International Journal for the Advancement of Counselling
https://doi.org/10.1007/s10447-024-09592-x

ORIGINAL ARTICLE

A Counselor Education's Community Clinics' Shift to Telehealth During COVID-19: a Programmatic Perspective

Sarah Mendoza[1] · Dania Fakhro[2] · Melissa Zeligman[3] · John Super[3]

Accepted: 3 December 2024

Abstract

COVID-19 caused a sudden shift for counselors-in-training and supervisors to transition from in-person counselling to telehealth counseling and supervision. Counselors-in-training and supervisors at large were forced to complete a rapid transition to telehealth. This article provides a detailed account of the transition made at a large Southeastern University to telehealth and takes a broader look at practical implications and recommendations that other university and/or college and community-based clinics can use for adding telehealth to their clinic. In addition, practices for the effective use of technology in professional counselors' preparedness for in person and telehealth counseling and supervision are outlined.

Keywords Training clinic · COVID-19 · Supervision · Telehealth · Counselors-in-training

The focus of this paper is a "how to" for university training and community-based clinics to effectively add telehealth counseling services and training for counselors. The authors all worked at the Community Counseling and Research Center (CCRC) during COVID-19 and will use the steps taken at the CCRC to exemplify options other clinics have for initiating telehealth at their site. The CCRS is a state-of-the-art research clinic housed in the College of Community Innovation and Education at the University of Central Florida.

✉ Sarah Mendoza
sarah.mendoza1@montana.edu

[1] Counseling Department, Montana State University, P.O. Box 172940, Bozeman, MT 59717, USA

[2] Counseling Department, University of North Carolina at Charlotte, Charlotte, NC, USA

[3] Department of Counselor Education and School Psychology, University of Central Florida, Orlando, FL, USA

Published online: 13 December 2024

The Clinic

The CCRC was established in 1998 and serves as a practicum, supervision, and research training site for Counselor Education and Supervision masters and Ph.D. graduate students. The University's Counselor Education program is accredited by the Council for the Accreditation of Counseling and Related Educational Programs (CACREP) for its preparation of mental health, marriage, couples, and family and school counselors as well as future counselor educators in the Ph.D. program. The CCRC is funded by the College of Community Innovation and Education, and the Counseling Department maintains all daily operations and oversight through designated faculty, graduate students, volunteers, and college leadership.

The CCRC is a primary training site for counseling master's and Ph.D. students to gain real-world experience in a free community-based clinic. The CCRC opens its doors to individuals, couples, and families seeking free mental health services. Clients are screened through an intake process to assess their appropriateness for the CCRC and the counselors-in-training (CITs) providing their counseling services. The master's students are then supervised via live video and audio recording process by a faculty member who is a licensed counselor and assigned faculty supervisor. Students receive weekly group and triadic clinical supervision throughout their practicum coursework. Similarly, Ph.D. students provide counseling services within the center and provide supervision to master's level students, as part of their supervision coursework. The CCRC provides a two-tier training approach to providing master's students with real-world clinical experience and Ph.D. students with supervision experience as both sets of students make their way toward professional counselors and educators.

The CCRC had never offered remote (i.e., telehealth) supervision or counseling services before the COVID-19 pandemic in spring 2020. The shift to telehealth created a need to make technological, ethical, and practical changes. The CCRS is one example of how other counselor education and community-based training clinics can implement such changes. During COVID-19, there was a rapid increase in telehealth care (Hoffman, 2020) and though there is some decrease since the end of the pandemic, there remains more telehealth care than prior to COVID-19 and a need to have a prepared workforce (Thomas et al., 2022).

Telehealth

In March of 2020, the CCRC was forced to close daily, in-person operations due to COVID-19 and state precautions for the wellness of student, faculty, and staff. The contagious nature of COVID-19 forced social distancing measures, along with stay-at-home orders in the United States to limit person-to-person transmission (Atkeson, 2020). Without a way to continue providing in-person treatment, the CCRC identified telehealth resources and the CCRC website was updated, and a provider list was made available to anyone seeking services.

Prior to COVID-19, Nobleza et al. (2019) found providing telehealth counseling in college counseling centers was a favorable option for students, with 81% of their respondents stating telehealth care was as good or nearly as good as in-person care. COVID-19 obviously forced the general population to transition to telehealth or risk losing access to any number of medical services (Hays & Skootsky, 2022). Gerton et al. (2022) found that CITs who had to move to telehealth did not lose their client working alliance, and symptoms of depression and anxiety were effectively treated. Gallo et al. (2022) completed an interpretive phenomenological analysis with CITs and the primary themes of maintaining the relationship via telehealth, emotional awareness of the client via the video intervention, the client's belief in counseling services being beneficial and worthwhile, and the importance of skill building, and counselor development emerged as key theme for telehealth counselor training and interventions. Batastini et al. (2021) completed a meta-analysis of mental health care and the emerging literature on telehealth counseling. The researchers concluded the lack of random control trials in telehealth counseling sessions makes it difficult to conclude that telehealth counseling is equivalent to in-person care (Batastini et al., 2021). Some clients reported higher rates of satisfaction from telehealth in integrative medical care systems in the US due to maintaining access to care (Hays & Skootsky, 2022).

Technology and Software

The faculty and graduate assistants focused on making all CCRC-related training and information available via Canvas, a university learning platform available to all CITs enrolled in clinical experiences at the CCRC. Orientation to practicum and the CCRC became a course available through Canvas and included a video introduction to the CCRC location, telehealth training, PowerPoint presentations with voice-over, and screenshots outlining step-by-step instructions for navigating technology utilized by the clinic. These training materials were separated into modules for accessibility from home and small pieces of digestible instruction. All the shared resources in the CCRC were moved into file groupings and folders labeled by topic and accessible through Canvas, which gave everyone online access to the CCRC resources. Canvas is one of many online learning platforms: Desire 2 Learn, Blackboard, Moodle (Perry, 2024). Organizations can utilize learning platforms to create online engagement for counselor and/or employee training. Training websites can be curated for the needs of an organization's unique policies and procedures. Providing videos, word documents, voice over PowerPoints, and more than one modality for training materials fits with Universal Design in education, because it provides a diverse way for learners to engage with the content (Houston, 2018).

At the CCRC, 20 laptops were purchased to meet the need for cameras and visualization during telehealth counseling sessions. The laptops enabled students to individually enter existing counseling rooms and connect with their clients via HIPAA-compliant Zoom. Zoom sessions were created by the supervising faculty members and emailed to clients and/or their parents if the clients were minors. This process allowed for faculty emails to be shared with clients, whereas student emails

remained private because of Family Education Rights and Privacy Act (FERPA). Students further created individual Google Voice accounts to communicate with their clients remotely, without having to share their phone numbers. HIPAA compliant Zoom is one option among other technologies allowing counseling sessions to be provided virtually, including but is not limited to Ring Central, Doxy Me, and Simple Practice. Purchasing laptops at the CCRC mitigated the risks of students using laptops that may lack proper security. Organizations may need to invest in technology and provide additional resources to counselors, to create increased telehealth options for their clients.

Titanium Schedule ®, which is a registered trademark of Titanium Software, Inc 2002–2022, and the schedule and client chart program or EHR was used in the CCRC. Titanium is a multifaceted program used in more than 1500 community mental health sites. (http://www.titaniumschedule.com/Main/). Once telehealth was initiated, an additional feature of Titanium was used to capture the needed information and forms: Titanium Webforms. Titanium Webforms is accessible via a web address, and clients can complete their paperwork with a password that enables access to complete forms with their names and dates of birth. Titanium Webforms is essential for capturing CCRC individual client data, which we used to evaluate client progress and research initiatives (e.g., *Outcome Questionnaire-45* [OQ-45], Wells et al., 1996, and *Perceived Stress Scale* [PSS], Cohen et al., 1983). We utilized Titanium's virtual Dataforms and report features to capture the client's de-identified clinical information. The data were used to create poster presentations for national conferences and two manuscripts presently under review.

Many EHRs have virtual platforms for clients to complete vital documents like their informed consent, demographic and background information, referral source, and so forth. Using a secure web-based paperwork process simplifies the process for clients to complete required forms before their arrival and processed to the chart without scanning paper documents. Assessment tools can be important in capturing client symptoms and overall wellbeing (McHenry & MacCluskie, 2018). Organizational data and client reports can help secure grant funding from federal organizations like the National Institute of Health and the Substance Abuse and Mental Health Administration and contract with insurance carriers.

Furthermore, the CCRC used *Milestone Xprotect* and VPN. The live camera and playback visualizations in the CCRC are through a digital recording program called Milestone Xprotect ® (https://www.milestonesys.com/solutions/platform/video-management-software/). Milestone is a digital recording program allowing students to playback their recorded sessions for self-reflection and clinical supervision. The Milestone program is web-based, and recordings are deleted within a short time frame for added protection. Students and faculty accessed Milestone from home for session review using a secure virtual private network (VPN).

Reviewing counseling sessions via video and/or digital recording is a cornerstone of supervision for CITs at the university. Video reviews enable the students to reflect on their counseling work and for clinical supervisors and peers to provide feedback on the CIT's interventions, case conceptualization, diagnosis, treatment planning, and professional development (Topor et al., 2017). Master's and Ph.D. students must review their sessions for group and triadic supervision with faculty and training

peers at the university. Ongoing supervision in clinical settings is common and considered best practice for even the most seasoned professional counselors. Engaging in group supervision provides benefits to the counselor and their clients when there is a trusted supervisor and/or peer support relationship (Corey et al., 2020).

The CCRC moved to a web-based phone system with encryption software security, which helped create a safe, remote way to continue regular contact with clients for the CCRC during the initial phase of COVID-19. Web-based phones offer remote access to quickly respond to clients and view voicemails as emails, rather than entering the physical location to access voicemail and receive phone calls. Skype for Business was first used for web-based phone services during the initial phases of the pandemic. Faculty, graduate student assistants, and master's students who volunteered as part of the intake team could use this program to make and receive phone calls from separate offices. The voicemail system was connected to Microsoft Outlook E-mail, and inbound voicemails generated emails with attached voice files and message transcriptions to the CCRC email. In a second evolution of web-based phones, Microsoft Teams replaced Skype for Business.

Counselor Education Clinic

The CCRC provides practicum training to all three master's counseling tracks for one to two semesters. The number of clients seen in the CCRC per semester varies based on cohort sizes. The CCRC has nine counseling rooms of varying sizes for family and couples' sessions, a children's playroom, and an adolescent playroom. At the time of this writing, the CCRC is open 5 days a week and hosts up to three practicum sections a day for concurrent, live supervision of student sessions by faculty. There are 68 master's students in training, yielding 202 scheduled appointments per week. Of these 202 appointments, 87 are telehealth. The opportunity to serve a greater portion of the state has been possible through the reach of telehealth services. Before COVID-19 and the expansion of telehealth, the CCRC had appointments in the Fall of 2019. The university closed in March of 2020; the adjustments for health and safety are outlined below. Setting an intentional pilot process and timeline can help counselor training and outpatient clinics to add new telehealth services with a plan for adjusting as deemed necessary.

Timeline

By the summer semester of 2020, the CCRC had reopened and piloted all the new technology and telehealth services with undergraduate student volunteers as clients. The aim of piloting the telehealth program with student volunteers was to ensure the CCRC had worked out unforeseen challenges before reopening to the community. After a successful pilot in the Fall of 2020, the CCRC reopened its doors physically and virtually to an expanded client population with the addition of telehealth services. The CCRC graduate assistants, faculty, and intake team conducted outreach to previous clients as well as other mental health providers to share the availability of

free in-person and telehealth services for outpatient mental health counseling with CITs. The CCRC website was updated to reflect the telehealth option, which made the center available for clients throughout the state. The unfortunate reality is that the CCRC lacked the necessary infrastructure to not close for a period of time, early on in the COVID-19. However, the addition of telehealth increased access to the state of Florida and that which held advantages to serve a larger community.

Implications and Recommendations

Community

Since the CCRC moved to providing telehealth sessions in Fall 2020 through Spring 2022, CITs have provided 2225 individual, 194 couples, and 64 family sessions in-person and 2222 individuals, 132 couple, and 16 family sessions via telehealth. These sessions account for 5304 sessions and 5558 treatment hours. The estimated value of the community counseling sessions at the CCRC can be measured through insurance payer, Blue Cross Blue Shield (BCBS) of Florida health, because BCBS insures approximately 70% of the privately insured persons in the state of Florida (https://www.floridablue.com/). An individual counseling session is coded as 90806 when billing insurance. The payment for an individual session under BCBS is approximately $72, and the payment increases for couple and family session reimbursement. Therefore, the CCRC has provided more than $380,000 in outpatient counseling services to the community for free while training CITs, nearly half of which was telehealth care. This calculation is limited by the fact that all student data entry may not be 100% accurate, yet it represents an important facet of providing free community-based care to persons willing to participate in the training and development of CITs.

Ethical and Legal

The privacy of clients and students was a primary ethical concern during the pivot to telehealth operations. As previously stated, the students did not personally email clients for telehealth sessions due to FERPA. Instead, all email correspondence was through supervising faculty. State regulations surrounding emails should also be considered. For example, Florida Sunshine State Law (§286.001, Fla. Stat. 2022) stated that all email correspondence is discoverable in a court of law. Therefore, the faculty supervisor provided all correspondence to introduce themselves to clients, orient the clients to telehealth expectations, and provide links for Zoom sessions. A Zoom contract through the university enabled all faculty to use their network identification numbers (NIDs) to securely host Zoom counseling sessions for the duration of their practicum class. At the same time, students could also use NIDs to join sessions. In addition to counseling, clinical supervision (individual and triadic) and classes were held over Zoom for the safe practice of social distancing. Further assisting with security, VPNs are used to ensure information is encrypted when using the

internet and protects against data breaches that violate HIPAA and FERPA privacy standards. Ensuring the training and/or outpatient community clinic abides by all state laws for telehealth care is vital for opening services. Ethical considerations are addressed later on as well.

Training

Counselor education has traditionally been a brick and mortar education and training process (Okech & Rubel, 2018). There had been a rise in online programs prior to the COVID-19 pandemic (Renfro-Michel et al., 2016; Snow et al., 2018); however, the pandemic propelled the counseling field into responding to the need for continued counselor training and development virtually. Simultaneously, the need for mental health counselors is expected to increase from 2020 to 2030 by 23% (U.S. Bureau of Labor Statistics, 2022). The CCRC transition to telehealth provides a framework for using an existing university or community mental health agency technology infrastructure to pivot a traditional in-person training program or treatment site to include telehealth. In consultation with other clinics, the CCRC team has learned that another university had CITs create free individual DoxyMe accounts for telehealth accounts for their counseling sessions and email links from the general clinic email address. This free option is included because offsetting costs in clinics can be vital to expanding telehealth services. Titanium© also has features that can text and/or email clients their appointment reminders with links to their virtual sessions. Similarly, other EHRs and RingCentral have features for HIPAA compliant text, email, and video calls with clients.

The CCRC is committed to training well-rounded counselors for the twenty-first century, and the need for telehealth preparation is not expected to decrease (Gajarawala & Pelkowski, 2021). Telehealth training has application beyond a global pandemic for rural community care, clients without reliable transportation, and supporting populations that cannot reach a treatment site (Butzner & Cuffee, 2021). In addition to counseling services, virtual supervision is another area likely to continue to grow (Flamez et al., 2013). The CCRC was able to meet the training needs of students by providing virtual supervision that maintained social distancing without losing the required aspects of session review and supervisor and CIT correspondence. Clinical supervisors should consider barriers to diversity, equity, and inclusion when navigating virtual therapy and barriers and impediments to online supervision.

CITs in each master's CACREP accredited track at the university are expected to familiarize themselves with the standards and policies of the American Counseling Association (ACA) and specialty areas of Clinical Mental Health, Marriage Couples, and Families, and School Counseling. The ACA code of ethics requires professional counselors and CITs to abide by state laws for the provision of telehealth care and in Section H of the ACA code of ethics, outlines standards for audio and video, distance counseling relationships, and provision of care (American Counseling Association, 2014). The American School Counselor Association has virtual and distance school counseling standards in their position statement to guide professional school counselors who work with students in audio- and video-based

platforms through virtual school (American School Counseling Association, 2017). Professional counselors are expected to abide by standards for informed consent, security practices, and records and web maintenance when providing telehealth services (American Counseling Association, 2014).

Limitations

The CCRC has established information technology, firewall protections against the violation of FERPA and HIPAA privacy laws, and contractual agreements with Canvas and Zoom. All this infrastructure supported the changes made for telehealth and continued client care in the CCRC during COVID-19 and thereafter. This infrastructure may not be as readily available at all community clinics or training sites, which would cause substantial barriers for switching to telehealth. Therefore, this article cannot compare the pivot to offering telehealth at the CCRC to other clinical sites within the community. Practical significance is limited to other universities with similar clinic setups and outpatient clinics that may train interns and CITs in their ongoing annual operations.

Conclusion

The current COVID-19 pandemic hastened the transition from in-person to telehealth therapy for the CCRC. The shift to telehealth allowed for continued outpatient, free, community-based care, as well as continuation of training and supervision for master and doctoral-level students with stay-at-home declarations. The shift also prompted reconsiderations of prior policies and procedures to meet the demands of CACREP standards and the continued preparation of CITs during a global pandemic. The positive benefits of continued telehealth care at the CCRC cannot be under-estimated for those clients who do not live locally to the clinic, do not have transportation, and/or benefit from a service they can access from home. The growing acceptance of telehealth counseling services is evident in the increased online options, such as Better Help and Cerebral. CITs benefit from being trained in both in-person and telehealth counseling as part of their preparation for entering the field. A pandemic is an event no one can prepare for, but global events that disrupt counseling can come from inclement weather, small- or large-scale natural disasters, and other unforeseen events. On an individual basis, it can be helpful to offer telehealth to a client who may for a single week be unable to make an in-person session and still would like to meet with their counselor. Telehealth is a valuable tool for long-term client engagement and retention for community-based clinics in the post-pandemic world.

Acknowledgements We acknowledge the work and dedication of all clinic students, faculty, administrative, and volunteer team members who supported the transition to telehealth.

Declarations

Competing Interests The authors declare no competing interests.

References

American Counseling Association. (2014). *2014 ACA code of ethics*. https://www.counseling.org/docs/default-source/default-document-library/2014-code-of-ethics-finaladdress.pdf

American School Counseling Association. (2017). *ASCA position statements*. https://www.schoolcounselor.org/getmedia/d597c40b-7684-445f-b5ed-713388478486/Position-Statements.pdf

Atkeson, A. (2020). What will be the economic impact of COVID-19 in the US? Rough estimates of disease scenarios. NBER Working Paper Series. 595. http://www.nber.org/papers/w26867

Batastini, A. B., Paprzycki, P., Jones, A. C., & MacLean, N. (2021). Are video conferenced mental and behavioral health services just as good as in-person? A meta-analysis of a fast-growing practice. *Clinical Psychology Review, 83*, 101944. https://doi.org/10.1016/j.cpr.2020.101944

Butzner, M., & Cuffee, Y. (2021). Telehealth interventions and outcomes across rural communities in the United States: Narrative review. *Journal of Medical Internet Research, 23*(8), e29575. https://doi.org/10.2196/29575

Cohen, S., Kamarck, T., & Mermelstein, R. (1983). A global measure of perceived stress. *Journal of Health and Social Behavior, 24*(4), 386–396. https://doi.org/10.2307/2136404

Corey, G., Haynes, R. H., Moulton, P., & Muratori, M. (2020). *Clinical supervision in the helping professions: a practical guide*. John Wiley & Sons.

Flamez, B, Scott, S., Erber, N, Cason, L, Matthews, D., Ondrus, C., Clark, A., & Bennett, R. (2013, October 16–20). *Fostering student development through online supervision.* [Roundtable presentation]. Association for Counselor Education and Supervision.

Gajarawala, S. N., & Pelkowski, J. N. (2021). Telehealth benefits and barriers. *The Journal for Nurse Practitioners: JNP, 17*(2), 218–221. https://doi.org/10.1016/j.nurpra.2020.09.013

Gallo, L. L., Moro, R., & Moran, M. (2022). Students' experiences conducting telehealth counseling during a pandemic. *Journal of Technology in Counselor Education and Supervision, 2*(1), 20–30. https://doi.org/10.22371/tces/0012

Gerton, J. M., Aoyagi, K., Leon, G. A., Bludworth, J., Spille, S., & Holzapfel, J. (2022). Outcomes in clients transitioning from in-person counselling to telehealth counselling with trainees. *Counseling and Psychotherapy Research, 23*(1), 188–197. https://doi.org/10.1002/capr.12541

Hays, R. D., & Skootsky, S. A. (2022). Patient experience with in-person and telehealth visits before and during the COVID-19 pandemic at a large integrated health system in the United States. *Journal of General Internal Medicine, 37*(4), 847–852. https://doi.org/10.1007/s11606-021-07196-4

Hoffman, D. A. (2020). Increasing access to care: Telehealth during COVID-19. *Journal of Law and the Biosciences, 7*(1), lsaa043. https://doi.org/10.1093/jlb/lsaa043

Houston, L. (2018). Efficient strategies for integrating Universal design for learning in the online classroom. *Journal of Educators Online, 15*(3), n3.

McHenry, B., MacCluskie, K. C., & McHenry, J. (2018). *Tests and assessments in counseling*. Routledge.

Nobleza, D., Hagenbaugh, J., Blue, S., Stepchin, A., Vergare, M., & Pohl, C. A. (2019). The use of telehealth by medical and other health professional students at a college counseling center. *Journal of College Student Psychotherapy, 33*(4), 275–289. https://doi.org/10.1080/87568225.2018.1491362

Okech, J. E. A., & Rubel, D. J. (Eds.). (2018). *Counselor education in the 21st century: Issues and experiences*. American Counseling Association.

Perry C. (2024, January, 4). Online learning platforms: the different types and their benefits. Forbes. Retrieved June 24, 2024 from https://www.forbes.com/advisor/education/career-resources/online-learning-platforms/

Renfro-Michel, E., Rousmaniere, T., & Spinella, L. (2016). Technological innovations in clinical supervision: Promises and challenges. In T. Rousmaniere & E. Renfro-Michel (Eds.), *Using technology to enhance clinical supervision* (pp. 3–18). American Counseling Association.

Snow, W. H., Lamar, M. R., Hinkle, J. S., & Speciale, M. (2018). Current practices in online counselor education. *The Professional Counselor, 8*(2), 131– 145. https://www.learntechlib.org/p/192026/.

Thomas, E. E., Haydon, H. M., Mehrotra, A., Caffery, L. J., Snoswell, C. L., Banbury, A., & Smith, A. C. (2022). Building on the momentum: Sustaining telehealth beyond COVID-19. *Journal of Telemedicine and Telecare, 28*(4), 301–308. https://doi.org/10.1177/1357633X20960638

Topor, D. R., AhnAllen, C. G., Mulligan, E. A., & Dickey, C. C. (2017). Using video recordings of psychotherapy sessions in supervision: Strategies to reduce learner anxiety. *Academic Psychiatry, 41*, 40–43. https://doi.org/10.1007/s40596-016-0605-0

U.S. Bureau of Labor Statistics. (2022). *Substance abuse, behavioral disorder, and mental health counselors: occupational outlook handbook*. //www.bls.gov/ooh/community-and-social-service/substance-abuse-behavioral-disorder-and-mental-health-counselors.htm

Wells, M. G., Burlingame, G. M., Lambert, M. J., Hoag, M. J., & Hope, C. A. (1996). Conceptualization and measurement of patient change during psychotherapy: Development of the outcome questionnaire and youth outcome questionnaire. *Psychotherapy: Theory, Research, Practice, Training, 33*(2), 275–283. https://doi.org/10.1037/0033-3204.33.2.275