HEMHA

HIGHER EDUCATION MENTAL HEALTH ALLIANCE

College Counseling from a Distance:

Deciding Whether and When to Engage in Telemental Health Services

About the Higher Education Mental Health Alliance (HEMHA)

Envisioned and formed in September 2008 under the leadership of the American College Health Association (ACHA), the Higher Education Mental Health Alliance (HEMHA) is a partnership of organizations dedicated to advancing college mental health. The Alliance affirms that the issue of college mental health is central to student success, and therefore is the responsibility of higher education. The current membership is:

The American Academy of Child and Adolescent Psychiatry (AACAP)

Adele Martel, M.D., Ph.D., DFAACAP, DFAPA
Health System Clinician (Community Faculty), Division of Child and Adolescent Psychiatry, Department of Psychiatry and Behavioral Sciences, Ann and Robert H. Lurie Children's Hospital of Chicago, Northwestern University Feinberg School of Medicine, Chicago, IL, USA

Co-Chair, AACAP Transitional Age Youth and College Student Mental Health Committee

Vivien Chan, M.D., DFAPA, DFAACAP
Associate Clinical Professor, Department of Psychiatry & Human Behavior School of Medicine and Chief of Psychiatry Student Health Center, University of California Irvine

Co-Chair, AACAP Transitional Age Youth and College Student Mental Health Committee

Jennifer Derenne, M.D.
Clinical Associate Professor of Psychiatry and Behavioral Sciences, Stanford University School of Medicine

Co-Chair, AACAP Transitional Age Youth and College Student Mental Health Committee

The American College Counseling Association (ACCA)

Kathryn P. Alessandria, PhD, LPCMH, NCC, ACS
Professor of Counselor Education, West Chester University

Monica Z. Osburn, PhD, LPC-S
Executive Director of the Counseling Center and Prevention Services, NC State University

The American College Health Association (ACHA)

John Kolligian, Ph.D.
Executive Director of University Health Services, Princeton University

ACPA – College Student Educators International (ACPA)

Eric Klingensmith, Psy.D., SPADA, PEM
Asst. Director and Coordinator of Crisis Services and Alcohol and Other Drugs Program (ACES), Grand Valley State University's University Counseling Center

The American Psychiatric Association (APA)

Amy Poon, M.D.
Clinical Assistant Professor, Dept. of Psychiatry & Behavioral Sciences, Stanford University School of Medicine. Co-Chair, APA College Mental Health Caucus

Ludmila De Faria, M.D.
Clinical Assistant Professor, Florida State University College of Medicine. Co-Chair, APA College Mental Health Caucus

Leigh Anne White, M.D.
Director, Student Psychiatry Services. Associate Director, Counseling and Psychiatry Services, Michigan State University

The American Psychological Association (APA)/Society of Counseling Psychology (SCP)

Shari Robinson, Ph.D., Licensed Psychologist
Director of Counseling Center, Western Washington University

Jenny Smulson
Senior Legislative and Federal Affairs Officer

The Association for University and College Counseling Center Directors (AUCCCD)

Dan Jones, Ph.D., ABPP
Director of Counseling Center,
East Tennessee State University

Micky M. Sharma, Psy.D.
Director of Student Life's Counseling and Consultation Service,
The Ohio State University

The Jed Foundation (JED)

Nance Roy Ed.D.
Chief Clinical Officer, JED
Assistant Clinical Professor of Psychiatry,
Yale University School of Medicine

Victor Schwartz MD, DLFAPA
Chief Medical Officer, JED
Clinical Associate Professor of Psychiatry,
NYU School of Medicine

NASPA - Student Affairs Administrators in Higher Education (NASPA)

Stephanie Gordon, Ed.D.
Vice President for Professional Development, NASPA

Patricia Telles-Irvin, Ed.D.
Vice President for Student Affairs,
Northwestern University

Support

This resource was made possible by additional generous support from these HEMHA member organizations:

The American Academy of Child and Adolescent Psychiatry (AACAP)

Representing 9,200+ child and adolescent psychiatrists worldwide, the American Academy of Child and Adolescent Psychiatry (AACAP) is the leading authority on children's mental illnesses. AACAP Members actively research, diagnose, and treat psychiatric disorders affecting children, adolescents, and their families. For more information, please visit www.aacap.org.

The American College Counseling Association (ACCA)

The American College Counseling Association, a division of the American Counseling Association, is made up of diverse mental health professionals from the fields of counseling, psychology, and social work whose common theme is working within higher education settings. Visit collegecounseling.org for more information.

The American College Health Association (ACHA)

Since 1920, The American College Health Association has linked college health professionals in order to provide advocacy, education, communications, products, and services, as well as promote research and culturally competent practices to enhance its members' ability to advance the health of all students and the campus community. See http://www.acha.org/ for more information.

ACPA–College Student Educators International

ACPA-College Student Educators International, headquartered in Washington, D.C. at the National Center for Higher Education, is the leading comprehensive student affairs association that advances student affairs and engages students for a lifetime of learning and discovery. Learn more at http://www.myacpa.org/.

The American Psychiatric Association (APA)

The American Psychiatric Association (APA) is the medical specialty society representing 36,000 psychiatrists in the U.S. and from around the world. APA, founded in 1844, is the largest and longest-serving psychiatric medical association. Its member physicians work together to ensure humane care and effective treatment for all persons with mental disorders. APA works to promote the highest quality care for individuals with mental disorders; promote

psychiatric education and research; and advance and represent the profession of psychiatry. Visit www.psychiatry.org for more information.

The American Psychological Association (APA)/Society of Counseling Psychology (SCP)

The American Psychological Association was founded in 1892 with 31 members and grew quickly after World War II. Today, APA has more than 115,700 members and 54 divisions in subfields of psychology. The mission of the APA is to advance the creation, communication and application of psychological knowledge to benefit society and improve people's lives. Division 17: Society of Counseling Psychology brings together psychologists, students, professional and international affiliates who are dedicated to promoting education and training, scientific investigation, practice, and diversity and public interest in professional psychology. See www.apa.org for more information.

The Association for University and College Counseling Center Directors (AUCCCD)

The Association for University and College Counseling Center Directors works to assist college/university directors in providing effective leadership and management of their centers, in accord with the professional principles and standards with special attention to inclusive excellence and social justice. See www.aucccd.org for more information.

Advisory Board

HEMHA is grateful to our Distance Counseling Guide Advisory Board, who provided resources, reviewed materials, and generously took the time to share anecdotes and insights from their own experiences with telemental health practice.

Calvin R. Chin, PhD
Director, Counseling & Psychological Services
Princeton University

Christopher S. Corbett, PsyD
Director of Counseling and Student Support
Savannah College of Art and Design

Richard Eichler, Ph.D.
Executive Director, Counseling and Psychological Services
Columbia University

Faye Freeman-Smith MS, LCPC, DCC, ACS
Director of Student Counseling Services
Heartland Community College

D. Catherine Fuchs, M.D.
Professor of Psychiatry and Behavioral Sciences and Pediatrics
Vanderbilt University
Former Director of Vanderbilt's Psychological and Counseling Center (PCC)
Currently Consultant to the PCC for Complex Students

Elizabeth Grady, LPCS, NCC, DCC
North Carolina State University

Tamara Knapp-Grosz, Ph.D., APRN, BC
Senior Director Counseling and Testing Services
University of North Texas

Rebecca Hambleton, M.Ed
Director, Study Abroad & International Partnerships
Grand Valley State University

Geoffrey Lee, PhD
Clinical Assistant Professor
University of Florida

Larry Long, Jr., PhD
Senior Director and Assistant Vice Chancellor of Academic and Student Affairs,
University of Kansas Medical Center

Fred R Volkmar, M.D.
Irving B. Harris Professor
Child Study Center, Yale School of Medicine,
Yale University

Weiyang Xie, Ph.D., HSPP
Staff Psychologist
University of Notre Dame

The Process of Developing the Distance Counseling Guide

As technology has evolved, so too has the implementation of telemental health practices and guidelines. The idea for this guide began several years ago in reaction to the proliferation of distance education and resulting questions about expectations that clinicians would provide mental health services to distant students. Recognizing that telemental health is a rapidly evolving area of practice, it was decided that creating a document to provide practitioners and higher education administrators a starting point to engage in conversations about how to best meet the needs of their stakeholders would be more valuable than a best practices document.

In 2015, the HEMHA committed itself to this project and formed a subcommittee of three representatives: Kathryn P. Alessandria, PhD (also served as Technical Writer), Monica Z. Osburn, PhD, and Shari Robinson, PhD, to develop a prospectus for the project and manage it. A multidisciplinary Advisory Group of experts in the field of telemental health was assembled with input from each of the HEMHA member organizations. HEMHA was careful to avoid conflicts of interest by excluding individuals from the Advisory Board who had vested interests in any for-profit products in the telemental health industry. The Advisory Board provided resources, practical knowledge, and reviewed drafts of the document. The document was then reviewed by each of the HEMHA representatives and approved by each member organization prior to publication.

There were four presentations on the HEMHA project at five conferences during this guide's development: American College Health Association (June, 2016), American College Counseling Association (February, 2017), American Counseling Association (March, 2017), American Psychological Association (August, 2017), and Association for University and College Counseling Center Directors (October, 2017). Audience input on the guide's content was solicited at each presentation, which enhanced the comprehensiveness and practical usefulness of the guide. Many case studies were contributed by audience members. Recent literature on the topic of telemental health was examined, and the quality of the available evidence was evaluated. When there is a paucity of evidence, we relied on clinical best practices and the consensus of conventional wisdom. The guide is funded by the HEMHA member organizations: AACAP, ACCA, ACHA, ACPA, American Psychiatric Association, American Psychological Association, AUCCCD, JED, and NASPA.

TABLE OF CONTENTS

THE PURPOSE OF THIS GUIDE IS TO:

1. Outline the potential benefits, limitations, and legal and ethical concerns regarding telemental health services in the field of college student mental health;

2. Aid mental health professionals who serve college students and Higher Education administrators in engaging in dialogue about these benefits, limitations, and concerns in order to make informed decisions about if, when, and to whom telemental health services should be provided.

THIS GUIDE IS NOT INTENDED TO:

1. Provide advice on how to implement telemental health services on campus;

2. Be a comprehensive literature review on the topic.

Note: The use of technology-assisted therapy is not included in this guide. This guide has been written with the focus on brick and mortar Institutions of Higher Education (IHEs) that engage in (or are contemplating engaging in) distance education and/or telemental health services. Online institutions are beyond the scope of this guide. Though there is a growing industry of third party providers of telemental health services, contracting with these vendors is outside the purview of this document.

Introduction

Distance counseling services, also referred to as telemental health services, have been gaining acceptance among clients and service providers alike. The practice of providing services when two parties are separated by distance began in the medical field early in the 20th century (Dart, Whipple, Pasqua, & Furlow, 2016). Psychiatrists in particular have provided treatment through synchronous videoconference since the 1950s (Shore, 2013), whereas other mental health disciplines have more recently forayed into this mode of service delivery. With the proliferation of technology and distance education, along with a marked expansion of students traveling internationally, there has been an increase in student requests for services delivered through technology and from a distance. Furthermore, many accrediting bodies expect that IHEs will provide the same services to students enrolled in all classes, regardless of the instruction delivery method. Thus, it is important for college counseling professionals to be prepared to decide: if, when, how, and to whom they will provide counseling services from a distance through technology. As distance education programs continue to grow and evolve, accrediting body expectations should be reviewed regularly for compliance.

The advent of distance education has brought to the foreground the issue of distance mental health services, also called telemental health (TMH), for IHE administrators and mental health professionals serving college students. The purpose of this guide is to:

1. Outline the potential benefits, limitations, and concerns regarding TMH services in the field of college student mental health.

2. Aid mental health professionals who serve college students and IHE administrators in engaging in dialogue about these benefits, limitations, and concerns in order to make informed decisions about whether to engage in providing TMH services.

3. Outline several areas to consider in order to ethically practice at a distance when the decision to provide TMH services is made.

4. Connect readers to resources on the topic of TMH.

Disclaimer: *This guide is not intended to serve as legal guidance. Practitioners should seek local legal opinion for concerns related to implementation of TMH services.*

Scope of the Distance Counseling Guide

The focus of this guide is on brick and mortar IHEs that are contemplating engaging in distance education and/or TMH services; online institutions are beyond its scope. Though there is a growing industry of third party providers of TMH services, contracting with these vendors is outside the purview of this document. Similarly, the use of technology-assisted therapy is not included in this guide. We define technology-assisted therapy as the implementation of apps or other electronic tools either during face-to-face therapy, TMH, or as homework between sessions. However, when contracting with third party services or considering apps to incorporate in treatment, this guide may be helpful in developing questions for the third party or app developer to ensure that the highest legal, ethical, and security standards are met.

How to Use This Guide

This is an interdisciplinary guide. It is our hope that this document will help facilitate conversations among stakeholders from a variety of roles in the IHE (including service providers, administrators, and students) about how to address the mental health needs of students and the role of technology in providing services. This is an interactive guide and is intended to foster ongoing conversations among stakeholders. Case examples and exercises are used throughout the document to prompt readers to stop and think about critical elements of designing and implementing TMH services. Throughout the following sections, readers will find Points to Ponder that invite them to stop and think through critical questions as they relate to the unique needs of their

institutions. Service providers and administrators are encouraged to develop a healthy dialogue and work collaboratively to make the best decisions for their institution and the students they serve.

COLLABORATING WITH STAKEHOLDERS: WHO SHOULD BE AT THE TABLE?

All stakeholders need to participate in the conversation about whether an IHE will offer TMH services. Stakeholder input will be key to the design and implementation of TMH services that 1) address an unmet need and 2) incorporate technological and therapeutic best practices while setting parameters and expectations for providing them. These stakeholders include (but are not limited to) the IHE's legal counsel, Counseling Center director, VP of Student Affairs, Institutional Technology expert, Psychiatry (if medical services are included), Director of Student Health Services if separate from the counseling center; Director of Wellness to ensure prevention programs are available, Dean of Students, Dean(s) of the programs that offer distance learning (typically the professional schools, etc.), and students.

Activity:

Make a list of all the stakeholders you think should participate in the conversation about implementing TMH services on campus.

NAME	CONTACT INFO
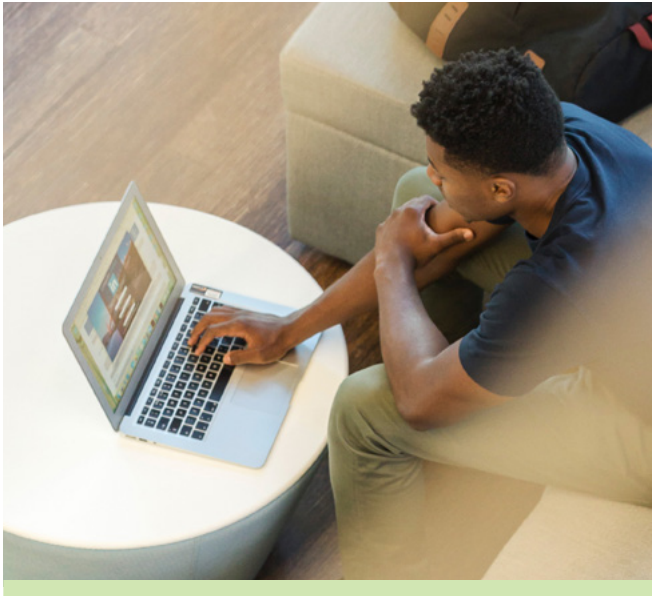
Defining Telemental Health

Telemental health services have existed in some form or another for over 50 years. The inventions of the Internet, wireless networks, smartphones, and other mobile devices have made access to telecommunication technology ubiquitous. The rapid evolution of telecommunication technology has called for the definition of TMH to be refined. Innovations in TMH have also raised concerns about its ethical implementation.

Telehealth is a broad term that refers to health services and information provided electronically (American Telemedicine Association [ATA], 2009). The ATA (2009) has defined TMH as "the practice of mental health specialties at a distance" (p. 5). However, the terminology has not been consistent in the literature. Other terms used in the literature range from being generic (e.g. distance counseling, E-therapy, teletherapies, cybertherapy) to discipline specific (e.g. telepsychiatry, telepsychology, telemental health, and telebehavioral health). The prefix "tele" primarily references the

communication tools used. These tools may include video conferencing, email, text messages, chat tools, and/or telephone (Dart et al., 2016). Typically these terms connote that the client and clinician are in separate physical spaces and connect via a computer (or another internet connected device) or telephone for mental health services.

TMH services can be delivered synchronously or asynchronously. Synchronous services are delivered in real time (e.g. through video conferencing technology, live chat, or telephone). Asynchronous services are delivered through communication that happens at different times (e.g. email, voicemail, text message, etc.). Most often the literature focuses on service delivery through synchronous video, as it is most similar to face-to-face treatment (Reinhardt, 2013). However, there has recently been a proliferation of online mental health service providers which match consumers who purchase a package of service options (e.g. video chats, text messaging, etc.) with clinicians. Another type of third party TMH product blends online psychoeducational and self-help tools with online therapy sessions through proprietary platforms. These service delivery formats may offer combinations of asynchronous and synchronous services.

Benefits, Risks, and Limitations of TMH

In an increasingly digital world, TMH is gaining acceptance because of its convenience and a growing body of research that indicates its effectiveness with specific populations. There are many potential legal, ethical, and technical issues to mitigate when implementing TMH services. Engaging in TMH services requires that one acknowledge the

potential benefits, risks, and limitations in order to effectively implement it (see Barnett & Kolmes, 2016 for a review of ethical, legal, and clinical issues for practitioners).

Prior to implementing TMH, mental health professionals and IHE administrators must:

- examine the levels of evidence of delivering TMH services for a particular use;
- carefully weigh the benefits, risks, and limitations;
- discern whether the benefits outweigh the risks and limitations; and
- put policies and procedures in place to maximize benefits and minimize risks and limitations.

On the next page we review many of the benefits, risks, and limitations of TMH to consider.

BENEFITS

Increased access. TMH services may remove barriers to access for clients who have disabilities or who live in remote locations. Individuals who have experienced trauma may particularly benefit from TMH services (Shealy, Davidson, Jones, Lopez, & de Arellano, 2015). For example, survivors of sexual violence, veterans, and individuals whose diagnoses may make it difficult to seek services (e.g. severe social anxiety, agoraphobia) may feel more comfortable receiving TMH services than face-to-face treatment (Aboujaoude, Salame, & Naim, 2015; Godleski, Darkins, & Peters, 2012; Shealy et al., 2015). Similarly, TMH may increase access to mental health services for deaf individuals (Crowe, 2017) or provide access to multilingual clinicians for clients with limited English proficiency. For those living in rural or hard to access areas, TMH can increase the availability and accessibility of therapists and specialists who may not be available within a drivable distance. During poor weather conditions, individuals may be able to continue with treatment.

TMH allows IHEs to offer services to students at off-site locations, such as those at satellite campuses, distance education students, and those who may

be temporarily away from campus (e.g. students in programs that require off-site field experiences, at home for breaks, etc.). This additional flexibility could allow for an increased continuity of care. There may be rare circumstances when it would be appropriate to use TMH to provide services to students who are studying abroad. However there are legal and ethical considerations when providing services across state and/or country lines. See more about this in the ethical and legal issues section.

Convenience. TMH services may reduce or eliminate travel time for both clients and clinicians, thus easing scheduling issues and reducing clients' time lost at work or in class. Many video conferencing software platforms are able to run on mobile devices. Clients may be able to log into the software from their wireless enabled mobile devices, which can increase access from their place of work, home, or while traveling.

Social justice. Underrepresented and/or marginalized groups may particularly benefit from the aforementioned increased accessibility and convenience of mental health services via TMH. According to the U.S. Department of Health and Human Services (2017) over 111 million people in the U.S. live in federally designated areas underserved for mental health. While wireless internet and broadband is less prevalent among underserved populations, the use of phones and smartphones is becoming more and more prevalent. Individuals who live in areas without adequate mental health services within a reasonable driving distance or whose mental health concerns or physical abilities make it difficult to travel to treatment may particularly benefit from increased ease of access to services. Individuals who lack transportation to treatment and clients who can minimize time away from work by eliminating travel time to appointments may be able to receive services that had once been inaccessible. TMH services may also improve access to bilingual practitioners for non-native English speakers (e.g. international and immigrant students).

Cost savings. In addition to the savings related to eliminating travel and time, TMH may provide significant savings in business costs for clinicians who may be able to work from a home office. Students who may need to arrange for childcare in order to attend face-to-face sessions may be able to reduce or eliminate this added cost.

Barrier removal. Those who struggle with PTSD, social anxiety, agoraphobia, disabilities, or similar conditions might feel less threatened by online counseling than by in-person sessions (Gilmore et al., 2016). In other words, for some individuals, TMH service delivery may be the only way to get the individual "through the door" to begin treatment.

Accommodate stigma and/or privacy concerns. Some individuals may be more likely to participate in online counseling because of the perceived stigma associated with seeing a mental health clinician (Aboujaoude et al., 2015). By avoiding the counseling center waiting room and parking lot, individuals may avoid accidental revelations of their decision to seek services, assuage stigma concerns, and increase their sense of privacy.

Authenticity of emotional expression. Services provided through technology can provide a semblance of anonymity that may lead to the client sharing more personal information or more intense emotion than might be displayed in person, also referred to as the "online disinhibition effect" (Suler, 2004).

Effectiveness. The growing body of research on TMH indicates that it (specifically the use of videoconferencing) can be an effective mode of treatment with equivalent therapeutic alliance ratings to face-to-face therapy (Simpson, Guerrini, & Rochford, 2015). "For most telemedicine applications, studies have shown that there is no difference in the ability of the provider to obtain

clinical information, make an accurate diagnosis, and develop a treatment plan that produces the same desired clinical outcomes as compared to in-person care when used appropriately" (ATA, 2013, p.4). There are limitations to this body of literature that are outlined in the section below.

Client empowerment. Other benefits of TMH may include a greater sense of personal control and empowerment for clients. TMH may improve access to mental health services for individuals who prefer technology mediated communications.

Increased clinical volume and capacity. More students may seek treatment due to improved access to services through TMH. University counseling centers (UCCs) may be able to increase their capacity to serve students through TMH toolsand products that offer self-help, psychoeducation, and/or contracting with TMH service providers to provide therapy.

Training and supervision. Many UCCs also serve as training sites for mental health practitioners. Trainees who receive supervised training in the ethical implementation of TMH

services from supervisors who have training and experience in the delivery of TMH services may be better prepared to work in settings that are likely to implement TMH services.

RISKS

The risks and limitations outlined below focus specifically on services provided through TMH.

Confidentiality. It is imperative that the service provider confirm the identity of the client prior to providing services, particularly via easily intercepted communication tools (e.g. email, text message) (Dart et al., 2016). When services are provided via technology that does not allow for visual verification, providers must develop a procedure for verifying client identity (e.g. such as a code word). When using videoconferencing, the client's identity can be verified more easily. However, clients will need instruction on how to protect their confidentiality. One must be sure that there is no one else in the room and that therapy is not occurring in a public space (e.g. coffee shop, library, computer lab, etc.).

Potential for interception of sensitive data. Large scale data breaches and email hacking have become commonplace. It is important that clients, clinicians, and IHE administrators understand the potential risks of data interception and that everything is done to meet current cyber security standards. The technology used to deliver TMH services must meet current encryption requirements. Service providers who use mobile phones or wireless devices to deliver services need to be mindful of automated tasks that the devices may perform (e.g. contact imports, synchronizing with other devices, location of saved text or email communication with clients, phone/video logs saved to device, and other users' access to the phone/device). Similarly when multiple devices are synchronized, the service provider needs to monitor these issues for all associated devices. It would be wise to keep personal and professional devices separate (e.g. phone, computer, email address). This also applies to vetting the privacy and security of any contracted TMH providers.

Another way data can be intercepted easily is when clinicians use asynchronous technology such as text messages and email. This is particularly true of text messages that appear on a locked phone screen or when someone leaves their email up on their computer and walks away. Furthermore there can be a high level of uncertainty regarding whether a message was received by the intended recipient and whether it was viewed by anyone else (Dart et al., 2016). On a related note, clients (or someone who intercepts a message) have the ability to forward counselor/client communications to others.

Keeping pace with ethical codes and best practices. Professional organizations have begun to address the role of technology in treatment and distance services in their ethical codes. Clinicians should review and stay updated on relevant ethical codes to ensure they are in compliance with the code of their professional organization(s). For example, the American Mental Health Counselors Association [AMHCA] *Code of Ethics* (2015) states: "Counselors only provide distance counseling when they have had training, experience, and supervision to do so" (p. 10). As technology advances, ethical codes are likely to become more specific regarding TMH. Practitioners must recognize that technology and TMH best practices may outpace ethical code revisions and healthcare laws. Clinical judgment and sound ethical decision making models are imperative.

To allow for technological advances in TMH, the ATA has put forth the following tentative guidelines.

> *An approach that differs from the ATA guidelines does not necessarily imply that the approach varied from the standard of care. If circumstances warrant, a practitioner may responsibly pursue a course of action different from these guidelines when, in the reasonable judgment of the practitioner, such action is indicated by the condition of the patient, restrictions or limits on available resources, or advances in information or technology subsequent to publication of the guidelines. Nonetheless, a practitioner who uses an approach that is significantly different from*
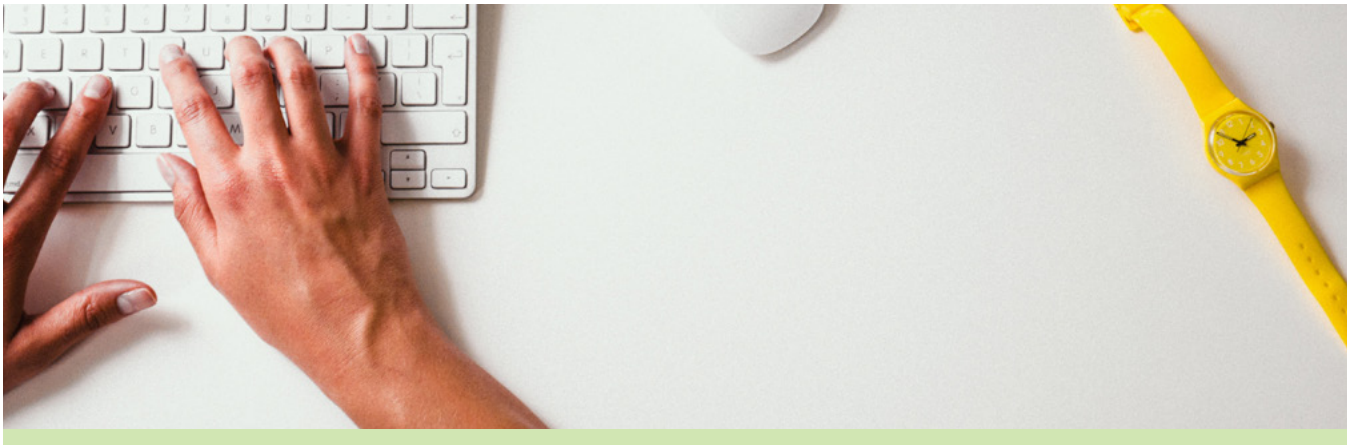
> *these guidelines is strongly advised to document in the patient record information adequate to explain the approach pursued. (p. 5)*

To illustrate this point, Appendix B presents an example of a creative use of technology. The example is from a university counseling center that created an online group for parents. While the intervention may be ambiguous as to whether it meets the threshold of being a TMH service, it was an innovative use of technology to support students and families.

⚠ Crisis intervention. Prior to engaging in TMH, clinicians and clients must develop an emergency plan and procedures. This is discussed further in the managing emergencies section.

👁 Training and supervision. UCCs that serve as training sites and implement TMH services must ensure that supervisors of trainees delivering TMH services have the knowledge and experience with TMH to provide effective and ethical clinical supervision.

🗔 Credentialing. Because licensure is regulated by each individual state, TMH providers need to be aware of state laws regarding TMH in the locations of both the clinician and client. In most cases, it will be required that the provider is credentialed in both locations. In the case of study abroad, TMH providers must similarly be familiar with the legal and ethical implications of practicing across country borders.

👤 Insurance. Not all malpractice/liability insurance covers TMH services. Providers must confirm their insurance policies cover TMH services delivery prior to offering them. See Ethical and Legal Issues section for more information.

🏛 Health Insurance Portability and Accountability Act (HIPAA) compliance. HIPAA and state law requirements about security and confidentiality that govern electronic personal health information (E-PHI) must be addressed (Dart et al., 2016). Recipients of TMH services cannot waive their right to HIPAA compliant services. According to Reamer (2013), it is the clinician's responsibility to investigate the security and encryption practices of any products used to save client information.

👥 Increased student volume without increase in clinical capacity. Many of the TMH benefits outlined above (e.g. increased access, reduced stigma, etc.) have the potential to increase the volume of students seeking services. Increasing volume without increasing the UCC's capacity to provide clinical services could exacerbate existing wait times for services.

LIMITATIONS

Providers who use technology to provide services (e.g. email, text messages, phone contact, websites, etc.) should be cognizant of the limitations below.

Service disruption due to technical issues. If the technology used by the client and the clinician are not adequate, there is the risk of: a) the connection being dropped, b) slow response times that can lead to talking over one another, and c) jerky motions in the video quality which can blur images, etc. (ATA, 2009). Even with the most updated technology tools, there is always a possibility of service disruption due to equipment or network failures. Alternate plans for communication in the event of technical issues should be in place at the outset (Palomares, Bufka, & Baker, 2016).

Emergent literature on the effectiveness of telemental health treatment. TMH tools are evolving rapidly due to technology advances. This limits researchers' ability to keep pace with the therapeutic application of the latest technologies. Often technology has changed, become obsolete, or perhaps become susceptible to malicious interception by the time researchers publish their studies. Because research on TMH with modern technology and its effectiveness is in its early stages, it is critical that TMH providers remain current with the latest literature on TMH outcomes, best practices, and current technologies for service delivery. Consumers of the literature should be careful to assess the quality of their sources and be cognizant of potential biases in the literature. Some psychotherapy interventions delivered via TMH have been studied disproportionately (e.g. Cognitive Behavioral Therapy) to other types of psychotherapy (Aboujaoude et al., 2015). Additional research is needed on the long-term effects of CBT and other treatments via TMH versus face-to-face treatment in order to better understand the benefits and limitations of TMH treatment.

Inability to see context of communication. More than 80% of communication is nonverbal. The ability to see the details of facial expressions and nonverbal communication is limited when

TMH methods are used. While video conferencing provides the greatest opportunity to see client nonverbal communication, poor camera quality and/or positioning as well as the size of the screen and the speed and reliability of the telecommunications methods can limit the quality of the clinician-client interaction. The resolution of the picture quality as well as the size of the screen display will significantly limit or enhance the quality of the therapist/client interaction. Services which are delivered without video or through asynchronous communication methods (e.g. emails, text messages) are stripped of context (including vocal tone and quality) and can be easily misinterpreted (Dart et al., 2016).

Gaze angles. Simulation of eye contact through technology takes practice. "Gaze angle is the angle between the participant's local camera and where the participant looks at the distant on-screen

participant (eye contact). The vertical location of the participant on the screen will affect gaze angle. Gaze angles of approximately 5 to 7 degrees are imperceptible to most people" (ATA, 2009, p. 9). Finding the right gaze angle will simulate eye contact through the video. It is human nature to want to look into the eyes of the image of a person on the screen, however this would appear on screen as not looking at the other person.

Difficulties of assessment. Administering formal assessment tools (e.g. WISC, BDI, MMPI, Rorschach, etc.) from a distance can be challenging as not all assessments have online versions. Clients may need someone available in case they have questions or experience discomfort as a result of the assessment. Instruments whose computer-administered versions are relatively recent may have limited reliability and validity data for these formats (McKay, Przeworski, & O'Neill, 2016).

Lack of infrastructure and technological competence. Prior to providing TMH services, it is critical to ensure the equipment and infrastructure to support the technology required is in place. In other words:

- Is the network reliable?
- Can it handle the internet speeds necessary to provide TMH services? and,
- Do clinicians have access to up to date devices in order to be able to provide a high quality TMH experience?

Clinicians will need to learn about the technology implemented and/or hire specialists to ensure the quality of the equipment and compliance with security and encryption standards. Qualified personnel will need to regularly review evolving security standards to ensure compliance as well as provide maintenance for all the necessaryequipment, from infrastructure to end user devices.

Social justice barriers. Individuals who do not have access to technology that meets the minimum requirements to participate in TMH may not be able to access these services. This could create a divide based on socioeconomic status (SES) and/or client technology competence. Client comfort and skill with technology may also hinder or enhance the effectiveness of TMH services. As college and university counseling centers consider implementing TMH services, the question of how to pay for these services arises. If additional fees associated with access to TMH services are passed along to students who use them, institutions should consider whether this will create an equity and access issue for lower socioeconomic status students.

> **STOP!** Points to Ponder
>
> - *How might technology be a benefit and/or a liability when serving students who need translation services (e.g. hard of hearing or foreign language)?*
> - *Are students who may not be as comfortable with technology good candidates for this mode of service delivery?*

Ethical and Legal Issues

Prior to engaging in TMH services, it is important to understand the unique ethical and legal issues that can arise (Barnett & Kolmes, 2016). Specifically, it is important to consider the ethical and legal implications of providing services to students who are not in the jurisdiction where the service provider is licensed. In these instances, clinicians must check licensure laws in both their own location and that of

the student before engaging in TMH. In many cases, the clinician will be required to be licensed in both locations[1].

LICENSURE AND CREDENTIALING ISSUES

At this time, there are no national licenses available; instead, each State Board sets discipline-specific requirements for licensure of mental health practitioners. State Boards generally assume that service providers and service recipients are located in the same state. As TMH becomes more accepted, State Boards may begin to address these issues in their regulations. A few federal agencies (e.g. Dept. of Defense, Veterans Affairs, etc.) have enacted regulations that allow practitioners who are licensed in a single state to provide services through said federal agencies (see Title 10, United States Code, Section 1094(d), Kramer et al., 2015). In the meantime, the generally accepted solution has been for practitioners to maintain licenses in both their location and that of the client (Kramer et al., 2015). Unfortunately, this solution does not address issues of temporary distances (for example students studying abroad or at home for the weekend or a school break). Maintaining licensure in multiple states puts a financial burden on the practitioner (or the IHE if they pay licensure fees for their employees). Furthermore, it would be impossible to predict in

which other states practitioners would need to secure licenses; students from all 50 states may be enrolled at the IHE. **Practitioners and IHEs interested in engaging in TMH should pay close attention to licensure laws and portability issues.**

The ATA is tracking State Telemedicine Legislation. The most recent information available at the time of publication was from July 14, 2016 and can be found here:

https://higherlogicdownload.s3.amazonaws. com/AMERICANTELEMED/3c09839a-fffd-46f7-916c-692c11d78933/UploadedImages/Policy/ State%20Policy%20Resource%20Center/state-legislation-matrix_2016.pdf .

Psychiatrists must also pay attention to laws and regulations that restrict their ability to prescribe medications for individuals whom they have not met in person and regulations regarding the ability to prescribe controlled substances across state lines. In 2007 a psychiatrist in Colorado was found guilty of practicing medicine without a license in California after prescribing an antidepressant via an online pharmacy to a 19-year-old student who subsequently died by suicide (Neimark, 2009). This unique case has served as the 'poster child' for concerns regarding practicing across state lines. Select state statutes allow for mental health practitioners to receive permission to practice within their state for a specified period of time and under certain conditions (Kramer et al., 2015). Practitioners engaging in services across state lines should investigate the availability of and requirements for obtaining such a credential ahead of time. Below are two case illustrations of psychiatrist use of TMH.

---

1 *This is an area that should be monitored regularly for updates as mental health professions work to improve licensure portability and may move toward national credentials. Ethical codes should also be reviewed regularly for updates.*

Two Cases: Examples of Appropriate Use of TMH
Submitted by Vivien Chan, MD

CASE OF SARAH:

Dr. Campus Psychiatrist is part of a campus-only telepsychiatry service where the psychiatrist works in-person from the main campus but offers telepsychiatry services at the campus's many satellite locations. The distance locations are set up for telehealth service by being located in specially designated examination rooms with office and medical support staff. Dr. Campus Psychiatrist sees Sarah face-to-face on the main campus and continues her care regularly when she transfers to a satellite location over the course of her 4-year undergraduate studies. Sarah is prescribed an antidepressant and a controlled substance hypnotic drug for sleep on a regular basis. Dr. Campus Psychiatrist knows that, due to the federal Ryan Haight Online Pharmacy Consumer Protection Act of 2008, Sarah needs to be seen face-to-face on the main campus at least once in the previous 24 months in order to continue prescribing the controlled substance hypnotic medication across the 4 years of her treatment.

- Are you an IHE considering offering psychiatric care, including prescription of psychotropic medications via TMH? If so, what state and federal regulatory training will be provided prior to initiating this service?

- How would you communicate with practitioners and the Center about these regulatory requirements? What other notifications or parameters would you want to share with students?

- Is one face-to-face visit in 24 months for controlled substances the standard you want to follow at your institution? What degree of latitude or rigor would you also consider?

CASE OF SALLY:

Dr. Campus Psychiatrist initiates treatment with a different student, Sally, using telepsychiatry at a distance because she attends the satellite campus location exclusively. Although Sally presents with almost the same symptoms as Sarah, Dr. Campus Psychiatrist knows to only prescribe an appropriate antidepressant and not any controlled substance like a hypnotic or a benzodiazepine due to the Ryan Haight Act unless Sally is seen in person. Unless Dr. Campus Psychiatrist practices in one of the federally exempt settings, the practitioner knows to regularly check on federal and state regulations, as well as licensure rules.

⚯ Activity:

Engage prescribers in a discussion of practical implementation of the Ryan Haight Act, which sets a minimum standard.

PREVENTING MALPRACTICE

Professional competence. Possibly the most important consideration in avoiding practice errors is the issue of competence: clinical, technological, ethical, and cultural. A common expectation among all mental health professions is that clinicians are required to practice only within their areas of competence. There is a high likelihood of making a mistake when clinicians practice beyond their areas of competence.

There is likely a significant variability in digital competence among psychotherapists. Those who are practicing today include the entire spectrum of professionals, from those who were trained prior to the "digital age" to those who grew up with digital technology at their fingertips and

electronic connectedness as a way of life. Some of the former have migrated into the digital world as immigrants. Many of the latter are so comfortable with technology that they may actually prefer it as a medium for psychotherapy.

In addition to therapist competence, there can also be issues around patient technology competence that could reduce the effectiveness of TMH and become a barrier to acceptance of this treatment (Pruitt, Luxton, & Shore, 2014). In this situation a lack of confidence in technology use or equipment failures could become a distraction for the clinician and client. However, collaboration between the therapist and client around troubleshooting technical difficulties can yield therapeutic benefits like sustained rapport and cooperative problem solving (Pruitt et al., 2014).

While TMH is being widely practiced in a variety of forms, to date there are no consistent standards of competency (Truscott & Crook, 2004). Clinicians have a clear obligation to obtain training and/or support in areas with which they are not familiar, including technology, in order to be confident that they have both the technical and clinical competence to implement this service delivery method (Turvey et al., 2013). The general guidelines for ethical practice recommend choosing one of the following:

1. accept only cases for which we have existing competencies,

2. obtain training to learn new competencies, or

3. refer the client to a practitioner who does have the needed competencies.

Malpractice insurance. TMH providers must carefully review their malpractice insurance policies to ensure coverage of TMH services prior to providing them. Malpractice insurance is generally state-specific and may or may not explicitly cover TMH. **Furthermore, it is important to determine at what point a relationship is considered as established.** Kramer et al. (2015) posed the following questions: "does an initial phone consultation, an email, or even a brief live Internet connection establish professional contact and relationship" (p. 261)? While there is no one clear

answer, one must be prepared to mitigate risks of differing perspectives on when a relationship has been established. Furthermore, prior to delivery of TMH services, licensed mental health professionals should:

- contact their malpractice insurance carrier to determine whether they are covered for providing distance counseling services;

- read the state's statutes and contact the licensing board relevant to the client's location to determine whether or not the services provided fall under their jurisdiction and what, if any, restrictions exist (Turvey et al., 2013);

- determine whether their IHE accepts insurance, and if so, confirm the client's insurance covers TMH treatment?

University Counseling Center Triage Services via TMH
Submitted by Chris Corbett, PsyD

When exploring how to meet the demand for access to services, many counseling centers have chosen to incorporate a model which utilizes a phone triage system. In these scenarios, the first point of contact is a triage assessment conducted over the phone. In these situations, questions of history are asked, current risk to self and/or others is assessed, and current concerns are also noted in order to determine the best model of treatment for the student.

Questions to consider:

1. Is this student considered a client?

2. How is it handled if the student presents immediate concerns of risk? What if they are unwilling to present in person, or share their location?

3. What is the duty to care (or follow-up) if the student is referred to a community provider?

4. What is the documentation process regarding these contacts?

5. How would the situation be different if this was a distance learning student?

Assessing TMH appropriateness. TMH has many benefits, but may not always be appropriate for the client. UCCs should consider 1) the circumstances under which TMH will be offered, 2) criteria for terminating TMH and requiring face-to-face treatment, and 3) how to respond to students who are requesting services from a distance but whose needs are not appropriate for TMH. Would the response be different if the student lived on or near campus as opposed to being a distance education student who does not travel to campus? Counseling centers that provide TMH services should prepare in advance for how they will respond to these types of requests and be explicit with students about the limits of TMH services and the circumstances under which they will be referred to local in-person resources.

Risk management recommendations. Kramer et al. made several risk management recommendations with respect to licensure and malpractice liability (2015, see Kramer et al. for full discussion).

1. Obtain licensure in any state in which you expect to practice. Contact the State Licensing Board before you practice in that state; familiarize yourself with any local laws and/or policies regarding TMH. The amount of time necessary to obtain permission for a temporary period of practice in a foreign state may surpass the ability to provide service in a timely manner.

2. Obtain malpractice insurance for both the state in which you are located **and** the state in which the client is located. Contact your insurance company with questions, and confirm answers in writing.

3. "Assume that any contact with a patient or potential patient using any form of technology (email, phone, Internet chat), however brief, may create or be considered part of a professional relationship, particularly if it is reasonable to believe that the patient may rely upon that contact as professional advice" (Kramer et al., 2015, p. 262).

4. Stay informed of best practices and regulations and standards of care in the TMH field through professional organizations.

5. Create a local network of TMH providers with whom you can consult and discuss ongoing professional issues.

Informed consent. Informed Consent is a critical element of the counseling process, regardless of whether services are provided face-to-face or at a distance. Practitioners must be explicit with potential clients about what constitutes an established professional relationship; both parties should be clear on the type of relationship that exists and their roles and responsibilities. In order to avoid ambiguity in explaining the professional relationship to clients, practitioners should be clear in their own minds about the definition of a TMH professional

relationship and how it differs from a face-to-face professional relationship.

Clients must be informed of the risks and benefits of TMH services at informed consent as well as the circumstances under which TMH services **will or will not** be provided. Below are several practical considerations related to informed consent (See Kramer et al., 2015 and Palomares et al., 2016 for additional information).

1. Review and discuss informed consent with the client in real time, regardless of whether the actual services will take place synchronously and/or asynchronously.

2. Ensure that all laws (and ethical best practices) regarding informed consent are followed and documented in writing, even if your state allows for verbal consent.

3. Review and incorporate any state-specific TMH requirements for informed consent.

4. Acknowledge and discuss the limits of the technology being used.

5. Follow all applicable state and federal laws. Information about state and federal laws can be found here: http://www.healthinfolaw.org/state.

6. Consult all professional codes of ethics that apply to the TMH provider (e.g. licensure boards, professional organizations, best practice guidelines, etc.) to ensure all required information is addressed during informed consent. Plan ahead for how you will address discrepancies among the codes that apply to you.

7. Kramer et al. (2015) recommended that, at a minimum, the following are addressed:

   a. confidentiality and the limitations to confidentiality when using electronic means of communication;

   b. develop emergency plans and procedures and identify the on site collaborator; the client's physical location should be confirmed by the practitioner each time services are provided in case an emergency arises and the collaborator and/or local authorities must be contacted (see Emergency Management section for more information about collaborators);

   c. develop an action plan for technology failures, including procedures for coordinating care with other professionals;

   d. identify a back-up mode of communication.

8. Understand that email conversations with clients become a permanent written record that has the potential to be misconstrued (Dart et al., 2016). Prior to providing TMH services, one should decide whether transcripts of written correspondence (e.g. email, text messages) and/ or audio/video recordings will become part of the electronic health record. Determine a process for documentation and storage of information, including:

   a. what will be stored (e.g. emails, videos, text messages),

   b. where it will be stored,

   c. which types of information will become part of the health record,

   d. the length of time records will be kept, and

   e. who will have access to the records.

9. If you are a training facility, how will trainees TMH sessions be supervised? Will TMH sessions be recorded for supervision?

10. Discuss availability of the practitioner and expectations for contact between sessions, including response times.

11. Discuss the circumstances that would warrant the termination of TMH services and a referral to in-person treatment (Kramer et al., 2015).

12. Discuss expectations for clients' use of technology in maintaining their own confidentiality (e.g. they may not record sessions with therapist).

13. Review how to properly position cameras and lights for best TMH experience.

Informed Consent Resources

Appendix A: Sample Informed Consent Form

Video example of informed consent of a psychiatrist conveying informed consent for a session conducted synchronously via video conference with a client who is in a medical facility.

https://www.youtube.com/ watch?v=zWBJDj9owv0&feature=youtu.be (Shore, 2012)

Managing emergencies. Because emergencies are unpredictable, it is vital to proactively plan for the unexpected. It is crucial to have plans in place in the event of clinical, technical, and/or medical emergencies (Kramer, Kinn, & Mishkind, 2015). [For specific suggestions for managing emergencies, see Turvey et al., 2013 and Yellowlees, Shore, & Roberts, 2010.] Knowing the laws governing practice in both states is critical as expectations for responding in potential Duty to Warn situations and procedures for involuntary and voluntary commitment in the location of the client can vary by state. For example, some states are Tarasoff states and others are not. There are state by state differences in documentation, in reimbursement, and some states have laws specifically governing TMH.

Safety in the face of a crisis during TMH treatment has some key differences from face-to-face treatment that need to be prepared for ahead of time. In face-to-face circumstances safety assessments and implementation of emergency protocols can occur on the spot (Christie, 2016). These assessments and emergency plans require careful advance planning for TMH services because of the physical distance between the clinician and client.

During the informed consent process, the clinician and client should develop and record a detailed safety plan with the client (Christie, 2016). This plan should distinguish between safety procedures for home-based treatment (e.g. a remote clinician who provides treatment to clients in their homes) versus TMH services delivered in two separate clinics (e.g. a remote psychiatrist who provides services to clients while they are in the same building as their therapists).

For home based treatment it is recommended to have a "collaborator" on the premises (Kramer et al., 2015; Luxton, O'Brien, McCann, & Mishkind, 2012). Collaborators are an agreed upon person (by the client and practitioner) who is in the locale of the client and available to contact the local authorities in an emergency situation (e.g. medical or clinical crisis). Collaborators could be family or friends. The use of a collaborator may be more efficient and timely than a clinician in a different town, county, or state trying to contact emergency services in the client's location. In the event that immediate transportation is necessary, a collaborator is a valuable resource. In addition to offering local emergency help, collaborators can provide remote practitioners with an additional point of contact for clients in the event of a lost connection and possibly troubleshoot technical issues. The ATA calls the local collaborator the "Patient Support Person" (Turvey et al., 2013). [See Luxton et al., 2012 for more information about collaborators.] The clinician and client should determine who will be designated local collaborator, secure contact information and discuss the responsibilities and circumstances for contacting them.

A secondary mode of communication to reach the client in the event that a synchronous TMH connection is lost is imperative (Kramer et al., 2015;

Luxton, Pruitt, & Osenbach, 2014). Steps to solve technical problems that may arise and potential transportation issues that could be a concern during an emergency should be addressed during informed consent(Christie, 2016). Clinicians should be clear with their clients about whether the mental health professional is responsible if a crisis occurs while they are out of the office (Kramer et al., 2015). Be proactive in identifying procedures for emergency situations. A discussion about guns and gun safety may be warranted in some circumstances. Knowledge of client access to weapons can be critical in assessing a crisis situation. Similarly, the presence of drugs and/or alcohol in the environment may need to be fully explored as a condition of treatment if the client is receiving services for chemical dependency.

STOP! **Points to Ponder**

Prior to using local collaborators, it is important to consider some logistical, as well as potentially legal and ethical issues.

1. *Has the client been fully informed about the role of a local collaborator and provided written consent to their use?*

2. *Who will notify the selected collaborator of their status? Should there be an introduction to the collaborator prior to TMH service delivery?*

3. *Who will notify the collaborator that a session has been scheduled? Is it necessary to notify them of each session or merely that the therapeutic services are being rendered?*

4. *Should collaborators be required to sign a consent form indicating their understanding of their role in the client's treatment and what to do in the case of an emergency?*

5. *Is the collaborator required to be in the same building as the client while services are delivered or just nearby? What limits to confidentiality might this pose?*

PRIVACY AND CONFIDENTIALITY

Cybersecurity is a pressing concern in the world at large. Recent worldwide infections of ransomware have affected entire health systems (i.e. the WannaCry attack in May, 2017, C|Net, 2017; and the NotPetya attack in June, 2017, CSO, 2017). The increasing frequency of computer hacking of governments and industries is a concern that should be considered prior to engaging in TMH. Regulations such as ethical codes and laws identify the importance of practitioners implementing methods such as data encryption, firewalls, passwords, authentication, etc. to protect the technology, prevent service interception and protect the privacy and confidentiality of clients and their records. It is incumbent on the practitioner to learn about these data security measures, the vulnerabilities of the technologies

they implement, and how to best secure them. IHEs should be prepared to address these issues in their preparations to deliver TMH services and regularly review data security best practices and procedures to ensure equipment is regularly updated.

HIPAA, HITECH, AND FERPA REGULATIONS[2]

HIPAA. HIPAA legislation requires clinicians to implement measures to protect their clients' privacy and confidentiality, and verify client comprehension of the limits of confidentiality with respect to all modes of communication, including electronic (Christie, 2016). According to Reamer (as cited in Christie, 2016), it is the practitioner's responsibility to review whether any site used to store client information meets encryption and security standards. Clients cannot opt out of their right to privacy. For example, a client who is either temporarily or permanently distant from the therapist, and would like to continue seeing the therapist using standard Skype (which is not HIPAA compliant) cannot opt out, no matter how willing they are to accept the consequence of the technology's security limitations. According to Zuckerman (2016), HIPAA is "technologically neutral" meaning it does not prescribe how to maintain security; rather it sets goals for maintaining security of information. The responsibility for assuring compliance rests with the "Covered Entity" (Christie, 2016). In the case of TMH on campus, the IHE should carefully determine who on campus is responsible for ensuring compliance.

HITECH. The Health Information Technology for Economic Clinical Health Act of 2009 (HITECH) is part of the 2009 American Recovery and Reinvestment Act. This act focuses on regulating the healthcare informatics industry, including electronic healthcare records, and provides specific consequences for noncompliance (3Lions Publishing, 2009). The HITECH act provides for stricter enforcement of HIPAA requirements, data breach notification requirements, regulates electronic healthcare records access, and regulates the business associates of healthcare providers. This is a simplified summary of the HITECH Act. IHEs should seek legal advice on whether this Act applies to their institution and if yes, seek advice on how to comply with all regulations.

FERPA. The Family Educational Rights and Privacy Act (FERPA) requires that "school employees must protect the privacy of all student records from unauthorized access or accidental loss and destruction" (Dart et al., 2016, p. 350). It is also important to note that FERPA defines two types of records: educational and treatment records. Education records are broadly defined to mean those records that are: (1) directly related to a student, and (2) maintained by an educational agency or institution or by a party acting for the agency or institution (see Family Educational Rights and Privacy Act Regulations, 2009, 34 CFR § 99.3). At postsecondary institutions, medical and psychological treatment records of eligible students are excluded from the definition of "education records" if they are made, maintained, and used only in connection with treatment of the student and disclosed only to individuals providing the treatment (see Family Educational Rights and Privacy Act Regulations, 2009, 34 CFR § 99.3). These records are commonly called "treatment records." Most records at UCCs fall under the definition above, and are therefore separate from educational record guidelines.

Regarding HIPAA, it is also important to note entities subject to the HIPAA Administrative Simplification Rules (see 45 CFR Parts 160, 162, and 164), known as "covered entities," are health plans, health care clearinghouses, and health care providers that transmit health information in electronic form in connection with covered transactions. Because most UCCs do not electronically bill, they do not

---

fall under HIPAA guidelines. Additionally, many schools, even those that are HIPAA covered entities, are not required to comply with the HIPAA Privacy Rule because the only health records maintained by the school are "education records" or "treatment records" of eligible students under FERPA, both of which are excluded from coverage under the HIPAA Privacy Rule. See the exception at paragraph (2)(i) and (2)(ii) to what is considered "protected health information" (PHI) at 45 CFR § 160.103.

In summary, counseling center records could potentially not fall under the guidelines of FERPA or HIPAA. Therefore, they would fall under state privacy and confidentiality laws. While the above does not serve as legal advice, it is always important to be aware of all federal and state laws, professional licensure laws, and ethics when it comes to privacy and confidentiality. **If you work at an IHE, it is critical that you consult your institution's legal counsel regarding your records.**

To mitigate risks associated with data security, privacy, and confidentiality practitioners and IHE administrators should consider the recommendations of Kramer et al., 2015 and Palomares et al., 2016.

1. Revie.w and become familiar with all legal and ethical guidelines, such as HIPAA, HITECH, FERPA and compliance processes.

2. Pursue training in the technology systems that will be used to communicate with clients and store records. Identify technology experts with whom you can consult about data security and client privacy concerns.

3. Become familiar with and adhere to the highest standards for data security and regulations at the state and federal levels for protecting client confidentiality and privacy.

Activity:

It is important to include a variety of stakeholders in the process of determining whether TMH services should be offered by the IHE. Gather your interdisciplinary team and consider the following questions.

1. Make a list of the tools and resources already available on campus that can be leveraged to securely implement TMH services
    a.
    b.
    c.

2. Whom do we need to consult with prior to engaging in TMH practices (cybersecurity experts, IT services, legal counsel, etc.)?
    a. What is their name and contact info?
    b. Who will reach out?
    c. What is our deadline for reaching out?
    d. What questions do we need to ask? Create a list.

3. Have we reviewed our HIPAA, FERPA, and HITECH obligations with legal counsel? What state regulations also apply to the practice of TMH?
    a. Who will reach out?
    b. What is our deadline for reaching out?
    c. What questions do we need to ask? Create a list.

4. When and where will we meet to discuss next steps?

Deciding Whether TMH Services Should be Provided

In this section, we consider the IHE's identity, the role of accreditation, and student eligibility for TMH services. Many questions and case studies are presented to engage stakeholders in assessing for themselves whether to implement TMH services, how to go about it, and determine which campus subpopulations might be eligible for and provided access to TMH treatment. This section is presented as a series of questions for stakeholders to consider.

IHE MISSION

Prior to implementing TMH it should be determined whether these services would fill an unmet need. Furthermore, the institution should consider its identity and whether offering TMH services is congruent with the IHE's mission. At the most practical level, it should be determined whether the IHE can provide quality TMH services ethically and legally. The following questions will aid in making these determinations.

1. Are there students whose needs are currently unmet due to lack of access to TMH services?

2. What are the benefits and risks of offering TMH services? Do the benefits of offering TMH outweigh the risks?

BENEFITS	RISKS

3. Is it feasible to offer TMH services to students who telecommute to campus?

4. Do we have the expertise, technology infrastructure, human resources, and security measures in place to effectively provide this service format?

5. Is providing TMH services congruent with the overall mission of the institution and specifically that of the counseling center?

6. How will the need for increased staff be accommodated if the implementation of TMH results in an increase in student requests for services?

ACCREDITATION REQUIREMENTS

Many accrediting bodies have specific requirements regarding student access to campus mental health services. To ensure compliance with regional and program specific accrediting bodies the following questions should be considered:

1. What organizations have accredited our institution and/or specific programs?

2. What are the expectations of each of these accrediting bodies related to student access to mental health services?

3. Do IHE accrediting bodies expect services to be available to all students, regardless of matriculation status and instructional delivery methods?

4. Are these accreditation requirements met by the existing counseling services?

5. IHEs that have training programs for mental health clinicians should review programmatic accreditation requirements for teaching students about TMH and assess whether field sites on campus meet these requirements.

DEFINING STUDENT ELIGIBILITY FOR TMH SERVICES

When considering the implementation of TMH services, an institution must define who their students are and whether there is an unmet need that could be filled by adding TMH services. Reviewing student needs and characteristics will assist IHEs with determining:

- who would be eligible for TMH services;
- whether there is a sufficient need for TMH services;
- the costs and benefits of adding these services, and

- parameters to qualify for TMH services.

Several questions and case studies are presented next to aid stakeholders in this process.

1. Are students engaged in distance education paying the fees that support counseling services on campus? If yes, what are the IHE's obligations to provide access to university resources such as counseling and other psychological services?

2. Are students who are not matriculated, but taking an online course at your institution for credits that will be transferred back to their degree granting IHE, eligible for services?

Case of Susie: A Non-Matriculated Student Taking an Online Course for Credit

Kathryn P. Alessandria, PhD, LPCMH

Susie is a 20-year-old degree-seeking student at Utah State University. Over the summer, she takes an online course at Texas State University (while living in Utah). During the course, she has a bad break-up with her long-term (4 years) significant other and experiences severe depression and anxiety. The online instructor notices warning signs in Susie's coursework and makes a referral to the Texas State University counseling center. Is Susie eligible for services?

Questions to consider:

1. Did Susie's tuition include fees used to fund the Counseling Center?

2. Are there ethical issues in refusing to see Susie if it is deemed she is not eligible for counseling services?

3. How will the clinician be able to determine Susie's eligibility for services when the referral is received?

4. Is the clinician obligated to find a referral for Susie in her home state if it is determined that Susie is not eligible for services?

5. If both institutions were in the same state, would Susie be eligible for services?

6. If it is determined that Susie is NOT eligible for TMH services, what is the counselor's obligation to Susie?

3. Are students who enroll in Massive Open Online Courses (MOOCs) eligible for services (i.e. not matriculated and not paying tuition or fees)?

4. Would a student who needs mental health services, but who is auditing a course and not paying full tuition and fees, be eligible for services?

5. Are students who are on campus and taking online courses (within town) eligible for TMH services?

Case of Kylie: A Student Who Wants Services by Phone
A Community College Student Struggling with Academics and Depression
Vickie Wahler, MS, LPC

Kylie is a 26-year-old degree-seeking student who lives at home with her parents and is attending the regional Technical College. She started taking classes in spring of 2013, completing 12 credits and obtaining a 3.7 GPA. Following that semester, she decided to only take 6 or 7 credit hours. Kylie prefers online courses, and it appears that is where she obtains the best grades. She admits to struggling with social situations and tends to feel more comfortable at home working independently. She is attending school only because her parents are making that a condition to living at home.

In fall 2016, Kylie's online instructor noticed a drop in her academic performance and suggested that she attend the counseling services offered by the technical college. Kylie made a face-to-face appointment during the first three weeks of the semester. Kylie shares with the counselor that she has depression, and it usually gets worse in the fall. This particular summer was difficult as she had an unexpected breakup with her boyfriend of two years.

Kylie has a long history of depression and reported that she has been treated with a variety of medications for it since the age of 12. She has been hospitalized for depression and suicide attempts in the past, and her most recent hospitalization was this past month. She reported having a psychiatrist and counselor in the community. This was the first time Kylie sought any assistance from the college.

Kylie appeared guarded during this initial conversation and had a flat affect. However, she kept repeating that she wanted to get help. We discussed an action plan that included enrolling in the Disability Support Services, continuing with community counseling services, and returning to this counselor to manage her progress. Since Kylie had some difficulty getting to the office for this appointment, we agreed she would call in two days after her meeting with the psychiatrist. She failed to make the follow up phone call and only after two calls from the counselor did she return the call.

In this conversation, she indicated that she was considering attending an Intensive Outpatient Program, but had failed to call the Disability Support Services as planned to coordinate some assistance with her classes. Kylie was crying during this phone meeting vs. her flat affect in the initial face-to-face meeting. She stated her depression was still severe and was not sure if the medication was working. She stated her parents were at home, monitoring her in a manner that was uncomfortable. Kylie denied suicide feelings at this time but recognized that she was not in a good place. She did not feel like she wanted to make another face-to-face appointment but preferred to talk on the phone.

Questions to consider:

1. Based on the complexities of this case, is TMH an appropriate mode of treatment for Kylie?

2. What ethical issues arise for this counselor/student relationship?

    a. It is unclear whether the counselor has obtained releases of information for all the providers involved in the case. What ethical issues do you see as a result?

3. How might you address Kylie's noncompliance with the plan to receive services via telephone? Has a TMH professional relationship been established?

4. How responsible is the technical college in assessing the depression/suicide risk for this student? For ensuring Kylie's safety?

5. If you decide Kylie is no longer eligible for services provided by phone, how might you address this with Kylie?

6. Are students at an institution with smaller branches/programs that are implemented at a location geographically distant from a main campus, and that has mental health resources, eligible for TMH services?

7. Are high school students enrolled in advanced courses at community colleges eligible for TMH services? How will parental consent be secured?

8. Does a student have to be engaged in distance education to be eligible for TMH services?

a. If IHEs decide to engage in TMH services, will they consider using this service delivery method to meet with students who are on campus and do not feel comfortable being seen in the counseling center?

b. If the student is sick and contagious, or temporarily injured/immobile and does not want to cancel an appointment, will you use TMH to provide services?

Case of Bobby: A Student with Disabilities and Transitioning Careers Who Wants Services via Email

Vickie Wahler, MS, LPC

Bobby is a 39 year-old student who is returning to school after a career as an architectural engineer. He reported owning a lucrative business until the market crashed. He also reported getting injured on the job two years ago and having multiple back surgeries. Consequently, he is now working with the Division of Vocational Rehab (DVR) for retraining.

Bobby walked into the counseling office to talk with someone, as he was extremely overwhelmed. He reported not sleeping, medical issues, foreclosure on his home, financial issues, being in recovery for Alcohol and Other Drug Addiction (AODA), and poor emotional regulation. Bobby reported he was having trouble managing being a full-time student (as dictated by DVR) as well as all of the other personal barriers in his life. Following that initial meeting, all further correspondence was done via email or occasional phone calls.

Bobby reported he was recently diagnosed with Bipolar Disorder and ADHD but did not have a clear understanding of how to treat these issues. He would typically send emails asking procedural questions or advice on his best course of action for classes etc. He often wrote that he was pleasantly surprised that the counselor would respond quickly and show interest and follow through. He often did voice-to-email, so sometimes the information was not clear and needed clarification. The clinician recommended that the student connect with the Disability Support Services to establish accommodations and assist with academic concerns. Due to his hectic schedule, Bobby was not able to meet face-to-face and utilized email correspondence. On occasion he would share his mental health concerns and when asked for clarification, he would provide clarification and deny the intensity of the mental health concerns.

Questions to consider:

1. Based on the complexities of this case, is email correspondence an appropriate mode of service delivery? Why or why not?

2. What are the ethical and/or legal issues for this counselor-student relationship?

a. What concerns do you have with respect to informed consent and confidentiality? How might you address these with Bobby?

3.   In cases where email correspondence is deemed an appropriate mode of service delivery,

    a.   How do you manage client expectations for timely responses to questions?

    b.   While Bobby may appreciate the timely response from the counselor, how does the counselor discuss that this may not always be the case, such as after-hours, weekends, vacation?

    c.   Would your office have an expectation or policy that establishes a time at which TMH client emails or online requests will be read or answered ? At what point should you inform the client that you choose to use an away message (e.g. informed consent)? See appendix C for sample after-hours automatic office reply.

    d.   How (and at what point) will you convey to Bobby what will and will NOT be discussed over email and the confidentiality limitations of email?

    e.   How do you manage your workload (email and face-to-face clients) in order to provide timely responses to his various questions and concerns?

    f.   What would you do if you happen to be checking your email over the weekend and see an email from Bobby that contains concerning statements about his well-being? Is there any repercussion if you happen to check your work email and don't read his email and there is a crisis?

    g.   How might you assess the effectiveness of email services for Bobby? If you determine his needs are greater than what can be accomplished via email, how will you address this with Bobby?

9.   Will students who are completing a degree/program that is fully online (i.e. will never set foot on campus) be eligible for services?

10. Are International students who are not located in the U.S. and are only taking courses online eligible for TMH services? What are the multicultural competence issues that could arise?

Students temporarily away from campus.
An important question to answer when considering offering TMH services is whether students who are temporarily away from campus (out of state and/or country) are eligible for TMH services. These students could be studying abroad, away at internships or spring breaks. Several scenarios to consider are provided below.

Students who are studying abroad. For students studying abroad who have known mental health concerns, it is important to plan ahead for local and/or distance counseling service options prior to departure. Clinicians should know who their international partners are for supporting students. Typically U.S. embassies in the location of the student can be a helpful source of local information. Additional ethical dilemmas may arise when students in need of services are studying abroad in countries that do not have similar levels of mental health service to the United States. In these scenarios, mental health service providers must engage in an ethical decision-making model to make an intentional decision whether to provide TMH services outside of their state or not. This includes considering whether there would be an ethical issue if you DO NOT provide services to the student studying abroad. See NAFSA: Association of International Educators' (2006) document, *Best Practices in Addressing Mental Health Issues Affecting Education Abroad Participants* for more information.

Case of Gerard: A Student Studying Abroad

Chris Corbett, PsyD

Gerard is a 19-year-old full-time student who elected to take a study abroad experience out of the country. He has been receiving services from the university counseling center and would like to continue these services while studying abroad. He is open to receiving services via phone and video. It is understood that the school does not offer in-person, on-ground services at the study abroad location. Gerard has a history of generalized anxiety and had recently been experiencing symptoms related to panic attacks. He is currently prescribed a medication to assist with the symptoms of panic.

Questions to consider:

1. What factors might the provider need to consider with regards to the student's request?
2. What are the ethical and legal considerations to address, considering the service would be offered outside of the country?
3. With whom might you need to consult prior to deciding whether to offer these services from a distance? (e.g. attorneys, state licensing board, professional ethics board)
4. What plans need to be considered in the case of emergency?
5. How would one handle an increase in symptom severity?
6. What supports can be offered regarding his medication needs?
7. If you agree to see him, what is the process if there is a loss of ability to remotely connect?
8. What are the logistical issues to consider (e.g. time zones, quality of internet connection, security of internet connection, private location for sessions, other)?

Crisis intervention while students are studying away from campus. It may be helpful for IHEs to plan for how to address student needs in the event of a crisis while students are studying abroad and the circumstances under which (if any) it would be appropriate to provide TMH services. Crises can occur on an individual scale or have a large scale community impact.

Case of Karl: Student Needing Assistance When Outside of the U.S.

Micky M. Sharma, Psy.D.

Karl is a 20 year old, White male, undergraduate student studying at a large public institution. Karl is completing an internship in an Asian country, in a small town. He is on the internship with one other student from his university. While the internship was arranged by a faculty member, they are not accompanied by any university faculty or staff. Karl will be on the internship for several more weeks before returning to the U.S. During an outing with others from the local area, their guide for the day suffers a tragic accident and dies. Karl is a witness to the accident and is a 'first responder' who provides aid to the guide. Karl is understandably upset by this tragedy and has contacted the university for assistance.

The university counseling center is contacted by the institution's risk manager and queried as to what services they can provide Karl. The counseling center is informed that no local mental health resources

are present to refer the student to for assistance. Further, the student does not have an international calling plan on his cell phone and wishes to communicate via 'FaceTime' or Skype, as a regular cell call would be cost prohibitive for him.

Questions to consider:

1. What is an appropriate manner to provide assistance to Karl? What ethical considerations are present for the use of either FaceTime or Skype?

2. Who would you consult with, on or off campus, to decide how to provide assistance? Would a consultation with the State Board be of benefit in this situation?

3. What type of service would you provide Karl? Crisis counseling (time limited) or ongoing treatment? How would you decide what service to provide?ection, private location for sessions, other)?

Crises can also occur on a large scale (e.g. in natural disasters or acts of terrorism). For example, if an act of terrorism were to occur in either the location where students are studying or the home community would TMH services be offered to those who are away from campus?

STOP! **Points to Ponder**

In the wake of a large scale terrorist attack in a large international city where students were studying, counselors at a University Counseling Center were expected to be available during specified hours for students in the international city (in a different time zone) to receive an on-line counseling session via Skype. Staff were not provided training in TMH other than to make explicit to the student that the session was not confidential.

Questions to consider:

1. *What are the ethical issues this would raise?*

2. *Should it be the responsibility of practitioners at the home institution to attend to the mental health concerns of those abroad?*

3. *How could the needs of students abroad ethically be addressed in such instances?*

4. *Are there resources associated with the study abroad site that could address student needs?*

5. *What would be the responsibility of the IHE to assist friends and family concerned about the individual studying abroad?*

Though the scenarios above are international examples, similar situations could occur while students are temporarily away from campus domestically.

Students temporarily off-site in the USA. Another category of student to consider are those who are temporarily away from campus, but still in the region and country, for example out on rotations or field experiences. Should students who are temporarily away from campus be eligible for TMH services? Below is a case study that illustrates the challenges of providing services to a student who is doing a field placement a significant distance away from the IHE.

Case of Preetha: A Graduate Student at an Off-Site Rotation
Kimberly Werth, MA, LPC, NCC

Preetha is a second-year student in a Veterinary Medicine program that requires completion of off-site rotations in clinical care throughout the state. While at an off-site location, Preetha suffers the unexpected loss of her cousin. The faculty director of the off-site clinic encounters the student in tears and suggests she connect with the counseling center at the "home" campus, which offers distance counseling to accommodate students in situations such as this. Preetha and the three other students assigned to this rotation share a two bedroom condo. She currently shares a bedroom with the female classmate and common areas with the other male students. The housing has internet access, yet on occasion the access is intermittent. In order for Preetha to utilize the distance counseling offered by the "home" campus, she needs to ask her roommate if she can have the bedroom to herself (compromising confidentiality). Although the clinic to which she is assigned has wireless internet access, the students are not allowed to stay in the building past clinic hours, for liability and safety concerns. The student agrees to connect with a counselor at the "home" campus through the pre-installed software program on her assigned laptop. The software program is HIPAA compliant and has been vetted through Information Technology Campus Services and the university's general counsel.

Preetha has a history of depression in undergrad and used the university counseling center for a couple of months during her sophomore year; although her family is unaware she had this issue or that she sought out campus support services. She has managed fairly well thus far in grad school, yet this recent event triggers an episode of depression and anxiety. Her family lives on the other side of the state from where her clinical rotation is located. They have limited resources, and she only visits with them during holiday and semester breaks. Preetha is struggling to stay focused and has difficulty concentrating. She has not slept well in over two weeks, and she eats whatever she can grab on the go. She stopped "working out" with her roommates after clinic and has declined several other invitations to engage in activities. She spends more time alone and seems to be on her phone a lot. The faculty director notices that she is not performing as well as she should but is unsure what to do to get her "back on track."

Questions to consider:

1. How might the counselor provide and inform the student about privacy and confidentiality?

2. How might the counselor achieve informed consent and get a signature?

3. What are the implications for the grad program if the "home" campus did not have this service available?

4. What type of policies and procedures need to be in place prior to the students leaving the main campus for rotations?

5. What additional/supplemental training or information would be helpful (or needed) for the faculty who are in charge of the clinic and the students' educational experience at these rotation sites?

6. If the student's symptoms continue to decline, how can the counselor confirm the student's safety without compromising confidentiality?

Students away from campus during spring break. Preparations should be made for whether students are eligible for TMH services when they are away from campus for breaks. Below is a case to prompt critical thinking about TMH crisis intervention while a student is on a short break from campus.

Case of Jason: A University Student in Crisis
Elizabeth Grady, LPCS, NCC, DCC

Jason is a 20-year-old degree-seeking student who lives on campus at the University. He is currently home on Spring Break when he has a personal crisis related to his current relationship. Jason is usually an easy going, laid back student who self describes as a person who goes with the flow and takes life as it comes. He began seeing his current counselor because of mounting anxiety around getting school work done and meeting deadlines. Jason is a second year engineering student who typically earns good grades and maintains healthy relationships with both friends and classmates. Jason is responsive to counseling and has done some significant work to learn new ways of coping with stress and anxiety.

After several months of working together on Jason's initial presenting concern of anxiety, the counselor and Jason began to uncover other issues that were contributing to Jason's mounting stress. One of the central issues that Jason shared was his relationship with long-time friend and lover, Joseph. Jason feels that he has found his soulmate in Joseph and dearly misses him while he is away at school. Jason and Joseph agreed to maintain a more casual relationship when Jason went away to school last year. Joseph lives about 4 hours from Jason's home on campus, and the only time they see each other is when Jason is home on break. Joseph is currently attending the local community college and still lives and works in their hometown, which is in the same state as the university Jason attends. The two have maintained a long-distance relationship thus far, and Jason believes that they are both committed to each other and committed to building a life together in the future.

While on Spring break, Jason found out that Joseph has decided to end their relationship and has already begun a new relationship with a mutual friend of theirs from high school. Jason received this revelation at his home just before he was about to meet online with his University counselor to "check in" over Spring break. In fact, Joseph is still at Jason's home, while Jason logs in to meet with his counselor. Jason begs Joseph to stay and go to counseling together. Jason tells Joseph that if he leaves, or if he does not stay for counseling, he will kill himself. When the counselor logs in and starts the session, she is greeted by both Jason and Joseph, who are awaiting her counseling. Jason is visibly shaken, appears tearful and blurts out that Joseph is going to join the session today to work things out.

Questions to consider:

1. Based on the current crisis situation, is distance counseling an appropriate mode of treatment for Jason?

2. What ethical issues arise for this counselor and student relationship?

3. What responsibility does the university counselor have in ensuring Jason's safety?

4. How might the counselor respond to Jason's request to see both he and his partner?

5. Does the university counselor have the legal or ethical right to see non-university students?

6. What steps should the counselor take to ensure Jason's safety and provide remote crisis management?

Barriers to treatment. Ethical concerns can arise when a student's access to technology changes. Below is a case study that illustrates the ethical and practical complexities of economic constraints on students who may be eligible to receive TMH services.

Case of Tabitha: A University Student with Barriers to Treatment
Elizabeth Grady, LPCS, NCC, DCC

Tabitha is 22 years old, a full-time student in an online master's degree program, and lives alone in a town two hours away from her university. Tabitha is currently studying counselor education and has shown tremendous growth in her professional development in the last year, according to her advisor. Tabitha desires to become a school counselor some day soon and is working hard to achieve her goal. Tabitha is a bright, engaging person who naturally adopts counseling skills. She has the tendency to make others feel comfortable and relaxed. People often say she is the best person to talk to when feeling upset.

Due to Tabitha's full-time course load, full-time job as a case manager at the local county human services department, and her desire to help others in need, Tabitha rarely has time to rest and rejuvenate. After bursting into tears in her advisor's office one day while discussing a class assignment that she received a "D" on, Tabitha opened up and reported that she was feeling like a fraud. She told her advisor that she has never even been in counseling and that she didn't think she had what it takes to be a counselor. She reported that on the inside she is extremely nervous and can't concentrate. Tabitha's advisor asks her to seek counseling for her mounting stress and nervousness and encourages her to keep trying. Tabitha's advisor recognizes her feelings and reassures her that her feelings are common for counseling students. Tabitha complies and seeks out the University counseling center the next day.

After the initial intake, Tabitha and the counselor decide that Tabitha is a good fit for the new online counseling services offered to distance education students. Tabitha happily agrees to see her counselor online weekly. After a few sessions, Tabitha reports that she is having some financial difficulties and can no longer afford her high speed internet services. Downgrading her internet service means Tabitha is no longer able to log in to see her counselor as planned. Tabitha really wants to continue to see her counselor but cannot afford the 2-hour drive, each way, to see her counselor in person. Tabitha tells her counselor that she has a free app on her smart phone called Skype. Tabitha asks if she can use Skype to meet with her counselor one last time, just for closure. Tabitha reassures her University counselor that even though they both know the app is not private and confidential, she is willing to use it anyway to have one last closing session.

Questions to consider:

1. Based on the current situation, what should Tabitha's counselor do next?

2. What ethical issues arise for this counselor and student relationship?

3. What responsibility does the University counselor have regarding continuity of care and appropriate referral?

4. How might the counselor respond to Tabitha's request to use Skype just this one time?

5. What is the responsibility of the university counseling center when a technological barrier comes up that no longer allows distance counseling to take place?

Institutional Resources

In this section we consider system-wide institutional concerns and resources. IHE stakeholders and decision makers should take a holistic view of the necessary resources to implement TMH services. This includes reviewing not only the need for clinicians, but equipment, technology infrastructure, and interdisciplinary collaborations to ensure compliance with the latest guidelines for practice. IHEs should weigh the risks, benefits, and additional costs for the institution, as well as the clinicians, in order to make an informed decision.

CLINICIANS

Campus counseling services generally operate with a wait list and are often understaffed. When considering the implementation of TMH services, stakeholders should ask themselves the following questions:

1. What is the goal of implementing TMH on campus (e.g. increased student access, increased clinical capacity, etc.)?

2. How can we effectively utilize TMH modalities to increase clinical capacity? For example, online psychoeducational resources, self-help resources, and the like, versus therapy.

3. If we offer TMH services, is this in addition to existing campus resources or a shift in service delivery methods?

4. Implementation of TMH services has the potential to increase the amount of time needed to provide services to students (i.e. length of time to respond to emails or phone calls, maintaining technology and testing it prior to sessions, etc.) If the counseling center is already operating with a wait list and providing TMH services is intended to be a method of increasing access to services to students and the counseling center, then

   a. will additional mental health providers be needed to accommodate the anticipated increase in students accessing services through TMH?

   b. are there enough credentialed clinicians with TMH expertise in the area to provide these services?

   c. is there a way to ethically, legally, and competently implement services that will increase the ability to serve students in a timely manner?

   d. will we contract with a third party vendor to provide these services? Why or why not?

5. How can TMH be effectively utilized to reach distance learners who may be underserved by current service options?

6. Do clinicians on campus have the training and skills necessary to provide TMH services? If the answer is no,

   a. Will the institution need to invest in clinician training on TMH best practices so that they can provide effective and ethical services?

   b. What will it cost to invest in their training?

7. Will the institution have to purchase additional liability insurance for clinicians so that they can provide effective and ethical TMH services? What is the cost of additional insurance?

RISK MANAGEMENT

Legal counsel should be consulted to review whether any additional risks or liabilities are assumed by engaging in TMH. If additional risks or liabilities exist, how can they be managed?

FUNDING

When considering implementing TMH services, IHEs must consider the cost of delivering such services and how campus mental health services are funded. Institutions should assess whether implementing TMH services will necessitate changes in the ways counseling and psychological services on campus are funded.

Technology

Providers of TMH must understand the technology they are using, its vulnerabilities, and stay abreast of current changes in technology. Approach TMH services with the same level of data security as you would with electronic medical records. Communication tools should be encrypted on both ends of the connection point. Providing TMH services that meet current security standards may require a review of the existing hardware, software, technology infrastructure (e.g. internet speeds and security, etc.) and security practices on campus. This should occur in collaboration with campus IT experts.[3] The following questions may be helpful in assessing the technology needs for TMH services:

1. Is the institution able to provide the technology infrastructure and security to implement and maintain TMH services?
2. What will be the additional costs to the institution (e.g. technology infrastructure, devices, software, training of IT and counseling staff)?
3. Will additional personnel be required to manage the technology aspects of TMH services?

As IHEs consider the feasibility of implementing TMH services, several categories of questions with respect to technology must be addressed. It may be useful to ask your technology consultants "what haven't I asked you that I should be concerned about?"

COMMUNICATIONS TECHNOLOGY

1. What forms of technology will be implemented for counselor to client interactions (email, telephone, video conferencing, text-messaging)?
2. How will they be secured?
3. Who will have access to the data?

4. Who is responsible for the maintenance of the technology?
   a. How often will it be maintained and what will it cost?
5. Who will monitor the HIPAA and HITECH compliance?

DATA COLLECTION TECHNOLOGY

1. What types of information will be collected as part of the client record?
2. Where will this information be stored?
3. If therapists are using apps to supplement therapy, where is the information from those applications stored? Is it secure?

TECHNICAL SUPPORT

1. Who will train counseling center staff to use technology?
2. Who is responsible for troubleshooting technical problems that occur during treatment?
3. What are the IT professional's qualifications for maintaining confidentiality and how will clients be informed of their role during informed consent?

> **STOP!** **Points to Ponder**
>
> *Can your institution meet industry best practices regarding HIPAA, FERPA, and HITECH requirements for offering services?*

---

3   *The authors of this guide are not content experts in the field of technology.*

Practical Considerations

Prior to offering TMH services, there are several practical and logistical aspects to consider as well as assessment of the infrastructure needed to provide services that meet legal and ethical best practices. This may require developing specific policies and procedures related to TMH services. This will involve considering several additional questions.

ADMINISTRATIVE LOGISTICS

Issues related to insurance, fees, and billing practices will need to be addressed through formal policies and procedures.

1. How do campus counseling services currently do billing? Who does the billing? Will changes to this process be required?

2. Will the fees for TMH services be the same or different than for face-to-face counseling services?

3. Do health insurance policies offered through the IHE pay for TMH services provided by the UCC?

4. Are you currently a HIPAA and HITECH covered entity? (yes or no)

   a. Will adding TMH services change your HIPAA and HITECH covered entity status?

   b. If you become a HIPAA and HITECH covered entity what procedures must be implemented to comply with these laws/policies?
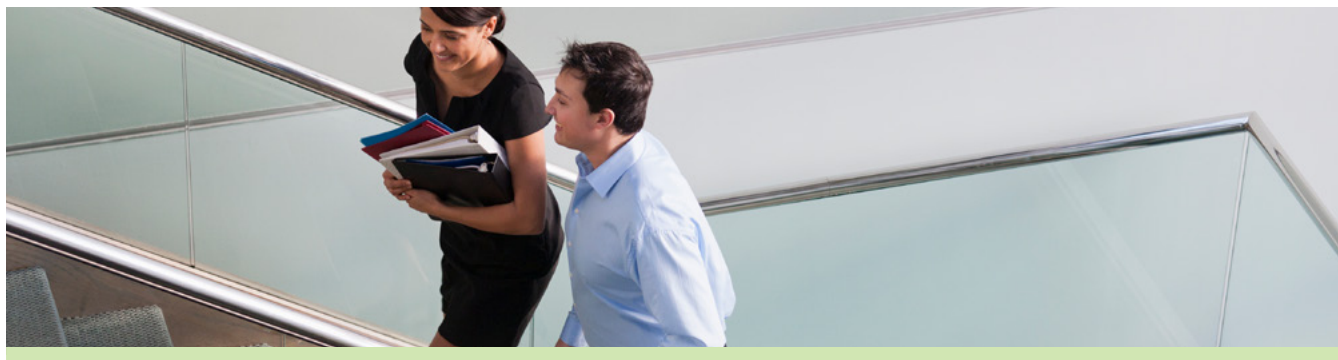
TMH practice requires clinicians to attend to details that are not necessary in face-to-face treatment, such as office space on campus, time zones and office hours, and staging the office environment. The following is not intended to serve as a "how to," but rather is shared to illustrate the required attention to detail and complexity of preparing to provide TMH services.

LOCATION OF SERVICE PROVIDER

Will clinicians be required to be on campus when they provide TMH services? If yes, where will they be located? If TMH providers are able to work remotely (e.g. from home or in the car on a mobile device), what additional data security measures must be in place for these alternate locations?

PARAMETERS ON SERVICES PROVIDED

The IHE should develop clear parameters on the level of care offered via TMH and procedures to follow when a client's need exceeds these parameters. Similarly, expectations for how to reach the clinician and their hours of operation should be in place and clearly communicated to clients. For example, what is the appropriate method for contacting the therapist during non-business hours and for non-emergencies? Policies should be in place to determine the types of services delivered through TMH and whether it will be time-limited. For example, will assessments and/or comprehensive treatment be offered? Should TMH be used to administer mandated evaluations required for students returning to campus when there has been a break in education for mental health related issues?

Activity:

Make a list of the pros and cons of administering mandated evaluations from a distance.

PRO	CON
....	....
....	....
....	....
....	....
....	....
....	....
....	....
....	....
....	....
....	....

Clear criteria for student eligibility for services should be outlined ahead of time. **When answering these questions, consider your responses to the above section on student eligibility for TMH services.**

HOURS OF OPERATION

The hours of operation for TMH services should be carefully considered. IHEs should consider whether services will be available outside of the UCCs formal business operation hours. If the goal is to increase access to specific populations, can this be done during normal business hours? If it is decided that practitioners will operate outside of the already established hours, careful consideration about staff compensation should be made. Similarly, IHEs should consider ahead of time how staff hours and responsibilities will be impacted if their caseload requires scheduling with students in different time zones or on weekends?

STAGING THE OFFICE ENVIRONMENT

The service provider and the client must be educated about how to prepare their respective counseling spaces to establish a clear view of the client's nonverbal cues (e.g proper lighting, gaze angle), good sound quality and have comfortable seating (ATA, 2009; Shore, 2013). For example, providers and clients should avoid sitting in a position with a light source behind them (e.g. a window or a lamp over the shoulder) or it will cast a shadow over their face. Both providers and clients should wear pale and solid colored clothing because it requires less bandwidth for data transmission. Privacy features such as video and audio muting, and the ability to easily change from public to private audio mode should be available to both the clinician and client. Controls that can ameliorate the video clarity (e.g. brightness and contrast) as well as microphone and speaker volume controls should be available to both the practitioner and client in order to reduce interruptions from technology (ATA, 2009). The ATA provides more suggestions in their document, *Evidence-Based Practice for Telemental Health* (2009).

NEXT STEPS

If it is determined that the IHE wishes to implement TMH services, then it is time to develop an interdisciplinary committee of stakeholders to develop the policies and procedures, consult

with IT and Legal Counsel and create a plan for implementation. This group should be careful to include all relevant stakeholders in the planning stages.

Third Party Providers of Telemental Health Services

There is a growing industry of third party providers of TMH services with which Institutions can contract for services. Reviewing these products is beyond the scope of this guide. However, it is recommended that IHEs considering contracts with these TMH vendors ensure that the service provider can answer the relevant questions raised in this guide (e.g. ethical practice, credentials, scope of practice, fee structure, confidentiality, HIPAA and HITECH compliance, etc.) and then conduct a careful cost-benefit analysis.

A Final Word of Caution

TMH is a service delivery method that is rapidly growing and changing. The body of research on this topic continues to grow as do the technologies through which services can be delivered. Prior to engaging in TMH, practitioners should consult the latest research, guidelines, and ethical codes of their particular discipline(s). State and Federal laws and regulations related to this category of service provision should also be reviewed on a regular basis. Practitioners involved in or considering TMH should avail themselves of continuing education offerings on this topic.

Resources[4]

HEMHA MEMBER ORGANIZATION RESOURCES

Of the member organizations of HEMHA, several home organizations also have produced resources specific to the use of telemental health:

American Academy of Child & Adolescent Psychiatry: Telehealth Guidelines and Policies https://www.aacap.org/AACAP/Clinical_Practice_Center/Business_of_Practice/Telepsychiatry/Telehealth_Guide_and_Pol.aspx

American Psychiatric Association: Telepsychiatry Toolkit https://www.psychiatry.org/psychiatrists/practice/telepsychiatry/telepsychiatry-toolkit-home

American Psychological Association. (2013). *Guidelines for the practice of telepsychology.* Washington, DC: Author. http://www.apapracticecentral.org/ce/guidelines/telepsychology-guidelines.pdf

American Psychological Association: Telepsychology 50-State Review (2013) http://www.apapracticecentral.org/advocacy/state/telehealth-slides.pdf

The Association of State and Provincial Psychology Boards: *Interjurisdictional Compact (PSYPACT).* http://www.asppb.net/?page=PSYPACT

OTHER RESOURCES

American Telemedicine Association: http://thesource.americantelemed.org/home (A variety of resources. Some are open access, and others require membership. Click on specific resources for more information.)

American Telemedicine Association: State Telemedicine Gaps Analysis: Coverage & Reimbursement

https://higherlogicdownload.s3.amazonaws.com/AMERICANTELEMED/3c09839a-fffd-46f7-916c-692c11d78933/UploadedImages/Policy/State%20Policy%20Resource%20Center/2017%20NEW_50%20State%20Telehealth%20Gaps%20%20Analysis-%20Coverage%20and%20Reimbursement_FINAL.pdf

American Telemedicine Association: State Telemedicine Gaps Analysis: Physician Practice: Standards & Licensure

https://higherlogicdownload.s3.amazonaws.com/AMERICANTELEMED/3c09839a-fffd-46f7-916c-692c11d78933/UploadedImages/Policy/State%20Policy%20Resource%20Center/Physici-%202016_50-state-telehealth-gaps-analysis-md-physician-practices-licensure.pdf

American Telemedicine Association: State Telemedicine Gaps Analysis: Psychologists Clinical Practice: Standards & Licensure

https://higherlogicdownload.s3.amazonaws.com/AMERICANTELEMED/3c09839a-fffd-46f7-916c-692c11d78933/UploadedImages/Policy/State%20Policy%20Resource%20Center/Psychol%20-%2050-state-telehealth-gaps-analysis-pysch-pgl_final.pdf

Barnett, J.E., & Kolmes, K. (2017, June 1). *Avoiding a disconnect with telemental health.* Retrieved from http://psyciq.apa.org/avoiding-disconnect-telemental-health/

Considerations for the Provision of E-therapy http://store.samhsa.gov/shin/content/SMA09-4450/SMA09-4450.pdf

Journal of Telemedicine and Telecare: http://journals.sagepub.com/home/jtt

---

4   NOTE: *There are commercial TMH products available which are popular and well-regarded. Because HEMHA does not endorse products, they have not been listed here.*

Luxton, D.D., Nelson, E., & Maheu, M.M. (2016). *A practitioner's guide to telemental health: How to conduct legal, ethical, and evidence-based telepractice.* Washington, DC: American Psychological Association.

National Telehealth Policy Resource Center: http://www.cchpca.org/national-telehealth-policy-resource-center

SAMHSA: Assessment Tools for Organizations Integrating Primary Care and Behavioral Health http://www.integration.samhsa.gov/operations-administration/assessment-tools

SAMHSA: Telebehavioral Health Training and Technical Assistance http://www.integration.samhsa.gov/operations-administration/telebehavioral-health

Substance Abuse and Mental Health Services Administration. (2015). *A treatment improvement protocol: Using technology-based therapeutic tools in behavioral health services.* Rockville, MD: U.S. Department of Health and Human Services. https://store.samhsa.gov/product/TIP-60-Using-Technology-Based-Therapeutic-Tools-in-Behavioral-Health-Services/SMA15-4924

Telebehavioral Health Standards, Guidelines, Best Practices & Other Statements** https://telehealth.org/ethical-statements/

Telehealth Resource Centers: http://www.telehealthresourcecenter.org/

Telemedicine and e-Health Journal: http://www.liebertpub.com/TMJ

Telemedicine Laws and Developments: A State-by-State Analysis http://www.beckershospitalreview.com/healthcare-information-technology/telemedicine-laws-and-developments-a-state-by-state-analysis.html

References

Aboujaoude, E., Salame, W., & Naim, L. (2015). Telemental health: A status update. *World Psychiatry, 14*(2), 223-230. doi: 10.1002/wps.20218

American Mental Health Counselors Association. (2015). *AMHCA code of ethics.* Alexandria, VA: Author.

American Telemedicine Association. (2009). *Evidence-based practice for telemental health.* Washington, DC: Author.

American Telemedicine Association. (2013). *Examples of research outcomes: Telemedicine's impact on healthcare cost and quality.* Washington, DC: Author.

Barnett, J. E., & Kolmes, K. (2016). The practice of tele-mental health: Ethical, legal, and clinical issues for practitioners. *Practice Innovations, 1*(1), 53-66. http://dx.doi.org/10.1037/pri0000014

Botella, C., Gallego, M.J., Garcia-Palacios, A., Baños, R.M., Quero, S., & Alcaniz, M. (2009). The acceptability of an Internet-based self-help treatment for fear of public speaking. *British Journal of Guidance & Counselling, 37*(3), 297-311. doi: 10.1080/03069880902957023

Bureau of Health Workforce, Health Resources and Services Administration (HRSA), U.S. Department of Health & Human Services (September 30, 2017). *Designated health professional shortage areas statistics fourth quarter of fiscal year 2017.* Retrieved from: https://ersrs.hrsa.gov/ReportServer?/HGDW_Reports/BCD_HPSA/BCD_HPSA_SCR50_Qtr_Smry_HTML&rc:Toolbar=false

Christie, L. (2016). *E-Therapy: Ethics & best practices* [PDF document]. Retrieved from https://www.pdresources.org

C|Net (May, 2017). *WannaCry ransomware: Everything you need to know.* Retrieved from: https://www.cnet.com/news/wannacry-wannacrypt-uiwix-ransomware-everything-you-need-to-know/

Committee on National Security Systems. (2010). *National information assurance (IA) glossary* (CNSS Instruction No. 4009). Washington, DC: U.S. Government Printing Office.

Crowe, T. V. (2017). Is telemental health services a viable alternative to traditional psychotherapy for deaf individuals? *Community Mental Health Journal, 53,* 154-162. https://doi.org/10.1007/s10597-016-0025-3

CSO, (October, 2017). *Petya ransomware and NotPetya malware: What you need to know now.* Retrieved from: https://www.csoonline.com/article/3233210/ransomware/petya-ransomware-and-notpetya-malware-what-you-need-to-know-now.html

Dart, E.H., Whipple, H.M., Pasqua, J.L., & Furlow, C.M. (2016). Legal, regulatory, and ethical issues in telehealth technology. In J.K. Luiselli & A.J. Fischer (Eds.), *Computer-assisted and web-based innovations in psychology, special education, and health* (pp. 339-363). Boston, MA: Academic Press.

Family Educational Rights and Privacy Act Regulations, 34 CFR § 99 (2009).

Gilmore, A.K., Davis, M.T., Grubaugh, A., Resnick, A., Birks, A., Denier, C., ... Acierno, R. (2016). "Do you expect me to receive PTSD care in a setting where most of the other patients remind me of the perpetrator?": Home-based telemedicine to address barriers to care unique to military sexual trauma and veterans affairs hospitals. *Contemporary Clinical Trials, 48,* 59-64. doi: http://dx.doi.org/10.1016/j.cct.2016.03.004

Godleski,L., Darkins, A., Peters, J. (2012) Outcomes of 98,609 U.S. Department of Veterans Affairs patients enrolled in telemental health services, 2006–2010. *Psychiatric Services, 63*(4), 383-385. doi: http://dx.doi.org/10.1176/appi.ps.201100206

Kramer, G.M., Kinn, J.T., & Mishkind, M.C. (2015). Legal, regulatory, and risk management issues in the use of technology to deliver mental health care. *Cognitive and Behavioral Practice, 22*(3), 258-268. doi: 10.1016/j.cbpra.2014.04.008

Luxton, D. D., O'Brien, K., McCann, R. A., & Mishkind, M. C. (2012). Home-based telemental healthcare safety planning: What you need to know. *Telemedicine and e-Health, 18*(8), 629-633. doi: 10.1089/tmj.2012.0004

Luxton, D.D., Pruitt, L.D., & Osenbach, J.E. (2014). Best practices for remote psychological assessment via telehealth technologies. *Professional Psychology: Research and Practice, 45*(1), 27-35. doi: 10.1037/a0034547

McKay, D., Przeworski, A., & O'Neill, S. (2016). Emerging technologies for clinical practice. In J.K. Luiselli & A.J. Fischer (Eds.), *Computer-assisted and web-based innovations in psychology, special education, and health* (pp. 365-378). New York, NY: Academic Press.

NAFSA: Association of International Educators. (2006). *Best practices in addressing mental health issues affecting education abroad participants.* Washington, DC: Author.

Neimark, G. (2009). Boundary violation. *Journal of the American Academy of Psychiatry and the Law, 37*(1) 95-97.

Palomares, R. S., Bufka, L. F., & Baker, D. C. (2016). Critical concerns when incorporating telepractice in outpatient settings and private practice. *Journal of Child and Adolescent Psychopharmacology, 26*(3), 252-259. doi: 10.1089/cap.2015.0013

Pruitt, L.D., Luxton, D.D., & Shore, P. (2014). Additional clinical benefits of home-based telemental health treatments. *Professional Psychology: Research and Practice, 45*(5), 340-346. doi: 10.1037/a0035461

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

Reinhardt, R. (2013, October 28). *Providing telehealth services - opportunities and cautions.* Retrieved from https://tameyourpractice.com/blog/providing-telehealth-services-opportunities-and-cautions

Shealy, K.M., Davidson, T. M., Jones, A. M., Lopez, C. M., & de Arellano, M. A. (2015). Delivering an evidence-based mental health treatment to underserved populations using telemedicine: The case of a trauma-affected adolescent in a rural setting. *Cognitive and Behavioral Practice, 22*(3), 331-344. doi: 10.1016/j.cbpra.2014.04.007

Shore, J.H. (2012, October 1). *Shore interview.* Retrieved from https://www.youtube.com/watch?v=zWBJD-j9owv0&feature=youtu.be

Shore, J. H. (2013). Telepsychiatry: Videoconferencing in the delivery of psychiatric care. *American Journal of Psychiatry, 170*(3), 256-262. doi: 10.1176/appi.ajp.2012.12081064

Simpson, S., Guerrini, L., & Rochford, S. (2015). Telepsychology in a university psychology clinic setting: A pilot project. *Australian Psychologist, 50*(4), 285-291. doi: 10.1111/ap.12131

Suler, J. (2004). The online disinhibition effect. *CyberPsychology & Behavior, 7*(3), 321-326. doi:10.1089/1094931041291295.

3Lions Publishing. (2009). *HITECH Act summary.* Retrieved from http://www.hipaasurvivalguide.com/hitech-act-summary.php

Truscott, D., & Crook, K.H. (2004). *Ethics for the practice of psychology in Canada.* Edmonton, AB: University of Alberta Press.

Turvey, C., Coleman, M., Dennison, O., Drude, K., Goldenson, M., Hirsch, P., … Bernard, J. (2013). ATA practice guidelines for video-based online mental health services. *Telemedicine and E-Health, 19*(9), 722-730. doi: http://dx.doi.org/10.1089/tmj.2013.9989

Yellowlees, P., Shore, J., & Roberts, L. (2010). Practice guidelines for videoconferencing-based telemental health. *Telemedicine and E-Health, 16*(10), 1074-1089. doi: 10.1089/tmj.2010.0148

Zuckerman, E. (2016, January 20). *Online backup is the best option.* Retrieved from /http://nationalpsychologist.com/2016/01/online-backup-is-the-best-option/103157.html

Sample Informed Consent for Telehealth Services

[5]KUMC Counseling & Educational Support Services

TeleHealth Informed Consent Form

I_____(name of client) hereby consent to engaging in telehealth with a psychological counselor at KUMC Counseling & Educational Support Services (CESS). I understand that "telehealth" includes the practice of education, goal setting, accountability, referral to resources, problem solving, skills training, and help with decision making. Telehealth psychotherapy may include psychological health care delivery, diagnosis, consultation, and psychotherapeutic treatment. Telehealth psychotherapy will occur primarily through interactive audio, video, telephone, email, instant messaging, and/or other data communications.

I understand that I have the following rights with respect to telehealth:

(1) I have the right to withhold or withdraw consent at any time. If consent is withheld or withdrawn, KUMC students and residents may meet with the psychological provider onsite at the KC campus or may request a referral to a local mental health provider.

(2) I must complete an onsite, in-person screening by a CESS psychological counselor before participating in telehealth. The CESS counselor will inform you if a referral for telehealth services is appropriate. Receiving telehealth services may be contraindicated with:

- Recent suicide attempt(s), psychiatric hospitalization, or psychotic processing (last 3 years)

- Moderate to severe major depression or bipolar disorder symptoms

- Moderate to severe alcohol or drug abuse

- Severe eating disorders

- Repeated "acute" crises (e.g., occurring once a month or more frequently)

 (3) For a KUMC student or resident to receive telehealth services, she/he must be physically located in a state where the telehealth provider is licensed (i.e., Kansas). Telehealth service may not be provided in international jurisdictions.

(4) The laws that protect the confidentiality of my personal information also apply to telehealth. As such, I understand that the information disclosed by me during the course of my sessions is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including, but not limited to reporting child, elder, and dependent adult abuse; expressed threats of violence towards an ascertainable victim; expressed threat to harm or kill self; and where I make my mental or emotional state an issue

---

5   *This form has been shared with permission by Larry Long, Jr., Licensed Psychologist, Senior Director, Counseling & Educational Support Services, University of Kansas Medical Center*

in a legal proceeding. I also understand that the dissemination of any personally identifiable images or information from the telehealth interaction to other entities shall not occur without my written consent.

(5) I understand that there are risks and consequences from telehealth, including, but not limited to, the possibility, despite reasonable efforts on the part of the psychological counselor, that: the transmission of my personal information could be disrupted or distorted by technical failures; the transmission of my personal information could be interrupted by unauthorized persons; and/or the electronic storage of my personal information could be accessed by unauthorized persons.

In addition, I understand that telehealth based services and care may not be as complete as face-to-face services. I also understand that if my psychological counselor believes I would be better served by another form of intervention (e.g. face-to-face services) I will be referred to a mental health professional who can provide such services in my area.

Finally, I understand that there are potential risks and benefits associated with any form of counseling, and that despite my efforts and the efforts of my psychological counselor, my condition may not improve, and in some cases may even get worse.

(6) I understand that I may benefit from telehealth psychological counseling, but that results cannot be guaranteed or assured.

(7) I understand that I have a right to access my personal information and copies of case records in accordance with Federal and Kansas law. I have read and understand the information provided above. I have discussed it with my psychological counselor, and all of my questions have been answered to my satisfaction.

(8)   By electronically signing this document I agree that certain situations including emergencies and crises are inappropriate for audio/video/computer based psychological counseling services.

- If I am in crisis or in an emergency I should immediately call 9-1-1 or seek help from a hospital or crisis oriented health care facility in my immediate area. I understand that emergency situations include if I have thought about hurting or killing either another person or myself, if I have hallucinations, if I am in a life threatening or emergency situation of any kind, having uncontrollable emotional reactions, or if I am dysfunctional due to abusing alcohol or drugs.

- I acknowledge I have been told that if I feel suicidal, I am to call 9-1-1 or the National Suicide Hotline Toll-Free Number at 1-800-784-2433 or other local suicide hotlines.

Signature of client _____ Date _____

Printed name of client _____

Appendix B

Online Parent Group –The Savannah College of Art and Design

Tamara Knapp-Grosz, Ph.D.
Senior Director, University of North Texas Counseling and Testing
Former Director, Savannah College of Art and Design-Savannah Campus (2000-2015)

Taffey Cunnien, Ed.D, LPC
Assistant Dean of Students | Director, Disability Services, Georgia Institute of Technology
Former Director, Savannah College of Art and Design – Atlanta Campus (2008-2016)

In 2009, the Savannah College of Art and Design Counseling Center began offering an online parent group. Participants were parents of new freshman who attended Jumpstart, a college transition program for students with disabilities. The group was a collaboration between the Atlanta and Savannah locations of the university. We created and co-facilitated the group. We developed the group in response to the numerous phone calls we received each week from parents, most of which were similar in content and concerns. Our intended outcome was to provide a supportive online environment for parents that could influence the successful transition of our students with disabilities to college. We also hoped that the group would decrease the number of weekly parent calls we each received. This case study highlights some of the lessons learned and successes of our first attempt at an online group.

In 2009, the concept of online counseling was still new. There were few regulations or standards for us to go to for information. We both completed our Distance Credentialed Counselor Certification to help us plan and anticipate any potential problems. Based upon our DCC training, we developed the group, not as a therapy group, but as a venue for parents to receive information, ask questions about university policies and procedures, and gain

knowledge about typical transition issues and solutions seen when students with disabilities begin college. The group was marketed to parents of students who attended the Jump Start College Transition Program and handouts describing the group were provided during the program orientation.

Having two counselors co-facilitating the group from two locations was beneficial for a number of practical reasons. First, if one of us had any technical issues in one location (sound or connection issues), the other counselor could get the group started while the other counselor was free to troubleshoot. If you are planning on a large group, we think this would be particularly useful as technical issues can increase with the size of your group. Second, since the group format was designed as a workshop/presentation with parent participation, rather than a traditional therapy group, two counselors were helpful to keep the group lively and move things along during periods of silence.

We did not utilize an informed consent since the online parent group was not designed as a therapy group. However, we reviewed the purpose of the group each week, as well as, crisis on call support if parents had an emergent concerns after hours concerning their student. Parents also received this

information as part of the Jump Start Program. We verified that parents went through the Jumpstart program prior to participating in the group. A group rule discussed every session was that parents were not to refer to their student by name to protect their student's confidentiality. We also made sure to remind them that we could not speak specifically about student situations; however, we could speak more generally. If we were to initiate this same group today, we would develop a workshop informed consent that would highlight confidentiality, limitations of the workshop format etc.

Surprisingly to us, most of the parents that participated in our group had little experience with technology had either never used a webcam before or participated in a webinar or an online chat. A technology orientation became an essential component to our workshop so parents would know how to use their microphones and chat function. Although the webcam option was available for parents, it was interestingly rarely used by parents who preferred to use the microphone or chat function only. We were always on webcams unless one of us was having some technology problems and then we would revert to microphone or chat format. Once parents were oriented to the use of this technology, many expressed the added benefit of now being able to chat and/or skype with their student for the first time!

The content of our weekly group varied and was in response to parent's questions and concerns. A good knowledge of the University and its programs and policies was essential as much of parental anxiety revolved around issues such as the Withdrawal or Add/Drop policy or what were the airport transportation options available at the Holiday break. We would be looking some of these answers up as the other handled other parental concerns. Other weekly topics included things like "managing the empty nest" and preparing for your college students return during the holiday break.

Although we are sure some counselors in college counseling would argue that an online group like this should probably be handled by someone in student life rather than in the counseling office we would argue that counseling services is actually an ideal office to provide this service. We noticed that once parents knew they had a place to have their questions answered the number of calls to our counselors did in fact decrease. In addition, counselors had a place to refer the anxious parents of the students they served. Our students reported that their contact with their parents was more positive.

Even more exciting, we got to hear about the positive changes in the parents lives. Many of these parents had spent years advocating for their children leaving little personal time for themselves. The parent group became a place to normalize the grief associated with letting a child become more independent and move forward into adulthood while at the same time celebrating this transition as a time for parents to begin a new chapter in their own lives. Parents shared stories of finally having the time to take a trip they had always wanted to take or begin a new hobby.

In closing, we would encourage college counselors to explore how an online platform might be utilized to provide parental support during a student's transition to college. While clearly not therapy-we found the addition of this group to be therapeutic for parents, students and for our staff.

Appendix C:
Sample Out of Office Replies

After Hours Out of Office Reply

Note: This work email account is not checked or monitored after business hours (M-F 8am-5pm) or on the weekends and university holidays.

If it is after business hours or on the weekend/holiday and this is an emergency please contact your housing staff member or 9-1-1 for assistance.

During Business Hours Out of Office Reply

I am involved in training today (away from desk) from 8:00am-5:00pm and will not be able to monitor/reply to email in a timely manner. I would expect not to able to read/respond until after 8:00am on MM/DD/YY. If this an urgent matter that needs Immediate attention during the center's business hours (8am-5pm) please call xxx-xxx-xxxx for assistance.

Note: This work email account is not checked or monitored after business hours (M-F 8am-5pm) or on the weekends and university holidays.

If it is after business hours or on the weekend/holiday and this is an emergency please contact your housing staff member or 9-1-1 for assistance.

HEMHA

HIGHER EDUCATION MENTAL HEALTH ALLIANCE