

The Practice of Tele-Mental Health: Ethical, Legal, and Clinical Issues for Practitioners

Jeffrey E. Barnett
Loyola University Maryland

Keely Kolmes
San Francisco, California

The integration of various technologies into clinical services and the provision of tele-mental health can help practices run more smoothly and efficiently, increase access to needed treatment for individuals in remote areas, and expand the reach of the professional services psychotherapists offer. While this brings many potential benefits to practitioners and clients alike, the practice of tele-mental health also brings a number of ethical, legal, and clinical challenges. These are addressed and highlighted through representative case examples. Ethics issues discussed include determining the appropriateness of tele-mental health services for clients, informed consent, confidentiality, clinical and technological competence, and emergency procedures and safeguards. Legal issues addressed include interjurisdictional practice and the role of laws in the jurisdictions where the practitioner and client each are located. Relevant ethics standards and professional practice guidelines are reviewed, and specific recommendations for the ethical, legal, and clinically effective practice of tele-mental health are provided.

Keywords: tele-mental health, technology, ethics, law, practice

Mental health practitioners incorporate a wide range of technologies into clinical practice just as these technologies are increasingly ubiquitous in society today. Initial forms of technology incorporated into mental health practice included telephones, fax machines, and photocopiers. More recently, personal computers have been used for psychological test administration, scoring, and interpretation; and e-mail, cell phones, text messaging, and videoconferencing have increasingly been incorporated into clinical practice for the direct provision of clinical services. Now, smartphone apps along with virtual reality and augmented reality technologies have significantly altered how mental health assessment and treatment services may be provided to clients, and these technologies and their uses continue to rapidly evolve.

These technologies may be used for both administrative and clinical purposes. Administrative uses of technology help a practice run more efficiently and smoothly. These can include the use of websites to share practice-related information with current and potential clients, e-mail or text messaging to schedule or change appointments, the electronic submission of insurance claims, and the ability to accept credit card payments from clients using either the client's or clinician's smartphone. Clinical uses of technological innovations in mental health practice include providing crisis intervention to clients over the telephone in between in-person sessions, providing clinical services across long distances via interactive videoconferencing to clients who would not otherwise be able to receive needed treatment, utilizing a range of apps on the client's smartphone to augment and enhance treatment services provided, and providing clients with treatments via virtual reality and augmented reality technologies that would not otherwise be possible.

While these technologies provide practitioners with numerous opportunities for enhanced clinical practice as well as providing clients with treatment for which they might not otherwise have access, the use of these technologies

This article was published Online First January 14, 2016.

Jeffrey E. Barnett, College of Arts and Sciences, Loyola University Maryland; Keely Kolmes, Independent Practice, San Francisco, California.

Correspondence concerning this article should be addressed to Jeffrey E. Barnett, College of Arts and Sciences, Loyola University Maryland, 4501 North Charles Street, Baltimore, MD 21210. E-mail: jbarnett@loyola.edu

introduces a number of ethical, legal, and clinical challenges. With careful attention to these issues, practitioners may utilize these technologies in clinical practice in a manner that meets each client's treatment needs, fulfills ethical obligations, and meets legal requirements.

Tele-Mental Health

This integration of various technologies into clinical practice has been referred to by a number of names to include telepsychology, telehealth, tele-mental health, online counseling, e-health, e-counseling, and others. In this article, the more general term "tele-mental health" is used to indicate applicability to all mental health professionals. Nickelson (1998) defined (tele-mental health) as "the use of telecommunications and information technology to provide access to health assessment, intervention, consultation, supervision, education, and information across distance" (p. 527). As the practice of tele-mental health and the various technologies associated with it have evolved, so has its commonly understood definition. More recently, the American Psychological Association (APA; 2013) added to and clarified this definition by stating that telecommunications include "the preparation, transmission, communication, or related processing of information by electrical, electromagnetic, electromechanical, electro-optical, or electronic means" (p. 792). Further, the various technological modalities that comprise telepsychology include but are not limited to "telephone, mobile devices, interactive videoconferencing, e-mail, chat, text, and Internet (e.g., self-help websites, blogs, and social media)" (APA, 2013, p. 792). These technologies, either alone or in various combinations, may be utilized to provide a wide range of mental health treatments to clients, both on their own and in conjunction with in-person treatments.

The goals of tele-mental health are to enhance the quality of professional services provided to clients and to provide greater access to needed services to individuals who might not otherwise have been able to access them.

Examples of various technologies in clinical practice that may enhance the quality of services clients receive include:

- Use of the telephone, cell phone, and text messaging for communications or crisis in-

tervention between in-person treatment sessions.

- Use of smartphone apps to monitor clients and provide practitioners with status reports and feedback on symptoms and functioning in real time.
- For clients being treated for PTSD or phobias, the use of virtual reality or augmented reality technology to expose clients to stimuli and stressors in a controlled manner with the practitioner's ongoing support and assistance.
- The use of various technologies to provide practitioners with the opportunity to receive consultation and clinical supervision from expert colleagues outside of their local geographic area; something that holds great potential for enhancing the quality of professional services offered.

Examples of the use of tele-mental health to provide treatment to individuals who likely would not be able to access treatment without it, but who have a telephone and/or a computer with an Internet connection, include:

- Individuals who reside in rural, remote, or otherwise isolated areas with limited or no treatment providers in their local area.
- Individuals who are homebound due to disability, lack of transportation, or symptoms of their mental health difficulties such as agoraphobia or a fear of driving a car.
- Individuals who because of discomfort with seeking mental health services or embarrassment over their symptoms may be more comfortable with the relative anonymity of receiving professional services over the telephone or the Internet.
- During inclement weather, such as a snowstorm, when the client and/or practitioner are not able to safely or comfortably get to the practitioner's office for regularly scheduled in-person treatment sessions.

Tele-mental health may also be of great benefit to individuals who are presently receiving in-person treatment services and those who have some treatment options in their local geographic area but for a variety of reasons want or need to receive treatment from a professional outside their local area. These include:

- Current in-person clients who travel for business or who go out of the local area on vacation but who want or need to continue their treatment and for whom seeking in-

person treatment with another practitioner during the brief times they are away would be impractical and likely not effective.

- Individuals who choose not to seek out mental health treatment services in their local community due to limited resources there such as needing specialty services or access to culturally competent providers that are not available within a reasonable driving distance, or when existing personal, social, and/or business relationships with local mental health professionals necessitate receiving treatment from a professional located outside the individual's local area.
- Couples or family members in need of relationship assistance who live in different states or countries, and who cannot reasonably afford to physically travel to the same location on a regular basis for ongoing treatment. These individuals may find that the only effective option is a provider who is willing to provide distance services to people in various locations since they otherwise would not likely be able to obtain any professional help for their relationship concerns.

Ethical Issues and Challenges: A Case Example

Dr. Ino Vater, a licensed mental health clinician in independent practice, has recently been hearing a lot about tele-mental health. While she has not previously practiced it, being a very entrepreneurial business person, she sees this as a potentially lucrative practice expansion opportunity. She develops a business plan that includes advertising her services widely via the Internet to expand her reach and tap into new markets. She plans to begin offering e-mail counseling with a guaranteed 24-hr response window at a rate of \$25 per e-mail. She also will offer online individual and group psychotherapy utilizing Skype.

Dr. Vater updates her website with an announcement about these new services, stressing her qualifications as a licensed practitioner with over 30 years of experience. Being somewhat technologically savvy, she already has her standard informed consent form on her website for new clients to review and sign electronically on the website. She also has an electronic calendar on her website so new clients can schedule their

initial appointment with her directly. Payments are easily accepted via PayPal, so clients can pay in advance for services without having to come to her office.

Apparently, there is a significant need for the psychotherapy and counseling services Dr. Vater provides, and word is spreading quickly, as numerous new clients are scheduling appointments with her for both e-mail and video-conference counseling. She is thrilled that individuals from numerous states across the nation and even from other countries are seeking treatment from her. She is also excited to see the very broad range of clients with so many different presenting problems who wish to enter treatment with her. Pleased with all the new business she is receiving, Dr. Vater continues accepting all new clients and is very gratified that the new business plan she developed is working so well.

Has Dr. Vater Overlooked Any Important Ethical, Legal, and Clinical Issues?

When considering integrating various technologies into one's clinical practice, it is important that consideration be given to a broad range of issues before utilizing these technologies. While tele-mental health can be helpful to many individuals and may be the treatment of choice for some clients, *how* it is applied is of great importance and requires careful forethought to ensure its appropriate use and application.

As a starting point, it is essential that practitioners understand that all requirements of their profession's ethics code apply to the provision of tele-mental health services. For example, it is stated in the Ethical Principles of Psychologists and Code of Conduct (APA, 2010) that the Ethics Code applies to all professional services provided by psychologists, regardless of their type (e.g., assessment, treatment, consultation, supervision, teaching) and that "This Ethics Code applies to these activities across a variety of contexts, such as in person, postal, telephone, Internet, and other electronic transmissions" (p. 2). Similarly, the National Association of Social Workers Code of Ethics (National Association of Social Workers, 2008) states that its standards apply to all professional activities of social workers. The recently revised American Association of Marriage and Family

Therapy Code of Ethics (American Association of Marriage and Family Therapy, 2015) states that its standards apply to all professional activities of American Association of Marriage and Family Therapy members and additionally Standard VI, Technology-Assisted Professional Services, provides specific standards on the use of various technologies to provide marriage and family therapy. Further, the recently revised American Counseling Association Code of Ethics (American Counseling Association, 2014) includes Standard H, Distance Counseling, Technology, and Social Media, which provides counselors with clear guidance for addressing each of these issues ethically in one's counseling practice.

Competence in Tele-Mental Health

Professional competence can be viewed as "the habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values, and reflection in daily practice for the benefit of the individual and community served" (Epstein & Hundert, 2002, p. 226). Within the mental health professions' ethics codes, competence is viewed as an enforceable standard. Competence requires that practitioners possess the knowledge and skills needed to ensure meeting minimum expectations for the quality of professional services provided. We should always be striving to provide the highest quality services possible to our clients.

Before providing any tele-mental health services, mental health practitioners should familiarize themselves with relevant guidelines for the practice of tele-mental health. Guidelines relevant to a wide range of mental health professions are available through the TeleMental Health Institute at <http://telehealth.org/ethical-statements/>. APA has also published guidelines at <http://www.apapracticecentral.org/ce/guidelines/telepsychology-guidelines.pdf> (Joint Task Force for the Development of Telepsychology Guidelines for Psychologists, 2013). While guidelines do not contain enforceable standards, they represent each profession's consensus statement on tele-mental health best practices. Being familiar with and following these guidelines should prove helpful for promoting the ethical and competent practice of tele-mental health.

Technological Competence

Prior to providing online services, it is important to ensure that practitioners possess two types of competence; technological competence and clinical competence. Technological competence includes possessing adequate knowledge of and familiarity with the various technologies being used in the practice of tele-mental health. This may include knowledge about various technology requirements for providing tele-mental health services to include hardware, software, type of Internet connection, privacy safeguards, and security precautions needed to help ensure each client's privacy is protected. Practitioners should possess adequate familiarity with systems used so that they can make needed adjustments to settings used to ensure that auditory and visual quality are sufficient for optimal professional services to be provided as well as to provide instruction to clients on the use of these systems (Godine & Barnett, 2013). Practitioners should also prepare clients for potential of loss of sound, video, or Internet connection during sessions, and have the ability to troubleshoot difficulties that may arise including loss of Internet connection or other interruptions of service. A backup plan for making contact or following-up should be in place for all meetings.

Practitioners need to be familiar with the strengths and weaknesses of various commercially available software programs to ensure that the ones selected for use in their practices will meet necessary requirements to provide the clinical services in a manner that assists clients without undue risks to their privacy. Thus, Dr. Ino Vater should have first educated herself about tele-mental health and consulted with experienced colleagues before offering these services to clients. While Dr. Vater may have over 30 years of clinical experience and may utilize certain technologies in her personal life, her failure to take any courses on tele-mental health, her choice of a nonsecure video platform, and her choice of text-based therapy as an alternative suggests that her professional understanding of tele-mental health may be limited. Developing technological competence and an awareness of the limitations of various services should occur prior to offering such services to clients. This is consistent with the requirements of the APA Ethics Code (American Psycholog-

ical Association, 2010), which states in Standard 2.01(c), Competence, “Psychologists planning to provide services, teach, or conduct research involving populations, areas, techniques, or technologies new to them undertake relevant education, training, supervised experience, consultation, or study” (p. 5).

For example, while Skype is widely used by the general public with over 74,000,000 active users at present (Statistic Brain Research Institute, 2015), due to not being compliant with the requirements of the Health Insurance Portability and Accountability Act (HIPAA), it would not be an optimal choice as a videoconferencing platform. Only those products that are HIPAA-compliant and that meet federal requirements for protecting each client’s privacy should be used. Practitioners with knowledge of these issues will know that HIPAA requires that all companies offering HIPAA-compliant products and services provide users with a Business Associate Agreement in which they certify their compliance with HIPAA requirements (U.S. Department of Health and Human Services, 2015). Several examples of such HIPAA-compliant videoconferencing platforms include: Vyzit, VSee, Zoom, Regroup Therapy, and Breakthrough. Detailed information is easily found on each of these through an online search by typing each name in a search engine such as Google.

By using a product that has worked well for her in her personal life without researching and attending to these issues and identifying a HIPAA-compliant service, Dr. Vater is both violating HIPAA and putting her tele-mental health clients’ confidentiality at risk. She is also failing to provide full informed consent if she does not notify her clients of the privacy limitations of the service she is using. Last, because she is entering into a new form of service delivery that she has not used previously, clients have a right to know that this is a new arena that Dr. Vater is exploring, and she may also, in the informed consent process, let each client know that if she finds that it is not serving the client’s clinical needs, she may recommend a different type of service for that client.

General Tele-Mental Health Competence

Dr. Vater, and all mental health clinicians considering the provision of tele-mental health

services, should carefully consider the appropriateness of each technology for each client’s particular treatment needs. As an example, numerous authors (e.g., Barnett & Scheetz, 2003; Maheu & Gordon, 2000; Mallen, Vogel, & Rochlen, 2005) have highlighted the many limitations associated with the use of e-mail for providing counseling and psychotherapy services. Relevant issues and concerns include the absence of visual cues and significant potential for miscommunication, difficulty adequately assessing and diagnosing individuals one does not have the opportunity to observe, and a lack of empirical support for the effectiveness of e-mail as the primary means of providing counseling services. Other concerns include difficulty knowing the identity of the individual one is corresponding with, and whether it is the same individual each time. Additional difficulties include ensuring that a valid informed consent process occurs and challenges with being sufficiently responsive to clients’ treatment needs including the ability to appropriately respond to crises and emergencies.

Yet, with appropriate familiarity with the relevant literature, Dr. Vater would know that some technologies may be effectively used in tele-mental health with some clients. There is a significant body of literature at present that demonstrates the value of videoconferencing for providing psychotherapy and counseling to a wide range of clients. Research has demonstrated that the therapeutic alliance in psychotherapy via videoconferencing is comparable with the alliance found in in-person treatment (e.g., Cook & Doyle, 2002; Hanley, 2006; Morgan, Patrick, & Magaletta, 2008).

There also exists a broad literature on the effectiveness of psychotherapy and counseling provided via videoconferencing in treating a wide range of mental health issues and concerns. It has been shown to be helpful in treating individuals, couples, families, and groups for issues such as anxiety disorders to include generalized anxiety disorder, posttraumatic stress disorder, and panic disorder (e.g., Germain, Marchand, Bouchard, Drouin, & Guay, 2009; Spence et al., 2008; Wims, Titov, Andrews, & Choi, 2010); depression and grief (e.g., Dominick et al., 2009; Ruwaard et al., 2009); addictions (e.g., Mermelstein & Turner, 2006; Riper et al., 2009); among others. Mental health clinicians should familiarize themselves with this

extensive and rapidly expanding literature to ensure that treatments offered have empirical support.

Yet, not all presenting problems are amenable to tele-mental health interventions and not all tele-mental health modalities are equally appropriate for use to address clients' various treatment needs. Thus, an important aspect of competence for practitioners to possess is the ability to determine the appropriateness of the use of tele-mental health services for clients in general as well to include the appropriate pairing of treatment modalities with specific clinical needs. Examples include the inappropriateness of using tele-mental health across large distances for those clients who suffer from serious mental illness including impairments in reality testing, serious depression and suicidality, and impulse control difficulties such as violence and homicidality (Manhal-Baugus, 2001).

Dr. Vater's business plan appears to involve accepting all prospective clients into her tele-mental health practice, regardless of their particular needs or circumstances. While some clients may benefit from counseling services offered via telephone or e-mail, some will need videoconferencing treatment, while others will need in-person treatment, and still others may benefit from a combination of these services. These decisions should be made following a careful screening of each potential client's treatment needs. This screening would include seriousness of diagnosis, whether or not the client is currently in crisis, level of rapport, and the client's motivation for therapy. It should also include consideration of the support system available to client, whether the client can find competent clinicians in the area in which services are needed, and client access to a secure and private space where the prospective client may participate in the tele-mental health services.

The clinician should document the rationale for concluding that a particular client is suitable for tele-mental health services. Ideally, clinicians will also begin with cases that present the best chance of success from receiving distance services. These individuals may be those who already have an established and positive treatment relationship with the clinician, those who are temporarily traveling for business, and those who have the ability to return for face-to-face sessions. Those individuals who, after careful

screening, are deemed to be best served exclusively by in-person treatment should be referred to professionals in their local geographic area. Further, to ensure that clients receive the most appropriate treatment possible and to minimize the risk of exploiting or harming them, these decisions should be made based primarily on each client's treatment needs and not the clinician's financial motivations.

Multicultural Competence and Tele-Mental Health

Mental health clinicians providing assessment and treatment services via the Internet may easily find themselves violating professional expectations for multicultural competence (e.g., APA, 2003). As Dr. Vater is accepting clients from across the nation and around the world, she likely will be interacting with individuals from a wide range of cultural, ethnic, and linguistic backgrounds. While available technologies expand our reach and many individuals who might not otherwise have access to needed treatment now may be able to benefit from them, a failure to give careful consideration to each client's individual differences may result in more harm than good. Representative of the mental health professions' ethics codes, the National Association of Social Workers Code of Ethics (National Association of Social Workers, 2015), states in Standard 1.05b, Cultural Competence and Social Diversity, "Social workers should have a knowledge base of their clients' cultures and be able to demonstrate competence in the provision of services that are sensitive to clients' cultures and to differences among people and cultural groups" (para. 34).

When treating clients from around the world, it would not be realistic to expect all clients to speak English fluently. In fact, many individuals with limited access to mental health services in their nation may actively seek out mental health treatment via the Internet. Yet, the ability to communicate effectively is essential for counseling to be successful. Thus, while Dr. Vater is hoping to provide a broad range of online counseling services to clients around the world, she may find her ability to effectively communicate with some of them to be quite limited. Similarly, clients may come from a wide range of cultural backgrounds. Even if there are no language barriers, in order to pro-

vide treatment that is beneficial to clients, practitioners should possess the necessary multicultural competence to ensure sensitivity to clients' beliefs and practices, so these are not misinterpreted or violated.

On the other hand, there may be clients who are seeking out a clinician in Dr. Vater's location, or Dr. Vater, herself, for the very reason that they cannot find a culturally competent clinician in their own jurisdiction. For example, a client who identifies as gender nonconforming may live in a community in which there are no professionals who possess the needed competence to offer such services. This client may wish to meet with a psychotherapist who is competent to work with transgender and gender nonconforming clients and has this special competence.

Clinical Competence and Tele-Mental Health

It is also important to keep general requirements for clinical competence in mind when providing tele-mental health services. Clinicians should not provide assessments and treatments via tele-mental health that they are not competent to provide in person. As it is stated in Standard 3.10, Scope of Competence, "Marriage and family therapists do not diagnose, treat, or advise on problems outside the recognized boundaries of their competencies" (American Association of Marriage and Family Therapy, 2015, para. 44).

It may be tempting to accept all new clients, regardless of their presenting problems, but regardless of the modality or medium used, the provision of mental health services must be done in accordance with the requirements of each professional's relevant code of ethics, to include clinical competence. If Dr. Vater is conceptualizing her e-mail communications with clients as "advice giving" or "a helping conversation," she may be minimizing or overlooking clients' treatment needs and expectations, issues relevant to how the informed consent process is addressed. She may also be misrepresenting the services she is providing as something other than psychotherapy. Or she may be calling it psychotherapy when she is providing something else.

Informed Consent

The process of informed consent is designed to ensure that prospective clients receive the information needed to make an informed decision about participation in the professional services to be offered. For this to happen, they must receive relevant information before the professional services are provided, and this information must be shared in a manner that ensures clients comprehend the information being shared and its implications for them. Standard 10.01(a), Informed Consent to Therapy (APA, 2010) requires psychologists to:

inform clients/patients as early as is feasible in the therapeutic relationship about the nature and anticipated course of therapy, fees, involvement of third parties, and limits of confidentiality and provide sufficient opportunity for the client/patient to ask questions and receive answers. (p. 13)

While following the dictates of this standard is important, practitioners providing tele-mental health services will need to modify the informed consent procedures they typically use when providing in-person treatment ([Joint Task Force for the Development of Telepsychology Guidelines for Psychologists, 2013](#)). Thus, Dr. Vater using her standard informed consent form with tele-mental health clients is inappropriate. There are several modifications that must be made to the content and focus of the informed consent agreement when providing tele-mental health services ([American Counseling Association, 2014](#)).

It is important to discuss openly with clients the options and alternatives reasonably available to them to include in-person treatment and the range of tele-mental health services that exist in order to assist them with deciding on the most appropriate means of receiving treatment. It would not be appropriate to only offer the form of treatment one has advertised (e.g., e-mail counseling services) without discussing its strengths and weaknesses or its appropriateness for the client based on her or his stated treatment needs relative to other available treatments. Dr. Vater lists only two tele-mental health modalities on her website, and both appear to be unacceptable forms of treatment for a clinician who is interested in evidence-based or HIPAA-compliant treatment. If clients' treatment needs are not amendable to these modalities, referrals to other competent professionals

who can offer services that are appropriate for each client's treatment needs should be made.

All fees should be discussed up front so that clients understand what the treatment being offered will cost. This should include any fees charged for contacts between regularly scheduled appointments such as phone calls, e-mails, and text messages. It also should be made clear whether insurance will cover the services provided. If unsure, potential clients should be directed to their insurer to find out which, if any, services are covered. Each of these steps is vital in that practitioners are required by their respective codes of ethics not to misrepresent their fees and to never exploit or take advantage of their clients financially. Clinicians need also to be aware of appropriate billing codes for tele-mental health services so that they are not inadvertently engaging in insurance fraud by billing these services the same as face-to-face services. One should add "GT" to the billing code to show that the service provided was a tele-mental health service so as not to unintentionally misrepresent to the insurance company the services actually provided (APA, 2005).

The issues of confidentiality and its limits are especially relevant for clients considering participating in tele-mental health. The informed consent agreement should include discussion of these issues, so that prospective clients have a realistic understanding of the threats and risks to confidentiality that exist and that absolute confidentiality can never be guaranteed. Steps clinicians may take to help protect confidentiality include encryption of e-mail communications, virus and malware protections, use of firewalls, and use of passwords and secure Internet networks. After learning of and accepting the potential risks of others accessing their electronic communications, if clients would like to be able to communicate with the psychologist using a cellphone this must specifically be agreed to in the informed consent (U.S. Department of Health and Human Services, 2015). Similar actions can be taken for the provision of e-mail or non-HIPAA-compliant videoconferencing.

Emergency contact information should be included in the informed consent agreement as well as procedures to follow when interruptions in electronic communications occur. Clients who are being treated via tele-mental health should be informed about the state in which the clinician is licensed, and some explanation

about how reporting laws may be different from the ones in which the client resides. The client should have a clear understanding about what will trigger an exception to confidentiality and to whom and in which state, information will be released. Regarding interruptions to sessions in progress, an agreement should be in place for who will contact the other if the connection is lost and how this communication will be made, such as using a cell phone or landline phone if both parties have access to one. Since tele-mental health is frequently provided across great distances, the ability for clinicians to respond to client emergencies may be limited. It is therefore important to research resources in each client's local area and to provide the client with recommended resources to contact if experiencing a crisis that cannot be addressed through tele-mental health. This may include local medical centers, psychiatric hospitals, and individual treatment providers. Further, to help ensure that clients have realistic expectations of the practitioner, anticipated response time to electronic communications by the client should be shared and agreed to as well (American Counseling Association, 2014).

Since not all individuals have the legal right to give consent to treatment, it is important to first obtain proof that the prospective client is legally an adult and thus allowed to consent to her or his own treatment. When using a tele-mental health modality that does not provide visual images, it may be possible for a minor to misrepresent her or himself as an adult and pay for treatment using a parent's credit card. In addition, we have a duty to ensure that someone does not "pose" as our client in order to gain access to someone else's psychotherapy. Procedures should be in place and consistently followed to ensure that this does not occur. An example of such procedures include the use of an agreed upon password exchanged through encrypted media or in the most recent session, when scheduling the next one.

It is important that practitioners see informed consent as an ongoing process, not as a single event. While practitioners must obtain each client's informed consent to treatment at the outset of the professional relationship, it is also important to continually update this agreement as circumstances change. Any substantive change to how treatment is provided, risks involved in participating in it, fees or financial arrange-

ments, and the like should be openly discussed with clients before these changes are made. Thus, if a client has agreed to videoconferencing for treatment, and the practitioner decides over time that a different tele-mental health modality would be preferable, the informed consent should be updated to include discussing the reasons for recommending the change, the other options reasonably available, the relative risks and benefits of each treatment option, and the rationale for any recommendations being made. Practitioners should also discuss with clients that if they find that the modality is not adequately meeting the client's treatment needs, they reserve the right to let the client know that a new plan or discontinuation of this form of treatment may be necessary.

Legal Issues and Requirements: A Case Example

Dr. Roule Breyker is a licensed counselor in Montana, the fourth largest state in the United States, covering 145,552 square miles over 56 counties. He practices in one of the state's four urban areas. Yet, Montana is a very rural state with an average of only 6.4 persons per square mile and many counties without a single mental health professional (see www.montana-map.org). Many state residents live in very rural and remote areas without any easy access to mental health services.

Dr. Breyker has decided to begin offering tele-mental health to residents throughout the state in an effort to better meet this need. He finds that it is going so well that he has recently begun receiving inquiries from potential clients who reside in the neighboring states of Wyoming, North Dakota, Idaho, and South Dakota as well as from the neighboring Canadian provinces of Alberta, Saskatchewan, and British Columbia. He is excited about how word of his tele-mental health services is spreading, and he is gratified to know that he is helping to meet the significant mental health treatment needs of so many rural communities.

When sharing the news about all the great work he is doing in a meeting with several Montana colleagues, he is shocked when they express concern about his interjurisdictional practice. Dr. Breyker states that he is helping people who would not otherwise be able to receive mental health treatment, and he ex-

presses dismay at his colleagues' concerns. Feeling upset by what these colleagues are saying, he abruptly leaves the meeting, chalking it up to their professional jealousy.

Legal Issues in the Practice of Tele-Mental Health

As has been highlighted, the practice of tele-mental health can help clients obtain needed services to which they might not otherwise have access. In a rural state with so many individuals not having easy access to in-person mental health treatment, the practice of tele-mental health may be of great benefit to them. Mental health professionals practicing remote care should be familiar with their jurisdiction's licensing law and regulations, specifically regarding tele-mental health. While some states have not addressed this issue, others have included telehealth in their licensing acts. For each state where we plan to practice tele-mental health, clinicians should contact that state's licensing board or visit its website for the most up-to-date information.

When Dr. Roule Breyker practices tele-mental health within Montana, the state where he is licensed to practice, he can follow the requirements of his licensing law and corresponding regulations to be sure he is in compliance with them. Examples include requirements for informed consent, documentation, and mandatory reporting statutes. But, when he uses tele-mental health to provide treatment to clients who are located in other states and even in another country, this results in what is known as interjurisdictional practice ([Joint Task Force for the Development of Telepsychology Guidelines for Psychologists, 2013](#)). While advertising one's services via the Internet can help ensure that individuals from across the nation and around the world may be able to have access to needed professional assistance, the crossing of state and national boundaries brings with it a number of important legal issues and challenges.

The American Counseling Association Code of Ethics ([American Counseling Association, 2014](#)) makes it clear that "Counselors who engage in the use of distance counseling, technology, and social media within their counseling practice understand that they may be subject to laws and regulations of both the counselor's

practicing location and the client's place of residence" (p. 17). In addition to age of consent, something that can vary by jurisdiction, there are a number of legal and regulatory issues that must be addressed as well.

Licensing Issues

Interjurisdictional practice raises the issue of professional licensing. In that all jurisdictions require health professionals to be licensed before they may provide professional services in that locale, clinicians know that they must be licensed before treating clients. When using tele-mental health services to provide treatment to clients within one's state, province, or territory, the practitioner simply follows the dictates of their license. As has been highlighted, this can be very helpful for clients in remote parts of one's state or who are unable to leave their home.

Licensure requirements may be less clear when a client is located in another jurisdiction. The question then is how do licensing authorities address this situation? In the interjurisdictional practice of tele-mental health, the clinician is providing a professional service from one location while the client is receiving it in another jurisdiction. Thus far, not all jurisdictions have addressed this issue in their licensing laws and regulations, and decisions about what is appropriate are subject to idiosyncratic jurisdictional authorities.

This can create a tremendous challenge for practitioners wishing to engage in interstate or international practice. It is not practical to think that clinicians will be licensed in every jurisdiction in preparation for receiving referrals of individuals in each of those locations. Some jurisdictions have temporary licensing provisions in their licensing laws to allow for the provision of brief clinical services in their location. When clients travel for business or vacation, this may be the most appropriate option for providing tele-mental health services to them in compliance with the law.

When clients are residents of other jurisdictions, it raises greater challenges. An important first step is to research the licensure laws and regulations in the jurisdiction where each client is located. If these documents lack clarity on interjurisdictional practice, submitting a written request for clarification to that jurisdiction's

licensing board is recommended. For jurisdictions that require in-state licensure, options include seeking licensure in that state, something that may be time consuming, expensive, and impractical, or practicing in that other jurisdiction without being licensed there. Unfortunately, this latter option can place the professional at significant legal risk. Some states will permit clinicians to practice short-term (e.g., a period of 30 days) in a state in which the clinician is unlicensed, if she or he is licensed in another state. Some of these provisions can be found at <http://www.apapracticecentral.org/advocacy/state/telehealth-slides.pdf> (APA, 2013).

Currently, several organizations are working to resolve the challenge of interjurisdictional practice. For psychologists, the Association of State and Provincial Psychology Boards (ASPPB), with the support of the American Psychological Association's Practice Directorate, is actively working with individual state licensing boards and legislatures to create an interjurisdictional practice certificate. They also are attempting to develop interstate compacts similar to what is present in the nursing profession that allows nurses to practice in other states with their license from their home state (APA, 2013). This arrangement is similar to the use of a driver's license. One must become licensed in their home state and follow all the requirements of that license there. But, when driving in another state, they may use that license, but must be knowledgeable of and follow the laws and regulations of the local jurisdiction. Until such an arrangement is adopted, psychologists (and other mental health professionals) will need to be cautious about cross-jurisdictional practice, keeping in mind that legal and regulatory requirements may vary from state to state.

The same issues are relevant when providing mental health services across international borders. Some nations have licensing laws and regulations, and they may or may not be similar to those in the United States. Other nations may not even regulate mental health professions. It is each clinician's responsibility to research any applicable licensing laws and regulations prior to providing professional services in those jurisdictions. All mental health professionals are bound by their profession's code of ethics and should follow its dictates at all times. The absence of licensing laws and regulations in other

jurisdictions does not excuse mental health professionals from this obligation. If licensing laws and regulations do exist in the international jurisdiction where the client resides, practitioners will need to determine the legality of providing professional services into that location by means of tele-mental health and consider the impact of any differences in the requirements of those laws and regulations. Should differences be found between another jurisdiction's requirements and the requirements of the clinician's profession's code of ethics, it is recommended that actions that are most protective of clients' rights and welfare be chosen. It should also be noted that identifying crisis and emergency services when providing tele-mental health services internationally can be especially challenging. This challenge can have additional cultural competency implications, such as, for example, when a gay male client in India is seeking tele-mental health from a U.S. clinician because he cannot locate a psychotherapist in his country who will accept his sexual orientation. He may be extremely disinclined to seek crisis services in his local area out of fear that it will lead to other unwanted treatments.

Duty to Report Suspected Abuse and Neglect and Conflicting Laws

While mental health professionals understand that they must follow the laws of the state where they are licensed and practice, when providing treatment to a client located in another jurisdiction, there are several legal issues and concerns that arise. What should Dr. Roule Breyker do if a client in Wyoming discloses in a tele-mental health session that she is physically or sexually abusing her child? Should he follow the laws in Montana? Should he follow the laws in Wyoming (and does he even know them)? Or, should he attempt to follow both states' laws simultaneously? If he is licensed in both jurisdictions, then he may have different requirements.

In an important and noteworthy study, [Maheu and Gordon \(2000\)](#) found that of the mental health professionals providing tele-mental health services whom they surveyed:

- 75% reported providing services across state lines.
- 60% inquired about each client's state of residence.

- 74% were uncertain or incorrect about each state's telehealth laws.
- 50% made advanced arrangements for responding to emergencies or crises.
- 48% used a formal informed consent procedure prior to providing online services.

It is vital that Dr. Breyker research the laws relevant to the mandatory reporting of suspected abuse and neglect of minors in each state in which he provides professional services. But, as is highlighted in the results of [Maheu and Gordon's \(2000\)](#) study, one must first find out where potential clients reside. Even if Dr. Breyker becomes licensed in the surrounding states or obtains temporary licensing permission to offer tele-mental health services in these states, he still needs to be knowledgeable about the laws in these states relevant to his role as a treating clinician. We are expected to follow the laws in the state in which we are licensed. We have to know the laws of that jurisdiction, and not practice in states in which we are not legally licensed to practice. We should also be aware that when one reports across state lines, one loses immunity. Interstate licensure compacts, may, however, more formally address this issue.

While every state has laws regarding the mandatory reporting of the suspected abuse and neglect of minors ([Werth, Welfel, & Benjamin, 2009](#)), there are differences among these laws with regard to how abuse and neglect are defined, the threshold to be followed for making reports, where the report should be filed (where the alleged abuse or neglect occurred or in the psychologist's jurisdiction), the age of majority in that state, and the like. Failure to know and follow these laws in the states where clients reside can place minors at risk unnecessarily. Knowledge of these laws also is necessary so that practitioners may appropriately address these potential limits to confidentiality as part of the informed consent process.

Similarly, all jurisdictions have laws that address mandatory reporting requirements for the suspicion of harm to other vulnerable individuals to include the elderly and developmentally delayed adults. Yet, each jurisdiction's laws are different, with some focusing on different definitions of what it means to be a vulnerable adult; different definitions of relevant terms such as abuse, neglect, self-neglect, and exploitation; and different reporting thresholds. Once again, possessing knowledge of these laws in

the jurisdictions where clients reside is essential for fulfilling both ethical and legal obligations.

Dangerousness and the Duty to Warn, Protect, or Treat

Based on the landmark *Tarasoff v. Regents of the University of California* (1974, 1976) legal decisions, many jurisdictions have laws regarding the requirement to take some action when a client discloses an imminent threat to do harm to an identifiable victim or group of victims. Yet, these laws vary quite significantly with some jurisdictions having duty to warn laws; some having duty to protect laws; some having duty to warn, protect, and treat laws; and some have none of these requirements. Thus, a clinician's good faith effort to protect others from harm may result in inappropriately violating the client's confidentiality and violating state law. Further, when practicing tele-mental health across national borders, the issue is further complicated since depending on the nation, these issues may be addressed quite differently, to include not being addressed at all.

It is essential that mental health professionals practicing tele-mental health cross-jurisdictionally be familiar with the laws in the jurisdictions where the clients reside. Yet, in a study by Pabian, Welfel, and Beebe (2009), 76.4% of clinicians surveyed "were misinformed about their state laws, believing that they had a legal duty to warn when they did not, or assuming that warning was their only legal option when other protective actions less harmful to client privacy were allowed" (p. 8). This failure to know and appropriately follow these laws can have lethal and tragic consequences, and thus is most important for practitioners practicing tele-mental health to be cognizant of and follow. Similar to other reporting requirements, knowledge of these laws impacts the informed consent agreement with regard to the limits to confidentiality that exist in the treatment relationship.

Issues regarding both voluntary and involuntary hospitalization across state lines are quite complex. In addition to understanding state laws where the client resides, it would be wise to have handy the numbers for local police and the address for the nearest ER when a client engages our services from another location.

Recommendations for the Responsible Practice of Tele-Mental Health

Based on the information shared in this article, the following recommendations are made to assist mental health clinicians to engage in the practice of tele-mental health consistently with prevailing professional standards in an ethical, legal, and clinically effective manner.

- Follow all requirements for ethical conduct from your profession's code of ethics regardless of the tele-mental health medium used.
- Become familiar with and be guided by relevant tele-mental health practice guidelines.
- Learn and follow the relevant tele-mental health laws in all jurisdictions in which you will be providing clinical services.
- Assess each potential client's treatment needs to ensure the appropriateness of participating in tele-mental health, and that the most appropriate medium is used. Make referrals to other competent professionals when in the client's best interest.
- Use a comprehensive informed consent process that addresses all issues relevant to the practice of tele-mental health.
- Take all reasonable actions and use all readily available technology to protect each client's confidentiality, such as the encryption of e-mail communications.
- Only use HIPAA-compliant software programs to provide videoconferencing with clients.
- Only provide clinical services that you are competent to provide based on your education, training, and relevant clinical experience.
- Before providing tele-mental health services, develop competence regarding all hardware and software you will be utilizing to communicate with clients.
- Ensure multicultural competence and attend to linguistic and other diversity issues in your online interactions with clients.
- Learn about and follow all duty to warn and mandatory reporting requirements in the jurisdictions where you are providing tele-mental health services to clients.
- Before providing tele-mental health services, learn about resources in each client's

local area and make arrangements there for emergency and crisis situations.

- Document all tele-mental health services provided just as you would document in-person mental health services, ensuring that all records are stored securely so that each client's confidentiality is preserved.
- When unsure if a client should be treated via tele-mental health, utilize an ethical decision-making model and consult with experienced colleagues.
- Maintain appropriate liability insurance coverage and confirm that your malpractice insurance policy covers the provision of tele-mental health services.

References

- American Association of Marriage and Family Therapy. (2015). *Code of ethics*. Retrieved from http://aamft.org/iMIS15/AAMFT/Content/Legal_Ethics/Code_of_Ethics.aspx
- American Counseling Association. (2014). *American Counseling Association code of ethics*. Retrieved from <http://www.counseling.org/docs/ethics/2014-aca-code-of-ethics.pdf?sfvrsn=4>
- American Psychological Association. (2003). Guidelines on multicultural education, training, research, practice, and organizational change for psychologists. *American Psychologist*, 58, 377–402.
- American Psychological Association. (2005). *Coding and reimbursement for practitioners: Answers to frequently asked questions*. Retrieved from <http://www.apa.practicentral.org/reimbursement/billing/cpt/secure/fac-coding.aspx>
- American Psychological Association. (2010). *Ethical principles of psychologists and code of conduct*. Retrieved from <http://www.apa.org/ethics>
- American Psychological Association. (2013). *Telepsychology 50-state review*. Retrieved from <http://www.apapracticentral.org/advocacy/state/telehealth-slides.pdf>
- Barnett, J. E., & Scheetz, K. (2003). Technological advances and telehealth: Ethics, law, and the practice of psychotherapy. *Psychotherapy: Theory, Research, Practice, Training*, 40, 86–93. <http://dx.doi.org/10.1037/0033-3204.40.1-2.86>
- Cook, J. E., & Doyle, C. (2002). Working alliance in online therapy as compared to face-to-face therapy: Preliminary results. *CyberPsychology & Behavior*, 5, 95–105. <http://dx.doi.org/10.1089/109493102753770480>
- Dominick, S. A., Irvine, A. B., Beauchamp, N., Seeley, J. R., Nolen-Hoeksema, S., Doka, K. J., & Bonanno, G. A. (2009). An internet tool to normalize grief. *Omega: Journal of Death and Dying*, 60, 71–87. <http://dx.doi.org/10.2190/OM.60.1.d>
- Epstein, R. M., & Hundert, E. M. (2002). Defining and assessing professional competence. *JAMA: Journal of the American Medical Association*, 287, 226–235. <http://dx.doi.org/10.1001/jama.287.2.226>
- Germain, V., Marchand, A., Bouchard, S., Drouin, M. S., & Guay, S. (2009). Effectiveness of cognitive behavioural therapy administered by video-conference for posttraumatic stress disorder. *Cognitive Behaviour Therapy*, 38, 42–53. <http://dx.doi.org/10.1080/16506070802473494>
- Godine, N., & Barnett, J. E. (2013). The use of telepsychology in clinical practice: Benefits, effectiveness, and issues to consider. *International Journal of Cyber Behavior, Psychology and Learning*, 3, 70–83. <http://dx.doi.org/10.4018/ijcbpl.2013100105>
- Hanley, T. (2006). Developing youth-friendly online counseling services in the United Kingdom: A small scale investigation into the views of practitioners. *Counselling & Psychotherapy Research*, 6, 182–185. <http://dx.doi.org/10.1080/14733140600857535>
- Joint Task Force for the Development of Telepsychology Guidelines for Psychologists. (2013). Guidelines for the practice of telepsychology. *American Psychologist*, 68, 791–800. <http://dx.doi.org/10.1037/a0035001>
- Maheu, M. M., & Gordon, B. L. (2000). Counseling and therapy on the Internet. *Professional Psychology: Research and Practice*, 31, 484–489. <http://dx.doi.org/10.1037/0735-7028.31.5.484>
- Mallen, M. J., Vogel, D. L., & Rochlen, A. B. (2005). The practical aspects of online counseling: Ethics, training, technology, and competency. *The Counseling Psychologist*, 33, 776–818. <http://dx.doi.org/10.1177/0011000005278625>
- Manhal-Baugus, M. (2001). E-therapy: Practical, ethical, and legal issues. *CyberPsychology & Behavior*, 4, 551–563. <http://dx.doi.org/10.1089/109493101753235142>
- Mermelstein, R., & Turner, L. (2006). Web-based support as an adjunct to group-based smoking cessation for adolescents. *Nicotine & Tobacco Research*, 8, 69–76. <http://dx.doi.org/10.1080/14622200601039949>
- Morgan, R. D., Patrick, A. R., & Magaletta, P. R. (2008). Does the use of telemental health alter the treatment experience? Inmates' perceptions of telemental health versus face-to-face treatment modalities. *Journal of Consulting and Clinical Psychology*, 76, 158–162. <http://dx.doi.org/10.1037/0022-006X.76.1.158>
- National Association of Social Workers. (2008). *National Association of Social Workers code of ethics*.

- Retrieved from http://aamft.org/iMIS15/AAMFT/Content/Legal_Ethics/Code_of_Ethics.aspx
- Nickelson, D. W. (1998). Telehealth and the evolving health care system: Strategic opportunities for professional psychology. *Professional Psychology: Research and Practice*, 29, 527–535. <http://dx.doi.org/10.1037/0735-7028.29.6.527>
- Pabian, Y. L., Welfel, E., & Beebe, R. S. (2009). Psychologists' knowledge of their states' laws pertaining to Tarasoff-type situations. *Professional Psychology: Research and Practice*, 40, 8–14. <http://dx.doi.org/10.1037/a0014784>
- Riper, H., Kramer, J., Conijn, B., Smit, F., Schippers, G., & Cuijpers, P. (2009). Translating effective web-based self-help for problem drinking into the real world. *Alcoholism: Clinical and Experimental Research*, 33, 1401–1408. <http://dx.doi.org/10.1111/j.1530-0277.2009.00970.x>
- Ruwaard, J., Schrieken, B., Schrijver, M., Broeksteeg, J., Dekker, J., Vermeulen, H., & Lange, A. (2009). Standardized web-based cognitive behavioural therapy of mild to moderate depression: A randomized controlled trial with a long-term follow-up. *Cognitive Behaviour Therapy*, 38, 206–221. <http://dx.doi.org/10.1080/16506070802408086>
- Spence, S. H., Donovan, C. L., March, S., Gamble, A., Anderson, R., Prosser, S., . . . Kenardy, J. (2008). Online CBT in the treatment of child and adolescent anxiety disorders: Issues in the development of BRAVE-ONLINE and two case illustrations. *Behavioural and Cognitive Psychotherapy*, 36, 411–430. <http://dx.doi.org/10.1017/S135246580800444X>
- Statistic Brain Research Institute. (2015). *Skype company statistics*. Retrieved from <http://www.statisticbrain.com/skype-statistics/>
- Tarasoff v. Regents of the University of California, 529 P. 2d 553 (Cal. 1974).
- Tarasoff v. Regents of the University of California, 551 P. 2d 334 (Cal. 1976).
- U.S. Department of Health and Human Services. (2015). *Health Insurance Portability and Accountability Act of 1996*. Retrieved from <http://www.hhs.gov/ocr/privacy/hipaa/administrative/statute/index.html>
- Werth, J. L., Welfel, E. R., & Benjamin, G. A. H. (Eds.). (2009). *The duty to protect: Ethical, legal, and professional considerations for mental health professionals*. Washington, DC: American Psychological Association. <http://dx.doi.org/10.1037/11866-000>
- Wims, E., Titov, N., Andrews, G., & Choi, I. (2010). Clinician-assisted Internet-based treatment is effective for panic: A randomized controlled trial. *Australian and New Zealand Journal of Psychiatry*, 44, 599–607. <http://dx.doi.org/10.3109/00048671003614171>

Received July 30, 2015

Revision received December 9, 2015

Accepted December 13, 2015 ■