Washington State Behavioral Health Workforce

Policy Recommendations – Straw Proposals

Topic II: Supervision Requirements

Proposal 2.1: Remove barriers to effective tele-precepting for supervision in clinical education and pre-licensure settings.

- **Policy Action**: Support the use of tele-precepting for clinical supervision, including but not limited to:
    a. Amending relevant laws and policies to allow tele-supervision hours to apply towards a greater percentage of the overall supervision hours required for clinical education requirements, and for licensure requirements.
    b. Address barriers in student access to electronic health records (EHRs) in tele-precepting, such as supports for secure remote access to the EHR for students/trainees, with appropriate data privacy protections and oversight in place.
- **Rationale**: As with provision of behavioral health services via phone- and video-based telehealth, provision of clinical supervision via telephonic or video interaction has become necessary, widespread, and is reported to be beneficial to clinicians and supervisors alike. Current laws limit the number of tele-supervision hours which can apply towards clinical education requirements and licensure requirements. Some students and trainees lack access to EHR patient information due to security and/or IT funding concerns, which is disrupting training and creating additional work for supervisors/preceptors of these students.

Proposal 2.2: Create a task force to assess the impact of, and potentially propose revisions to, current supervision requirements on the size, distribution, and availability of the behavioral health workforce in Washington.

- **Policy Action**: Form a specialized workgroup to investigate the extent to which and reasons why supervision requirements vary by behavioral health occupation, and the history and impact of the statutory authority. Taskforce could include experts in legal/judicial matters, behavioral health quality assurance, and behavioral health credentialing to examine options for how different types of supervisors (clinical, administrative, etc.) could work in concert to support more efficient and effective training for behavioral health trainees.
- **Rationale**: Changes to supervision requirements should involve behavioral health, legal, quality assurance, and credentialing experts to determine and develop consensus around recommendations for improving supervision requirements. A dedicated, member-assigned taskforce could ensure the necessary expertise is included. Considerations for the taskforce could include:
    - Why must different supervision requirements be completed for different behavioral health occupations to gain licensure?
    - Why are there significant limitations to which professional credentials are eligible to provide supervision for licensure hours? Both clinical and administrative skills are important for training pre-licensure clinicians, yet not all are equally valued.
    - There is a “career cul-de-sac” issue for some occupations which prevents experienced behavioral health workers from providing clinical supervision to trainees; e.g. mental health professionals (MHPs) may not be eligible to ascend the credential ladder and are not eligible for to provide clinical supervision for licensure, despite their significant experience in the field.

- Some professions have stricter requirements than others (e.g. years in practice, occupation of supervisor) – what is the rationale/basis for this, and could these requirements be made more rational and consistent between professions that are providing similar services?
- Consider standardization of terms related to supervision in behavioral health. For example, alignment of language, including language that translates beyond behavioral healthcare settings; "trainees" (post-graduate, pre-licensure) would be referred to as "residents" or "fellows" in other healthcare settings.

Proposal 2.3: Strengthen, broaden, and deepen training for clinical supervisors.

- **Policy Action**: Create more high-quality opportunities for supervisor training through a Center of Excellence model and/or hub-and-spoke model to promote, support, and sustain behavioral health community efforts for high-quality supervision, with engagement of rural agencies as training sites.
  - *Note: Needs more detail – please recommend!*
- **Rationale**: Clinical supervisors undergo some degree of training as part of the requirements to qualify for a supervisor credential, but stakeholders report there are insufficient opportunities for clinicians who wish to move into a supervisor role, and the existing available training teaches primarily to the Washington Administrative Codes (WACs). Effective training for supervisors should extend beyond WAC to advance general quality of supervision and to promote a more rapid uptake of evidence-based practices (EBPs).

Proposal 2.4: Reduce legal liabilities for providing supervision.

- **Policy Action**: Attract more clinical supervisors by reducing legal liabilities for providing supervision, while upholding measures that promote high quality clinical supervision.
- **Rationale**: Fear of medical legal liability for trainee conduct may be suppressing some interest in becoming a supervisor for behavioral health professions in Washington. Providing concrete assurances to potential supervisors regarding liability protections could help bring in more supervisors.

Proposal 2.5: Identify and provide support for ideas that make supervision easier.

- **Policy Action**: Structure funding supports to promote new models of supervision which allow for division of labor and multiple pathways to working as a supervisor. For example: some sites divide roles into (1) clinical supervision and (2) administrative supervision, which allows supervisors to specialize and master different content areas while distributing the burden of supervision.
- **Rationale**: Some stakeholders reported using bifurcated supervision roles (clinical and administrative) to help improve both quality and ease of supervision, and other stakeholders expressed interest in implementing a similar model. This model may be available without additional legislation.