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# Memo

**To:** Telehealth Committee

**Date:** May 26, 2022

**From:** Steve Sodergren
Executive Officer

**Telephone:** (916) 574-7904

**Subject: Telehealth Best Practice Guidance Document**

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During the last meeting on March 4, 2022, this Committee discussed creating a telehealth best practices guidance document to assist employers and supervisors who are utilizing telehealth with their pre-licensees. The goal of the document would be to help employers and supervisors better assess acceptable work settings for telehealth, and also to clarify the expectations for all parties utilizing telehealth.

Staff has researched current best practice documents to gain a better insight into the topics of concern that should be addressed in the Board's document. Some of the reviewed documents have been included as attachments.

The New York State Education Department-Office of the Professions has posted a telepractice guidance webpage for mental health practitioners. This simple format was easy to understand but may be too simplistic for what the Committee is considering as a best practice guidance document. However, the section entitled "Effective & Legal Telepractice" was a very concise and useful list of best practice considerations. (Attachment A)

One of the most recent documents reviewed was the American Association of Marriage and Family Therapy Regulatory Boards (AMFTRB) Teletherapy and Tele-supervision Guidelines II (August 2021). This was a very comprehensive document, and the content areas could be used as a structure for the Board's own document. While this document may contain more topics that the Committee would want to consider, the section on tele-supervision (page,14) was another good example of a concise list of considerations. (Attachment B)

Additionally, staff will be utilizing a past best practices document from the Board, a 2010 California Board of Behavioral Science (BBS) report entitled "The Use of Videoconferencing in Supervision of Associate Clinical Social Workers, Marriage and Family Therapist Interns, and Professional Clinical Counselor Interns: A Best Practice Guide". Although some of the information concerning technology is out of date this document contains pertinent language that may be used in the new document.

Staff will draft language that will address these topics and will be seek a subject matter expert to assist in the review and editing of the draft. The draft will be presented to the committee at an upcoming meeting.

## Recommendation

Conduct an open discussion regarding the following:

- If any additional topics and/or topic headings should be included in the guidance document.
- To identify any areas of concern.
- To identify any guidance in the attachment materials that the Committee finds particularly helpful and would like to use as a model.

Direct staff to proceed with drafting the document, including consulting with subject matter experts, as necessary.

## Attachments

**Attachment A:** New York State Education Department-Office of the Professions Telepractice Guideline for Mental Health Practitioners

**Attachment B:** American Association of Marriage and Family Therapy Regulatory Boards (AMFTRB) Teletherapy and Telesupervision Guidelines II (August 2021)

**Attachment C:** 2010 California Board of Behavioral Science (BBS) report "The Use of Videoconferencing in Supervision of Associate Clinical Social Workers, Marriage and Family Therapist Interns, and Professional Clinical Counselor Interns: A Best Practice Guide".

**Attachment D:** The National Association of Social Workers (NASW), Association of Social Work Boards (ASWB), Council on Social Work Education (CSWE) and Clinical Social Work Association (CSWA) Standards for Technology in Social Work Practice (2017)

**Attachment E:** American Psychiatric Association and The American Telemedicine Association Videoconferencing-Based Telemental Health (April 2018)

## New York Office of the Professions: Mental Health

## Telepractice

**Disclaimer:** Practice guidelines provide licensees with general guidance to promote good practice. Law, rules and regulations, not guidelines, specify the requirements for practice and what may constitute professional misconduct.

### What is Telepractice?

Telepractice includes the use of telecommunications and web-based applications to provide assessment, diagnosis, intervention, consultation, supervision, education and information across distance. It may include providing non-face-to-face psychological, mental health, marriage and family, creative arts, psychoanalytic, psychotherapy and social work services via technology such as telephone, e-mail, chat and videoconferencing.

Telecommunications and Electronic Medical Records (EMRs) may include computer files, documents, e-mails, interactive media sessions, CD's, audio-tapes, video-tapes, fax images, phone messages and text messages.

### Telepractice Issues

Telepractice issues of concern to practitioners include the therapeutic relationship, specifically, one's ability to maintain an effective working relationship in spite of physical distance. Potential licensure and jurisdiction issues mean that practitioners should become familiar with and abide by competency and licensure requirements when practicing across state and national borders. In order to practice in a safe, legal, and confidential manner, it is important for licensed mental health professionals to understand the technology and potential limitations to confidentiality of both the software and hardware they are using. In order to ensure confidentiality, encryption and other technologies should be used whenever possible. Guidance regarding specific telepractice issues appears below.

To the extent it involves providing professional services in a jurisdiction other than the one in which the practitioner is physically located, telepractice raises the issue of the jurisdiction or jurisdictions in which the practitioner must be licensed. In New York State, a practitioner must hold a New York license, or be otherwise authorized to practice, when providing professional services to a patient located in New York or when the practitioner is located in New York.

## EMRs: Same Responsibilities as any Other Medical Record

EMRs are subject to the same confidentiality and privilege as any other medical record. Privacy and security should be maintained and, to ensure this, encryption or password-restricted access may be necessary. It is necessary that EMRs can be reproduced if requested by patients or by court order and that fees charged for such reproduction are consistent with New York laws and regulations. Practitioners should also be aware that they are responsible for maintaining the confidentiality of the records of their patients and, therefore, must ensure that the billing or storage vendors engaged by them agree to follow all relevant privacy and security rules regarding medical records, and that the records will not be destroyed or released unless so directed by the licensee.

## Cautions Regarding e-Data

One must remain cognizant of the fact that cell phones, e-mail, and text messages may not be secure modes of communication, specifically recognizing the question of who has access to the communication device and/or communication. Web-based applications vary in the level of security that is provided. In addition, digital storage devices (including computer hard drives) and fax and copy machines can retain images unless they are electronically wiped. Before disposing of a computer, it is the licensed professional's responsibility to ensure that all patient information is securely deleted. It is strongly recommended that once the memory is cleared of patient information, the device should be destroyed in a secure manner. It is important that patients are informed that there are risks to electronic communication. In addition, one should have a contingency plan in the event that telecommunications fail (i.e., another way to contact patient). Finally, one must be aware that there is always a potential for an individual to misrepresent his/her name, presenting problem or other information when engaging in electronic communications and the licensee bears responsibility for assuring the identity of the client.

## Social Media Telecommunications

Social Media has great potential as a public education tool that can be used to reach a wide audience with information about mental health. One should, however, remain aware that a professional web presence must be consistent with laws and regulations related to advertising and engaging in professional relationships. A personal web presence can potentially involve issues of boundary violations and should not allow client access.

Example: Friend requests on social media sites should be confined to friends and colleagues, while not accepting such requests from clients or potential clients.

An individual licensed under Title VIII of the Education Law may be charged with unprofessional conduct under section 29.1 of the Rules of the Board of Regents for advertising that is not in the public interest if he/she engages in advertising on web-postings that are fraudulent, false, deceptive or misleading, to the same extent as advertising in more traditional media.

While a licensed professional cannot be responsible for the client's social media interactions, when appropriate, the licensee should provide information to patients or discuss with them some of the pitfalls of social media as it may relate to the receipt of professional services. Due to the persistent stigma about mental illness and treatment, the licensed professional may want to point out to the client that certain activities may provide more information than the client is comfortable with sharing in the social media community, such as:

- posting a status update of "waiting in Dr. Smith's office for my weekly psychotherapy session" or
- allowing the GPS device in his/her smart-phone, tablet or computer to identify his/her location as the office of "Dr. Jones, Psychotherapist."

The licensee may be wise to consider including similar examples as a cautionary note to be discussed as part of the informed consent process, to avoid unfortunate, accidental disclosures of information.

### Videoconferencing

Videoconferencing includes varied points of delivery, including hospitals/ER's, Community Mental Health Centers (CMHCs), doctors' offices, institutional settings (e.g., nursing homes, prisons, schools), and clients' homes

Clinical applications of videoconferencing include clinical interviews for intake and diagnosis, consultation with other providers including the referring provider and with family members, emergency pre- and post-hospitalization evaluations, outpatient psychotherapy (scheduled and crisis), medication management or consultation, and professional consultation.

Videoconferencing may include supervision and consultation. A licensed professional who is consulting with other health professionals or, if allowed by State law and regulation, receiving supervision through video technology,

should exercise caution in these interactions, in order to ensure the confidentiality of patient information. A licensed professional remains responsible for the security of patient communications and information to the same extent as if the session or consultation were occurring with all parties in the practitioner's office. Prior to using any videoconferencing technology, the licensed professional should verify the encryption and security of data to protect the confidentiality of patient information.

Potential benefits of videoconferencing may include that it:

- can reduce costs to both client and practitioner,
- can reach individuals who might not otherwise have access to treatment,
- has overall empirical support for outcomes similar to traditional psychotherapies, and
- clients report positive experiences with videoconferencing.

Concerns regarding videoconferencing include whether practitioners are:

- ensuring that clients are able to adequately participate and understand the appropriate uses of videoconferencing (Informed Consent);
- whether videoconferencing technologies that are used are secure;
- whether the empirical validation of this methodology is sufficient; and
- whether individual states require that practitioners are qualified and licensed to practice within that state.

If using telecommunications, it is recommended that patients are informed there are risks to electronic communications. Clinicians should also have a contingency plan for telecommunications failures (e.g., a back-up way of contacting the patient). Patients should be informed as to how they can verify the clinician's professional license (the license status of all New York licensees can be ascertained here), and clinicians should be aware of the potential for patient misrepresentation.

### Avatars & Virtual Environments (VE)

Avatars and virtual environments (VE) are increasingly being researched for clinical application possibilities. Applications being investigated include treatment of depression, eating disorders, social anxiety and other phobias, autism spectrum disorders, PTSD and schizophrenia.

Avatars are used to create a virtual representation of the client, the practitioner (agent) or both; however, it may be unclear whether the "agent" is an actual trained clinician or a computer programmer. *Professional*

*services must be rendered only by those authorized to do so.* VEs are used to create planned and controlled environments that allow the client to be exposed to a situation or to explore an environment that relates to the issues of focus.

The potential benefits of avatars and VEs include some empirical support for the effectiveness of these techniques, reduction of costs to both client and practitioner, and greater accessibility to environments for exposure therapies.

Concerns regarding avatars and VEs include determining who the virtual therapeutic agents are, ensuring that they are authorized to provide professional services, ; defining the roles and training of virtual therapeutic agents; and determining whether these techniques are safe and effective, whether the technologies used are secure, and whether each client knows how to exit the program if under duress (e.g., during an immersion).

## Effective & Legal Telepractice

Telepractice should be considered a modality and applied only as appropriate to address the client's needs. In order to engage in telepractice in an effective, safe and legal manner, licensed mental health professionals should:

- Develop procedures for and obtain informed consent prior to providing remote services.
- Ensure that informed consent includes both benefits and risks.
- Conduct an initial assessment of each client to determine whether the telepractice modality is appropriate, given the client's treatment needs. If not, determine available alternatives and consider referrals.
- Learn relevant telepractice laws across all jurisdictions in which they will be providing online services before such services are provided.
- Not practice outside the scope of their license and training.
- Attend to issues of danger to self or others in duty to warn and protect situations, and to mandated reporting requirements in accordance with law.
- Make arrangements, as appropriate, in the consumer's local area to address emergency and crisis situations that may arise, and be knowledgeable of community resources that may be accessed in such situations.
- Ensure the accuracy of advertising and public statements about telephone and online services offered without making statements that imply a level of treatment or effectiveness that is beyond what is actually provided.

- Remain aware of the limitations of the online services provided and the technology used to offer these services.
- Evaluate online services offered to ensure their effectiveness and to modify them, as needed, on the basis of outcome data to most effectively meet client needs.
- Stay within one's scope of practice and limits of competence. As with all emerging areas of practice, one should use caution to ensure competence of the practitioner and the protection of clients.
- Attend to cultural, ethnic, language and other differences that may impact on their ability to effectively communicate with and treat clients.
- Employ professional standards of practice that include adequate documentation and record keeping, adherence to termination and abandonment guidelines, and appropriate practices for fees and financial arrangements.
- Verify the client's state of residence prior to providing telepractice services, as this may dictate those states in which a practitioner must be licensed.
- Possess the technological competence and clinical competence necessary to provide services via the online modality offered.
- Consult knowledgeable colleagues, relevant statutes, applicable ethical codes and available professional standards when unsure of any of the above.
- Consult with an attorney specifically experienced in these matters when legal questions arise.

# Association of Marital and Family Therapy Regulatory Boards

# Teletherapy & Telesupervision Guidelines II

*August 2021*

# AMFTRB
# Teletherapy Guidelines

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## Overview

In August 2021, due to the impact of the global Covid-19 Pandemic on training for and delivery of teletherapy behavioral health services for Licensed Marriage and Family Therapists (LMFTs), candidates for licensure as LMFTs, and on training programs in MFT, for the use of teletherapy and telesupervison, a review and update of the original guidelines developed by the AMFTRB Teletherapy Committee was conducted. These guidelines are for the consideration and use of AMFTRB member boards as they work on the regulation of the practice of teletherapy and telesupervison by LMFTs.

## Key Assumptions of the Teletherapy Committee

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

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

III. There are nuances of difference in clinical treatment depending on the delivery of service modality that should be considered.

IV. All state and federal regulations and rules for in person clinical treatment apply for the use of teletherapy practice.

V. A teletherapy standard must not be unnecessarily more restrictive than the respective in person standard for safe practice.

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

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

## The Process

The committee met and reviewed each of the elements of the guidelines due to the major impact of the global pandemic in 2020 and the significant changes stimulated to clinical practice and training. The immediate growth of teletherapy which was necessitated for providing treatment to clients during the pandemic challenged thinking about the efficacy of teletherapy, for what constituted appropriate training for teletherapy practice, and for when it was appropriate for clinicians to begin practice with teletherapy (pre-licensed or fully licensed practitioners). Resources also reviewed were the 2021 Role delineation Study conducted for the MFT National Examination, the April 2021 State Survey on complaints to state boards regarding teletherapy, a review in July 2021 of state websites for current regulations and rules regarding teletherapy and the mobility of licenses, the Commission on Accreditation for Marriage and Family Therapy Education's (COAMFTE) proposed Version 12.5 training standards for COAMFTE accredited programs, and current research publications on telebehavioral health practice.

Please be advised that the committee did not draft specific guidelines regarding the appropriateness of telemental health and working with domestic violence victims, completing child custody evaluations, treating cyber addiction, or using technology for supervised sanctions as the research in each of these areas was limited. As well, the question remains to be addressed of state board's established rules for a limited number of teletherapy experience hours and of telesupervison hours that are accepted to attain licensure.

## Definitions

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

**Electronic communication** - Using Web sites, cell phones, e-mail, texting, online social networking, video, or other digital methods and technology to send and receive messages, or to post information so that it can be retrieved by others or used at a later time. (Technology Standards in Social Work Practice, 2017)

**HIPAA compliant** - The Health Insurance Portability and Accountability Act (HIPAA), sets the standard for protecting sensitive patient data. Any company that deals with protected health information (PHI) must ensure that all the required physical, network, and process security measures are in place and followed. This includes covered entities (CE), anyone who provides treatment, payment and operations in healthcare, and business associates (BA)**,** anyone with access to patient information and provides support in treatment, payment or operations. Subcontractors, or business associates of business associates, must also be in compliance. (What is HIPAA Compliance? 2016; https://www.hhs.gov/hipaa/for-professionals/index.html)

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

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

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

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

# Guidelines for the Regulation of Teletherapy Practice

## 1. Adhering to Laws and Rules in Each Jurisdiction

A. Therapists of one state who are providing marriage and family therapy to clients in another state must comply with the laws and rules of both jurisdictions.

B. Treatment, consultation, and supervision utilizing technology-assisted services will be held to the same standards of appropriate practice as those in traditional (in person) settings.

## 2. Training and Continuing Competency Requirements

A. Therapists must adhere to their jurisdiction's training requirements for teletherapy prior to initiating teletherapy.

B. Therapists must review their discipline's definitions of "competence" prior to initiating teletherapy to assure that they maintain recommended technical and clinical competence for the delivery of care in this manner.

C. Therapists must have completed basic education and training in suicide prevention.

D. Therapists must assume responsibility to continually assess both their professional and technical competence when providing teletherapy services.

E. Therapists must demonstrate competence in a variety of ways (e.g., encryption of data, HIPAA compliant connections). Areas to be covered in training must include, but not be limited to, the following seven competency domains as researched and identified by Maheu, et al (2018) and Hertlein et al (2021):

Telebehavioral Health Domains:

1.Clinical Evaluation and Care
2. Virtual Environment and Telepresence
3. Technology
4. Legal & Regulatory Issues
5. Evidence-Based & Ethical Practice
6. Mobile Health Technologies Including Applications
7. Telepractice Development

F. Therapists conducting teletherapy must demonstrate continuing competency each license renewal cycle in their jurisdiction.

## 3. Diversity, Bias, and Cultural Competency

A. Therapists must be aware of and respect clients from diverse backgrounds and cultures, and have basic clinical competency skills providing treatment with these populations.

B. Therapists must be aware of, recognize, and respect the potential limitations of teletherapy for diverse cultural populations .

C. Therapists must remain aware of their own potential projections, assumptions, and biases.

D. Therapists must select and develop appropriate online methods, skills, and techniques that are attuned to their clients' cultural, bicultural, or marginalized experiences in their environments.
E. Therapists must know the strengths and limitations of current electronic modalities, process and practice models, to provide services that are applicable and relevant to the needs of culturally and geographically diverse clients and of members of vulnerable populations.
F. Therapists must be cognizant of the specific issues that may arise with diverse populations when providing teletherapy and make appropriate arrangements to address those concerns (e.g., language or cultural issues; cognitive, physical or sensory skills or impairments; or age may impact assessment).
G. Therapists must recognize that sensory deficits, especially visual and auditory, can affect the ability to interact over a videoconference connection. Therapists must consider the use of technologies that can help with visual or auditory deficit. Techniques should be appropriate for a client who may be cognitively impaired, or find it difficult to adapt to the technology.

## 4. Establishing Consent for Teletherapy Treatment

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

## 5. Identity Verification of Client

A. Therapists must recognize the obligations, responsibilities, and client rights associated with establishing and maintaining a therapeutic relationship.
B. The therapist is responsible for assessing and documenting the client's appropriateness for teletherapy treatment.

C. It is the therapist's responsibility to document appropriate verification of the client's identity.
D. The therapist must take reasonable steps to verify the location and identify of the client(s) at the onset of each session before rendering therapy using teletherapy.
E. Therapists must develop written procedures for verifying the identity of clients, their current location, and their appropriateness and readiness to proceed at the beginning of each contact. Examples of verification means include the use of code words, phrases, or inquiries. (For example, "is this a good time to proceed?").

## 6. Informed Consent

### Availability of Professional to Client

A. The therapist must document the provision of informed consent in the record prior to the onset of therapy.
B. In addition to the usual and customary protocol of informed consent between therapist and client for in-person therapy the following issues, unique to the use of teletherapy, technology, and/or social media, must be addressed in the informed consent process:
    a. confidentiality and the limits to confidentiality in electronic communication.
    b. teletherapy training and/or credentials, physical location of practice, and contact information.
    c. licensure qualifications and information on reporting complaints to appropriate licensing bodies.
    d. risks and benefits of engaging in the use of teletherapy, technology, and/or social media.
    e. possibility of technology failure and alternate methods of service delivery.
    f. process by which client information will be documented and stored.
    g. anticipated response time and acceptable ways to contact the therapist.
        i. agreed upon emergency procedures.
        ii. procedures for coordination of care with other professionals.
        iii. conditions under which teletherapy services may be terminated and a referral made to in-person care.
    h. time zone differences.
    i. cultural and/or language differences that may affect delivery of services.
    j. possible denial of insurance benefits.
    k. social media policy.
    l. specific services provided.
    m. pertinent legal rights and limitations governing practice across state lines or international boundaries, when appropriate; and
    n. Information collected and any passive tracking mechanisms utilized.

C. The information must be provided in language that can be easily understood by the client. This is particularly important when discussing technical issues like encryption or the potential for technical failure.
D. Local, regional and national laws regarding verbal or written consent must be followed. If written consent is required, electronic signatures may be used if they are allowed in the relevant jurisdiction.
E. Therapists may be offering teletherapy to individuals in different states at any one time, the therapists must meet each jurisdiction's regulations and rules related to informed

consent and document that in the respective record(s). The therapist is responsible for knowing the correct informed consent forms for each applicable jurisdiction.

F. Therapists must provide clients clear mechanisms to:

   a. access, supplement, and amend client-provided personal health information (PHI);
   b. provide feedback regarding the site and the quality of information and services; and

register complaints, including information regarding filing a complaint with the applicable state licensing board(s).

### Working with Children

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

## 7. Acknowledgement of Limitations of Teletherapy

A. Therapists must:
   (a) determine that teletherapy is appropriate for clients, considering clinical, relational, cultural, cognitive, intellectual, emotional, and physical needs
   (b) inform clients of the potential risks and benefits associated with teletherapy
   (c) ensure the security of the therapist's communication medium
   (d) only commence teletherapy after appropriate education, training, or supervised experience using the relevant technology
B. Therapists are to advise clients in writing of the risks and of both the therapist's and clients' responsibilities for minimizing such risks.
C. Therapists must consider nonverbal and verbal communication cues and how these may affect the teletherapy process. Therapists must educate clients on how to prevent and address potential misunderstandings arising from the lack of visual cues and voice intonations when communicating electronically.
D. Therapists must recognize the members of the same family system may have different levels of competence and preference using technology. Therapists must acknowledge power dynamics when there are differing levels of technological competence within a family system.
E. Before therapists engage in providing teletherapy services, they must conduct an initial assessment to determine the appropriateness of the client(s) for teletherapy service. An assessment should include examination of the potential risks and benefits to provide teletherapy services for the client's particular needs, the multicultural and ethical issues that may arise, and a review of the most appropriate medium (e.g., video conference, text, email, etc.) or best options available for service delivery.
F. It is incumbent on the therapist to engage in a continual assessment of the client's appropriateness for teletherapy services throughout the duration of treatment.

## 8. Confidentiality of Communication

A. Therapists utilizing teletherapy must meet or exceed applicable federal and state legal requirements of health information privacy including HIPAA (https://www.hhs.gov/hipaa/for-professionals/privacy/index.html) and HITECH (https://www.hhs.gov/hipaa/for-professionals/special-topics/hitech-act-enforcement-interim-final-rule/index.html) (https://www.hipaajournal.com/new-hipaa-regulations/).
B. Therapists must assess the remote environment in which services will be provided, to determine what impact there might be to the efficacy, privacy and/or safety of the proposed intervention offered via teletherapy.
C. Therapists must understand and inform their clients of the limits to confidentiality and risks to the possible access or disclosure of confidential data and information that may occur during service delivery, including the risks of access to electronic communications.

## 9. Professional Boundaries Regarding Virtual Presence

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

## 10. Impact of Social Media and Virtual Presence on Teletherapy

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

B. Therapists separate professional and personal web pages and profiles for social media use to clearly distinguish between the two kinds of virtual presence.
C. Therapists who use social networking sites for both professional and personal purposes must review and educate themselves about the potential risks to privacy and confidentiality and consider utilizing all available privacy settings to reduce these risks.
D. Therapists must respect the privacy of their clients' presence on social media unless given consent to view such information.
E. Therapists must avoid the use of public social media sources (e.g., tweets, blogs, etc.) to provide confidential information.
F. Therapists must refrain from referring to clients generally or specifically on social media.
G. Therapists who engage in online blogging must be aware of the effect of a client's knowledge of their blog information on the therapeutic relationship, and place the client's interests as paramount.

## 11. Documentation/Record Keeping

A. All client-related electronic communications, must be stored and filed in the client's record, consistent with standard record-keeping policies and procedures.
B. Written policies and procedures for teletherapy must be maintained at the same standard as in-person services for documentation, maintenance, and transmission of records.
C. Services must be accurately documented as remote services and include dates, place of both therapist and client(s) location, duration, and type of service(s) provided.
D. Requests for access to records require written authorization from the client with a clear indication of what types of data and which information is to be released. If therapists are storing video or audio recorded data from sessions, these cannot be released unless the client authorization indicates specifically that this is to be released.
E. Therapists must maintain policies and procedures for the secure destruction of data and information and the technologies used to create, store, and transmit data and information.
F. Therapists must inform clients on how records are maintained electronically. This includes, but is not limited to, the type of encryption and security assigned to the records, and if/for how long archival storage of transaction records is maintained.
G. Clients must be informed in writing of the limitations and protections offered by the therapist's technology.
H. The therapist must obtain written permission prior to recording any part of the teletherapy session. The therapist must request that the client(s) obtain written permission from the therapist prior to recording the teletherapy session.

## 12. Payment and Billing Procedures

A. Prior to initiating teletherapy, the client must be informed of any and all financial charges that may arise from the services to be provided. Payment arrangements must be established prior to beginning teletherapy.
B. All billing and administrative data related to the client must be secured to protect confidentiality. Only relevant information may be released for reimbursement purposes as outlined by HIPAA.

C. Therapist must document who is present and use appropriate billing codes.
D. Therapist must ensure online payment methods by clients are secure.

## 13. Emergency Management

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

## 14. Synchronous vs. Asynchronous Contact with Client(s)

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

## 15. HIPAA Security, Web Maintenance, and Encryption Requirements

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

## 16. Archiving/Backup Systems

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

## 17. Standardized & Non-standardized Testing for Assessment

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

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

## 18. Telesupervision

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

be aware of the potential benefits and limitations in their choices of technologies for particular supervisees in particular situations.

## References


American Association for Marriage and Family Therapy. (2015). Code of Ethics. http://aamft.org/imis15/AAMFT/Content/Legal_Ethics/Code_of_Ethics.aspx

Blumer, M. L., Hertlein, K. M., Smith, J. M., & Allen, H. (2013). How Many Bytes Does It Take? A Content Analysis of Cyber Issues in Couple and Family Therapy Journals. *J Marital Fam Ther Journal of Marital and Family Therapy, 40*(1), 34-48. doi:10.1111/j.1752-0606.2012.00332.x

Brew, L., Cervantes, J. M., & Shepard, D. (2013). Millennial Counselors and the Ethical Use of Facebook.
*TPC The Professional Counselor, 3*(2), 93-104. doi:10.15241/lbb.3.2.93

Epstein Becker Green. (2016, May). *Survey of Telemental/Telebehavioral Health*. Chicago, IL.

Haberstroh, S., Barney, L., Foster, N., & Duffey, T. (2014). The Ethical and Legal Practice of Online
Counseling and Psychotherapy: A Review of Mental Health Professions. *Journal of Technology in Human Services, 32*(3), 149-157. doi:10.1080/15228835.2013.872074

Haberstroh, S. (2009). Strategies and Resources for Conducting Online Counseling. *Journal of Professional Counseling, Practice, Theory and Research, 37(2),* 1-20.

Hertlein, K.M., Drude, K.P., Hilty, D.M., Maheu, M.M. (2021) Toward proficiency in telebehavioral health: applying interprofessional competencies in couple and family therapy., Journal of Marital and Family Therapy, 47: 359-374 https://doi-org.libproxy.uccs.edu/10.1111/jmft.12496

Hertlein, K. M., Blumer, M. L., & Mihaloliakos, J. H. (2014). Marriage and Family Counselors' Perceived Ethical Issues Related to Online Therapy. *The Family Journal, 23*(1), 5-12. doi:10.1177/1066480714547184

HIPAA 'Protected Health Information': What Does PHI Include? - HIPAA.com. (2009). Retrieved July 07, 2016, from http://www.hipaa.com/hipaa-protected-health-information-what-does-phi-include/

Hughes, R. S. (2000). *Ethics and regulations of cybercounseling*. Greensboro, NC: ERIC Clearinghouse on Counseling and Student Services.

Maheu, Marlene M., Drude, Kenneth P., Hertlein, Katherine M., Lipschutz, Ruth, Wall, Karen, Hilty, Donald M. (2018) Correction to: *An Interprofessional Framework for Telebehavioral Health Competencies.* Journal of Technology in Behavioral Science 3: 108 -140; https://doi.org/10.1007/s41347-018-0046-6

Mitchell, D. (2000). Chapter 10, Email Rules! In L. Murphy (Ed.), *Cybercounseling and cyberlearning: Strategies and resources for the Millennium* (pp. 203-217). Alexandria, VA: ACA

Reamer, F. G. (2013). Social Work in a Digital Age: Ethical and Risk Management Challenges. *Social Work, 58*(2), 163-172. doi:10.1093/sw/swt003

Secretary, H. O. (n.d.). HITECH Act Enforcement Interim Final Rule. Retrieved July 07, 2016, from http://www.hhs.gov/hipaa/for-professionals/special-topics/HITECH-act-enforcement-interim-final-rule/index.html

Serious Question: What Exactly Is Social Media? (n.d.). Retrieved July 07, 2016, from http://webtrends.about.com/od/web20/a/social-media.htm

"Technology and Social Work Practice - ASWB." N.p., n.d. Web. 7 July 2016.

Trepal, H., Haberstroh, S., Duffey, T., & Evans, M. (2007). Considerations and Strategies for Teaching Online Counseling Skills: Establishing Relationships in Cyberspace. *Counselor Education and Supervision, 46*(4), 266-279. doi:10.1002/j.1556-6978.2007.tb00031.x
Twist, M. L., & Hertlein, K. M. (2015). E-mail Me, Tweet Me, Follow Me, Friend Me: Online Professional Networking Between Family Therapists. *Journal of Feminist Family Therapy, 27*(3-4), 116-133. doi:10.1080/08952833.2015.1065651
Virtual relationship. (n.d.). Retrieved July 07, 2016, from http://www.urbandictionary.com/define.php?term=Virtual relationship
What is HIPAA Compliance? (n.d.). Retrieved July 07, 2016, from http://www.onlinetech.com/resources/references/what-is-hipaa-compliance

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# The Use of Videoconferencing in Supervision of Associate Clinical Social Workers, Marriage and Family Therapist Interns, and Professional Clinical Counselor Interns:

# A Best Practices Guide

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

**California Board of Behavioral Sciences, 2010**

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# Introduction

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

# Background and Supervision-Related Laws

Legislation to permit marriage and family therapist (MFT) interns and associate clinical social workers (ASWs) to gain supervision via videoconferencing was signed by the Governor in 2009 and took effect January 1, 2010. Supervision provided via videoconferencing has not been permitted in the past. However, the legislation was introduced in response to requests from stakeholders, especially those who work in public mental health or in rural areas where supervision can be difficult to obtain.

Under these new provisions, videoconferencing is considered the same as face-to-face direct supervisor contact. It is only permitted for MFT interns or ASWs working in a government entity, a school, college, university, or an institution that is both nonprofit and charitable. It is not permitted for students who have not yet completed their degree or those who have not yet registered with the Board of Behavioral Sciences as an MFT intern or an ASW. Additionally, it is not allowed in a private practice setting or other setting not explicitly permitted in the code.

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

- **MFT Interns:** BPC §4980.43(c) states that, effective January 1, 2010, supervision shall include at least one hour of direct supervisor contact in each week for which experience is credited in each work setting. According to Paragraph 2 of the same section, "an individual supervised after being granted a qualifying degree shall receive at least one additional hour of direct supervisor contact for every week in which more than 10 hours of client contact is gained in each setting. No more than five hours of supervision, whether individual or group, shall be credited during any single week."

  BPC §4980.43(c)(6) addresses the issue of videoconferencing: "an intern working in a governmental entity, a school, a college, or a university, or an institution that is both nonprofit and charitable may obtain the required weekly direct supervisor contact via two-way, real-time videoconferencing. The supervisor shall be responsible for ensuring that client confidentiality is upheld."

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

- **LPCC Interns:** BPC §4999.46(f)(1) and (2) state that supervision "shall include at least one hour of direct supervisor contact in each week for which experience is credited in each work setting…an intern shall receive an average of at least one hour of direct supervisor contact for every 10 hours of client contact in each setting[2]." Additionally, BPC §4999.46(f)(4) states:

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

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

> "an intern working in a governmental entity, a school, a college, or a university, or an institution that is both nonprofit and charitable, may obtain up to 30 hours of the required weekly direct supervisor contact via two-way, real-time videoconferencing. The supervisor shall be responsible for ensuring that client confidentiality is upheld."[3]

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

## Recommended Best Practices in Supervision with Videoconferencing

### *Establishing a Supervisory Alliance*

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

<u>Alliance Issues and Videoconferencing</u>

Supervision via videoconferencing, by its very nature, involves a more distant relationship between the supervisor and supervisees than face-to-face supervision. Clinical supervisors who are new to this practice may find it difficult to "tune in" to the

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

challenges faced by supervisees, when meeting on a remote basis. However, supervisors experienced in the use of this technology claim that over time they are able to tune in to more subtle communication and non-verbal behaviors of the supervisee and a supervisory alliance is formed. It is recommended as a best practice that one or more initial in-person meetings between the supervisor and supervisee be held to jump-start the relationship-building process, develop of the learning/supervision contract and establish protocol for use of the technology. It is also recommended that face-to-face supervisory sessions occur periodically throughout the supervisory relationship in addition to the supervision meetings held through videoconferencing. Additional forms of technology may also be used to supplement videoconferencing and mitigate limitations that the distance may impose, including email, web-ex meetings, on line discussions, and phone conferences.

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

### *Contracting for Supervision*

Formality and structure are also key elements of effective clinical supervision (Coleman, 2003), as are clearly articulated expectations (Munson, 2002). Thus, best practice as it relates to supervision involves the use of a written contract between the supervisor and supervisee that outlines how and when supervision will occur, what is expected of each in preparation for supervisory sessions, and how supervision time will be utilized, tracked, documented, and evaluated. Additional components that may be added to this contract include clarification regarding the parameters of confidentiality and the nature of the supervisor-supervisee relationship. Additionally, Milne (2009) emphasizes the

importance of supervisees being informed of the values-base that the supervisor will bring to the supervisory process (such as respect, empowerment, commitment to life-long learning, valuing of social work ethics, and cultural competency,).

### Contracting for Supervision via Videoconferencing

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

## *Assessing the Learning Needs of the Supervisee*

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

An assessment of the learning style of the supervisee also contributes to high quality supervision. Neil Fleming (2001) defines learning style as an individual's characteristic and preferred ways of taking in and giving out information. He proposes the use of the

VARK Inventory (www.vark-learn.com) for assessing the extent to which the learner has an instructional preference that is visual (V), aural (A), Read/Write (R), or kinesthetic (K). Visual learners are said to prefer charts, diagrams, and other spatial configurations, while aural learners prefer lectures and discussion. Read/write learners prefer lists, books and articles, while kinesthetic learners like hands-on approaches. As applied to clinical supervision, knowledge of learning styles can guide the use of tools and activities that are tailored to the preferences of the supervisee.

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

### Assessment of Learning Needs and Supervision via Videoconferencing

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

### *Developing a Learning Plan*

Following the assessment of learning needs, the supervisor and supervisee should collaborate to develop a learning plan. Best practice would recommend that this collaboration occur in a face to face meeting. This plan will ideally include goals and

objectives for the clinician, as well as activities that will be performed to meet those objectives. According to Milne (2009), the best supervisory goals are SMARTER (specific, measurable, achievable, realistic, time-phased, evaluated, and recorded). Learning activities that should be documented on the plan may be those performed inside or outside of the supervision sessions. Activities that take place during supervisory sessions might include: on-going case review; case presentations; role plays; review of process recordings, audio taped or video-taped sessions and/or online video vignettes, etc. Those that take place outside of the meeting include shadowing experienced or licensed clinicians, co-facilitating therapeutic sessions, and/or performing solo clinical activities that are observed or recorded.

### The Learning Plan and Supervision via Videoconferencing

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

### *Facilitating Learning*

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

of live supervision and video modeling of clinically appropriate behavior and interactions.

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

### Facilitating Learning Through Videoconferencing

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

### *Monitoring the Supervisee's Progress Toward Goals*

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

include direct observation of practice and review of documented assessments and case notes written by the supervisee.

Monitoring Within the Context of Supervision Via Videoconferencing

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

### *Evaluating the Supervisory Process*

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

the Supervision Analysis Questionnaire (SAQ) – a tool that could be utilized or adapted for this purpose.

Evaluating Supervision Conducted Through Videoconferencing

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

## Advantages and Disadvantages of Using Videoconferencing for Supervision

Advantages

- Reduces stress and time involved in traveling to supervision.
- Provides access to supervision expertise that might otherwise be unavailable.
- Access to supervision empowers professionals and ensures good standards of care are maintained.
- Cognitive and Enactive methods for facilitating learning in supervision are well suited for videoconferencing.
- The use of videoconferencing for supervision may enhance a supervisee's confidence with technology and encourage the use of technology to enhance their practice outside of supervision.
- The distance relationship often encourages supervisors to provide supervisees with more options for consultation and feedback outside of the scheduled supervision time which can result in the supervisee being able to receive feedback more often with practice situations requiring consultation.
- The lack of ability to view written documents using videoconferencing means that documents are shared ahead of time and both the supervisee and supervisor are

then able to prepare questions and items for discussion regarding these documents ahead of time.

Disadvantages

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

## Selecting a Videoconferencing Medium

Today, videoconferencing can be defined as connecting two or more locations at the same time utilizing cameras, microphones, monitors and a network. Videoconferencing can be computer-based or involve more expensive room-based systems.

Computer-based videoconferencing solutions are inexpensive and easy to set up if a high bandwidth connection and a computer are already available. Examples of computer-based videoconference software include: Skype, Oovoo, SightSpeed, Adobe Connect Now, WebEx and many others. The features available vary by product but many allow multiple participant connections, file sharing, white board sharing, and 128-bit security encryption.

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

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

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

## Adobe Connect Now

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

## Adobe Connect Pro

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

## MegaMeeting

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

## Oovoo

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

## SightSpeed

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

## Skype

Skype is free software that allows two users to videoconference. The software does not provide an option for multiple users in the same meeting. It does allow screen and file

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

sharing. The literature suggests that security is an issue and that the software is more vulnerable to hacking.

## Best Practices for Computer-based Videoconferencing

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

### Meeting Etiquette

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

### Connect with Participants

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

### Lighting and Background

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

Audio Quality

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

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

## Computer-based Two-way Videoconferencing Security

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

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

## Best Practices for Room-based Videoconferencing

Room based videoconferencing systems can be expensive to install, maintain and operate and may be cost prohibitive for supervisors and/or supervisees. Modifying and equipping a room for videoconferencing can range from $20,000 to $100,000 per room. Supervisors and supervisees may want to research local agencies or companies to determine if any pre existing systems exist in their locale. If participants have free access to previously installed videoconference rooms this may make this form of videoconferencing supervision accessible.  The following recommendations are considered best practice for the use of room based videoconferencing:

Meeting Etiquette

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

Audio

Mute your microphone when you are not speaking. This will minimize the possibility of audio echoing and creating feedback. Also remember there will be a one second delay in

the audio as it is being transmitted; therefore it is common for participants from two sites to "speak-over" each other making it difficult for either participant to be understood.

### Non-Verbal Communication

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

### Canceling Meetings

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

### Room-based Two-way Videoconferencing Security

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

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

## Best Practices for Computer and Room-based Videoconferencing

- Accessible technology support at both sites
- Agreed upon plan/follow-up actions should technology fail
- Periodically scheduled in-person meetings

- Established agreed-upon method for review of clinical documentation
- Instruction/introduction to use of technology to include basic trouble-shooting and procedures for technical assistance
- Frequent and on-going assessment of the technology as well as the supervisory process

## Potential Ethical Concerns

Quality

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

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

Quantity

Current videoconferencing technology does allow for increased accessibility to supervision. Supervisees who live in diverse geographical regions will have access to supervision that logistics may have previously prevented. Access to discussions that

allow reflection on issues or factors that impact the supervisee's practice can lead to decreased feelings of isolation and enhance the supervision experience. The ethical issue in question is whether or not supervision provided solely through the use of technology is adequate for the demands of a particular supervisee and his or her clinical responsibilities. It is important to evaluate whether additional local or on-site supervision should be provided.

## Cultural Competence

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

## Security and Confidentiality

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

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

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

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

### Liability and Insurance Coverage

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

## Group Supervision Best Practices

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

Advantages

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

Disadvantages

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

Best Practice Recommendations

- Establish group rules that encourage trust and safety
- Containment – equal sharing time for supervisees
- Confidentiality – parameters, security issues with audio-visual technology
- Meeting time, attendance, expectations
- Identify adjunctive communication methods; email, on line discussions
- Establish a structure for each meeting

<u>Issues to Keep in Mind with Group Supervision</u>

(Bogo & Globerman, 2004)

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

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

The group facilitator can be most effective by:

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

- Setting clear expectations how the group will operate – the process for deciding who will present, how much time will be allotted for each student, how feedback will be given, group norms and behavior expectations.

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

## References

Algar, C. & Kopcha,T.J. (2009). *eSupervision: A technology framework for the 21st century field experience in teacher education.* Issues in Teacher Education, 18 (2), 31-46.

American Board of Examiners in Clinical Social Work. (2004). *Clinical supervision: A practice specialty of social work*. Retrieved from American Board of Examiners in Clinical Social Work website: http://www.abecsw.org/pub-position-papers.html.

Beretta-Herman, A. (2001). *Fulfilling the commitment to competent social work practice through supervision.* In L. Beddoe & J. Warall (Eds.), International supervision conference proceedings 2000: From rhetoric to reality (pp. 1-9). Auckland, New Zealand: University of Auckland.

Bernard, J.M. & Goodyear, R.K. (2004). *The fundamentals of clinical supervision*. Massachusetts: Allyn & Bacon.

Bogo, M., Globerman, J. & Sussman, T. (2004). *The field instructor as group worker: Managing trust and competition in group supervision.* Journal of Social Work Education, 40 (1), 13-26.

Bogo, M., & McKnight, K. (2005). *Clinical supervision in social work: A review of the research literature.* The Clinical Supervisor (The Haworth Press Inc.), 24(1/2), 49-67.

Coleman, M (2003, June). *Supervision and the clinical social worker.* Clinical Social Work Practice Update, 3, 1-4.

Conn, S.R., Roberts, R.L. & Powell, B. (2009). *Attitudes and satisfaction with a hybrid model of counselling supervision.* Education Technology & Society, 12 (2), 298-306.

Cummings, P., (2002). *Cybervision: Virtual peer group counselling supervision – hindrance or help?* Counselling and Psychotherapy Research, 2 (4), 223-229.

Falender, C. A. and Shafranske, E. P. (2004). *Clinical supervision: A competency-based approach.* Washington, DC: American Psychological Association.

Fleming, N.D. (2001). *Teaching and learning styles: VARK strategies.* Christchurch, New Zealand: N.D. Fleming.

Hara, N., Bonk, C., & Angeli, C., (2000). *Content analyses of on-line discussion in an applied educational psychology course.* Instructional Science. 28(2), 115-152.

Kadushin, A., & Harkness, D. (2002). *Supervision in social work* (4th ed.). New York: Columbia University Press.

Kolb, D. A. (1984). *Experiential learning: Experience as the source of learning and development*. Englewood Cliffs, NJ: Prentice-Hall.

Maheu, M.M., Whitten, P., Allen, A., (2001). *E-Health, telehealth, and telemedicine: a guide to start-up and success.* San Francisco: Jossey-Bass, Inc.

Marrow, C.E., Hollyoake, K. & Hamer, D. (2002). *Clinical supervision using videoconferencing technology: A reflective account.* Journal of Nursing Management, 10, 275-282.

Milne, D. (2007). *An empirical definition of clinical supervision. The* British Journal of Clinical Psychology, 46, 437-446.

Milne, D. (2009). *Evidence-based clinical supervision: Principles and practice*. The Atrium, Southern Gate, Chichester, West Sussex, PO19 8SQ, UK: BPS Blackwell Publishing.

Milne, D., Aylott, H., Fitzpatrick, H., & Ellis, M. V. (2008). *How does clinical supervision work? Using a "best evidence synthesis" approach to construct a basic model for supervision.* The Clinical Supervisor, 27(2), 170-190.

Munson, C. (2002). *The handbook of clinical social work supervision*. New York: Haworth Press.

National Association of Social Workers website. (2008 n.d.). www.socialworkers.org

Olson, M.M., Russell, C.S. & White, M.B., (2001). *Technological Implications for clinical supervision and practice,* The Clinical Supervisor 20 (2), 201-215.

Panos, P.T., Panos, A., Cox, S.E., Roby, J.L. & Matheson, K.W. (2002). *Ethical issues concerning the use of videoconferencing to supervise international social work field practicum students.* Journal of Social Work Education, 38 (3), 421-427.

Stebnicki, M.A. & Glover, N.M. (2001). *eSupervision as a complementary approach to traditional face-to-face clinical supervision in rehabilitation counselling: Problems and solutions.* Rehabilitation Education, 15 (3), 283-293.

Tsui, M. S., & Ho, W. S. (1997). *In search of a comprehensive model of social work supervision.* The Clinical Supervisor, 16(2), 181-205.

U.S. Department of Health and Human Services, Office of the Secretary, (2000). *Standards for privacy of individually identifiable health information; Final rule.*

Walter, C.A. & Young, T.M. (1999). *Combining individual and group supervision in educating for the social work profession.* The Clinical Supervisor, 18 (2), 73-89.

Weingardt, K.R., Cucciare, M.A. Bellotti, C. & Wen, P. L. (2009). *A randomized trial comparing two models of web-based training in cognitive-behavioral therapy for substance abuse counsellors.* Journal of Substance Abuse Treatment, 37, 219-227.

Wood, J.A., Hargrove, D.S. & Miller, T.W. (2005). *Clinical supervision in rural settings: A telehealth model.* Professional Psychology: Research and Practice, 36 (2), 173-179.

# Addendum 1: Matrix for Computer-based Videoconference Systems

## Videoconference Software Applications Reviewed

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

March, April and May 2010

## Addendum 2: Additional Resources

American Telemedicine Association
http://www.americantelemed.org

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

Center for Connected Health
http://www.connected-health.org/

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

Mobile Health Watch
http://www.mobilehealthwatch.com/

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

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NASW, ASWB, CSWE, & CSWA Standards for

# Technology in Social Work Practice

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**About the Associations**

The **National Association of Social Workers (NASW)** is the largest membership organization of professional social workers in the nation. Membership in NASW includes over 130,000 social workers from 50 states, the District of Columbia, New York City, the U.S. Virgin Islands, Guam, Puerto Rico, and U.S. social workers practicing abroad. NASW's primary functions include promoting the professional development of its members, establishing and maintaining professional standards of practice, advancing sound social policies, and providing services that protect its members and enhance their professional status.

The **Association of Social Work Boards (ASWB)** is the nonprofit organization of social work regulatory bodies in the United States and Canada, including all 50 U.S. states, the District of Columbia, the U.S. Virgin Islands, Guam, the Northern Mariana Islands, and all 10 Canadian provinces. ASWB's mission is to strengthen protection of the public by providing support and services to the social work regulatory community to advance safe, competent, and ethical practices. In March 2015, ASWB published *Model Regulatory Standards for Technology and Social Work Practice* that were developed by an international task force of social work regulators and subject matter experts convened by ASWB. These standards provided the foundation for the development of this edition of *Technology Standards in Social Work Practice*. ASWB's current initiative is developing and implementing a plan to achieve social work practice mobility and licensure portability for social work practitioners in the United States.

The **Council on Social Work Education (CSWE)** is a nonprofit national association representing more than 2,500 individual members as well as graduate and undergraduate programs of professional social work education. Founded in 1952, this partnership of educational and professional institutions, social welfare agencies, and private citizens is recognized by the Council for Higher Education Accreditation as the sole accrediting agency for social work education in this country.

The **Clinical Social Work Association (CSWA)** is a national individual membership organization dedicated to providing to its members information and professional support on the ethical and educational basis of clinical social work, and advocacy at the state and national level for access to clinical social work mental health services. The association membership includes clinical social workers, new professionals (clinical social workers who have graduated within the last four years), emeritus members, and students.

**Foreword**

NASW partnered with ASWB, CSWE, and CSWA to develop a uniform set of technology standards for professional social workers to use as a guide in their practice. The four associations formed the Task Force for Technology Standards in Social Work Practice and jointly developed the ***Technology Standards in Social Work Practice***.

The task force met for almost two years reviewing technology literature in social work services and emerging standards in multiple professions. The task force also reviewed relevant statutes and licensing regulations in various jurisdictions. Multiple drafts were prepared and a draft was released for public comment during the summer of 2016. Many comments were received from individual social workers, social work academicians, and groups including the Grand Challenges for Social Work initiative (American Academy of Social Work and Social Welfare) and representatives of a Web-based macro social work group.

The task force thoroughly reviewed and discussed every submitted comment and revised the draft accordingly. Based on the comments received, the task force established a sub–task force advisory group consisting of social work professionals with extensive technology-related expertise and experience. This group submitted a favorable review of the standards and offered recommendations that the full task force reviewed, discussed, and incorporated into the draft.

In developing these standards, the Task Force for Technology Standards in Social Work Practice used several foundation documents, including the NASW ***Code of Ethics*** and the ASWB ***Model Social Work Practice Act***, along with many other sources. The standards use a humanistic framework to ensure that ethical social work practice can be enhanced by the appropriate use of technology.

NASW wishes to thank the task force and the sub–task force advisory group for their persistence and hard work in the development of this document.

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## Introduction

Social workers' use of technology is proliferating. Technology has transformed the nature of social work practice and greatly expanded social workers' ability to assist people in need. Contemporary social workers can provide services to individual clients by using online counseling, telephone counseling, videoconferencing, self-guided Web-based interventions, electronic social networks, mobile apps, automated tutorials, e-mail, text messages, and a host of other services. Social workers' use of technology has created new ways to interact and communicate with clients, raising fundamentally new questions about the meaning of the social worker–client relationship.

In addition, social workers use various forms of technology to access, gather, and otherwise manage information about clients. Social workers maintain encrypted electronic records, store sensitive information on their smartphones and in the "cloud," and have the capacity to search for information about clients using Internet search engines. Social workers use technology in creative ways to address compelling social justice issues, organize communities, administer organizations, and develop social policy. Social workers also explore and develop new technologies for practice and disseminate them with colleagues.

Technology has also influenced social work education and broadened its reach. Today's students may take courses online, view prerecorded lectures posted on Internet-based course sites, participate in online social work practice simulations, interact with fellow students enrolled in a course from multiple locations around the world, and listen to podcasts. Social workers have expanded options to satisfy their continuing education requirements by enrolling in live online webinars and attending lectures

delivered from remote locations that are transmitted electronically. They may provide and obtain training, supervision, and consultation from distant locations using videoconferencing technology.

These dramatic developments require practice standards in technology. The following standards are divided into four main sections and address social workers' use of electronic technology to (1) provide information to the public; (2) design and deliver services; (3) gather, manage, store, and access information about clients; and (4) educate and supervise social workers. These standards are designed to guide social workers' use of technology; enhance social workers' awareness of their ethical responsibilities when using technology; and inform social workers, employers, and the public about practice standards pertaining to social workers' use of technology. Social workers should consider these standards in conjunction with the NASW *Code of Ethics*, other social work standards and relevant statutes, and regulations. As new forms of technology continue to emerge, the standards provided here should be adapted as needed.

Each practice standard provides social workers with general guidance on how to use technology in an ethical manner; the "interpretation" sections offer suggestions for implementing these standards in a wide range of circumstances and social work settings. The interpretations provide examples of factors that social workers may consider when making decisions about the appropriate use of technology. The standards and their interpretations are intended to set a minimum core of excellence for professional practice when social workers use technology and to provide a framework to address possible benefits, challenges, and risks that arise when using technology. These guidelines are not intended to suggest that the use of technology is inherently riskier or more problematic than other forms of social work.

**Special Note: The order in which the standards appear does not reflect their order of importance.**

**These standards address a wide range of key concepts related to social workers' use of technology. By necessity, some concepts (for example, informed consent, confidentiality, boundaries, social media policies) are discussed in multiple places in the document. Readers are encouraged to review the document in its entirety.**

## Section 1: Provision of Information to the Public

Social workers who use technology to provide information to the public about the services they offer and on social work topics of general interest, and who engage in social advocacy, should uphold the values of the profession and adhere to the following standards.

### Standard 1.01: Ethics and Values

**When social workers use technology to provide information to the public, they shall take reasonable steps to ensure that the information is accurate, respectful, and consistent with the NASW *Code of Ethics*.**

**Interpretation**

When communicating with the public using Web sites, blogs, social media, or other forms of electronic communication, social workers should make every effort to ensure that the information reflects the values, ethics, and mission of the profession. Social workers should consult relevant standards in the NASW *Code of Ethics* for guidance (especially related to competence; conflicts of interest; privacy and confidentiality; respect; dishonesty, fraud, and deception; misrepresentation; solicitations; private conduct; and acknowledging credit).

### Standard 1.02: Representation of Self and Accuracy of Information

**When social workers use technology to provide information to the public, they shall take reasonable steps to ensure the accuracy and validity of the information they disseminate.**

**Interpretation**

Social workers should post information from trustworthy sources, having ensured the accuracy and appropriateness of the material. They should advertise only those electronic services they are licensed or certified and trained to provide in their areas of competence. Social workers should periodically review information posted online by

themselves or other parties to ensure that their professional credentials and other information are accurately portrayed. Social workers should make reasonable effort to correct inaccuracies.

## Section 2: Designing and Delivering Services

### Part A: Individuals, Families, and Groups

Technology may be used to facilitate various forms of services, including counseling, case management, support, and other social work functions. Technology may also be used to facilitate communication with clients, obtain information from clients, provide information to clients, and facilitate various interventions.

The ability to provide services electronically has many benefits as well as risks that social workers should consider. Social workers who use technology to provide services should assess whether clients will benefit from receiving services through electronic means and, when appropriate, offer alternative methods of service delivery.

#### Standard 2.01: Ethical Use of Technology to Deliver Social Work Services

**When providing services to individuals, families, or groups using technology, social workers shall follow the NASW *Code of Ethics* just as they would when providing services to clients in person.**

#### Interpretation

When using technology to provide services, practitioner competence and the well-being of the client remain primary. Social workers who use technology to provide services should evaluate their ability to

- assess the relative benefits and risks of providing social work services using technology (for example, in-person services may be necessary when clients pose a significant risk of self-harm or injurious behavior, are cognitively impaired, require

sustained support by a social worker with whom they have an ongoing professional relationship, or are in crisis)

- reasonably ensure that electronic social work services can be kept confidential. For example, the information provided by the client should only be accessible by those who require access and that the host of the server used for electronic communication agrees to abide by the privacy policies of the social worker
- reasonably ensure that they maintain clear professional boundaries (for example, social workers should be mindful of boundary confusion that may result if they disclose personal information about themselves or others in an online setting to which clients have access)
- confirm the identity of the client to whom services are provided electronically at the onset of each contact with the client (examples include confirming a client's online consent with a telephone call; providing the client with a password, passcode, or image that is specifically for the client's use when providing consent electronically)
- assess individuals' familiarity and comfort with technology, access to the Internet, language translation software, and the use of technology to meet the needs of diverse populations, such as people with differing physical abilities

### Standard 2.02: Services Requiring Licensure or Other Forms of Accreditation

Social workers who provide electronic social work services shall comply with the laws and regulations that govern electronic social work services within both the jurisdiction in which the social worker is located and in which the client is located.

#### Interpretation

Social workers should be aware of all laws, regulations, and other rules that govern their work using technology, particularly licensure

laws. Most jurisdictions have adopted the position that electronic social work practice takes place in both the jurisdiction where the client is receiving such services (irrespective of the location of the practitioner) and in the jurisdiction where the social worker is licensed and located at the time of providing such electronic services (irrespective of the location of the client). If the client and social worker are in different jurisdictions, the social worker should be aware of and comply with the laws in both the jurisdiction where the social worker is located and where the client is located.

Here are some examples:

- The social worker and client are initially located in one jurisdiction and the client moves to another jurisdiction to attend college. It is the social worker's responsibility to contact the other jurisdiction's regulatory board to determine what requirements are necessary to provide services legally in that jurisdiction. The other jurisdiction may allow for temporary practice for a duly licensed social worker who they determine meets "substantial equivalency."
- The social worker is traveling for an extended time outside of the jurisdiction where she is licensed. A client asks the social worker to provide electronic services during the social worker's absence. It is the social worker's responsibility to contact the local jurisdiction's regulatory board to determine what is required for the social worker to provide services legally in that jurisdiction.
- The social worker is employed by the U.S. Department of Veterans Affairs or the U.S. military and provides electronic services under the auspices of those organizations. The laws and rules of these national organizations apply and are recognized by the jurisdiction(s) in which the social worker and client are located.

### Standard 2.03: Laws That Govern Provision of Social Work Services

Social workers who provide social work services using technology shall understand, comply, and stay current with any and all laws that govern the provision of social work services and inform clients of the social worker's legal obligations, just as they would when providing services in person.

#### Interpretation

In addition to professional regulation and licensure laws, there are many other jurisdictional laws that social workers need to understand, comply with, and inform clients of. It is the social worker's responsibility to comply with existing laws and keep apprised of new legislation. Specific obligations may include mandatory reporting of suspected abuse or neglect of a child, older adult, or person with a disability; a practitioner's verbal or electronic sexual communication with a client; a practitioner's impairment in the ability to practice by reason of illness, use of alcohol or drugs, or as a result of mental or physical conditions; or a practitioner's improper or fraudulent billing practices. Social workers should also be familiar with other laws governing social work practice, such as those related to mental health, addictions, duty to protect clients and third parties, and social worker–client privilege.

### Standard 2.04: Informed Consent: Discussing the Benefits and Risks of Providing Electronic Social Work Services

When providing social work services using technology, social workers shall inform the client of relevant benefits and risks.

#### Interpretation

Possible benefits of providing social work services through electronic means include

- enhancing access to social work services that are unavailable in person because of geographical

- real-time monitoring of clients' status, when appropriate
- being able to respond to clients rapidly
- enhancing access to services because of clients' scheduling challenges
- providing more cost-effective delivery of social work services
- ease of communication
- reducing the frequency of clients' travel to obtain social work services

Possible risks of providing social work services through electronic means include

- potential for technology failure and interruption of services
- potential for confidentiality breaches
- prevention of unauthorized use or unethical purposes
- higher cost of technology

### Standard 2.05: Assessing Clients' Relationships with Technology

**When conducting psychosocial assessments with clients, social workers shall consider clients' views about technology and the ways in which they use technology, including strengths, needs, risks, and challenges.**

#### Interpretation

Historically, social workers have been taught to assess the psychosocial well-being of clients in the context of their environment, including relationships with family members, peers, neighbors, and coworkers. With the increasing use of technology in society, it is important for social workers to also consider clients' relationships and comfort with technology. Such assessments could include client strengths, such as access to particular forms of technology and the ability to use technology for family, work, school, social, recreational, and other purposes. In addition, social workers should consider relevant needs, risks, and challenges, such as clients' reluctance to use technology; difficulty affording technology; limited computer knowledge or fluency with

technology; and the risk of cyberbullying, electronic identity theft, and compulsive behaviors regarding the use of technology.

### Standard 2.06: Competence: Knowledge and Skills Required When Using Technology to Provide Services

Social workers who use technology to provide services shall obtain and maintain the knowledge and skills required to do so in a safe, competent, and ethical manner.

#### Interpretation

Social workers who provide electronic services should be competent in the use of technology and maintain competency through relevant continuing education, consultation, supervision, and training. Social workers should continuously learn about changes in technology used to provide these services. Competence depends on the type of technology and how it is used, and may include knowing how to

- communicate effectively while using the technology to provide social work services
- handle emergency situations from a remote location
- apply the laws of both the social worker's and client's location
- be sensitive to the client's culture, including the client's cultural community and linguistic, social, and economic environment
- attend to clients' unique needs and challenges
- ensure that the technology is in working order to provide effective services and avoid disruption
- keep abreast of the changing landscape of technology and adapt accordingly

### Standard 2.07: Confidentiality and the Use of Technology

When using technology to deliver services, social workers shall establish and maintain confidentiality policies and procedures consistent with relevant statutes, regulations, rules, and ethical standards.

### Interpretation

Social workers who provide electronic services should develop protocols and policies to protect client confidentiality. They should use encryption software and firewalls and periodically assess confidentiality policies and procedures to ensure compliance with statutes, regulations, and social work standards.

## Standard 2.08: Electronic Payments and Claims

Social workers who submit insurance claims for payment electronically shall take reasonable steps to ensure that business associates use proper encryption and have confidentiality policies and procedures consistent with social work standards and relevant laws.

### Interpretation

The processing of electronic claims and payments includes information about the client that should be protected. Use of electronic payment systems should comply with social work confidentiality standards and relevant statutes and regulations.

## Standard 2.09: Maintaining Professional Boundaries

Social workers who provide electronic social work services shall maintain clear professional boundaries in their relationships with clients.

### Interpretation

Social workers who use technology to provide services should take reasonable steps to prevent client access to social workers' personal social networking sites and should not post personal information on professional Web sites, blogs, or other forms of social media, to avoid boundary confusion and inappropriate dual relationships. Although social workers have a right to freedom of speech, they should be aware of how their personal communications could affect their professional relationships.

When using technology, social workers should make distinctions between professional and personal communications. Social workers should not post any identifying or confidential information about clients on professional Web sites, blogs, or other forms of social media.

Social workers should be aware that they and their clients may share "friend" networks on Web sites, blogs, and other forms of social media; social workers may or may not realize they have these shared online connections. Social workers should be aware that shared membership in online groups based on race, ethnicity, language, sexual orientation, gender identity or expression, disability, religion, addiction recovery, or personal interests may create boundary confusion and inappropriate dual relationships and should avoid relationships that are likely to lead to a conflict of interest, particularly when there is risk of harm to the client (for example, if the online social relationship may compromise the social worker's ability to maintain a clear professional–client relationship).

### Standard 2.10: Social Media Policy

**Social workers who use social media shall develop a social media policy that they share with clients.**

#### Interpretation

Social media policies inform clients regarding their social worker's professional use of social networking sites, e-mail, text messaging, electronic search engines, smartphone applications, blogs, business review sites, and other forms of electronic communication. A carefully constructed social media policy that social workers share with clients can enhance protection of private information and maintain clear boundaries. The social media policy should be reviewed with clients during the initial interview in the social worker–client relationship and revisited and updated as needed.

### Standard 2.11: Use of Personal Technology for Work Purposes

Social workers shall consider the implications of their use of personal mobile phones and other electronic communication devices for work purposes.

#### Interpretation

If a social worker's employment setting expects the social worker to use mobile phones or other technology to communicate with clients, ideally the employer or organization should provide the devices and technology and have clear policies regarding clients' electronic access to the social worker. As a matter of fairness, employers should cover the costs of the devices and technology that are required for social workers to fulfill their work obligations. Providing clients with the personal mobile phone number of the social worker might limit the social worker's ability to maintain appropriate boundaries with clients and compromise client confidentiality. In situations where social workers use personal mobile phones or other electronic communication devices for work purposes, they should take reasonable steps to protect confidentiality and maintain appropriate boundaries.

### Standard 2.12: Unplanned Interruptions of Electronic Social Work Services

Social workers shall plan for the possibility that electronic services will be interrupted unexpectedly.

#### Interpretation

Electronic social work services can be interrupted unexpectedly in a variety of ways. Technology failure is always a possibility, especially as a result of power outages or lost, damaged, or stolen devices. Social workers should develop policies on how to manage technology failures and discuss them with clients at the beginning of their relationship. Social workers should have specific backup plans to handle technological failures or interruptions in services during emergency or crisis situations. If such failures

interfere with a social worker's ability to assist clients (including difficulty clients may have managing technology failures), social workers should consider seeing the client in person or referring clients to service providers who can assist the client in person.

### Standard 2.13: Responsibility in Emergency Circumstances

Social workers who provide electronic services shall be familiar with emergency services in the jurisdiction where the client is located and share this information with clients.

#### Interpretation

Social workers who provide electronic services may have clients who encounter emergencies or crisis situations. Some crisis services may be provided remotely, but others may require in-person communication or intervention. Social workers should take reasonable steps to identify the location of the client and emergency services in the jurisdiction. If the social worker believes that a client may be at risk (for example, having suicidal thoughts), the social worker should mobilize resources to defuse the risks and restore safety. Social workers should develop policies on emergency situations that include an authorized contact person whom the social worker has permission to contact.

### Standard 2.14: Electronic and Online Testimonials

Social workers shall refrain from soliciting electronic or online testimonials from clients or former clients who, because of their particular circumstances, are vulnerable to undue influence.

#### Interpretation

Electronic and online testimonials about social work services (including text, audio, or video) create the potential for boundary confusion and conflicts of interest. Social workers should not solicit testimonial endorsements (including solicitation of consent to use a client's prior statement as a testimonial endorsement) from

current or former clients who, because of their particular circumstances, are vulnerable to undue influence.

## Part B: Communities, Organizations, Administration, and Policy

Technology can greatly enhance social workers' ability to engage in social action, promote social justice, work with communities, administer organizations, and develop social policy. This section provides social workers with guidance on the use of technology in the context of social work with larger systems. In these contexts, social workers may use technology for various purposes, including

- engaging, empowering, and organizing community members and groups
- coalition and capacity building
- advocating for changes in social policy to improve the social and economic well-being of individuals, families, groups, and communities
- providing supervision to social workers, other professionals, and volunteers
- planning, implementing, managing, and evaluating social programs

### Standard 2.15: Organizing and Advocacy

When using technology to organize communities and advocate, social workers shall take reasonable steps to ensure that the information shared using technological tools is honest, accurate, and respectful.

#### Interpretation

Social workers have a rich heritage advocating for social change; engaging in policy practice; and improving the services provided to individuals, families, groups, organizations, and communities. Social workers use Web sites, online social networking, and other electronic communications to mobilize and organize communities and advocate about policy issues. Social workers who use thought-provoking language and stories to attract attention and motivate people to action should ensure that the content of their communications is honest,

accurate, respectful, and is neither exploitative of clients nor sensationalistic.

When social workers establish or facilitate online communities, they should inform participants that information shared with the community may be open to the public. Social workers should also establish and maintain rules of "netiquette," that is, guidelines for respectful communication within the online community.

Social workers may use technology to communicate political messages and mobilize clients, colleagues, and citizens to engage in social action and monitor legislative activities. As with in-person advocacy and communication, social workers who use technology for these purposes should do so respectfully and in a manner that is consistent with professional, legal, and ethical standards. Social workers should not use technology to harass, threaten, insult, or coerce individuals or groups.

### Standard 2.16: Fundraising

When social workers use technology for fundraising, they shall take reasonable steps to ensure that information provided to potential donors clearly and accurately identifies the purposes of the fundraising and how the funds will be used.

#### Interpretation

Using technology for fundraising may open up new and broad channels for raising money for social work services or other causes. As with any fundraising, social workers should use honest, accurate, and respectful language to explain why they are fundraising, including information about the intended beneficiaries and how the funding will be used to help them. Social workers should ensure that the system used to collect payment is secure, so that the donors' confidential information is protected and the funds collected are used only for the intended purposes.

Because technology allows fundraising from various states or countries, social workers should consider jurisdictional issues pertaining to fundraising (for example, tax laws, laws governing charitable donation status, and laws pertaining to support for causes or groups deemed to be related to terrorist organizations).

## Standard 2.17: Primary Commitment to Clients

When social workers who are responsible for program administration, planning, and development consider whether and how to use technology in conjunction with social work programs or services, they shall prioritize the needs of their clients.

### Interpretation

Social work organizations may find it beneficial to use technology to generate revenue, expand services, or provide services in a more cost-efficient manner. Regardless of the organization's motivation for considering the use of technology, social workers who are responsible for program administration, planning, and development should ensure that the needs and interests of potential and current clients are taken into account. For example, social workers should consider not only whether technology could make service provision more cost-efficient, but also whether the use of technology would foster more effective services for the people intended to be served by the organization.

## Standard 2.18: Confidentiality

Social workers who use technology to facilitate supervision, consultation, or other confidential meetings shall use appropriate safeguards to protect confidentiality.

### Interpretation

Social workers who conduct supervision or consultation, and those who facilitate other confidential meetings through the use of technology, should take appropriate precautions to protect the confidentiality of those

communications. Precautions to protect confidentiality depend on the type of technology being used, and may include

- using passwords, firewalls, encryption, and antivirus software
- using electronic service providers that rely on standards of security for data that are transmitted and stored
- ensuring a private setting when using their electronic devices

### Standard 2.19: Appropriate Boundaries

**Social workers who work with communities and organizations shall ensure that they maintain appropriate boundaries when they use technology.**

#### Interpretation

The types of boundaries that social workers should maintain when doing organizational or community work may be different from those required when providing clinical services to individuals, families, and groups. Because social workers sometimes assume multiple roles and functions in their organizations and communities, they may not be able to avoid all dual or multiple relationships. Still, they should consider how to maintain appropriate boundaries and, in particular, how to avoid significant conflicts of interest.

Boundary issues may be particularly complicated when social workers participate in online discussions hosted on social networks and other forms of electronic communication that are intended to be available to the public. For instance, if a social worker posts political or personal opinions on a blog or social networking site, the worker should be aware that this posting may be seen by people in the organization and community in which the worker is practicing. This does not mean that social workers must avoid all political or personal communication through electronic means. However, social workers should be careful in determining what information or opinions they post, where they post the information or opinions, what language

they use, and who might access the information or opinions they post. Social workers should consider how members of their organizations and communities may react to information that social workers decide to share electronically. Social workers should apply the principles of honesty, respect, and social justice, whether their electronic communications are for personal or work-related purposes.

### Standard 2.20: Addressing Unique Needs

Social workers who help communities and organizations advocate for changes in policies, practices, and programs regarding the use of technology shall ensure that the unique needs of individuals and groups are considered, including factors related to different cultures, ways of learning, abilities, educational levels, and economic circumstances.

#### Interpretation

The use of technology has the potential to improve the economic and social well-being of various individuals, families, groups, organizations, and communities. Social workers who are engaged in policy or program development activities should consider how the use of technology may have differential impacts on people given their unique biopsychosocial circumstances and should share these concerns with appropriate decision makers. For instance, when developing Web sites, social workers should consider how to ensure that the information is accessible to people with visual impairments or other physical challenges. When considering an online social work program for people with depression, anxiety, psychosis, or phobias, social workers should consider whether online or in-person services would be more appropriate. When people are expected to use text-based application forms to access social work services or benefits, social workers should consider options to help people who prefer to use a language other than English and people who are not comfortable with the use of electronic devices.

Social workers who provide electronic services should also be aware of economic challenges, for instance, services that require the use of data plans, computers, tablets, smartphones, or other technology that individuals and groups may not be able to afford. Furthermore, social workers should note that some individuals and groups may not have access to technology at certain times because of religious reasons (for instance, prohibitions from using technology on a Sabbath).

### Standard 2.21: Access to Technology

When appropriate, social workers shall advocate for access to technology and resources for individuals, families, groups, and communities who have difficulty accessing them because they are a member of a vulnerable population such as people with disabilities, limited proficiency in English, limited financial means, lack of familiarity with technology, or other challenges.

#### Interpretation

Access to technology includes access to data plans, electronic devices (such as computers, tablets, or mobile phones), relevant software or apps (through purchase or subscription), and technical support (as needed). Advocating for access to electronic services is part of social workers' commitment to social justice. Access to technology, particularly for vulnerable and disadvantaged populations, is important for the following reasons:

- Potential clients may not have reasonable access to needed social work services unless they have appropriate access to technology.
- Having access to technology empowers people to participate in democratic and political processes, for instance, expressing their concerns and advocating through online social media, registering to vote, engaging government officials and other policymakers, organizing social action events, tracking legislative and public policy processes, and accessing other information about public policy issues.
- Having access to technology allows access to

online communities and groups that may provide various forms of social support.

Advocating for access to services on a case-by-case basis may not be sufficient, so social workers may consider addressing access issues through community organizing and other forms of advocacy (for example, ensuring that entire neighborhoods, communities, or vulnerable groups have access to certain forms of technology).

Having access to appropriate technology may also be a concern for social workers themselves. Social workers may need to advocate within their organizations and communities to ensure that they have access to technology that is required to perform their jobs effectively.

### Standard 2.22: Programmatic Needs Assessments and Evaluations

Social workers who use technology to conduct needs assessments and program evaluations shall obtain participants' informed consent and provide information about how they will ensure confidentiality.

#### Interpretation

Social workers use online surveys or other technology to gather information for needs assessments, evaluations, or other research activities. For example, when social workers use technology to conduct needs assessments or evaluations for communities or organizations, they may plan for the information to be shared with government officials, policymakers, program administrators, other decision makers, or the general public. As part of the informed consent process, social workers should ensure that participants are aware of the intended uses of the information gathered, including who will receive the information and what information will be shared. For some purposes, such as legislative advocacy, it may be appropriate for community residents to share personal stories and identifying information, with the participants'

informed consent. For other purposes, it may be appropriate to allow participants to share information on an anonymous basis or to ensure that any identifying information is removed before it is shared with others. Participants should also be apprised of how the results of the needs assessment or program evaluation will be distributed, for instance, through in-person meetings, paper documents, or electronic means.

### Standard 2.23: Current Knowledge and Competence

Social workers practicing with communities, organizations, and in policy positions shall strive to maintain knowledge of current technology, adhere to best practices for its use, and periodically update their knowledge and skills.

#### Interpretation

Technology is constantly evolving, as is its use in various forms of social work practice. Social workers should keep apprised of the types of technology that are available and research best practices, risks, ethical challenges, and ways of managing them. Social workers should also ensure that they know how to use technology in an effective manner so that they perform functions required for work with communities, organizations, and in policy practice.

### Standard 2.24: Control of Messages

Social workers who use technology for community organizing and social advocacy shall be aware that they may have limited or no control over how their electronic messages may be used, shared, revised, or distorted.

#### Interpretation

When social workers post information on blogs, Web sites, and social networking sites, they should be aware that others may use, share, and adapt their messages. For instance, if a social worker posts a written article, photo, or video online, others may edit the posting and share it with others. Postings and other electronic

messages may be misinterpreted, misrepresented, or taken out of context. Although it would be unreasonable to expect social workers to keep track of all uses of their postings, when feasible social workers should try to correct misuses of their postings when such misuses come to their attention.

### Standard 2.25: Administration

**Social work administrators shall ensure that they plan and budget for the use of technology in a manner that promotes the organizations' mission and goals in a cost-effective manner.**

#### Interpretation

Social workers may use technology to facilitate various administrative functions, including budgeting, forecasting, planning, meeting, communicating with stakeholders, personnel management, project management, and program evaluation. Although technology can be used to streamline an organization's administrative processes, social work administrators should also be aware of the implications of its use for clients, social workers, and other employees. When making decisions about the appropriate use of technology for administrative purposes, social workers should take the potential benefits and costs of its use into account (for example, how new technology might improve services, how workers and clients might respond to new technology, and the best use of an organization's limited resources).

### Standard 2.26: Conducting Online Research

**Social workers who conduct online research shall assess the quality, strengths, and limitations of the research.**

#### Interpretation

Social workers should evaluate the credibility and limitations of research obtained from online sources. This includes taking reasonable steps to assess authorship and sponsorship; the credentials and competencies of the researchers; the reliability,

validity, currency, and limitations of the research; and the accuracy of the reported findings or results.

### Standard 2.27: Social Media Policies

**Social work administrators and supervisors shall consider developing social media policies to guide employees and volunteers who work in their organizations.**

#### Interpretation

When employees and volunteers post information on social media, that information may have an impact on their organization, whether or not that information was posted for work or personal purposes. By establishing clear social media policies, administrators and supervisors can provide employees and volunteers with guidance on how to maintain professional standards, including protection of client confidentiality, maintaining appropriate boundaries, and the use of accurate and respectful language.

## Section 3: Gathering, Managing, and Storing Information

Social workers may use various forms of technology to gather, manage, and store client information. *Gathering information* refers to collecting information for the purposes of psychosocial assessments, progress notes, community or organizational needs assessments, program evaluation, research, advocacy, social action, supervision, education, or other social work functions. *Managing information* refers to how information is handled after it has been gathered, for instance, how it is entered into client and other administrative files; how it may be shared with supervisors or others within the social worker's practice setting; how the data is used within a database; how certain information may be shared with colleagues, funders, insurance companies, researchers, or others outside the worker's practice setting; and how social workers

manage information about colleagues. *Storing information* refers to how information is saved and maintained electronically. Using technology in these ways may serve a number of valuable purposes, including accessing information easily, storing information safely, and saving time and money. When social workers use technology to gather, manage, and store information, they must uphold ethical standards related to informed consent, client confidentiality, boundaries, and providing clients access to records.

### Standard 3.01: Informed Consent

As part of the informed consent process, social workers shall explain to clients whether and how they intend to use electronic devices or communication technologies to gather, manage, and store client information.

#### Interpretation

When social workers plan to use technology to gather, manage, and store client information, they should ensure that clients know how the information is being gathered, how it will be used, who will have access to it, how it will be stored, and how it will be retained. They should also explain the potential benefits and risks of using the particular electronic methods for gathering, managing, and storing information.

Often, the primary benefits of gathering, managing, and storing information electronically are convenience and cost. Using technology can save time and money for organizations, social workers, clients, and research and evaluation participants. Other benefits depend on the context of practice.

Risks of gathering, managing, and storing information electronically may include the following:

- Someone intentionally hacks the system and gains access to the data.
- Computers, smartphones, flash drives, external hard drives, or other devices used to gather

and store the data are stolen or misplaced.
- Information stored electronically may be subpoenaed for use during legal proceedings, just as with paper records.
- Government or law enforcement organizations may try to gain access to information stored electronically.
- Electronic information may be unintentionally sent to the wrong person, especially when sending e-mail or text messages.

The types of precautions to minimize risks will depend on the situation, including the type of electronic devices and programs being used. Social workers should periodically review the types of precautions they use to ensure that they are appropriate given recent changes and identified risks in the use of technology (that is, new forms of viruses, cyberattacks, or other potential problems).

### Standard 3.02: Separation of Personal and Professional Communications

When social workers gather, manage, and store client information electronically, they shall ensure clear delineation between personal and professional communications and information.

#### Interpretation

Social workers should clearly delineate between personal and professional information when using personal technology to gather, manage, and store information about clients. This is important to maintain ethical boundaries with clients, maintain proper client files, and possibly protect the social worker's personal or other files from disclosure. When feasible, social workers should consider using their professional or organization's electronic devices to gather, manage, and store information. If this is not feasible, then other means should be implemented, for example, the use of separate accounts, separate storage media or folders, et cetera. Social workers should note that clients generally have a right to access their records; thus any blurring of

personal versus professional communication and data storage, for example, through the use of social workers' personal devices, might risk the privacy of the social worker's personal information.

### Standard 3.03: Handling Confidential Information

**Social workers shall take reasonable steps to ensure that confidential information concerning clients or research participants is gathered, managed, and stored in a secure manner and in accordance with relevant federal and state statutes, regulations, and organizational policies.**

#### Interpretation

Social workers who gather, manage, and store information electronically should take reasonable steps to ensure the privacy and confidentiality of information pertaining to clients or research participants. Federal and state statutes and regulations may dictate how electronic records are to be stored and social workers are responsible for being aware of and adhering to them. Organizations in various practice settings may have additional policies regarding the storage of electronic communications.

Electronic information should be stored in secure locations. Access should be limited to appropriate parties. When electronic files are backed up, reasonable precautions should also be taken to maintain confidentiality of the backed-up files.

Social workers should have policies that incorporate risk management strategies. For example, depending on the practice context, social workers can use a closed server, whereby access to information is limited to people within the organization and is not accessible through the Internet. Also, if identifying information is not needed, social workers can gather data on an anonymous basis so a particular client or research participant cannot be linked with the information. Social workers should ensure that their means of electronic data gathering are in keeping with

ethical standards and best practice guidelines. Social workers should adhere to the privacy and security standards of applicable laws such as the Health Insurance Portability and Accountability Act of 1996 (HIPAA) (P.L. 104-191), the federal policy for the Protection of Human Subjects (45 CFR Part 46), federal regulations for the protection of alcohol and drug abuse patient records (42 CFR Part 2), federal regulations for the protection of students' education records under the Family Educational Rights and Privacy Act of 1974 (P.L. 93-380, § 513), section 215 of the USA Patriot Act of 2001 (P.L. 107-56), and other relevant federal and state laws. These laws may address electronic transactions, client and research participant rights, and allowable disclosure. They may also include requirements regarding data protection. It may be helpful for social workers to consult information technology specialists to ensure that electronically stored information is gathered, stored, and disposed in a safe manner that meets federal and state laws that protect the privacy and confidentiality of the client or research participant.

Social workers should be aware that some free services for gathering, managing, and storing data may not be as secure as fee-for-service options. For instance, when collecting data on some free survey services, the Internet Protocol addresses of survey respondents may be identifiable. If clients or research participants are using an online social network program to log on to the survey, their participation in the survey might be disclosed on their social networking site.

Cloud storage has become technically appropriate and increasingly popular. Social workers who use cloud storage should adhere to privacy and security standards in compliance with HIPAA regulations and other relevant federal and state laws.

### Standard 3.04: Access to Records within an Organization

**Social workers shall take reasonable steps to develop and implement policies regarding which personnel have access to clients' electronic records, keeping in mind the value of limiting access to those colleagues who truly require it, to respect client privacy.**

#### Interpretation

When information is stored electronically, it may be easy for various personnel within an organization to access that information. Social workers should protect client confidentiality by developing and implementing policies that restrict access to colleagues who truly have a need for that access. For personnel who need access to client information for research and evaluation purposes, data could be made available anonymously. As part of the informed consent process, social workers should inform clients about which personnel in the workplace may have access to information in their records.

Social workers should take special safeguards to ensure that clients' electronic records are stored in an accessible manner. Social workers should ensure that electronic records continue to be retrievable when they update their software and technology, at least for any statutory record retention period. Social workers should establish protocols to ensure that appropriate colleagues can get access to secure electronic records in the event of a social worker's sudden incapacity or death.

### Standard 3.05: Breach of Confidentiality

**Social workers shall develop and disclose policies and procedures concerning how they would notify clients of any breach of their confidential records.**

#### Interpretation

Regardless of the precautions that social workers take to ensure that client records are gathered, managed, and stored in a secure manner,

confidential electronic records may be breached. Social workers should comply with ethical standards and relevant federal and state laws regarding any duty to inform clients about possible breaches of confidentiality. Social workers should also develop policies and procedures detailing how they would inform clients regarding breaches of confidentiality.

### Standard 3.06: Credibility of Information Gathered Electronically

When social workers use technology to gather information for social work practice or research, they shall gather information in a manner that reasonably ensures its reliability and accuracy.

#### Interpretation

Social workers may use online forms, Web sites, or other electronic means to collect data. To maintain the credibility of the information collected, social workers should establish and verify the identity of the client, research participant, or other person who is submitting the information. For instance, when collecting data from research participants or when asking a client to submit information online (for example, for an intake assessment), the worker could provide the client with a unique identifier or passcode.

### Standard 3.07: Sharing Information with Other Parties

Social workers who share confidential client information with other parties electronically shall take reasonable steps to protect the confidentiality of the information.

#### Interpretation

Social workers may at times share sensitive information electronically with professional colleagues within their workplace or with other organizations. Before sharing information outside the organization, social workers should ensure that they have informed consent from the client. When sharing information electronically,

social workers should ensure that they are sending information to the accurate e-mail address, Web site, or other electronic location. Because of the ease with which information shared electronically can go astray (for example, with a mistake of just one digit or letter in an electronic address), social workers should double-check their addresses before sending information electronically.

When sending information electronically, social workers should advise recipients that the information is confidential and should not be shared with others without the explicit consent of the client, and when appropriate with the consent of the social worker who prepared the records.

Methods to manage risks when sharing client records electronically may include

- ensuring that the social worker has the correct e-mail address, fax machine or telephone number, or other electronic destination
- using secure servers and encrypted information
- limiting the information sent to what is required (for example, if it is not necessary to include information that identifies the client or information that is particularly sensitive, then this information should be redacted)
- ensuring that the recipient of the information will respect the social worker's request to maintain confidentiality and not share the information with others without the explicit consent of the client

### Standard 3.08: Client Access to Own Records

Social workers shall ensure that client access to electronic records is provided in a manner that takes client confidentiality, privacy, and the client's best interests into account.

#### Interpretation

Social workers recognize that clients generally have a right to access their own records. When records are created or available in electronic form, access may be facilitated electronically.

Electronic access can be less expensive. It can also be more convenient and timelier than having the client come to the office to pick up paper copies or having to mail paper copies. Despite the convenience, when records can be accessed electronically there may be risks to client confidentiality and the client's best interests. Examples include the following:

- Electronic information systems could be hacked or electronic communication devices may be lost or stolen.
- If the client experiences abuse or exploitation from a partner or other family member, it may be particularly important to ensure that the family member in question does not have access to the client's records.
- If a client is suicidal or otherwise vulnerable, having immediate access to certain information electronically may not be in the client's best interests.

In some practice settings, clients have accounts that provide them with immediate access to their records and other information posted by social workers or other organizations. In some practice settings, it may not be appropriate for clients to have access to raw data without having the opportunity to consult with a social worker or other professional to help interpret the information and to provide supportive counseling as needed. For example, if a client completes an online psychosocial instrument, the client might misinterpret the results or may react to troubling findings. Social workers should develop and implement policies to manage risks while ensuring adherence to client's legal right of access.

### Standard 3.09: Using Search Engines to Locate Information about Clients

Except for compelling professional reasons, social workers shall not gather information about clients from online sources without the client's consent; if they do so, they shall take reasonable steps to verify the accuracy of the found information.

### Interpretation

Social workers gather information from a variety of sources to perform their assessments, including from family, schools, other professionals, and clients themselves. Client information discovered on the Internet using search engines is different from information that clients share directly with the social worker. Before social workers gather information from the Internet or other electronic sources, they should obtain the client's informed consent. Intentionally gathering information about a client through electronic means without consent should only be done if there is an emergency situation or specific reason that the information cannot or should not be obtained from the client directly or from third parties designated by the client.

Social workers should respect the privacy of client information posted on online social networks or other electronic media and not communicate with clients through these formats or gather information about clients through them without the client's knowledge and consent. If a social worker unintentionally comes across information about a client through electronic forms of communication, the social worker should avoid reading or gathering further information from this source once the identity of the client becomes evident. If information about a client is unintentionally accessed through electronic means (for instance on a social networking site belonging to another person), the social worker should make this known to the client and discuss the implications of the social worker having this knowledge.

Exceptions to seeking client consent to gather information online may arise in emergency situations, for instance, when the client poses a serious, imminent risk to self or others, and the only way to identify where the client is would be to search for information online. Even in such cases, social workers should consider whether it is appropriate for them to search for client

information online, or whether it would be more appropriate for police, emergency response teams, or other protective services professionals to do so. Social workers who search online for information about clients for compelling professional reasons should include proper documentation in the client's record.

It is important to verify online information gathered about a client. This may be done by contacting the original source of the information, checking the accuracy of the information with the client, or checking the accuracy of the information with other appropriate sources.

### Standard 3.10: Using Search Engines to Locate Information about Professional Colleagues

**When gathering online information about professional colleagues, social workers shall respect colleagues and verify the accuracy of the information before using it.**

#### Interpretation

Social workers may need to gather information about professional colleagues for a variety of reasons, for instance to

- find contact information to facilitate client referrals
- determine client eligibility for services
- determine the credentials and experience of colleagues
- identify policies and practices of the colleague
- gather information in relation to a potential complaint or lawsuit concerning the colleague

When searching for information about a colleague online, social workers should take reasonable steps to verify the accuracy of the information before relying on it. To verify information, it may be appropriate to contact the original source of the information that is posted or speak directly with the professional colleague. It may also be appropriate to confirm the accuracy of the information by checking other sources.

Social workers should also pay attention to who is posting and monitoring information on the Internet. For instance, if information about a colleague comes from a professional association or regulatory body that is responsible for reviewing professional conduct, the information would likely be more reliable than information coming from an anonymous source with no system for accountability or checks for accuracy. Social workers should be aware of the laws and regulations in their state about mandated reporting of colleagues if a social worker discovers online information about a colleague that violates the social work scope of practice or ethical standards. In such a situation, the social worker may have a legal obligation to report the colleague.

Social workers should avoid using technology to pry into the personal lives of professional colleagues (for example, searching for information that is not pertinent to the work they are doing). Social workers should respect the privacy of professional colleagues in relation to personal activities and electronically accessible information that is not relevant to their professional services.

### Standard 3.11: Treating Colleagues with Respect

**Social workers who communicate using electronic tools shall treat colleagues with respect and shall represent accurately and fairly the qualifications, views, and obligations of colleagues.**

#### Interpretation

Social workers should adhere to strict ethical standards when they communicate with and about colleagues using electronic tools, draw on colleagues' professional work, and review electronic information posted by colleagues. Social workers should

- abide by professional values and ethical standards when communicating with and about colleagues, avoiding cyberbullying, harassment, or making derogatory or defamatory comments

- avoid disclosing private, confidential, or sensitive information about the work or personal life of any colleague without consent, including messages, photographs, videos, or any other material that could invade or compromise a colleague's privacy
- take reasonable steps to correct or remove any inaccurate or offensive information they have posted or transmitted about a colleague using technology
- acknowledge the work of and the contributions made by others and avoid using technology to present the work of others as their own
- take appropriate action if they believe that a colleague who provides electronic social work services is behaving unethically, is not using appropriate safeguards, or is allowing unauthorized access to electronically stored information; such action may include discussing their concerns with the colleague when feasible and when such discussion is likely to produce a resolution—if there is no resolution, social workers should report through appropriate formal channels established by employers, professional organizations, and governmental regulatory bodies
- use professional judgment and take steps to discourage, prevent, expose, and correct any efforts by colleagues who knowingly produce, possess, download, or transmit illicit or illegal content or images in electronic format

### Standard 3.12: Open Access Information

When information is posted or stored electronically in a manner that is intended to be available to certain groups or to the public in general, social workers shall be aware of how that information may be used and interpreted, and take reasonable steps to ensure that the information is accurate, respectful, and complete.

#### Interpretation

For information falling under open access to information laws for government entities, social workers may need to ensure that the data can be

accessed by the public. Social workers should be aware of the digital footprint created by such postings, including the breadth of access and the period of time during which the information may be available (perhaps to all people, and forever). Given the broad and open access to electronic information, social workers should be aware of the potential uses and misuses of this material, and the potential for misunderstandings when people attempt to communicate humor, sarcasm, or emotionally charged opinions.

### Standard 3.13: Accessing Client Records Remotely

Social workers shall develop and follow appropriate policies regarding whether and how they can access electronic client records remotely.

#### Interpretation

Social workers may have or desire remote access to electronic client records when they are away from their organization or usual place of practice. They should be aware that accessing records from remote locations may pose risks to client privacy and confidentiality. The use of unencrypted e-mail servers by a social worker to communicate with clients increases the risk of privacy violations and should be avoided. Confidentiality risks may increase if a social worker accesses work-related e-mail, text messages, voice mail, or other electronic messages from a nonwork computer, smartphone, or other personal electronic device.

### Standard 3.14: Managing Phased Out and Outdated Electronic Devices

When an electronic device is no longer needed, is phased out, or is outdated, social workers shall take steps to protect their clients, employer, themselves, and the environment.

#### Interpretation

Social workers should recognize that technology changes and various forms of software, hardware, devices, and information storage tools may become obsolete. When disposing of obsolete electronic devices, social workers should take

steps to prevent data leaks and unauthorized access to confidential information. Determining the appropriate safeguards may require consultation with information technology experts. When social workers dispose of electronic devices, they should follow current environmental protection guidelines and relevant statutes and regulations in their jurisdictions related to record retention and disposal of records and electronics.

## Section 4: Social Work Education and Supervision

This section provides guidance on the use of technology to social workers who are involved in the design and delivery of education and supervision. Technology advances have greatly expanded opportunities for social workers to deliver education, training, and supervision in a variety of formats. Technology is used to deliver social work courses and training and is a widely used, evolving part of social work education. The use of technology in social work education and training can enhance access, skill development, student engagement, and learning outcomes. Social work education includes undergraduate, graduate, and postgraduate programs, field instruction, supervision, continuing education, and organization-based education. Social workers who use technology in social work education must adhere to standards related to online and distance learning and education. Social workers who use technology for education, training, and supervision also ensure that students and supervisees are familiar with prevailing practice, regulation, accreditation, and ethical standards pertaining to the use of technology.

### Standard 4.01: Use of Technology in Social Work Education

**Social workers who use technology to design and deliver education and training shall develop competence in the ethical use of the technology in a manner appropriate for the particular context.**

#### Interpretation

Social workers who use technology for instructional purposes should be familiar with technology-mediated tools that provide social work education in the classroom, field, and within workplace settings. Technology tools and instruction can be used to deliver education in traditional, online, or hybrid formats. When appropriate, social workers who use technology for educational purposes should ensure that students and trainees achieve the learning competencies and objectives of the educational programs as required by accreditation and regulatory bodies.

Social workers should examine the extent to which education provided using technology enables students to master core and essential professional skills. Social workers who develop, design, and deliver education and training programs using technology should

- engage in appropriate education, study, training, consultation, and supervision with professionals who are competent in the use of technology-mediated tools for educational purposes
- keep current with emerging knowledge related to the delivery of technology-mediated education
- consider pedagogical theory and research on the use of technology, to make decisions about whether and how to use technology for educational purposes
- create learning experiences to enable student success and develop social work competencies
- use student-centered instructional strategies that are connected to real-world practice applications to engage students in learning,

such as peer-based learning, inquiry-based activities, collaborative learning, discussion groups, self-directed learning, case studies, small group work, and guided design

- incorporate technology-based adaptive devices in the curriculum to ensure delivery of accessible services
- address cultural competency issues affecting the use of technology in practice, such as students' familiarity and comfort with technology; access to the Internet; language translation software; and the use of technology to meet the needs of diverse populations, such as people with differing physical abilities
- use a range of existing and emerging technologies that effectively support student learning and engagement in the online environment
- facilitate and monitor appropriate interaction among students
- promote student success by providing clear expectations, prompt responses, and regular feedback
- model, guide, and encourage legal, ethical, and safe behavior related to technology use
- assess students considering varying learning styles, literacy levels, disabilities, access to technology, and needs for accommodations (including possible use of adaptive and assistive technologies)
- ensure that students are competent to use the proposed technology in an effective and ethical manner
- take appropriate steps to protect the confidentiality of personal student information in accordance with relevant laws and ethical standards

### Standard 4.02: Training Social Workers about the Use of Technology in Practice

Social workers who provide education to students and practitioners concerning the use of technology in social work practice shall provide them with knowledge about the ethical use of technology, including potential benefits and risks.

### Interpretation

Social workers who teach students and practitioners about ways to use technology in social work practice should be knowledgeable about effective and ethical use of technology. When appropriate and applicable, social work educators should ensure that this information is included in classroom instruction and supervision.

Social workers who teach about the use of technology should address ways to adhere to best practices in social work, including whether and when technology is an appropriate way to provide services, evidence of effectiveness, assessment and outcome measures, and ways to accommodate individual learning needs and cultural diversity. Social work educators, practitioners, and students should develop protocols to evaluate client outcomes to expand knowledge that promotes ethical, effective, and safe use of technology in social work practice.

Social work educators should teach students to think critically about the potential benefits and risks of using technology in social work practice. Key topics include the implications of technology for

- establishing and maintaining meaningful and effective relationships with clients and others
- maintaining confidentiality
- developing risk management strategies in response to crisis situations
- developing a social media policy
- using the latest technology software and apps in assignments and other learning activities to develop skills for client assessment, intervention planning, service delivery, monitoring, and evaluation
- developing ways to monitor and assess client progress and outcomes
- complying with relevant ethical and legal standards in social work (especially related to informed consent, confidentiality, maintaining appropriate boundaries, termination of services, and documentation)

### Standard 4.03: Continuing Education

Social work educators who use technology in their teaching and instruct students on the use of technology in social work practice shall examine and keep current with relevant emerging knowledge.

#### Interpretation

Social work educators should keep current with developments related to the use of technology to teach, supervise, and practice social work. Social workers should review relevant professional literature and attend relevant continuing education classes, seminars, workshops, webinars, and other in-person and online courses and workshops. When examining research evidence, social workers should give precedence to research that meets prevailing professional methodological and ethical standards.

### Standard 4.04: Social Media Policies

When using online social media for educational purposes, social work educators shall provide students with social media policies to provide them with guidance about ethical considerations.

#### Interpretation

When using social media for educational purposes, it is important for students to understand how to use social media in a professional manner. The type of language, personal disclosures, and ways of communicating that students use for personal purposes may not be appropriate for the classroom or professional social work purposes. Social work educators should inform students about organizational policies and relevant standards related to confidentiality, demonstrating respect, academic integrity, copyright and plagiarism, maintaining appropriate boundaries, and upholding other social work ethical standards.

### Standard 4.05: Evaluation

**When evaluating students on their use of technology in social work practice, social work educators shall provide clear guidance on professional expectations and how online tests, discussions, or other assignments will be graded.**

#### Interpretation

For some online assignments and tests, grading may be similar to grading for traditional assignments. However, students may not be familiar with the criteria for grading for certain types of assignments using various forms of technology. For instance, if students are expected to participate in online discussions, to post information or opinions on social media, or to use PowerPoint software to develop group presentations, they should be informed of the specific criteria that will be used to evaluate their performance.

### Standard 4.06: Technological Disruptions

**Social work educators shall provide students with information about how to manage technological problems that may be caused by loss of power, viruses, hardware failures, lost or stolen devices, or other issues that may disrupt the educational process.**

#### Interpretation

Social work educators should prepare themselves and their students for the possibility of technological disruptions. For instance, if there is a technological failure during a class taught using live video, students may be instructed to use a teleconference as a backup or to participate in a rescheduled class. If students are supposed to complete an online test or assignment, but the technology is not permitting them to do so by the due date, students should know how to advise the professor or technology assistants about the problems.

### Standard 4.07: Distance Education

When teaching social work practitioners or students in remote locations, social work educators shall ensure that they have sufficient understanding of the cultural, social, and legal contexts of the other locations where the practitioners or students are located.

#### Interpretation

Technology enables educators to teach students and social workers in different communities, states, and countries. Social workers should ensure that they have the knowledge, skills, and awareness to provide education that is culturally appropriate for the locations where students and social workers are learning and working. Social work educators should be knowledgeable about the cultures of the students and the clients whom the students may be serving. To enhance cultural competence, educators may consult with locally trained social workers when developing their curricula to better address local challenges with culturally appropriate interventions.

### Standard 4.08: Support

Social work educators who use technology shall ensure that students have sufficient access to technological support to assist with technological questions or problems that may arise during the educational process.

#### Interpretation

When students and social workers use technology for educational purposes, they may experience challenges, particularly when they are first learning to use the technology and in situations where the technology fails to work. Educators should provide students with information on how to access help to preempt and resolve problems with technology.

### Standard 4.09: Maintenance of Academic Standards

When social work educators use technology to facilitate assignments or tests, they shall take appropriate measures to promote academic standards related to honesty, integrity, freedom of expression, and respect for the dignity and worth of all people.

#### Interpretation

When using technology, educators may face unique challenges ensuring that students maintain appropriate academic integrity. For instance, when students submit assignments or tests online, educators should take precautions to ensure that assignments or tests are submitted by the students themselves, they submit original work, and they have not been assisted by others (unless working with others is part of the assignment). When facilitating online discussions among students, educators should provide students with guidance on how to communicate in a professional manner, including how to maintain appropriate professional boundaries and how to use respectful language.

### Standard 4.10: Educator-Student Boundaries

Social work educators who use technology shall take precautions to ensure maintenance of appropriate educator-student boundaries.

#### Interpretation

When using technology to communicate with students, some social work educators use personal devices or accounts. This may facilitate more timely and convenient communication. Also, the educational institution or setting may not provide educators with devices or sufficient technology.

To maintain appropriate boundaries with students, social work educators should

- determine whether the policies of the educational institution or setting permit the use of personal devices or accounts
- determine whether it is ethical and appropriate to use personal technological devices and

accounts for professional educational purposes

- assess and manage the risk of educators using personal mobile devices, which includes maintaining confidential student records on the device, the risk of losing the device or the device being stolen, downloading a virus or malware, shared use of the device with family or friends, and the use of unsecured Wi-Fi networks
- provide clear policies on appropriate methods, expectations, and times for using technology to communicate with educators and field supervisors
- model appropriate professional boundaries in all online communications with students
- educate students about the risks of online dual relationships

### Standard 4.11: Field Instruction

**Social workers who provide field instruction to students shall address the use of technology in organizational settings.**

#### Interpretation

When appropriate, field instructors should discuss with students

- the ways in which technology is used in organizational settings
- the importance of protocols to ensure access to secure electronic records in the event of a social worker's field placement termination, incapacity, or death
- similarities and differences between the school's and organization's social media policies
- appropriate use of personal and professional social media considering its potential impact on clients, students, colleagues, employers, and the social work profession
- ways to comply with relevant laws, regulations, ethical standards, and organizational policies to ensure protection of confidential information

### Standard 4.12: Social Work Supervision

**Social workers who use technology to provide supervision shall ensure that they are able to assess students' and supervisees' learning and professional competence.**

#### Interpretation

Some social workers use technology to provide supervision in a timely and convenient manner. When using technology to provide supervision, social workers should ensure that they are able to assess sufficiently students' and supervisees' learning and professional competence and provide appropriate feedback. Social workers should comply with guidelines concerning provision of remote supervision adopted by the jurisdictions in which the supervisors and supervisees are regulated. Social workers who provide remote supervision should comply with relevant standards in the NASW *Code of Ethics*, relevant technology standards, applicable licensing laws and regulations, and organization policies and procedures.

## Glossary

This glossary contains definitions of key terms used in this document that are relevant to these practice standards, including terms related to the use of electronic technology in various areas of social work practice.

#### App

An application or software that is downloaded onto mobile devices to perform a specific function.

#### Boundary Confusion

Failure to recognize the psychological distinctiveness of individuals or confusion of interpersonal roles.

#### Client

The individual, family, group, organization, or community that seeks or is provided with professional social work services.

### Clinical Social Work

The professional applications of social work theory and methods to the treatment and prevention of psychosocial dysfunction, disability, or impairment, including emotional and mental disorders.

### Cloud

A remote platform for storing and accessing software (applications) and data through the Internet rather than through a direct connection to a local server or personal computer.

### Confidentiality

A principle of ethics according to which the social worker may not disclose information about a client without the client's consent. This information includes the identity of the client, content of communications, professional opinions about the client, and material from records.

### Digital Footprint

Trails or traces of data that may be stored without the original user's knowledge or consent (for example, Internet protocol addresses, cookies, browsing history, metadata, and other information that may or may not include identifying data about the user). Also referred to as digital shadow or cyber shadow.

### Electronic Communication

Using Web sites, mobile phones, e-mail, texting, online social networking, video, or other electronic methods and technology to send and receive messages, or to post information so that it can be retrieved by others or used at a later time.

### Electronic Social Work Services

The use of computers, mobile phones, video technology, and other means of communication and information, acquisition, transmission, and storage used on the Internet and with other technology to (a) provide information to the public; (b) deliver services to clients; (c) gather, manage, and store information about clients; and (d) educate, supervise, and train social workers.

**Encryption**
The process used to protect the privacy of electronic transmissions of information by converting the information into a code (preventing unauthorized people from gaining access to the information).

**Health Insurance Portability and Accountability Act of 1996 (HIPAA)**
A set of federal standards that protect electronic health information through the implementation of privacy and security rules and the establishment of electronic transactions and code sets.

**Malware**
Malicious software (electronic program) that is designed to destroy data or harm the functioning of computers or other electronic devices. Examples include trojans, viruses, and worms.

**Netiquette**
Norms or behavioral guidelines concerning appropriate or acceptable ways to engage in communication using the Internet, online social networking, e-mail, chatrooms, or other forms of electronic communication (for example, what type of information may be shared or posted, how often and when it should be posted, what type of language is acceptable, who may post or share information, who may have access to the information). Some forms of communication that may be deemed inappropriate include *spamming* (sending large numbers of messages that recipients may view as junk) and *flaming* (publicly criticizing someone for the purpose of embarrassing the person).

**Online Social Networking**
Use of electronic programs that allow individuals, groups, organizations, and communities to connect with each other and share information. The information may be in the form of electronic messages, photographs, artwork, videos, audio recordings, or other forms of communication.

**Pedagogical Theory**
The study of the theory and practice of education.

**Practice Setting**
The organizational context in which a social worker practices (for example, independent practice, publicly funded agency, nonprofit agency, for-profit agency, school, hospital, nursing home, hospice program, residential program, military base, prison, community organization, or government agency).

**Practice Standards**
Benchmarks that describe the services that social workers should provide, that employers should support, and that consumers should expect. Practice standards reflect current and emerging best practice trends and are a critical component of the professional social worker's toolkit.

**Risk Management**
The practice of ethical, competent social work services and accurate documentation of practice decisions and interventions to protect clients and prevent litigation and ethics complaints.

**Security**
The protection of hardware, software, and data through physical forms of protection (for example, locks, doors, padded cases, waterproofing) and electronic forms of protection (for example passwords, firewalls, and encryption).

**Social Media**
Computer-mediated technologies that allow for the sharing of information, ideas, and other forms of communication through virtual communities and networks.

**Social Work Education**
The formal training and subsequent experience that prepare social workers for their professional roles. The formal training takes place primarily in accredited colleges and universities and includes

undergraduate, graduate, and postgraduate programs, field instruction, supervision, continuing education, and organization-based education.

**Substantial Equivalency**
Demonstration that a state's licensure is comparable to that of other jurisdictions.

**Technology**
Any electronic device or program that may be used to communicate, gather, store, analyze, or share information (for example, computers, mobile phones, tablets, facsimile machines, smart watches, monitors, Web sites, social networking applications, and computer software).

## Resources


American Counseling Association. (2014). *ACA code of ethics*. Retrieved from www.counseling.org/docs/ethics/2014-aca-code-of-ethics.pdf?sfvrsn=4

American Psychological Association. (2010). *Ethical principles of psychologists and code of conduc*t. Retrieved from www.apa.org/ethics/code/index.aspx

American Telemedicine Association. (2013, May). *Practice guidelines for video-based online mental health services*. Retrieved from www.americantelemed.org/docs/default-source/standards/practice-guidelines-for-video-based-online-mental-health-services.pdf?sfvrsn=6

Association of Social Work Boards. (2015). *Model regulatory standards for technology and social work practice: ASWB International Technology Task Force, 2013–214*. Retrieved from www.aswb.org/wp-content/uploads/2015/03/ASWB-Model-Regulatory-Standards-for-Technology-and-Social-Work-Practice.pdf

Barak, A., & Grohol, J. M. (2011). Current and future trends in Internet-supported mental health interventions. *Journal of Technology in Human Services*, *29*, 155–196.

Barak, A., Hen, L., Boniel-Nissim, M., & Shapira, N. (2008). A comprehensive review and a meta-analysis of the effectiveness of Internet-based psychotherapeutic interventions. *Journal of Technology in Human Services*, *26*, 109–160.

Barsky, A. E. (2017). Social work practice and technology: Ethical issues and policy responses. *Journal of Technology in Human Services*, *35*, 1–12.

Dowling, M., & Rickwood, D. (2013). Online counseling and therapy for mental health problems: A systematic review of individual synchronous interventions using chat. *Journal of Technology in Human Services*, *31*, 1–21.

Family Educational Rights and Privacy Act of 1974, P.L. 93-380, § 513, 34 CFR 99 (August 21, 1974). Retrieved from www2.ed.gov/policy/gen/guid/fpco/pdf/ferparegs.pdf

Federation of State Medical Boards. (2014). *Model policy for the appropriate use of telemedicine technologies in the practice of medicine*. Retrieved from www.fsmb.org/Media/Default/PDF/FSMB/Advocacy/FSMB_Telemedicine_Policy.pdf

Finn, J., & Barak, A. (2010). A descriptive study of e-counsellor attitudes, ethics, and practice. *Counselling and Psychotherapy Review*, *24*(2), 268–277.

Fitch, D. (2015). A conceptual framework for information technology in social work practice. *Advances in Social Work*, *16*, 15–30.

Gupta, A., & Agrawal, A. (2012). Internet counselling and psychological services. *Social Science International*, *28*, 105–122.

Gutheil, T. G., & Simon, R. (2005). E-mails, extra-therapeutic contact, and early boundary problems: The Internet as a "slippery slope." *Psychiatric Annals*, *35*, 952–960.

Health Insurance Portability and Accountability Act of 1996, P.L. 104-191, 100 Stat. 2548 (August 21, 1996). Retrieved from www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/HIPAA GenInfo/downloads/hipaalaw.pdf

Kolmes, K. (2014, April 26). *My private practice social media policy*. Retrieved from www.drkkolmes.com/docs/socmed.pdf

Lamendola, W. (2010). Social work and social presence in an online world. *Journal of Technology in Human Services*, *28*, 108–119.

Midkiff, D. M., & Wyatt, W. J. (2008). Ethical issues in the provision of online mental health services (etherapy). *Journal of Technology in Human Services*, *26*, 310–332.

National Association of Social Workers. (2015). *Code of ethics of the National Association of Social Workers*. Retrieved from www.naswdc.org/pubs/code/code.asp

Newfoundland and Labrador Association of Social Workers. (2012). *Standards for technology use in social work practice*. Retrieved from www.nlasw.ca/pdf/Standards_For_Technology_Use_In_Social_Work_Practice.pdf

Online Therapy Institute. (2014). *Ethical framework for use of technology in mental health*. Retrieved from http://onlinetherapyinstitute.com/ethical-training/

Reamer, F. G. (2013). Social work in a digital age: Ethical and risk management challenges. *Social Work*, *58*, 163–172.

Reamer, F. G. (2015). Digital technology in social work. In C. Franklin (Ed.-in-Chief), *Encyclopedia of social work online*. New York and Washington, DC: Oxford University Press and NASW Press. doi:10.1093/acrefore/9780199975839.013.1160

Richards, D., & Vigano, N. (2013). Online counseling: A narrative and critical review of the literature. *Journal of Clinical Psychology*, *69*, 994–1011.

Schoech, R. (2014). Human services technology, 1980+: Retrospective and perspective. *Journal of Technology in Human Services*, *32*, 240–253.

Singer, J. B., & Sage, M. (2015). Technology and social work practice: Micro, mezzo, and macro applications. In K. Corcoran & A. R. Roberts (Eds.), *Social workers' desk reference* (3rd ed., pp. 179–188). New York: Oxford University Press.

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# Best Practices in Videoconferencing-Based Telemental Health
# (April 2018)

The American Psychiatric Association

*and*

The American Telemedicine Association

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# INTRODUCTION

This document represents a collaboration between the American Psychiatric Association (APA) and the American Telemedicine Association (ATA) to create a consolidated update of the previous APA and ATA official documents and resources in telemental health to provide a single guide on best practices in clinical videoconferencing in mental health. The APA is the main professional organization of psychiatrists and trainee psychiatrists in the United States, and the largest psychiatric organization in the world. The ATA, with members from throughout the United States and the world, is the principal organization bringing together telemedicine practitioners, healthcare institutions, government agencies, vendors and others involved in providing remote healthcare using telecommunications.

Telemental health in the form of interactive videoconferencing has become a critical tool in the delivery of mental health care. It has demonstrated its ability to increase access and quality of care, and in some settings to do so more effectively than treatment delivered in-person.

The APA and the ATA have recognized the importance of telemental health with each individual association undertaking efforts to educate and provide guidance to their members in the development, implementation, administration and provision of telemental health services. It is recommended that this guide be read in conjunction with the other APA and ATA resources that provide more detail.

| OFFICIAL APA AND ATA GUIDELINES, RESOURCES AND TELEMENTAL HEALTH TRAININGS | |
|---|---|
| **APA** | **ATA** |
| 1) APA Web-based Telepsychiatry Toolkit (2016)<br>2) Resource Document on Telepsychiatry and Related Technologies in Clinical Psychiatry, Council on Law and Psychiatry (2014)<br>3) American Psychiatric Association. Telepsychiatry via Videoconferencing. (1998) | 4) Practice Guidelines for Telemental Health with Children and Adolescents (2017)<br>5) Telemental Health Resource Toolbox (2017)<br>6) Online Training for Video-Based Online Mental Health Service (2014)<br>7) A Lexicon of Assessment and Outcome Measures for Telemental health (2013)<br>8) Practice Guidelines for Video-Based Online Mental Health Service (2013)<br>9) Practice Guidelines for Videoconferencing-Based Telemental Health (2009)<br>10) Evidence-Based Practice for Telemental Health (2009) |

These guidelines focus on interactive videoconferencing-based mental health services (a.k.a., telemental health). The use of other technologies such as virtual reality, electronic mail, electronic health records, telephony, remote monitoring devices, chat rooms, or social networks



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are not a focus of this document except where these technologies interface with videoconferencing services.

The document was created by a joint writing committee drawn from the APA Committee on Telepsychiatry and the ATA Telemental Health Special Interest Group (TMH SIG). This document draws directly from ATA's three previous guidelines, selecting from key statements/guidelines, consolidating them across documents and then updating them where indicated. Following internal review processes within the APA and the ATA, the Board of Directors of the ATA and the Joint Reference Committee (JRC) of the APA, have given approval to its publication.

The reference list includes several detailed reviews providing justification and documentation of the scientific evidence supporting telemental health. Following ATA guideline writing convention, this document contains requirements, recommendations, or actions that are identified by text containing the keywords "**shall**," "**should**," or "**may**." "Shall" indicates that it is required whenever feasible and practical under local conditions. "Should" indicates an optimal recommended action that is particularly suitable, without mentioning or excluding others. "May" indicates additional points that may be considered to further optimize the telemental health care process.

It should be recognized that compliance with these recommendations will not guarantee accurate diagnoses or successful outcomes. The purpose of this guide is to assist providers in providing effective and safe medical care founded on expert consensus, research evidence, available resources, and patient needs.

This document is not meant to establish a legal standard of care.

## ADMINISTRATIVE CONSIDERATIONS

### A. PROGRAM DEVELOPMENT

Providers or organizations delivering mental health services ***should*** conduct a telehealth needs assessment prior to initiating services. This needs assessment ***should*** include, at a minimum, the following components: program overview statement, services to be delivered, proposed patient population, provider resources, technology needs, staffing needs, quality and safety protocols, business and regulatory processes, space requirements, training needs, evaluation plan, and sustainability.

### B. LEGAL AND REGULATORY ISSUES

#### *1) Licensure and Malpractice*

Health care services have been defined as delivered in the state where the patient is located. Providers of telemental health services ***shall*** comply with state licensure laws, which typically entail holding an active professional license issued by the state in which the patient is physically located during a telemental health session, and ***shall*** have appropriate malpractice coverage. Providers ***shall*** conduct their own due diligence to determine the type of licensure required, and ensure they are in compliance with state licensing board regulations. If providing care within a federal healthcare system (e.g., Department of Veterans Affairs, Department of Defense, Indian Health Service), providers ***shall*** follow the specific organization guidelines around licensure, which may allow for a single state licensure across multiple jurisdictions. Providers ***may*** utilize


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the interstate licensure compact or special telemedicine licensures offered by certain states provided they comply with all individual state licensure and program requirements.

*2) Scope of Practice*

Providers or organizations offering telemental health services ***shall*** ensure that the standard of care delivered via telemedicine is equivalent to in-person care. Persons engaged in telemental health services ***shall*** be aware of their professional organization's positions on telemental health and incorporate the professional association standards and clinical practice guidelines whenever possible. Providers in practice and trainees ***should*** stay current with evolving technologies, telemental health research findings, and policies.

*3) Prescribing*

Providers ***shall*** be aware of both federal and state guidelines around the prescription of controlled substances, including the Ryan Haight Online Pharmacy Consumer Protection Act of 2008. Providers ***shall*** comply with federal and state regulations around the prescription of controlled substances based on the setting, model of care, scope of practice and locations in which they are practicing and where the patient is located at the time of treatment.

*4) Informed Consent*

Local, state, and national laws regarding verbal or written consent ***shall*** be followed. If written consent is required, then electronic signatures, assuming these are allowed in the relevant jurisdiction, may be used. The provider ***shall*** document the provision of consent in the medical record.

*5) Billing and Reimbursement*

The patient ***shall*** be made aware of any and all financial charges that may arise from the services to be provided prior to the commencement of initial services. Appropriate documentation and coding ***should*** be undertaken specifying when services are rendered via telemental health.

## C. STANDARD OPERATING PROCEDURES/PROTOCOLS

Prior to initiating telemental health services, any organization or provider ***shall*** have in place a set of Standard Operating Procedures or Protocols that ***should*** include (but are not limited to) the following administrative, clinical, and technical specifications:

- Roles, responsibilities (i.e., daytime and after-hours coverage), communication, and procedures around emergency issues.
- Agreements to assure licensing, credentialing, training, and authentication of practitioners as well as identity authentication of patients according to local, state, and national requirements.
- A systematic quality improvement and performance management process that complies with any organizational, regulatory, or accrediting, requirements for outcomes management.


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*1) Patient-Provider Identification*

All persons at both sites of the videoconference ***shall*** be identified to all participants at the beginning of a telemental health session**.** Permission from the patient ***should not*** be required if safety concerns mandate the presence of another individual or if the patient is being legally detained.

At the beginning of a video-based mental health treatment with a patient, the following information ***shall*** be verified and documented:

- The name and credentials of the provider and the name of the patient.
- The location(s) of the patient during the session.
- Immediate contact information for both provider and patient (phone, text message, or email), and contact information for other relevant support people, both professional and family.
- Expectations about contact between sessions shall be discussed and verified with the patient, including a discussion of emergency management between sessions.

*2) Emergencies*

***i. General Considerations***

Professionals ***shall*** maintain both technical and clinical competence in the management of mental health emergencies. Provisions for management of mental health emergencies ***shall*** be included in any telemental health procedure or protocol. Clinicians ***shall*** be familiar with local civil commitment regulations and ***should*** have arrangements to work with local staff to initiate/assist with civil commitments or other emergencies.

***ii. Clinically supervised settings***

Clinically supervised settings are patient locations where other medical or support staff are available in real-time to support the telemental health sessions. Emergency protocols ***shall*** be created with clear explanation of roles and responsibilities in emergency situations. These include determination of outside clinic hours emergency coverage and guidelines for determining when other staff and resources should be brought in to help manage emergency situations. Clinicians ***shall*** *b*e aware of safety issues with patients displaying strong affective or behavioral states upon conclusion of a session and how patients may then interact with remote site staff.

***iii. Clinically unsupervised settings***

In instances where the mental health provider is providing services to patients in settings without clinical staff immediately available:

- Providers ***should*** discuss the importance of having consistency in where the patient is located for sessions and knowing a patient's location at the time of care, as it impacts emergency management and local available resources.


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- As patients change locations, providers ***shall*** be aware of the impact of location on emergency management protocols. These include emergency regulations, resources (e.g., police, emergency rooms, crisis teams), and contacts. These ***should*** be documented and available to providers.
- For treatment occurring in a setting where the patient is seen without access to clinical staff, the provider ***should*** consider the use of a "Patient Support Person" (PSP) as clinically indicated. A PSP is a family, friend or community member selected by the patient who could be called upon for support in the case of an emergency. The provider ***may*** contact the Patient Support Person to request assistance in evaluating the nature of emergency and/or initiating 9-1-1 from the patient's home.
- If a patient and/or a PSP will not cooperate in his or her own emergency management, providers ***shall*** be prepared to work with local emergency personnel in case the patient needs emergency services and/or involuntary hospitalization.

*3) Care Coordination*

With consent from the patient and in accordance with privacy guidelines, telemental health providers ***should*** arrange for appropriate and regular communication with other professionals and organizations involved in the care of the patient.

## TECHNICAL CONSIDERATIONS

### A. VIDEOCONFERENCING PLATFORM REQUIREMENTS

Providers and organizations ***should*** select video conferencing applications that have the appropriate verification, confidentiality, and security parameters necessary to be properly utilized for this purpose. In the event of a technology breakdown, causing a disruption of the session, the professional shall have a backup plan in place (e.g., telephone access). Telemental health ***shall*** provide services at a bandwidth and with sufficient resolutions to ensure the quality of the image and/or audio received is appropriate to the services being delivered.

### B. INTEGRATION OF VIDEOCONFERENCING INTO OTHER TECHNOLOGY AND SYSTEMS

Organizations ***shall*** ensure the technical readiness of the telehealth equipment and the clinical environment. They ***shall*** have policies and procedures in place to ensure the physical security of telehealth equipment and the electronic security of data. Organizations ***shall*** ensure compliance with all relevant safety laws, regulations, and codes for technology and technical safety.

**Privacy, Security, HIPAA**

For telemental health services provided within the United States, the United States Health Insurance Portability & Accountability Act (HIPAA) of 1996, and state privacy requirements, ***shall*** be followed at all times to protect patient privacy. Privacy requirements in other countries ***shall*** be followed for telemental health services provided in those countries.

Patients receiving mental health and substance use disorder services are afforded a higher degree of patients' rights as well as organizational responsibilities (e.g., need for specific consent from patients to release information around substance use). Telemental health organizations


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***shall*** be aware of these additional responsibilities and ensure that they are achieved. Telemental health organizations and providers ***shall*** determine processes for documentation, storage, and retrieval of telemental health records.

**C. PHYSICAL LOCATION/ROOM REQUIREMENTS**

During a telemental health session, both locations *shall* be considered a patient examination room regardless of a room's intended use. Providers *shall* ensure privacy so clinical discussion cannot be overheard by others outside of the room where the service is provided. To the extent possible, the patient and provider cameras *should* be placed at the same elevation as the eyes with the face clearly visible to the other person. The features of the physical environment for both *shall* be adjusted so the physical space, to the degree possible, maximizes lighting, comfort and ambiance.

When asynchronous telemental health consultations are occurring, the interviewer ***should*** be appropriately trained, and the digital recording of the interview ***shall*** be shared and stored in accordance with HIPAA regulations.

## CLINICAL CONSIDERATIONS

**A. PATIENT AND SETTING SELECTION**

There are no absolute contraindications to patients being assessed or treated using telemental health. The use of telemental health with any individual patient is at the discretion of the provider. For clinically unsupervised settings (e.g., home, office) where support staff is not immediately available, providers ***shall*** consider appropriateness of fit for an individual patient. Provision of telemental health services in professionally unsupervised settings requires that the patient take a more active and cooperative role in the treatment process than would be the case for in-person locales. Patients need to be able to set up the videoconferencing system, maintain the appropriate computer/device settings, establish a private space, and cooperate for effective safety management. Factors to consider include:

- Providers ***should*** consider such things as patient's cognitive capacity, history regarding cooperativeness with treatment professionals, current and past difficulties with substance abuse, and history of violence or self-injurious behavior.
- Providers ***shall*** consider geographic distance to the nearest emergency medical facility, efficacy of patient's support system, and current medical status.
- The consent process ***shall*** include discussion of circumstances around session management so that if a patient can no longer be safely managed through distance technology, the patient is aware that services may be discontinued.
- Providers ***should*** consider whether there are any medical aspects of care that would require in-person examination including physical exams. If the provider cannot manage the medical aspects for the patient without being able to conduct initial or recurrent physical exams, this shall be documented in the record, and arrangements ***shall*** be made to perform physical exams onsite as clinically indicated.


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## B. MANAGEMENT OF HYBRID PATIENT-PROVIDER RELATIONSHIPS

Telemental health interviews can be conducted as part of a wider, in-person and online clinical relationship using multiple technologies by providers working individually or in teams. The telemental health interview can be an adjunct to periodic face-to-face in person contact or can be the only contact. It is typically supported by additional communications technologies such as faxed or emailed consultation information, patient portals, telephone, mobile devices, and electronic health records. Providers ***should*** have clear policies pertaining to communications with patients. These ***should*** describe the boundaries around ways in which patients can communicate with a provider, which content is appropriate to share over different technology platforms, anticipated response times, and how and when to contact a provider. Providers **should** identify clearly which platforms are acceptable for communication of an emergency and expected response times. Providers ***should*** be attentive of the impact of different technology platforms on patient rapport and communication. All modes of communication of personal health history ***shall*** be HIPAA compliant.

## C. ETHICAL CONSIDERATIONS

Health professionals ***shall*** be responsible for maintaining the same level of professional and ethical discipline and clinical practice principles and guidelines as in person care in the delivery of care in telemental health, as well as additional telemental health related concerns such as consent processes, patient autonomy, and privacy.

## D. CULTURAL ISSUES

Telemental health providers ***should*** be culturally competent to deliver services to the populations that they serve. Providers ***should*** familiarize themselves with the cultures and environment where they are working and ***may*** use site visits and cultural facilitators to enhance their local knowledge when appropriate and practical. Providers ***should*** assess a patient's previous exposure, experience, and comfort with technology/video conferencing. They **shall** be aware of how this might impact initial telemental health interactions. Providers ***should*** conduct ongoing assessment of the patient's level of comfort with technology over the course of treatment.

## E. SPECIFIC POPULATIONS AND SETTINGS

### *1) Child/Adolescent Populations*

Telemental health procedures for the evaluation and treatment of youth ***shall*** follow the same guidelines presented for adults with modifications to consider the developmental status of youth such as motor functioning, speech and language capabilities, relatedness, and relevant regulatory issues. When working with younger children the environment ***should*** facilitate the assessment by providing an adequate room size, furniture arrangement, toys, and activities that allow the youth to engage with the accompanying parent, presenter, and provider and demonstrate age-appropriate skills.

Extended participation of family members or other relevant adults is typical of mental health treatment of children and adolescents. Providers ***should*** adhere to usual in-person practices for including relevant adults with appropriate modifications for delivering service through videoconferencing in the context of resources at the patient site. Extended participation ***may*** include a "presenter" who ***may*** facilitate sessions (e.g., vital signs, assistance with rating


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scales, managing active children, assisting with any urgent interventions) Providers ***should*** consider how the presenter's involvement can affect service delivery (e.g., social familiarity with the family, perceived confidentiality, sharing information with other team members).

When telemental services are delivered outside of traditional clinic settings (e.g., schools) providers ***should*** work with staff to ensure safety, privacy, appropriate setting, and accommodations. This is particularly true if multiple staff participate in sessions. Appropriateness for telemental care ***shall*** consider safety of the youth, the availability of supportive adults, the mental health status of those adults, and ability of the site to respond to any urgent or emergent situations.

*2) Forensic and Correctional*

Providers ***shall*** be aware of systems issues in working in forensic and correctional settings and follow applicable standard consent around both treatment and evaluation in terms of patient's legal status and rights. Provider ***shall*** have clear site-specific protocols about working with patients and staff in forensic and correctional settings.

*3) Geriatric*

The geriatric patient often has multiple medical problems and the inclusion of family members ***should*** be undertaken as clinically appropriate and with the permission of the patient. Interviewing techniques ***shall*** be adapted for patients who may be cognitively impaired, find it difficult to adapt to the technology, or have visual or auditory impairment. Cognitive testing may be provided via videoconferencing but might need to be modified for use via video. Organizations administrating cognitive testing via videoconferencing ***shall*** be aware of the properties of the individual test instrument, how it may be impacted by videoconferencing, and any potentially needed modifications.

*4) Military, Veteran and other federal populations*

Providers ***shall*** be familiar with the federal and specific organizational structures and guidelines for patients related to the location of care. Providers ***should*** familiarize themselves with the culture of the patients (e.g., military cultural competency) and the organizational systems in which they practice.

*5) Substance Use Disorder Treatment*

Providers ***shall*** be aware of and comply with federal, state and local regulations around prescription of controlled substances involved in Substance Use Disorder treatment. Providers ***shall*** coordinate with onsite staff to provide appropriate standard of care including care coordination and monitoring of physiological parameters for monitoring of ongoing treatment as clinically indicated.

*6) Inpatient and Residential Settings*

Providers ***should*** work to integrate themselves into inpatient and residential care settings where they practice through virtual participation in administration and organizational meetings including clinical case staffing on a routine/regular basis. Remote providers ***should*** optimize use of patient site staff for help with telemental health consultations and case coordination as clinically indicated. Inpatient units should provide the telemental health provider with adequate


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access to patients, members of the interdisciplinary treatment team, and primary medical providers and nursing support when appropriate.

7) *Primary Care Settings*

Providers ***should*** be aware of best practice in leveraging telepsychiatry to support integrated care across a continuum of models including direct patient assessment, consultative models, (e.g., asynchronous) and team-based models of care. Providers practicing integrated care telepsychiatry should attend to the impact of virtual interactions on team processes, dynamics, and patient outcomes in the delivery of integrated care.

8) *Rural*

Providers ***should*** be familiar with the impact of rural environments on treatment including firearm ownership, kinship in small communities, local geographic barriers to care and general availability of healthcare resources.

## KEY REFERENCES

**Foundational Documents**

1. APA Web-based Telemental health Toolkit (2016) https://www.psychiatry.org/psychiatrists/practice/telemental health
2. Recupero, P., & Fisher, J. C. E. (2014). Resource Document on Telemental health and Related Technologies in Clinical Psychiatry.
3. American Psychiatric Association. Telemental health via Videoconferencing. (1998)
4. Myers, K., Nelson, E. L., Rabinowitz, T., Hilty, D., Baker, D., Barnwell, S. S.,. & Comer, J. S. (2017). American Telemedicine Association Practice Guidelines for Telemental Health with Children and Adolescents. Telemedicine and e-Health.
5. Turvey C, Yellowlees P, Shore JH, Shore P. Delivering Online Video Based Mental Health Services. American Telemedicine Association Learning Center, 2014. (http://learn.americantelemed.org/diweb/catalog/item/id/241193;jsessionid=811FB256406248FFC1A45D3835DF3A99.worker1)
6. Turvey C, Coleman M, Dennison O, Drude K, Goldenson M, Hirsch P, Jueneman R, Kramer GM, Luxton DD, Maheu MM, Malik TS, Mishkind MC, Rabinowitz T, Roberts LJ, Sheeran T, Shore JH, Shore P, van Heeswyk F, Wregglesworth B, Yellowlees P, Zucker ML, Krupinski EA, Bernard J.(2013). ATA practice guidelines for video-based online mental health services. Telemedicine Journal and E Health, 19(9),722-30. doi: 10.1089/tmj.2013.9989
7. American Telemedicine Association. (2013). Practice guidelines for video-based online mental health services. Washington, DC, USA.
8. Yellowlees, P., Shore, J., & Roberts, L. (2010). Practice guidelines for videoconferencing-based telemental health–October 2009. Telemedicine and e-Health, 16(10), 1074-1089.
9. Grady, B., Myers, K. M., Nelson, E. L., Belz, N., Bennett, L., Carnahan, L., ... & Rowe, N. (2011). Evidence-based practice for telemental health. Telemedicine and e-Health, 17(2), 131-148.

**Key Reviews and Updates**

10. Hubley, S., Lynch, S. B., Schneck, C., Thomas, M., & Shore, J. (2016). Review of key


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telemental health outcomes. World journal of psychiatry, 6(2), 269.

11. Bashshur, R. L., Shannon, G. W., Bashshur, N., & Yellowlees, P. M. (2016). The empirical evidence for telemedicine interventions in mental disorders. Telemedicine and e-Health, 22(2), 87-113.
12. Hilty, D. M., Ferrer, D. C., Parish, M. B., Johnston, B., Callahan, E. J., & Yellowlees, P. M. (2013). The effectiveness of telemental health. Telemedicine and e-Health, 19(6), 444-454
13. Shore, J. H. (2013). Telemental health: videoconferencing in the delivery of psychiatric care. American Journal of Psychiatry, 170(3), 256-262.



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