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TeleMental Health & COVID-19: Is it Ethical to Return to Seeing Clients in Person?

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COVID-19 and 2020 has been an unprecedented time for therapy as a profession. There is still so much we do not know about this virus, and everyone is learning how to navigate the "new normal" with most therapists conducting primarily telemental health for the first time. Last Friday, our Governor lifted the shelter in place order, which was followed by a lot of discussion on listservs here in Georgia about therapists returning to in-person care of their clients. People are asking, "should I wear a mask in my office?".... "How are other people handling social distancing in their waiting rooms?"...."Is anyone taking clients' temperatures before allowing them to enter?"...."Is it prudent to have clients sign a waiver?" etc. Therefore, I've done some research and decided to weigh in from an ethical perspective.

First, I need to preface this article with an experience I had the same day the Georgia Governor lifted the shelter in place order. I taught a live-streaming webinar that day for 230 therapists, all of whom at least had a master's degree, and several in attendance were doctoral level clinicians. I took an anonymous poll asking everyone how well-informed they were about COVID-19. Much to my surprise, the least endorsed option (3% of participants) was "I feel very well-educated about COVID-19." Additionally, at least half endorsed the option that they had become overwhelmed by the news and had fallen behind in staying up with the latest information. Therefore, I feel it is important to start with just a few basic facts from the medical experts. The Center for Disease Control (CDC) states on their website as of today that when possible, the general public should work from home until further notice. The CDC also states that when possible, healthcare professionals should practice telemedicine. We know that COVID-19 is transmissible via respiratory droplets in the air or on surfaces and that asymptomatic individuals are also contagious through contact with their respiratory droplets via mouth, nose, and eyes. Since a person could spread the illness before becoming symptomatic, taking someone's temperature has become an obsolete strategy to determine if someone is contagious. The CDC also recommends we maintain social distance of at least six feet and wear a mask while in public and especially when in a confined place for any prolonged length of time with other individuals, particularly when there is no ventilation. With these few basic facts in mind, let us think about the

nature of clients coming into a therapy office, a confined space for a prolonged period of time, generally with doors and windows closed to maintain confidentiality.

All therapy ethics codes start with a "Do no Harm" meta-ethical principle. The Ethical Principles of Psychologists and Code of Conduct General Principle A: Beneficence and Nonmaleficence states: “Psychologists strive to benefit those with whom they work and take care to do no harm. In their professional actions, psychologists seek to safeguard the welfare and rights of those with whom they interact professionally and other affected persons . . .” Of course, seeing our clients in person may benefit them. However, whether we like it or not, the research supports that telemental health can be just as effective (Hilty, et al., 2013, Maheu, 2015, Quashi, 2015). But, it may also harm clients, other professionals in our offices, ourselves, and those with whom any of us interact in the greater community. I could go back to my office, infected but asymptomatic, and not have any idea. I could give COVID-19 to one of my clients who, in turn, gives this potentially deadly virus to their family. How would that impact our therapeutic trust and alliance? Or, one client of mine could come in asymptomatic but infected and touch a metal doorknob where the virus can live up to five days (WebMD, 2020). Perhaps I did not have time to clean the front doorknob and surrounding metal thoroughly between each session, and an office-mate’s client touches that metal and then rubs their eye and they become infected. Should any of us become infected, it would be hard to prove the exposure happened in our office. Nonetheless, during an ethical consultation with Joe Scroppo, PhD, JD of The Trust malpractice insurance, he stated we have a “moral and ethical obligation to let our clients know they could have been exposed to COVID-19” in our office. Of course, we would not reveal by whom in order to maintain client confidentiality.

I completely understand that there is not only a health risk that COVID-19 puts before us; there is also an economic risk. That is part of the ongoing politicizing of this pandemic as well as the inherent double bind. And, with an economic risk, Maslow’s hierarchy of needs comes to mind. How am I going to pay for the shelter over my head, have enough money for food, etc.? In this instance, however, the potential economic hit of not returning to work does not land on the client. The impact is on the therapist. The second part of Principle A states, “Psychologists strive to be aware of the possible effect of their own physical and mental health on their ability to help those with whom they work.” It is possible that fear of financial hardship could get in the way of making the best decision for the client. As stated in the APA Ethical Code 3.04(a) Avoiding Harm, “Psychologists take reasonable steps to

avoid harming their clients/patients, students, supervisees, research participants, organizational clients, and others with whom they work, and to minimize harm where it is foreseeable and unavoidable." Therefore, we need to consider is this risk "foreseeable and unavoidable?" Are there other options available?

Additionally, it is important to think about the standard of care. Standard of care is essentially what a reasonable professional would do under similar circumstances. If telemental health has been the avenue taken for the past 4-6 weeks, and most professionals are providing therapy remotely, what are the reasons to discontinue that option? Is that a deviation from the standard of care, and have you documented the reasons for deviating? Perhaps telemental health has not been an option because you have clients who do not own a computer or reside in area with bad cellular phone service. Then, we might need to ask, is immediate psychological care critical enough to take precedence over the physical safety for all concerned? If so, would an intensive outpatient program be more appropriate? There are many considerations, and documenting your decision-making is our ethical obligation. Additionally, do your clients understand the risks involved? According to ethical standard 3.10, we have a duty to provide Informed Consent. Informed Consent is an ongoing process as well. During today's consultation with Dr. Scroppo, he stated that The Trust recommends creating an addendum to your current Informed Consent that delineates the potential risks associated with seeing one's therapist in person. After all, only 3% of the well-educated therapists polled at my ethics workshop last week felt like they knew what they should about COVID-19. How can we expect our clients to know? Dr. Scroppo also stated that regarding the decision made, the outcome burden is on the therapist and not the client.

Dr. Scroppo went on to state that there are four steps to take and/or consider: 1) Due diligence: Do you know the medical facts, and have you implemented all the procedures in your office that will minimize risk according to health experts such as the CDC and the World Health Organization?; 2) Informed Consent: Create an addendum which states the risks involved in in-person care and how you plan to implement your risk-minimizing procedures; 3) Standard of Care: What are most therapists doing in this circumstance and reflect upon the standards that you may be judged against. Also consider ethical codes, statements from associations, published guidelines, or any other sources from which the standard of care is derived. 4) Document your decision-making process. Dr. Scroppo encouraged us to go to a page on The Trust's website (see references below) which has nine factors to consider while

documenting your decision-making. Also on this website, The Trust states: “It is our view that providing in-person services during this crisis will add significant risk to patients/clients, providers, and the broader community. Our advice is that if telepsychology is available as an alternative, it is very risky not to use it in the absence of very significant clinical or logistical contraindications. These risks are, of course, to life and to health; but they also include malpractice claims, licensing board complaints, and other government investigatory and enforcement processes.”

I am acutely aware that each therapist needs to make their own decision about what is best for all concerned. Nonetheless, it is imperative to really think this decision through, and as always, consult with trusted peers and thoroughly document your decision-making.

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