

# Association of Marital and Family Therapy Regulatory Boards

---

## Teletherapy Guidelines

*September 2016/Reviewed 11-2020\**

---



# AMFTRB

Association of Marital & Family Therapy Regulatory Boards

---

# AMFTRB Teletherapy Guidelines

---

## Table of Contents

Overview.....	4
Key Assumptions of the Teletherapy Committee .....	4
The Process .....	4
Introduction to Teletherapy Guidelines .....	5
Definitions.....	7
Guidelines for the Regulation of Teletherapy Practice .....	9
1. Adhering to Laws and Rules in Each Jurisdiction .....	9
2. Training/Educational Requirements of Professionals .....	9
3. Identity Verification of Client .....	9
4. Establishing the Therapist-Client Relationship .....	10
5. Cultural Competency .....	10
6. Informed Consent/Client Choice to Engage in Teletherapy .....	11
Availability of Professional to Client.....	11
Working with Children .....	12
7. Acknowledgement of Limitations of Teletherapy .....	12
8. Confidentiality of Communication .....	13
9. Professional Boundaries Regarding Virtual Presence .....	13
10. Social Media and Virtual Presence .....	13
11. Sexual Issues in Teletherapy .....	14
12. Documentation/Record Keeping.....	14
13. Payment and Billing Procedures.....	15
14. Emergency Management .....	15
15. Synchronous vs. Asynchronous Contactwith Client(s).....	16
16. HIPAA Security, Web Maintenance, and Encryption Requirements .....	16
17. Archiving/Backup Systems .....	17
18. Electronic Links .....	17
19. Testing/Assessment .....	17
20. Telesupervision .....	18

Contributors ..... 19  
    MFT Training Programs and Faculty ..... 19  
    State Licensing Boards, Executive Directors, and Board Members ..... 20  
    Teletherapy Committee Members ..... 21  
Resources ..... 22  
References ..... 24

## Overview

The AMFTRB Teletherapy Committee was created and tasked with developing a set of guidelines for use by Member Boards when regulating the practice of teletherapy by Licensed Marriage and Family Therapists (LMFTs) across the country. The Committee reviewed current AAMFT Codes of Ethics and other professional codes of ethics, state laws, research articles, and telehealth guidelines of many disciplines in creating the following guidelines for Licensed Marriage and Family Therapists.

## Key Assumptions of the Teletherapy Committee

The committee agreed upon the following tenets which informed each of the guidelines herein:

- I. Public protection must be the overriding principle behind each guideline.
- II. Each guideline shall be written with special consideration of those uniquely systemic challenges.
- III. All existing minimum standards for face-to-face client interaction are assumed for teletherapy practice.
- IV. A teletherapy standard shall not be unnecessarily more restrictive than the respective face-to-face standard for safe practice.
- V. Each guideline must be a recommendation for a minimum standard for safe practice *not* a best practice recommendation.
- VI. The regulation of teletherapy practice is intertwined with the challenges of portability of LMFT licensure across state lines.
- VII. Each guideline shall be written with consideration for the possibility of a national teletherapy credential.

## The Process

The AMFTRB Teletherapy Committee members were identified in fall 2015. The committee began with a review of literature and current telehealth practice publications within the field of marriage and family therapy and across professional disciplines. Topical areas for telemental health guidelines were identified, and each committee member was charged with researching the critical elements to be included in the final draft. The committee met and reviewed each of the elements of the guidelines. Please be advised that the committee did not draft specific regulations regarding the appropriateness of telemental health and working with domestic violence victims, completing child custody evaluations, treating cyber addiction, or using technology for supervised sanctions as the research in each of these areas was limited. We also acknowledge that a method by which cultural competency may be measured is needed and encourage Member Boards to advise therapists to seek training in this area.

Committee members identified stakeholders whose input was desired in reviewing the draft guidelines. Comments were requested from marriage and family therapy graduate programs, continuing education resources, and state licensing boards. The committee reviewed and analyzed the comments from stakeholders, consulted the AAMFT Code of Ethics, and Guidelines, and incorporated this information into the final document. The draft guidelines were then submitted to the 2016 AMFTRB delegate assembly for discussion and adoption.

## Introduction to Teletherapy Guidelines

Electronic practice in behavioral health has continued to garner momentum. With the creation of Facebook in 2004, the onset of 140 character messages through Twitter in 2006, and the proliferation of video conferencing platforms, therapists and clients have more options available to interact with each other than ever before. Telemental health is experiencing an “evident boom” for many reasons. Social media has significantly contributed to the growth. For example, as of July 2016, Facebook reports over 950 million users, 500 million of whom log in daily. The Pew Research Center (January 2014) reported 87% of American adults use the internet, up from 14% in 1995 (Pew, 2014). The Internet World Stats estimates 3,611 millions of users of the internet (Zephoria, 2016).

The State of Telemental Health in 2016 identifies five reasons for this growth. First, telemental health does not require physical contact with patients; therefore, technology based services are not that different from face-to-face therapy. While this statement overlooks the nuances of providing telemental health, it does support a burgeoning practice of clients receiving services without needing to step foot in a therapist’s office. Second, telemental health has been accepted by a large number of payers, more than other telehealth disciplines. As more and more payers cover services provided through electronic practice, it is anticipated that a growing number of therapists will provide care electronically. Third, telemental health may reduce the stigma of those seeking care. One of the unspoken benefits of telemental health is that clients do not need to be seen entering a therapist’s office. Therapists are cognizant of the concern clients have for confidentiality when determining where to house their brick-and-mortar practices. With the opportunity to receive telemental health electronically, the stigma of receiving counseling may be lessened. Not only is the potential for the stigma of mental health diminishing, more and more clients may also have an opportunity to receive care through telemental health. Fourth, the prevalence of mental health services and the shortage of mental health counselors is incentivizing stakeholders to look for alternatives to face-to-face care. For psychiatry, the American Medical Association reported that 60 percent of psychiatrists nationwide are at least 55 years old, with about 48 percent considering retiring in the next five years. “According to Mental Health American’s latest report on mental health, there is only one mental health provider for every 566 people in the country.” Maine has the highest number of mental health providers with a 1:250 ratio and Texas has the fewest (1:1,100). Finally, the patients who have received telemental health services have perceived their care to be effective (Epstein, Becker, & O’Brien, 2016).

Since the early discussions about telemental health, the technological landscape has changed. Cybercounseling (Hughes, 2000), e-counseling, e-therapy (Epstein, Becker, & O’Brien, 2016) and the current term of telemental health services have evolved as the shifting sands of modalities used in electronic practice have altered the modalities therapists use. Early publications about telemental

health services asked questions such as, “Should emails be encrypted?” (Mitchell, 2000), “What fee structures should be established for online services?” (Hughes, 2000), “Can a client decline to use secure systems?”, and “What if a client emergency is received, and there is no identifying information?” (Mitchell, 2000).

Discussions about online therapy have shifted as technologies available for therapy have shifted. Early discussions involved telephonic counseling and emails which evolved into video counseling, avatars, chats, blogs, and more. Social media and social networking sites have also altered the therapy landscape. Although the technologies have changed, the concerns associated with the provision of telemental health services have not. The assurance of confidentiality continues to be a concern (Hertlein, Blumer, & Mihaloliakos, 2014; Derrig-Palumbo & Eversole, 2011), as does boundary management ((Hertlein, Blumer, & Mihaloliakos, 2014; Hertlein et al, 2014), and management of crises (Hertlein, Blumer, & Mihaloliakos, 2014; Perle et al., 2013; Chester & Glass, 2006). Other concerns identified in research include the impact technology has on the therapeutic relationship, liability and licensing issues, and training and education required to provide effective telemental health services (Hertlein, Blumer, & Mihaloliakos, 2014).

As millennials enter the counseling field, the use of technology is anticipated to continue. Reith (2005) noted millennials are more comfortable with technology and have been dubbed the “digital natives”. Digital natives were “born into” a world of technology, more so than previous generations who have been termed “digital immigrants” (Prensky, 2001). Furthermore, Blumer, Hertlein, Allen, & Smith (2012) reported that millennials also feel technology is private and safe. This perception could impact the decisions made in the care and safekeeping of clinical information which fuels the need for technology specific regulations.

The proliferation of counseling-related websites has also impacted the need for technology-related regulations. In September 2008, Haberstroh (2009) identified 4 million websites when searching “online counseling”. In July 2016, a recent search of the same term netted 94 million results. This growth clearly indicates more and more counselors are turning to the internet to provide services of some type. Blumer, Hertlein, Allen, & Smith (2012) noted in their research that therapists used technology to augment treatment and Twist & Hertlein (2015) noted the use of technology for online professional networking.

While research indicates a growing use of technology in professional communications, Maheu & Gordon (2000) discovered that 78% of counselors acknowledged treating clients from other states online. Furthermore, Shaw & Shaw (2004) and Heinlen et al (2003) “found many online clinicians did not regularly follow ethical guidelines in their practices”. In a study of Swedish physicians, Brynold et al (2013) noted that physicians were tweeting in a manner deemed “unprofessional,” and the tweets were considered violations of patient privacy. Nearly 84% of family therapists were noted, in one study, to have communication with clients via email (Hertlein, Blumer & Smith, 2013).

Therapists may be confused about how to ethically and legally provide telemental health services. Haberstroh, Barney, Foster, & Duffey (2013) noted while no state licensing boards prohibit telemental health services, the language is vague. “Less than half of state boards directly allowed the practice of online clinical work through their local state laws or ethical codes...However, the specificity of the guidance provided by licensure boards varied greatly.” States seem to be grappling with the challenges of writing effective and somewhat timeless technology regulations. Therapists must comply with the

relevant licensing laws in the jurisdiction where the therapist is licensed when providing the care and the relevant licensing laws where the client is located when receiving care. Many states will only process complaints from residents of their state. Note, in the United States, the jurisdictional licensure requirement is usually tied to *where the client is physically located* when he or she is receiving the care, *not* where the client lives; however, therapists must ensure they are also compliant with any and all state and federal laws.

While the technologies and opportunities continue to emerge, few graduate programs provide meaningful guidance in how to establish a telemental health practice. Feedback received from graduate programs indicate the majority of programs, if they are addressing telemental health practice at all, are covering telemental health services typically in one class period. Many noted that the lack of clear regulations impacted their willingness to provide more comprehensive education about telemental health practice.

Therapists currently in the field rely on post-graduate training, typically in the form of continuing education workshops and programs, to expand their professional competence. Hertlein, Blumer & Smith (2013) noted that therapists should be trained in providing telemental health services, and yet, at the 2010 AAMFT conference, they note 1 of 220 workshops/posters focused on telemental health. Williams et al (2013) suggested a “framework that includes e-professionalism” be drafted. All of these events support the need for AMFTRB to establish telemental health guidelines.

## Definitions

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

**Competency** - Marriage and family therapists ensure that they are well trained and competent in the use of all chosen technology-assisted professional services. Careful choices of audio, video, and other options are made in order to optimize quality and security of services and to adhere to standards of best practices for technology-assisted services. Furthermore, such choices of technology are to be suitably advanced and current so as to best serve the professional needs of clients and supervisees. (AAMFT Code of Ethics, 2015)

**Electronic communication** - Using Web sites, cell phones, e-mail, texting, online social networking, video, or other digital methods and technology to send and receive messages, or to post information so that it can be retrieved by others or used at a later time. (Technology Standards in Social Work Practice, 2016)

**Encryption** – A mathematical process that converts text, video, or audio streams into a scrambled, unreadable format when transmitted over the internet. (Trepal, Haberstroh, Duffey, & Evans, 2007)

**HIPAA compliant** – HIPAA, the Health Insurance Portability and Accountability Act, sets the standard for protecting sensitive patient data. Any company that deals with protected health information (PHI) must ensure that all the required physical, network, and process security measures are in place and followed. This includes covered entities (CE), anyone who provides treatment, payment and operations in healthcare, and business associates (BA), anyone with access to patient information and provides

support in treatment, payment or operations. Subcontractors, or business associates of business associates, must also be in compliance. (What is HIPAA Compliance? 2016)

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

**PHI** – Protected Health Information (HIPAA, 2016)

**Social media/social networking** - Social media are web-based communication tools that enable people to interact with each other by both sharing and consuming information (Webtrends, 2016)

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

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

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

**Verification** – Measures to verify both counselor and client identities online (Haberstroh, 2009)

**Virtual relationship** - A relationship where people are not physically present but communicate using online, texting, or other electronic communication devise (Urban Dictionary, 2016)



## Guidelines for the Regulation of Teletherapy Practice

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

- A. Therapists of one state who are providing marriage and family therapy to clients in another state must comply with the laws and rules of both jurisdictions.
- B. Treatment, consultation, and supervision utilizing technology-assisted services will be held to the same standards of appropriate practice as those in traditional (in person) settings.

### 2. Training/Educational Requirements of Professionals

- A. Therapists must be accountable to states of jurisdiction education requirements for teletherapy prior to initiating teletherapy.
- B. Therapists may only advertise and perform those services they are licensed and trained to provide. The anonymity of electronic communication makes misrepresentation possible for both therapists and clients. Because of the potential misuse by unqualified individuals, it is essential that information be readily verifiable to ensure client protection.
- C. Therapists shall review their discipline's definitions of "competence" prior to initiating teletherapy client care to assure that they maintain recommended technical and clinical competence for the delivery of care in this manner. Therapists shall have completed basic education and training in suicide prevention. While the depth of training and the definition of "basic" are solely at the therapist's discretion, the therapist's competency may be evaluated by the state board.
- D. Therapists shall assume responsibility to continually assess both their professional and technical competence when providing teletherapy services.
- E. Minimum 15 hours initial training. Must demonstrate continued competence in a variety of ways (e.g. encryption of data, HIPAA compliant connections). Areas to be covered in the training must include, but not be limited to:
  - a. Appropriateness of Teletherapy
  - b. Teletherapy Theory and Practice
  - c. Modes of Delivery
  - d. Legal/Ethical Issues
  - e. Handling Online Emergencies
  - f. Best Practices & Informed Consent
- F. Minimum of 5 continuing education hours every 5 years is required.

### 3. Identity Verification of Client

- A. Therapists must recognize the obligations, responsibilities, and client rights associated with establishing and maintaining a therapeutic relationship.
- B. An appropriate therapeutic relationship has not been established when the identity of the therapist may be unknown to the client or the identity of the client(s) may be unknown to the therapist. An initial face-to-face meeting, which may utilize HIPAA compliant video-conferencing, is highly recommended to verify the identity of the client. If such verification

is not possible, the burden is on the therapist to document appropriate verification of the client.

- C. A therapist shall take reasonable steps to verify the location and identify the client(s) at the onset of each session before rendering therapy using teletherapy.
- D. Therapists shall develop written procedures for verifying the identity of the recipient, his or her current location, and readiness to proceed at the beginning of each contact. Examples of verification means include the use of code words, phrases or inquiries. (For example, "is this a good time to proceed?").

#### 4. Establishing the Therapist-Client Relationship

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

#### 5. Cultural Competency

- A. Therapists shall be aware of and sensitive to clients from different cultures and have basic clinical competency skills providing these services.
- B. Therapists shall be aware of the limitations of teletherapy and recognize and respect cultural differences (e.g. when therapist is unable to see the client, non-verbal cues). Therapists shall remain aware of their own potential projections, assumptions, and cultural biases.
- C. Therapists shall select and develop appropriate online methods, skills, and techniques that are attuned to their clients' cultural, bicultural, or marginalized experiences in their environments.
- D. Client perspectives of therapy and service delivery via technology may differ. In addition, culturally competent therapists shall know the strengths and limitations of current electronic modalities, process and practice models, to provide services that are applicable and relevant to the needs of culturally and geographically diverse clients and members of vulnerable populations.

- E. Therapists shall consider cultural differences, including clarity of communications.
- F. Sensory deficits, especially visual and auditory, can affect the ability to interact over a videoconference connection. Therapists shall consider the use of technologies that can help with visual or auditory deficit. Techniques should be appropriate for a client who may be cognitively impaired, or find it difficult to adapt to the technology.

## 6. Informed Consent/Client Choice to Engage in Teletherapy

### Availability of Professional to Client

- A. The therapist must document the provision of consent in the record prior to the onset of therapy. The consent shall include all information contained in the consent process for in-person care including discussion of the structure and timing of services, record keeping, scheduling, privacy, potential risks, confidentiality, mandatory reporting, and billing.
- B. This information shall be specific to the identified service delivery type and include considerations for that particular individual.
- C. The information must be provided in language that can be easily understood by the client. This is particularly important when discussing technical issues like encryption or the potential for technical failure.
- D. Local, regional and national laws regarding verbal or written consent must be followed. If written consent is required, electronic signatures may be used if they are allowed in the relevant jurisdiction.
- E. In addition to the usual and customary protocol of informed consent between therapist and client for face-to-face counseling, the following issues, unique to the use of teletherapy, technology, and/or social media, shall be addressed in the informed consent process:
  - a. confidentiality and the limits to confidentiality in electronic communication;
  - b. teletherapy training and/or credentials, physical location of practice, and contact information;
  - c. licensure qualifications and information on reporting complaints to appropriate licensing bodies;
  - d. risks and benefits of engaging in the use of teletherapy, technology, and/or social media;
  - e. possibility of technology failure and alternate methods of service delivery;
  - f. process by which client information will be documented and stored;
  - g. anticipated response time and acceptable ways to contact the therapist;
    - i. agreed upon emergency procedures;
    - ii. procedures for coordination of care with other professionals;
    - iii. conditions under which teletherapy services may be terminated and a referral made to in-person care;
  - h. time zone differences;
  - i. cultural and/or language differences that may affect delivery of services;
  - j. possible denial of insurance benefits;
  - k. social media policy;
  - l. specific services provided;
  - m. pertinent legal rights and limitations governing practice across state lines or international boundaries, when appropriate; and
  - n. Information collected and any passive tracking mechanisms utilized.

- F. Given that therapists may be offering teletherapy to individuals in different states at any one time, the therapists shall document all relevant state regulations in the respective record(s). The therapist is responsible for knowing the correct informed consent forms for each applicable jurisdiction.
- G. Therapists must provide clients clear mechanisms to:
  - a. access, supplement, and amend client-provided personal health information;
  - b. provide feedback regarding the site and the quality of information and services; and
  - c. register complaints, including information regarding filing a complaint with the applicable state licensing board(s).

#### Working with Children

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

## 7. Acknowledgement of Limitations of Teletherapy

- A. Therapists must: (a) determine that teletherapy is appropriate for clients, considering professional, intellectual, emotional, and physical needs; (b) inform clients of the potential risks and benefits associated with teletherapy; (c) ensure the security of their communication medium; and (d) only commence teletherapy after appropriate education, training, or supervised experience using the relevant technology.
- B. Clients must be made aware of the risks and responsibilities associated with teletherapy. Therapists are to advise clients in writing of these risks and of both the therapist's and clients' responsibilities for minimizing such risks.
- C. Therapists shall consider the differences between face-to-face and electronic communication (nonverbal and verbal cues) and how these may affect the therapy process. Therapists shall educate clients on how to prevent and address potential misunderstandings arising from the lack of visual cues and voice intonations when communicating electronically.
- D. Therapists shall be aware of the limitations of teletherapy and recognize and respect cultural differences (e.g. when therapist is unable to see the client, non-verbal cues). Therapists shall remain aware of their own potential projections, assumptions, and cultural biases.
- E. Therapists shall recognize the members of the same family system may have different levels of competence and preference using technology. Therapists shall acknowledge power dynamics when there are differing levels of technological competence within a family system.
- F. Before therapists engage in providing teletherapy services, they must conduct an initial assessment to determine the appropriateness of the teletherapy service to be provided for the client(s). Such an assessment may include the examination of the potential risks and benefits to provide teletherapy services for the client's particular needs, the multicultural

and ethical issues that may arise, and a review of the most appropriate medium (e.g., video conference, text, email, etc.) or best options available for the service delivery. It may also include considering whether comparable in-person services are available, and why services delivered via teletherapy are equivalent or preferable to such services. In addition, it is incumbent on the therapist to engage in a continual assessment of the appropriateness of providing teletherapy services throughout the duration of the service delivery.

## 8. Confidentiality of Communication

- A. Therapists utilizing teletherapy must meet or exceed applicable federal and state legal requirements of health information privacy including HIPAA/HITECH.
- B. Therapists shall assess carefully the remote environment in which services will be provided, to determine what impact, if any, there might be to the efficacy, privacy and/or safety of the proposed intervention offered via teletherapy.
- C. Therapists must understand and inform their clients of the limits to confidentiality and risks to the possible access or disclosure of confidential data and information that may occur during service delivery, including the risks of access to electronic communications.

## 9. Professional Boundaries Regarding Virtual Presence

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

## 10. Social Media and Virtual Presence

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

- B. In cases where therapists wish to maintain a professional and personal presence for social media use, separate professional and personal web pages and profiles shall be created to clearly distinguish between the two kinds of virtual presence.
- C. Therapists must respect the privacy of their clients' presence on social media unless given consent to view such information.
- D. Therapists must avoid the use of public social media sources (e.g., tweets, blogs, etc.) to provide confidential information.
- E. Therapists shall refrain from referring to clients generally or specifically on social media.
- F. Therapists who use social networking sites for both professional and personal purposes are encouraged to review and educate themselves about the potential risks to privacy and confidentiality and consider utilizing all available privacy settings to reduce these risks. They are mindful of the possibility that any electronic communication can have a high risk of public discovery.
- G. Therapists who engage in online blogging shall be aware that they are revealing personal information about themselves and shall be aware that clients may read the material. Therapists shall consider the effect of a client's knowledge of their blog information on the professional relationship, and when providing marriage and family therapy, place the client's interests as paramount.

## 11. Sexual Issues in Teletherapy

- A. Treatment and/or consultation utilizing technology-assisted services must be held to the same standards of appropriate practice as those in face to face settings.
- B. Therapists must be aware of statutes and regulations of relevant jurisdictions regarding sexual interactions with current or former clients or with known members of the client's family system.

## 12. Documentation/Record Keeping

- A. All direct client-related electronic communications, shall be stored and filed in the client's medical record, consistent with traditional record-keeping policies and procedures.
- B. Written policies and procedures must be maintained at the same standard as face-to-face services for documentation, maintenance, and transmission of the records of the services using teletherapy technologies.
- C. Services must be accurately documented as remote services and include dates, place of both therapist and client(s) location, duration, and type of service(s) provided.
- D. Requests for access to records require written authorization from the client with a clear indication of what types of data and which information is to be released. If therapists are storing the audiovisual data from the sessions, these cannot be released unless the client authorization indicates specifically that this is to be released.
- E. Therapists must create policies and procedures for the secure destruction of data and information and the technologies used to create, store, and transmit data and information.
- F. Therapists must inform clients on how records are maintained electronically. This includes, but is not limited to, the type of encryption and security assigned to the records, and if/for how long archival storage of transaction records is maintained.

- G. Clients must be informed in writing of the limitations and protections offered by the therapist's technology.
- H. The therapist must obtain written permission prior recording any/or part of the teletherapy session. The therapist shall request that the client(s) obtain written permission from the therapist prior to recording the teletherapy session.

### 13. Payment and Billing Procedures

- A. Prior to the commencement of initial services, the client shall be informed of any and all financial charges that may arise from the services to be provided. Arrangement for payment shall be completed prior to the commencement of services.
- B. All billing and administrative data related to the client must be secured to protect confidentiality. Only relevant information may be released for reimbursement purposes as outlined by HIPAA.
- C. Therapist shall document who is present and use appropriate billing codes.
- D. Therapist must ensure online payment methods by clients are secure.

### 14. Emergency Management

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

commencement of the treatment and may also be included in the general emergency management protocol.

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

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

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

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



## 17. Archiving/Backup Systems

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

## 18. Electronic Links

- A. Therapists shall regularly ensure that electronic links are working and are professionally appropriate.

## 19. Testing/Assessment

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

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

## 20. Telesupervision

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

## Contributors

AMFTRB wants to acknowledge and thank the following stakeholders who contributed their responses to the surveys and documents that the Teletherapy Committee has developed. In addition, a special appreciation to the three research assistants who worked with the committee: from Alaska, **Ryan Bergerson**, B.S. and **Lauren Mitchell**, M.S. and from Colorado, **Cody Eden**, B.A.

### MFT Training Programs and Faculty:

Abilene Christian University (MMFT)	<b>Dale Bertram</b>
Antioch University Seattle (MA)	<b>Paul David, Kirk Honda</b>
Argosy University - Salt Lake (MA)	<b>Anthony Alonzo</b>
Argosy University- Twin Cities (MA)	<b>Jody Nelson</b>
Central Connecticut State University (MS)	<b>Ralph Cohen</b>
Converse College-(MMFT)	<b>Kelly Kennedy</b>
Council for Relationships (PDI)	<b>Michele Southworth</b>
East Carolina University (MS)	<b>Damon Rapplelea</b>
East Carolina University (PhD)	<b>Jennifer Hodgson</b>
Edgewood College (MS)	<b>Will Hutter, Peter Fabian</b>
Evangelical Theological Seminary (MA)	<b>Joy Corby</b>
Kansas State University (MS) (PhD)	<b>Sandra Stith</b>
Lewis and Clark College (MCFT)	<b>Carmen Knudson-Martin</b>
Louisville Presby. Theol. Sem. (MA)	<b>Loren Townsend</b>
Minnesota, University of (PhD)	<b>Steven Harris</b>
Mount Mercy University	<b>Randy Lyle</b>
Northcentral University (MA)	<b>Lisa Kelledy</b>
Northcentral University (PhD)	<b>James Billings, Mark White</b>
Nova Southeastern University (MS)	<b>Anne Rambo</b>
Our Lady of the Lake University-Houston (MS)	<b>Leonard Bohanon</b>
Pfeiffer University (MA)	<b>Laura Bryan, Susan Wilkie</b>

Philadelphia Child & Family Ctr (PDI)	<b>Marion Lindblad-Goldberg</b>
Purdue University-Calumet (MS)	<b>Megan Murphy</b>
Reformed Theological Seminary (MA)	<b>Jim Hurley</b>
Rochester, University of (MS)	<b>Jenny Speice</b>
Seattle University (MA)	<b>Christie Eppler</b>
Southern Mississippi, University of (MS)	<b>Pam Rollins</b>
St. Cloud State University (MS)(PDC)	<b>Jennifer Connor</b>
St. Mary's University (MA) (PhD)	<b>Jason Northrup</b>
St. Mary's University of Minnesota-(MA) (PDI)	<b>Samantha Zaid</b>
Texas Tech University (PhD)	<b>Doug Smith</b>
Virginia Tech University-Blacksburg (PhD)	<b>Scott Johnson</b>
Virginia Tech University-Falls Church (MS)	<b>Eric McCollum</b>
Wisconsin Stout, University of (MS)	<b>Dale Hawley</b>

[State Licensing Boards, Executive Directors, and Board Members:](#)

Alabama	<b>Alan Swindall</b>
Alaska	<b>Laura Carrillo</b>
Arizona	<b>Tobi Zavala</b>
Arkansas	<b>Michael Loos</b>
Delaware	<b>Bill Northey</b>
Guam	<b>Vincent Pereda, Mamie Balajadia</b>
Hawaii	<b>Lynn Bhanot</b>
Idaho	<b>Piper Field</b>
Illinois	<b>David Norton</b>
Kentucky	<b>Jane Prouty</b>
Louisiana	<b>Penny Millhollon</b>
Maryland	<b>Tracey DeShields</b>
Massachusetts	<b>Jacqueline Gagliardi</b>
Massachusetts	<b>Erin LeBel</b>

Minnesota	<b>Jennifer Mohlenhoff</b>
Missouri	<b>Loree Kessler</b>
Montana	<b>Cyndi Reichenbach</b>
New Mexico	<b>Evelyn Tapia-Barnhart</b>
New York	<b>David Hamilton</b>
Ohio	<b>Brian Carnahan</b>
Oregon	<b>Charles Hill, LaRee Felton</b>
Pennsylvania	<b>Joy Corby</b>
Rhode Island	<b>Arlene Hartwell</b>
South Carolina	<b>Danny Garnett</b>
South Dakota	<b>Mary Guth</b>
Texas	<b>Rick Bruhn</b>
Washington	<b>Brad Burnham</b>
West Virginia	<b>Roxanne Clay</b>
Wisconsin	<b>Peter Fabian</b>
Wyoming	<b>Kelly Heenan</b>

[Teletherapy Committee Members:](#)

Most importantly, AMFTRB wants to recognize the exceptional and dedicated work of the Teletherapy Committee.

**Mary Alice Olsan**, Committee Chair (Louisiana)

**Jennifer Smothermon** (Texas)

**Leon Webber** (Alaska)

**Jeremy Blair** (Alabama)

**Susan Meyerle** (Nebraska)

**Lois Paff Bergen**, AMFTRB Executive Director

## Resources

Alaska Board of Marital & Family Therapy, Professional Licensing, Division of Commerce, Community, and Economic Development, Corporations, Business, & Professional Licensing, Board of Marital and Family Therapy

[www.commerce.alaska.gov/web/cbpl/ProfessionalLicensing/BoardofMaritalFamilyTherapy](http://www.commerce.alaska.gov/web/cbpl/ProfessionalLicensing/BoardofMaritalFamilyTherapy)

American Association for Marriage and Family Therapy (AAMFT)

[www.aamft.org](http://www.aamft.org)

American Counseling Association (ACA)

[www.counseling.org](http://www.counseling.org)

Association of Social Work Boards (ASWB)

[www.aswb.org](http://www.aswb.org)

American Psychological Association (APA)

[www.apa.org](http://www.apa.org)

American Telemedicine Association (ATA)

[www.americantelemed.org](http://www.americantelemed.org)

Australian Psychological Society (APS)

[www.psychology.org.au](http://www.psychology.org.au)

Federation of State Medical Boards

[www.fsmb.org](http://www.fsmb.org)

International Society for Mental Health Online

[www.ismho.org](http://www.ismho.org)

National Association of Social Workers (NASW)

[www.socialworkers.org](http://www.socialworkers.org)

National Board for Certified Counselors (NBCC)

[www.nbcc.org](http://www.nbcc.org)

Ohio Psychological Association

[www.ohpsych.org](http://www.ohpsych.org)

Online Therapy Institute

[www.Onlinetherapyinstitute.com](http://www.Onlinetherapyinstitute.com)

Renewed Vision Counseling Services

[www.renewedvisioncounseling.com](http://www.renewedvisioncounseling.com)

Texas State Board of Examiners of Marriage and Family Therapists

[www.dshs.texas.gov/mft/mft\\_rules.shtm](http://www.dshs.texas.gov/mft/mft_rules.shtm)

TeleMental Health Institute

[www.telehealth.org](http://www.telehealth.org)

U.S. Department of Health and Human Services\_

[www.hhs.gov/hipaa/for-professionals/special-topics/mental-health](http://www.hhs.gov/hipaa/for-professionals/special-topics/mental-health)

Zur Institute

[www.zurinstitute.com/telehealthresources.html](http://www.zurinstitute.com/telehealthresources.html)

## References

- American Association for Marriage and Family Therapy. (2015). Code of Ethics. Retrieved on July 7, 2016 from: [http://aamft.org/imis15/AAMFT/Content/Legal\\_Ethics/Code\\_of\\_Ethics.aspx](http://aamft.org/imis15/AAMFT/Content/Legal_Ethics/Code_of_Ethics.aspx)
- Blumer, M. L., Hertlein, K. M., Smith, J. M., & Allen, H. (2013). How Many Bytes Does It Take? A Content Analysis of Cyber Issues in Couple and Family Therapy Journals. *J Marital Fam Ther Journal of Marital and Family Therapy*, 40(1), 34-48. doi:10.1111/j.1752-0606.2012.00332.x
- Brew, L., Cervantes, J. M., & Shepard, D. (2013). Millennial Counselors and the Ethical Use of Facebook. *TPC The Professional Counselor*, 3(2), 93-104. doi:10.15241/lbb.3.2.93
- Epstein Becker Green. (2016, May). *Survey of Telemental/Telebehavioral Health*. Chicago, IL.
- Haberstroh, S., Barney, L., Foster, N., & Duffey, T. (2014). The Ethical and Legal Practice of Online Counseling and Psychotherapy: A Review of Mental Health Professions. *Journal of Technology in Human Services*, 32(3), 149-157. doi:10.1080/15228835.2013.872074
- Haberstroh, S. (2009). Strategies and Resources for Conducting Online Counseling. *Journal of Professional Counseling, Practice, Theory and Research*, 37(2), 1-20.
- Hertlein, K. M., Blumer, M. L., & Mihaloliakos, J. H. (2014). Marriage and Family Counselors' Perceived Ethical Issues Related to Online Therapy. *The Family Journal*, 23(1), 5-12.  
doi:10.1177/1066480714547184
- HIPAA 'Protected Health Information': What Does PHI Include? - HIPAA.com. (2009). Retrieved July 07, 2016, from <http://www.hipaa.com/hipaa-protected-health-information-what-does-phi-include/>
- Hughes, R. S. (2000). *Ethics and regulations of cybercounseling*. Greensboro, NC: ERIC Clearinghouse on Counseling and Student Services.



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

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

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

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

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

Trepal, H., Haberstroh, S., Duffey, T., & Evans, M. (2007). Considerations and Strategies for Teaching Online Counseling Skills: Establishing Relationships in Cyberspace. *Counselor Education and Supervision, 46*(4), 266-279. doi:10.1002/j.1556-6978.2007.tb00031.x

Twist, M. L., & Hertlein, K. M. (2015). E-mail Me, Tweet Me, Follow Me, Friend Me: Online Professional Networking Between Family Therapists. *Journal of Feminist Family Therapy, 27*(3-4), 116-133. doi:10.1080/08952833.2015.1065651

Virtual relationship. (n.d.). Retrieved July 07, 2016, from [http://www.urbandictionary.com/define.php?term=Virtual relationship](http://www.urbandictionary.com/define.php?term=Virtual+relationship)

What is HIPAA Compliance? (n.d.). Retrieved July 07, 2016, from <http://www.onlinetech.com/resources/references/what-is-hipaa-compliance>

**Adopted September 13, 2016, by AMFTRB Annual Meeting Delegates.  
\*Committee Review 11-2020. As state temporary rules and regulations either become permanent or are dropped, guidelines will again be reviewed.**