This past year has proven to be a time of great change and metamorphosis for the counseling profession as many practitioners were forced to adapt from in-person appointments to telehealth appointments seemingly overnight due to the pandemic. Telehealth has quickly become the new normal with its convenience, lower-cost, and opportunities for better interdisciplinary care of clients. With so much change occurring so quickly, counseling professionals must be ready to face the rising challenges that come with it. The Council for Accreditation of Counseling and Related Educational Programs (CACREP) and Chi Sigma Iota (CSI) are organizations that have a powerful impact on the counseling profession and its ability to adapt to our ever-changing world, including the current shift to normalized technology use in counseling.

In many ways, telehealth services have created greater access to counseling. Some examples include those in rural areas have increased counseling options (Sanchez et al., 2019), ethnic and racial minorities have greater access to counseling in their primary language (Sanchez et al, 2019), and cancer patients have benefited from more mental health follow-up sessions (Guzman et al., 2020). Despite these improvements, some argue that telehealth is making necessary healthcare even more inaccessible to vulnerable populations with less than 20 percent of those diagnosed with mental health conditions get the treatment they need (Sanchez et al., 2019). According to Mahtta et al., 90% of telehealth visits are considered “additional visits” which might not have been prioritized with an in-person visit (2019). This overuse of health services due to the convenience creates a shortage of available appointments for those who need them. The high demand also increases the price of appointments and overall health expenditure without additional public benefit (Mahtta et al., 2019). Those with populations are less likely to utilize telehealth services including black persons, those with lower incomes, and those on Medicaid (Mahtta et al., 2019). Also, the lack of access to or knowledge of technology can lead to a greater disparity in mental health care. Thirty-three percent of rural areas do not have high-speed internet, and reliance on telehealth methods of care during the pandemic has increased inequality in access to care (Mahtta et al., 2019).
It is important to bring to light the data that shows how socioeconomic and racial disparities are being exacerbated rather than being narrowed by telehealth. Mahtta et al. suggests the need for policy that prevents the overuse of telehealth services to prevent high prices, shortages of care, and better consideration of equality (2019). Mahtta et al. also suggests reimbursing those in rural communities without high-speed internet for telephone-only appointments as well as limiting telehealth visits in urban areas so appointments can be distributed more evenly to high need situations (2019). Another initiative includes recruiting retired professionals to volunteer part-time to administer services over telehealth to increase the supply of mental health services (Mahtta et al., 2019). It is also important that guidelines are created and emphasized for mental health professionals to be continually trained and supervised properly over telehealth, so clients can receive the same quality of care as in-person appointments (Mahtta et al., 2019).

In addition to striving for more competent and equitable telehealth care, mental health professionals must recognize that technology can be a powerful tool for working with other care providers in their agencies. Sanchez et al. explain how interdisciplinary mental health provider teams could incorporate emergency department representatives over telehealth to improve the outcomes of patients who over-utilize emergency resources due to anxiety disorders (2019). Guzman et al. shares that their interdisciplinary palliative care team, which includes medical doctors, nurses, pharmacists, counselors, and psychologists, uses telehealth to meet regularly. As a result, their medical team can easily refer patients to counselors when they recognize the need (2020). One way a counselor can improve in leadership and advocacy is by communicating with interdisciplinary stakeholders in their field (Chang et al., 2011), and this can be done regularly using telehealth.

CACREP and CSI have powerful influence and ability to alter and improve the counseling profession. Over 800 educational programs are accredited through CACREP (CACREP Annual Report, 2018), and CSI has more than 390 chapters (csi-net.org). These organizations have a huge impact in mentoring, encouraging, and empowering future and current professionals to be “servant-leaders” that advocate for high quality and easily accessible counseling for all (Herr, 2010). To narrow the disparity in counseling accessibility, CACREP can require new courses (or new content within current courses) that emphasize the competent and equitable use of telehealth services. With CSI’s numerous chapters within the United States and around the world, the framework is already in place for national and local advocacy efforts. Members can advocate for policy that preempts the overuse of telehealth that prevents lower income clients from receiving needed care and for better technology access and education for rural areas and others that need it. As part of their meetings, CSI chapters can learn and discuss the disparities that have been caused due to telehealth and make specific plans to combat this problem.

One of CAPREP’s core values states that counseling standards must “reflect the needs of society…and encourage program improvement and best practices” (CACREP Annual Report, 2018). CSI also voices that advocating for clients and students is “especially
significant when individuals or vulnerable groups lack access to needed student services” (Chang et al., 2011). While inequalities have risen with the increased use of technology, the right policies and training can make telehealth a vehicle for better and more accessible counseling services.

References