of the *Supervisory Plan* form.

Recommendation: *The Committee should consider implementing a Supervisory Plan form for the LMFT profession. See Attachment B for a draft of this form, which includes changes suggested by licensing staff.*

D. Requirements Only in LCSW Law

LCSW law requires the supervisor to "complete an assessment of the ongoing strengths and limitations of the associate. The assessments shall be completed at least once a year and at the completion or termination of supervision. A copy of all assessments shall be provided to the associate by the supervisor."

Recommendation: *The Committee may want to consider implementing this language for the LMFT and LPCC professions, as these laws do not address ongoing assessments.*

III. Other Possible Changes for Consideration

Staff reviewed the laws in other states[1] to gain a sense of what is commonly required in the field pertaining to the definition of supervision, monitoring the supervisee, and evaluation of the supervisee's performance (see Attachment C). The California Board of Psychology's (BOP) requirements were also reviewed.

A. Board of Psychology's Requirements

The BOP's regulations require supervisors to develop a plan that includes "goals and objectives of the plan for supervised professional experience." This plan must be submitted to the BOP upon application for licensure, unless the setting is a private practice, where it must be submitted prior to initiating supervision for approval by the BOP. The reason is due to "the lack of standardization in training" in a private practice, and "to assure protection of clients."

Additionally, the BOP requires supervisors to submit an annual report for each supervisee, certifying that the "psychological functions performed" were "at a level satisfactory to ensure safety to the public." Upon completion of supervised experience, the BOP requires supervisors to indicate whether the supervisee "…demonstrated an overall performance at or above the level of minimal competence expected for the supervisee's level of education, training and experience."

B. California and Other States

1. *Monitoring and Knowledge of Each Client:* California law implies that all client records be reviewed by the supervisor but does not state this explicitly. For example, LMFT law requires supervision to include "reviewing client/patient records" and "monitoring and evaluating assessment, diagnosis, and treatment decisions." Half of the states surveyed[2] explicitly require each client's record be reviewed in some way, depending on the jurisdiction (see Attachment C for more information on other states).

Recommendation: *Require that the supervisor have knowledge of each client. Two options for possible language: "The supervisor has sufficient knowledge of all clients for whom supervision is provided" or "Supervision includes reviewing the applicant's assessment, evaluation and treatment of each client."*

2. *Frequency of Performance Evaluation:* California law requires supervisors to evaluate supervisee performance and provide feedback, but does not specify how often. Most states require performance to be evaluated on a regular basis (some are specific as to how often, others just state "regularly"). The Board's Supervision Survey indicated that the vast majority of supervisors do evaluate performance on some sort of a regular basis,

[1] Colorado, Florida, Illinois, Indiana, New York, Ohio, Oregon, South Carolina, Texas and Washington
[2] Colorado, Florida, New York, Oregon (LPCC and LMFT), and South Carolina (LPCC and LMFT)

but the Committee may want to consider how often is enough. The Supervisor survey results are below:

How frequently do you provide an informal evaluation to your supervisees? Mark all that apply.		
	Response Percent	**Response Count**
Weekly	45%	177
Monthly	22%	88
Quarterly	25%	100
Yearly	8%	32
Never	4%	14
Other (please specify)	14%	55
	Response Count	**396**
	Skipped Question	**32**
Common Other responses included: Varies, when needed, depends on the setting, when requested, depends on the supervisee		

How frequently do you provide a formal written evaluation to your supervisees?		
	Response Percent	**Response Count**
Weekly	1%	4
Monthly	3%	9
Quarterly	31%	108
Yearly	41%	136
Never	18%	55
Other (please specify)	15%	53
	Response Count	**339**
	Skipped Question	**32**
Common Other responses included; twice a year, at the end of supervision, when requested, as needed.		

3. *Plan for Remediation of Deficits and Supervisory Plan Form*

The list of topics remaining to be addressed by the Committee includes possibly requiring a "written plan for remediation" of deficits in supervisee performance. As previously mentioned, the LCSW and LPCC professions require supervisors to complete a *Supervisory Plan* form at the commencement of supervision that includes goals and objectives (see Attachment B). However, the *Supervisory Plan* form does not address supervisee performance, is not ever required to be updated, and is submitted to the Board upon application for licensure.

Texas is the only state of the ten surveyed that requires a plan for remediation of deficits. Texas law states, *"If the supervisor determines that the supervisee lacks the professional*

skills and competence to practice under a regular license, the supervisor shall develop and implement a written remediation plan for the supervisee."

As indicated in the Board's Supervision Survey, 18% of supervisors never provide a formal written evaluation to their supervisee

Recommendations:

- *Require supervisee performance to be evaluated on a regular basis, and that feedback also be provided on a regular basis. Consider specifying how often.*
- *Determine whether to require a written plan for remediation, and under what circumstances.*

4. Experience Verification

Five of the 10 states surveyed[3] require the supervisor, at the end of supervision, to provide an evaluation of the supervisee's performance to the Board. It is not known what the Boards do with this information, should the evaluation be negative. However, if the Committee is interested in exploring this idea, staff will investigate further and report back.

Attachment A: Excerpts from California law
Attachment B: Draft *Supervisory Plan* form
Attachment C: Supervisor Responsibilities – Other States

[3] Colorado, Florida, Oregon, South Carolina and Texas

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ATTACHMENT A

Excerpts from California Law
Re: Monitoring and Evaluating Supervisee Performance

Title 16, California Code of Regulations (16CCR) and Business and Professions Code (BPC)

LMFT

16CCR§1833(b): The term "supervision", as used in this article, includes ensuring that the extent, kind, and quality of counseling performed is consistent with the education, training, and experience of the person being supervised; reviewing client/patient records, monitoring and evaluating assessment, diagnosis, and treatment decisions of the intern or trainee; monitoring and evaluating the ability of the intern or trainee to provide services at the site(s) where he or she will be practicing and to the particular clientele being served; and ensuring compliance with laws and regulations governing the practice of marriage and family therapy. Supervision shall include that amount of direct observation, or review of audio or video tapes of therapy, as deemed appropriate by the supervisor.

16CCR§1833.1(a)(9): The supervisor shall monitor and evaluate the extent, kind, and quality of counseling performed by the trainee or intern by direct observation, review of audio or video tapes of therapy, review of progress and process notes and other treatment records, or by any other means deemed appropriate by the supervisor.

LPCC

16CCR§1820(b): The term "supervision", as used in this article, includes ensuring that the extent, kind, and quality of counseling performed is consistent with the education, training, and experience of the person being supervised; reviewing client/patient records, monitoring and evaluating assessment, diagnosis, and treatment decisions of the intern; monitoring and evaluating the ability of the intern to provide services at the site(s) where he or she will be practicing and to the particular clientele being served; and ensuring compliance with laws and regulations governing the practice of professional clinical counseling. Supervision shall include that amount of direct observation, or review of audio or video tapes of counseling, as deemed appropriate by the supervisor.

16CCR§1821(b)(9): The supervisor shall monitor and evaluate the extent, kind, and quality of counseling performed by the intern by direct observation, review of audio or video tapes of therapy, review of progress and process notes and other treatment records, or by any other means deemed appropriate by the supervisor.

16CCR§1822(a): All licensed mental health professionals acceptable to the board as defined in Section 4999.12 of the Code who assume responsibility for providing

LPCC (continued)

supervision under section 4999.46 of the Code shall develop a supervisory plan that describes the goals and objectives of supervision and shall complete and sign under penalty of perjury the “Supervisory Plan”, (form no. 1800 37A-521, Rev. 3/10), hereby incorporated by reference.

(b) This supervisory plan shall be completed by each supervisor providing supervision and the original signed plan shall be submitted by the professional clinical counselor intern to the board upon application for examination eligibility.

LCSW

BPC§4996.23(e): The supervisor and the associate shall develop a supervisory plan that describes the goals and objectives of supervision. These goals shall include the ongoing assessment of strengths and limitations and the assurance of practice in accordance with the laws and regulations. The associate shall submit to the board the initial original supervisory plan upon application for licensure.

16CCR§1870(a)(7): The supervisor shall do all of the following:

(A) Ensure that the extent, kind and quality of clinical social work performed by the associate is consistent with the training and experience of the person being supervised.

(B) Review client/patient records and monitor and evaluate assessment and treatment decisions of the associate clinical social worker.

(C) Monitor and evaluate the ability of the associate to provide services at the site(s) where he or she will be practicing and to the particular clientele being served.

(D) Ensure compliance with all laws and regulations governing the practice of clinical social work.

16CCR§1870(a)(11): The supervisor shall complete an assessment of the ongoing strengths and limitations of the associate. The assessments shall be completed at least once a year and at the completion or termination of supervision. A copy of all assessments shall be provided to the associate by the supervisor.

16CCR§1870.1(a): On and after January 1, 1999, all associate clinical social workers and licensed clinical social workers or licensed mental health professionals acceptable to the board as defined in Section 1874 who assume responsibility for providing supervision shall develop a supervisory plan that describes the goals and objectives of supervision and shall complete and sign under penalty of perjury the “Supervisory Plan”, (form no. 1800 37A-521, revised 3/10), hereby incorporated by reference.
(b) This supervisory plan shall be completed by each supervisor providing supervision and the original signed plan shall be submitted by the associate clinical social worker to the board upon application for licensure.

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SUPERVISORY PLAN

Title 16, California Code of Regulations (CCR) ~~S~~sections 1870.1, (add LMFT section later) and 1822 require all ~~a~~Associate ~~c~~Clinical ~~s~~Social ~~w~~Workers, Marriage and Family Therapist Trainees and Interns, and ~~p~~Professional ~~c~~Clinical ~~c~~Counselor ~~i~~Interns, as well as ~~and~~ licensed mental health professionals acceptable to the Board as defined in law ~~Business and Professions Code Section 4996.23(a), 4999.12(h) ,and CCR Section 1874~~, who assume responsibility for providing supervision to those working toward a license as a Licensed Clinical Social Worker, Licensed Marriage and Family Therapist or Licensed Professional Clinical Counselor to complete and sign the ~~following~~ ~~s~~Supervisory ~~p~~Plan form. The original signed plan shall be submitted by the registrant to the board upon application for ~~examination eligibility~~ evaluation of supervised experience.

REGISTRANT: *(Please type or print clearly in ink)*

Legal name: Last	First	Middle

BBS File Number (if known):	Registration Type: ☐ ASW – Number: _____ ☐ MFT Trainee - (No numbers issued) ☐ MFT Intern – Number: _____ ☐ PCC Intern – Number: _____

Address: Number and Street

City	State	Zip Code

Business Telephone ( )	Residence Telephone ( )

Employer Name:	Employer Telephone: ( )

Employment Setting Type:

- ☐ Private Practice
- ☐ Governmental Entity
- ☐ Nonprofit and Charitable Corporation
- ☐ School, College, or University
- ~~☐ Social Rehabilitation Facility/ Community Treatment Facility~~
- ~~☐ Pediatric Day Health and Respite Care Facility~~
- ☐ Licensed Health Facility
- ☐ Licensed Alcoholism or Drug Abuse ~~Recovery or~~ Treatment Facility
- ☐ Community Mental Health Facility

Registrant's Last Name	First	Middle

LICENSED SUPERVISOR: *(Please type or print clearly in ink)*

Name: Last	First	Middle	Telephone Number: ( )

License Type: ☐ LCSW ☐ LMFT ☐ LPCC ☐ Clinical Psychologist ☐ Physician Board-Certified in Psychiatry by the American Board of Psychiatry and Neurology	License ~~No~~Number:	Expiration Date:

Address: Number and Street

City	State	Zip Code

~~Employer Name~~ Were you employed by the same employer as the supervisee? ☐ Yes ☐ No

If NO, provide your employer's name below AND attach letter of agreement with registrant's employer (see the Board's website for a sample letter):

Briefly describe the goals and objectives of supervision for this supervisee:

I certify that I understand the responsibilities regarding clinical supervision, including the supervisor's responsibility to perform ongoing assessments of the supervisee, and I declare under penalty of perjury under the laws of the State of California that the information submitted on this form is true and correct.

Supervisor's Signature Date signed

Registrant's Signature Date signed

The **original** of this form must be submitted to the board upon application for ~~examination eligibility~~ evaluation of supervised experience**.**

Attachment C

10-State Survey - Supervisor Qualifications & Responsibilities / Employer & Work Setting Requirements

States: Colorado, Florida, Illinois, Indiana, New York, Ohio, Oregon, South Carolina, Texas, Washington

STATE	Supervisor Responsibilities
Colorado ***LCSW***	**Has sufficient knowledge of all clients for whom supervision is provided, including face-to-face contact with the client when necessary, to develop and to monitor effective service delivery procedures and the supervisee's treatment plan.** All decisions requiring the special skill, knowledge, and/or training of a social worker are made in collaboration with, and with the approval of, the approved supervisor. Such decisions include, but are not limited to: type, duration, effectiveness, and method of social work services provided; fees and billing procedures; approval of cases; and personal observation, evaluation, oversight, review, and correction of services provided by the supervisee. Must keep records that enable her/him to effectively train, evaluate, and credit the applicant with the exact number of acceptable hours. Must keep and make available the records for 5 years from the date of supervision. Attest to the applicant's satisfactory completion of the required post-degree practice in individual and marriage and family therapy/psychotherapy under supervision and attest to the applicant's having met the generally accepted standards of practice.
Colorado ***LMFT***	SAME AS LCSW ABOVE
Colorado ***LPCC***	SAME AS LCSW ABOVE

STATE	Supervisor Responsibilities
Florida ***LCSW*** ***LMFT*** ***LPCC (LMHC)***	Supervision is the relationship between the qualified supervisor and intern that promotes the development of responsibility, skills, knowledge, attitudes and adherence to ethical, legal and regulatory standards in the practice of clinical social work, marriage and family therapy and mental health counseling. **Supervision is face-to-face contact between an intern and a supervisor during which the intern apprises the supervisor of the diagnosis and treatment of each client,** client cases are discussed, the supervisor provides the intern with oversight and guidance in diagnosing, treating and dealing with clients, and the supervisor evaluates the intern's performance. Supervision includes a focus on the raw data from the intern's clinical work, which is made directly available to the supervisor through such means as written clinical materials, direct observation and video and audio recordings. The intern and supervisor must notify the Board of the supervision and the Board must approve it. The supervisor must attest to satisfactory completion of the supervised experience.
Illinois ***LCSW***	NONE SPECIFIED
Illinois ***LMFT***	Supervision means the direct clinical review, for the purposes of training or teaching by a supervisor, of the applicant's interaction with a client. The purpose of supervision shall be to promote the development of clinical skills. Supervision is face to face conversation with a supervisor, usually in periods of approximately one hour each. The learning process is sustained and intense. Appointments are scheduled on a regular basis. Supervision focuses on the raw data from a supervisee's continuing clinical practice, which is available to the supervisor through a combination of direct live observation, co-therapy, written clinical notes, audio and video recordings, and live supervision.

STATE	Supervisor Responsibilities
Illinois ***LPCC***	Supervision means the review of counseling and case management. Counseling activities must be performed pursuant to the supervisor's order, control, oversight, guidance and full professional responsibility
Indiana ***LCSW***	Supervision must be face-to-face contact between the supervisor and supervisee for the purpose of assisting the supervisee in the process of learning the skills of social work or clinical social work practice.
Indiana ***LMFT***	NONE SPECIFIED
Indiana ***LPCC (LMHC)***	NONE SPECIFIED

STATE	Supervisor Responsibilities
New York ***LCSW***	Supervision means that a qualified supervisor is available for consultation, assessment and evaluation when professional services are being rendered by an applicant and the supervisor exercises the degree of supervision appropriate to the circumstances. **Supervision includes:** • **Reviewing the applicant's assessment, evaluation and treatment of each client** under his or her general supervision • Providing oversight, guidance and direction in developing clinical skills • Appropriate oversight of all services provided under his or her supervision. **Supervision consists of:** • **Apprising the supervisor of the diagnosis and treatment of each client** • Providing oversight and guidance in diagnosing and treating clients • Regularly reviewing and evaluating the applicant's professional work • Maintain records of the client contact hours in diagnosis, psychotherapy • Assessment-based treatment planning Must submit a plan for supervised experience for review and approval by the board. The plan shall include an attestation from the supervisor(s) that he/she is responsible for any services provided.
New York ***LMFT***	SAME AS LCSW ABOVE
New York ***LPCC***	SAME AS LCSW ABOVE

STATE	Supervisor Responsibilities
Ohio ***LCSW***	Supervision means: • The quantitative and qualitative evaluation of the supervisee's performance • Professional guidance to the supervisee • Approval of the supervisee's intervention plans and their implementation • Responsibility for the welfare of the supervisee's clients • Assurance that the supervisee functions within the limits of their license. The assessment, diagnosis, treatment plan, revisions to the treatment plan and transfer or termination shall be cosigned by the supervisor and shall be available to the board upon request.
Ohio ***LMFT***	The purpose of supervision is for the following: • To provide for the protection of consumer and client welfare • To ensure supervisees function within the limits of their competence • To enhance professional development • To provide training in activities relevant to the supervisee's position and academic background.
Ohio ***LPCC***	The purpose of supervision is for the following: • To provide for the protection of consumer and client welfare • To ensure supervisees function within the limits of their competence • To enhance professional development • To provide training in activities relevant to the supervisee's position and academic background. A supervisor must complete and forward to the board all supervision evaluation forms required by the board The supervisor is responsible for all diagnoses, change in diagnoses, individualized services plans, and correspondence to any third party outside of the agency.

STATE	Supervisor Responsibilities
Oregon ***LCSW***	”Supervision” means a professional relationship between a qualified supervisor and an intern, counselor, or therapist during which the supervisor provides guidance and professional skill development and oversight to the intern, counselor or therapist. **The associate presents assessments, diagnoses, and treatment plans of clients to the supervisor.** The treatment plans presented by the associate must be appropriate, and the supervisor must focus on the therapeutic skill of the associate in promoting change in the client. Supervision includes discussing case notes, charts, records, and audio or visual tapes of clients, if available. The supervisor must submit a plan of practice and supervision to the board for approval, and a biannual evaluation. The supervisor must report to the board immediately if the associate is not complying with the plan of practice and supervision.
Oregon ***LMFT***	The supervisor must: • **Review and evaluate appropriateness of client population and caseload, individual charts, case records**, and methodologies for keeping client confidentiality • Recommend that the intern to refer clients to other therapists when client needs are outside the intern’s scope of practice • Hold discussions based on case notes, charts, records, and available audio or visual tapes • **Review assessments and treatment plans for the clients being seen** • Determine the appropriateness of the plans and the supervisee's therapeutic skill

STATE	Supervisor Responsibilities
Oregon ***LMFT (continued)***	The supervisor must submit a written evaluation of the intern's skills and progress every six months and at the conclusion of the plan. If a supervisor has concerns about a supervisee being licensed, the supervisor must notify the Board.
Oregon ***LPCC***	SAME AS LMFT ABOVE
South Carolina ***LCSW***	Clinical supervision means an interactional professional and educational relationship between a clinical supervisor and a social worker that provides evaluation and direction over the supervisee's practice of clinical work and promotes continued development of the social worker's knowledge, skills and abilities to engage in practice in an ethical and competent manner. A plan for clinical supervision must be filed with the board before beginning supervision and at the end of supervision and include a termination evaluation.
South Carolina ***LMFT***	**"Supervision" means face-to-face contact between a supervisor and an intern during which the person supervised apprises the supervisor of the diagnosis and treatment of each client.** The supervisor provides oversight and guidance in diagnosing, treating, and dealing with clients, and evaluates performance. The focus of a supervision session is on raw data from clinical work which is made directly available to the supervisor through such means as written clinical materials, direct (live) observation, co-therapy, audio and video recordings, and live supervision. Supervision is a process clearly distinguishable from personal psychotherapy and is contrasted in order to serve professional goals. The supervisor shall provide nurturance and support to the supervisee, explaining the relationship of theory to practice, suggesting specific actions, assisting the supervisee in exploring various models for practice, and challenging discrepancies in the supervisee's practice.

STATE	Supervisor Responsibilities
South Carolina ***LMFT (continued)***	The supervisor shall ensure the supervisee's familiarity with important literature in the appropriate field of practice. The supervisor shall model effective practice. A Plan for Supervision must be completed by each supervisor and submitted to the Board. The supervisor shall provide written reports as required by the Board and shall be available for consultation with the Board or its committees regarding the supervisee's competence for licensure. The process of supervision shall be outlined in a contract for supervision. Supervisors must follow the Board's *Code of Ethics for All Supervisors*
South Carolina ***LPCC***	SAME AS LMFT ABOVE
Texas ***LCSW***	Within 30 days of initiating supervision, submit to the board a clinical supervisory plan for each location of practice for approval by the board The supervisor and the supervisee bear professional responsibility for the supervisee's professional activities. The supervisor is responsible for the social work services provided within the supervisory plan. The supervisor is obligated to keep legible, accurate, complete, signed supervision notes and must be able to produce such documentation for the board if requested. The notes shall document the content, duration, and date of each supervision session.

STATE	Supervisor Responsibilities
Texas ***LCSW (continued)***	The supervisor shall ensure that the supervisee knows and adheres to the Code of Conduct and Professional Standards of Practice of this chapter. A supervisor is responsible for developing a well-conceptualized supervision plan with the supervisee, and for updating that plan whenever there is a change in agency of employment, job function, goals for supervision, or method by which supervision is provided. If the supervisor determines that the supervisee lacks the professional skills and competence to practice social work under a regular license, the supervisor shall develop and implement a written remediation plan for the supervisee. The supervisor must indicate specific reasons for not recommending the supervisee on the clinical supervision verification form. The board may consider the supervisor's reservations as it evaluates the supervision verification. Supervision must promote professional growth. Therefore, all supervision formats must encourage clear, accurate communication between the supervisor and the supervisee, including case-based communication that meets standards for confidentiality. Though the board favors supervision formats in which the supervisor and supervisee are in the same geographical place for a substantial part of the supervision time, the board also recognizes that some current and future technology, such as using reliable, technologically-secure computer cameras and microphones, can allow personal face-to-face, though remote, interaction, and can support professional growth. Supervision formats must be clearly described in the supervision plan, explaining how the supervision strategies and methods of delivery meet the supervisee's professional growth needs and ensure that confidentiality is protected. The plan must be approved by the board.

STATE	Supervisor Responsibilities
Texas ***LMFT***	The supervisor shall ensure that the supervisee is aware of and adheres to pertinent law and ethics. If a supervisor determines that the supervisee may not have the competence to practice under a regular license, the supervisor shall develop and implement a written plan for remediation. Supervisory status may be denied, revoked, or suspended following a fair hearing for violation of the Act or rules. A supervisor whose supervisory status has expired shall refund all supervisory fees received after the expiration. Fees charged by a supervisor during the course of supervision, which occurred without a board-approved supervision contract in place and resulted in the experience hours of the supervisee being denied, must be reimbursed to the supervisee.
Texas ***LPCC***	Supervisors shall review board rules and note such on logs. The supervisor shall ensure that the Intern is aware of and adheres to the code of ethics. A supervisor must submit a change of site/supervision form into the board office for approval before commencing supervision at a new site or with a new supervisor. A supervisor shall maintain and sign a record(s) to document the date of each supervision conference and document the total number of hours of supervised experience accumulated. The record shall reflect the approved site where the hours were accrued and the content of the supervision. If a supervisor determines that the LPC Intern may not have the counseling skills or competence to practice professional counseling under a regular license, the supervisor shall develop and implement a written plan for remediation of the LPC Intern. A supervisor shall submit accurate documentation of supervised experience to the board within 30 days of completion of hours.

STATE	Supervisor Responsibilities
Texas ***LPCC (continued)***	A supervisor whose supervisory status has expired may be required to refund all supervisory fees received after the expiration of the supervisory status to the intern(s) who paid the fees. Supervision of the intern without being approved as a supervisor or after expiration of the supervisor status may be grounds for disciplinary action.
Washington ***LCSW***	Prior to the commencement of any supervision, provide the supervisee with a declaration, on a form provided by the department, that the supervisor has met the requirements to qualify as an approved supervisor. The approved supervisor must attest to having thorough knowledge of the supervisee's practice activities including: • Practice setting; • Recordkeeping; • Financial management; • Ethics of clinical practice; and • A backup plan for coverage.
Washington ***LMFT***	SAME AS LCSW ABOVE
Washington ***LPCC (LMHC)***	SAME AS LCSW ABOVE

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Board of Behavioral Sciences

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Memo

To:	Supervision Committee Members	**Date:**	April 20, 2016
From:	Christy Berger Regulatory Analyst	**Telephone:**	(916) 574-7817
Subject:	**Supervisor's Availability While Supervisee is Providing Clinical Services**		

One of the primary purposes of having an experienced licensee oversee the work of an unlicensed counselor is to protect the client. When a registrant is seeing a client and a crisis arises when the supervisor is not on site, there is nothing in law that requires the supervisor to be available. Nor is there a requirement that the supervisor have a plan in place to protect the client in the event of a crisis while the supervisor is not on site.

In response to the Board's supervision survey, 11% of supervisees reported being dissatisfied or somewhat dissatisfied with their supervisor's responsiveness when faced with a client crisis. While this means that the vast majority of supervisees do have a responsive supervisor, 11% of registrants represents 4,011 individuals, each seeing multiple clients, who do not. Additionally, the potentially severe impact of mishandling a crisis makes this an issue that is deserving of emphasis consistent with the Board's consumer protection mandate.

The Board of Psychology requires the following:

- The supervisor must be available 100% of the time the supervisee is performing psychological functions. The availability can be in person, by telephone, by pager or by other appropriate technology.

- The supervisor must have a plan in place to protect the client in the event a client crisis or an emergency occurs during any time the supervisor is not physically present. The supervisor must ensure that the supervisee thoroughly understands the plan.

The American Counseling Association's Ethical Code requires the following:

- Supervisors must establish and communicate to supervisees procedures for contacting supervisors or, in their absence, alternative on-call supervisors to assist in handling crises.

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Memo

To:	Supervision Committee Members	**Date:**	April 19, 2016
From:	Christy Berger Regulatory Analyst	**Telephone:**	(916) 574-7817
Subject:	**Supervisor Self-Assessment Form**		

At the February 5, 2016 meeting, the Committee tentatively approved a structure for requiring all supervisors to register with the Board, with the goal of increasing accountability and improving communication without major changes to the current system. Benefits include protecting registrants, ensuring that supervisors are fully aware of all requirements to supervise, and allowing a targeted channel for the Board to provide guidance to supervisors.

The supervisor's registration with the Board would be initiated by submission of a *Supervisor Self-Assessment* form, to be completed by the supervisor, certifying under penalty of perjury that he or she meets all requirements to be a supervisor. The original is proposed to be provided to the Board within 60 days of commencing supervision, with a copy to the supervisee prior to commencing supervision. The Board would not verify a supervisor's qualifications except during a random audit.

The draft form is attached for the Committee's review.

Attachment: Draft *Supervisor Self-Assessment* Form

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NEW CLINICAL SUPERVISOR SELF-ASSESSMENT REPORT - DRAFT

A licensee who will be supervising for the first time must do the following:

- *Complete and submit this form to the Board within 60 days of commencing supervision for the first time, and*
- *Provide a copy of this completed form and the Supervision Brochure to each of your supervisees prior to commencement of supervision.*

Type or print clearly in ink

1. Supervisor's Legal Name: Last	First	Middle

2. BBS File Number (if known):	3. Business Telephone:	4. E-Mail Address:

5. California License Type: ☐ LCSW ☐ LMFT ☐ LPCC ☐ Clinical Psychologist
☐ Physician Board-Certified in Psychiatry by the American Board of Psychiatry and Neurology

6. License Number:	7. Date Issued:	8. Expiration Date:	9. Date You Began Supervising:

10. Address of Record*: Number and Street

City	State	Zip Code

11. Is this a new address? ☐ Yes ☐ No *If YES, we will update our records accordingly*

12. Do you hold an equivalent license in another state? Yes ☐ No ☐

If YES, *provide information below:*

State	License Type	License Number	Date Issued	Status

** The address you enter on this application is public information and will be placed on the Internet pursuant to BPC section 27. If you don't want your home or work address available to the public, provide an alternate mailing address.*

Supervisor's Last Name	First	Middle

13. Have you been issued any of the following "approved supervisor" designations? Yes ☐ No ☐

If YES, (1) Mark the box next to the type of certification held; (2) List the date issued and (3) Skip questions 14, 15 and 16 below.

☐ American Association for Marriage and Family Therapy (AAMFT): Date Issued: _____

☐ American Board of Examiners in Clinical Social Work (ABECSW): Date Issued: _____

☐ California Association of Marriage and Family Therapists (CAMFT): Date Issued: _____

☐ Center for Credentialing and Education (CCE): Date Issued: _____

14. Have you held an active license in California or any other state for at least two (2) of the past five (5) years? Yes ☐ No ☐ N/A ☐

15. EXPERIENCE: Have you practiced psychotherapy or provided direct clinical supervision of trainees, interns, or associates who perform psychotherapy for at least two (2) of the past five (5) years? Yes ☐ No ☐ N/A ☐

16. TRAINING COURSE: Have you completed the required 15-hour supervisor training course? Yes ☐ No ☐ N/A ☐

Course Provider: _____ Date: _____

17. LPCCs: Will you be supervising an MFT Trainee or MFT Intern; or, a Professional Counselor Intern gaining experience with couples or families? Yes ☐ No ☐ N/A ☐

18. If you marked ***YES to question 17***, have you met all of the qualifications to assess and treat couples and families under your LPCC license? Yes ☐ No ☐ N/A ☐

19. I understand that if I do not renew my California license on time, any hours gained by my supervisees during the time my license is lapsed will NOT be counted toward licensure. Initials: _____

Supervisor's Last Name	First	Middle

20. I understand that I must provide a copy of this form and a copy of the Supervision Brochure to each supervisee upon commencement of supervision. Initials: _____

21. I understand that if I do NOT hold one of the supervisor certifications in question 13, I must complete a minimum of six (6) hours of continuing professional development in supervision during each license renewal period while providing supervision. Initials: _____

I certify under penalty of perjury that all of the foregoing is true and correct.

_____ _____

Signature of Applicant ***Date***

Date you provided each supervisee with a copy of this form and the Supervision Brochure:

Supervisee Name: _____ *Date Provided:* _____

Supervisee Name: _____ *Date Provided:* _____

Supervisee Name: _____ *Date Provided:* _____

Supervisee Name: _____ *Date Provided:* _____

Supervisee Name: _____ *Date Provided:* _____

Supervisee Name: _____ *Date Provided:* _____

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Memo

To: Supervision Committee Members **Date:** April 21, 2016

From: Rosanne Helms
Legislative Analyst **Telephone:** (916) 574-7897

Subject: **Revised LMFT Statute and Regulations: Proposed Supervision Amendments**

Attachment A contains a draft of proposed amendments to LMFT statute and regulations based on the prior discussions and decisions of this Committee. This draft was first presented at the February 5, 2016 Supervision Committee meeting. Additional amendments have been made based on feedback from that meeting.

This draft is not intended to be a final product of the work of the Supervision Committee. It will need further amendments later, as the Committee is still discussing some topics related to supervision.

Significant changes are as follows:

1. **Supervisors Licensed for at Least Two Years (No changes since last meeting):** The amendments allow a licensee to supervise if he or she has been actively licensed in California or in any other state for at least two of the past five years immediately prior to commencing any supervision.

   Sections Affected: BPC §4980.03(g)(1), CCR §1833.1(a)(1), 1833.2

2. **Split BPC Section 4980.43 (No changes since last meeting):** BPC Section 4980.43 has been divided into smaller sections, with each new section focused on a specific topic of supervision.

   Sections Affected: BPC §§4980.43-4980.43.4

3. **Definition of Supervision (No changes since last meeting):** The definition of "supervision" has been revised to include responsibility for, and control of, the quality of

services being provided. The amendments also state that consultation or peer discussion is not supervision. These changes are consistent with what is already in LCSW and LPCC law.

A statement about providing regular feedback to the intern or trainee has also been included.

Section Affected: BPC §4980.43.1(b)

4. **Direct Supervisor Contact (Changes have been made since last meeting):** There have been revisions to the basis for the amount of required direct supervisor contact. Currently, trainees and interns must receive one hour of direct supervisor contact when they perform a specified amount of client contact in each setting.

   The amendment changes "client contact" to "direct clinical counseling" as the basis for which the amount of supervision is determined. References to "direct counseling" in Sections 4980.03(f) and 4980.43(a)(8) have been amended to instead reference "direct clinical counseling" for consistency.

   These changes will also be made in LCSW and LPCC law.

   Section Affected: BPC §§ 4980.03(f), 4980.43(a)(8), 4980.43.2(a)(1), (2)

5. **Definition of "One Hour of Direct Supervisor Contact"; Triadic Supervision (No changes since last meeting):** These revisions provide a specific definition of one hour of direct supervisor contact. Triadic supervision is included in this definition.

   Section Affected: BPC §4980.43.2(b)

6. **Discussion of Definition of a Week for Supervision Purposes (Changes have been made since last meeting):** The law currently requires direct supervisor contact to occur in the same week as the hours claimed. Previously, the Committee had discussed an amendment defining a week as beginning on Sunday and ending on the following Saturday. After further discussion, however, the Committee decided against doing this.

   Section Affected: None.

7. **Amount of Individual Supervision (No changes since last meeting):** Current regulations specify that one hour per week of supervision for 52 weeks must be individual supervision.

   Staff believes this requirement is significant and it is more appropriately stated in statute rather than regulations. The requirement has also been amended to allow this 52 weeks of supervision to either be individual or triadic.

Section Affected: BPC §4980.43.2(d)

8. **Supervision in a Group (Changes have been made since last meeting):** Current law allows group supervision to consist of up to 8 supervisees. An amendment states that the supervisor must ensure that the amount of supervision is appropriate to each supervisee's needs.

   Section Affected: BPC §4980.43.2(e)

9. **Supervision in a Non-Private Practice Setting (Changes have been made since last meeting):** Currently, a supervisor in a non-private practice only needs to sign a written agreement with the supervisee's employer if the supervisor is a volunteer. An amendment was made to require a written agreement when the setting is a non-private practice and the supervisor is not employed by the applicant's employer or is a volunteer.

   Sections Affected: BPC §4980.43.4(e) and (f), CCR §1833(a)

10. **Unprofessional Conduct (No changes since last meeting):** This section currently states that the following two items are unprofessional conduct:

    4982(r) Any conduct in the supervision of any registered intern, associate clinical social worker, or trainee by any licensee that violates this chapter or any rules or regulations adopted by the board.

    4982 (u) The violation of any statute or regulation governing the gaining and supervision of experience required by this chapter.

    Staff believes these two sections are duplicative, and that subsection 4982(r) is unnecessary. Subsection 4982(u) already gives the Board the authority to take disciplinary action on, or to issue a cite and fine to, a licensee or registrant who violates any of the supervision provisions in statute and regulation. Therefore, this proposal deletes subsection 4982(r).

    In addition, unprofessional conduct language related to discipline is inconsistent between LMFT, LCSW, and LPCC law. For consistency, the language in 4982(u) will be amended into the LCSW and LPCC unprofessional conduct provisions as well.

    Section Affected: BPC §4982

11. **Delete Duplicative and Obsolete Language in Regulations (No changes since last meeting):** Many of the provisions in regulation section 1833 are either already in statute, or they became obsolete with the passage of SB 620 (Chapter 262, Statutes of 2015), which streamlined many of the supervised experience hour requirements for licensure. These subsections were deleted. Other subsections were moved to statute, if staff believed that location was more appropriate. The remaining provisions of section 1833 discuss specific forms that supervisors or supervisees are required to complete.

    Section Affected: CCR §1833

12. **Required Training and Coursework for Supervisors (Changes have been made since last meeting):** A section was added to regulations to require supervisors commencing supervision for the first time to complete a 15 hour supervision course covering specified topic areas. This is consistent with a similar requirement already in place for LCSW supervisors. Age limits for the course are specified, and the course can be counted as continuing education if taken from an accepted provider. Any supervisor who has not supervised in 2 of the last 5 years, must re-take a 6 hour course.

    This new section also specifies that supervisors must complete 6 hours of continuing professional development in each renewal period while supervising. This can consist of a supervision course, or other professional development activities such as teaching, research, or supervision mentoring.

    In place of the above requirements, a supervisor may obtain and maintain a supervision certification from one of four specified entities. The Board also has discretion to accept certification from another entity if it believes its requirements are equivalent or greater. Such a certification exempts the supervisor from the 15 hour coursework and 6 hour professional development requirements, and it allows them to waive the requirement that they must be licensed and be either supervising or practicing psychotherapy for two of the past five years prior to commencing any supervision.

    The proposed language is specifically worded so that it only applies to supervisors who are also Board licensees. Supervisors who are licensed psychologists or psychiatrists would not need to complete the supervision training and coursework.

    Section Added: CCR §1834

13. **Documentation of Supervisor Qualifications and Audits (Changes have been made since last meeting):** A regulation section was added to allow the Board to audit supervisor's records to verify they meet the supervisor qualifications. It requires supervisors to maintain records of completion of the required supervisor qualifications for seven years after the completion of supervision, (consistent with statute regarding record retention) and to make these records available to the Board for an audit upon request.

    The Board would likely audit a supervisor during a continuing education audit or if a complaint was received. The "Responsibility Statement for Supervisors of a Marriage and Family Therapist Trainee or Intern" (revised 3/10, form #1800 37A-523), which supervisors must sign under penalty of perjury, will need to be amended to include the supervisor qualifications as well as instructions for appropriate documentation.

    Section Added: CCR §1835

14. **Amount of Direct Supervisor Contact Required for Applicants Finished Gaining Experience Hours (Changes have been made since last meeting):** Currently, the law

does not specifically define how much direct supervisor contact an MFT or PCI intern needs once he or she is finished gaining experience hours needed to count toward licensure. (An intern gaining experience hours must obtain at least one hour of direct supervisor contact in each week, plus one additional hour if more than 10 hours of direct client contact is gained, in order for the hours to count.)

At its previous meeting, the Committee recommended that the amount of supervision should be specified even if experience hours are no longer being counted. This amendment specifies that interns and applicants who have finished gaining experience hours must obtain at least one hour of supervision per week for each setting in which direct clinical counseling is performed.

A clarifying amendment was also made to BPC §4980.43.2(a)(2). This subsection defines how much supervision an intern who is gaining experience hours must receive. The phrase "an individual supervised after being granted a qualifying degree" has been replaced with the term "An intern and intern applicant…" This more accurately describes someone gaining experience hours, since they will either be an intern, or a recent graduate who has begun gaining hours while waiting for the intern registration under the 90-day rule.

Section Affected: BPC §4980.43.2(a)(2) and (i)

ATTACHMENTS:

Attachment A: Proposed LMFT Supervision Language

Attachment B: Reference Sections – Current Law: BPC §4980.43, 16 CCR §§ 1833, 1833.1, 1833.2

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ATTACHMENT A
PROPOSED LMFT SUPERVISION LANGUAGE

§4980.03. DEFINITIONS

(a) "Board," as used in this chapter, means the Board of Behavioral Sciences.

(b) "Intern," as used in this chapter, means an unlicensed person who has earned his or her master's or doctoral degree qualifying him or her for licensure and is registered with the board.

(c) "Trainee," as used in this chapter, means an unlicensed person who is currently enrolled in a master's or doctoral degree program, as specified in Sections 4980.36 and 4980.37, that is designed to qualify him or her for licensure under this chapter, and who has completed no less than 12 semester units or 18 quarter units of coursework in any qualifying degree program.

(d) "Applicant," as used in this chapter, means an unlicensed person who has completed a master's or doctoral degree program, as specified in Sections 4980.36 and 4980.37, and whose application for registration as an intern is pending, or an unlicensed person who has completed the requirements for licensure as specified in this chapter, is no longer registered with the board as an intern, and is currently in the examination process.

(e) "Advertise," as used in this chapter, includes, but is not limited to, any public communication, as defined in subdivision (a) of Section 651, the issuance of any card, sign, or device to any person, or the causing, permitting, or allowing of any sign or marking on, or in, any building or structure, or in any newspaper or magazine or in any directory, or any printed matter whatsoever, with or without any limiting qualification. Signs within religious buildings or notices in church bulletins mailed to a congregation shall not be construed as advertising within the meaning of this chapter.

(f) "Experience," as used in this chapter, means experience in interpersonal relationships, psychotherapy, marriage and family therapy, direct clinical counseling, and nonclinical practice that satisfies the requirements for licensure as a marriage and family therapist pursuant to Section 4980.40.

(g) "Supervisor," as used in this chapter, means an individual who meets all of the following requirements:

(1) Has been actively licensed ~~by a state regulatory agency~~ in California or in any other state for at least two of the past five years as a marriage and family therapist, licensed clinical social worker, licensed professional clinical counselor, licensed psychologist, or licensed physician certified in psychiatry by the American Board of Psychiatry and Neurology~~.~~, immediately prior to commencing any supervision.

(2) If a licensed professional clinical counselor, the individual shall meet the additional training and education requirements specified in paragraph (3) of subdivision (a) of Section 4999.20.

(3) Has not provided therapeutic services to the trainee or intern.

(4) Has and maintains a current and ~~valid~~active California license that is not under suspension or probation.

(5) Complies with supervision requirements established by this chapter and by board regulations.

(h) “Client centered advocacy,” as used in this chapter, includes, but is not limited to, researching, identifying, and accessing resources, or other activities, related to obtaining or providing services and supports for clients or groups of clients receiving psychotherapy or counseling services.

§4980.43. PROFESSIONAL EXPERIENCE; INTERNS OR TRAINEES

(a) To qualify for licensure as specified in Section 4980.40, each applicant shall complete experience related to the practice of marriage and family therapy under a supervisor who meets the qualifications set forth in Section 4980.03. The experience shall comply with the following:

(1) A minimum of 3,000 hours of supervised experience completed during a period of at least 104 weeks.

(2) A maximum of 40 hours in any seven consecutive days.

(3) A minimum of 1,700 hours obtained after the qualifying master’s or doctoral degree was awarded.

(4) A maximum of 1,300 hours obtained prior to the award date of the qualifying master’s or doctoral degree.

(5) A maximum of 750 hours of counseling and direct supervisor contact prior to the award date of the qualifying master’s or doctoral degree.

(6) No hours of experience may be gained prior to completing either 12 semester units or 18 quarter units of graduate instruction.

(7) No hours of experience may be gained more than six years prior to the date the application for examination eligibility was filed, except that up to 500 hours of clinical experience gained in the supervised practicum required by subdivision (c) of Section 4980.37 and subparagraph (B) of paragraph (1) of subdivision (d) of Section 4980.36 shall be exempt from this six-year requirement.

(8) A minimum of 1,750 hours of direct clinical counseling with individuals, groups, couples, or families, that includes not less than 500 total hours of experience in diagnosing and treating couples, families, and children.

(9) A maximum of 1,250 hours of nonclinical practice, consisting of direct supervisor contact, administering and evaluating psychological tests, writing clinical reports, writing progress or process notes, client centered advocacy, and workshops, seminars, training sessions, or conferences directly related to marriage and family therapy that have been approved by the applicant’s supervisor.

(10) It is anticipated and encouraged that hours of experience will include working with elders and dependent adults who have physical or mental limitations that restrict their ability to carry out normal activities or protect their rights.

This subdivision shall only apply to hours gained on and after January 1, 2010.

(b) An individual who submits an application for examination eligibility between January 1, 2016, and December 31, 2020, may alternatively qualify under the experience requirements that were in place on January 1, 2015.

~~(c) All applicants, trainees, and registrants shall be at all times under the supervision of a supervisor who shall be responsible for ensuring that the extent, kind, and quality of counseling performed is consistent with the training and experience of the person being supervised, and who shall be responsible to the board for compliance with all laws, rules, and regulations governing the practice of marriage and family therapy. Supervised experience shall be gained by an intern or trainee only as an employee or as a volunteer. The requirements of this chapter regarding gaining hours of experience and supervision are applicable equally to employees and volunteers. Experience shall not be gained by an intern or trainee as an independent contractor.~~

~~(1) If employed, an intern shall provide the board with copies of the corresponding W-2 tax forms for each year of experience claimed upon application for licensure.~~

~~(2) If volunteering, an intern shall provide the board with a letter from his or her employer verifying the intern's employment as a volunteer upon application for licensure.~~

~~(d) Except for experience gained by attending workshops, seminars, training sessions, or conferences as described in paragraph (9) of subdivision (a), supervision shall include at least one hour of direct supervisor contact in each week for which experience is credited in each work setting, as specified:~~

~~(1) A trainee shall receive an average of at least one hour of direct supervisor contact for every five hours of client contact in each setting. No more than six hours of supervision, whether individual or group, shall be credited during any single week.~~

~~(2) An individual supervised after being granted a qualifying degree shall receive at least one additional hour of direct supervisor contact for every week in which more than 10 hours of client contact is gained in each setting. No more than six hours of supervision, whether individual or group, shall be credited during any single week.~~

~~(3) For purposes of this section, "one hour of direct supervisor contact" means one hour per week of face-to-face contact on an individual basis or two hours per week of face-to-face contact in a group.~~

~~(4) Direct supervisor contact shall occur within the same week as the hours claimed.~~

~~(5) Direct supervisor contact provided in a group shall be provided in a group of not more than eight supervisees and in segments lasting no less than one continuous hour.~~

~~(6) Notwithstanding paragraph (3), an intern working in a governmental entity, a school, a college, or a university, or an institution that is both nonprofit and charitable may obtain the required weekly direct supervisor contact via two-way, real-time videoconferencing. The supervisor shall be responsible for ensuring that client confidentiality is upheld.~~

~~(7) All experience gained by a trainee shall be monitored by the supervisor as specified by regulation.~~

~~(8) The six hours of supervision that may be credited during any single week pursuant to paragraphs (1) and (2) shall apply to supervision hours gained on or after January 1, 2009.~~

~~(e) (1) A trainee may be credited with supervised experience completed in any setting that meets all of the following:~~

~~(A) Lawfully and regularly provides mental health counseling or psychotherapy.~~

~~(B) Provides oversight to ensure that the trainee's work at the setting meets the experience and supervision requirements set forth in this chapter and is within the scope of practice for the profession as defined in Section 4980.02.~~

~~(C) Is not a private practice owned by a licensed marriage and family therapist, a licensed professional clinical counselor, a licensed psychologist, a licensed clinical social worker, a licensed physician and surgeon, or a professional corporation of any of those licensed professions.~~

~~(2) Experience may be gained by the trainee solely as part of the position for which the trainee volunteers or is employed.~~

~~(f) (1) An intern may be credited with supervised experience completed in any setting that meets both of the following:~~

~~(A) Lawfully and regularly provides mental health counseling or psychotherapy.~~

~~(B) Provides oversight to ensure that the intern's work at the setting meets the experience and supervision requirements set forth in this chapter and is within the scope of practice for the profession as defined in Section 4980.02.~~

~~(2) An applicant shall not be employed or volunteer in a private practice, as defined in subparagraph (C) of paragraph (1) of subdivision (e), until registered as an intern.~~

~~(3) While an intern may be either a paid employee or a volunteer, employers are encouraged to provide fair remuneration to interns.~~

~~(4) Except for periods of time during a supervisor's vacation or sick leave, an intern who is employed or volunteering in private practice shall be under the direct supervision of a licensee that has satisfied subdivision (g) of Section 4980.03. The supervising licensee shall either be employed by and practice at the same site as the intern's employer, or shall be an owner or shareholder of the private practice. Alternative supervision may be arranged during a supervisor's vacation or sick leave if the supervision meets the requirements of this section.~~

~~(5) Experience may be gained by the intern solely as part of the position for which the intern volunteers or is employed.~~

~~(g) Except as provided in subdivision (h), all persons shall register with the board as an intern to be credited for postdegree hours of supervised experience gained toward licensure.~~

~~(h) Postdegree hours of experience shall be credited toward licensure so long as the applicant applies for the intern registration within 90 days of the granting of the qualifying master's or doctoral degree and is thereafter granted the intern registration by the board. An applicant shall not be employed or volunteer in a private practice until registered as an intern by the board.~~

~~(i) Trainees, interns, and applicants shall not receive any remuneration from patients or clients, and shall only be paid by their employers.~~

~~(j) Trainees, interns, and applicants shall only perform services at the place where their employers regularly conduct business, which may include performing services at other locations, so long as the services are performed under the direction and control of their employer and supervisor, and in compliance with the laws and regulations pertaining to supervision. For purposes of paragraph (3) of subdivision (a) of Section 2290.5, interns and trainees working under licensed supervision, consistent with subdivision (c), may provide services via telehealth within the scope authorized by this chapter and in accordance with any regulations governing the use of telehealth promulgated by the board. Trainees and interns shall have no proprietary interest in their employers' businesses and shall not lease or rent space, pay for furnishings, equipment, or supplies, or in any other way pay for the obligations of their employers.~~

~~(k) Trainees, interns, or applicants who provide volunteered services or other services, and who receive no more than a total, from all work settings, of five hundred dollars ($500) per month as reimbursement for expenses actually incurred by those trainees, interns, or applicants for services rendered in any lawful work setting other than a private practice shall be considered employees and not independent contractors. The board may audit applicants who receive reimbursement for expenses, and the applicants shall have the burden of demonstrating that the payments received were for reimbursement of expenses actually incurred.~~

~~(l) Each educational institution preparing applicants for licensure pursuant to this chapter shall consider requiring, and shall encourage, its students to undergo individual, marital or conjoint, family, or group counseling or psychotherapy, as appropriate. Each supervisor shall consider, advise, and encourage his or her interns and trainees regarding the advisability of undertaking individual, marital or conjoint, family, or group counseling or psychotherapy, as appropriate. Insofar as it is deemed appropriate and is desired by the applicant, the educational institution and supervisors are encouraged to assist the applicant in locating that counseling or psychotherapy at a reasonable cost.~~

§4980.43.1 SUPERVISION DEFINITION; REGISTRATION AS AN INTERN

(a) All applicants, trainees, and registrants shall be at all times under the supervision of a supervisor as specified in this chapter and by regulation.

(b) The term "supervision", as used in this chapter, means responsibility for, and control of, the quality of services being provided. It includes ensuring that the extent, kind, and quality of counseling performed is consistent with the education, training, and experience of the person being supervised; reviewing client/patient records, monitoring and evaluating assessment, diagnosis, and treatment decisions of the intern or trainee and providing regular feedback; monitoring and evaluating the ability of the intern or trainee to provide services at the site(s) where he or she will be practicing and to the particular clientele being served; and ensuring compliance with laws and regulations governing the practice of marriage and family therapy. Supervision shall include that amount of direct observation, or review of audio or video tapes of therapy, as deemed appropriate by the supervisor. Consultation or peer discussion shall not be considered to be supervision.

(c) Except as provided in subdivision (d), all persons shall register with the board as an intern to be credited for postdegree hours of supervised experience gained toward licensure.

(d) Postdegree hours of experience shall be credited toward licensure so long as the applicant applies for the intern registration within 90 days of the granting of the qualifying master's or doctoral degree and is thereafter granted the intern registration by the board. An applicant shall not be employed or volunteer in a private practice until registered as an intern by the board.

§4980.43.2 DIRECT SUPERVISOR CONTACT

(a) Except for experience gained by attending workshops, seminars, training sessions, or conferences as described in paragraph (9) of subdivision (a) of section 4980.43, supervision shall include at least one hour of direct supervisor contact in each week for which experience is credited in each work setting, as specified:

(1) A trainee shall receive an average of at least one hour of direct supervisor contact for every five hours of ~~client contact~~ direct clinical counseling that is performed in each setting. No more than six hours of supervision, whether individual or group, shall be credited during any single week.

(2) ~~An individual supervised after being granted a qualifying degree~~ An intern and intern applicant shall receive at least one additional hour of direct supervisor contact for every week in which more than 10 hours of ~~client contact~~direct clinical counseling is ~~gained~~performed in each setting. No more than six hours of supervision, whether individual or group, shall be credited during any single week.

(b) "One hour of direct supervisor contact" means any of the following:

1) Face-to-face contact between one supervisor and one supervisee for one hour.

2) Face-to-face contact between one supervisor and two supervisees for one hour.

3) Face-to-face contact between one supervisor and no more than eight supervisees for two hours.

(c) Direct supervisor contact shall occur within the same week as the hours claimed.

(d) The applicant shall have received at least one (1) hour per week of direct supervisor contact meeting the criteria of subdivisions (1) or (2) of subsection (b), for a minimum of 52 weeks.

(e) Direct supervisor contact provided in a group shall be provided in a group of not more than eight supervisees and in segments lasting no less than one continuous hour. The supervisor shall ensure that the amount and degree of supervision is appropriate to each supervisee's needs.

(f) Notwithstanding subsection (b), an intern working in a governmental entity, a school, a college, or a university, or an institution that is both nonprofit and charitable may obtain the required weekly direct supervisor contact via two-way, real-time videoconferencing. The supervisor shall be responsible for ensuring that client confidentiality is upheld.

(g) All experience gained by a trainee shall be monitored by the supervisor as specified by this chapter and by regulation.

(h) The six hours of supervision that may be credited during any single week pursuant to paragraphs (1) and (2) of subsection (a) shall apply to supervision hours gained on or after January 1, 2009.

(i) Notwithstanding any other provision of law, interns and applicants who have finished gaining experience hours toward licensure shall receive a minimum of one hour of direct supervisor contact per week for each setting in which direct clinical counseling is performed.

§4980.43.3 SUPERVISION: ACCEPTABLE SETTINGS; ACCEPTABLE SUPERVISION PRACTICES

(a) Supervised experience shall be gained by an intern or trainee only as an employee or as a volunteer. The requirements of this chapter regarding gaining hours of experience and supervision are applicable equally to employees and volunteers. Experience shall not be gained by an intern or trainee as an independent contractor.

(1) If employed, an intern shall provide the board with copies of the corresponding W-2 tax forms for each year of experience claimed upon application for licensure.

(2) If volunteering, an intern shall provide the board with a letter from his or her employer verifying the intern's employment as a volunteer upon application for licensure.

(b) (1) A trainee shall not perform services in a private practice. A trainee may be credited with supervised experience completed in any setting that meets all of the following:

(A) Lawfully and regularly provides mental health counseling or psychotherapy.

(B) Provides oversight to ensure that the trainee's work at the setting meets the experience and supervision requirements set forth in this chapter and is within the scope of practice for the profession as defined in Section 4980.02.

(C) Is not a private practice owned by a licensed marriage and family therapist, a licensed professional clinical counselor, a licensed psychologist, a licensed clinical social worker, a licensed physician and surgeon, or a professional corporation of any of those licensed professions.

(2) Experience may be gained by the trainee solely as part of the position for which the trainee volunteers or is employed.

(c) (1) An intern may be credited with supervised experience completed in any setting that meets both of the following:

(A) Lawfully and regularly provides mental health counseling or psychotherapy.

(B) Provides oversight to ensure that the intern's work at the setting meets the experience and supervision requirements set forth in this chapter and is within the scope of practice for the profession as defined in Section 4980.02.

(2) An applicant shall not be employed or volunteer in a private practice, as defined in subparagraph (C) of paragraph (1) of subdivision (b), until registered as an intern.

(3) While an intern may be either a paid employee or a volunteer, employers are encouraged to provide fair remuneration to interns.

(4) Experience may be gained by the intern solely as part of the position for which the intern volunteers or is employed.

(d) Any experience obtained under the supervision of a spouse, relative, or domestic partner shall not be credited toward the required hours of supervised experience. Any experience obtained under the supervision of a supervisor with whom the applicant has had or currently has a personal or business relationship which undermines the authority or effectiveness of the supervisor shall not be credited toward the required hours of supervised experience.

(e) Trainees, interns, and applicants shall not receive any remuneration from patients or clients, and shall only be paid by their employers.

(f) Trainees and interns shall have no proprietary interest in their employers' businesses and shall not lease or rent space, pay for furnishings, equipment, or supplies, or in any other way pay for the obligations of their employers.

(g) Trainees, interns, or applicants who provide volunteered services or other services, and who receive no more than a total, from all work settings, of five hundred dollars ($500) per month as reimbursement for expenses actually incurred by those trainees, interns, or applicants for services rendered in any lawful work setting other than a private practice shall be considered employees and not independent contractors. The board may audit applicants who receive reimbursement for expenses, and the applicants shall have the burden of demonstrating that the payments received were for reimbursement of expenses actually incurred.

(h) For purposes of paragraph (3) of subdivision (a) of Section 2290.5, interns and trainees working under licensed supervision, consistent with this chapter, may provide services via telehealth within the scope authorized by this chapter and in accordance with any regulations governing the use of telehealth promulgated by the board.

(i) Each educational institution preparing applicants for licensure pursuant to this chapter shall consider requiring, and shall encourage, its students to undergo individual, marital or conjoint, family, or group counseling or psychotherapy, as appropriate. Each supervisor shall consider, advise, and encourage his or her interns and trainees regarding the advisability of undertaking individual, marital or conjoint, family, or group counseling or psychotherapy, as appropriate. Insofar as it is deemed appropriate and is desired by the applicant, the educational institution and supervisors are encouraged to assist the applicant in locating that counseling or psychotherapy at a reasonable cost.

~~§4980.45. EMPLOYMENT OR SUPERVISION OF REGISTRANTS; MAXIMUM NUMBER OF REGISTRANTS~~ 4980.43.4 SUPERVISION AND EMPLOYMENT SETTINGS

(a) Trainees, interns, and applicants shall only perform services at the place where their employers regularly conduct business, which may include performing services at other locations, so long as the services are performed under the direction and control of their employer and their supervisor, and in compliance with the ~~laws~~statutes and regulations pertaining to supervision.

(b) Except for periods of time during a supervisor's vacation or sick leave, an intern who is employed or volunteering in private practice shall be under the direct supervision of a ~~licensee that has satisfied subdivision (g) of Section 4980.03. The supervising licensee shall~~ supervisor who is either ~~be~~ employed by and practices at the same site as the intern's employer, or ~~shall be~~ an owner or shareholder of the private practice.

~~(a)~~(c) A licensed professional in private practice who has satisfied the requirements of subdivision (g) of Section 4980.03 may supervise or employ, at any one time, no more than a total of three individuals registered as a marriage and family therapist intern, clinical counselor intern, or associate clinical social worker in that private practice.

~~(b)~~(d) A marriage and family therapy corporation may employ, at any one time, no more than a total of three individuals registered as a marriage and family therapist intern, clinical counselor intern, or associate clinical social worker for each employee or shareholder who has satisfied the requirements of subdivision (g) of Section 4980.03. In no event shall any marriage and family therapy corporation employ, at any one time, more than a total of 15 individuals registered as a marriage and family therapist intern, clinical counselor intern, or associate clinical social worker. In no event shall any supervisor supervise, at any one time, more than a total of three individuals registered as either a marriage and family therapist intern, clinical counselor intern, or associate clinical social worker. Persons who supervise individuals registered as either a marriage and family therapist intern, clinical counselor intern, or associate clinical social worker shall be employed full time by the marriage and family therapy corporation and shall be actively engaged in performing professional services at and for the marriage and family therapy corporation. Employment and supervision within a marriage and family therapy corporation shall be subject to all laws and regulations governing experience and supervision gained in a private practice setting.

(e) In a private practice setting, the intern's supervisor must be an owner or shareholder of the private practice. Alternatively, the supervisor may be employed by the private practice and regularly conduct business at the same site as the applicant.

(f) In a setting which is not a private practice, a written agreement, as specified in regulation, must be executed between the applicant's supervisor and employer when the supervisor is not employed by the applicant's employer or is a volunteer.

(g) In any setting that is not a private practice, a supervisor shall evaluate the site(s) where a trainee or intern will be gaining hours of experience toward licensure and shall determine that: (1) the site(s) provides experience which is within the scope of practice of a marriage and family therapist; and (2) the experience is in compliance with the requirements set forth in ~~section 1833 and section 4980.43 of the Code.~~ this chapter and in regulation.

(h) Alternative supervision for an intern or trainee may be arranged during a supervisor's vacation or sick leave if the supervision meets the requirements set forth in this chapter and in regulation.

§4982. UNPROFESSIONAL CONDUCT

The board may deny a license or registration or may suspend or revoke the license or registration of a licensee or registrant if he or she has been guilty of unprofessional conduct. Unprofessional conduct includes, but is not limited to, the following:

(a) The conviction of a crime substantially related to the qualifications, functions, or duties of a licensee or registrant under this chapter. The record of conviction shall be conclusive evidence only of the fact that the conviction occurred. The board may inquire into the circumstances surrounding the commission of the crime in order to fix the degree of discipline or to determine if the conviction is substantially related to the qualifications, functions, or duties of a licensee or registrant under this chapter. A plea or verdict of guilty or a conviction following a plea of nolo contendere made to a charge substantially related to the qualifications, functions, or duties of a licensee or registrant under this chapter shall be deemed to be a conviction within the meaning of this section. The board may order any license or registration suspended or revoked, or may decline to issue a license or registration when the time for appeal has elapsed, or the judgment of conviction has been affirmed on appeal, or, when an order granting probation is made suspending the imposition of sentence, irrespective of a subsequent order under Section 1203.4 of the Penal Code allowing the person to withdraw a plea of guilty and enter a plea of not guilty, or setting aside the verdict of guilty, or dismissing the accusation, information, or indictment.

(b) Securing a license or registration by fraud, deceit, or misrepresentation on any application for licensure or registration submitted to the board, whether engaged in by an applicant for a license or registration, or by a licensee in support of any application for licensure or registration.

(c) Administering to himself or herself any controlled substance or using of any of the dangerous drugs specified in Section 4022, or of any alcoholic beverage to the extent, or in a manner, as to be dangerous or injurious to the person applying for a registration or license or holding a registration or license under this chapter, or to any other person, or to the public, or, to the extent that the use impairs the ability of the person applying for or holding a registration or license to conduct with safety to the public the practice authorized by the registration or license. The board shall deny an application for a registration or license or revoke the license or registration of any person, other than one who is licensed as a physician and surgeon, who uses or offers to use drugs in the course of performing marriage and family therapy services.

(d) Gross negligence or incompetence in the performance of marriage and family therapy.

(e) Violating, attempting to violate, or conspiring to violate any of the provisions of this chapter or any regulation adopted by the board.

(f) Misrepresentation as to the type or status of a license or registration held by the person, or otherwise misrepresenting or permitting misrepresentation of his or her education, professional qualifications, or professional affiliations to any person or entity.

(g) Impersonation of another by any licensee, registrant, or applicant for a license or registration, or, in the case of a licensee, allowing any other person to use his or her license or registration.

(h) Aiding or abetting, or employing, directly or indirectly, any unlicensed or unregistered person to engage in conduct for which a license or registration is required under this chapter.

(i) Intentionally or recklessly causing physical or emotional harm to any client.

(j) The commission of any dishonest, corrupt, or fraudulent act substantially related to the qualifications, functions, or duties of a licensee or registrant.

(k) Engaging in sexual relations with a client, or a former client within two years following termination of therapy, soliciting sexual relations with a client, or committing an act of sexual

abuse, or sexual misconduct with a client, or committing an act punishable as a sexually related crime, if that act or solicitation is substantially related to the qualifications, functions, or duties of a marriage and family therapist.

(l) Performing, or holding oneself out as being able to perform, or offering to perform, or permitting any trainee or registered intern under supervision to perform, any professional services beyond the scope of the license authorized by this chapter.

(m) Failure to maintain confidentiality, except as otherwise required or permitted by law, of all information that has been received from a client in confidence during the course of treatment and all information about the client that is obtained from tests or other means.

(n) Prior to the commencement of treatment, failing to disclose to the client or prospective client the fee to be charged for the professional services, or the basis upon which that fee will be computed.

(o) Paying, accepting, or soliciting any consideration, compensation, or remuneration, whether monetary or otherwise, for the referral of professional clients. All consideration, compensation, or remuneration shall be in relation to professional counseling services actually provided by the licensee. Nothing in this subdivision shall prevent collaboration among two or more licensees in a case or cases. However, no fee shall be charged for that collaboration, except when disclosure of the fee has been made in compliance with subdivision (n).

(p) Advertising in a manner that is false, fraudulent, misleading, or deceptive, as defined in Section 651.

(q) Reproduction or description in public, or in any publication subject to general public distribution, of any psychological test or other assessment device, the value of which depends in whole or in part on the naivete of the subject, in ways that might invalidate the test or device.

~~(r) Any conduct in the supervision of any registered intern, associate clinical social worker, or trainee by any licensee that violates this chapter or any rules or regulations adopted by the board.~~

(~~s~~r) Performing or holding oneself out as being able to perform professional services beyond the scope of one's competence, as established by one's education, training, or experience. This subdivision shall not be construed to expand the scope of the license authorized by this chapter.

(~~t~~s) Permitting a trainee or registered intern under one's supervision or control to perform, or permitting the trainee or registered intern to hold himself or herself out as competent to perform, professional services beyond the trainee's or registered intern's level of education, training, or experience.

(~~u~~t) The violation of any statute or regulation governing the gaining and supervision of experience required by this chapter.

(~~v~~u) Failure to keep records consistent with sound clinical judgment, the standards of the profession, and the nature of the services being rendered.

(~~w~~v) Failure to comply with the child abuse reporting requirements of Section 11166 of the Penal Code.

(~~x~~w) Failure to comply with the elder and dependent adult abuse reporting requirements of Section 15630 of the Welfare and Institutions Code.

(~~y~~x) Willful violation of Chapter 1 (commencing with Section 123100) of Part 1 of Division 106 of the Health and Safety Code.

(~~z~~y) Failure to comply with Section 2290.5.

(~~aa~~z) (1) Engaging in an act described in Section 261, 286, 288a, or 289 of the Penal Code with a minor or an act described in Section 288 or 288.5 of the Penal Code regardless of whether the act occurred prior to or after the time the registration or license was issued by the board. An act described in this subdivision occurring prior to
the effective date of this subdivision shall constitute unprofessional conduct and shall subject the licensee to refusal, suspension, or revocation of a license under this section.

(2) The Legislature hereby finds and declares that protection of the public, and in particular minors, from sexual misconduct by a licensee is a compelling governmental interest, and that the ability to suspend or revoke a license for sexual conduct with a minor occurring prior to the effective date of this section is equally important to protecting the public as is the ability to refuse a license for sexual conduct with a minor occurring prior to the effective date of this section.

(~~ab~~aa) Engaging in any conduct that subverts or attempts to subvert any licensing examination or the administration of an examination as described in Section 123.

§1833. ~~EXPERIENCE~~SUPERVISION: REQUIRED DOCUMENTATION

~~(a) In order for experience to qualify under Section 4980.40 of the Code, it must meet the following criteria:~~

~~(1) It, it must have been gained in accordance with Sections 4980.42 through 4980.45 of the Code and the regulations contained in this article.~~

~~(2) Experience shall not be credited for more than forty (40) hours in any week.~~

~~(3) No more than five hundred (500) hours of experience will be credited for providing group therapy or group counseling.~~

~~(4) For any person who enrolls in a qualifying degree program on or after January 1, 1990, not less than five hundred (500) total hours of experience shall have been gained in diagnosing and treating couples, families, and children.~~

~~(b) The term "supervision", as used in this article, includes ensuring that the extent, kind, and quality of counseling performed is consistent with the education, training, and experience of the person being supervised; reviewing client/patient records, monitoring and evaluating assessment, diagnosis, and treatment decisions of the intern or trainee; monitoring and evaluating the ability of the intern or trainee to provide services at the site(s) where he or she will be practicing and to the particular clientele being served; and ensuring compliance with laws and regulations governing the practice of marriage and family therapy. Supervision shall include~~

~~that amount of direct observation, or review of audio or video tapes of therapy, as deemed appropriate by the supervisor. Supervision shall be credited only upon the following conditions:~~

~~(1) During each week in which experience is claimed and for each work setting in which experience is gained, an applicant shall have at least one (1) hour of one-on-one, individual, face-to-face supervisor contact or two (2) hours of face-to-face supervisor contact in a group of not more than eight (8) persons receiving supervision. No more than five (5) hours of supervision, whether individual or group, shall be credited during any single week.~~

~~(2) The applicant shall have received at least one (1) hour of one-on-one, individual, face-to-face supervisor contact per week for a minimum of fifty-two (52) weeks.~~

~~(3) Any experience obtained under the supervision of a spouse, relative, or domestic partner shall not be credited toward the required hours of supervised experience. Any experience obtained under the supervision of a supervisor with whom the applicant has had or currently has a personal or business relationship which undermines the authority or effectiveness of the supervisor shall not be credited toward the required hours of supervised experience.~~

~~(4)~~ (a) Pursuant to Section 4980.43.4 of the Business and Professions Code, ~~In~~in a setting which is not a private practice, ~~the authorized supervisor may be employed by the applicant's employer on either a paid or a voluntary basis. If such employment is on a voluntary basis,~~ a written agreement must be executed between the applicant's supervisor and the ~~organization~~employer when the supervisor is not employed by the applicant's employer or is a volunteer. ~~,~~ The written agreement must be executed prior to commencement of supervision, ~~in which the supervisor agrees~~ and must contain an agreement by the supervisor to ensure that the extent, kind, and quality of counseling performed by the intern or trainee is consistent with the intern or trainee's training, education, and experience, and is appropriate in extent, kind, and quality. The agreement shall contain an acknowledgment by the employer that the employer:

(A) Is aware of the licensing requirements that must be met by the intern or trainee and agrees not to interfere with the supervisor's legal and ethical obligations to ensure compliance with those requirements; and

(B) Agrees to provide the supervisor access to clinical records of the clients counseled by the intern or trainee.

~~(c) Professional enrichment activities may be credited toward the experience requirement as specified in this article and by Section 4980.43 of the Code.~~

~~(1) No more than two hundred fifty (250) hours of verified attendance, with the approval of the applicant's supervisor, at workshops, seminars, training sessions, or conferences directly related to marriage and family therapy will be credited.~~

~~(2) No more than one hundred (100) hours of psychotherapy, which will be triple counted, received as specified in Section 4980.43 of the Code, will be credited.~~

~~(d) Experience gained by interns and trainees shall be subject to the following conditions, as applicable:~~

~~(1) When an intern employed in private practice is supervised by someone other than the employer, the supervisor must be employed by and practice at the same site(s) as the intern's~~

~~employer.~~

~~(2) A trainee shall not perform services in a private practice.~~

~~(3) Interns and trainees may only perform services as employees or volunteers and not as independent contractors.~~

(b) Prior to the commencement of any counseling or supervision, the supervisor shall sign under penalty of perjury the "Responsibility Statement for Supervisors of a Marriage and Family Therapist Trainee or Intern", as specified in section 1833.1.

~~(e)~~(c) ~~Effective January 1, 1991, trainees~~Trainees and interns shall maintain a log of all hours of experience gained toward licensure. The log, form #1800 37A-524 (REV 1/11) and form #1800 37A-524a (REV 1/11) shall be signed by the supervisor on a weekly basis. An applicant shall retain all logs until such time as the applicant is licensed by the board. The board shall have the right to require an applicant to submit all or such portions of the log as it deems necessary to verify hours of experience.

NOTE: Authority cited: Section 4980.35 and 4980.60, Business and Professions Code. Reference: Sections 4980.35, 4980.40, and 4980.42 through 4980.45, Business and Professions Code.

§1833.1. REQUIREMENTS FOR SUPERVISORS

Any person supervising a trainee or an intern (hereinafter "supervisor") within California shall comply with the requirements below.

(a) Prior to the commencement of any counseling or supervision, the supervisor shall sign under penalty of perjury the "Responsibility Statement for Supervisors of a Marriage and Family Therapist Trainee or Intern" (revised 3/10, form #1800 37A-523), hereby incorporated by reference, requiring that:

(1) The supervisor possesses and maintains a current ~~valid~~ and active California license as either a marriage and family therapist, licensed clinical social worker, licensed professional clinical counselor, licensed psychologist, or physician who is certified in psychiatry as specified in Section 4980.03 (g) of the Code and has been so licensed in California or in any other state for at least two of the past five years immediately prior to commencing any supervision. ~~; or~~

~~(A) Provides supervision only to trainees at an academic institution that offers a qualifying degree program as specified in Section 4980.40 (a) of the Code; and~~

~~(B) Has been licensed in California as specified in Section 4980.03 (g) of the Code, and in any other state, for a total of at least two years prior to commencing any supervision.~~

(2) A supervisor who is not licensed as a marriage and family therapist, shall have sufficient experience, training, and education in marriage and family therapy to competently practice marriage and family therapy in California.

(3) The supervisor shall be competent in the areas of clinical practice and techniques being supervised, and shall keep~~The supervisor keeps~~ himself or herself informed of developments in marriage and family therapy and in California law governing the practice of marriage and family

therapy.

(4) The supervisor has and maintains a current and active California license in good standing and will immediately notify the trainee or intern of any disciplinary action, including revocation or suspension, even if stayed, probation terms, inactive license status, or any lapse in licensure that affects the supervisor's ability or right to supervise.

(5) The supervisor has practiced psychotherapy or provided direct supervision of trainees, interns, associate clinical social workers, or professional clinical counselor interns who perform psychotherapy for at least two (2) years within the five (5) year period immediately preceding any supervision.

(6) The supervisor has had sufficient experience, training, and education in the area of clinical supervision to competently supervise trainees or interns. Persons licensed by the board who provide supervision shall complete the minimum supervision training or coursework specified in Section 1834.

> ~~(A) Persons licensed by the board who provide supervision shall complete a minimum of six (6) hours of supervision training or coursework in each renewal period while providing supervision. This training or coursework may apply towards the continuing education requirements set forth in Sections 4980.54, 4996.22, and 4999.76 of the Code.~~
>
> ~~(B) Persons licensed by the board who provide supervision and who have not met requirements of subsection (A), shall complete a minimum of six (6) hours of supervision training or coursework within sixty (60) days of commencement of supervision.~~

(7) The supervisor knows and understands the laws and regulations pertaining to both the supervision of trainees and interns and the experience required for licensure as a marriage and family therapist.

(8) The supervisor shall ensure that the extent, kind, and quality of counseling performed is consistent with the education, training, and experience of the trainee or intern.

(9) The supervisor shall monitor and evaluate the extent, kind, and quality of counseling performed by the trainee or intern by direct observation, review of audio or video tapes of therapy, review of progress and process notes and other treatment records, or by any other means deemed appropriate by the supervisor.

(10) The supervisor shall address with the trainee or intern the manner in which emergencies will be handled.

(b) Each supervisor shall provide the trainee or intern with the original signed “Responsibility Statement for Supervisors of a Marriage and Family Therapist Intern or Trainee”(revised 3/10, form #1800 37A-523) prior to the commencement of any counseling or supervision. Trainees and interns shall provide the board with the signed “Responsibility Statement for Supervisors of a Marriage and Family Therapist Intern or Trainee” (revised 3/10, form #1800 37A-523) from each supervisor upon application for licensure.

(c) A supervisor shall give at least one (1) week's prior written notice to a trainee or intern of the supervisor's intent not to sign for any further hours of experience for such person. A supervisor

who has not provided such notice shall sign for hours of experience obtained in good faith where such supervisor actually provided the required supervision.

(d) The supervisor shall obtain from each trainee or intern for whom supervision will be provided, the name, address, and telephone number of the trainee's or intern's most recent supervisor and employer.

~~(e) In any setting that is not a private practice, a supervisor shall evaluate the site(s) where a trainee or intern will be gaining hours of experience toward licensure and shall determine that: (1) the site(s) provides experience which is within the scope of practice of a marriage and family therapist; and (2) the experience is in compliance with the requirements set forth in section 1833 and section 4980.43 of the Code.~~

(f) Upon written request of the board, the supervisor shall provide to the board any documentation which verifies the supervisor's compliance with the requirements set forth in this section.

~~(g) The board shall not deny hours of experience gained towards licensure by any supervisee due to failure of his or her supervisor to complete the training or coursework requirements in subsection (a) (6) (A).~~

NOTE: Authority cited: Sections 4980.40, 4980.60, and 4990.20 Business and Professions Code. Reference: Sections 4980.03,4980.35, 4980.42 through 4980.45, 4980.48, 4980.54 ,4996.22, and 4999.76, Business and Professions Code.

§1833.2. SUPERVISION OF EXPERIENCE GAINED OUTSIDE OF CALIFORNIA

Experience gained outside of California ~~on or after January 1, 1991~~ must have been supervised in accordance with the following criteria:

At the time of supervision, the supervisor was licensed or certified by the state in which the supervision occurred and possessed a current and active license which was not under suspension or probation. The supervisor was licensed or certified by that state, for at least two (2) of the past five (5) years immediately prior to acting as supervisor, as either a psychologist, clinical social worker, licensed physician certified in psychiatry ~~as specified in Section 4980.40(f) of the code~~by the American Board of Psychiatry and Neurology, professional clinical counselor, or a marriage and family therapist or similarly titled marriage and family practitioner.

In a state which does not license or certify marriage and family therapists or similarly titled marriage and family practitioners, experience may be obtained under the supervision of a person who at the time of supervision held a clinical membership in the American Association of Marriage and Family Therapists for at least two years and who maintained such membership throughout the period of supervision.

Note: Authority cited: Sections 4980.35, 4980.40(f) and 4980.60, Business and Professions Code. Reference: Sections 4980.35, 4980.40(f), 4980.42-4980.45 and 4980.90, Business and Professions Code.

§1834. SUPERVISOR TRAINING AND COURSEWORK

Persons licensed by the board who provide supervision shall complete, at a minimum,

supervision training or coursework as follows:

(a) Beginning January 1, 2019, supervisors who commence supervision for the first time shall obtain fifteen (15) contact hours in supervision training or coursework obtained from a government agency or from a continuing education provider specified as acceptable by the Board in regulation. If taken from a continuing education provider specified as acceptable by the Board in regulation, training may apply towards the approved continuing education requirements set forth in Sections 4980.54, 4996.22, and 4999.76 of the Code.

1) The content of such training shall include, but not be limited to, current best practices and current standards regarding the following:

(A) Competencies necessary for new supervisors;
(B) Goal setting and evaluation;
(C) The supervisor-supervisee relationship;
(D) California law and ethics, including legal and ethical issues related to supervision;
(E) Cultural variables, including, but not limited to, race, gender, social class, and religious beliefs;
(F) Contextual variables, such as treatment modality, work settings, and use of technology;
(G) Supervision theories and literature; and
(H) Documentation and record keeping of the supervisee's client files, as well as supervision.

2) If taken from a government agency or a continuing education provider, this course shall have been taken within 2 years prior to commencing supervision, or within 60 days after commencing supervision. If taken at a master's or higher level from an accredited or approved postsecondary institution, this course shall have been taken within 4 years prior to commencing supervision, or completed within 60 days after commencing supervision.

(b) A six (6) hour supervision training course shall be taken by an individual who has previously qualified as a supervisor, but has not supervised for at least 2 years within the 5 year period immediately preceding any supervision.

(c) Supervisors shall complete a minimum of six (6) hours of continuing professional development in supervision in each renewal period while providing supervision. This shall consist of one or more of the following activities:

1) Training or coursework directly covering the topic of supervision, obtained from a government agency or from a continuing education provider specified as acceptable by the board in regulation. If taken from a continuing education provider specified as acceptable by the board in regulation, it may apply towards the continuing education requirements set forth in Sections 4980.54, 4996.22, and 4999.76 of the Code;

2) Teaching a supervision course as specified in subparagraph (1).

3) Authoring research pertaining to supervision that has been published professionally.

4) Receiving mentoring of supervision or supervision of supervision from another board licensee who also qualifies as a supervisor.

5) Documented attendance at supervisor peer discussion groups.

(d) (1)In lieu of subparagraphs (a), (b), and (c), the Board shall accept a valid and active approved supervisor certification from one of the following entities:

(A) The American Association for Marriage and Family Therapy (AAMFT)
(B) The American Board of Examiners in Clinical Social Work (ABECSW)
(C) The California Association of Marriage and Family Therapists (CAMFT)
(D) The Center for Credentialing and Education (CCE)

(2)These licensees shall maintain a current and active California license, but are not required to have been actively licensed for at least two of the past five years immediately preceding any supervision, and are not required to have practiced psychotherapy or provided direct supervision of trainees or registrants for at least two of the past five years immediately preceding any supervision.

(3)The board may, in its sole discretion, accept an approved supervisor certification from another entity if the licensee can demonstrate that the certification requirements of that entity meet or exceed those of the above entities.

(e) The board shall not deny hours of experience gained towards licensure by any supervisee due to failure of his or her supervisor to complete the training or coursework requirements in this section.

§1835. DOCUMENTATION OF SUPERVISOR QUALIFICATIONS: AUDITS

The board shall have the right to audit the records of any supervisor to verify the completion of the supervisor's qualifications. Supervisors shall maintain records of completion of the required supervisor qualifications for a period of seven (7) years after completion of supervision, and shall make these records available to the board for auditing purposes upon request.

ATTACHMENT B

Reference Sections – Current Law: BPC §4980.43, 16 CCR §§ 1833, 1833.1, 1833.2

§4980.43. PROFESSIONAL EXPERIENCE; INTERNS OR TRAINEES

(a) To qualify for licensure as specified in Section 4980.40, each applicant shall complete experience related to the practice of marriage and family therapy under a supervisor who meets the qualifications set forth in Section 4980.03. The experience shall comply with the following:

(1) A minimum of 3,000 hours of supervised experience completed during a period of at least 104 weeks.

(2) A maximum of 40 hours in any seven consecutive days.

(3) A minimum of 1,700 hours obtained after the qualifying master's or doctoral degree was awarded.

(4) A maximum of 1,300 hours obtained prior to the award date of the qualifying master's or doctoral degree.

(5) A maximum of 750 hours of counseling and direct supervisor contact prior to the award date of the qualifying master's or doctoral degree.

(6) No hours of experience may be gained prior to completing either 12 semester units or 18 quarter units of graduate instruction.

(7) No hours of experience may be gained more than six years prior to the date the application for examination eligibility was filed, except that up to 500 hours of clinical experience gained in the supervised practicum required by subdivision (c) of Section 4980.37 and subparagraph (B) of paragraph (1) of subdivision (d) of Section 4980.36 shall be exempt from this six-year requirement.

(8) A minimum of 1,750 hours of direct counseling with individuals, groups, couples, or families, that includes not less than 500 total hours of experience in diagnosing and treating couples, families, and children.

(9) A maximum of 1,250 hours of nonclinical practice, consisting of direct supervisor contact, administering and evaluating psychological tests, writing clinical reports, writing progress or process notes, client centered advocacy, and workshops, seminars, training sessions, or conferences directly related to marriage and family therapy that have been approved by the applicant's supervisor.

(10) It is anticipated and encouraged that hours of experience will include working with elders and dependent adults who have physical or mental limitations that restrict their ability to carry out normal activities or protect their rights.

This subdivision shall only apply to hours gained on and after January 1, 2010.

(b) An individual who submits an application for examination eligibility between January 1, 2016, and December 31, 2020, may alternatively qualify under the experience requirements that were in place on January 1, 2015.

(c) All applicants, trainees, and registrants shall be at all times under the supervision of a supervisor who shall be responsible for ensuring that the extent, kind, and quality of counseling performed is consistent with the training and experience of the person being supervised, and who shall be responsible to the board for compliance with all laws, rules, and regulations governing the practice of marriage and family therapy. Supervised experience shall be gained by an intern or trainee only as an employee or as a volunteer. The requirements of this chapter regarding gaining hours of experience and supervision are applicable equally to employees and volunteers. Experience shall not be gained by an intern or trainee as an independent contractor.

(1) If employed, an intern shall provide the board with copies of the corresponding W-2 tax forms for each year of experience claimed upon application for licensure.

(2) If volunteering, an intern shall provide the board with a letter from his or her employer verifying the intern's employment as a volunteer upon application for licensure.

(d) Except for experience gained by attending workshops, seminars, training sessions, or conferences as described in paragraph (9) of subdivision (a), supervision shall include at least one hour of direct supervisor contact in each week for which experience is credited in each work setting, as specified:

(1) A trainee shall receive an average of at least one hour of direct supervisor contact for every five hours of client contact in each setting. No more than six hours of supervision, whether individual or group, shall be credited during any single week.

(2) An individual supervised after being granted a qualifying degree shall receive at least one additional hour of direct supervisor contact for every week in which more than 10 hours of client contact is gained in each setting. No more than six hours of supervision, whether individual or group, shall be credited during any single week.

(3) For purposes of this section, "one hour of direct supervisor contact" means one hour per week of face-to-face contact on an individual basis or two hours per week of face-to-face contact in a group.

(4) Direct supervisor contact shall occur within the same week as the hours claimed.

(5) Direct supervisor contact provided in a group shall be provided in a group of not more than eight supervisees and in segments lasting no less than one continuous hour.

(6) Notwithstanding paragraph (3), an intern working in a governmental entity, a school, a college, or a university, or an institution that is both nonprofit and charitable may obtain the required weekly direct supervisor contact via two-way, real-time videoconferencing. The supervisor shall be responsible for ensuring that client confidentiality is upheld.

(7) All experience gained by a trainee shall be monitored by the supervisor as specified by regulation.

(8) The six hours of supervision that may be credited during any single week pursuant to paragraphs (1) and (2) shall apply to supervision hours gained on or after January 1, 2009.

(e) (1) A trainee may be credited with supervised experience completed in any setting that meets all of the following:

(A) Lawfully and regularly provides mental health counseling or psychotherapy.

(B) Provides oversight to ensure that the trainee's work at the setting meets the experience and supervision requirements set forth in this chapter and is within the scope of practice for the profession as defined in Section 4980.02.

(C) Is not a private practice owned by a licensed marriage and family therapist, a licensed professional clinical counselor, a licensed psychologist, a licensed clinical social worker, a licensed physician and surgeon, or a professional corporation of any of those licensed professions.

(2) Experience may be gained by the trainee solely as part of the position for which the trainee volunteers or is employed.

(f) (1) An intern may be credited with supervised experience completed in any setting that meets both of the following:

(A) Lawfully and regularly provides mental health counseling or psychotherapy.

(B) Provides oversight to ensure that the intern's work at the setting meets the experience and supervision requirements set forth in this chapter and is within the scope of practice for the profession as defined in Section 4980.02.

(2) An applicant shall not be employed or volunteer in a private practice, as defined in subparagraph (C) of paragraph (1) of subdivision (e), until registered as an intern.

(3) While an intern may be either a paid employee or a volunteer, employers are encouraged to provide fair remuneration to interns.

(4) Except for periods of time during a supervisor's vacation or sick leave, an intern who is employed or volunteering in private practice shall be under the direct supervision of a licensee that has satisfied subdivision (g) of Section 4980.03. The supervising licensee shall either be employed by and practice at the same site as the intern's employer, or shall be an owner or shareholder of the private practice. Alternative supervision may be arranged during a supervisor's vacation or sick leave if the supervision meets the requirements of this section.

(5) Experience may be gained by the intern solely as part of the position for which the intern volunteers or is employed.

(g) Except as provided in subdivision (h), all persons shall register with the board as an intern to be credited for postdegree hours of supervised experience gained toward licensure.

(h) Postdegree hours of experience shall be credited toward licensure so long as the applicant applies for the intern registration within 90 days of the granting of the qualifying master's or doctoral degree and is thereafter granted the intern registration by the board. An applicant shall not be employed or volunteer in a private practice until registered as an intern by the board.

(i) Trainees, interns, and applicants shall not receive any remuneration from patients or clients, and shall only be paid by their employers.

(j) Trainees, interns, and applicants shall only perform services at the place where their employers regularly conduct business, which may include performing services at other locations, so long as the services are performed under the direction and control of their employer and supervisor, and in compliance with the laws and regulations pertaining to supervision. For purposes of paragraph (3) of subdivision (a) of Section 2290.5, interns and trainees working under licensed supervision, consistent with subdivision (c), may provide services via telehealth within the scope authorized by this chapter and in accordance with any regulations governing the use of telehealth promulgated by the board. Trainees and interns shall have no proprietary interest in their employers' businesses and shall not lease or rent space, pay for furnishings, equipment, or supplies, or in any other way pay for the obligations of their employers.

(k) Trainees, interns, or applicants who provide volunteered services or other services, and who receive no more than a total, from all work settings, of five hundred dollars ($500) per month as reimbursement for expenses actually incurred by those trainees, interns, or applicants for services rendered in any lawful work setting other than a private practice shall be considered employees and not independent contractors. The board may audit applicants who receive reimbursement for expenses, and the applicants shall have the burden of demonstrating that the payments received were for reimbursement of expenses actually incurred.

(l) Each educational institution preparing applicants for licensure pursuant to this chapter shall consider requiring, and shall encourage, its students to undergo individual, marital or conjoint, family, or group counseling or psychotherapy, as appropriate. Each supervisor shall consider, advise, and encourage his or her interns and trainees regarding the advisability of undertaking individual, marital or conjoint, family, or group counseling or psychotherapy, as appropriate. Insofar as it is deemed appropriate and is desired by the applicant, the educational institution and supervisors are encouraged to assist the applicant in locating that counseling or psychotherapy at a reasonable cost.

§1833. EXPERIENCE

(a) In order for experience to qualify under Section 4980.40 of the Code, it must meet the following criteria:

(1) It must have been gained in accordance with Sections 4980.42 through 4980.45 of the Code and the regulations contained in this article.

(2) Experience shall not be credited for more than forty (40) hours in any week.

(3) No more than five hundred (500) hours of experience will be credited for providing group therapy or group counseling.

(4) For any person who enrolls in a qualifying degree program on or after January 1, 1990, not less than five hundred (500) total hours of experience shall have been gained in diagnosing and treating couples, families, and children.

(b) The term "supervision", as used in this article, includes ensuring that the extent, kind, and quality of counseling performed is consistent with the education, training, and experience of the person being supervised; reviewing client/patient records, monitoring and evaluating

assessment, diagnosis, and treatment decisions of the intern or trainee; monitoring and evaluating the ability of the intern or trainee to provide services at the site(s) where he or she will be practicing and to the particular clientele being served; and ensuring compliance with laws and regulations governing the practice of marriage and family therapy. Supervision shall include that amount of direct observation, or review of audio or video tapes of therapy, as deemed appropriate by the supervisor. Supervision shall be credited only upon the following conditions:

(1) During each week in which experience is claimed and for each work setting in which experience is gained, an applicant shall have at least one (1) hour of one-on-one, individual, face-to-face supervisor contact or two (2) hours of face-to-face supervisor contact in a group of not more than eight (8) persons receiving supervision. No more than five (5) hours of supervision, whether individual or group, shall be credited during any single week.

(2) The applicant shall have received at least one (1) hour of one-on-one, individual, face-to-face supervisor contact per week for a minimum of fifty-two (52) weeks.

(3) Any experience obtained under the supervision of a spouse, relative, or domestic partner shall not be credited toward the required hours of supervised experience. Any experience obtained under the supervision of a supervisor with whom the applicant has had or currently has a personal or business relationship which undermines the authority or effectiveness of the supervisor shall not be credited toward the required hours of supervised experience.

(4) In a setting which is not a private practice, the authorized supervisor may be employed by the applicant's employer on either a paid or a voluntary basis. If such employment is on a voluntary basis, a written agreement must be executed between the supervisor and the organization, prior to commencement of supervision, in which the supervisor agrees to ensure that the extent, kind, and quality of counseling performed by the intern or trainee is consistent with the intern or trainee’s training, education, and experience, and is appropriate in extent, kind, and quality. The agreement shall contain an acknowledgment by the employer that the employer:

(A) Is aware of the licensing requirements that must be met by the intern or trainee and agrees not to interfere with the supervisor's legal and ethical obligations to ensure compliance with those requirements; and

(B) Agrees to provide the supervisor access to clinical records of the clients counseled by the intern or trainee.

(c) Professional enrichment activities may be credited toward the experience requirement as specified in this article and by Section 4980.43 of the Code.

(1) No more than two hundred fifty (250) hours of verified attendance, with the approval of the applicant's supervisor, at workshops, seminars, training sessions, or conferences directly related to marriage and family therapy will be credited.

(2) No more than one hundred (100) hours of psychotherapy, which will be triple counted, received as specified in Section 4980.43 of the Code, will be credited.

(d) Experience gained by interns and trainees shall be subject to the following conditions, as applicable:

(1) When an intern employed in private practice is supervised by someone other than the employer, the supervisor must be employed by and practice at the same site(s) as the intern's employer.

(2) A trainee shall not perform services in a private practice.

(3) Interns and trainees may only perform services as employees or volunteers and not as independent contractors.

(e) Effective January 1, 1991, trainees and interns shall maintain a log of all hours of experience gained toward licensure. The log, form #1800 37A-524 (REV 1/11) and form #1800 37A-524a (REV 1/11) shall be signed by the supervisor on a weekly basis. An applicant shall retain all logs until such time as the applicant is licensed by the board. The board shall have the right to require an applicant to submit all or such portions of the log as it deems necessary to verify hours of experience.

NOTE: Authority cited: Section 4980.35 and 4980.60, Business and Professions Code. Reference: Sections 4980.35, 4980.40, and 4980.42 through 4980.45, Business and Professions Code.

§1833.1. REQUIREMENTS FOR SUPERVISORS

Any person supervising a trainee or an intern (hereinafter "supervisor") within California shall comply with the requirements below.

(a) Prior to the commencement of any counseling or supervision, the supervisor shall sign under penalty of perjury the “Responsibility Statement for Supervisors of a Marriage and Family Therapist Trainee or Intern” (revised 3/10, form #1800 37A-523), hereby incorporated by reference, requiring that:

(1) The supervisor possesses and maintains a current valid California license as either a marriage and family therapist, licensed clinical social worker, licensed professional clinical counselor, licensed psychologist, or physician who is certified in psychiatry as specified in Section 4980.03 (g) of the Code and has been so licensed in California for at least two years prior to commencing any supervision; or

(A) Provides supervision only to trainees at an academic institution that offers a qualifying degree program as specified in Section 4980.40 (a) of the Code; and

(B) Has been licensed in California as specified in Section 4980.03 (g) of the Code, and in any other state, for a total of at least two years prior to commencing any supervision.

(2) A supervisor who is not licensed as a marriage and family therapist, shall have sufficient experience, training, and education in marriage and family therapy to competently practice marriage and family therapy in California.

(3) The supervisor keeps himself or herself informed of developments in marriage and family therapy and in California law governing the practice of marriage and family therapy.

(4) The supervisor has and maintains a current license in good standing and will immediately

notify the trainee or intern of any disciplinary action, including revocation or suspension, even if stayed, probation terms, inactive license status, or any lapse in licensure that affects the supervisor's ability or right to supervise.

(5) The supervisor has practiced psychotherapy or provided direct supervision of trainees, interns, associate clinical social workers, or professional clinical counselor interns who perform psychotherapy for at least two (2) years within the five (5) year period immediately preceding any supervision.

(6) The supervisor has had sufficient experience, training, and education in the area of clinical supervision to competently supervise trainees or interns.

(A) Persons licensed by the board who provide supervision shall complete a minimum of six (6) hours of supervision training or coursework in each renewal period while providing supervision. This training or coursework may apply towards the continuing education requirements set forth in Sections 4980.54, 4996.22, and 4999.76 of the Code.

(B) Persons licensed by the board who provide supervision and who have not met requirements of subsection (A), shall complete a minimum of six (6) hours of supervision training or coursework within sixty (60) days of commencement of supervision.

(7) The supervisor knows and understands the laws and regulations pertaining to both the supervision of trainees and interns and the experience required for licensure as a marriage and family therapist.

(8) The supervisor shall ensure that the extent, kind, and quality of counseling performed is consistent with the education, training, and experience of the trainee or intern.

(9) The supervisor shall monitor and evaluate the extent, kind, and quality of counseling performed by the trainee or intern by direct observation, review of audio or video tapes of therapy, review of progress and process notes and other treatment records, or by any other means deemed appropriate by the supervisor.

(10) The supervisor shall address with the trainee or intern the manner in which emergencies will be handled.

(b) Each supervisor shall provide the trainee or intern with the original signed “Responsibility Statement for Supervisors of a Marriage and Family Therapist Intern or Trainee”(revised 3/10, form #1800 37A-523) prior to the commencement of any counseling or supervision. Trainees and interns shall provide the board with the signed “Responsibility Statement for Supervisors of a Marriage and Family Therapist Intern or Trainee” (revised 3/10, form #1800 37A-523) from each supervisor upon application for licensure.

(c) A supervisor shall give at least one (1) week's prior written notice to a trainee or intern of the supervisor's intent not to sign for any further hours of experience for such person. A supervisor who has not provided such notice shall sign for hours of experience obtained in good faith where such supervisor actually provided the required supervision.

(d) The supervisor shall obtain from each trainee or intern for whom supervision will be provided, the name, address, and telephone number of the trainee’s or intern’s most recent

supervisor and employer.

(e) In any setting that is not a private practice, a supervisor shall evaluate the site(s) where a trainee or intern will be gaining hours of experience toward licensure and shall determine that: (1) the site(s) provides experience which is within the scope of practice of a marriage and family therapist; and (2) the experience is in compliance with the requirements set forth in section 1833 and section 4980.43 of the Code.

(f) Upon written request of the board, the supervisor shall provide to the board any documentation which verifies the supervisor's compliance with the requirements set forth in this section.

(g) The board shall not deny hours of experience gained towards licensure by any supervisee due to failure of his or her supervisor to complete the training or coursework requirements in subsection (a) (6) (A).

NOTE: Authority cited: Sections 4980.40, 4980.60, and 4990.20 Business and Professions Code. Reference: Sections 4980.03,4980.35, 4980.42 through 4980.45, 4980.48, 4980.54 ,4996.22, and 4999.76, Business and Professions Code.

§1833.2. SUPERVISION OF EXPERIENCE GAINED OUTSIDE OF CALIFORNIA

Experience gained outside of California on or after January 1, 1991 must have been supervised in accordance with the following criteria:

At the time of supervision, the supervisor was licensed or certified by the state in which the supervision occurred and possessed a current license which was not under suspension or probation. The supervisor was licensed or certified by that state, for at least two (2) years prior to acting as supervisor, as either a psychologist, clinical social worker, physician certified in psychiatry as specified in Section 4980.40(f) of the code, professional clinical counselor, or a marriage and family therapist or similarly titled marriage and family practitioner.

In a state which does not license or certify marriage and family therapists or similarly titled marriage and family practitioners, experience may be obtained under the supervision of a person who at the time of supervision held a clinical membership in the American Association of Marriage and Family Therapists for at least two years and who maintained such membership throughout the period of supervision.

Note: Authority cited: Sections 4980.35, 4980.40(f) and 4980.60, Business and Professions Code. Reference: Sections 4980.35, 4980.40(f), 4980.42-4980.45 and 4980.90, Business and Professions Code.

Board of Behavioral Sciences

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Memo

To:	Supervision Committee Members	**Date:**	April 22, 2016
From:	Christy Berger Regulatory Analyst	**Telephone:**	(916) 574-7817
Subject:	**Allowing Supervision of Students to Satisfy Supervisor Two-Year Experience Requirement**		

For a licensee to qualify as a supervisor for any of the professions regulated by the Board, he or she must meet the following requirements:

- Be licensed for at least two (2) years
- For at least two (2) years within the five (5) year period immediately preceding any supervision, meet one of the following:
    - Have practiced psychotherapy OR
    - Provided direct supervision to pre-licensees who perform psychotherapy (depending on the profession may include trainees, interns, associate clinical social workers)

The Committee has been asked by stakeholders with the County of San Bernardino to consider allowing a licensee, who directly supervises students providing clinical counseling services as part of a degree program that leads to LPCC or LCSW licensure, to be counted toward the two years of experience required to become (and remain) a BBS-qualified supervisor. Additionally, several stakeholders attending a Marriage and Family Therapist consortium meeting expressed the desire to see this changed.

Stakeholders believe that a change would help increase the availability of supervisors, which can be hard to find, and also believe that it would correct what appears to be an inequity between the professions.

The scenario that stakeholders described is when the agency hires a licensee who qualifies to be a BBS supervisor as a Clinic Supervisor or Program Manager, and the job does not involve providing psychotherapy (which is common). If this individual was supervising only social work

students and LPCC trainees, in two years they would no longer be qualified to supervise and would lose their job. In order to re-qualify, they must take a job performing psychotherapy.

Upon review of the regulations, staff found that the types of supervisees allowed to count toward the two years varies somewhat between the professions (see Attachment). However, all professions allow direct supervision of LMFT students who are providing psychotherapy to count toward the two years of experience, likely because pre-degree hours count toward licensure. However, two of the professions allow supervision of LPCC students to count, even though pre-degree hours are not accepted toward licensure.

Although pre-degree hours do not count toward LCSW or LPCC licensure, the supervision of students providing clinical services is very similar, with the main difference being that the supervisor does not have to meet all of the BBS-imposed requirements (for the BBS requirements they must meet, see the Attachment). These individuals would instead be following the school's and employer's requirements, and for social work students, requirements set forth by the Council on Social Work Education.

Recommendation: *Allow supervision of students who are providing psychotherapy in degree program for any of the three professions to count toward the "two of the past five years" experience requirement to remain a supervisor, if the supervision provided is substantially equivalent to supervision provided for those gaining experience toward licensure.*

Suggested language:

> "The supervisor has practiced psychotherapy or provided direct clinical supervision of LMFT trainees, LMFT interns, LPCC interns, or associate clinical social workers who perform psychotherapy, for at least two (2) years within the five (5) year period immediately preceding any supervision.
>
> Supervision of LPCC trainees or social work students enrolled in an accredited master's or doctoral program who perform psychotherapy, shall be accepted toward the required two (2) years if the supervision provided to the student is substantially equivalent to the supervision required for registrants."

ATTACHMENT

Comparison of Law - Types of Supervisees who Count Toward Two Years

LMFT – Title 16, CCR section 1833.1(a)(5)
The supervisor has practiced psychotherapy or provided **direct supervision of trainees, interns, associate clinical social workers, or professional clinical counselor interns** who perform psychotherapy for at least two (2) years within the five (5) year period immediately preceding any supervision.

LCSW – Title 16, CCR section 1870(a)(4)
The supervisor has practiced psychotherapy or provided **direct supervision of associates, or marriage and family therapist interns or trainees** who perform psychotherapy for at least two (2) years within the last five (5) years immediately preceding supervision.

LPCC – Title 16, California Code of Regulations (CCR) section 1821(b)(5)
The supervisor has practiced psychotherapy or provided **direct supervision of trainees, interns, or associate clinical social workers** who perform psychotherapy for at least two (2) years within the five (5) year period immediately preceding any supervision.

Other Statutes Re: Students/Trainees

LMFT - Business and Professions Code (BPC) section 4980.42. TRAINEES' SERVICES
(a) Trainees performing services in any work setting specified in subdivision (e) of Section 4980.43 may perform those activities and services as a trainee, provided that the activities and services constitute part of the trainee's supervised course of study and that the person is designated by the title "trainee."

(b) Trainees subject to Section 4980.37 may gain hours of experience and counsel clients outside of the required practicum. This subdivision shall apply to hours of experience gained and client counseling provided on and after January 1, 2012.

(c) Trainees subject to Section 4980.36 may gain hours of experience outside of the required practicum but must be enrolled in a practicum course to counsel clients. Trainees subject to Section 4980.36 may counsel clients while not enrolled in a practicum course if the period of lapsed enrollment is less than 90 calendar days, and if that period is immediately preceded by enrollment in a practicum course and immediately followed by enrollment in a practicum course or completion of the degree program.

(d) All hours of experience gained pursuant to subdivisions (b) and (c) shall be subject to the other requirements of this chapter.

(e) All hours of experience gained as a trainee shall be coordinated between the school and the site where the hours are being accrued. The school shall approve each site and shall have a written agreement with each site that details each party's responsibilities, including the methods

by which supervision shall be provided. The agreement shall provide for regular progress reports and evaluations of the student’s performance at the site. If an applicant has gained hours of experience while enrolled in an institution other than the one that confers the qualifying degree, it shall be the applicant’s responsibility to provide to the board satisfactory evidence that those hours of trainee experience were gained in compliance with this section.

LCSW – BPC section 4996.15. PERFORMANCE OF PSYCHOSOCIAL WORK BY PERSONS IN ACADEMIC INSTITUTIONS, GOVERNMENT AGENCIES OR NONPROFIT ORGANIZATIONS; SOCIAL WORK INTERN

Nothing in this article shall restrict or prevent activities of a psychosocial nature on the part of persons employed by accredited academic institutions, public schools, government agencies, or nonprofit institutions engaged in the training of graduate students or social work interns pursuing the course of study leading to a master's degree in social work in an accredited college or university, or working in a recognized training program, provided that these activities and services constitute a part of a supervised course of study and that those persons are designated by such titles as social work interns, social work trainees, or other titles clearly indicating the training status appropriate to their level of training. The term "social work intern," however, shall be reserved for persons enrolled in a master's or doctoral training program in social work in an accredited school or department of social work.

LPCC – BPC section 4999.36. TRAINEE ACTIVITIES AND SERVICES; APPLICANT AND SCHOOL RESPONSIBILITIES

(a) A clinical counselor trainee may perform activities and services provided that the activities and services constitute part of the clinical counselor trainee's supervised course of study and that the person is designated by the title "clinical counselor trainee."

(b) All practicum and field study hours gained as a clinical counselor trainee shall be coordinated between the school and the site where hours are being accrued. The school shall approve each site and shall have a written agreement with each site that details each party's responsibilities, including the methods by which supervision shall be provided. The agreement shall provide for regular progress reports and evaluations of the student's performance at the site.

(c) If an applicant has gained practicum and field study hours while enrolled in an institution other than the one that confers the qualifying degree, it shall be the applicant's responsibility to provide to the board satisfactory evidence that those practicum and field study hours were gained in compliance with this section.

(d) A clinical counselor trainee shall inform each client or patient, prior to performing any professional services, that he or she is unlicensed and under supervision.

(e) No hours earned while a clinical counselor trainee may count toward the 3,000 hours of postdegree internship hours.