

# COVID-19's nudge to modernise: An opportunity to reconsider telehealth and counselling placements

 [pacja.org.au/2021/04/covid-19s-nudge-to-modernise-an-opportunity-to-reconsider-telehealth-and-counselling-placements](https://pacja.org.au/2021/04/covid-19s-nudge-to-modernise-an-opportunity-to-reconsider-telehealth-and-counselling-placements)

Nathan Beel

## Introduction

In response to COVID-19, the Australian federal and state governments enforced changes to the way society conducted business while the contagion threatened to overwhelm its health services (Duckett & Stobart, 2020; WHO, 2020). Social distancing requirements were implemented to reduce the spread of the potentially lethal virus. Those working in the social services, including counsellors, were also affected by these measures. The Australian Government responded by enabling approved health professionals' access to Medicare for delivering online health services (Australian Government, 2020), showing the scope of need and confidence that services can be delivered in non-traditional formats. Due to social distancing requirements, counsellors and psychotherapists were prevented from conducting face-to-face (F2F) therapy, and if they wished to continue practicing, had to transition to telehealth[1] formats. The Psychotherapy and Counselling Federation of Australia (PACFA) responded to the pandemic by emailing its members advertisements for professional development in online counselling (PACFA, 2020a). At the time of writing, it is hard to predict what business and society will look like post COVID-19 and what changes made in the pandemic will have ripple effects into the future (Price-Robertson et al., 2020). The pandemic triggered an urgency in the upskilling of counsellors around Australia to learn and engage in more diverse and contemporary formats of treatment delivery. Evidence is emerging that therapists are more open to using telehealth in the future as a result of COVID-19 (Békés & Aafjes-van Doorn, 2020).

To maintain practice in the pandemic period, F2F counsellors transitioned to telehealth. This transition provided a catalytic opportunity to reconsider the place of telehealth in the education of counsellors. Lewis (2015) warned that the then 2014 Training Standards (TS) had not kept pace with technology and therefore provided little support for therapists in telehealth. Lewis urged that PACFA keep abreast with evolving technological integration in society and that its TS and ethics codes promote the use of technology in education and practice.

PACFA plays an important role in guiding and ensuring the quality of counsellor education for courses that voluntarily submit themselves for accreditation. This accreditation enables potential students to recognise courses that have professional endorsement and enables smoother transition into the profession for applicants who have completed

accredited training. The TS (PACFA, 2020b) guide decisions on content (i.e. what is taught) and process (i.e. how students are taught). These standards were developed by PACFA's Professional Standards Committee and reported input from a range of stakeholders (PACFA, 2020b).

In line with similar practice professions such as social work and psychology, PACFA requires students to participate in work integrated learning (WIL) as an essential part of its accredited studies (Mayer, 2002; PACFA, 2020b). Its TS require students to complete 40 hours of client counselling while on a placement within (or in tandem with) a counselling course (PACFA, 2020b). It does not explicitly describe the purposes of placement though the importance it places on WIL is implicit in requiring its inclusion in accredited higher education training.

The PACFA TS have been updated every few years, with modifications often related to broader changes in distance learning technologies and usage. In the PACFA TS 2009, students were required to do at least 40 hours of client contact as part of their training program. In 2014, the TS specified that the client contact that could be logged was explicitly restricted to therapy conducted in the same room, whilst telehealth could be logged over and above the 40 hours of F2F experience (PACFA, 2014). This restriction is maintained in the current standards (PACFA, 2020a). In comparison, the Australian Counselling Association's Training Standards (ACA, 2012) and the generally more stringent standards of the international Council for Accreditation of Counseling and Related Educational Programs (CACREP, 2016) do not mandate F2F practice on placements.

In this paper, I will argue that there are insufficient grounds for what might be viewed as inappropriate gatekeeping of professional experience for students (Aprile & Knight, 2020) and, conversely, that there are sufficient grounds for more inclusive recognition of diverse counselling treatment delivery formats. Additionally, I will argue that this limitation is not justified by existing telehealth research and may signal a failure to appropriately recognise and support counselling format diversity in the 21st century.

## **Face-to-Face Superiority**

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The mandating and thus privileging of F2F experience in placements implicitly suggest that F2F experience is qualitatively more essential, beneficial, and appropriate for trainees than alternative counselling formats. In a letter describing PACFA's COVID-19 updated adjustments to accredited training providers, it claims "Counselling and psychotherapy are relational professions therefore PACFA considers face to face learning to be an essential element of the student's experience" (M. Brett, personal communication, August 19, 2020, p. 1). The context of this section was specifically referring to delivery of teaching; however, it explicitly links F2F delivery to the counselling profession's relational identity. The same document temporarily allows students on placements in the pandemic to use videoconferencing because it was deemed closer to F2F counselling, whilst warning "telephone is to be avoided if possible" (p. 2) and, if used as a last resort, the student must have been trained in telephone counselling[2]. From the

absence of rationale in the TS, the treating of F2F delivery as inherently linked with being a relational profession, and the high degree of caution with telephone counselling, it seems PACFA implicitly links physical/visible proximity with relationships and counsellor training. Given this lack of telehealth recognition only applies to the first 40 hours, it implies that trainees have (unspecified) developmental needs that necessitates F2F-only formats until sufficient F2F experience has been obtained. Therefore, in this paper, I will operate on the assumption that the available evidence in the TS and COVID-19 adaptations correspondence suggests that PACFA considers formats other than F2F to be relationally deficient experiences for counselling students on placements.

The appeal of recognising only F2F counselling for interns may seem intuitive, especially for those who primarily deliver counselling in the F2F format. F2F counselling is the format most commonly associated with counselling. When one does a search for the word “counsellor” in Google Images, most pictures shown are of a counsellor with clients in close physical proximity. It is the normative delivery format that general counselling textbooks rarely need to mention, in contrast to phone and internet counselling which require special mentions and sections that highlight the distinctiveness and adaptations required (See Geldard & Geldard, 2017; McLeod, 2019; O’Donovan et al., 2013). F2F has long been considered the gold benchmark of therapy formats (Simpson & Reid, 2014).

Concerns have been cited in the literature that telehealth offers an impaired or lesser quality therapeutic relationship and client care in comparison to the F2F delivery format (Ramsey et al., 2016; Rees & Stone, 2005). F2F offers more complete physical/visual information and cues, a more thorough and rich experience of the interpersonal dynamics with the client, and a shared local environment for communication (Jerome & Zaylor, 2000). F2F interactions are contrasted with alternative forms of counselling that are limited to what might be considered two-dimensional modes: video, voice, virtual reality, and text, depending on the format, and for some, may include asynchronicity (e.g. email) (Zack, 2010). These modes may limit channels and contexts of communication information, potentially impairing the therapeutic relationship.

## **Telehealth – The Poor Cousin or Valid Alternative?**

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At the time of writing, telehealth has existed for approximately 60 years. Telephone counselling has been offered since the late 1950s (Ormond et al., 2000) and internet counselling emerged in the mid-1990s (Monaghan & Blaszczyński, 2009), making even internet counselling a quarter of a century old. Telehealth is not new and continues to evolve in the context of rapidly unfolding technological advancement. As cyber-counselling was newly emerging at the turn of the century, questions were being posed as to what effect these reduced non-verbal and the environmental differences would have in the therapeutic context (Jerome & Zaylor, 2000). For example, Richards and Viganó (2013) noted online researchers were asking whether it was “possible to establish a therapeutic relationship in cyberspace?” (p. 994). Over the last two decades, research has answered many of the concerns that both researchers and practitioners have raised.

## **Does Telehealth Offer an Inferior Therapeutic Relationship?**

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Each telehealth remote format has qualitative differences from the others and from F2F. The issue is not that differences exist but whether these differences are of such importance that the PACFA TS indirectly restrict intern experience in telehealth. As with any variable in treatment, the format selected will have various advantages and disadvantages. One key concern noted was regarding practitioners establishing effective therapeutic relationships using telehealth (Rees & Stone, 2005). Practitioners have been concerned it represents a threat of dehumanising the therapy context (Lovejoy et al., 2009) and dampening of the interpersonal dynamics (Anton & Jones, 2017). Given the centrality of the therapeutic relationship to therapy and to outcomes (Flückiger et al., 2018; Horvath & Symonds, 1991), at face value, this argument appears valid and deserves appropriate attention.

Videoconferencing (VC) is the form of remote delivery that is most similar to F2F of all telehealth formats, given its inclusion of visual and audio cues. For this reason, it is a delivery format that was deemed preferable to telephone counselling by PACFA in COVID-19 adjustments for placements (M. Brett, personal communication, August 19, 2020). VC has demonstrated equivalence in 14 of 16 studies in one metaanalysis that measured the therapeutic relationship (Backhaus et al., 2012). A later systematic review supported these findings after examining 22 studies that met their inclusion criteria (Simpson & Reid, 2014). A more recent metaanalysis examining 12 studies found VC to be inferior to F2F in the therapeutic alliance, though noted it still facilitated strong alliances (Norwood et al., 2018).

Telephone counselling was the modality about which PACFA's letter expressed especially strong caution and recommended to avoid if at all possible (M. Brett, personal communication, August 19, 2020). There is limited research that directly compares the therapeutic alliance in telephone counselling against F2F (Irvine et al., 2020). In one systematic review of 15 studies comparing telephone and F2F counselling, the researchers found both formats to be comparable in alliance, empathy, participation, and disclosure (Irvine et al., 2020). They noted that "the available evidence does suggest a lack of support for arguments that the telephone has a detrimental effect on interactional aspects of psychological therapy" (Irvine et al., 2020, p. 129).

E-therapy is a term that is equivalent to telehealth but is delivered by a mental health professional via technology such as email, VC, text-only chat, virtual reality or a combination (Sucala et al., 2012). A systematic review that examined 11 studies in e-therapy noted "A surprising finding, given the previous concerns related to the lack of nonverbal cues in e-therapy, is that e-therapy seems to be at least equivalent to face-to-face therapy in terms of the therapeutic relationship" (Sucala et al., 2012, p. 10). In three studies that compared the therapeutic relationship in F2F with e-therapy, two were equal, and the third showed e-therapy in front (Cook & Doyle, 2002; Kiropoulos et al., 2008; Reynolds et al., 2006; Sucala et al., 2012).

As in F2F, the therapeutic alliance in telehealth has been positively correlated with treatment outcomes across its different modes (e.g. text, voice, video) (Kaiser et al., 2021).

## **Are Telehealth Outcomes Inferior to Those of Face-to-Face?**

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Existing research suggests that not only is the therapeutic relationship consistently similar between telehealth and F2F, but the outcomes are consistently similar (Flückiger et al., 2018). In an earlier systematic review on VC, Backhaus et al. (2012) argued that, although the research studies reviewed were insufficient for firm conclusions due to volume and sample size and methodological weaknesses, they nonetheless pointed towards comparable outcomes with F2F. Norwood et al. (2018) also found VC outcomes were not inferior to the F2F format, thus strengthening confidence in the earlier findings. Telephone counselling has been demonstrated to be as effective as similar treatments (Castro et al., 2020). Text-based chat interventions, while improving mental health outcomes, did not reach the same level of effectiveness as telephone and F2F formats (Hoermann et al., 2017). Reviews of research across formats of telehealth tend to find it just as effective as F2F (Barak et al., 2008; Osenbach et al., 2013).

## **How do Clients Experience Telehealth?**

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The client's experience of telehealth is an equally important factor to consider. A review of telehealth across health domains, including mental health, found that it met patients' expectations irrespective of the mode of telehealth delivery (Kruse et al., 2017). Satisfaction links with several factors, including convenience, accessibility and saving of travel costs, similar outcomes to F2F, and reducing social barriers (Orlando et al., 2019). Evidence suggests that clients generally experience satisfaction with telehealth comparable to F2F (Dami & Waluwandja, 2019; Jenkins-Guarnieri et al., 2015; Morgan et al., 2008; Murphy et al., 2009; Richardson et al., 2015) and some clients show preferences for telehealth over F2F (Simpson et al., 2005). Although therapists may experience perceptions of lower quality therapeutic connections with clients online, there is evidence that clients may feel increased sense of connection with their therapists (Mishna et al., 2015). Clients may find it easier to disclose and build trust, appreciate the increased sense of control, display increased focus on tasks, and experience decreased distractions (Horowitz, 2014).

## **Practitioner and Profession Reluctance**

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"Nothing, in my estimate, can replace face to face contact with clients.... technology-based tools place a chasm of mistrust between client and [valuable] treatment..." (A therapist quoted in Ramsey et al., 2016, p. 62).

If the research supporting the use of telehealth as equivalent or near equivalent is so compelling (though less accessible to practitioners due to often being in fee-based research databases), what other factors might influence the reluctance to recognise and encourage telehealth experience for interns? Mora et al. (2008) state that therapist resistance is the biggest problem facing telehealth. Therapists often perceive telehealth as more difficult, less effective, not relational enough, not equally valued, lower status work, and as less accepted by clients (Faija et al., 2020). In addition, they report insufficient preparation in university (Faija et al., 2020).

The research has identified a few factors that influence how practitioners feel towards telehealth. Familiarity with providing online counselling or being educated in telehealth has been relatively rare (until COVID-19) for practitioners (Cipolletta & Mocellin, 2018) and practitioners often have a cautiously open or neutral attitude towards it (Perle et al., 2013; Wangberg et al., 2007). Therapists with F2F experience who lacked telehealth experience, universally tended to critically evaluate telehealth against their F2F experience (Springer et al., 2020). This comparison acted as a professional developmental impediment to overcome, and was associated with anxiety and doubt when using telehealth (Springer et al., 2020). More experienced and older therapists are more hesitant with telehealth, while psychoanalytic-oriented therapists were much less likely to endorse online counselling in comparison to cognitive behavioural therapists (Mora et al., 2008; Perle et al., 2013; Wangberg et al., 2007). Conversely Yellowlees et al. (2015) noted that younger mental health professionals do not have to be convinced of the potential for meaningful connecting online due to their deep familiarisation with online relating. Those with less experience using telehealth are more likely to be cautious and negative about telehealth than its users, which also changed direction as therapists gained experience and practice with it (Connolly et al., 2020). Decisions about whether to equally recognise the legitimacy of telehealth within the professional mental health community (and government funding models) may potentially be more influenced by existing normative attitudes, fears, and a lack of knowledge and experience in delivering telehealth and be less influenced by the existing research evidence.

Research findings can take two or more decades to be recognised and enacted by practitioners (Karlin et al., 2014) so these findings may have yet to be updated in the profession's common discourses. Lewis (2015) noted the lack of change to this specific training standard (in the 2014 version) indicated a resistance caused by clinging to "professional traditions developed in the twentieth century for very different social contexts" (Lewis, 2015).

If the alliance developed between counsellors and clients over telehealth is mostly comparable, yet with some contextual adaptations, I would argue there are insufficient grounds to discriminate against telehealth experience for interns. I would go so far to argue that any synchronous format of delivery should be treated with equal regard[3]. This would include placements that could be entirely via one mode of telehealth, in the same way that placements have traditionally been delivered via F2F predominantly. Counselling by distance is not an inferior form of counselling as it has historically been treated. Existing research suggests it is a different *and* generally equivalent experience of counselling, of which accordingly, I argue, should be equally recognised as equivalent to F2F.

## **Education as Preparation for Employment**

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"...core training rests on being immersed in the face-to-face environment on which it is assumed future practice will occur. However, we are not in a position to make that assumption any more." (Anthony, 2015, p. 40)

With job markets in developed economies becoming more insecure due to rapid technology advances, gig work, global competition, economic stagnation and fragility, and rising unemployment, higher education must adjust by producing graduates who are better prepared for flexibility, adaptability, technological adoption, and skill transferability (Jackson & Tomlinson, 2020). Counselling has not remained unaffected by social megatrends. Telehealth services have increased in volume over the years and are potential employers for counselling graduates. Included in these are Lifeline, Kids Helpline, Parentline, MensLine, TurningPoint, Suicide Call Back Service, Beyond Blue, 1800RESPECT, and more. Several of these services offer multi-modal treatment formats, providing potential clients with more diverse service contact points and services that may be single session or ongoing. The increasingly diverse delivery formats of counselling offered in these agencies reflect the range of communication mediums adopted by modern society.

Placements (otherwise known as internships or WIL) are a key pedagogical means of helping prepare students for work within the diverse contemporary society from which they will practice. They transition students from classes and simulated learning environments towards entry into their professional occupation (Reinhard et al., 2017). Placements prepare students with a wide scope of competencies and skills that are desired by industry and aim to integrate education and workplace experience (Coll et al., 2009). The Tertiary Education Quality and Standards Agency note that the intention of WIL is to enhance student employability and work-readiness (TEQSA, 2017). The placement experience is the student's opportunity to be immersed in the work environment and experience delivering therapy in authentic settings (Jackson, 2015). They have the benefit of more intensive clinical and line supervision and the educational staff support to assist in transitioning from student to practitioner. Placements give students an opportunity to select available workplace experiences that align with their aspirations at best or, at the least, give students an opportunity to gain any "required" experience that may be available. Placement guidelines provided by accrediting bodies must be very careful if adding regulations that might artificially limit professional experience in the absence of ethical prerogatives.

PACFA's TS support the gaining of diverse experience for students on placement which, in turn, will support employability. The TS allow students to count client contact hours delivering counselling to a diversity of clients (e.g. age, gender, sexuality, culture), a diversity of issues, and to use a diversity of modalities and formats (e.g. individual, couple, family, group). In addition, the TS core curriculum emphasises the importance of telehealth in that it requires graduates "to be able to *apply* knowledge and skills to: ... Alternative modes of working with clients, including synchronous online counselling and telephone counselling" (emphasis added, PACFA, 2020b, p. 3).

### **How is Essentialising Face-to-Face Experience Problematic?**

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PACFA's TS enable almost full diversity of treatment experiences for students on placement, thus at least partially aligning with the purposes of placement experiences. The TS also specifically emphasise that training providers ensure graduates have applied

skills and knowledge in telehealth, though appears reluctant to allow full scaffolding of telehealth learning (cf. Springer et al., 2020). The insistence on essentialising client and counsellor physical proximity in placements sends a confused message that, although the TS appear to accept diversity of placement experience and promote the importance of telehealth competency, it unequivocally insists on F2F-only[4]. Such an insistence relegates telehealth to “left over” hours and reinforces unhelpful, uninformed perceptions about telehealth (Ramsey et al., 2016).

While the TS do not explicitly prevent students from conducting telehealth on placements, the essentialising of F2F delivery may act to disincentivise and discourage students, education providers, and organisations from providing telehealth experience on placements. The group supervision experience offered by placements and higher education facilities will be more likely to be limited to supervision focused on F2F practice, so students who do not gain direct telehealth experience are also unlikely to hear cases and supervisory guidance related to these mediums. Interns will be more likely to miss out on both direct experience and participation in supervision that discusses telehealth cases. In my view, this is discouraging and impairing learning opportunities from both direct practice and supervision.

The TS also effectively rule out placement experiences in services that solely provide telehealth, thus reducing the pool of available opportunities for students across Australia. For some students, this may lead to delays in completing their placements, delaying their graduation, and delaying employment and financial opportunities. It may further disadvantage and reduce opportunities for students (and clients) located in regional, rural, or remote locations, while having less impact on students living in metropolitan areas. For higher education providers, it means fewer opportunities for students to be placed, costing time and expense in searching and maximising a smaller pool of opportunities. Take, for example, a hypothetical student living in a remote location. She aspires to be an online counsellor due partly to her locality and partly due to the benefits she has personally received via telehealth. She does not have the funds to temporarily relocate to the closest service hundreds of kilometres away to complete a F2F placement, a mode she does not intend to use in her future practice. What she wants is accessible, relevant, and affordable experience of authentic counselling. The exclusivist F2F position has real world ramifications for this student that are not equally shared by students with greater physical access and more opportunities for “acceptable” placements. More than anything, the current standards will disadvantage and discourage those who are unable, through their circumstances, to meet these arguably non-essential requirements.

The lack of telehealth recognition also impacts other higher education decisions, apart from the selection of placement organisations. It disincentivises incorporation of telehealth into the training institution’s student-run counselling clinics. Such a service extension would help increase access to placements for regional and remote interns, help students gain valuable telehealth experience, improve accessibility to services for clients who find it difficult to access traditional services, and provide additional opportunities to conduct research. The primary barrier to progressing this idea is that it would not count



towards student placement experience. The university funding of staff, and the student time commitment for an activity that is treated as superfluous to placement experience is unlikely to be viable or sustainable. While this lack of recognition might disincentivise counsellor training clinics from incorporating telehealth, it also disincentives trainers from ensuring sufficient telehealth preparation in the curriculum. If training providers knew their students were potentially to be required to perform telehealth in their placements, this would provide additional incentive to ensure their students were adequately and sufficiently prepared to deliver in these formats.

As an educator, I want students to have maximum choice in what type of counselling experience they gain on placement. Ideally, the experience aligns with their employment and professional aspirations and exposes them to a diversity of practice opportunities for which they can learn to adapt their practice. There is a recognition that each placement will offer different opportunities and that no placement will provide a complete range of experiences. Viewing the placement as a bridging experience into authentic practice means that rather than seeking to funnel experience towards a reductionist mode of treatment, the TS should be encouraging diversity of experience where possible or, alternatively, for students to gain experience in the areas where they aspire to work or where the opportunities for placement are available. Artificially reducing experience to a traditional treatment format appears out of touch with an employability focus that prepares counsellors for modern day practice settings.

## **Future Research**

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The research presented earlier showed general equivalence of the therapeutic relationship and outcomes. However, it did not address whether telehealth and F2F offer equivalent benefits for intern learning on placements. One social work program in Canada which trialled telehealth counselling placements indicated the interns found the experiences added practical and relational value to their fieldwork (Mishna et al., 2015). With PACFA's temporary loosening of F2F placement restrictiveness, there are opportunities to research counselling student experiences with a full or partial telehealth placement. How do their placement experiences and competencies compare with student placements confined to F2F prior to COVID-19? Research might be undertaken on educator experiences in changes they have experienced with organising and supervising for telehealth placements in comparison to pre-COVID-19 placements. The findings from these studies may contribute to future counselling TS. Practitioners who have felt compelled to deliver using telehealth might be surveyed about their transition from F2F, how they adapted, and how their attitudes towards telehealth have been impacted. How did they adjust their practice and adapt their modalities for telehealth formats? The answers to these questions may inform future research questions, training, and practice frameworks.

## **Conclusion**

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In this paper, I have argued that the 40 F2F internship hours required in the PACFA TS (PACFA, 2020b) should be revised to enable students to count all forms of synchronous experience with clients, including formats delivered using various technologies. This is partly due to a purpose of placements, which is to introduce students to real-life practice as delivered in contemporary society. Concerns about an inferior therapeutic relationship in the absence of physical presence and cues may reflect a preference for variables that may be prized by F2F practitioners but are not shown to be essential to therapeutic relationships or outcomes, as has been consistently demonstrated in available research over the last two decades. In my view, the existing position reflects a broader problem in the mental health field in relation to its ambivalent relationship towards the less familiar: “Yet despite evidence of comparable clinical outcomes, adoption amongst services is challenged by practitioner ambivalence, embedded views and systems that favour face-to-face” (Irvine et al., 2020, p. 129).

In the time of COVID-19, it might now be opportune to revisit questions of what is legitimate counselling experience for interns, to review the current position in light of existing research evidence, and to potentially extend the profession’s values of inclusiveness to alternative formats of practice. Telehealth may now be sufficiently mainstream in contemporary counselling, or at least in future counselling, to shift thinking of it as an outlier, towards seeing experience and skills in telehealth as integral a requirement to counsellor preparation as F2F delivery, including in placements. Given PACFA is one of two peak accrediting bodies in Australia, retaining an outdated and unjustifiable requirement in its TS is costly to students and educational providers alike and may undermine the profession’s credibility and desirability to its stakeholders, while providing little, if any special benefit to interns. Is it time to reassess?

## Author

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**Dr. Nathan Beel** (*PhD, MCoun, GradDipCC, BACC*) is a Senior Lecturer and Counselling Discipline Lead at the University of Southern Queensland where he delivers and oversees external undergraduate and postgraduate education in counselling. He has served as Chair of the National Heads of Counselling and Psychotherapy Education network, and has served on PACFA’s Professional Standards Committee. Nathan was formerly employed as a Counselling Manager at Lifeline (Fraser District), and Counsellor Coordinator at Salvo Care Line Brisbane. He served as Regional Development Coordinator with the Queensland Counsellors Association where he strategically advocated and built capacity to deliver professional development to regional members via online workshops. Nathan is a registered clinical member and supervisor with PACFA, and maintains a part-time private practice via phone, video, and face-to-face modes. Nathan has published on a range of counselling related topics including telephone counselling, internet counselling ethics, and male-friendly counselling.

## Acknowledgements

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The author would like to thank the National Heads of Counselling and Psychotherapy Education and PACFA members who provided guidance, who offered arguments for and against, and/or who proofread drafts and provided critical feedback.

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## Endnotes

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[1] The term telehealth is used to delineate the delivery of health-related services using telecommunication and/or internet technology (Nickelson, 1998). Telehealth formats include videoconferencing, telephone, chat, and email.

[2] Curiously, special training in videoconferencing was not mentioned as a requirement, neither was there guidance on synchronous chat/text-based counselling, which affords less paralinguistic information than phone counselling. One can presume the omission of synchronous text-based counselling was in error rather than ignorance.

[3] I am more cautious with the asynchronous modes primarily due to the logistics in measuring and monitoring the time records, not for any other reason.

[4] The TS (PACFA, 2020b) repeat the requirement that the first forty hours of placement must be “face-to-face” no less than five times. In contrast, the essential client contact activity (i.e. counselling) performed by the trainee on placement lacks parameters of what might not be considered as counselling or psychotherapy treatment. Case management, psychoeducation, intake/assessment only, supportive listening, or a range of other client contact activities interns might do with clients could potentially be interpreted as “counselling” and countable towards the 40 hours, but telehealth is clearly and explicitly excluded. The 2020 TS appear more concerned with the client’s physical proximity to the intern than whether the activity being conducted could be appropriately logged as counselling.

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