# ETHICS AND TELEMENTAL HEALTH

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**Learning Objectives:**

Upon completion of the course, learners will be able to:

1. Define terminology basic to telemental health, computers, and technology.
2. Differentiate types of computer security measures.
3. Identify common ethical nuances of telehealth service delivery.
4. Describe best practices in telemental health.
5. Recognize risk management and ethical conduct in telemental health with children, couples, families, groups.
6. Describe supervision via videoconferencing.
7. Identify relevant information related to telehealth from ethics codes from the NASW, APA, and ACA.

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# INTRODUCTION

Prior to the pandemic, telemedicine was gaining traction but usually only in select instances and geographic areas. The use of telehealth necessitated by the pandemic may signal its permanence in many settings. Behavioral health practitioners are adjusting quickly to the demands of providing services via virtual platforms. This type of service provision carries unique ethical challenges. Through the use of potential scenarios, literature review and discussion, this learning material will address the specific ethical challenges, requirements, and demands of telehealth services.

The healthcare industry is widely experiencing a digital transformation. Prior to the pandemic, some estimates anticipated upwards of a 15% increase in telehealth provision from 2014 to 2020 (Gustin et al., 2019). Within the last decade, practitioners and systems have adjusted to electronic health records, which paved the way to patient portals. Telemedicine was slowly gaining traction in healthcare provision, with the most common goal being to increase access to health care in rural areas. The Office for the Advancement of Telehealth (OAT, n.d.) which promotes the use of telehealth technologies for health care delivery, education, and health information services states: "Telehealth is especially critical in rural and other remote areas that lack sufficient health care services, including specialty care".

The pandemic has now sown the seeds for permanent changes in the ways health care is provided, regardless of locale. The initial need for telehealth, prompted by access and efficiency needs, is now bolstered by the need to meet Centers for Disease Control and Prevention (CDC; 2020) safety and accessibility guidelines. The use of telehealth options enables the healthcare workforce to provide essential care to consumers despite the strain of COVID-19 limitations such as social distancing and wearing masks outside of the home.

The Health Resources and Services Administration (2020) defines telehealth as the "use of electronic information and telecommunication technologies to support long-distance clinical health care, patient and professional health-related education, public health, and health administration. Technologies include video conferencing, the internet, store-and-forward imaging, streaming media, and terrestrial and wireless communications" (OAT, n.d.).

There are close to twenty different terms used by regulatory boards that refer to the practice of telemental health services. This course is designed for human services and mental healthcare practitioners including social workers, psychologists, counselors, and marriage and family

therapists and makes use of the terms telehealth, telemental health, and telebehavioral health interchangeably.

Digital options for providing care have existed for some time but used only as the exception. Barriers for its use included digital illiteracy, broadband access, security concerns, and licensing requirements. From January 2020 to April 2020 Zoom reported an increase daily from 10 million to 300 million meetings (Iqbal, 2020). Virtual care provider Teladoc received 50% more patient visits a day in March than was experienced in February. During the same time the Cleveland Clinic reported 17 times more telemedicine visits than its customary monthly usage and speculates that the pandemic has redesigned healthcare communication for good. At the time of this writing 80% of healthcare visits at the Cleveland Clinic are done via telehealth. Telehealth allows for a quick check-in more easily than an in-person meeting. Patients report feeling reassured with these types of virtual "house calls". The Cleveland Clinic has learned:

- Patients and families are desperate for information and look forward to the consistent communication and continual follow up. In almost every case, patients answer their phones when nurses call.
- Patients yearn to understand even the most basic details for properly managing COVID-19 symptoms. They want to know how to deal with the congestion, treat the fever, cope with the difficulty in breathing, and more.
- Patients feel more confident in their ability to overcome COVID-19 when they know nurses are keeping tabs on them. Patients greatly appreciate their nurses and the public health model of care they are providing (Cleveland Clinic, 2020).

The federal government and private insurance companies are facilitating the use of telehealth with unprecedented ease. The Department of Health and Human Services (HHS; 2020) continues to encourage the use of telehealth to deliver non-life-threatening care such as wellness visits, eye exams, nutrition counseling, and mental health support. Several initiatives support this shift in service delivery:

- The Federal Communication Commission (FCC) launched the Keep America Connected Initiative in response to the lack of equal broadband access.

- The FCC COVID-19 Telehealth program supports eligible providers by funding essential elements in delivering care, like devices, telecommunications services, and information services.
- The Center for Medicare and Medicaid Services (CMS) quickly issued measures to make billing and receiving telehealth services easier for those enrolled in Medicare, Medicaid, and Children's Health Insurance Program. Early restrictions, such as reimbursing only for telehealth in rural areas and requiring live video sessions, quickly succumbed to public pressure emphasizing that Medicare and Medicaid recipients often do not have internet access or digital knowledge to use virtual platforms. Thus, phone only visits were also funded. (Groshong, 2020).
- HHS also waived penalties and enforcement discretion related to HIPAA violations for providers delivering service in good faith if using non-compliant platforms out of necessity. In addition, cost-sharing (i.e., co-pays and deductibles) was waived (HHS, 2020).

"As virtual care becomes more integrated into the patient-provider engagement ecosystem through technology and regulatory advancements, traditional "bedside manner" will become "webside manner" (InstaMed, 2020). This shift to increased virtual interactions between consumers and clinicians will force providers to reexamine previous "ways of doing" certain components of care such as building rapport and establishing trust through positive communication skills. In addition to managing all the practical transitions necessary to provide telehealth, providers must ensure that they are practicing within legal and ethical parameters.

'With crisis comes opportunity' is a commonly touted mantra. Tourous and Wykes (2020) assert that the corona virus offers an opportunity for transforming psychiatric care with telehealth. In addition to protecting personal and public health, telehealth increases access to care. However, training to utilize this modality skillfully is needed. Callan and colleagues (2020) identify six areas of needed training in telehealth:

1) tele-mental health therapy,
2) case conceptualization and change mechanisms,
3) cognitive neurosciences,
4) ethics and professional guidelines,
5) governing legislation and regulations pertinent to behavioral health practice, and

6) professional communication and record-keeping.

As precedence telehealth was used temporarily after other natural disasters, such as September 11 in 2001 and Hurricane Katrina in 2005. The current pandemic crisis exceeds the scope of telehealth demands in those circumscribed events. The protracted nature of the crisis contributes to the increase in mental health difficulties. In addition to the concerns about contracting the illness, disruptions in daily life brought about by quarantining, school and business closures, unemployment and financial insecurity create ambiguity and uncertainty that people find difficult to reconcile. "The mental health protective factors of physical activity, sleep, routines, social interactions, and more are being disrupted" (Tourous & Wykes, 2020, p. E1).

Disasters undoubtedly can result in an increase in mental health needs and mental health practitioners have risen to the need during times of disaster as first responders and crisis-intervention experts. Desai and colleagues (2020) assert that psychologists are in a unique position to provide "ongoing and adapted care during a global emergency" (p.1).

As a result of the physical distancing requirements, the healthcare industry has returned to telehealth as a primary vehicle for provision of care. Finding practitioners who excel in using the medium can be difficult. "The need for training among health care professionals is the number 1 priority", particularly skills for building rapport and therapeutic alliance since those skills are often cited by clinicians as reasons NOT to use telehealth (Desai, 2020, p.E1). There is some evidence that clinicians may be more concerned about alliance and rapport than consumers are (McConnochie, 2018).

Undoubtedly, compared to in-person appointments, some clinical nuance is lost. For example, those attending partial hospitalization programs were abruptly terminated without suitable virtual replacement. Both clients and practitioners who are hard of hearing have reported difficulty with using phone sessions. Figure 1, extrapolated from Essig (2020), compares risks and rewards for in-person sessions.

Cost-effectiveness and increased availability to services afforded by telehealth reduces some health disparity in psychiatric and mental health services. Including clients and consumers in designing and lobbying for increased access through digital means would help with the so-called 'digital divide' in society. Telehealth should be offered not because of disasters but rather to offer

improved options for consumers regardless of situational demands. Data supporting the use of telehealth effectively is needed to bolster regulation that may solidify its permanence.

| FIGURE 1: IN-PERSON MENTAL HEALTH THERAPY DURING THE COVID-19 PANDEMIC | |
|---|---|
| REWARDS | RISKS |
| What takes place on screen is fundamentally different relationally. | In-person psychotherapy won't be "normal" with needed safety precautions (e.g., social distancing, masks, safe time limits for being enclosed spaces). |
| Initial intakes provide more contextual nuance and info; easier to establish rapport? | Possibility of contact tracing threatens promise of confidentiality. |
| Insurance companies may impose time limit on teletherapy prematurely, compared to office visits. | Each participant a potential virus threat; may need to conduct session behind mask or shield. Risks personal and public health. |
| Greater need for mental health services after protracted pandemic and its consequences. | Barrier to access: Clients may stop treatment if they feel office or commuting to office is too dangerous. |
| | The personal and public health vigilance required reduces therapeutic benefit. |

With the increase in telehealth as a primary source of healthcare delivery comes a whole new set of ethical challenges, heretofore never encountered. Thus, the exploration of ethical encounters engendered by telehealth is more important than ever.

## COMPUTER BASICS

*A social worker in private practice has a client walk her through the needed technology changes to her videoconferencing set up to improve the video quality during their session. He works in tech and advises her on what security measures to take to ensure his privacy. He advises her to use an ethernet cable so that she is less reliant on Wi-Fi and recommends that she change platforms to one that his company uses.*

Essential principles for ethical practice are that of competency and privacy. As many practitioners switch to providing telehealth services, having basic competency in using the technology becomes a central concern. As such, the technology involved in providing telehealth services is reviewed here. Computers use a combination of hardware and software components. Computer hardware is any part that has a physical structure, such as the internal parts, keyboard, or mouse. Software is the set of instructions that is used to obtain and use the information wanted by an individual. Word processing programs, games, Internet browsers, PowerPoint, spreadsheet programs, and other programs are examples of software. Individuals rely on both hardware and software. Below is a list of terms that are helpful to know.

Many people think of a personal desktop or laptop when they think of computers. However, computers come in diverse shapes and sizes and perform many different functions in daily lives. Several examples of different types of computers are: ATM machines, automobile computer chips, smartphones, personal digital assistants (PDAs), tablets, game consoles, smart televisions, and wearable technologies, such as fitness trackers and smart watches.

## Computer Terminology Basics

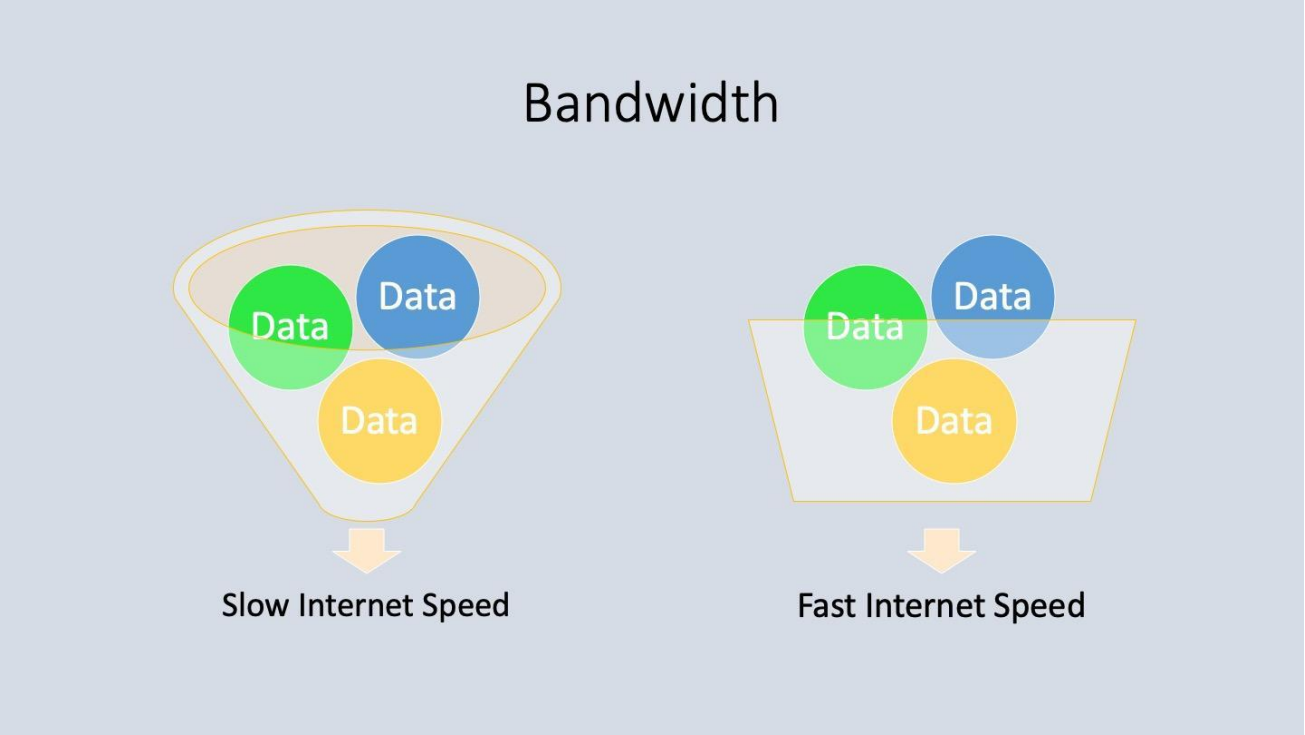
The following discussion provided here is to help therapists interested in implementing a telemental health practice become familiar with commonly used terms and their meanings. These terms relate to computer and internet use (GCFGlobal, 2020; IBM, 2020).

***Application***: An application, or app, is a type of software that allows a user to perform specific tasks. If an application is for a desktop or laptop computer, it's called a desktop application. If it's used for a mobile device, it's called a mobile app. An application program can be self-contained or embedded within a group of programs. It uses the computer's operating system and other supporting systems, such as database programs, word processors, web browsers, social media platforms, wikis (website that visitors can edit), and spreadsheets. There are also many desktop applications. Some offer a variety of features, such as word processing programs, like Microsoft Word, while others offer one to two features, such as a clock or a calendar app. Apps tend to be user friendly, unique, and focused.

***Authentication*:** Authentication is the process of verifying the identity of a person or a device sending or receiving information using passwords, keys, and other automated identifiers (ATA,

2020). Examples of authentication practices are entering in a four- or six-digit passcode to unlock a device, having a username and password for an account, verifying an email at another location in order to enter into an account, or having a code sent to a phone via text message to be entered into a field to gain access. Authentication is discussed in greater detail below in the discussion on computer security.

***Bandwidth:*** Bandwidth is a measure of the information capacity of a communication channel (American Telemedicine Association, 2020). High bandwidth, which allows for fast internet speed (i.e. high-speed internet), is optimal for telemental health videoconferencing, whereas lower bandwidths (e.g., slow internet speed) may result in quality issues like interrupted, slow, or "glitchy" video and audio.

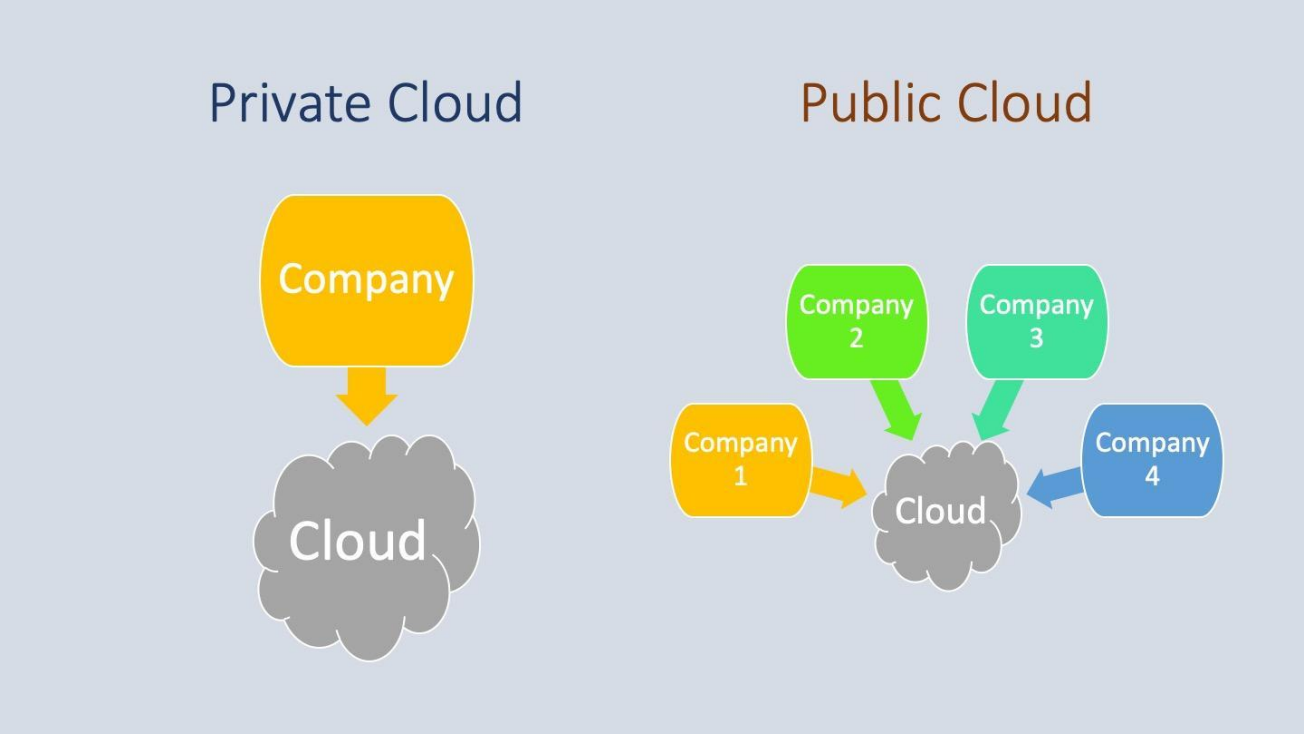



***Bluetooth Card (or Adaptor*)**: Bluetooth is a technology for wireless communication over short distances. It is used to communicate with wireless devices, such as keyboards, mobile phones, laptops, PCs, digital cameras, mice, printers, speakers, and headphones. The communication connection that Bluetooth facilitates is over a secure, globally unlicensed short-range radio frequency and most devices have Bluetooth technology built into the motherboard or included in a wireless network card.

***Broadband:*** This term refers to a high-capacity transmission technique using a wide range of frequencies that allows a number of electronic messages to be communicated simultaneously. It refers to the transmission of signals in a frequency-modulated way over a segment of the total *bandwidth* (see above) that is available (American Telemedicine Association, 2020).

***Cloud:*** The cloud, also called cloud computing or cloud storage, refers to the Internet. When something is stored in the cloud, it means that the data are saved onto an Internet server rather than the computer's hard drive. All email services are web-based, which are stored on an Internet server rather than a personal computer. When data are stored on the cloud (i.e., the Internet), they can be retrieved from any computer with an Internet connection. Individuals commonly use the cloud for file storage, file sharing, and backing up (saving) data.

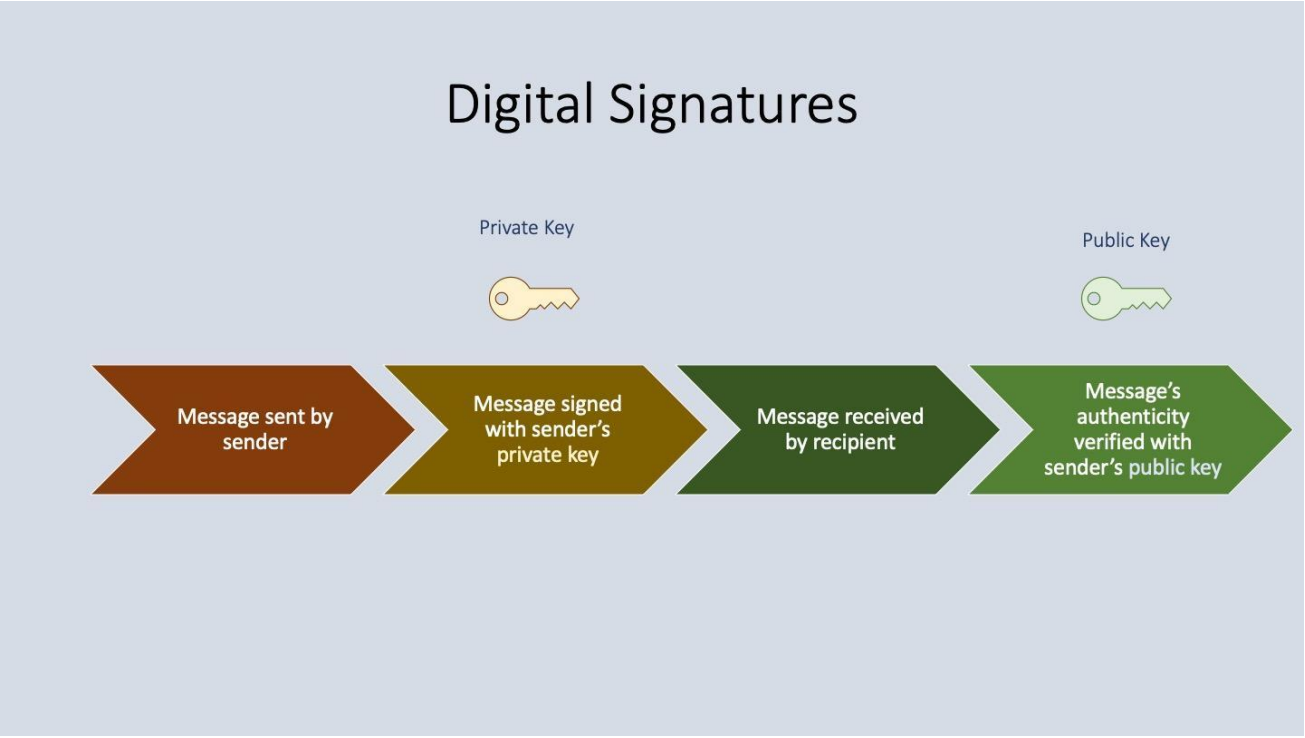
***Cloud Computing:*** This term refers to computer hardware and software that are delivered as a service over the Internet (American Telemedicine Association, 2020). These computing services include servers, storage, databases, networking, software, analytics, and intelligence (Microsoft Azure, 2020). Typically, a customer pays only for the cloud services used, which helps to lower operating costs, run infrastructure more efficiently, and scales up or down as the business changes.



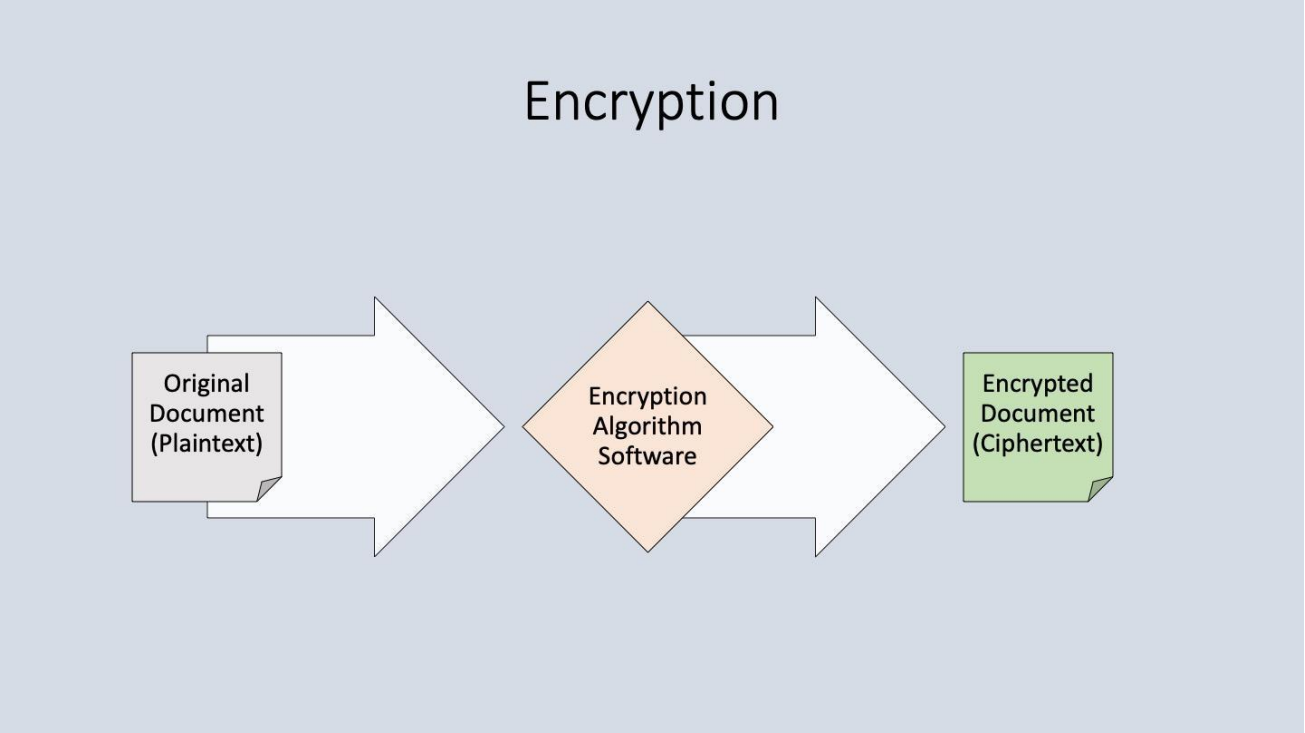
***CPU (Central Processing Unit)/Processor:*** The central processing unit (CPU) is also known as the computer's processor. It is located internally and connected to the motherboard. The CPU is the brain of the computer and carries out the commands of the user. When a user presses a key or clicks the mouse, she is sending instructions to the CPU. The CPU is usually a two-inch ceramic square with a silicon chip embedded in it. A processor can be different speeds. A higher speed processor is desirable for videoconferencing.

***Digital Camera:*** A digital camera allows an individual to capture pictures and videos in a digital format. When connected to a computer through a port, it can transfer images from the camera to the computer. These images can then be sent through e-mail to other individuals or saved and stored as part of an electronic health record. Related to this is the *depth of field* which refers to the degree to which an image remains in focus from front to back as the camera focuses on the main subject (California Telemedicine & eHealth Center, 2020).

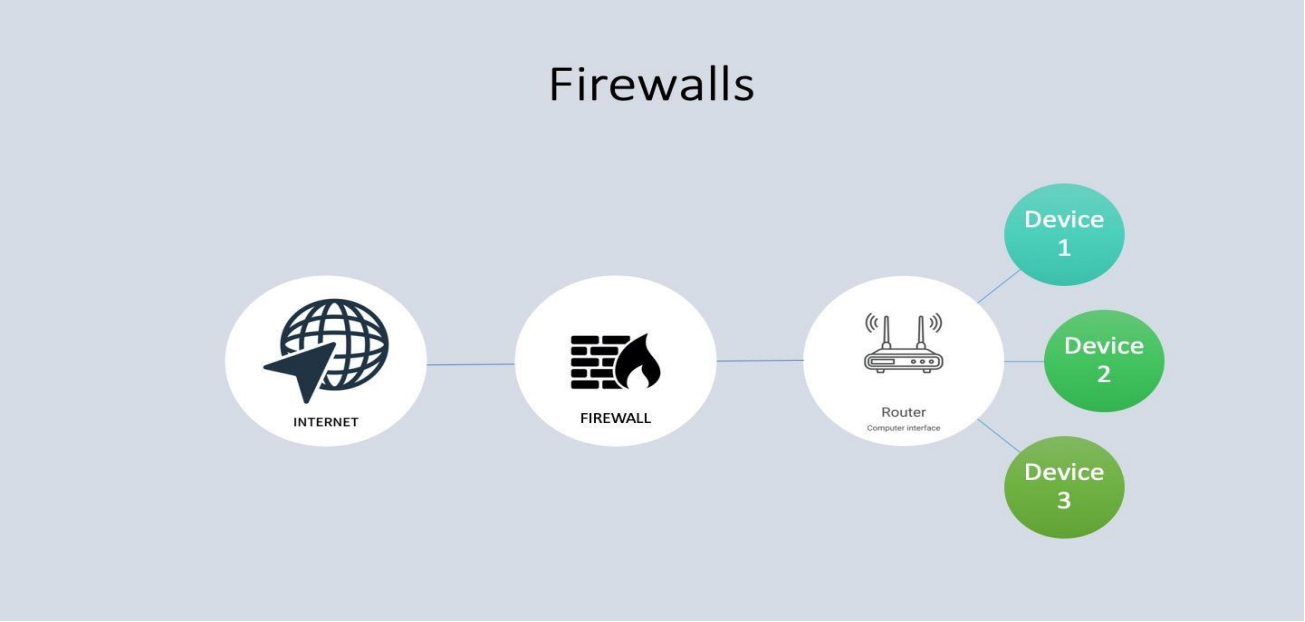
***Digital Signature:*** A digital signature is a mathematical process for authenticating digital messages or documents (American Telemedicine Association, 2020). This digital signature gives the recipient of a document evidence that the message was created by a known sender and not altered in transit. In telemental health services, agency forms, such as consent for treatment, can be signed digitally by clients and then be entered into an electronic health record.



***Encryption:*** Encryption is a process of encoding electronic data so the information cannot be retrieved or decoded by an unintended recipient (American Telemedicine Association, 2020). Only the person or computer system authorized can access encrypted data.



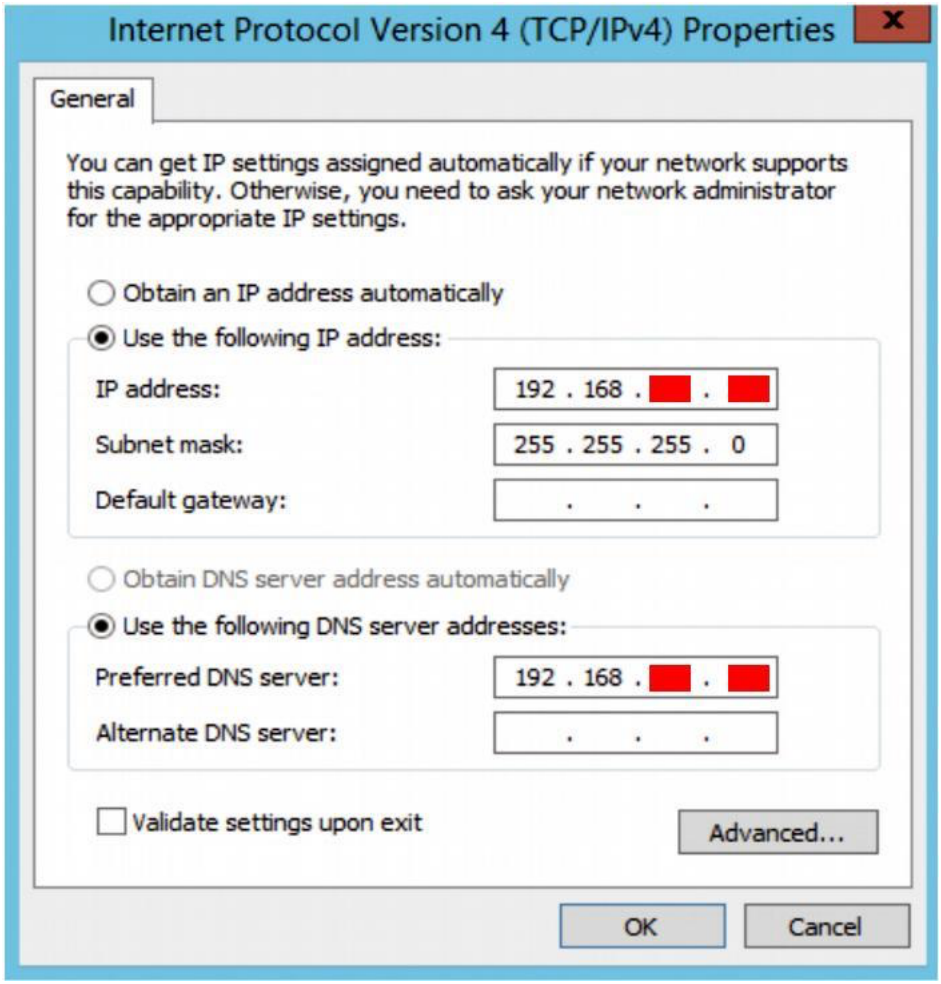

***Firewall:*** A firewall is a computer hardware and software system that blocks unauthorized communications between a clinician's or agency's computer network and external networks.



***GPU (Graphics Processing Unit):*** A GPU is an electronic circuit device that controls what the user sees on the monitor. Most computer GPUs are already built into the motherboard of different devices, such as computers, cell phones, and game consoles. Some GPUs are stored on small video cards that can be plugged into a computer GPU slot. The GPU handles video images while a "sound card" manages audio.

***Hard Drive:*** A hard drive is where software, documents, and other files are stored for long-term. When data on the hard drive are stored, they are saved even when the computer is turned off or unplugged.

***Internet Protocol (IP):*** An internet protocol is the computer's address that uniquely identifies it from other computers on the Internet (American Telemedicine Association, 2020). An IP address does not have an established connection between the end points that are communicating.



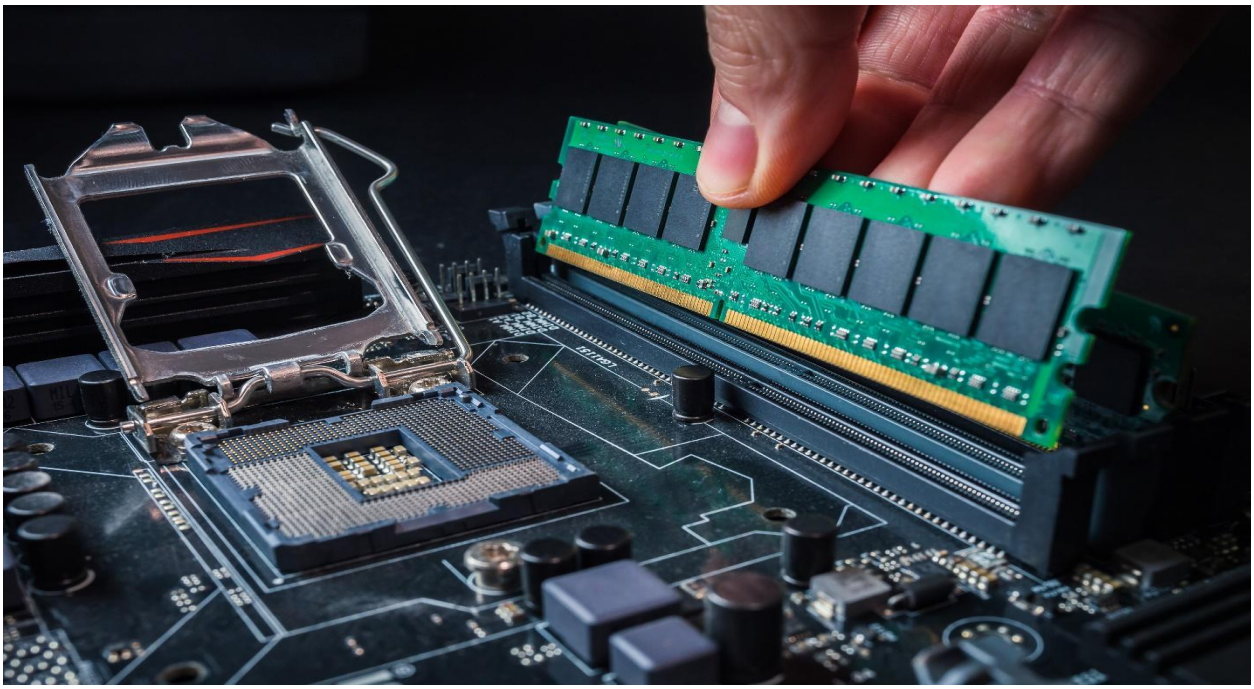
***Malware/Malicious Software:*** Malware is a computer software that is designed to damage computers or steal computer files without the user's consent. It is a general term that can apply to specific types of threats, such as viruses, spyware, worms, trojans, and rootkits.

***Microphone:*** A computer microphone is an integrated device that receives information from a user. This allows an individual to listen to sound or talk to someone using the Internet.

***Mobile Applications:*** Mobile applications are used for devices, such as smartphones and tablets. Examples of mobile apps are Gmail, and Instagram. There are thousands of mobile apps for different types of interests, such as travel, reading, games, navigation, and fitness. Mobile applications can include mental health-related programs, such as managing depression, anxiety, addiction, eating disorders, and post-traumatic stress disorder (PTSD). Some applications are free while others charge its users fees for using it.

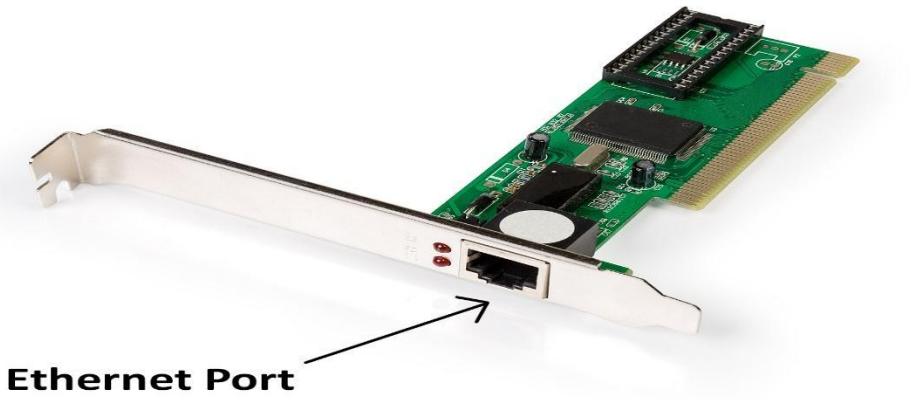
***Mobile Technology:*** Mobile technology is a device that goes where the user goes. It has portable two-way communication devices, computing components, and the ability to connect to Internet networks. Examples of mobile technology are smartphones, tablets, and watches.

***Motherboard:*** A motherboard is the computer's main circuit board. It is a thin metal plate that holds the connectors, memory, CPU, and other hardware to control the video, audio, and connections to the port. It contains the principal components of the device or computer and allows other connectors to other circuit boards.



***Mouse:*** A mouse is a corded or wireless device that moves the computer cursor. Its name originated at the Stanford Research Institute because earlier models had a cord that resembled a mouse tail.

***Network Card:*** A network card allows the computer to communicate over an Internet network. It can either connect with an Ethernet cable, which is plugged into a computer port and into an Internet access point, or through a wireless connection (i.e., Wi-Fi). Network cards can also be expanded and used in a dedicated computer slot.




***Operating System (OS):*** An operating system is the most important software that runs on a computer. This system manages the computer's memory, processes, software, and hardware. This system allows a user to communicate with the computer without having to use computer code language. It coordinates all of the computer components in order to allow the user to complete desired tasks. The three most common operating systems are Microsoft Windows, macOS, and Linux. Microsoft Windows 10, released in 2015, is one of the most popular operating systems; Microsoft Windows 11 is scheduled to be released August 29, 2020 and will be available to the general public. It often comes pre-loaded on most new personal computers. MacOS is an operating system created by Apple and is pre-loaded on all Macintosh computers, called Macs. Some of its newer specific versions are Mojave (released in 2018), High Sierra (released in 2017), and Sierra (released in 2016). Linux is an open-source operating system that is accessible to anyone in the

world. Unlike Windows or macOS, Linux is free and has different versions from which to choose. Mobile devices, such as smartphones, tablets, wearables, and game players have different operating systems than computers or laptops. There are different operating systems for mobile devices. Two of the most popular ones are Google Android and Apple iOS.

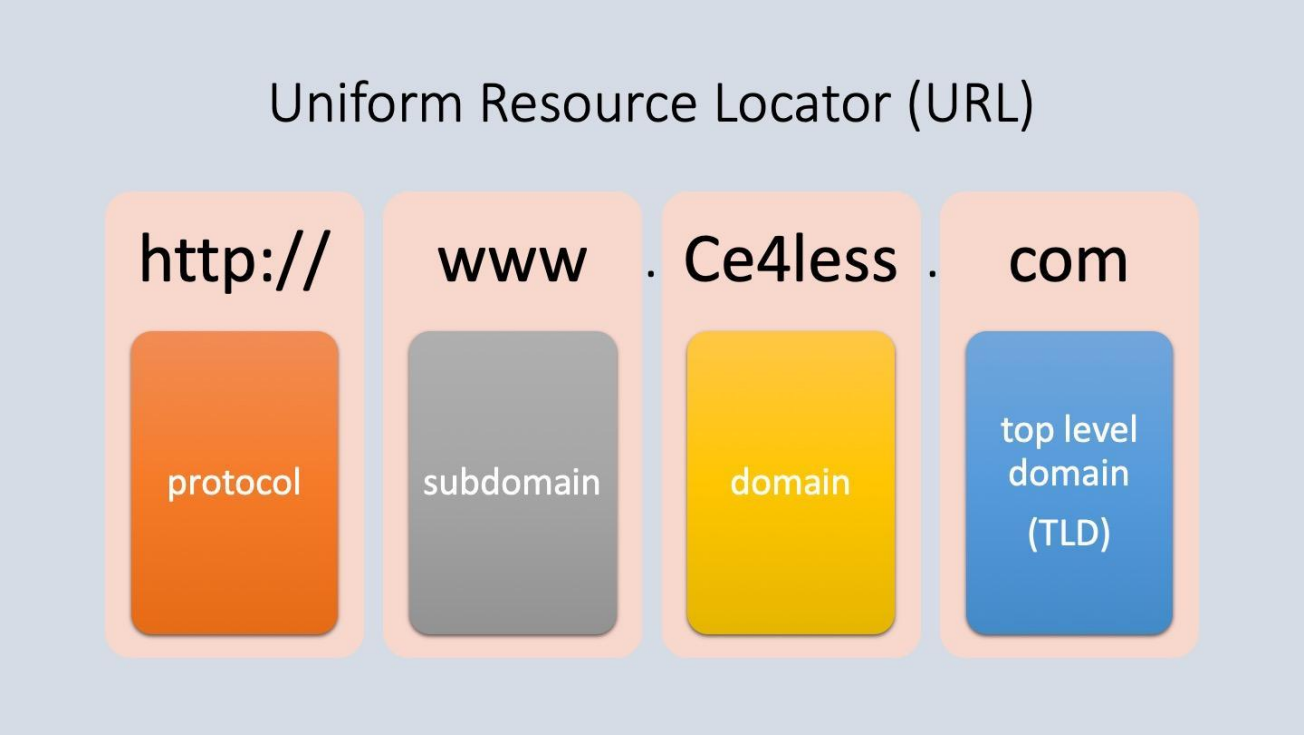
***Port:*** A computer port is a hole or connection on a computer that allows external devices, called peripherals, to be plugged in, such as a printer, an external drive, and a mouse.


***RAM (Random Access Memory):*** RAM is the computer's short-term memory. When the computer performs calculations, it stores the data in the RAM temporarily. When the computer is turned off, the short-term memory disappears unless the user saves the data on a document, spreadsheet, or other type of file. The more RAM a computer has, the more things can be done on a computer at the same time.

***Sound Card/Audio Card:*** A sound card is responsible for the audio sounds in speakers or headphones. Most motherboards have integrated sound cards, but the user can install an additional card to upgrade to a higher quality sound.

***Tablet:*** A tablet is a form of personal computer that is smaller and more portable than a desktop or laptop. It often includes a touch screen, microphone, and web cam. Tablets are compatible with wireless Internet connections and cellular data networks. They are lighter and easier to carry than laptops.

***Uniform Resource Locator (URL):*** A uniform resource locator (URL) is the address of a webpage on the Internet.




***Web browser:*** A web browser is a type of computer application that allows user to access the Internet. Most computers have web browsers pre-installed, but others can be downloaded. Examples of web browser applications are Internet Explorer, Mozilla Firefox, Google Chrome, and Safari.

***Web camera (aka webcam):*** A webcam is type of camera that is either integrated into a computer or is plugged into a computer as an external device. It can record videos, take pictures, and transmit audio or video across the Internet in real time. The webcam is a required component for videoconferencing.

***Wi-Fi:*** Wi-Fi is a wireless networking protocol that allows devices to communicate without having direct cable connections (Pinola, 2020). When not connected via direct cable, devices need Wi-Fi

(usually sourced by a router) to access the Internet – which is then how teleconferencing and other technologies are facilitated for telemental health. In some instances, users can connect to Wi-Fi using their smart phone as the Wi-Fi source (i.e., turning on the phone's "hotspot"). Wi-Fi allows for multiple devices (e.g. lap top, printer, tablet) to connect to the Internet, whereas broadband is a wired connection through a cable attached to a single device. The image below shows the Wi-Fi router as the source in the middle connecting the internet to a smart phone, lap top, desk top, and watch.

## Computer Security

A computer that is attached to the Internet can potentially have many threats, including viruses, malware, and hard drive failure. Malware is a general term used to describe any type of software that can damage computers or files, steal files, or track key strokes without a user's consent (GCFGlobal, 2020). Most malware is distributed over the Internet and is bundled with other software. Antivirus software helps to prevent malware from being installed and removes it from a computer.

Many malware programs exploit the security flaws in other software programs (GCFGlobal, 2020). One way to help prevent this exploitation is to make sure your operating system, browser,

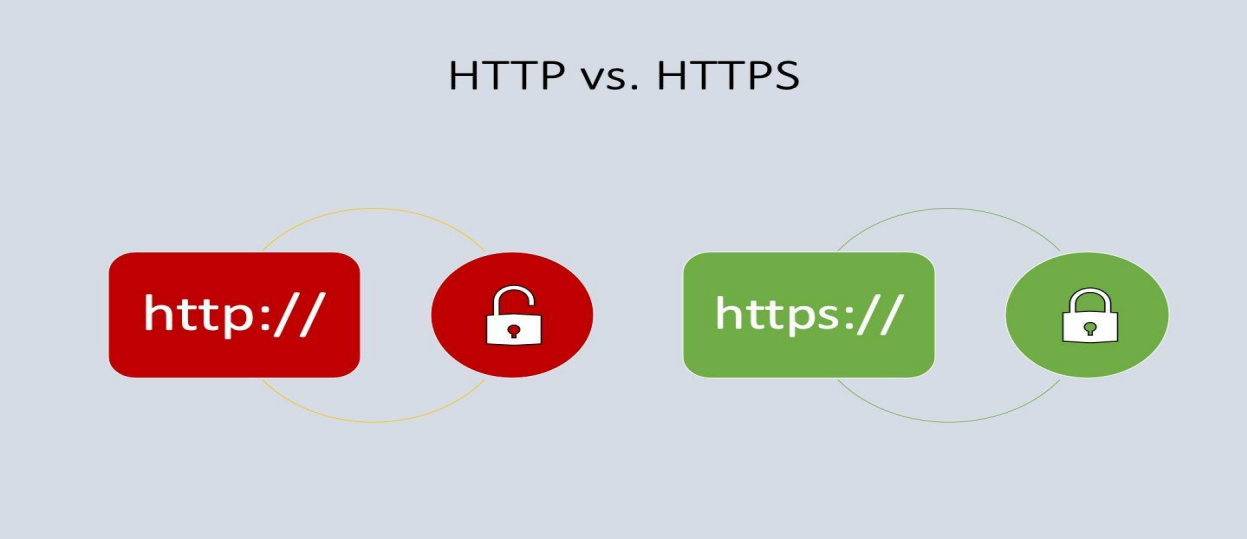
and other programs are updated. These companies often send out "security patches," or updates in order to protect computers from these types of threats. Another way to avoid losing files because of malware, is back up computer files. When a user backs up files, it means she saves her data on an external hard drive that is connected to the computer or uses an online backup service. Then, if files are damaged or stolen, the user has them saved in another place.

Another way of preventing others from stealing or altering data is to create a strong password for files, programs, and applications (GCFGlobal, 2020). Passwords should be long, strong, and difficult for someone else to guess. Below are some tips for creating strong passwords (GCFGlobal, 2020).

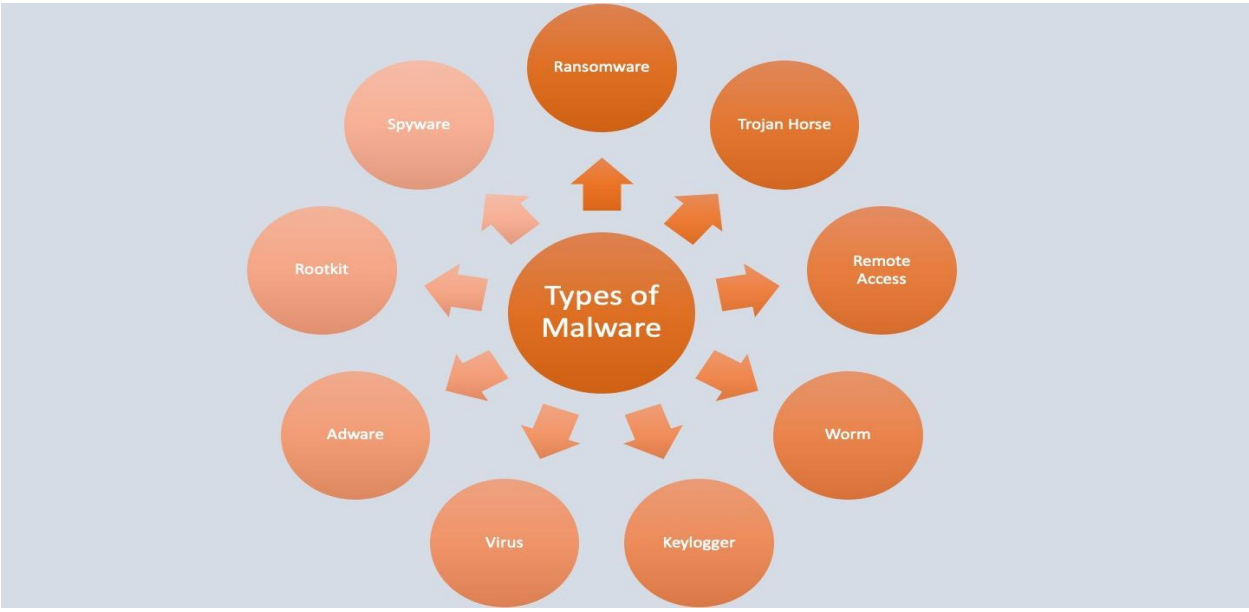
- Do not use personal information, such as your name, birthday, user name, or email address.
- Use a password that is at least six characters long, includes numbers and symbols, and uses both uppercase and lowercase letters.
- Use different passwords for different accounts.

Some common mistakes with passwords are using family names, the same password on multiple accounts, simple patterns, and short passwords.

Malware systems often use deceptive web addresses to trick users into allowing access to their files (GCFGlobal, 2020). Sometimes the web address link will look similar to legitimate web addresses. Double-check the web address (i.e., domain name) for any alterations. A lock symbol in the address bar, usually followed by https://, usually means the website is using a secure connection, which makes it safer to enter information. Not all websites have the symbol. Use caution when a website does not have the lock symbol or the https://.



Avoid suspicious links because often there are malware program hidden in them (GCFGlobal, 2020). Many malware programs require the user to click on a link or download and install a program that appears to be legitimate, but is not. Advertisements on websites that display boxes with "system messages" or "diagnostics" frequently contain malware. Other messages indicating that the user has won a prize or is being investigated often contain malware. Pop-up windows that attempt to lead the user to a different web site can sometimes be malware.




Using Wi-Fi can present a user with security risks. If a home Wi-Fi network is used, the user should make sure it is secure with strong passwords. The user should "disable SSID broadcasting" so that the home network name is not visible to others within the signal range (GCFGlobal, 2020). The user can "enable MAC (Media Access Control) address filtering" to prevent unauthorized wireless users to break into the home network. An SSID broadcast can be disabled by changing the settings on a router or on the web by typing the router's IP address. Directions can be found in the router instruction manual. She can make sure the network uses "WPA (Wi-Fi Protected Access)" or "WPA2." Public Wi-Fi is not as secure as a home network (GCFGlobal, 2020). Sometimes criminals on the Internet, called cybercriminals or hackers, can create seemingly legitimate network names like "Free Wi-Fi," but connect you to a malware network.

***Authentication***

Authentication is a security process of verifying a person's identity or device (Smith, Zhou, & Watzlaf, 2017). Authentication can occur through a variety of ways, such as:

- requiring a user name and password or PIN (personal identification number).

- signing into a website from a known device.
- using a four- or six-digit passcode to unlock a device.
- using a password to open a laptop or computer.
- using biometrics, such as fingerprints or eye scans, to unlock a device.
- enabling a two-factor authentication which requires two steps: a correct login and another verification check (Smith, Zhou, & Watzlaf, 2017).

Authentication allows a user to verify their digital identity. The American Psychiatric Association (2018) recommends that for teleconferencing, administrative and technical specifications should be followed to authenticate practitioners as well as the identity of patients. For telemental health services, the identities of persons at both sites (i.e., practitioners and clients) should be identified, verified, and documented. This documentation can include a) the name and credentials of the provider and the name of the client, b) the location of the client during the session, c) the immediate contact information for both the provider and the client (phone, text message, and/or email), and contact information for other relevant support people, including professional support and family members, and d) expectations about contact between sessions, including a discussion of emergency management between sessions.

The integration of mobile health applications (mHealth)with treatment has become widespread. Typically, these applications are used with smartphone devices and present unique challenges to security (Smith, Zhou, & Watzlaf, 2017). Small devices, such as smartphones and tablets, can be easily stolen or lost and if used for telemental health services can have sensitive information, such as passwords and usernames stored on them. Authentication capabilities for smartphones is a way to prevent unauthorized access to a device (Smith, Zhou, & Watzlaf, 2017).

Knowledge-based authentication, such as a username, password, or PIN, is an easy and convenient way for authentication. However, users must ensure that their passwords, PINs, and usernames have a high level of security (Smith, Zhou, & Watzlaf, 2017). Strong passwords that incorporate a number of features can help users avoid their information being stolen or hacked. Biometric authentication, such as fingerprints, eye scans, and facial scans, are simple to use and have a higher level of security compared to passwords (Smith, Zhou, & Watzlaf, 2017). The increased security of biometric authentication arises from the unique physiology of users. However, this type of authentication can be slow, socially awkward, and may require additional hardware. Behavioral biometric authentication uses a signature, voice, gait, or touch to secure

information (Smith, Zhou, & Watzlaf, 2017). This type of authentication is convenient and utilizes a user's unique traits for secure information. There is a level of increased security because individual behaviors are difficult to replicate. However, some mobile devices have less computational capacity and require increased battery use.

There are currently no HIPAA requirements for specific authentication procedures (Smith, Zhou, & Watzlaf, 2017). A behavioral health provider is responsible for protecting the confidentiality, security, and privacy of client information. Authentication for device access is one way to strengthen protective measures. Single, two- and three-factor authentication measures can be used to increase security for private data.

# TELEMENTAL HEALTH TECHNOLOGY BASICS

Telemental health technologies are mechanisms to provide behavioral health services remotely.

## Types of Technology

### *Live videoconferencing*

Live videoconferencing is a mechanism for providing synchronous services, meaning live interaction in real time (American Telemedicine Association, 2020). Videoconferencing is a way for a provider and client to see one another, interact, and engage on a live monitor or screen. Providers can use live videoconferencing to conduct screenings and assessments, render diagnoses, and provide treatment sessions.

### *Store and forward*

Store and forward is an asynchronous mechanism that transmits information not in real time. It allows for information, resources, images, or video clips to be saved, forwarded, and used whenever convenient. Examples of store and forward technology are: patient data, video clips, photos, or other types of information that can be sent at a later time through texts or emails. These have benefit in behavioral health; for example, clients engaged in cognitive behavioral therapy can use store and forward technology to track targeted behaviors.

### *Remote patient monitoring*

Remote patient monitoring are devices that remotely collect and send data to providers at a remote location (American Telemedicine Association, 2020). Remote patient monitoring systems can help providers assess the health status of a client by collecting information, such as vital signs,

weight, and blood pressure. Psychiatrists or prescribers may use remote patient monitoring to check health status before adding or changing medications.

***Mobile health (mHealth)***

Mobile health applications use the Internet and wireless devices, such as smartphones and tablets, for clients to obtain specialized health information, participate in online discussion groups, collect personal data, or receive peer support (American Telemedicine Association, 2020). There are a number of mHealth apps that can be used for behavioral health services for a range of ages and conditions. An example of an mHealth application is AnxietyCoach that is a self-help app that addresses fears and worries using cognitive-behavioral strategies. The app instructs clients through a variety of exercises from making a list of feared activities to making a plan and tracking anxiety levels to viewing progress. The app is offered free of charge, but only though the iPhone store (https://apps.apple.com/us/developer/mayo-clinic/id350350016). Another mHealth app is the CPT Coach for individuals suffering from symptoms of PTSD who are in active treatment with a professional. This app is designed to be used by a client while in active treatment. The app provides education about PTSD symptoms and step-by-step approach to assessments that align with face-to-face sessions. The app utilizes a number of approaches, including prompts and reminders for appointments and homework assignments. This app is available from the Apple iPhone store and Google Play (https://www.mobile.va.gov/app/cpt-coach). Often behavioral health providers use a variety of approaches to optimize client engagement and participation in treatment.

In general, telemental health technology services are commonly delivered through HIPAA-compliant, cloud-based telehealth sites. These services can be delivered through a variety of devices, including desktop computers, laptops, tablets, smartphones, and smart watches. Telemental health platforms can allow providers to conduct online assessments, secure document storage, schedule appointments, offer online billing, provide secure messaging sites, and offer pdf forms and the ability to sign the forms electronically (eSign).

Telemental health services can be offered in a variety of settings, including private practice, agencies, and large consumer systems, such as hospitals. The types of technologies that are most effective may vary depending upon setting. Telemental Health Comparisons (2020) is an independent website that provides comparisons for telemental health software

(https://telementalhealthcomparisons.com/). This site can be used when a provider registers for a free account.

Practitioners who would like to establish a telemental health practice should keep a few things in mind. One primary issue is being reimbursed for your services. It should be easy to use, HIPPA compliant, and include a variety of useful provider tools, such as e-prescribing, client custom folders, scheduling system, appointment alert, data export options, electronic health record integration, and automated workflows. Providers should understand whether the telemental health system is cloud-based, compatible with provider equipment, such as computers or tablets, and incorporates adequate video resolution, full screen video options, mobile access, and camera abilities, such as tilting, rotating, and zooming. Finally, the technology a provider chooses should include, even if at an additional cost, technical support. Providers are responsible for maintaining their equipment and assisting clients when problems arise. Technical support is vital and should include a variety of mechanisms, such as phone support, email, chat, live video, and/or website support.

## Secured vs. Unsecured Technology

There are many advantages to using telemental health technologies, including ease of delivering services, access to services that many otherwise be inaccessible, ability to receive specialized care, obtain consultations, cost-effectiveness, and increased collaboration among professionals (Zhou et al., 2019). However, clients and providers may be concerned about privacy and security of personal health information. Health data breaches and cyber-attacks targeting medical information has steadily increased with the more frequent reliance on technology. Breaches to protected health information (PHI) are costly for service providers. When breaches occur, the provider is responsible for conducting investigations, notifying clients, recovering data, subscribing to credit monitoring services for clients, hiring security personnel, and strengthening the security of the telemental health technology (Zhou et al., 2019). In order to provide education to consumers and engage in practices that protect clients, clinicians should be familiar with the security of the technologies they use.

An unsecured network refers to an Internet connection that does not require a secure authentication process. Unsecured networks are generally public free wireless Wi-Fi connections (WhatIsMyIPAddress.com, 2020). Free Wi-Fi access allows anyone to use a network without a special authentication system. While a public network is easy and convenient to use, it is

unsecured, so that someone could breach the connection and obtain personal data without consent of the user. Some public connections, also called hot spots, will have a user acknowledge terms and conditions. However, this does not secure the network site.

Most home wireless networks have built-in security features in their routers. There are typically passwords that allow access. However, in order for a home network to be secure, individuals need to take steps to set this up (WhatIsMyIPAddress, 2020). To secure a home network, the user needs to enable security settings and create a router password. There are different levels of encryption, such as WEP, WPA2, and WPA1. WPA2, but each offers a level of security (WhatIsMyIPAddress, 2020). Update and change passwords regularly.

A secured Wi-Fi network is one that uses passwords and security encryption methods to send wireless data (HealthIT.gov, 2020). WPA2 offers encryption that meets the IEEE 802.11i security standard of the Mobile Device Privacy and Security subsection of HealthIT.gov. Another way of providing a secure network is to use a Virtual Private Network (VPN). A VPN provides encryption between a device and the servicer, so information that is sent or received is protected.

## Platforms

A platform is a group of technologies that are used as a base for other applications, processes, or technologies and are commonly offered by a managed service provider (described earlier, examples are Theranest and Simple Practice) for use in telemental health (Techopedia, 2019). A platform uses the computer (hardware) and operating system (software) on which applications run. The platform has a set of standards and functions that are purchased by the user. There are a number of telemental health platforms from which providers can choose:

**Doxy.me:** is a cloud-based platform that does not require downloads. It is free to use and its website notes that it is compliant with several national standards. Website: https://doxy.me/

**Secure Video:** is a telemental health/telehealth platform that offers unlimited technology support, scheduling, branding, virtual waiting room, and a business associate agreement, which verifies that it complies with federal regulatory standards. Website: https://www.securevideo.com/

**Thera-link:** is a telemental health platform that includes several features, such as scheduling, billing, progress notes, virtual waiting room, multiple device capability, and a business associate agreement verifying that it meets federal regulatory standards. Website: https://www.thera-link.com/

**Vidyo:** is a video-based telemental health platform that offers low costs, but does not include hardware and maintenance costs. Website: https://www.vidyo.com

**VSee:** is a platform that includes telemental health, telehealth, and telemedicine kits. Medical device kits can be used with this platform. Website: https://vsee.com/

**WeCounsel:** is a telemental health platform that offers a variety of features, including scheduling, assessments, billing, eSign capabilities, and video- or text-based counseling. Website: https://www.wecounsel.com/telemental-health-platform/

## COMMON TELEHEALTH ETHICAL ENCOUNTERS

Confidentiality is a paramount principle in the provider-patient relationship. Internet-related technologies have complicated privacy and confidentiality responsibilities. In fact, most ethical transgressions that occur in telehealth are related to confidentiality (Aboujadoude, 2019).

> *A clinician has a separate room for providing telehealth to his clients. His adolescent children are in the next room watching TV or playing video games. Although he wears headphones so they can't hear the clients talk, they can hear him through the wall. One of them later comments to him, "Jeez you are pretty repetitive, you say the same thing to different clients."*

Since the kids have no idea who the client is and can't hear the client, does this situation pose an ethical violation?

> *A client is told that because of the pandemic the clinic where he receives therapy will be switching to a video conferencing platform to provide services. The client voices concern about privacy. He will only provide consent to have therapy by phone.*

Self-determination is another guiding principle, particularly in the social work profession, thus we might just abide by the client's wishes. To take his concerns as a cautionary tale though we might also want to reassure each client at the beginning of each session as to the setting and how privacy is protected.

Privacy is related to confidentiality and is also primary in serving clients. Lustgarten and colleagues (2020) expand the definition of telehealth privacy to include more than the client session. Technology use is described as progress in therapy services, emails, texting,

telebehavioral health therapy, electronic medical records, cloud-based storage, application, and standardized assessments are increasingly used to expedite service provision and more efficient collaboration with payors. However, any of these uses can pose a threat of unintended breaches of confidentiality/privacy with untoward consequences. The following is a list of terms commonly used when discussing technology (and technology failures!):

- *Asynchronous Communication* -This term is synonymous with "store and forward" transmission of images and/or data. The data transfer takes place over a period of time that are typically separate, examples include e-mail or texts. The transmission does not take place simultaneously. Asynchronous is contrasted to "synchronous" (see below) (American Telemedicine Association, 2020; California Telemedicine & eHealth Center, 2020). E-mail is increasingly used between providers and clientele but Protected Health Information (PHI) is vulnerable to breaches through this medium. There is no control over the systems that maintain e-mail. In addition, human errors can result in breaches such as sending emails to the wrong recipient. E-mail phishing is another threat to client data. One study found that 25% of psychologists surveyed reported some type of breach to their digital mailbox (Lustgarten et al., 2020). It is recommended that practitioners use encrypted e-mail services. Practitioners should also inform clients about the potential risks in using e-mail.
- *Synchronous* connections are in-person, live interactions that transmit information in both directions at the same time (i.e., in real-time) (American Telemedicine Association, 2020). Examples of synchronous communication are speaking on the telephone or using video conferencing.
- *Applications* (i.e., "apps") used in telemedicine often are self-help tools for clients to record data or symptoms. Although incredibly convenient, and more and more a way of life for many, apps tend to not offer sufficient security to protect client data. For example, text messaging (i.e., texting) is widely used socially, particularly with teenagers and young adults. Commonly, clients expect to be able to use it for communicating about their therapy services. It can be used to schedule and remind them of appointments, send links to psychoeducation information, and sometimes even to suggest an interventive treatment. The ease of texting often results in clients, particularly young ones, expecting to use this as their sole form of communication. "Threats to text messaging privacy can emerge from

individual, corporate, and government actors" (Lustgarten et al., p.26). Individual's phones can be hacked, corporations may scan data for advertising or marketing purposes, and government agencies may intercept messages as part of surveillance programs. Therefore, clients should be informed that privacy is not assured with text messaging. Informed consents can include risks of texting and suggest that notifications be set to locked. Providers concerned with compliance are encouraged to de-identify information when transmitting via text message. (Lustgarten et al., p. 26). Further, providers must be aware that recipients of texts may not be alone when they receive texts. Some providers use 'end-to-end encryption' for the most security.

- An *electronic health record* (EHR) is a digital collection of health information about individual patients that is recorded in electronic formats and is capable of being shared across health care settings across network-connected information systems (American Telemedicine Association, 2020). Electronic health records (EHRs) generally include client demographic information, intake forms, consent forms, medical history, medication, allergies, immunization status, laboratory results, medical test results, collateral client data, crisis plans, progress notes, intake assessments, treatment plans, and financial information. Other terms for EHR are electronic medical record (EMR), personal health record (PHR) and electronic patient record (EPR). EHRs in telemental health and their storage are a possible service provided by managed service providers (defined below) – including health record templates that clinicians or clients complete which are then stored in HIPAA compliant ways for the clinician's access and use.
- A *managed service provider* can offer various applications on a central server. Customers generally pay a fee to access the applications over secure Internet connections or a private network. Customers do not need to purchase, install, or maintain the software themselves. Rather, they rent (e.g., monthly subscriptions) the applications from a managed service provider that they need. The managed service provider generally handles software upgrades and software fixes (American Telemedicine Association, 2020). Mental health practitioners may already access these types of services if they use on-line billing applications or interact with particular applications when working with insurance companies. Examples, which are discussed in greater detail later in section on platforms, include doxy.me, Simple Practice, and Theranest.

- *Distant Site* - Sometimes telemental health services are provided to clients at remote clinics, called "originating sites" (see more below). The distant site is *where the practitioner or physician is located* while delivering remote services to clients in other physical locations (i.e., originating site).
- *Originating Site* - When receiving telemental health services, the originating site is where the client is located (as opposed to the *distant site*, where the practitioner is located) (American Telemedicine Association, 2020).

*A client comes to the telesession visibly agitated. She explains that she has just had an argument with her neighbor. As she is explaining it the neighbor comes in her door and says, "You better not be talking to your therapist about me." The client screams at her to get out of her house.*

This type of unexpected intrusion would not happen in an office setting. While it does give in-vivo exposure to what the client is experiencing, it is also an example of sessions being "maliciously observed by outside parties" (Lustgarten et al., p.26).

*About forty-five minutes into the video session the client asks her clinician if she would like to see the room renovation project she has been working on. The clinician agrees and the client takes her on a "tour" of the work being done in her house. While she is walking around with her video phone, the clinician sees a man in the background. Immediately she asks the client who is also in the room with her only to learn it is the handyman who is helping her remodel! It becomes clear that this man was able to hear both client and clinician. The clinician expresses her concern and the client says "Oh, he's okay."*

Clearly this situation represents a confidentiality breach but since the clinician was not told of the person in the background, is she at fault? Does ignorance of a breach exonerate one from sanctions? This above scenario points to the need to have an informed consent specific to the provision of telehealth which includes both the clinician's *and* the client's roles, rights, and responsibilities. Would it be appropriate to include in such consent the client's responsibility to

inform the clinician if another person is in the room? Might it be best practice to check each time with the client to see if they are in a private setting?

*At the next video session with the same client the clinician notes that the client is in a different space than usual.*

*Clinician: "Where are you? I don't recognize the space you are in."*

*Client: "I'm in my bedroom upstairs with the doors shut because the carpenter is downstairs and I know how you feel about that!"*

*Clinician: "How do YOU feel about it? I am just trying to protect your privacy and confidentiality. Would you bring him to your session if we were meeting in person?*

*[client laughs] He shouldn't be privy to our conversations unless you want him to be and then I need permission."*

*Client: "I know, I get it. I appreciate it."*

The ethical breach became a teachable moment that the client absorbed both cognitively and behaviorally.

Informed consent for telebehavioral health should include risks associated with telebehavioral health, exceptions to confidentiality, backup plans for technological difficulties, interruption of service, and emergency plans. Some insurers require that a separate informed consent is signed for telehealth services as a condition of reimbursement (Felton, 2020).

## Creating an Informed Consent Form for Telehealth

Informed consent is typically obtained before or during the intake session that outlines in writing the client and clinician's plan and guidelines for treatment. Informed adult consent typically include treatment issues, such as: a) privacy and confidentiality (e.g., HIPAA), b) type of services that will be provided, c) client rights and responsibilities, d) clinician rights and responsibilities, e) potential risks and benefits of services, f) guidelines for appointments (e.g., scheduling and canceling), g) billing and fees associated with treatment, h)insurance coverage, i)record keeping, j) cases where disclosure is needed, k) how to contact the clinician, l) and other issues relevant to practice (The Center for Ethical Practice, 2020). Informed consent for telemental health services will contain all of the elements as a typical consent form, but with added information that relates specifically to telehealth technology.

Informed consent for telemental health services includes information that specifically relates to the risks, benefits, responsibilities, and roles of using technology (Person-Centered Tech, 2020). Included in a telemental health consent, clinicians may want to include:

a) the name of the software, service, or tool that will be used,

b) the benefits (e.g., convenience, flexibility) and risks of using telemental health services (e.g., potential for faulty Internet connections or disruptions),

c) conditions under which telemental health may be inappropriate and the rights of the therapist to make this determination,

d) rights of the client to decide not to use telemental health technology,

e) telemental health setting and environment (e.g., etiquette, space, video skills),

f) back-up communication plan,

g) information about scheduling and canceling appointments (e.g., reminders of the time zones for the client and practitioner, especially if each is located in a different time zone),

h) safety and emergency plan,

i) security and privacy concerns,

j) whether or not video or audio recordings are allowed, and

k) any other telemental health-related issues specific to a given circumstance.

Telemental health consent adds a layer of considerations that is different than face-to-face sessions. Clinicians may need to practice first with a client before beginning regular therapy sessions. Both the clinician and client may need time to become familiar with the nuances of a specific software or application. They will likely need to discuss potential problems and solutions in order to reduce reluctance or anxiety about using technology. Some telemental health technology providers offer electronic consent forms built-in to their platforms. Clinicians should review their consent forms and other documentation forms in order to ensure that they cover the scope of practice for telemental health.

Preparation is an important step to setting up a telehealth practice. Preparation for telemental health includes choosing a secure platform, learning how to use it, and also creating the necessary intake and informed consent paperwork. Receiving telemental health services is similar to face-to-face services in that treatment approaches, methods of engagement, setting goals, providing treatment, and monitoring outcomes may be similar. The context and environment in which these services are provided are different. There are aspects of telemental health about which clients

should know. For example, there are potentials for different types of privacy breaches when technology is used. There may be unexpected disruptions or equipment failures. A client may decide to suddenly sign off of the technology without the clinician having a chance to discuss something further. Even the physical distance between the provider and client creates a need for planning and preparation in cases of emergency, like psychiatric hospitalization. The most important feature of informed consent for treatment that a client signs is that it includes written protocols and procedures, including emergency situations (Crowe, 2017). Providers should know the contact information for local clinics and hospitals in case the client needs emergency intervention. Clinicians may need to establish collaborative relationships with local agencies so that crises are handled efficiently. All of this information should be included in an informed consent form. Below is an example of a telemental health informed consent form. The National Association of Social Workers (2020) offers a sample of an informed consent form as a template that is different from the one provided below (https://www.socialworkers.org/About/Legal/HIPAA-Help-For-Social-Workers/Telemental-Health). There are varied other professional templates available.

***EXAMPLE OF A CONSENT FORM FOR TELEMENTAL HEALTH SERVICES THAT IS INCLUDED WITH OTHER INTAKE PAPERWORK REQUIRED BY THE BEHAVIORAL HEALTH CARE PROVIDER***

Client Name:

I, _____, agree to participate in teletherapy with a mental health provider at [Name of Agency].

This means that:

- I authorize information about my medical and mental health care to be transferred electronically through an interactive video connection between [Originating Site Agency Name, if applicable] and [Distant Site Agency or Provider].
- I understand that I will be informed of the identities of all people who are present during the teletherapy session and informed of their purpose for attending the session.
- My provider has explained how the teletherapy system works and how it will be used for my treatment.

- My provider has explained how this service will differ from face-to-face sessions, including emotional reactions that may arise due to technology use.
- I understand that my provider will not be physically present during my teletherapy session. Instead, we will see each other electronically.
- I understand that teletherapy is an evolving modality for therapy. As such, there may be potential risks that may not yet be recognized.
- Potential risks include: a) at times the video image may be unclear or inadequate, b) a disruption in the connection may occur, or c) in rare circumstances, the information may be intercepted by unauthorized persons.
- I authorize the release of information pertaining to me determined by my mental health care providers or by my insurance company for the purpose of processing insurance claims.
- I understand that at any time, I may decide to discontinue teletherapy sessions with my provider. My provider will refer me to a local mental health provider who can provide face-to-face services.
- I agree to take every precaution to preserve the confidentiality of my sessions, such as ensuring that calls are taken in a safe and secure location to the extent possible.
- I understand that, under the law, my mental health provider may be required to report to the authorities any information suggesting that I have engaged in behaviors that are dangerous to myself or others.
- My provider has explained the risks and benefits of receiving teletherapy. I understand that I still may need to see a specialist in-person.
- I understand that information from my teletherapy sessions will be protected by HIPPA privacy laws. I may request a copy of my electronic record in writing.

The contact information for my provider is:

- Name:
- Email:
- Phone:

These are the names and phone numbers of my local emergency contacts:

- Local mental health provider:
- Primary care physician:

- Local hospital emergency room:

I voluntarily consent to participate in telemental health services using videoconferencing equipment for the care, treatment, and services deemed necessary and advisable under the terms set forth herein.

Name: Date:

Parent or Legal Guardian: Date:

Usually all video conferencing platforms, such as Skype, Zoom for Healthcare, Doxy.me; Google GSuite Hangouts, are required to sign a Business Associate Agreement (BAA) as HIPAA compliant. This requirement was also waived due to the COVID-19 to emergency. Thus, the need for clients to be aware of possible privacy concerns using these platforms should be included in any informed consent. Practitioners should also take every precaution when using these applications such as using password enabled connections. It should be noted that many regulatory changes and loosening of restrictions are temporary for the duration of the pandemic.

As another risk management strategy practitioners should ensure that their malpractice insurer covers cyber-liability and the provision of telebehavioral health services.

Consider these scenarios:

*Client calls into the telehealth session while she is walking home from the grocery store. Should the clinician advise her to call back when she gets in a more private place?*

*Client tells the clinician to hold on a minute while she goes to the bathroom. Surprisingly. the client takes the phone into the bathroom with her.*

*Client asks the clinician to hold on because someone was at the door. Clinician hears her accepting a package. Client explains she just got a medication delivery.*

*Client does the telehealth session while she is driving. She has the video on the dashboard and reception varies. She tells the clinician to hold on because she has to stop and pick up her daughter.*

*Client puts the laptop on the kitchen counter during the session while she makes dinner.*

*Client in his wheelchair attends the video session shirtless.*

These actual telehealth occurrences demonstrate how telehealth lends itself to an air of informality not usually seen in an office setting. The sometimes more casual nature of telehealth can have the benefit of increasing authenticity and 'humanness' in the therapeutic encounter and also can be disconcerting to both clinicians and clients who prefer a relationship with distinct boundaries.

These scenarios demonstrate the potential for telehealth to take on a casual nature and raise other questions. Should there be a dress code? What was the norm in an office-setting? Should it be the same? Should clinicians dress professionally or casually or 'business casual'? In instances where an agency is employing the clinician there maybe formal platforms and policies that dictate the clinician's behavior while conducting telehealth. But even in scenarios where it is at the discretion of an individual clinician (e.g., when in private practice), that clinician should employ practices that demonstrate respect for the client and the process. In other words, regardless of setting, clinicians will still set the tone for their sessions when using telehealth.

Social platforms characteristically are informal and this informal approach can interfere with the development of professional interpersonal relationships (Gustin et al., 2020). "The casual use of technology for social connections can actually have a disinhibiting effect on behaviors" (Gustin et al., 2020, p.88). In addition, the buffer of technology in interpersonal interactions can result in less empathic connection. Increasing reliance on the internet may influence one's ability to pick up on behavioral nuances, non-verbal cues, and facial expressions. "Telehealth requires professionals to develop the patient-professional relationship in a different and more deliberate way than during in-person encounters...most failures with telehealth uses are associated with these human factors or soft skills" (Gustin et al., 2020, p.89).

The pandemic resulted in an unusual shared stressor between client and clinician. The national rally 'We are all in this together' became a tangible equalizer in the consultation room. Conversation about the impact and experience of the meta-threat creates instant common ground. Because clinicians are not immune to the same stressors and psychological impact of the pandemic as their clients it can also create a barrier. Avoidance of discussion related to the impact on the

client because it triggers anxiety in the clinician is a distinct possibility. How much emotional or other types of clinician self-disclosure is appropriate in such shared trauma?

Self-disclosure has always been a central topic for clinicians to consider ethically and one in which the clinician usually has control. In the face of telehealth and the pandemic self-disclosure is increasingly evident and less control is maintained by the clinician.

> *A clinician is conducting video sessions from her home office. She has worked to make it private and professional looking so she is surprised when the client opens the session by saying, "Where are your dogs?" The clinician is a little uncomfortable thinking that perhaps their relationship has become too familiar. Her coworker suggests that it could be viewed positively as the client is reassured by their mutual like of dogs.*
>
> *A clinician is forced to cancel a scheduled session because her daughter is very ill and had to get tested for COVID at the time of a session. She has never cancelled a session with this long-term client and feels the need to explain why to the client since it is so uncharacteristic. The client is very understanding. Two days later the client calls the clinician to let her know she is thinking of her and hoping all is well. She prefaces her voicemail with "I hope this is not too personal, but if you need someone to talk to or something, I just wanted you to know you could call me."*

Has a seismic shift happened in their relationship and if so, was it the result of an ethical boundary breach by the clinician in sharing information that made the client feel she needed to take care of her therapist? Or has it equalized the relationship in an authentic show of concern?

*A client and clinician have had a steady therapeutic relationship in-person for almost a year. They often start the session with "chit-chat" about current events or interesting experiences but have remained attuned to the client's clinical needs for the most part. At the start of the pandemic they quickly transitioned to telehealth and the chit-chat portion of their sessions has grown longer. They begin sharing the Netflix series each are watching and decide to watch particular episodes during the week so they can discuss it together at each session.*

Has telehealth and its resulting isolation dissolved a therapeutic boundary in quest of a "just-like-me" connection, or has it equalized the relationship in a therapeutic way? Can it be said

for certain whose needs this type of interaction is serving? Is it an example of a dual relationship blossoming? Is this self-disclosure on the therapist's part beneficial to the client?

Creating psychological and physical boundaries are another mainstay of the therapeutic relationship that has been affected by the pandemic and telehealth. As a result of the pandemic, some clinicians have had to use their personal cell phones to either contact clients and/or conduct sessions. The increased accessibility can result in text messages or calls outside normal business hours, blurring the physical boundary of the professional relationship. The American Telemedicine Association (2013) recommends that strategies to curtail the possibility of boundary violations include setting clear parameters and rules for technology use in both verbal agreements and informed consents.

> *A client is discussing the pandemic and makes it clear that she thinks it is all overblown and probably a ploy by the government to "control the people", a belief to which the clinician does not subscribe. She directly asks the clinician: "What do you think? You're smart, I trust you and I want to know your opinion."*

Does the clinician self-disclose his disagreement? How does he respond to be certain, both ethically and clinically, that he is appropriate in protecting the client's psychological safety and trust? Best practices would recommend keeping the primacy of client and protecting therapeutic rapport in any response. As in any direct personal question, responding to the feelings behind the words might sound like:

> *'There certainly are differing opinions on the situation and I wonder how your belief might affect your mood and behavior right now. I do know that you are a very respectful and rule-abiding person so I see that you are following the government recommendations even if you don't totally believe it. I wonder what's behind that decision."*

Certainly, if the client pursues the clinician's non-direct answer to the client's direct question and still asks for an answer therapeutic trust would require a more direct answer:

*"As you can imagine, I like to err on the side of caution and listen to the science and facts of the situation. I can't begin to speculate on suspicions about the government without some more evidence to back it up."*

Confidence in addressing dilemmas demands that the clinician can identify whether the telehealth interaction poses a chance of client exploitation. For example, if a client begins to whisper during the session because a family member is in the next room and she doesn't want them to hear what she is saying, what does the clinician do?

*A client explains to the clinician that she is in the garage because she doesn't want her abusive boyfriend to know she is in a session. In previous sessions he has made transparent excuses to be near her while she talks to clinician. The client asks the clinician to please "play along" and pretend she is her sister if the boyfriend walks in unexpectedly.*

*Doing a session from her bedroom, a client is describing to the clinician upsetting disagreements she has encountered with her roommates during the past week. Suddenly there is a loud banging on her bedroom door. A roommate bursts in and proceeds to scream at her and hurl insults. The client tells her to leave because she is in a therapy session but the roommate continues to barrage her with insults and name-calling. Does the clinician handle it in the same way she might handle an argument in-person?*

In the second example, the altercation is not really similar to an argument between partners in an office setting because one participant is not invited. Ensuring the client is both physically and emotionally safe would be the clinician's priority. In this actual case, the client often referred to the incident in subsequent sessions and the clinician continued to validate her responses and reassure the client. The client stated,

*"I already thought you believed me but now you really believe me!"*

In a different scenario:

*During a session a client tells the therapist that he shared their last conversation with his partner so that the partner could understand him better. The therapist asks for clarification and learns that the client has been recording their sessions for subsequent review by the partner.*

Clinicians are cautious to preserve a client's confidence, but what level of confidentiality can the clinician expect? Is sharing his expertise without his knowledge a form of plagiarism or theft of intellectual property? Some clinicians have written Right and Responsibilities for both parties in the therapeutic relationship. Minimally, an informed consent could include that recording of any kind is not to be done without the consent of all participants.

Telehealth etiquette skills are not necessarily intuitive and need to be taught. (Gustin et al., 2020). Such skills "lay the foundation for a successful telehealth encounter with providers and patients" (Gustin et al., 2020, p. 91).

## BEST PRACTICES IN TELEBEHAVIORAL HEALTH

The National Association of Social Workers (NASW) advises that before providing telebehavioral health services social workers should check with their:

1. state licensing board,
2. client's state licensing board if it a different state from where the social worker is practicing;
3. malpractice insurance/professional liability insurance carrier, and
4. client's payor (private insurance / Medicaid / Medicare)

(Felton, 2020).

Regulations and restrictions vary per state for emergency telemedicine services. Most states require that the practitioner be licensed in the state where the client resides. However, some latitude has been afforded during the pandemic. In addition, different payors have differing parameters regarding the use of telehealth. For example, some insurers actually waived co-pay responsibilities early on in the pandemic. The Centers for Medicare and Medicaid Services (CMS) expanded regulatory flexibility for telehealth services under emergency declaration. Initially the regulation required that the provider use an interactive audio and video platform that afforded real-time communication. After public pressure and advocacy by organizations, such as the NASW,

citing that many underserved populations have no access to the internet, this requirement was lifted and audio only sessions were permitted. Also, initially telehealth was only authorized by CMS to clients who had a prior relationship with the provider. Again, this restriction was lifted so that new clients needing services could obtain them via telehealth.

Several training programs in telebehavioral health have emerged offering suggestions and guidelines. Some even offer a certification in Telemental health although not necessarily sponsored by accredited organizations. Anecdotally, the following tips have been provided by telehealth platforms, trainers, and researchers. Clinicians should:

- *familiarize themselves with the technology before sessions to avoid technical difficulties, such as glitches, muted microphones, lighting glares, video or audio failures, and too high levels of volume,*
- *maintain eye contact by looking into the camera, rather than the spot on the screen where the client's face appears,*
- *exaggerate facial expressions and other physical gestures so facilitate the client's sense of the clinician's engagement and key communications,*
- *communicate to the client verbally about what the clinician is doing if the look away or move from the camera so that their actions are not misinterpreted, and*
- *take 10-15-minute breaks between telehealth sessions to move or stretch their body and clear their mind.*

In previous scenarios the casual feel afforded to telehealth was demonstrated. Should there be a dress code? What is the norm in an office-setting? Should it be the same? Should clinicians dress professionally or casually or 'business casual'? Again, the tone set by the clinician during sessions should be one that shows respect for the client and the process.

What should be expected if telehealth becomes permanent? Because telehealth has made engaging in services more accessible and convenient, many practitioners and patients are hoping to make telehealth a permanent option. Cautionary advice to practitioners (Shook, 2020) is to not downplay telehealth by calling in-person therapy "real therapy" or, for clinicians in fee for service models, by charging less for virtual sessions (although many 3rd party payors do, in fact, reimburse teletherapy at lower rates than office visits). Describing telehealth services on a website is also important.

Dr. Pamela Harmell (2020) suggests that an ethical approach to a first intake assessment via telehealth would use the CCARQ pneumonic as a guide:

- Culture – is there anything culturally that would help illuminate the context in which the services are being provided or that would help to understand the client more fully.
- Countertransference – does the client's situation represent a personal challenge for the clinician?
- Competency – does the clinician have the required competency to work with this client? Expertise is not necessary, but competency is.
- Rule-out – assess any physical or medical issues that may be pertinent to the symptom presentation.
- Question - the informant's capacity to provide accurate verbal responses to assessment questions.

Although these areas are important in any clinical assessment, they are particularly important in telebehavioral health encounters because of the heavier reliance on verbal contributions.

## Offer Orientation to the Technology Before Beginning Treatment

Clinicians should first know how to operate the equipment and use the telemental health platform before beginning work with actual clients. Practitioners should provide an orientation to clients about what telemental health is and how it is to be provided. This orientation can include reviewing intake paperwork, obtaining informed consent, explaining emergency protocols, and teaching clients how to physically use the equipment and/or telemental health software platform (Crowe, 2017). If teleconferencing systems are used (e.g., Polycom), clinicians should know how to operate the equipment and assist clients if they are using a similar system at a remote location. Clinicians can experiment with video displays, video lag, eye contact, picture-in-picture display, and other elements before beginning a session (Crowe, 2017). Orientation to the technology can include walking clients through the use of links or sending screen shots about entering URLs or using links to access the virtual waiting room, enter the virtual session room, explain privacy precautions, emergency protocols, and explain about the importance of lighting, audio, and connectivity. For example, some systems will cut video in order to improve the audio by

increasing bandwidth if connectivity is an issue. The platform the clinician or agency chooses to use will likely offer some type of client orientation.

## Video Etiquette

Videoconferencing requires certain knowledge and skills that may be unfamiliar to practitioners who only provide face-to-face treatment. Being on camera may make providers and/or clients feel uncertain and uncomfortable seeing themselves in a picture-in-picture display. A client will rely on the clinician to know how to use the equipment and may need guidance about video etiquette as well. There are several basic rules for videoconferencing (George, 2020; Hart, 2020; Mendoza, 2020):

1. Mute yourself when not speaking. This minimizes background noise and feedback when someone is speaking.
2. Be on time or log-on a few minutes before the session is to begin.
3. Ensure that the technology works correctly. Practice beforehand to make sure you do not have any problems. Make sure the computer camera, speakers, and microphone work.
4. Choose the proper software and hardware for telemental health services. Have a back-up plan for contact if the software and/or hardware fails.
5. Wear work-appropriate professional clothing and expect the client to wear what they would to an office visit.
6. Frame the camera correctly. Ensure that your camera is positioned so that the client has the feel of direct eye contact during the session.
7. Have the right lightening. Make sure that you can see the client and the client can see the clinician clearly.
8. Pay attention during the session. This may seem like a basic idea, but in a telemental health environment there is the potential for a significant number of distractions during a session. For example, if dogs start barking that someone is at the front door, how does the practitioner handle this in the middle of a session? If a child enters the session room and waves on camera to the client, how does the clinician handle this?
9. Take into account there may be lag time in visual and audio transmission. Allow for sufficient time to receive and express information without overlap or interruption.
10. Use a direct, wired connection rather than Wi-Fi if available. This will reduce the risk for transmission disruption by an Internet glitch.

11. Have all the materials needed for the session downloaded prior. Many software platforms have a screen-sharing function that allows a practitioner to show the client what is on the computer screen. This could be a resource website for the client, a chart of progress throughout therapy, or an example of a visual reference. When clinicians use the screen-sharing function, it is important that they know the clients will be able to see everything on the screen, including tabs, website names, and other information that may be personal or otherwise inappropriate to share with clients.
12. Choose an appropriate virtual background. Some platforms allow for the individual users to change the background image for videos. A clinician may want to change the background if video conferencing is in a clutter room or office. Users can choose a blank background or one that has animation or images. Whatever background is chosen, it should not be distracting.

Video etiquette is an important part of conducting an effective session. Clients may not have the skills or experience with telemental health technology. So, it is important for the practitioner to have mastery in order to guide the client toward proper use. In addition to practical matters of communicating, seeing and hearing clearly, appropriate etiquette of video conferencing conveys to the client that this type of contact is professional and structured. Often practitioners need to practice their skills, especially when learning a new platform or platform features. During the session with the client is not the appropriate time to try different functions and features.

## Video Space

When clinicians offer telemental health services, they should be cognizant of the nuances of the virtual office, the video space. The video space is the visual area in both the client's and practitioner's screen. Video space that is cluttered or interrupted by passersby can distract from the focus of the session. There are several components about video space about which clinicians should be aware. Preparation and planning are key tools in helping to make sure that video conferencing telehealth is a success.

A clinician should make sure that everyone is clearly seen in the video space (Campos, 2019). In order to do this, the equipment and office surroundings must work together to increase compatibility and comfort for the client. This can mean choosing a particular space that is free from distractions or that has walls that are coated in soothing colors rather than stark white. A

smaller room may help to make the client feel more secure from anyone looking at the camera; it may feel more like an actual therapy room. A clinician can evaluate the field of view, the view that is captured by the camera angle, to make sure that there is a wide enough visual space so that each person, or group of persons, is seen clearly (Campos, 2019). Some cameras have remote automatic focus functions that can track the movements of a person and keep the image clear. Some cameras can be configured to accommodate different amounts of people. If a clinician does a lot of group work, this type of camera could be helpful. This camera feature enables the clinician to easily adjust the angle and lens and with facial recognition features, can create the ideal zoom and focus.

Another aspect of video space is audio. Some microphones are better than others. Inexpensive or out-of-date microphones and speakers may have trouble filtering out ambient noise (Campos, 2019). Microphones and speakers can create an overlap effect when multiple people are talking at the same time. A quality sound system can filter or reduce noise while enhancing voice clarity. Microphone noise range can vary depending upon the product. The direction of the microphone is important as well. If you have clients seated in a group around a table, then a 360-degrees microphone may be more helpful than one that is unidirectional.

The space where the session takes place is an important consideration. Excess sunlight or sunlight facing into the camera can affect picture quality (Barr, 2020; Campos, 2019). A balance of natural lighting with ceiling light can reduce shadows that can create distractions during a session (Barr, 2020). Use curtains or soft lighting to help enhance picture quality. Uncovered or cement floors can create excessive echo and sound distortion (Campos, 2019; Barr, 2020). Softening floors and walls with rugs and wall-hangings can help reduce echo.

Lighting is a crucial element of video conferencing. Barr (2019) offers tips about how to improve lighting to enhance videoconferencing:

1. Avoid illuminating the surrounding walls too much; this makes faces appear darker on camera.
2. Try to keep the contrast less than 1:1.5. In other words, keep the brightness lower on the faces than on the table or surroundings.
3. Reduce sunlight to a comfortable level; excessive sunlight makes faces difficult to see and can be reflective in a camera.
4. Adjust the brightness to a lower intensity on faces; work towards illuminating faces that feel comfortable to the viewer.

The room where the session is held is an important factor, but in practical terms, a room may be used for more than one type of activity. If the clinician is providing services from home, the "therapy room" may also serve as a dining area or living room. If the therapy room is in an agency, it may also be used as a conference room. When a clinician uses a space for telemental health services, prior to beginning a session, she may want to create a therapeutic space. Furniture placement is an important part of video space (Barr, 2020). A comfortable chair or sofa will have a different effect than a metal office or fold-away chair. Comfortable surroundings can provide both the clinician and the client and enhance the therapeutic value of the space. Pay attention to the location of the door and the impact on the display. An opened door that impedes the camera view is less than ideal. Similarly, the camera view should not be angled where people can enter the visual space or see the face of the other person.

The size of the video screen can impact a session. If the clinician uses a smaller screen, such as a cell phone screen, visual comfort may be difficult. A larger screen may be more comfortable; some video set-ups include multiple screens (Barr, 2020). However, client privacy and comfort are of key importance. Clinicians may want to avoid a larger screen if it is easily seen by people passing by.

## Video Presentation Skills

Clinicians may be more comfortable with video conferencing than others. Prior experience with these technologies and an evolved skill set can help individuals feel more confident and competent. However, all individuals must go through the introductory development of skills in order to become comfortable and competent. Video communication skills are important because a clinician's comfort and competence with the technology can put a client at ease. Some clients (and clinicians) may feel uncertain or insecure with their communication skills or appearance on a screen.

Basic therapeutic communication skills transfer from the face-to-face environment to the video conferencing work environment. Active listening involves paying close attention to what the other person is saying (Doyle, 2019). In face-to-face sessions, a clinician shows active listening by asking clarifying questions, maintaining eye contact, paraphrasing, and reflecting. In video sessions, the subtle movements that are seen in a face-to-face session may not be easily seen by the client. The clinician's eye contact may be focused on the screen, rather than the camera

depending upon its location. If the practitioner's sight line is skewed from the camera, the view on the client's screen may convey distraction or disinterest. The camera should be positioned so that the clinician's line of sight appears as much as possible to align with the client's sight line. The clinician can use conscious body movements, such as head nodding, to show attention. She can ask clarifying questions while being careful not to talk over the client and being aware of lag time between video capture and voice.

Nonverbal language that is so essential in traditional services is also important in telemental health. Body language, such as eye contact, hand gestures, tone of voice, may be altered when using video conferencing technology (Doyle, 2019). Eye contact that is off-center with certain cameras can make either or both the clinician's and client's view appear slightly askew. If correcting the camera angle is difficult, other body language can be added, such as leaning forward and using facial expressions, which serves to convey the message that the clinician is listening closely.

Doyle (2019) offers specific suggestions for using body language and body position to enhance therapeutic presence. Clinicians should:

- Avoid slouching in the chair; rather, they can lean forward to encourage engagement
- Use hand animation and facial expressions to project presence and attention.
- Avoid drinking, eating, or looking at the phone during the session.
- Take care to eliminate fidgeting or trembling limbs, such as bobbing legs or repetitive hand movements, in order to create a "quiet" visual presence.
- Observe the client's reactions to your statement to detect understanding or misunderstanding.
- Ask clarifying questions, if needed.
- Encourage the client to ask questions and let the practitioner know when something is not understood.
- Avoid looking at the clock or phone during a session. The clinician can set a timer or glance at the clock on the computer screen.

Practitioners may recognize that video conferencing is not the ideal option for a particular session. If Internet connection is poor on either the clinician's or the client's end, a forced telesession may be frustrating and counterproductive. If a client seems distracted, for example if their children are home from school, it may be better to reschedule the session for a time when

there are less distractions. Sometimes a client's body language will display disinterest or distraction, such as yawning, looking at a phone, or broken eye-contact. A practitioner can inquire about these nonverbal cues to see whether another time would be better.

Appearance is an important factor for video presentation. Both practitioners and clients should dress as they would for an in-person meeting, following the workplace's dress code (Chaudhry, 2020). When at home, one may be inclined to dress informally, but care and attention should be given to dress. If a client is dressed inappropriately for a video session, the clinician should address this as they would for an in-person session, perhaps asking the client to change or put on a sweater. Clothing patterns, such as stripes or polka dots, may be distracting in a video session (Chaudhry, 2020). The camera may or may not automatically adjust if the individual wears a bright white or black shirt, causing shadows or lack of lighting on the face. Plain, neutral colors may be a good choice for video.

During a video session, the clinician should be aware of the need to signal when she wants to talk. Typically, in face-to-face situations, there are small and subtle visual cues to let individuals know who wants to speak. These cues may be less obvious on a video call, especially when there is sound delay. A clinician can raise her hand or use a chat function to let an individual know that she has a question (Chaudhry, 2020). The speaker should speak clearly and at a normal volume; there is typically no need to raise the volume because the microphones are usually sensitive. A speaker may want to adjust the pace of speech, opting for a slightly slower rate since the interaction occurs across video and may have lag.

If the clinician wants to share her screen or pull up a document or email for reference, she should explain that to the client beforehand (Chaudhry, 2020). Remember when a person shares their screen, the entire screen is shared including bookmarks, tabs, and other images. Long stretches of silence may indicate that the Internet connection has been lost. Communicating one's intentions and actions is important. In a video conference, it is difficult to differentiate when someone is looking at the video or looking at another screen on the computer.

The following scenario demonstrates the utility of all these tips:

> *During a session the discussion topic reminded the clinician of a graphic that he wanted to share with the client that was relevant. He only had a paper copy of the graphic so while the client was talking, he surreptitiously tried to open his file drawer and retrieve the paper.*

*As he was doing so the wires on his headset connected to his laptop got entangled and the headset went flying off his head. The client of course stopped talking and tried to suppress a giggle. He had to apologize and explain what he was doing and, luckily, they both got a laugh out of his clumsiness. With a different client his actions could have just as easily turned into an irritation or even an empathetic failure.*

Another scenario speaks to immediate ethical decision-making sometimes encountered in telebehavioral health:

*A new client is smoking cannabis, during a session. It is over Zoom, so the therapist is not personally/ directly impacted by it. The client doesn't feel like they have a problem with substances, but they do identify a history of self-medicating and low motivation.*

This scenario raises several questions:

- Is the cannabis medically prescribed? If so, is it comparable to a client taking a pill during an in-person session?
- How would the client answer if asked 'would you smoke cannabis if we were meeting in the office?'
- If it is not prescribed what is the reason for the obvious action? Should it be addressed clinically or legally?
- Is the client a teen? If so, does the incident reflect an act of defiance, power-seeking, or self-soothing? Do parents need to be notified?
- Does the therapist view it the same as drinking a beer during a session?
- Does such behavior need to be included in a practice policy or a patient's bill of rights/responsibilities?
- Does the therapist document the behavior in the chart notes?

## Risks of Teletherapy

To better identify best practices in teletherapy it is important to anticipate some of the inherent risks of providing services via the associated technology. In a blog hosted by the American Association of Marriage and Family Therapists (2017), Dr. Benjamin Caldwell identifies four areas of risk in teletherapy.

1. Confidentiality

Protection of confidentiality is important for both client and clinician. Implicit in this assumption is also the protection of privacy. There is less control over the setting where services are provided and received, therefore reasonable steps must be taken to strive for the privacy that an in-office setting provides. Risk-management strategies include ensuring the video platform is HIPAA compliant and having a discussion with clients about what they can do to ensure safety in their setting. It must be recognized that confidentiality is less protected in teletherapy thus having a separate informed consent acknowledging this fact is an optimal practice.

> *For an initial telehealth session, a clinician asks the client where she is and if she is in a place where their conversation would be private. The client ensures that she is in a room in her cousin's house and no one can hear. However, the clinician thinks she hears people talking in the background. To be safe, she puts her headphones on and asks the client again who talks to a woman off screen. They start making plans for the evening interrupting the session for about two full minutes.*

Most breaches of confidentiality are not with the platforms, but rather with ordinary situations like public or non-related exposure. For example, a client calls in to a session via FaceTime sitting in a Starbucks, using ear buds. She insists she feels safer and more "anonymous" there than in her home. Should the clinician insist she go somewhere else more private or accept the client's perceived sense of comfort? The answer is 'it depends' and requires documentation. Some clients may not have access to more private settings, for example, a client in a group home who shares living and sleeping space with other residents. Brainstorming with the client to ensure more secure confidentiality is recommended. Using earbuds or headphones is one way to partially ensure confidentiality. If the clinician deems that the optimal situation is not available but clinical intervention is still warranted, documentation of the setting in which it occurred and attempts to ensure privacy and confidentiality is paramount. There may be situations where the clinician just does not feel comfortable in proceeding with the session and that too should be documented.

2. Technology

Yet another situation over which clinicians have little control is the technology itself. Even with the best of preparation on the clinician's part, there are at least two devices involved which increases the possibility of tech fails because they can happen on the clinician's end, the client's

end, or both! Best practice requires there to be a back-up plan and inform the client of it at the beginning of session or even written in the informed consent or policies. Back-up plans should address who will initiate another platform or call to continue the session. Clinicians are advised to have the client's contact information (e.g., phone number) on hand during a telehealth session so that it is immediately available to the clinician in the event of a technology fail. This will avoid searching for the client's information during the session time.

3. Inappropriate forum

Best practice advice is to assess a client's appropriateness for telehealth at each session. Does a different symptom presentation preclude telehealth? Are they in a safe private area? Is available technology sufficient? Are they sufficiently adept with technology use? For example, a client who suffered a stroke or TBI may have aphasia residuals that make communicating via telehealth more frustrating. Teletherapy may be contraindicated if a client or clinician have strong accents that make it difficult or impossible to communicate. Additionally, clients who have thought disorders may find the process suspicious. Teletherapy may also be contraindicated if clients are actively abusing substances or if a couple asking for teletherapy has a history of interpersonal violence. Any situation in which the clinician feels an unmanageable ability to intervene, protect clients, or control the process may preclude the use of telebehavioral health.

4. Crisis care

Many clinicians understandably feel the lack of control inherent in the teletherapy platform. If a client experiences a crisis during or after a session, what might happen? Although there are some additional considerations, the approach to a client crisis is fundamentally the same as in-person (e.g., safety plans with the names and numbers of collateral contacts) with some preventive risk management strategies to mitigate the circumstances created by the distance. Crisis resources in the community should be readily identified and a crisis plan in the informed consent for teletherapy is advisable. Technology is also beneficial in addressing some crises, including for example, increased access to therapy or in the case of a dissociative episode, pre-recorded grounding exercises could be used in between sessions (Caldwell, 2017).

In addition to a crisis plan, the risk for suicide can also be assessed and mitigated in the telehealth environment. Gallindo (2020) advises that as part of a comprehensive suicide prevention plan via telehealth certain guidelines apply:

- Always determine the physical location of where the client is participating in the telehealth session.
- Determine the client's local crisis numbers.
- Assess the client's social support system with specific suggestions.
- Use evidence-based suicide risk assessments.
- Most importantly, have a back-up plan for reestablishing contact if technology fails.

*A clinician had been seeing an adolescent (17 y.o.) with a history of depression and self-injury (in the form of cutting) for about a year. Half of their treatment had been conducted in-person prior to the pandemic then switched exclusively to telehealth, usually via video, sometimes by phone. One hour prior to a scheduled video session the client called the clinician crying hysterically. She had experienced some 'mean girl' bullying at school. The client told the clinician she was sitting in a drugstore parking lot. The clinician inquired as to what she needed to get at the drugstore and was told "scissors for a school project". The answer seemed highly unlikely and with probing the client said she had already purchased the scissors and was cutting her thighs. The clinician advised the client to drive home where she resided with her parents and text or call her as soon as she was there. No consent to talk to her parents existed and state law gave mental health consent to teens at fourteen years old. As soon as they hung up the clinician second-guessed her instruction to the client and decided to call the police to do a wellness check since the client had reported furtherance of the intent to harm. A short time later the client texted the clinician and said she was home. The clinician was reluctant to believe her until the client sent her an angry text, acknowledging that the police were there and told the clinician in no uncertain terms that they were "done". The clinician's decision to err on the side of the client's safety ended in an irreconcilable therapeutic rupture.*

Did the clinician do the right thing? If she was sued by the client could she justify the breach of trust? Is there anything that could have prevented this outcome? Had this session

occurred in-person it seems clear that it could have been handled more adeptly and certainly points to a risk of telebehavioral health. Reviewing limits of confidentiality is always wise, and particularly important when not able to be in-person and adequately assess the severity of a crisis. An informed consent would cover this situation and such consents specific to telehealth should include crisis plans.

### Graduate Education and Teletherapy

Because of the COVID-19 pandemic schools of graduate education scrambled to adjust their internship programs and field education opportunities. Students' internship appointments in some instances were abruptly terminated and, in others, quickly adjusted to telehealth platforms. Again, informed consents specific to telehealth might have to include consent for an intern to also be sitting in on a telehealth session as an observer, which increases the chances of a 'third party rule' quandary.

## Multicultural Considerations

Cultural considerations are those practices that encompass beliefs, values, rituals, customs, and language from differing world views (Johnston et al., 2018). Culture is embedded in personal identity and defines group membership and behaviors. Many individuals have intersectional identities that are part of macro- and micro-cultures. These cultures include gender, sexuality, ethnicity, race, religion, and socioeconomic status. Practitioners become culturally competent through training and education about other cultures. They learn to interact with and provide care for clients who are part of different cultures.

Cultural humility is a term that addresses the challenges of becoming fully competent in a culture of which one is not a member (Johnston, et al., 2018). Because an individual who is not part of a particular culture cannot fully understand what it is like to be a member of a particular culture, she must assume a stance of openness and an acknowledgment of inherent personal biases. Cultural humility is process-oriented that contrasts with cultural competence that is destination-oriented. Clinicians who practice cultural humility know they can never be fully competent, but are willing to continue to learn and interact in ways that are respectful of another's culture.

Using technology to interact can be a complicated endeavor when working with clients who are members of different cultures. Technology presents greater risks for misunderstandings and

miscommunication between providers and their clients (Johnston et al., 2018). To improve the chances of clear communication, a provider can take into consideration several issues. Johnston et al. (2018) provide several examples of ways that practitioners can convey cultural humility while using technology. A clinician can:

1. Adapt clinical style and process to accommodate different communication styles,
2. Wear proper attire and have an appropriate room set-up for direct in-home videoconferencing,
3. Be aware of different understandings and uses of voicemail, return calls, and texts,
4. Be cognizant that clients may not understand text message abbreviations, such as LOL (laughing out loud) or SMH (shaking my head).
5. Understand that there are different understandings and expectations regarding the immediacy of response to e-mails.

Telepractitioners who practice cultural humility are aware that they may be prone to specific assumptions about culture and environment based upon the clinical setting or client's home (Johnston et al., 2018). For example, they will refrain from particular assumptions, if a client who lives in a rural setting has hunting paraphernalia in the background. They incorporate contextual knowledge of a client's environment, culture, and resources into treatment approaches.

There are benefits to the cross-cultural service telehealth service provision. Telemental health services provide increased access to care and can be used to reach a wide range of diverse populations, such as Native Americans and Alaska Native communities, Latino populations, and international clients (Johnston et al., 2018). It allows providers to offer services to diverse age groups, settings, communities, and environments. Individuals from underserved and marginalized communities can have access to services that were previously inaccessible. Telebehavioral health practitioners can provide outreach, education, and community engagement in creative ways to address the needs of communities. They can target specific populations through an array of culturally-specific platforms. Also, because of limitations related to distance and availability clients using telehealth services will possibly have access to greater choices of clinicians and may choose to connect with a clinician from a similar cultural background (e.g. ethnicity, sexual orientation) if so desired or deliberately choose a clinician from a different background if so desired. Finally, technology now provides greater access to translation services. Videoconferencing platforms as well as text-based, mobile, and voice recognition services can help bridge language barriers that can inhibit service provision.

Telemental health technologies can be used to allow members of underserved populations and diverse cultural groups have greater access to services that meet their needs (Garney et al., 2016). Communities that have difficulty with access to services due to geographic, economic, or medical limitations can be served in their homes by providers who practice cultural humility and are culturally competent and who may not be in the immediate area. However, there can be challenges as well. Communities whose members are underserved or remote may be reluctant to try services with unfamiliar technologies. There may be limited connectivity, such as in rural areas. In this case community members can invest in the process as peers or advocates to help others obtain needed services and resources.

While many technologies can have a far reach to multiple client populations, telepractitioners are still responsible for practicing with diverse populations within the parameters of their knowledge, values, and skills (Barnett & Kolmes, 2016). Some individuals may seek treatment through the Internet because of limited access. When treating diverse individuals, it is not appropriate for teleclinicians to expect their clients to speak English fluently. Knowing one's own abilities and limits of working with specific populations is not only a part of regular clinical practice, but also telepractice. For example, it may not be appropriate for a telepractitioner to use the automatic closed-captioning with a deaf individual as a replacement for American Sign Language. A telepractitioner may need to make referrals to other providers who are better prepared to deal with specific needs of a particular individual.

## RISK MANAGEMENT IN DOCUMENTING ENCOUNTERS

Many ethical risks occur in the documentation or lack of documentation of clinician encounters. Essentially, documenting telebehavioral encounters is the same as recording in-person encounters; however, more contextual documentation is prudent, such as where the client was during the encounter, or if there was someone else accompanying the session, either intentionally or unintentionally.

Pamela Harmell (2020) talks about the 'law of no surprises' regarding documentation, meaning when working with a client there should be no surprise things in the chart, nothing that either the client or another professional or regulatory body would be surprised by. For example, there should be nothing in the chart about yourself ("I wasn't feeling too good during our session so couldn't give the client much attention") or your personal feelings about the client ("This client is really

frustrating"). Documentation is open to public and client review. Documentation is always for an audience. There are four features to consider for risk management and documentation (explained in figure 2):

1. content,
2. language,
3. credibility, and
4. access.

**Figure 2 Documentation Strategies for Risk Management**

| **Content** | **Language** | **Credibility** | **Access** |
|---|---|---|---|
| Should have a clear, readable structure. | Use easily understood language. | Provide evidence for statements and outcomes. | Write for an audience. |
| Balance between too much and too little information. | Avoid repetition. | Avoid spelling and grammatical errors. | Remember personal (shadow) notes are not confidential. |
| Include sufficient detail to enable service delivery. | Avoid defamatory or dehumanizing language. | Provide timely documentation. | Be familiar with legal, regulatory and agency mandates governing release of records. |
| Avoid excessive detail, over-documentation or extraneous information. | Use clear, unambiguous and specific wording. | Acknowledge and notate errors. | Provide security for records, physically and electronically. |

| | | | |
|---|---|---|---|
| Use separate notes when seeing couples or families. | Do not use casual language or excessive professional jargon. | Do not speculate without substantiation. | Ensure and monitor client access to records as requested. |

(Wheel Health Team, 2018; Edelson, 2018)

# ETHICAL ISSUES IN TELEHEALTH WITH CHILDREN, COUPLES, AND GROUPS

## Working with Children Virtually

Citing an increasing evidence base, the American Psychiatric Association (2020) has promoted the use of telepsychiatry with children and adolescents stating:

- For some youth who pose challenges (e.g., behavioral) to traditional clinic settings, telepsychiatry may be a preferable alternative.
- Use of school-based telepsychiatry is increasing rapidly, but is not well described in the literature. It offers the opportunity to reach the most youth in need of services, in a comfortable setting, and with incorporation of parents who are acquainted with their child's educational experiences while minimizing disruptions to their work schedules.
- Home-based telepsychiatry is the newest setting to be explored and to be described in the literature. In-home telepsychiatry offers the opportunity to assess the youth in a naturalistic and ecologically valid setting with minimal disruptions to the family's day, although new challenges in service delivery must be addressed.
- Correctional settings are another growing, but under-reported, area of success for child and adolescent telepsychiatry. As these youth have high rates of under-diagnosed and/or untreated psychiatric disorders, telepsychiatry offers an opportunity to provide needed care. Telepsychiatry also presents an opportunity to educate correctional staff regarding the role of mental health disorders in adolescents' conduct problems.
- Kids and youth like to use technology, so things like social media are being researched for how they change care for the better and (potentially) for the worse.

The evidence shows that:

- Satisfaction has been rated as very high by parents, teens, and referring providers.
- Various disorders have been successfully treated, starting with depression in the early 2000s, and extending to anxiety, obsessive-compulsive disorder, tics, attention-deficit hyperactivity, and behavioral disorders (e.g., Oppositional Defiant Disorder).
- Models of care are varied, from traditional video-based direct care, to collaborative care by telepsychiatry, to primary care, as well as consultative and collaborative services with other professionals in non-clinic settings.
- Services for this population have been provided in varied sites, including mental health clinics, primary care settings, schools, juvenile correctional facilities, state health agencies, and in the home (APA, n.d.)

Engaging children and teens in treatment in-person can be challenging, and, for some, the element of virtual engagement and frustration increases for both child and clinician. The U.S, Dept. of Health and Human Services Office for the Advancement of Telehealth (OAT) has demonstrated the effectiveness of using technology for children with special health care needs (Wasem & Puskin, 2000). Teletherapy now includes teleplay therapy which was used occasionally before the pandemic and, now, is recognized as a viable approach. Filial therapy may be easily adapted to the online environment and is a collaborative way to encourage a child's engagement. Adapting play therapy to a virtual environment raises both ethical and clinical questions.

What is teleplay therapy and what is it not?

> *"…teleplay therapy refers to the use of a systematic approach to play therapy using play and play therapy interventions in a virtual context by a professional mental health practitioner expressly trained in play therapy. Teleplay would refer to use of the systematic approaches to play therapy and use of play therapy interventions, the difference in teleplay is that the clinician has not been specifically trained in play therapy (Fazio-Griffith et al., 2020)".*

The terms teleplay and teleplay therapy are often used interchangeably. There is a scarcity of research literature regarding clinical and ethical practice of teleplay, or supervision of teleplay, primarily because it is so new (Strauss & O'Neil, 2020)! Play therapy and supervision of teleplay

requires attention to the ethical situations that can occur working exclusively with children and/or adolescents. A variety of ethical concerns can become present during the play therapy process, which, in turn can influence the supervision process. Ethical issues salient in teleplay therapy primarily speak to clinician competence, record-keeping and confidentiality.

## Work with Couples and Families

Couple counseling provided outside the office setting can be conducted via telehealth video platforms, audio only, or even via texting, email or chat as some of the therapy subscription businesses provide.

Gould (2020) summarizes the pros and cons of virtual couple counseling illustrated in Figure 3. Topping the positive aspects of couple counseling online is the convenience and accessibility factor. Scheduling is easier for busy couples, especially if child care poses another barrier. In some cases, the comfort of clients being in their own home lends itself toward sharing personal matters more readily than being in an unfamiliar setting. Sometimes, the goal of couple counseling is "to do something different" to break patterned problematic couple behavior. Learning new skills in the office does not always carry back to the home setting. Practicing skills in the home setting may help them "stick". Certainly, the online format is perfect for couples in long-distance relationships since it puts them together for counseling.

Drawbacks include the inability to read non-verbal cues or body language for both client and clinician. Similarly, it might be more difficult to establish a personal connection or therapeutic alliance. Interruptions are bound to occur from technology or kids or pets. Finally, the lack of physical presence makes it harder for a therapist to control or intervene with behavioral or emotional outbursts (Gould, 2020).

**Figure 3**

**COUPLES COUNSELING ONLINE**

| **BENEFITS** | **DRAWBACKS** |
|---|---|

| | |
|---|---|
| Convenient and Accessible | Can't read body language |
| Comfortable | Interruptions |
| Easier skills learning in vivo | Less personal |
| Easy for long-distance relationships | Harder to control |

(Gould, 2020)

In the rare peer-reviewed literature regarding telehealth and couples and family counseling, Wrape & McGinn (2019) reviewed the unique clinical, ethical and practical considerations of using telehealth to provide couple or family therapy. These areas of concern were categorized into five domains:

- confidentiality/privacy,
- safety,
- managing multiple patients in session,
- therapy process, and
- logistics for treatment planning

(Wrape & McGinn, 2019, p. 297).

The usual privacy and confidentiality concerns are magnified when providing couple or family therapy. "having multiple members participate meant that some common methods for increasing privacy (i.e., the use of headphones) are not readily available…. if members are connecting from different locations, there is the possibility that someone else may be present outside the view of the screen without the other family member's knowledge" (Wrape & McGinn, 2019, p. 297). Additionally, therapist awareness of this possibility may inhibit their willingness to provide open and honest feedback or contribute to avoiding certain areas of discussion.

As previously mentioned, an informed consent is the best coverage a clinician can use. Sharing the responsibility for their own privacy and confidentiality is clearly indicated and stipulated in an informed consent for telebehavioral health. Documenting any inadvertent potential confidentiality risks (i.e. other family members walking in and out of the room in which the couple is taking the video telehealth session) is further protection and a solid risk management strategy.

Safety is another ethical and clinical consideration that is heightened in couples or family counseling. Even just having to sit closer together to be seen simultaneously on the screen could make for uncomfortable scenarios. In an office setting the therapist could interview partners separately to assess for safety or ask one to take a "time-out" in the waiting room or walk around the parking lot to cool down if tensions escalate. The same physical separation may not be so easily enforced in a telehealth session. Wrape (2019) recommends that therapists establish where couples are at the beginning of each session in the worst-case scenario that police might have to be called. Some therapists ascribe to the view that this modality is contraindicated when severe violence or substance abuse is present and will refuse to treat couples and rather choose to work exclusively with one individual or the other. Others assess that some intervention, particularly during the isolation of the pandemic in which domestic violence has reportedly increased, is safe to provide in certain situations (e.g., it is the only help the couple will receive) where the therapy is not escalating the situation. These decisions about teletherapy in families where there is violence must be made in consultation with experts on family violence intervention.

Managing multiple patients in session is another concern inherent to couple/family therapy, both in-person and online. Imagine four people in family therapy squished on a couch where they cannot sit comfortably in view of the camera. If emotions get intense, will the physical proximity become problematic? Novice and seasoned therapists alike can easily envision an angry teenager leaving the session to the sound of a slamming door as he locks himself in his bedroom. This escape might not happen as easily in an in-person session particularly when the angry teen needs a ride home.

Couples may also split their attention in session as one may be answering kids' homework questions or another is folding laundry, which would not happen in-person. Situations like these can be curtailed with limit-setting and a mutual expectation that the session should be treated no differently than an in-person session as much as possible. Wrape (2019) sees such examples as teachable moments in which problem-solving and communication skills can be assessed or practiced as couple work to set the parameters demanded of the therapy process.

There are certain elements of the conjoint therapy process that are altered dramatically if not totally missing in a telehealth platform. Subtle interpersonal or body language can easily be missed. The intimacy and vulnerability evoked in particular marital therapy approaches (e.g.,

Imago, Emotion Focused Therapy, Gestalt) require attention to mind-body connections and body awareness, which is much more difficult to observe and use through a screen. The techniques of Structural Family Therapy or Transformative Systemic Therapy, such as joining, positioning, or posturing are also not easily accomplished via video. Additionally, family-based (i.e., in-home) therapy is severely limited by telehealth. Therapists cannot as easily provide in-vivo parenting or communication guidance when much of the interaction is taking place off screen. Conversely, techniques such as reenactments could translate well to a virtual platform where participants can 'perform' for the camera.

Finally, objective outcome measures through quantitative assessments to assist in treatment planning, review and evaluation are not as easily administered via telehealth, compared to paper copies that may be used in an office setting. Creative ways of collecting this important data are necessary.

## Group Counseling via Telehealth

Possible breaches to confidentiality could stem from a member attending in a non-secure location where others could see or hear group members, members recording or taking a picture of the group or leader and using the information for unethical or illegal purposes. A separate signed informed consent spelling out do's and don'ts of participating in a group via teletherapy is a necessary safeguard.

According to the American Psychological Association (n.d.), despite increased risk to members and clinicians, "online groups also offer therapists an efficient and effective way to support the mental health of the larger community during the COVID-19 epidemic."

Suggested rules for clients attending group are similar to expectations for individual sessions.

1. Be in a safe, secure space where client can be free of distractions and speak freely.
2. Clothing worn should be similar to what is expected in an office setting.
3. Be familiar with the technology necessary to participate in the group fully, such as secure internet, no other devices being used.

Group members must have the technological means to attend the group. This includes being on a secure internet connection, rather than public or free Wi-Fi. The clinician and group members should keep the video on and do their best to be attentive and engaged. Phones or computers should

be put on airplane mode to minimize interruptions. If the privacy of the client's location is an issue, wearing headphones or keeping the volume low can prevent sound from travelling to another room.

Follow any group-established policy regarding if a member, or the entire group, gets disconnected. If the group agrees, this may include having a member call in for the remainder of the session. Adhere to the group policy about how to handle a breach in confidentiality, such as a nonmember bystander witnessing the group or someone walking into a room while the group is meeting. For more information the American Group Psychotherapy Association (AGPA) provides specific tips on using technology for group therapy (AGPA.org).

The American Group Psychotherapy Association (AGPA; n.d.) provides a quick-start guide for facilitating virtual groups. They encourage providers not to be daunted, stating "getting started in telehealth practice is not as difficult as it might seem so long as you take your time to understand the ins and outs of providing mental health services utilizing online tools and platforms." They direct providers to assess the following prior to starting a telehealth group:

- *client suitability* – make clinical determinations on a client's suitability for group and, separately, telehealth services considering cognitive functioning, clinical presentation and risk level, and level of independence operating technology and technology literacy;
- *state laws and licensing regulations about providing telehealth* – an app related to telemental health laws is provided via Epstein Becker Green (2020);
- *provider access to the proper telehealth technology and necessary equipment* – the AGPA advises that a computer or tablet with an internet connection is the bare minimum required to begin a telehealth group, but that clinicians should also consider the quality of their microphone, camera, speakers or headphones, internet speed, and the platform they will use to facilitate their groups (e.g., some platforms charge more for the multidevice use necessary to facilitate a group);
- *the provider's familiarity with the ethical issues associated with telehealth practice* – clinicians are responsible for knowing the risks and benefits of providing services in a group modality via telehealth, state laws and statutes governing the practice, and ethical guidelines from their professional organizations;
- *client access to technology, necessary equipment, and appropriate setting* – clinician's must assess each group member's access to the technology and internet strength necessary

to engage in effective telehealth, a private space to use for the sessions, and each group member's ability to address any confidentiality issues for the group as a whole (e.g., roommates or family members, thin walls where people can be overheard, device used); and

- *provider tasks necessary to reduce and manage risks associated with telehealth practice* – clinicians must consider how they will implement their practice in ways that manage risk, ensure their competence, establish crisis plans for each group member (especially considering each client's physical distance, risk level, and appropriateness for the group, emergency contacts, and emergency procedures for the client's location), ensure security and privacy of provider and each group member in relation to physical location and the software used to facilitate group sessions, explain risks to confidentiality and privacy inherent in the use of the technology, and obtain informed consent that acknowledges those risks.

# SUPERVISION VIA VIDEOCONFERENCING

This quote provides an optimistic viewpoint of the changes in supervision with telehealth: "…the experiences grappling with ethical consideration within an ever-evolving clinical and global landscape will inform how these trainees operate as future supervisors, with an enhanced awareness of the challenges trainees may face" (Desai et al., 2020, p.10).

As did the delivery of behavioral health services, the provision of clinical supervision abruptly switched to a telehealth platform when the pandemic forced social isolation. Even the best clinical supervisors may not be prepared or trained in this modality. Ethically this situation speaks to the competence standard in most codes of ethics. The NASW (2017a) stipulates competence according to sufficient training and specifically addresses the issue of technology use:

> ***1.04 Competence***
>
> (a) Social workers should provide services and represent themselves as competent only within the boundaries of their education, training, license, certification, consultation received, supervised experience, or other relevant professional experience.
>
> (b) Social workers should provide services in substantive areas or use intervention techniques or approaches that are new to them only after engaging in appropriate study, training, consultation, and supervision from people who are competent in those interventions or techniques.

(c) When generally recognized standards do not exist with respect to an emerging area of practice, social workers should exercise careful judgment and take responsible steps (including appropriate education, research, training, consultation, and supervision) to ensure the competence of their work and to protect clients from harm.

**(d) Social workers who use technology in the provision of social work services should ensure that they have the necessary knowledge and skills to provide such services in a competent manner. This includes an understanding of the special communication challenges when using technology and the ability to implement strategies to address these challenges.**

**(e) Social workers who use technology in providing social work services should comply with the laws governing technology and social work practice in the jurisdiction in which they are regulated and located and, as applicable, in the jurisdiction in which the client is located.**

(NASW Code of Ethics, 2017a)

The NASW Code of Ethics also addresses technology in supervision.

***3.01 Supervision and Consultation***

(a) Social workers who provide supervision or consultation **(whether in-person or remotely)** should have the necessary knowledge and skill to supervise or consult appropriately and should do so only within their areas of knowledge and competence.

While the NASW Code weaves technology use into different sections, The American Counseling Association (ACA; 2014) Code of Ethics devotes an entire section to Supervision and one entirely for distance technology. Section F addresses **Supervision, Training and Teaching.**

**F.2. Counselor Supervision Competence**

**F.2.a. Supervisor Preparation**

Prior to offering supervision services, counselors are trained in supervision methods and techniques. Counselors who offer supervision services regularly pursue continuing education activities, including both counseling and supervision topics and skills.

**F.2.c. Online Supervision**

When using technology in supervision, counselor supervisors are competent in the use of those technologies. Supervisors take the necessary precautions to protect the confidentiality of all information transmitted through any electronic means.

Section H addresses **Distance Counseling, Technology and Social Media.**

**Introduction**

Counselors understand that the profession of counseling may no longer be limited to in-person, face-to-face interactions. Counselors actively attempt to understand the evolving nature of the profession with regard to distance counseling, technology, and social media and how such resources may be used to better serve their clients. Counselors strive to become knowledgeable about these resources. Counselors understand the additional concerns related to the use of distance counseling, technology, and social media and make every attempt to protect confidentiality and meet any legal and ethical requirements for the use of such resources.

**H.1. Knowledge and Legal Considerations**

**H.1.a. Knowledge and Competency**

Counselors who engage in the use of distance counseling, technology, and/or social media develop knowledge and skills regarding related technical, ethical, and legal considerations (e.g., special certifications, additional course work).

**H.1.b. Laws and Statutes**

Counselors who engage in the use of distance counseling, technology, and social media within their counseling practice understand that they may be subject to laws and regulations of both the counselor's practicing location and the client's place of residence. Counselors ensure that their clients are award of pertinent legal right and limitations governing the practice of counseling across state lines or international boundaries.

(ACA, 2014)

Of course, by extension the supervisor may be supervising the supervisee's own provision of telehealth. Thus, conveying these competency standards to the trainee is incumbent on the supervisor. It is the supervisor's responsibility to address the supervisee's competency in the provision of telehealth services and its concomitant challenges; however, in some instances, trainees may be more literate in the use of technology, which may evoke varied feelings about competence between the supervisor and the trainee.

The American Psychological Association (APA) Code of Ethics (2017) is less specific. The only mention relevant to supervision and telehealth is found in Section 2 addressing competence.

(c) Psychologists planning to provide services, teach, or conduct research involving populations, areas, techniques, or technologies new to them undertake relevant education, training, supervised experience, consultation, or study.

(e) In those emerging areas in which generally recognized standards for preparatory training do not yet exist, psychologists nevertheless take reasonable steps to ensure the competence of their work and to protect clients/patients, students, supervisees, research participants, organizational clients, and others from harm.

The APA published Guidelines for the Practice of Telepsychology (2013) because "the expanding role of telecommunication technologies in the provision of services and the continuous development of new technologies that may be useful in the practice of psychology support the need for the development of guidelines for practice in this area. Technology offers the opportunity to increase client/patient access to psychological services" (2013, p.792). Although the APA guidelines do not reference the use of technology for supervision, the standards of competence and confidentiality addressed in the document can be applied to telesupervision.

Adjusting supervision to an online platform could include addressing the setting, expectations of both supervisor and supervisee, and the potential differences from in-person supervision. Consideration needs to be given to protecting the confidentiality of supervisee, supervisor, and any client information being discussed.

*A supervisor providing telesupervision ensures that she is in a private setting with no distractions for the session. Although the supervisee is wearing headphones so that the supervisor cannot be heard by anyone but her, her husband frequently walks by and is seen in the background making dinner. What is the expectation? If her husband's presence doesn't bother the supervisee should the supervisor say anything? Would the supervisee bring her husband along to supervision in-person?*

*During their meeting, a contracted fee-for-service supervision session, the supervisee mentions that she replayed their previous session because it was so helpful and even shared it with a colleague during the past week. The supervisor asks for clarification only to find out the supervisee had recorded their previous supervision session. There are multiple ethical transgressions here. First, the supervisee recorded the session without the supervisor's knowledge and secondly, she shared it with a colleague, without the*

*supervisor's permission. Although the supervisee might consider it flattering, the supervisor's expertise has been provided gratis.*

Adjusting the structure and process of supervision includes developing some type of hybrid format in which there is remote live supervision with additional "homework" for the supervisee. Telesupervision can be provided via various video platforms or audio only platforms. It is prudent to check to ensure that audio only hours count toward licensure as some states require live video sessions.

Dr. Benjamin Caldwell (2020) suggests that an ethical approach to online supervision would be to assess preparedness by looking at legal and competency issues. Some questions for supervisors to ask themselves:

- What are the legal basics in my locale to provide online supervision? Is it permitted?
- What training requirements, if any, exist for providing online supervision?
- What is my profession's ethics code regarding use of technology?
- Have I received proper training in the technology? Have I tested it before using it with clients?
- Can I attest to a skill set needed to supervise online?
- Am I able to adequately assess if a supervisee can utilize telesupervision appropriately?
- Have I considered ways of assessing performance and providing constructive criticism online?
- Have I developed policies and procedures specific to telesupervision?
- Have I shared with supervisees the roles and responsibilities of each person in the telesupervision relationship?
- Have I ensured privacy and confidentiality in my provision of telesupervision?
- Have I framed my written supervisory contract to address some of the differences and expectations for telesupervision?
- Do I have an informed consent for clients that indicates that supervision may be provided online, thus adding another security risk?
- Is my virtual platform HIPAA compliant? Do I need a Business Associates Agreement (BAA)?

- Does my platform have the ability to provide group supervision?

Skills of telesupervision demand creative ways of building rapport, providing a holding environment, attending to expressive cues, both verbally and physically. It also may require self-reflection about performance anxiety. What is the supervisor's own comfort level providing supervision in this way? Does the supervisor find it a watered-down version of clinical supervision, and easier to cut sessions short? Does the supervisor deal with explorative questions, non-participation, or silence differently? What is the expectation of supervisees' behavior and participation in telesupervision (i.e., dress code, distractions, multi-tasking)?

Group supervision via videoconferencing platforms presents exponential challenges described previously. Each issue previously discussed can pose a security or confidentiality risk for each member and member's clients; however, with proper protocols confidentiality can be maintained and videoconferencing technology can confer all the benefits of group supervision and peer group consultation.

# STANDARDS PERTINENT TO TELEHEALTH

> *Establishing sound standards of care is an essential feature of professional practice. Standards of care constitute the measuring rod with regard to acceptable practice in a profession (Reamer, 2018, p. 258).*

To keep up with the ever-changing landscape of cybertechnology in behavioral health, standards have emerged in three areas: 1) regulatory law: government regulations, either through legislation or through licensing boards; 2) codes of ethics: standards promulgated by national professional associations (i.e., ACA, APA, NASW, AMA); and/or 3) standards of professional practice: best practice standards or guidelines adopted by professional groups and associations (Reamer, 2018).

Several states have adopted telehealth legislation. In the absence of legislation, licensing jurisdictions have also established standards as their mission is to protect the public. The American Psychological Association (APA,) NASW, and ACA all have codes of ethics that have enforceable rules and aspirational guidelines for best practice. Several categories relevant to telehealth include those dealing with competence, privacy, confidentiality, conflict of interest, boundaries, social

justice, practice settings, self-determination, and supervision. In addition, the NASW has revised their Code of Ethics and in collaboration with the Association of Social Work Boards (ASWB) and the Clinical Social Work Association (CSWA) and the Council of Social Work Education (CSWE) has established specific standards and guidelines to address the use of technology in clinical care (NASW, 2017b).

Lastly, standards of care are meant to guide professional behavior and provide a basis for adjudicating sanctionable offenses or lawsuits. Standards regarding telehealth have emerged in most health care professions. The NASW published Technology Standards (2017b) which includes a total of 55 standards integrated into four sections of the technology standards:

- Provision of Information to the Public,
- Designing and Delivering of Services,
- Gathering, Managing, and Storing Information, and
- Social Work Education and Supervision.

The American Medical Association (AMA) and APA have also published standards specific to the use of cybertechnology. In addition, the American Psychiatric Association has developed an extensive and evolving "Telepsychiatry Toolkit" to inform psychiatrists about legal, financial, and ethical use of remote or distance psychiatry (American Psychiatric Association, n.d.).

The American Psychiatric Association Ethics Committee has published answers to ethical issues members are facing during the COVID-19 pandemic (2020). The following is pertinent to cognate professionals' ethical practice of telehealth:

> *QUESTION 1: When we use unfamiliar technologies (e.g. telehealth technologies) to provide treatment during COVID19, what considerations should psychiatrists be aware of to ensure disruptions of care are minimized?*
>
> *ANSWER: The availability of technology is incredibly helpful during this public health crisis as it allows psychiatrists and patients to continue treatment while apart because of physical distancing. While using these technologies, psychiatrists have an ongoing ethical responsibility to maintain patient confidentiality and proper therapeutic boundaries. Psychiatrists should inform patients that there may be limits to confidentiality given the risks inherent to the use of internet that would not necessarily exist for an in-person session and establish the expectations of the changed treatment relationship by informing patients*

*that telehealth sessions are treatment sessions in the course of care and will be billed as such. If a psychiatrist encounters a patient who expresses a preference to be seen in-person even when physical distancing recommendations are in place, the psychiatrist may try to work with the patient to make them more comfortable with the use of technology, including by informing the patient that it is in his/her/their best interest to avoid environments (such as the psychiatrist's office building) that could increase one's chances of contracting or disseminating the infectious disease. All psychiatrists have a duty to think about the greater good given the present circumstances of the COVID-19 global pandemic. It is worth noting that reliance on technology to provide remote treatment at this time is not a matter of convenience or personal preference on the part of the psychiatrist, but instead is motivated by the responsibility to care for individual patients while also contributing to life-saving physical distancing measures to flatten the curve and minimize contagion. In these circumstances, the individual preference of the patient cannot alone justify departure from the public health responsibilities of the psychiatrist. However, where an urgent or emergent clinical situation exists, psychiatrists should, similarly, be aware that exigency may require in-person assessment and/ or treatment and that principles of competent care and ethics both require that the psychiatrist provide or arrange for this care notwithstanding public health concerns, with adequate personal protections in place to decrease the risk of contracting or disseminating infection during the encounter.*

This question alludes to the 'third party rule' as important in the world of teletherapy. The legal doctrine states that there is no reasonable expectation of privacy when clients voluntarily give information to a third party using digital media, particularly internet service providers or email servers. This rule conflicts with the mandate of patient-therapist privilege. Example:

*A therapist is conducting a group therapy session via Zoom Healthcare, which is a HIPAA compliant platform. He begins the session emphasizing the need for everyone establishing a private and confidential setting to participate. During the session a man walks into view of the screen. After he is out of view, a group member remarks that he will be leaving the session and abruptly signs off. The therapist subsequently reaches out to that member and discovers that the non-member man who came into view is a co-worker of the member. Confidentiality was certainly in question and although the therapist had done everything*

*possible (using a compliant platform and emphasizing the need for establishing a safe setting) a client felt unsafe bringing the third-party rule into focus as a result.*

## Practicing Across State Lines

The ease of access afforded by telehealth would imply that services could be provided to anyone anywhere. "Telehealth provides both a means to increase access, and to reengineer the processes of care, enhancing the equality and effectiveness of health services" (Wasem & Puskin, 2020, p.1). However, practitioners generally cannot practice across state lines. As of this writing, no federal provisions allow mental health professionals to practice teletherapy over state lines; clinicians must register or be licensed in their client's state to provide teletherapy. The general directive is that treatment can only be provided to a client who is currently residing in the state where the clinician is licensed. Therefore, a client must be receiving services while physically located in a state where the clinician is licensed and the clinician has to be licensed in the state where the clinician is physically located while delivering services.

A frequently asked question is what if the client or clinician is temporarily out of state on vacation or business? Can therapy be provided? No clear guidance exists, some states specify, some don't. It is a risk to do so and safely handled by providing only short-term consultation (Zencare, 2020). To be on solid ground clinicians should check the licensing board and relevant legislation in the state where they practice or where the client resides.

However, there is some federal loosening of regulations and some states have temporarily waived licensing requirements to practice across state lines, with time restrictions. During the COVID 19 emergency, Medicare and Medicaid provided some leniency to this restriction with the exception of clinicians in private practice.

## Telehealth Training

Most states do not require training in telehealth but, again, checking with your own state requirement is recommended, as well as making sure your liability insurance covers you for telehealth.

The American Association of Marriage and Family Therapists (AAMFT) Code of Ethics addresses the provision of online therapy or supervision in Standard VI. In particular, Standard 6.1 outlines the steps MFTs should take before commencing therapy or supervision services through

electronic means. In addition to Standard VI, the remaining provisions of the AAMFT Code of Ethics also apply to online therapy or supervision.

Some states have additional requirements that apply to therapy or supervision through electronic means. Some professional standards strongly suggest it. NASW, ASWB, CSWE, and CSWA Standards for Technology and Social Work Practices (2017) states in Standard 1.01:

> *Social Workers who choose to provide electronic social work services shall do so only after engaging in appropriate education, study, training, consultation and supervision from people who are competent in the use of this technology to provide social work services.*

Subsequent standards emphasize the need for continuing education to keep current with emerging knowledge related to the delivery of electronic social work services. Members should check their state's licensure law or contact their state licensure board.

# SUMMARY

The previous slow growth of telebehavioral health experienced a rapid increase necessitated by the COVID-19 pandemic shut-down. Behavioral health practitioners are adjusting quickly to the demands of providing services via virtual platforms. This type of service provision carries unique ethical challenges.

Common telebehavioral encounters have been identified with suggested best practices and tips for effective and ethical service delivery, acknowledging risks and situations specific to specific modalities and populations. Relevant professional association guidelines and codes of ethics and standards, along with legal mandates, have been reviewed.

Telebehavioral health, along with clinical supervision via telehealth, currently take center stage in the delivery of mental health services and its permanence in the field seems highly likely. Ensuring ethical and effective practice requires awareness, training, and a multi-layered level of competence.

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