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Legal and Ethical Issues in Telepsychology: A Handbook for Psychologists

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LOMA LINDA UNIVERSITY
School of Behavioral Health
in conjunction with the
Department of Psychology

Legal and Ethical Issues in Telepsychology: A Handbook
for Psychologists

by

Dexter Chia

A Project submitted in partial satisfaction of
the requirements for the degree
Doctor of Psychology

September 2022


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Each person whose signature appears below certifies that this project in his/her opinion is adequate, in scope and quality, as a project for the degree Doctor of Psychology.



Janet L. Sonne, Adjunct Professor of Psychology



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ABSTRACT OF THE DOCTORAL PROJECT

Legal and Ethical Issues in Telepsychology: A Handbook for Psychologists

by

Dexter Chia

Doctor of Psychology, Graduate Program in Psychology
Loma Linda University, September 2022
Dr. Janet Sonne, Chairperson

This doctoral project sought to examine the various aspects of the modality of telepsychology in a handbook that can be referenced by licensed psychologists.

Telepsychology's growth in the general psychology community has caused greater attention towards its unique legal and ethical considerations when working with clients.

We analyze legal and ethical issues inherent to the domains of licensure, clinical practice liability coverage, billing/payment, competence, client welfare, consent, confidentiality, and boundary navigation. After this analysis, we introduce a series of scenarios for readers to apply the discussed considerations to exercise critical thinking.

CHAPTER ONE

INTRODUCTION

As a relatively new aspect to the practice of psychology, there are number of things about telehealth, and by extension, telepsychology, that are not clearly defined. Such topics should be acknowledged and examined so a psychologist can be aware of what can come with the application of modern technology to professional practice. Lack of proper preparation can cause unnecessary stress to a practitioner as well as potential confusion or harm to a client. Being informed is the first step in embracing any new form of practice, and telehealth methods are no different.

The intent of this doctoral project is to present an informational handbook for California psychologists to help guide the development of their telepsychology services in their professional practices. Although telepsychology services can encompass numerous practice aspects, this handbook will focus on the ethical and legal issues inherent in the application of technology to the provision of synchronous psychotherapy intervention services to adult patients.

Brief Historical Overview of Telehealth

Historically, telehealth services were first offered in the practice of medicine. The interest in and provision of medical health intervention by telecommunication has increased dramatically over the last decade (Boydell, Hodgins, Pignatiello, Teshima, Edwards, & Willis, 2014; Campbell, Millan, & Martin, 2018; Mathias, Dodd, Walters, Yoo, Erik, & Huttenlocher, 2010; Ringel, Mishna, & Sanders, 2017). For example, REACH Health sampled 436 medical professionals in a 2017 survey regarding the

prominence of telecommunication in their clinical practices. Sixty-three percent of acute care medical professionals and 30% of primary care clinics reported active employment of telecommunication in providing care to their patients (REACH Health 2017). And in a survey conducted by the American Telemedicine Association (ATA) 88% of 171 respondents in executive leadership positions in various healthcare settings planned to invest in telehealth technology. Ninety-eight percent of this sample believed that offering telehealth in their respective practices gave them a competitive advantage over practices that did not (APA 2017).

One reason for the apparent increase in the use of telehealth medical practices is the demand for services for underserved populations for whom service accessibility is limited. Clinical populations such as war veterans and those living in rural areas are just two examples of demographics whose unique accommodation needs are aided by telecommunication methods. Recent reports suggest that the use of telehealth practices can indeed extend the reach of health care provides beyond in-person contact. In 2015, the Department of Veterans Affairs reported delivery of 2.1 million telehealth consultations to more than 677,000 veterans via videoconferencing, home telehealth, and store-and-forward telehealth to improve overall health, cost of care, and patient experience (Elliot, 2016). And, in Waycross, Georgia, the South East Health District conducted a qualitative, longitudinal case study from 1988-2008 to determine if adoption of telehealth was sustainable in a rural setting. The institution was able to maintain the innovation in their community through careful internal management and active interaction with members of the social system (Singh, Mathiassen, Stachura, & Astapova, 2010).

Another reason for the expansion of telehealth medical practices has been the rapid development of various means and devices for service administration through technology. A recent review of telehealth services indicated that the main methods are video, telephone-based, web-based, and telemetry/remote-monitoring (Chi & Demiris, 2015). In the span of time since the survey, telecommunication systems have grown to better integrate users' own devices, employing mobile phones and tablets along with cloud-based services (Alverson, Krupinski, Erps, Rowe, & Weinsten, 2019).

And finally, it appears from early research findings that telehealth medical practices produce some positive results. The ATA study cited above found that patient responses to the application of technology in treatment has largely been positive (ATA 2017b). Further, Kruse and his colleagues performed a systematic review of medical telehealth and patient satisfaction, with the majority of the selected research literature demonstrating high ratings of patient satisfaction based on a variety of factors (Kruse, Krowski, Rodriguez, Tran, Vela, & Brooks, 2017). It is recommended however, that these results be interpreted with caution as the basis for evaluation of the effectiveness of telehealth methods since the outcome measure was patient satisfaction. This topic will be expanded on in a later section.

CHAPTER TWO

TELEPSYCHOLOGY

Telepsychology is a unique form of telehealth service. Much like the emergence of telehealth medical interventions, telepsychology practice has also increased in the last two decades. In a 2008 survey of American Psychological Association members (N = 1226), 87.3% of polled clinical psychologists stated that they used telepsychology (defined as the provision of health services to patients/clients by a health professional, where the parties are physically separated) in their practices.

Despite the surge of interest and activity among psychologists, the emerging practice of telepsychology remains complex and, thus, often off-putting to professionals. As Campbell and colleagues note, “Psychologists have received the development of telepsychology as they have other new...aspects of practice—with interest, skepticism, curiosity, dread, appreciation, reluctance, enthusiasm, anxiety, and other reactions that span the emotional range” (Campbell, Millan, & Martin, 2018, p. 4). This off-putting complexity comes in several forms.

Definition

Some of the complexity comes from a general lack of clear definitions of clinical psychological practices using technology. Terms such as “telecommunication,” “telecare,” “telemedicine,” “telehealth,” “telemental health,” and “telepsychology” are often used interchangeably or without specificity. Some confusion likely stems from the fact that the domain of technology-based medical services was not initially clearly and consistently defined. Soods and his associates identified no less than 104 publications,

spanning from the 1970s to the 2000s, which differently define the concept of “telemedicine” in terms of medical, technological, spatial, and beneficial perspectives (Sood, Mbarika, Jugoo, Dookhy, Doarn, Prakash, & Merrell, 2007). More recently, the ATA associated telehealth with telemedicine within the context of telecare. Their definition of telecare acknowledged exceptions to the domain of healthcare which: “...encompass a broader definition of remote health care that does not always involve clinical services” (ATA 2007). In comparison, Canada’s National Initiative for Telehealth (NIFTE) used the term “telehealth” to include all types of telecare and telemedicine services (NIFTE 2003). These examples of definitions demonstrate not only the confusion of terms, but an ongoing tendency to leave out aspects of psychological intervention in patient care. This is not a unique situation, as the healthcare industry has only recently begun to integrate psychological services in traditional clinical settings (Brown et al., 2002).

The American Psychological Association (APA) has now defined the more specific term of “telepsychology” as “the provision of psychological services using telecommunication technologies” (Joint Task Force for the Development of Telepsychology Guidelines for Psychologists, 2013, p. 792). The APA purposefully took a broad approach to their proposed definition to avoid the potential of changing the scope or definition of a psychologist’s practice. Throughout this handbook we will use the term “telepsychology” as defined by the APA to achieve two goals: avoid the confusion of using superfluous terminology and normalize the usage of a singular term.

Services

Telepsychology complexity issues can occur from the various (and ever-expanding) types of and means with which psychological services can be delivered through telecommunication. In a systematic review of telehealth services focused on caregiver outcomes, Chi and Demiris (2015) identified several categories of services delivered via technology: education, consultation, psychosocial/cognitive behavioral therapy, social support, and data collection and monitoring. The means with which these various services can be delivered now range from the telephone to far more advanced computer technologies, including emails, internet chat rooms, videoconferences, emails, and phone calls to enable communication (Jacobsen & Kohout, 2010).

Using these media resources, a clinician can provide services through one of the three primary modalities: synchronous, asynchronous, and remote patient monitoring. Synchronous services involve real-time interaction between patient and provider, allowing for immediate intervention; however, they also require the professional to dedicate time, money, and attention to the case at hand. Asynchronous services, also known as “store-and-forward” services, generally rely on evaluation of received clinical data for consultation or diagnosis to be rendered at a future time. The last type of service is remote patient monitoring, which involves the continual tracking of a patient’s health care data once they have left a care facility (Yang 2016). Each modality has their own strengths and weaknesses, but research conducted on the financial implications of telehealthcare has projected clinicians and health entities will be able to save millions of dollars regardless of chosen modality (Pan, Cusack, Hook, Vincent, Kaelber, Bates, & Middleton 2008).

Effectiveness

While the research base for the positive effects of in-person psychotherapy interventions has existed for about 50 years, research findings regarding the effectiveness of telepsychology intervention services is still in its infancy and has several limitations. Chief among these limitations is that the existing empirical studies lack generalizability across the various domains of diagnoses and populations (Richardson, Frueh, Grubaugh, Egede, & Elhai 2009). While traditional in-person psychotherapy intervention studies can partially control the setting for therapy administration, telecommunication removes this ability and comes with its own subset of variables. In a study conducted by Nelson and his associates (2006), a randomized trial of cognitive behavioral therapy (CBT) was conducted with children diagnosed with depression and their parents. The intervention was conducted either face-to-face or through the usage of televideoconference, with both styles of CBT provision achieving similar remission rates of depressive symptoms. However, these results come with some caveats. The sample size of 28 children for this study was too small to generalize to a population and the specific advantages and disadvantages of each method was not clearly established.

The comparable effectiveness of in-person psychotherapy and telepsychology for adult patients was examined in a review of Post-Traumatic Stress Disorder treatment by Bolton and Dorstyn (2015). While telepsychology modalities, such as internet and videoconferencing, demonstrated short-term cognitive and behavioral symptom reduction, the comparative effectiveness versus traditional in-person psychotherapy (e.g., face-to-face) could not be determined. Due to limitations of follow-up data in the 1 to 6 months after treatment cessation, ongoing rates of gains and deterioration also could not

be accurately identified. Reese and colleagues (2016) asked the question: does telepsychology achieve the required therapeutic alliance for change when compared to in-person therapy? Study participants who received psychotherapy either in-person, through videoconference, or on the telephone reported similar scores on measure of therapeutic alliance and empathy.

Perhaps some of the limitations to telepsychology effectiveness is related to clinician perception of the medium. Clinicians report issues such as difficulty developing rapport over video, difficulty balancing a traditional practice schedule with a telepsychology schedule, and a lack of preparation for telepsychology services as obstacles to utilizing telepsychology (Martin-Khan et al., 2015; Lambert et al., 2016; Lerman & Quashie, 2016).

Another limitation is that a large portion of telepsychology intervention studies to date focus on patient and provider satisfaction (Kruse et. al, 2017; Sansom-Daly, Wakefield, McGill, Wilson, Patterson, 2016; Seelman & Hartman, 2009; Reese, Conoley, & Brossart, 2002) as the outcome indicator of the effectiveness of telepsychology. While assessment of satisfaction is valuable in providing evidence of a strong practitioner-client relationship (Rees & Stone, 2005), caution should be applied when considering satisfaction measures as indication of treatment effectiveness. Instead it is recommended that other domains, such as symptom-specific outcomes (e.g. symptom reduction, general functioning) be measured, to better assess the effectiveness of an intervention delivered through technology (Myers, Valentine, & Melzer, 2008). Fortunately, it appears the professional community at large is beginning to move more intentionally to the empirical study of the overall effectiveness and efficacy of telepsychology services. In 2017 the

National Quality Forum (NQF) met to address the discrepancies of telepsychology research and to determine a standard method of measuring efficacy. The committee identified six key areas of assessment: travel, timeliness of care, actionable information, added value of telehealth in providing evidence-based practice, patient empowerment, and care coordination. From these chosen domains a total of 16 measures were chosen by the committee to be implemented in pilot studies. (National Quality Forum 2017).

Since the conference, new literature has begun to cite NQF's proposed criteria to help with the analysis of effectiveness (Mullen-Fortino, Rising, Duckworth, Gwynn, Sites, & Hollander, 2019; Powell, Stone, & Hollander, 2018; Rising, Ward, Goldwater, Bhagianadh, & Hollander, 2018). However, studies employing the framework as the basis for their research have yet to emerge. In the coming years it will be imperative for investigators to commit to a uniform framework to be able to accurately detect the degree to which intervention services delivered through technology are effective, with whom, and in what context.

While the research literature for effectiveness and efficacy of telepsychology services within the United States may be limited, the literature for worldwide telepsychology practice is virtually nonexistent. The international community at large has acknowledged the potential of telepsychology but are acutely aware of the barriers to access behavioral health care that might be inherent to low- middle-, and high-income countries (World Health Organization [WHO], 2016). However, these barriers have not prevented the proposal of international setting frameworks. Bischoff and associates (2017) propose five integral components when working on an international basis: (1) community stakeholder involvement; (2) expansion of the community's capacity to

develop local resources; (3) plans of intervention that include both conventional and unconventional strategies; (4) delivery interventions in unconventional settings; and (5) usage of family-centered practices.

International telepsychology also helps to serve the needs of communities experiencing humanitarian crises. Given the stress of countries beset by natural disasters, warfare, epidemics, or famine, the mental health needs are significant but often overlooked (Ventevogel, van Ommeren, Schilperoord, & Saxena, 2015). As telepsychology becomes more integrated into international settings, there will be an increasing need to regulate and evaluate its services. In addition to examining efficacy and effectiveness, a clinician providing telepsychology in an international context needs to be familiar with symptom manifestation and the connection to culture, background, language, body language, and social cues (Crowe, 2018). These additional factors in international telepsychology will require further research to develop adapted evidence-based practices for the various locations outside of the United States.

CHAPTER THREE

HANDBOOK PURPOSE

Although the technologies are advancing, and the advancement of empirical evidence regarding the effectiveness is promising, there are additional concerns that arise for practitioners considering practice expansion to include telepsychology services. Much of the practitioner ambivalence regarding telepsychology likely arises from ethical and legal concerns unique to this type of practice, the standards for which are just emerging and/or rapidly evolving. The primary goal of this handbook is to raise awareness of the ethical and legal issues inherent to the complex practice of synchronous telepsychology interventions with adults and present potential ways in which they might be addressed to reduce risk to clients and practitioners.

This handbook first examines the legal and ethical considerations unique to the practice of telepsychology by California-licensed psychologists. We analyze legal and ethical issues inherent to the domains of licensure, practice liability coverage, billing/payment, competence, client welfare, consent, confidentiality, and boundary navigation. Second, we introduce a series of scenarios with the intention of applying the legal and ethical considerations listed above to a specific clinical situation in hopes of further informing practitioners. These two key components of the handbook are written with the intention to assist readers in achieving two primary objectives: First, we hope to increase practitioners' familiarity and compliance with relevant ethical and professional standards of care at the onset and during the provision telepsychology service; and with state-specific laws and regulations when providing telepsychology services across jurisdictional and international borders (APA, 2013). Second, we hope to facilitate

continued critical thinking for clinicians regarding the practice of telepsychology in California. As it continues to grow as an intervention, telepsychology's presence in the field will likely introduce situations that practitioners have not previously encountered. As is the case with any new form of practice, keeping up with its innovations and standards will be its own challenge.

CHAPTER FOUR
LEGAL AND ETHICAL ISSUES IN THE PRACTICE OF TELEPSYCHOLOGY
FOR CALIFORNIA PSYCHOLOGISTS

Given the relative newness of telepsychology interventions, statewide (and eventually nationwide) standardization of its provision is ongoing. The indirect nature of the interventions further complicates how to best regulate services. With the ability to conduct clinical work across the span of many miles, questions of ethical and legal standard of care for intervention practice now must include considerations of different regional laws and regulations. How might a therapist effectively provide these innovative services while simultaneously ensuring the safety of a client? The standards of care call on psychologists to use reasonable judgment expected of competent psychologists to determine the appropriateness and safety of telepsychology services for each client who is offered services (Clough & Casey, 2015). There are numerous issues to be considered and decisions made in developing an ethical and legal telepsychology practice.

The standards for legal and ethical practice of telepsychology in California cited in this handbook come from several sources. Legal standards are presented in the federal HIPAA laws and in California law, including those statutes specifically relevant to the practice of clinical psychology. California's Board of Psychology publishes a yearly edition of laws and regulations that address a variety of subjects including state standards specifically for telehealth practice such as consent, practice construction, and restrictions (California Board of Psychology, 2019).

California law does not specifically distinguish telepsychology as a unique entity of telehealth; the law requires telehealth practitioners to follow all state laws relevant to

the traditional practice of psychotherapy (BPC Section 686). Per the California Business and Professions Code (BPC 2290.5) telehealth is “the mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient’s health care while the patient is at the originating site and health care provider is at a distant site. The originating site is defined...as ‘a site where a patient is located at the time health care services are provided via a telecommunications system or where the asynchronous store and forward service originates (BPC 2290.5(a)(4), p. 68).”

As a note, compliance with California laws and regulations is relatively more straightforward for the psychologist’s use of telepsychology practice for clients residing in California than for clients living out-of-state. Interstate practice requires knowledge of how individual state statutes and policies interact with one another. While California statutes do not prohibit provision of services to a client in another jurisdiction, it is legally mandated that a professional rendering out-of-state services be permitted to do so by the client’s residential state’s governing (licensing) agency (BPC 2912). Various resources have already been developed to identify and compile state differences in laws and regulations (e.g., APA 2013).

Ethical standards for the practice of telepsychology referred to in this handbook are defined in the current APA Ethical Principles and Code of Conduct (2017), as well as in the *APA Guidelines for the Practice of Telepsychology* (APA, 2013). Ethical implications of telepsychology have been a topic of interest for numerous researchers. For example, Fiene, Stark, Kreiner, & Walker (2019) conducted a study that used the *APA’s Guidelines for the Practice of Telepsychology* to create a 38-item checklist of

practices that fulfill the guidelines. They employed the checklist to evaluate the extent that online service providers' websites meet the proposed standards. On average the 55 websites assessed only met 39% of the checklist criteria. In another study, Sansom-Daly, Wakefield, McGill, & Patterson (2015) conducted a study evaluating the ethical and clinical challenges involved in providing cognitive-behavioral therapy using videoconferencing technology with adolescents and young adults with cancer. They found that the biggest challenges that arose involved mental health risk without in-person contact, difficulty facilitating group discussion about cancer-related experiences, appropriate health change response, and mindfulness of the "survivorship" experience. Understandably, an intervention style that removes many aspects of the interpersonal benefits of psychotherapy is rich with potential legal and ethical quandaries. We have identified several domains of legal and ethical issues in the practice of telepsychology in California below.

Licensure

Generally, the professional licensing requirements are tied to the client's and the professional's physical location when the telepsychology services are provided (Swenson, Smothermon, Rosenblad & Chalmers, 2016). As of January 2020, there is yet to be a specialized license required to conduct telepsychology in the state of California. Rather, the practitioner must have an active license awarded by the California Board of Psychology to conduct a telepsychology therapy intervention in the state of California. A psychologist licensed under the Board of Psychology is considered a health care provider subject to their provisions of telemedicine, barring drug prescription, surgery, or

administration of electroconvulsive therapy (BPC 2904 & 2904.5; cited in the California Board of Psychology, 2019). Those with an active license are required to follow the state's legal and ethical standards when engaging in telepsychology.

The California Board of Psychology also provides licensure exception to unlicensed employees of accredited or approved academic institutions, public schools, or government agencies in order to obtain the necessary qualifying experience to obtain licensure. Any unlicensed trainee must be supervised by a licensed psychologist or psychiatrist. However, this policy deems the employee is not to exceed a total of five years without obtaining a license (BPC 2910b). Proper consent should state that they are being supervised by a licensed clinician in order to meet the legal and ethical standards for therapeutic service.

As mentioned above, the Business Professions Code views telehealth as providing treatment across an originating site and a distant site. These sites may encompass various areas in California but can also include areas outside the state of California. Currently no state prohibits the provision of telepsychology services (Swenson et al., 2016), but each state addresses telepsychology differently.

In-State Clients

As California does not require a specialized license to provide telepsychology, the laws and regulations related to the general practice of psychotherapy apply to California-licensed telepsychology practitioners who serve clients within the state. In California, those statutes include the practitioner's adherence to the current APA "Ethical Principles of Psychologist and Code of Conduct" (BPC 2936). Legally speaking, there are no

additional criteria for providing telepsychology.

For out-of-state licensed professionals who have not acquired licensure in California, there are regulations that allow for the provision of short-term treatment for up to 30 days to a California-based client (BPC 2912). Those in the process of obtaining a California license are allowed up to 180 days (BPC 2946).

Out-of-State Clients

Not only should a California-licensed clinician be aware of their state's regulations and laws that govern telepsychology therapy practice, they should be aware of interstate laws. When therapy services are provided by a psychologist licensed in California to out-of-state clients, the therapist becomes subject to the other states' licensing or certification regulations. As state requirements for licensure differ, it is increasingly likely that aspects of one state's license does not meet criteria for another state. Many states lack cooperative licensure reciprocity (Lustgarten, 2017). Some states have remedied this by providing temporary certification for out-of-state practitioners to provide services within their state. However, this too, has become a complex interaction of varying standards regarding time allowances for the rendering of services and service type.

In an attempt to streamline interstate psychotherapy, the Association of State and Provincial Psychology Boards (ASPPB) has sought to moderate the legally regulated provision of telepsychology practice at a national level. This effort resulted in the organization of the Psychology Interjurisdictional Compact (PSYPACT) which is a psychology interjurisdictional compact that intends to create some uniformity in interstate

practice for its participating states. Professionals within the states that have adopted PSYPACT are able to apply for certificates issued by the ASPPB (known as an “E.Passport”) that authorize them to practice therapy in the selected states (PSYPACT, 2016). The purpose behind the E. Passport are two-fold: to promote standardization in the criteria of interjurisdictional telepsychology practice and to enhance consistent regulation of interjurisdictional telepsychology practice (Cooper, Campbell, & Barnwell, 2019).

As of April 23, 2019, PSYPACT became officially operational after the state of Georgia became the eighth state to adopt their regulations. Since then, four additional U.S. states have officially joined the compact with an additional thirteen states awaiting legislation (ASPBB, 2019). The rise in participating states is promising, however the current limited number of member states continues to restrict certain psychologists. Until there is a national license, the ability to use telepsychology will remain constrained for those whose routine work is interjurisdictional or cross-national (Cooper & Neal, 2015).

At present, California is not yet a participating state in PSYPACT; as such, California practitioners must be aware of other state-specific licensure or certification regulations. Despite not yet being part of this organization, it is recommended California telepsychology practitioners follow its development to see how collaborative interstate regulation unfolds in the United States. Our recommendation is to use the PSYPACT website created by the ASPPB at www.asppb.net that provides professionals updates regarding states’ adoption of PSYPACT as well as resources regarding telepsychology practice.

State Differences for the Provision of Telepsychology Therapy Services to Out-of-State Clients

The following table is intended to be resource for California psychologists to reference for state-specific laws regarding telepsychology. Each state's telepsychology statutes or regulations (if existing), temporary/guest practice provision and statute citations, and PSYPACT involvement will be noted to assist the California licensed psychologist who is considering provision of synchronous (real-time; live, in-person) telepsychology therapy services to out-of-state clients. This table integrates information from an array of sources that provided more specific details on the chosen domains. Those sources are available for further information (e.g., APA, 2013; ASPBB, 2019).

Table 1. Telepsychology State Regulations (as of January 22, 2020).

State	Telepsychology Statutes/Regulations	Temporary License/ Guest Practice	Guest Practice Citation	PSYPACT Member
Alabama	No	Yes; up to 30 days	Code of Alabama 34.26.41	No
Alaska	No	Yes; up to 30 days in 12-month period	Alaska Admin. Code 60.035	No
Arizona	Yes; Arizona Revised Statutes 36-3601	Yes; up to 20 days in a 12-month period	ARS 20-1057.13	Yes
Arkansas	No	No	n/a	No
California	Yes; Cal. Business & Prof. Code 2290.5	Yes; up to a 30-day period	Cal. Business & Prof. Code 2912	No
Colorado	No	Yes; up to 20 days per year	Colorado Revised Statutes 12-43-215	Yes
Connecticut	No	No	n/a	No

Table 1. (continued)

	Yes – includes telephone, email, internet-based communication, and videoconferencing			
Delaware	Del. Code 24-3500	Yes; up to 6 days	Del. Code 3510	Yes
District of Columbia	No	Yes; licensed pros in adjoining states	D.C. Code 3-1205.02	Pending
Florida	No	Yes; no more than 5 days per month, no more than 15 days per year	Fla. Stat 490.014	No
Georgia	Yes; Georgia Code (O.C.G.A.) 33-24-56.4	Yes; up to 30 days per year.	OCGA 43-39-7	Yes
Hawaii	No	Yes; up to 90 days per year. Must petition with board	Hawaii Revised Statutes 465-9	Pending
Idaho	Yes; Idaho Code 54-2305	Yes; up to 30 days per year with IPC	Idaho Admin Code 24.01.300	No
Illinois	No	Yes; up to 10 days per year	Illinois Compiled Statutes 225	Yes

Table 1. (continued)

Indiana	No	Yes; up to 30 days per 2 years	Burns Ind. Code Annotate 25-33-1-4.5	Pending
Iowa	No	Yes; up to 10 sequential days or 15 days in 90-day period	Iowa Code 1548.3	No
Kansas	No	Yes; up to 15 days per year, can request additional 15 days	Kansas Statutes (K.S.A.) 74-5316a	No
Kentucky	Yes – as telehealth; must obtain consent Kentucky Admin Regulations 26:310	Yes; up to 30 days per 2 years	Kentucky Revised Statutes 304.17A	Pending
Louisiana	No	No; limited to physicians	Louisiana Revised Statutes 37.2365	No
Maine	No	Yes; as a consultant up to 10 days per year	Maine Revised Statute 3812	No
Maryland	No	Yes; duration is dependent on Board	Md. Health Code 18-301	No

Table 1. (continued)

Massachusetts	No	Yes; up to 1 year if registered with Board	Annotated Laws of MA: General Laws	No
Michigan	No	No; but adjoining states have limited abilities	Michigan Compiled Laws 333.16171	No
Minnesota	No	Yes; up to 7 days per year, additional days require Board review	Minn. Statutes 148.916	No
Mississippi	No	Yes; up to 30 days per year	Miss. Code Annotated 73-31-14	No
Missouri	No	Yes; up to 10 sequential days in 90-day period or 15 days in 9-month period	Missouri Revised Statutes 337.045	Yes
Montana	No	Yes; up to 60 days as consult per year	Montana Code Annotated 37-17-104	No
Nebraska	No	Yes; up to 30 days per year	Revised Statutes of Nebraska 38-3119	Yes
Nevada	No	Yes; up to 30 days per year	Nevada Revised Statutes 641.410	Yes

Table 1. (continued)

New Hampshire	Yes – licensed persons must follow standards for telehealth Revised Statutes Annotated 329; 541		Yes; up to 30 days per year	Revised Statutes Annotated 329	Yes
New Jersey	No		Yes; up to 10 sequential days or 15 days in 90-day period	NJ Statutes 45:14	No
New Mexico	No		Yes; up to 6 months	NM Statutes Annotated 61-9-10.1	No
New York	No		Yes; up to 10 sequential days or 15 days in 90-day period	NY Con. Laws Services 7605	No
North Carolina	No		Yes; up to 5 days per year	NC General Statutes 90-270.4	Pending
North Dakota	No		Yes; up to 30 days per year	ND Century Code 43-32-30	No
Ohio	Yes – must be licensed or under licensed individual Ohio Admin Code 4732-3-01		Yes; up to 30 days per year	Ohio Admin Code 4732.22	Pending

Table 1. (continued)

Oklahoma	Yes – as telemedicine; must obtain consent	Yes; up to 5 days per year	OK Statutes 1353	Yes
Oregon	No	Yes; up to 30 days per year	Oregon Revised Statutes 675.063	No
Pennsylvania	No	Yes; up to 6 months (with 6-month extension)	63 PA Statutes 1203	Pending
Rhode Island	No	Yes; up to 10 days per year (no more than 5 sequential days)	RI Gen. Laws 5-44-23	Pending
South Carolina	No	Yes; up to 60 days per year	SC Code Annotated 40-55-50	No
South Dakota	No	Yes; up to 20 days per year	SD Codified Laws 40-55-110	No
Tennessee	No	Yes; up to 12 days per year for specific services	Tenn. Code Annotated 63-11-211	No
Texas	Yes – as telehealth via advanced telecommunications Tex. Insurance Code 1455.001; Tex. Occupation Code 111.001, 106.001	Yes; up to 30 days per Board	Texas. Occupation Code 501.263	Yes

Table 1. (continued)

Utah	No	Yes, but more of a transitional role	Utah Code Annotated 58-61-307	Yes
Vermont	Yes – as “telepractice” and is overseen by board VT Statutes Annotated 3018	Yes; up to 10 days or 80hrs per year	VT Admin Code 04-030-270	No
Virginia	No	Yes; must be consult, education, or pro bono	VA Code Annotated 54.1.3601	Pending
Washington	No	Yes; up to 90 days per year	Revised Code of Wash. 18.83.082	Pending
West Virginia	No	Yes; up to 10 days per year	W. VA. Code 30-21-3	Pending
Wisconsin	No	Yes; up to 60 days per year	Wisc. Statutes 455.03	No
Wyoming	No	Yes; up to 30 days per year	Wyo. Statute 33-27-117	No

International Clients

Similar to interstate telepsychology, providing services to a client residing outside of the U.S. requires a California-licensed practitioner to meet the standards of the participating country or province. A newfound challenge that might arise for international service provision is that not every country regulates psychological practice. As interstate telepsychology practice already requires careful navigation of state-specific regulations, considerations at a country-level for those that do regulate the practice of psychology brings obstacles such as differing government standards, cultural views regarding mental health, and language barriers. Further, the threat that illegally practicing without a license or certification in some countries may carry significant punishments (including criminal and/or civil sanctions) may trigger practitioners' reluctance to engage in international telepsychotherapy (Maheu, Drude, & Wright, 2017).

Malpractice/Liability Insurance Coverage

Considering the practitioner's malpractice (liability) insurance coverage for telepsychology services can bring about different scenarios when compared to traditional psychotherapy. What is the procedure if a client files a grievance regarding telepsychology services provided through your practice? Or what happens if an out-of-state client harms themselves or someone else after a telepsychology therapy session? Prior to providing telepsychology it is important to have knowledge of how a malpractice or liability insurance carrier addresses the unique components inherent in providing treatment through a remote device. However, many malpractice insurance companies have yet to offer guidelines specifically addressing liability insurance for telepsychology

(Kramer & Luxton, 2016). In addition, there is a severe lack of empirical data that analyzes the extent and adequacy of coverage for telepsychology practice.

Understandably, the precise factors that constitute sufficient coverage is largely dependent on issues of logistics that are beyond the scope of this handbook.

The best method of navigating this component of telepsychology is to consult and collaborate. Deborah Baker, J.D., current Director of Legal & Regulatory Policy in the Office of Legal and Regulatory Affairs of the American Psychological Association's Practice Directorate, has recommended that the practitioner “contact the malpractice carrier to confirm telehealth services – both interstate and across jurisdictional lines – are covered...They are likely to be covered for in-state practice but not necessarily for interjurisdictional practice.” (DeAngelis, 2012, p. 52). Her opinion is reflected by an array of unofficial recommendations in the professional literature that broadly tell psychologists to ask their insurance carriers directly about telepsychology policies. As an added precaution, it is recommended that a written confirmation be obtained from the insurance carrier to protect the provider after consulting about service coverage (Koocher & Morray, 2000).

Payment/Reimbursement

The two primary methods of payment for telepsychology services are through Medicare/Medicaid and private pay options. Medicare and Medicaid are two U.S. government-sponsored medical insurance programs that help with medical costs for people with limited income or resources. Medicare is federally funded and provides health insurance for those aged 65 or older as well as people on disability status.

Medicaid is partially state-funded and provides health insurance to individuals largely based on low income (Centers for Medicare & Medicaid Services 2019). It is important to note at the outset of this section, that not all states include psychologists as “healthcare providers” eligible for reimbursement under these insurance programs. For example, California does not exclude psychologists as an eligible site practitioner but does have its own unique limitations on reimbursements. California’s version of Medicaid, Medi-Cal, reimburses both live video and store-and-forward modalities as long as the service meets three requirements: (1) be a service Medi-Cal reimburses in general; (2) the service meets the general definition and components of the used CPT or HCPCS code; and (3) all confidentiality laws of health care information and patients’ rights to their medical information are met. The distant site provider dictates whether it is appropriate to employ telehealth based on his or her knowledge and experience (California Telehealth Resource Center, 2019b).

These two government-sponsored insurance programs can assist in the payment of certain psychotherapy services depending on related state designations. Medicare Part B covers certain telehealth services, generally having the involved party pay 20% of the Medicare-approved amount with the addition of a deductible (Medicare, 2019). Medicare employs either current procedure terminology (CPT) or healthcare common procedural coding system (HCPC) to bill for services (Lambert et al., 2016). As a federally regulated institution, Medicare standards are strict about how telehealth is provided. For example, a Medicare beneficiary must receive services at an approved “originating site,” which is a term to describe a location considered appropriate by the government to receive telehealth. The specific distinctions for a site to be approved can range from the county

level (i.e., a rural area that has limited access to behavioral health) to the accommodations of the building used for the service provision (i.e. a hospital or a renal dialysis facility). For the most part, Medicare policies favor locations that are equipped to provide professional healthcare although there are rare occasions that they have approved other services for patients with certain diagnoses (Center for Medicare & Medicaid Services, 2019b).

Medicaid assistance policies vary from state to state and can have certain stipulations such as the type of service being provided to limitations to what facility can conduct the session (Center for Connected Health Policy, 2019). Many U.S. states provide Medicaid reimbursement for live video services, but do not specifically identify mental health as a billable service. Instead, practitioners must bill synchronous telepsychology sessions as a regular in-office service. Medicaid has also enabled 26 states to have facility and transmission fees be paid to the originating sites (Lambert et al., 2016).

Private payment involves reimbursement from private insurance companies to a practitioner without direct interaction at a federal level. Each insurance carrier has individualized policies regarding healthcare. Some policies directly address telehealth or telepsychology, while others do not. State regulation of telepsychology private payers hinges primarily on their definition of telehealth and its related health plan requirements. Certain states do acknowledge the concept of mental health parity, which is the idea that an insurance plan's mental health coverage should equal the allocated physical health coverage.

For California practitioners rendering telepsychology therapy services to clients

within California, the California legislature has identified telehealth as a legitimate form of healthcare that does not require in-person interactions. No healthcare service plan can require in-person contact to be made between provider and client prior to the payment of the covered service. No healthcare service plan shall limit the type of setting where services are provided to the patient or provider (HSC 1374.13).

Of note is that a California assembly bill that was signed in October 2019 (and to be enacted in 2021) makes several amendments to the Health and Safety Code. One key change is that health plans and providers can continue to negotiate reimbursement rates under their participation agreement; however, the rate must be the same rate of a specified service whether provided in-person or through telehealth (HSC 1374.14; 2019). California restricts the ability of healthcare insurance carriers to develop independent reimbursement rates for telepsychological services, thereby lessening the likelihood that a potential provider or client will face obstacles to this care option.

Psychologists considering offering telepsychology intervention services should be aware that there is not uniform coverage across health insurance plans, including Medicare and MediCal/Medicaid. Some states and some private payers may have higher reimbursement rates than other. As such then, insurance reimbursement from federal, state, and private payers do not cover the full cost of telepsychology services (including not only the time of the provider but the technology involved).

It is beyond the scope of this handbook to identify the Medicaid and private payer policies for each state; however, a table that lists whether policies exist in each state is presented below. The data is based on reports by the National Telehealth Policy Resource Center (Center for Connected Health Policy, 2019) and the Telemedicine policies from

the U.S. medical boards (Federation of State Medical Boards, 2019).

Table 2. U.S. State Reimbursement Policies

State	Medicaid Reimbursement			Private Payer
	Live Video	Store-and-Forward	Patient Monitoring	
AL	x		x	
AK	x	x	x	
AZ	x	x	x	x
AR	x			x
CA	x	x		x
CO	x		x	x
DE	x			x
DC	x			x
FL	x			x
GA	x	x		x
HI	x			x
ID	x			
IL	x		x	x
IN	x		x	x
IA	x			x
KS	x		x	x
KY	x			x
LA	x		x	x
ME	x		x	x
MD	x	x	x	x
MA	x			x
MI	x			x
MN	x	x	x	x

Table 2. (continued)

MS	x		x	x
MO	x		x	x
MT	x			x
NE	x		x	x
NV	x	x		x
NH	x			x
NJ	x			x
NM	x	x		x
NY	x	x	x	x
NC	x			
ND	x			x
OH	x			x
OK	x			x
OR	x		x	x
PA	x			
RI	x			x
SC	x		x	
SD	x			x
TN	x	x		x
TX	x	x	x	x
UT	x		x	x
VT	x	x	x	x
VA	x	x	x	x
WA	x	x	x	x
WV	x			
WI	x			
WY	x			

Competence

Like any psychological practice, psychotherapy via telepsychology requires proper competence to skillfully enact. Noting the broader ethical and legal standards of competence for traditional psychotherapy in California (e.g., BPC 101.6; BPC 2960 [p]; APA 2017, Standard 2), this handbook will examine specific competencies needed for telepsychology practice. In the general sense, the core competencies of any practicing psychologist remain the same but require the additional competency of using technology to enact psychotherapy. The Business & Professions Code is explicit in this aspect as their standards for telehealth “shall not be construed to alter the scope of practice... or authorize the delivery of health services...not otherwise authorized by law” (BPC 2290.5e)

In 2013, the APA Joint Task Force for the Development of Telepsychology Guidelines for Psychologists proposed eight key guidelines in achieving an effective telepsychology practice (APA, 2013). These guidelines encapsulate an array of ethical duties that each psychologist should strive for in his or her practice and serve as a basis for several the sections in this handbook. While it would be an overgeneralization to group these guidelines as “competencies,” the aspirational nature of these recommendations can be interpreted as goals for a would-be telepsychologist to achieve. Since these guidelines pertain specifically to the provision of psychotherapy, we reference these proposed standards throughout the handbook, but for further explanation of each domain it is recommended the original document be reviewed, for details such as rationale and application.

Competency is directly addressed in guideline #1: “Psychologists who provide the

telepsychology services strive to take reasonable steps to ensure their competence with both the technologies used and the potential impact of the technologies on clients/patients, supervisees, or other professionals” (APA, 2013, p. 793). In extending practice into telepsychology it is critical to maintain a standard of competence equivalent to that for traditional psychotherapy. The effectiveness of a psychologist who is clinically competent in treatment interventions, relational skills, and other elements of psychotherapy might not transfer to telepractice without further training or consultation (Campbell et al., 2019). Having the insight to make necessary adaptations to an existing skillset can be key to fully utilizing one’s experience in providing psychotherapy. Telepsychology is rarely an intervention in itself.

Guideline #8 for Telepsychology Guidelines for Psychologists can be argued that it pertains to competency as well. “Psychologists are encouraged to be familiar with and comply with all relevant laws and regulations when providing telepsychology services to clients/patients across jurisdictional and international borders” (APA, 2013, p. 799). Similar to the Code of Ethics, considerations in psychotherapy must also account for applicable laws and psychology board regulations. Familiarity with the laws of other states or communities requires a continually evolving knowledge of regulatory developments. A telepsychology professional should know state-specific regulations for privacy, confidentiality, data protection/integrity and security (Maheu et al., 2018).

The considerations of telepsychology competencies have also evolved to include interdisciplinary practices. In 2014, the Coalition for Technology in Behavioral Science (CTiBS) organized their own telebehavioral health (TBH) task force that consisted of addiction specialists, behavioral analysts, counselors, marriage and family therapists,

psychologists, psychiatric nurses, psychiatrists and social workers. Their intention was to collaborate on key universal competencies that would be required over these eight distinct yet overlapping orientations. They surmised that seven competency domains must be addressed by every telehealth professional: (1) clinical evaluation and care; (2) virtual environment and telepresence; (3) technology; (4) legal and regulatory issues; (5) evidence-based and ethical practice; (6) mobile health technologies including applications; and (7) telepractice development. These competencies could be organized into three levels of proficiency: starting with *novice*, then *proficient*, and finally to *authority* (Maheu, Drude, Hertlein, Lipshutz, Wall, & Hilty, 2018).

Client Welfare

A primary goal of psychotherapy to clients is to improve the well-being of the individual; at the same time, however, the practitioner must ensure the protection of the client's welfare. From the legal perspective, California laws and regulations are designed to protect the welfare of the psychotherapy client. Throughout the Business & Professional Code, the California Board of Psychology exercises its licensing, regulatory, and disciplinary functions to protect the public (BPC 2920.1). The BPC does not explicitly address client welfare concerns for telepsychology. Instead one might infer components of BPC 2290.5 as requirements to protect the welfare of a telepsychology client, and failure to adhere to those standards is considered unprofessional conduct.

In a similar vein, the APA recognizes the central importance of client welfare as the basis for the current Ethical Principles of Psychologists and Code of Conduct: The Ethics Code "has as its goals the welfare and protection of the individuals and groups

with whom psychologists work and the education of its members, students, and the public regarding ethical standards of the discipline” (APA, 2017, p.3). The standards established by the Ethics Code apply to the general practice of psychologists.

Perhaps one of the biggest obstacles in properly addressing client welfare in telepsychology practice is that a clinician may feel that it is one of many legal / ethical issues they need to juggle. A telehealth system is just one layer of the larger socio-technological system that includes a hierarchy of healthcare ecosystems, healthcare organizations, entity subsystems, and individualized components (Monteagudo, Salvador, & Kun, 2014). It is not difficult to imagine how a psychologist might become so inundated by the sheer amount of issues involved in creating a telepsychology practice that addressing aspects of client welfare are overlooked.

Fortunately, more specific guidelines for safeguarding the welfare of the client in the practice of telepsychology psychotherapy are increasingly highlighted in professional activities and the literature. One example is a committee formed by the ATA to advise practitioners on contemporary and emerging issues when using videoteleconference to treat mental health problems. To assist in providing safety, they suggest that ethical issue navigation hinges on having a consistent protocol. This includes session setup, population-specific accommodations, and emergency preparation. For example, as part of session setup, after completing the standardized procedure to ready the client for the intervention, it is recommended that all persons involved in the conference be identified by either using the camera to record them or to announce their names before beginning the session (ATA 2009). Also, because the nature of telepsychology limits the ability for a therapist to consistently monitor certain physical aspects of a patient, such as body

posture, movement, and other nonverbal cues, it is imperative that therapist identify methods or alternatives to track those features in an ethical manner (Goetter et al., 2013).

Plans for emergency assessment and management is an integral aspect of safeguarding the welfare of patients in telepsychology practice. Three core guidelines provide administrative, legal, and general clinical elements for an emergency protocol. Administrative issues involve assessing a client's site and the available local regulations and emergency resources to help with crisis management. The emergency protocol must be clear regarding roles and responsibilities of the therapist, client, and others. Legal issues involve clinician familiarity with local civil commitment regulations and whether there is the possibility to work with local staff. General clinical issues encapsulate broader themes of consideration such as a provider's awareness of their perception of control or the ongoing safety issues for a telehealth patient (Shore, Yellowlees, & Hilty, 2007).

Another element of a protocol to protect client welfare is the determination of whether a client is suitable for psychotherapy delivered via telepsychology. There are a number of approaches. Campbell and associates (2019) recommend engaging in a risk versus benefit assessment to evaluate the client's specific needs and current status. An assessment of benefits might include access to care, convenience, and attention to special needs, while risks might include information security, emergency management, and technology limitations. Other factors include the client's medical condition, substance use, treatment history, hospitalizations, and support systems. Once these factors are compiled, a telepsychology practitioner can reasonably assess whether a client is an appropriate candidate for their modality.

Certain methodologies employ an evaluation with a broader approach – one that assesses the suitability of telepsychology intervention with an entire population of potential clients. For example, the California Health Benefits Review Program (CHBRP) has a framework that assesses the social determinants of health (SDoH). This approach considers components of education, economic stability, social context, physical environment, and healthcare for a population (CHBRP 2016). With this larger dataset, it can be determined whether telepsychology services may assist with existing sociocultural barriers to traditional mental health treatment.

Some proposed frameworks are intended to evaluate suitability after a trial or pilot study. Garney and her associates (2016) suggest using an interactive systems framework (ISF) that distills information gathered from the implementation of the intervention. The ISF framework evaluates the intervention from a systems perspective at three levels: its delivery system, its support system, and its synthesis and translation system. First, it evaluates the delivery system, and whether it is conducive for the implementation of the necessary steps in an intervention. Second, it assesses the support system's ability to sustain the program's activities as well as its general capacity to adapt to a new setting. The final step is the synthesis of data from the trial period and translation of the information so it might be disseminated. This method is more intended for long-term evaluation but can provide a better empirical basis of how telepsychology interventions fit the needs of a specific population.

There will be instances when a client is not a good fit for telepsychology. Studies have been able to identify special populations that might be less suited for telepsychology intervention: patients with substance abuse/dependence, active psychosis, or suicidal or

homicidal ideation (Veazie, Bourne, Peterson, & Anderson, 2019). Given the symptom acuity of these populations, remote treatment is discouraged because safety issues are likely to arise that require in-person intervention. The determination of a lack of goodness-of-fit might also be dependent on clinician factors. Using Campbell's risk/benefit assessment, something like cultural differences might highlight a clinician's language limitations that could hinder rapport (Campbell et al., 2019). Ultimately the determination of the suitability of the client for telepsychology services is responsibility of the clinician.

Informed Consent

California law details the many obligations and rights of clients in its various legal code sections (e.g. BPC, W&I Code). In terms of telepsychology, the law expressly states that "prior to the delivery of health care via telehealth, the health care provider initiating the telehealth service must obtain verbal or written consent from the patient for the use of telehealth as an acceptable mode of delivery health care services and public health. The consent shall be documented" (BPC 2290.5b). To proceed with psychotherapy, the client must confirm they received the aforementioned information and consent to the provision of services. The specific details of the consent form can vary from practice to practice, but it is recommended that practice policies be explicitly given along with relevant risks and limitations associated with telepsychology. Appendix B presents a checklist to help psychologists track the necessary steps when initiating psychotherapy services with their clients, informed consent included.

The APA's Ethical Principles of Psychology (APA, 2017) Standard 3.10(a) states:

“When psychologists....provide...therapy, counseling, or consulting services in person or via electronic transmission or other forms of communication, they obtain the informed consent of the individual or individuals using language that is reasonably understandable to that person or persons except when conducting such activities without consent is mandated by law or governmental regulation or as otherwise provided in this Ethics Code” (p. 11). The Code encourages this interaction to occur as early as feasible to inform and answer questions regarding the nature and anticipated course of therapy, fees, third-party involvement, and confidentiality limitations (10.01a). Standard 10.01b is especially relevant to the provision of telepsychology: “...treatment for which generally recognized techniques and procedures have not been established, psychologists inform their clients/patients of the developing nature of the treatment, the potential risks involved, alternative treatments that may be available, and the voluntary nature of their participation (p.14).” Introducing telepsychology to a client new to its intricacies requires thoughtful preparation. Psychoeducation can be considered just as integral to the psychotherapy itself, and by addressing questions at the onset of the psychotherapy services a clinician can help provide better clarity for their clients.

In guideline #2 for the ethical delivery of telepsychology services, APA states that “psychologists strive to obtain and document informed consent that specifically addresses the unique concerns related to telepsychology services they provide. When doing so, psychologists are cognizant of the applicable laws and regulations, as well as organizational requirements, that govern informed consent in this area” (APA, 2013, p. 795). The degree to which the information is considered “adequate” is open to interpretation. Cooper, Campbell, and Barnwell (2019) recommend crafting and

obtaining the client's consent for telepsychology practice in addition to the informed consent obtained for in-person practice. The supplemental consent should include eight components: (a) screening for appropriateness with consideration of client variables, (b) limits of confidentiality and potential breaches, (c) emergency procedures inclusive of specific resources, (d) means of communication and reasonable timeline for response, (e) identification of language or cultural factors, (f) clarification of storage and disposal methods, (g) agreement on the conditions of the remote site, and (h) billing. Not addressing these components is not de facto a failure to meet state legal requirements; however, it likely constitutes an ethical lapse and a disservice to the client.

Appendix A presents an example of an informed consent form for telepsychology psychotherapy practice crafted by the APA's Joint Task Force (2013). It is intended to supplement the practitioner's general informed consent form for psychotherapy; that is, both should be completed by the telepsychology client. As informed consent is already an integral part of establishing the contract between therapist and client for psychotherapy, it is arguably even more crucial for telepsychology interventions. The use of technology to conduct psychotherapy adds an additional level of factors to the client-therapist interaction that are important details to address pre-therapy. A well thought-out and comprehensive informed consent form can serve as the foundation for a strong telepsychology therapist-client relationship.

Confidentiality

In the case of in-person, office-based psychotherapy confidentiality is essential to maintaining a safe and ethically- and legally-sound practice. By the nature of their work,

psychologists often are privy to clients' sensitive information that could be potentially distressful or harmful if disclosed. Psychologists have the legal and ethical duty to protect their clients' confidentiality. Most covered entities, psychotherapy practices included, must follow the federal Health Insurance Portability and Accountability Act (HIPAA). This legal statute mandates the privacy rules of the client's personal health information, ensuring the security of the information and the client's right to view them on request (Office for Civil Rights, 2000). There are administrative, physical, and technical safeguards, as well as notification of any breach of the confidentiality of protected health information, delineated in the law for HIPAA compliance (U.S. Department of Health and Human Services, 2013). California law is clear that, except under rare circumstances, client disclosures to a psychotherapist are to be kept confidential (e.g., Civil Code 56.10, BPC 2960(h)). In addition, the APA Ethics Code (2017) asserts that psychologists have an obligation to take reasonable precautions to protect confidential information obtained through or stored in any medium, while simultaneously recognizing that the limitations may be regulated by law (Standard 4.01). Further, psychologists who offer services, products, or information via electronic transmission inform clients/patients of the risks to the privacy and limits of confidentiality" (Standard 4.02[c], p. 13).

Adopting telecommunication as a means of delivery services brings its own set of confidentiality concerns in addition to those in traditional psychotherapy. What was once a therapeutic transaction that occurred behind closed doors has now become an interaction across technology. Communicating through a proxy adds an additional risk of violating the client's confidentiality. Beyond general legal and ethical standards for the maintenance of confidentiality of client disclosures in traditional psychotherapy practice,

California law and APA Guidelines address the topic with regard specifically to telepsychology practice. The California Business and Professions Code states: “All laws regarding the confidentiality of health care information and a patient’s rights to his or her medical information shall apply to telehealth interactions (BPC 2290.5f).”

Further, the APA Joint Task Force addressed the issue of clients’ confidentiality in three of their eight ethical guidelines specifically for telepsychology practice, thus underscoring the importance of the practitioner’s careful consideration and planning. First, “(p)sychologists who provide telepsychology services make reasonable efforts to protect and maintain the confidentiality of the data and information relating to their clients/patients and inform them of the potentially increased risks of loss of confidentiality inherent in the use of the telecommunication technologies, if any” (APA, 2013, p.796). Second, “(p)sychologists who provide telepsychology services take reasonable steps to ensure that security measures are in place to protect data and information related to their clients/patients from unintended access or disclosure” (APA, 2013, p.797). And, third “(p)sychologists who provide telepsychology services make reasonable efforts to dispose of data and information and the technologies used in a manner that facilitates protection from unauthorized access and accounts for safe and appropriate disposal” (APA, 2013, p.798). It is not enough to know about the safeguards, but to actively set out to achieve them.

Given the increased risk of information exposure when conducting therapy in the semi-uncontrolled environment inherent in telepsychology practice, HIPAA compliance becomes more complicated. In addition to connecting client and provider, programs or devices used to enact telepsychology should adhere to all legal (HIPAA and California)

and ethical standards in order to protect its users' medical information over the course of treatment. As there are a variety of ways for a psychotherapist to conduct telepsychology, it is important the all involved users are aware of the security of the utilized technology. For example, if a videoconferencing software program is used to provide intervention services between the client's and the therapist's computers, certain questions will arise and should be addressed. Certain programs record videos during the session, and if this occurs, where is the recording saved? Knowing that the data is saved on a local computer drive versus a storage drive on the internet leads to different protocols for confidentiality. Another question could involve the software's security measures. What must occur to access the program? Safeguards may include passwords or authorization via a second connected electronic device, but is it a sufficient deterrent by a would-be interloper? Independent assessment of a chosen program or device's security measures is recommended to assess its strengths and weaknesses.

Simultaneous integration of HIPAA and state-specific legal standards with program development would be ideal; however, to date, there is no set procedural protocol to meet those standards (Luxton, Kayl, & Mishkind, 2012). Without an official protocol, program developers are left to independently plan on how to best address security and confidentiality issues. Whether they appropriately meet such standards for HIPAA compliance can be difficult to decipher. Further, organizations can be subjected to client and customer complaints directed to the Office of Civil Rights (OCR), who are responsible for reviewing cases to enforce privacy and security rules (Code of Federal Regulations, 2015). Claims under the current penalty structure for HIPAA violations can range from the \$117 to upwards of \$1.7 million depending on the level of culpability (45

CFR 102, 2019). Suffice to say, the repercussions for lackluster security precautions can be immense. Both the technology company and telepsychology practice must adhere to HIPAA standards to avoid such penalties.

Another aspect of confidentiality to consider when deciding on the technology to provide telepsychotherapy is whether the program/device requires a business associate agreement (BAA). HIPAA considers business associates as entities that create, receive, maintain, or transmit identifiable health information to perform a function or service on the behalf of a covered entity (Code of Federal Regulations 160.103, 2015). Many, if not most, telehealth platforms seek to establish an agreement with the health provider via a BAA to share the responsibility of maintaining clients' confidentiality. This agreement can outline procedural steps for various events such as if a confidential information breach occurs. By establishing such a document, a professional at the very least has a written contract with the platform managers to collaboratively work toward the maintenance of client confidentiality. While the BAA itself does not guarantee that a breach will never occur, it demonstrates a two-pronged approach in protecting the client.

In addition to the device itself, a telepsychology practice must consider what network is being used to administer treatment. To be able to utilize the platform of telecommunication, a device must be able to connect to another device. Achieving this is done via a network, which is a broad term that describes wired and wireless connections bridging devices together. The distance range of networks is variable, with some not moving past a building while others span across countries. The main underlying question that should be asked when either selecting an established network or constructing a new one is: when and where is confidential information potentially vulnerable? Preventing the

exposure of data should always be the motivation behind any professional interaction.

However, circumstances might only allow for security options for one practice but not the other. Figuring out the best option for your practice requires careful evaluation.

A good starting point for these considerations is to determine how your chosen device interfaces with various types of networks. Doing this allows the practitioner to identify where there might be potential points of confidentiality breaches. For example, if a device employs a personal area network (PAN), then the computer network is centered on an individual person's workspace of devices. These kinds of networks aim to connect one person's technology into a contained system, which in turn, creates a smaller network radius. While this method restricts the breadth of information disclosure, it makes it harder to share information with others. For example, this kind of network allows an individual to track their health data across several devices but does not give them the ability to share the data with their physician or healthcare specialist. A chosen device that strictly uses a PAN would have information sent to a person's personal network first. From there the client (or even the practitioner) would need an additional way to provide this information, such as in-person or through a computer network with a wider range. On the other hand, using something like a wide area network (WAN) enables numerous devices from different people to connect over a large geographic area. This allows for a wider range of connectivity (e.g. group therapy, consultation from a distant provider), but can also allow for increased vulnerability of confidential information. A self-contained clinic might not need an extensive network, but having a wider range allows a practice to connect to outside resources.

Regardless of the chosen networking style, the device ultimately must connect to

an application hosting device (AHD) before being directed to the device of the psychologist (Koster, Asim, & Petkovic, 2011). While there may be differences in how a psychotherapist utilizes this connection with their clients, knowing the architecture of the network can assist in providing protection. Choice of network architecture may be limited given the location and available resources and may then present inevitable vulnerabilities. If these vulnerabilities are properly addressed, it might beg the question whether telepsychology is an appropriate intervention.

One method that has proven helpful in identifying potential risks in security is threat analysis. By studying the various domains of the data sharing with a client, a professional can consider aspects that could pose a threat to confidentiality and how to best address them. A simple analysis table can help organize the multiple concerns that can arise. This handbook took inspiration from a Norwegian telehealth analysis for COPD patients (Gerdes & Fensli, 2015), but this template can easily be adapted for use by mental health practitioners.

Table 3. Example of Threat Assessment

Threat	Requirement	Solution
Unintended access to patient data	Encryption of communication between PCs	Purchase of software that provides secure data transfers
Unequal knowledge of device among users	Baseline education given to all users	Didactic for employees, brief training with clients
Limited access to technology resources	Research of sufficient options for tech support	Provide list of researched options

Boundary Navigation

One aspect in the therapist-client relationship that might be easily overlooked in conducting telepsychology is the management of boundaries. Boundaries are a way to describe the therapeutic relationship, defining the roles of client and therapist in psychotherapy and differentiating these roles from a business or social relationship (Knapp & Slattery, 2004). The APA Ethics Code uses the term, “multiple relationship,” to describe when a psychologist enacts an additional role outside of the typical professional role with their client. While not de facto a harmful relationship (and thus unethical), a psychologist should refrain from embarking on a multiple relationship when it raises the risk of impairing their objectivity, competence, or effectiveness (3.05; APA, 2013).

With the addition of technology this traditionally in-person relationship is challenged. Drum and Littleton (2014) conducted a study that examined potential issues that might arise when navigating therapeutic boundaries in telepsychology. They identified two specific factors that could increase the risk of harmful boundary crossings: flexibility of service delivery prompting more casual interactions and the assumption that physical distance will provide protection from boundary crossings. They argue that the flexibility of service delivery (such as through a home computer or working in a public location) can jeopardize the professionalism of the relationship. Traditional boundaries in psychotherapy that normally separate the roles of client and professional are tested in new ways.

Time is one of the primary boundaries in psychotherapy that sets the roles of client and therapist apart due to the typical business hours within which services are

provided. Even outside the field of psychology most professions have culturally accepted timeframes within the day to be contacted. However, with the advent of telepsychology communication can exist in a synchronous and an asynchronous manner. While synchronous interactions might be similar to in-person psychotherapy, it can also experience delays because of technology limitations (i.e. delayed transmission due to poor connectivity) or intervention method (i.e. text messaging). Asynchronous telepsychology is easily identifiable for variable time allotments, as review of a case(s) or consultation can occur during non-business hours for a clinician.

The setting of formal office environment can enact and reinforce appropriate therapeutic boundaries by providing a sense of security and safety for clients (Knapp & Slattery, 2004). However, with the flexibility of telepsychology, such a localized workspace may not be a requirement for conducting sessions. A clinician might be tempted to conduct therapy in a variety of places if they are considered “non-public.” Even with proper precautions, changing locations might hurt the therapeutic interactions as there can be concerns of privacy in a new place or a distraction, such as noise, nearby. Also affecting the therapeutic setting could be the therapist themselves, as they might not be wearing business clothes when conducting therapy out of the office. In addition to not presenting as professional, it might cause the client to view the therapist as more of a friend than a clinician (Andersen, Van Raalte, & Brewer, 2001).

Drum and Littleton caution against taking the role of a psychologist too casually in the telepsychology therapist-client relationship. They make a number of recommendations for the best practice: (1) maintain professional hours and respect timing of sessions; (2) ensure timely and consistent feedback and manage excessive

communications; (3) ensure a private, consistent, professional, and culturally-sensitive setting; (4) ensure privacy of non-clients and prevent unintentional self-disclosures; (5) ensure telecommunication technologies convey professionalism; (6) model self-boundaries; (7) ensure privacy of the therapist's work; (8) use professional language and consider alternative interpretations; and (9) ensure competence in the practice of telepsychology (Drum & Littleton 2014).

Models for the Development of an Effective, Legal, and Ethical Telepsychology Practice

Various researchers have attempted to disseminate the steps toward creating an effective telepsychology practice. Anton and Jones (2017) used a broad approach to the field in preparation for future practice and research. Their model consisted of five steps: (1) Optimize technology-enhanced services for adoption and use; (2) devise and augment regulations for its use; (3) disseminate information about the services; (4) improve organizational readiness to adopt said services; and (5) ensure the continuation of training and technical support. Luxton and his colleagues (2016) suggest using a needs assessment to target questions of “who, what, where, when, why, and how” to begin the development of a telepsychology business plan. From these questions a clinician can branch into topics of technical, administrative, and professional needs. Drum and Littleton (2014) focused on identifying areas where potential boundary crossings may occur and to proactively develop strategies for prevention.

As the primary intention of this handbook was to specifically navigate legal and ethical issues inherent in the development of a telepsychology practice, our proposed

model analyzes legal and ethical considerations in lieu of questions more associated with practice establishment (e.g., a business plan, etc.). That is not to discount the importance of practice-centric models as continual analysis of how one should conduct business is an invaluable step. The model presented in this handbook attempts to triage ethical and legal issues that might surprise even the experienced clinician given certain aspects of telepsychology that have yet to be explored or documented by professionals.

The framework we suggest follows a series of nine steps:

1. Identify the presenting issue – are there salient details?
2. What are the legal and ethical issues?
3. Are there relevant state-specific or federal laws/regulations/mandates?
4. Are there relevant professional ethical standards or guidelines from the APA?
5. Were there pre-emptive plans or protocols setup prior to the event?
6. Consider and map out potential decisions and their related consequences.
7. Do you require additional assistance in decision-making? Consider consultation.
8. Commence with the “best” course of action.
9. Review results.

Regardless of a clinician’s choice of framework(s) used to develop a telepsychology practice that is sensitive to and compliant with legal and ethical standards, it is recommended that continual collaboration with other professionals and peers occurs during the development of an effective, legal, and ethical telepsychology practice. For example, practitioners considering or engaged in telepsychology practice may attend professional conferences and/or workshops to enhance their competencies. Practitioners

are often provided with updates on federal and/or state statutes regarding the practice of telepsychology, written resources, and collegial networking. In a 2017 survey conducted at various APA conventions, psychologists identified the major concerns of their telepsychology health practices (Glueckauf, et. al, 2018). Other conventions such as the Western Psychological Association (WPA) and the Society for Personality and Social Psychology (SPSP) have had presentations by its members talking about various concerns and applications of telepsychology (Chavez, Yang, & Nehoray, 2016; Yang, Rose, & Crask, 2018).

Such consultation and collaboration need not occur only in formal settings such as conventions or organized trainings. The International Society for Mental Health Online (ISMHO) is an example of an organization that works together via discussions on internet forums and emails to create an online community of those interested in telepsychology practice (Reamer 2013). Through such resources, clinicians can use technology to assist one another without being restricted by geographical proximity.

The development of telepsychology knowledge in emerging psychologists, such as those in graduate school programs, requires further emphasis. The acknowledgement of its importance to students has been reflected by the APA, whom promote the need for considerations similar to those mentioned in this handbook: confidentiality, privacy, informed consent, licensing, and safety nets (Walton, 2013). How well it has been sufficiently integrated in graduate development is unclear, given the rarity of telepsychology training programs (McCord, Saenz, Armstrong, & Elliot, 2015). However, that is not to say they do not exist in less formal settings. There is an increasing amount of resources such as webinars and online continued education courses that seek to

both raise awareness and build competencies (Crown, 2018; Maheu, 2020). Still, more comprehensive integration in various education settings will be an invaluable asset moving forward.

CHAPTER FIVE

SCENARIOS

In this section, the handbook will present several hypothetical situations that may arise within the unique domain of telepsychology. Recall from the past sections the different legal and ethical considerations required when enacting a telepsychology intervention. Real-life events may challenge these considerations and require a clinician to think on his or her feet to handle unforeseen circumstances. While hypothetical scenarios cannot substitute for real-life application nor account for all the variance for each practice, they serve to introduce the kind of critical thinking each professional should be able to apply to their practice. We present key questions after each vignette to consider prior to a proposed solution. Then, we employ our 8-step model to demonstrate how one might use the protocol to formulate a decision. For the sake of consistency assume these scenarios occur within the state of California. You can use these scenarios to trigger discussion among colleagues and employees on how they might choose a course of action.

Scenario 1: Technology Malfunction

Dr. Hanson has been treating Hank, a veteran on disability, for depressive symptoms. They have been communicating via a teleconference program on a weekly basis so that his client did not have to make a long drive to the clinic. During a recent telepsychology session, Dr. Hanson's client disconnects halfway through the meeting. Dr. Hanson waits for several minutes for his client to reconnect, but he does not. A few hours later he receives a phone call from his client: "I tried to reconnect to our session, but I

think my program is broken!” How should Dr. Hanson handle this situation?

Framework Application

One: Identify Presenting Issue

- Client states that the telepsychology program is broken, causing an obstacle to the current (and potentially future) psychotherapy session.
- Is the technology broken or malfunctioning, or is the problem related to the user?

Two: Legal or Ethical Issues

- Legal: Scenario does not appear to challenge any existing laws; actions in this scenario will likely not break any laws unless the practitioner has failed to obtain informed consent from his client regarding telepsychology practice.
- Ethical: A technology malfunction is preventing the client from receiving care and it could be argued that the clinician’s resolution of this situation is an ethical obligation to safeguard the client’s welfare. However, attempting to fix this issue might result in boundary crossings between client/therapist. For example, the therapist might now be fulfilling the role of technology technician in addition to providing psychotherapy. A client might start thinking the therapist can be utilized for services outside of the consented psychotherapy services. Also, there is the potential that the client is being subjected to breaches in confidentiality (e.g., attempting to reconnect inadvertently exposes the client to other websites).

Three: State Laws & Mandates

- None; technology troubleshooting/maintenance is not legally mandated.

Four: Ethical Standards & Guidelines

- The APA Ethics Code Ethical Principle A (Beneficence and Nonmaleficence) and Standards 3.04 and 3.12, and the APA Guidelines for Telepsychology recommend psychologists seek to safeguard the welfare of their clients, take reasonable steps to avoid harming their clients, make reasonable efforts to provide orderly and appropriate resolution for facilitating services when therapy is interrupted (APA, 2017).
- Guidelines 4 and 5 from the Guidelines for the Practice of Telepsychology speak about making reasonable efforts to protect and maintain client confidentiality while also taking reasonable steps to enact security measures (APA, 2013).

Five: Pre-Emptive Preparations

- Informed consent: outlining how technological issues are handled prior to the onset of therapy would negate the need for additional time to be spent on explaining the protocol for troubleshooting. Early designation of how an ancillary service, such as technology support, will be handled over the course of treatment can provide clarity of procedures for both client and therapist. Addressing a practice's technology policy in an informed consent or initial session maps out how a future encounter might proceed.
- Keep in mind the technology competency of both the client and the clinician.

Awareness of one's competency can help determine the extent to which a clinician can aid their client. If the topic is too complex, identify how best to aid the client. In addition, early examination of technology competence can allow for more realistic expectations when using the medium with a client.

Six: Plan Solutions

- a) Have client detail what happened leading up to disconnect and then assess whether Dr. Hansen (the therapist) has the technical competency to assist in fixing the problem. If so, setup a separate time to assist in fixing the malfunction. The time that can be dedicated to this scenario in the moment can be variable. It may appear callous to delay an attempt to find an immediate solution, but the day-to-day of a functioning practice might not allow for extra (unpaid) time to be spent with a client. Respecting one's professional obligations and boundaries remains important.
- b) Provide the client with information about IT (information technology) services. It will be important to distinguish whether this service will be provided via a clinic-affiliated individual or through a third-party company. It is also advised to provide information on how the client's confidentiality and security will be maintained when working with this individual.
- c) If referring client to an IT professional associated with Dr. Hansen, consider whether (1) Dr. Hansen has a BAA contract with the IT person and (2) Dr. Hansen needs to provide client with an authorization for release of information (to the IT person) for client to sign. Clearly dictate how the

process of communication will proceed. Will the client or the technician lead the troubleshooting? It is recommended that the client initiates contact (since they can allocate a time where they are in a safe and confidential setting), however the decision is ultimately up to the clinician.

- d) If technology malfunction cannot be remedied, Dr. Hansen should meet in person with the client, if possible, and review referrals to alternative forms of psychotherapy for client, including in-person or another telepsychology provider who uses a different telepsychology program/modality or device.

Seven: Additional Assistance

- Consulting an IT resource can help Dr. Hanson determine the severity of the presented malfunction and might affect his decision of involving a third-party.

Eight: Commence Action

- Time necessary to resolve this problem might not be possible during work hours given the busy nature of Dr. Hanson's practice. Referring Hank to an IT professional might increase the chance of successful resolution to his technology issue. The referral does affect Hank's level of confidentiality, so it is important to properly inform him of the aspects of the involvement of an individual that is not his therapist (explain the BAA if in place; explain other potential breaches).

Nine: Review Results

- After enacting the solution, review the outcomes. Did the inclusion of the

technician help the client solve the problem? Did the referral affect the therapeutic relationship? Did the technology assistance cause the client's information to be vulnerable at any point?

- Review the teleconference program by conducting a thorough assessment of its functionality, security, and accessibility. Has the patient's technology issue been a common occurrence? Can the program be used reliably in the future? It might be possible that after review there is a requirement for a new program or a change in how psychotherapy services are provided.

Scenario 2: Suicide Risk

Dr. Anderson has been seeing an adult patient, Jody, in weekly psychotherapy via a teleconference program after she was discharged from the hospital for a suicide attempt. During the most recent session Jody presented with flat affect and was mostly unresponsive to Dr. Anderson's queries. Eventually Jody speaks, saying "This is not working, Doctor. I feel trapped...I think I'll go to the bathroom and do it right this time." Before Dr. Anderson can respond Jody ends the teleconference session. How should Dr. Anderson proceed?

Framework Application

One: Identify Presenting Issue

- Jody has just ended a session after making comments that might be interpreted as a pending plan of self-harm.

Two: Legal or Ethical Issues

- Legal: No legal regulations are overtly being compromised in this scenario. However, it could be argued that by not taking any action Dr. Anderson is neglecting her duty to keep her client safe from harm. In this instance Dr. Anderson would be committing the offense of being grossly negligent in the practice of her profession (BPC 2960(j)).
- Ethical: It is an ethical obligation to protect a client's welfare if it is determined that they are in imminent danger. Given the circumstance it will be difficult to directly affect the outcome. By requesting assistance to handle this incident, Dr. Anderson compromises Jody's confidentiality in receiving psychotherapy as well as potentially affecting the therapeutic relationship. However, it might be necessary to do so to ensure the welfare of her patient.

Three: State Laws & Mandates

- The state of California does not require clinicians to report suspicions of suicidal intent. By not reporting this incident Dr. Anderson is not breaking any explicit laws, but she might be considered negligent in the care of her patient. California law regarding psychotherapist-patient confidentiality and privilege permits disclosure of confidential information by the professional if they perceive the related client to be a danger to self (Civil Code 56.10; Evidence Code 1024).

Four: Ethical Standards & Guidelines

- Principle A of the APA's Ethic Code asks psychologists to strive to "safeguard

the welfare and rights of those with whom they interact professionally” (APA, 2017, p. 3).

- Ethics Code 4.05b states that a psychologist can disclose confidential information without the consent of the individual where permitted by law for a valid. One of the distinctions is to “protect the client/patient, psychologist, or others from harm” (APA, 2017, p. 8).

Five: Pre-Emptive Preparations

- An emergency plan at the onset of therapy is highly recommended, especially when working with a client that has a history of self-harm. Development of said plan should occur at the time of the informed consent given at the onset of telepsychology services. It is important this emergency plan address factors such as a contact person for the client, nearby resources, and the precise protocol for the plan. The client should be made an active participant in this process.

Six: Plan Solutions

- a) Contact local resources (such as local law enforcement) to perform a wellness check. Going this route might require Dr. Anderson to share the reason and rationale behind the visit, which compromises aspects of Jody’s confidentiality.
- b) Enact an emergency plan that was reviewed at the onset of the telepsychology intervention. As mentioned in the previous section, early adoption of an emergency protocol at the beginning of treatment provides a protocol that the client agreed to. While Jody did not engage with Dr. Anderson in this most recent

session, her previous participation in the emergency plan allows some insight on how the situation should be handled.

- c) Evaluate the situation as not life-threatening and document how this decision was reached. If there is enough evidence that suggests that the client is not a threat to themselves, Dr. Anderson can opt to not intervene. This decision can be a difficult to make, as conscious inaction might feel like shirking professional duties.

Although in some cases (such as a client that has had a history malingering) then the professional might have reasonable cause not to intervene. Although it remains important to document how the decision was made.

Seven: Additional Assistance

- Consulting with another clinician might be worth considering given the likely stress resulting from this situation. The client's words are troubling, but Dr. Anderson might know more about Jody's previous case presentation and the context of this recent session. Another mental health professional might allow for a plan given the immediate factors. However, because the scenario appears to be time-sensitive, there might not be enough time for a full consultation.

Eight: Commence Action

- If explained and prepared properly, enacting an emergency plan might be the best method to work toward Jody's safety. A protocol might review aspects such as crisis behaviors, warning signs/triggers, and mental health history, which can potentially help both patient and provider to recognize distress before a crisis.

Then a flowchart could be developed integrating identified behavioral support to assist in ensuring safety in crises. An example might be: (1) attempt to re-establish contact with the client; (2) call an established contact (such as a neighbor) to check on client; (3) If neither option is able to connect with client, it is agreed that law enforcement be contacted to conduct a wellness check.

- Given the implied severity of what the client said to the clinician it is important to act immediately. Remember: Because Jody has consented to the telepsychology intervention, it is the therapist's legal and ethical duty to protect her welfare. Whether the solution involves contacting the appropriate resources or deciding a threat is not apparent, a decision must be made immediately.
- It is possible that all the proposed crisis interventions are unable to make contact with the client. A clinician should also have a protocol for when they have exhausted their planned resources (which should also be explicitly explained and written out at treatment onset).
- Regardless of how the situation is resolved, it is important to document this encounter. Be certain to track each action leading up to the resolution, as documentation will likely be requested if any legal action occurs. Having accurate notes can safeguard a therapist in the event they are accused of wrong-doing or negligence (given they conduct themselves professionally).

Nine: Review Results

- After enacting the emergency plan, Dr. Anderson should review the results and determine what worked and did not work at a later date. She may want to

collaborate with Jody to adjust the emergency plan, working together to setup an improved protocol if necessary.

- If the client self-harms in this scenario, review and document the process leading up to the act. Even with the best of intentions, a clinician might not be able to prevent a client's actions. What can be improved to prevent the likelihood of a similar situation?
- Clients with a high risk of suicide are generally not ideal candidates for remote therapy. Due to the nature of telepsychology one's influence on a client's immediate outcome might be limited due to distance. Acknowledging this dynamic can allow for more realistic expectations from the clinician when conducting this line of work. With this scenario, Dr. Anderson might want to reconsider seeing future clients with a similar presentation.

Scenario 3: Breach in Confidentiality

Dr. Chan has been conducting telepsychology via a HIPAA-compliant teleconference program. However, he was recently notified by the program's company that they are under investigation for potential breaches in the security of their device. Multiple users have reported that their data has been leaked to third-party sellers that sent them health-related advertisements. Thus far, Dr. Chan has not heard such complaints from his clients. The company dismisses these allegations and assures Dr. Chan that they have conducted a security check and are working on additional safeguards to remove any doubt of the program's integrity. How might he handle this situation?

Framework Application

One: Identify Presenting Issues

- Dr. Chan has just discovered that the confidentiality and security of the technology that he has been using to conduct telepsychology might be compromised. Should Dr. Chan continue to use the program? If not, is it feasible to use it later?

Two: Legal or Ethical Issues

- Legal: No legal regulations have yet to be broken in this scenario. However, if Dr. Chan investigates and discovers that recordings of past sessions were exposed to the public, his clients' confidentiality has been compromised. If he continues to conduct psychotherapy with the compromised teleconference program, it might be considered willful and unauthorized communication of information as well as gross negligence (BPC 2960 [j]).
- Ethical: It is an ethical obligation to protect a client's confidentiality as well as to notify a client if their confidentiality may be under threat. In addition, there are questions of past and present information exposure that occurred during teleconference sessions.

Three: State Laws & Mandates

- Neither federal nor state law would penalize Dr. Chan's practice as this time. However, if he continues to utilize the teleconference program without informing

his clients of the incident, he would not be doing his due diligence while willfully risking their confidentiality. Such an action could be grounds for the OCR to conduct an audit that fines Dr. Chan and his practice (45 CFR 160 & 164).

Four: Ethical Standards & Guidelines

- Principle A of the APA's Ethic Code asks psychologists to strive to "safeguard the welfare and rights of those with whom they interact professionally" (APA, 2017, p. 3).
- Principle B of the APA's Ethical Code asks psychologists to strive for a level of integrity that "keep promises and to avoid unwise or unclear commitments" (APA, 2017, p. 3).
- Ethics Code 4.05b states that a psychologist can disclose confidential information without the consent of the individual where permitted by law for a valid. One of the distinctions is to "protect the client/patient, psychologist, or others from harm" (APA, 2017, p. 8).
- Ethics Code 6.02a requires psychologists to "maintain confidentiality in creating, storing, accessing, transferring, and disposing of records under their control, whether...written, automated, or in any other medium (APA, 2017, p.9).

Five: Pre-Emptive Preparations

- The informed consent can explicitly state how the practice will handle technology-related risks to a client's confidentiality. The form might designate a timeframe when the practice must notify a client of changes to therapy (if any). At

the same time, the initial session should provide contact information for a client in the case they have questions about such a development. In some cases, the client might be the first person to hear news about issues that affect ongoing therapy.

- Continual assessment of the security for a modality of psychotherapy gives a practice a method to maintain a baseline for ethical psychotherapy. Appendix C has an example of a HIPAA compliance checklist that can be used to guide a security audit.

Six: Plan Solutions

- a) Stop using the teleconference program and evaluate its functionality. The duration of the stoppage is up to the clinician, as the time dedicated to evaluation can vary. The immediate ability to evaluate efficiently and concisely allows for a shorter suspension, while more extensive and methodical evaluation might require a longer suspension. Stopping telepsychology sessions during this interim lessens the likelihood that clients' data will be compromised. Regardless of the duration of the stoppage, a decision should be made whether the suspension of the teleconference program is temporary or complete.
- b) Write a letter to clients detailing how their treatment might be affected by the compromised program and how the practice intends to handle this situation. Clients must respond to this letter for them to continue receiving telepsychology, and they must state whether they wish to continue therapy.
- c) Continue using the technology but inform clients of the news regarding the teleconference program at the onset of their next session (careful not to begin

therapy work). If the client wishes to stop the telepsychology at that time, provide contact information and end the session. The clinician will then employ a different form of communication to work with the client to determine an alternative form of treatment.

Seven: Additional Assistance

- Consulting with another clinician that has utilized the same teleconference program might give insight on how they chose to handle the situation.
- The practice may want to reach out to the program's company to consult on the planned trajectory of remedying the safety concerns. If their procedure is deemed to be realistic and timely, a decision might be made to continue using the program.
- Dr. Chan might also consider reaching out to an IT consultant to determine if there are methods to protect against the reported exposure. Thus, he can enact independent measures to combat flaws in the program. Whether that would be enough to negate the suspected exposure would require careful examination.

Eight: Commence Action

- A chosen solution to this scenario can vary, but it is essential that it continues to protect the client's confidentiality in a reasonable capacity. It is an ethical obligation to notify one's clients of the new potential risks to their confidentiality. Whether to stop or continue telepsychology with a given program is up to the provider, but the client deserves the autonomy to choose whether to participate in

treatment with this new knowledge.

- Consider the difference in the decision-making process when such a notification might occur. For example, receiving this information during business hours might result in more triage-like decisions, while after-hours notification might allow for more methodical planning. Navigating this issue takes time (time a practicing therapist might not have in the moment due to other professional duties).
- It is wise to consider alternative methods to continue the therapy. This might include employing a different program, changing the mode of treatment delivery (i.e., have the client come into the office or do telephone sessions), or even referring out clients. The rationale behind such decisions vary depending on the scope of one's practice. Waiting for the situation to resolve gives no definitive timeline and leaves a professional vulnerable to variable outcomes. Be proactive in these situations.

Nine: Review Results

- After enacting the chosen decision, Dr. Chan should review the results and determine what worked versus what did not work at an appropriate time.
- How has the compromised teleconference program fared so far? Whether the practice chooses to maintain or release the program's usage, ongoing news might still affect the clinical practice. For example, if the teleconference company reports that recordings from a certain date range were proven to be exposed to security risks, the clinician would need to know how to best address this issue.
- Was the chosen method of proving information sufficient? It should ideally reach

and inform every client efficiently and succinctly. Also, to consider: what was the rate of response from clients? If a lower rate responded to Dr. Chan, re-evaluation might account for the method of replying.

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APPENDIX A

INFORMED CONSENT FOR TELEPSYCHOLOGY (Joint Task Force, 2013)

This Informed Consent for Telepsychology contains important information focusing on doing psychotherapy using the phone or the Internet. Please read this carefully and let me know if you have any questions. When you sign this document, it will represent an agreement between us.

Benefits and Risks of Telepsychology

Telepsychology refers to providing psychotherapy services remotely using telecommunications technologies, such as video conferencing or telephone. One of the benefits of telepsychology is that the client and clinician can engage in services without being in the same physical location. This can be helpful in ensuring continuity of care if the client or clinician moves to a different location, takes an extended vacation, or is otherwise unable to continue to meet in person. It is also more convenient and takes less time. Telepsychology, however, requires technical competence on both our parts to be helpful. Although there are benefits of telepsychology, there are some differences between in-person psychotherapy and telepsychology, as well as some risks. For example:

- Risks to confidentiality. Because telepsychology sessions take place outside of the therapist's private office, there is potential for other people to overhear sessions if you are not in a private place during the session. On my end I will take reasonable steps to ensure your privacy. But it is important for you to make sure you find a private place for our session where you will not be interrupted. It is also important for you to protect the privacy of our session on your cell phone or other device. You should participate in therapy only while in a room or area where other people are not present and cannot overhear the conversation.
- Issues related to technology. There are many ways that technology issues might impact telepsychology. For example, technology may stop working during a session, other people might be able to get access to our private conversation, or stored data could be accessed by unauthorized people or companies.
- Crisis management and intervention. Usually, I will not engage in telepsychology with clients who are currently in a crisis situation requiring high levels of support and intervention. Before engaging in telepsychology, we will develop an emergency response plan to address potential crisis situations that may arise during our telepsychology work.
- Efficacy. Most research shows that telepsychology is about as effective as in-person psychotherapy. However, some therapists believe that something is lost by not being in the same room. For example, there is debate about a therapist's ability to fully understand non-verbal information when working remotely.

Electronic Communications

We will decide together which kind of telepsychology service to use. You may have to have certain computer or cell phone systems to use telepsychology services. You are solely responsible for any cost to you to obtain any necessary equipment, accessories, or software to take part in telepsychology.

[Below are some optional provisions to add more detail about the use of email/text messaging and communication between sessions. Modify as appropriate if you have secure, encrypted email that you use differently with clients or delete if not applicable or redundant.]

For communication between sessions, I only use email communication and text messaging with your permission and only for administrative purposes unless we have made another agreement. This means that email exchanges and text messages with my office should be limited to administrative matters. This includes things like setting and changing appointments, billing matters, and other related issues. You should be aware that I cannot guarantee the confidentiality of any information communicated by email or text. Therefore, I will not discuss any clinical information by email or text and prefer that you do not either. Also, I do not regularly check my email or texts, nor do I respond immediately, so these methods **should not** be used if there is an emergency.

Treatment is most effective when clinical discussions occur at your regularly scheduled sessions. But if an urgent issue arises, you should feel free to attempt to reach me by phone. I will try to return your call within 24 hours except on weekends and holidays. If you are unable to reach me and feel that you cannot wait for me to return your call, contact your family physician or the nearest emergency room and ask for the psychologist or psychiatrist on call. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact in my absence if necessary.

Confidentiality

I have a legal and ethical responsibility to make my best efforts to protect all communications that are a part of our telepsychology. However, the nature of electronic communications technologies is such that I cannot guarantee that our communications will be kept confidential or that other people may not gain access to our communications. I will try to use updated encryption methods, firewalls, and back-up systems to help keep your information private, but there is a risk that our electronic communications may be compromised, unsecured, or accessed by others. You should also take reasonable steps to ensure the security of our communications (for example, only using secure networks for telepsychology sessions and having passwords to protect the device you use for telepsychology).

The extent of confidentiality and the exceptions to confidentiality that I outlined in my Informed Consent *[use whatever title you have for your informed consent document]* still apply in telepsychology. Please let me know if you have any questions about exceptions to confidentiality.

Appropriateness of Telepsychology

From time to time, we may schedule in-person sessions to “check-in” with one another. I will let you know if I decide that telepsychology is no longer the most appropriate form of treatment for you. We will discuss options of engaging in in-person counseling or referrals to another professional in your location who can provide appropriate services.

Emergencies and Technology

[Providers must work with their telepsychology clients to develop a plan for dealing with crisis/emergency situations and technology failures when providing telepsychology services. These plans should include things such as: how crisis/emergency situations will be addressed (local resources, hotlines, trusted people identified by the client, etc.); how to confirm client’s location; how to deal with technology failures during sessions and in crisis situations; how to deal with billing in the event of technology failures; and similar considerations. Some optional

language is included below – these are only suggestions and should be modified as appropriate for your specific circumstances.]

Assessing and evaluating threats and other emergencies can be more difficult when conducting telepsychology than in traditional in-person therapy. To address some of these difficulties, we will create an emergency plan before engaging in telepsychology services. I will ask you to identify an emergency contact person who is near your location and who I will contact in the event of a crisis or emergency to assist in addressing the situation. I will ask that you sign a separate authorization form allowing me to contact your emergency contact person as needed during such a crisis or emergency.

If the session is interrupted for any reason, such as the technological connection fails, and you are having an emergency, do not call me back; instead, call 911, ***[include any local hotlines or other resources]***, or go to your nearest emergency room. Call me back after you have called or obtained emergency services.

If the session is interrupted and you are not having an emergency, disconnect from the session and I will wait two (2) minutes and then re-contact you via the telepsychology platform on which we agreed to conduct therapy. If you do not receive a call back within two (2) minutes, then call me on the phone number I provided you (XXX-XXX-XXXX).

If there is a technological failure and we are unable to resume the connection, you will only be charged the prorated amount of actual session time.

Fees

The same fee rates will apply for telepsychology as apply for in-person psychotherapy. However, insurance or other managed care providers may not cover sessions that are conducted via telecommunication. If your insurance, HMO, third-party payer, or other managed care provider does not cover electronic psychotherapy sessions, you will be solely responsible for the entire fee of the session. Please contact your insurance company prior to our engaging in telepsychology sessions in order to determine whether these sessions will be covered.

Records

The telepsychology sessions shall not be recorded in any way unless agreed to in writing by mutual consent. I will maintain a record of our session in the same way I maintain records of in-person sessions in accordance with my policies.

Informed Consent

This agreement is intended as a supplement to the general informed consent that we agreed to at the outset of our clinical work together and does not amend any of the terms of that agreement. Your signature below indicates agreement with its terms and conditions.

Client

Date

Therapist

Date

APPENDIX B

Checklist: Provision of Telehealth in California (Lien, 2016)

Name of Client: _____

Date of Initial Session: _____

Initiation of Telehealth Services:

- Informed the client about the use of telehealth for the provision of psychotherapy services
- Obtained from the client verbal or written consent for the use of telehealth as an acceptable mode of delivering psychotherapy services
- Documented the consent obtained by the client in the client's treatment record
- Provided the client with his or her license or registration number and the type of license or registration (written or verbal)
- Informed the client of the potential risks and limitations of receiving treatment via telehealth
 - Provided the client with written information **and/or**
 - Provided the client verbally with the information and documented such in the client's treatment record
- Documented reasonable efforts to ascertain the contact information of relevant resources, including emergency services in the client's geographic area
 - Provided the client with written information **and/or**
 - Provided the client verbally with information and documented such in the client's treatment record

Documentation of Telehealth Session:

Date of Session: ___/___/___

Client's Name: _____

Client's Location: _____

Appropriateness of telehealth for this client:

Utilization of industry-best practices to ensure the security of the communication medium and client confidentiality

- Researched and verified the telehealth medium used is secured (e.g. transmission of voice and video is encrypted)
- If the telehealth medium includes the storage of voice or video data, such storage is secured
- If a personal computer is used, antivirus software and/or firewalls are up to date

If a personal device is used (e.g. mobile phone), the most recent security update for the device was installed

APPENDIX C

HIPAA Compliance Checklist (HIPAA Journal, 2018)

The HHS Office for Civil Rights has identified the following areas to be essential elements of an effective HIPAA compliance program. How does your organization fare?

Use the checkboxes below to self-evaluate HIPAA compliance in your practice or organization.

- The following six annual audits/assessments are required elements of a HIPAA compliance program. Have they been completed?**
 - Security Risk Assessment
 - Privacy Assessment (Not required for BAs)
 - HITECH Subtitle D Audit
 - Security Standards Audit
 - Asset and Device Audit
 - Physical Site Audit

- Do you have documentation to show you have conducted the above audits/assessments for the past six years?**

- Have you identified all gaps uncovered in the audits above?**
 - Have you documented all deficiencies?

- Have you created remediation plans to address deficiencies found in all six audits?**
 - Are these remediation plans fully documented in writing?
 - Do you update and review these remediation plans annually?
 - Are annually documented remediation plans retained in your records for six years?

- Have all staff members undergone annual HIPAA training?**
 - Do you have documentation to confirm each employee has completed their annual training?
 - Is there a staff member designated as the HIPAA Compliance, Privacy, and/or Security Officer?

- Have you developed a contingency plan for emergencies?**
 - Have you developed policies and procedures for responding to emergency situations?
 - Are you creating backups for all ePHI to ensure an exact copy can be recovered in the event of a disaster?
 - Have you developed procedures to ensure critical business processes continue when operating in emergency mode?
 - Are your contingency plans regularly updated and tested?

- Have you, by means of a risk analysis, assessed whether encryption of ePHI is appropriate?**

- If encryption is not appropriate, have you implemented alternative and equivalent measures to ensure the confidentiality, integrity, and availability of ePHI?
- Have you implemented controls to guard against unauthorized accessing of ePHI during electronic transmission?
- Has the decision-making process covering the use of encryption been documented?
- Have you implemented identity management and access controls?**
 - Have you assigned unique usernames/numbers to all individuals who require access to ePHI?
 - Is access to ePHI restricted to individuals that require access to perform essential work duties?
 - Have you implemented policies and procedures for assessing whether employees' access to ePHI is appropriate?
 - Have you developed policies and procedures for terminating access to ePHI when an employee leaves an organization or their role changes?
 - Do you have policies for recovering all electronic devices containing ePHI when an employee leaves your organization?
 - Does your system automatically logout a user after a period of inactivity?
- Do you create and monitor ePHI access logs?**
 - Are auditable ePHI access logs created for successful and unsuccessful login attempts?
 - Are ePHI access logs routinely monitored to identify unauthorized accessing of ePHI?
 - Have you implemented controls to ensure ePHI cannot be altered or destroyed in an unauthorized manner?
- Are all permitted uses and disclosures of PHI/ePHI limited to the minimum necessary information to achieve the purpose for which the PHI/ePHI is disclosed?**
- Have you developed policies and procedures covering the secure disposal of protected health information and electronic PHI?**
 - Have you developed policies and procedures for rendering physical PHI unreadable, indecipherable, and incapable of being reconstructed when no longer required?
 - Have you developed policies and procedures for permanently erasing ePHI on electronic devices when they are no longer required, or the devices reach end of life?
 - Are electronic devices containing ePHI and physical PHI stored securely until they are disposed of in a secure fashion?
- Have you developed policies and procedures for providing patients with access to their health information?**
 - Are you providing individuals with access to their health information or copies of their health information on request?

- Are you providing copies of PHI in the format requested by the individual?
- Are you providing individual copies of their health information in a timely manner and within 30 days?
- If fees are charged, are those fees reasonable and cost-based?

- Do you obtain and store HIPAA authorizations for uses and disclosures of PHI not otherwise permitted by the HIPAA Privacy Rule?**
 - Do your authorizations clearly explain the specific uses and disclosures of PHI and are they written in plain language?
 - Do your authorizations state the classes of people to whom PHI will be disclosed?
 - Do the authorizations include an expiry date or event?
 - Do the authorizations contain the individual's signature and date of signature?

- Have you created a Notice of Privacy Practices (NPP)?**
 - Do you provide periodic reminders to reinforce security awareness training?
 - Have you provided your notice of privacy practices to all patients?
 - Has every patient stated in writing that they have received the notice of privacy practices?
 - Has your notice of privacy practices been published in a prominent location and on your website?
 - Have you developed procedures for dealing with complaints about failures to comply with the NPP?

- Do you have policies and procedures relevant to the annual HIPAA Privacy, Security, and Breach Notification Rules?**
 - Have all staff members read and legally attested to the HIPAA policies and procedures?
 - Do you have documentation of their legal attestation?
 - Do you have documentation for annual reviews of your policies and procedures?

- Have you identified all of your vendors and business associates?**
 - Do you have Business Associate Agreements (BAAs) in place with all business associates?
 - Have you performed due diligence on your business associates to assess their HIPAA compliance?
 - Are you tracking and reviewing your Business Associate Agreements annually?
 - Do you have Confidentiality Agreements with non-business associate vendors?

- Do you have a defined process for security incidents and data breaches?**
 - Do you have the ability to track and manage the investigations of all incidents?
 - Are you able to provide the required reporting of minor or meaningful breaches or incidents?
 - Do your staff members have the ability to anonymously report a privacy/security incident or potential HIPAA violation?