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Technology and Social Work Practice: Micro, Mezzo, and Macro Applications

Jonathan B. Singer
Loyola University Chicago, jsinger1@luc.edu

Melanie Sage

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23 Technology and Social Work Practice
Micro, Mezzo, and Macro Applications

Jonathan B. Singer & Melanie Sage

Social workers have an ethical responsibility to attend to the environmental forces that create, contribute to, and address problems in living (National Association of Social Workers [NASW], 1999). Developments in Internet and computer technologies (ICT) such as social networks, webcams, texting, virtual reality, and smart phone apps, have significantly changed the way we communicate with one another and interact with our environment (Mishna, Bogo, Root, Sawyer, & Khoury-Kassabri, 2012). Consider the following: Most Americans now get their health-related information from the Internet, instead of from friends, family, and health professionals as they did a decade ago (Fox & Duggan, 2013). In 2012, nearly a third of Americans reported trying to diagnose themselves or someone else using *only* information found on the Internet (Fox & Duggan, 2013). As people combine new ways of communicating with new ways of seeking health-related information, there has been a natural evolution toward new ways of providing social work services. Just as the Internet evolved from a collection of static Web pages (Web 1.0) to a virtual community called Web 2.0 (O'Reilly, 2005), the integration of social work with ICTs has created a new paradigm for social work, called *Social Work 2.0* (Singer, 2009).

The National Association of Social Workers (NASW) and the Association of Social Work Boards (ASWB) recognize technology as a significant environmental force and have published 16 standards for technology in social work, covering clinical practice, administration, advocacy and community organizing, and research (NASW, 2005). Although these standards provide a foundation for Social Work 2.0, the integration of ICTs and social work services has been limited by micro factors such as the fact that traditional consumers of social work services are the least likely to have access to ICTs (Fox & Duggan, 2013) as well as macro factors such as limited funding for current technology, and training in its possible uses (Wodarski & Frimpong, 2013). The purpose of this chapter is to review existing literature on technology and social services; identify and define key terms and concepts; and describe uses, benefits, and limitations of technology and social service delivery at the micro (clinical practice), mezzo (community practice), and macro (policy) levels. The goal is to promote dialogue and discussion about the role of current and emerging technology in social service delivery.

KEY CONCEPTS

The 15 most important Social Work 2.0 concepts are defined and illustrated in Table 23.1. Some concepts, such as online therapy, e-therapy and telehealth, have overlapping yet distinct meanings (McCarty & Clancy, 2002). For simplicity, the term "online therapy" is used when referring to any mental health service that is provided using ICTs.

USES, BENEFITS, AND LIMITATIONS OF TECHNOLOGY IN SERVICE DELIVERY

The uses, benefits, and limitations of technology in the micro, mezzo, and macro areas of clinical practice, community organizing, and policy issues have been addressed by a number of authors (Barak & Grohol, 2011; Dowling & Rickwood, 2013; Kanani & Regehr, 2003; Mishna et al., 2012; Perron, Taylor, Glass, & Margerum-Leys, 2010; Richards & Viganó, 2013; Singer, 2009; Slone, Reese, & McClellan, 2012; Wodarski & Frimpong, 2013). Whereas the clinical literature is written mostly by psychologists and counselors, with some notable contributions by social workers (Freddolino & Blaschke, 2008; Langlois, 2011), social workers have contributed extensively to the community organizing and policy literature and have addressed issues such as how to use technology for advocacy of social action (Hick & McNutt, 2002; J. Young, 2012) and how online mental health services are regulated and reimbursed (Reamer, 2013a).

ONLINE MENTAL HEALTH

Since the publication of the previous version of this chapter (Singer, 2009), scholars have written over 500 articles about online mental health services. Meta-analyses and comprehensive reviews of those studies suggest that online mental health services are effective in reducing symptomatology and that they increase functioning for some mental health disorders (e.g., depression, anxiety, eating disorders, posttraumatic stress disorder [PTSD], and substance use disorders), but not for others, such as weight loss (Barak, Hen, Boniel-Nissim, & Shapira, 2008). This body of research has found no significant difference in outcomes between synchronous (e.g., live webcam) and asynchronous (e.g., e-mail) online therapy. While it is possible that certain online environments are better suited for certain problem areas (e.g., virtual reality for treating PTSD or phobias, and text-based reminders for medication compliance), that remains a question for empirical investigation (Pallavicini et al., 2013). Finally, and perhaps most importantly, research comparing face-to-face (F2F) therapies to online therapies has consistently found that client outcomes in online therapy are as good (Barak et al., 2008; Beatty & Lambert, 2013; Champion, Newton, Barrett, & Teesson, 2013; Dowling & Rickwood, 2013; Richards & Viganó, 2013; Slone et al., 2012), and in some cases better (Birgit, Horn, & Andreas, 2013) than F2F therapies.

Research on online and F2F therapies share many similarities: most research is on individual therapy, although interventions exist for couples (Doss, Benson, Georgia, & Christensen, 2013) and groups (van der Zanden, Kramer, Gerrits, & Cuijpers, 2012); most consumers of online mental health services are women; and most empirical studies use cognitive-behavioral and behavioral approaches (Barak et al., 2008). According to a 2008 meta-analysis, the most effective online treatment interventions were

TABLE 23.1 Definitions and Examples of Technology Terms

Term	Definition	Example of Use
Asynchronous communication	Delayed communication; does not occur in real time	Correspondence via letters or e-mail
Chat/messaging	Synchronous web-based communication	Crisis hotline provides real-time text-based services using a program that loads into a browser, allowing the worker and client to communicate instantly
E-supervision	Supervision using e-mail, chat, phone, or webcams—anything but traditional face-to-face supervision	Four clinicians from different states dial in to the same telesupervision group
Online therapy (synonymous with e-, cyber-, e-mail, or chat therapy)	Therapy using technologies, rather than traditional face-to-face services	Client and therapist conduct therapy over e-mail, chat, webcam, or a virtual-world-like Second Life
GIS (Geographical Information Systems)	Computer software that allows social workers to map services and identify where service needs exist	Crisis worker at a nationwide crisis hotline locates local referrals for a suicidal client using GIS software
mHealth	Health care delivered on mobile communication devices such as mobile phones smartphones, and tablets.	Client downloads an app that reminds her to take her medicine, prompts her to rate her mood, and uses the built-in GPS to trigger an alarm when she enters a bar.
Podcast/vodcast	Subscription-based downloadable audio/video files	Client downloads and listens to an audio file created by the therapist on a clinically relevant topic (e.g., relaxation training)
Second Life	An Internet-based virtual world where people can interact with each other and communicate via chat or voice	Services, such as a rape-crisis shelter, are developed and accessed by members of the virtual community
Social Work 2.0	The integration of computer and Internet technologies with traditional social work	Service plans include relevant technology in service provision and goal attainment
Synchronous communication	Communication that occurs in real time	Traditional face-to-face social work, such as a therapy session; e-therapy using real time technology (e.g., chat)
Telehealth	The use of communication technology to provide services to remote locations	Social worker in a rural area uses the phone for assessment and diagnosis
Microblog/micropost	Short posts (usually less than 160 characters) intended to be distributed to "followers."	Stakeholders use Twitter and Facebook to disseminate information and organize "calls to action."
VoIP (voice over Internet protocol)	The routing of voice conversations over the Internet	Client uses VoIP to make free phone therapy appointments
Webinar	Internet-based seminar that allows for synchronous communication between people in remote locations and the presenter	Three social workers in different states give an interactive continuing education presentation to social workers from all over the world
Web 2.0	A conception of the Internet as an interactive medium	Consumers and staff co-create the information on an agency Web site using a wiki

cognitive behavioral therapies (CBTs), followed by psycho-educational and behavioral therapies (Barak et al., 2008). Online treatments using narrative therapy or psychodynamic approaches have received a great deal of conceptual attention because of their use of text (narrative) and self-reflection/insight (psychodynamic) (Balick, 2012; Migone, 2013), but have rarely been used in empirical studies (Andersson et al., 2012).

There are a number of notable limitations to online therapy and its existing evidence base. Although online therapies have been evaluated with people of all ages, there is some evidence to suggest that older adults and older therapists are less likely to trust online mental health services (Dowling & Rickwood, 2013; Miller & Bell, 2012). Although this might lend some support to the notion that online therapy is better suited for people who grew up with ICTs (e.g., "digital natives") than for people who did not (e.g., "digital immigrants") (Prensky, 2001), there has been no research to support the notion that online therapy is inherently more effective or feasible with younger versus older adults. There are problem areas for which no online treatments have been developed or tested (e.g., online family therapy); problem areas with only a single study (e.g., gambling addiction) (Gainsbury & Blaszczynski, 2011); and problem areas with conflicting evidence (e.g., the evidence for the efficacy of computerized CBT for depression; cf., Andrews, Cuijpers, Craske, McEvoy, & Titov, 2010; So et al., 2013). Even with problem areas for which there is evidence of efficacy, online therapies are susceptible to becoming irrelevant because of the rapid changes in technologies that are being evaluated and used in practice. Finally, in part because of the recency of online therapy, the long-term effectiveness of most online treatments has yet to be established (Dowling & Rickwood, 2013; So et al., 2013).

Types of Online Mental Health Services

Barak and Grohol suggest four distinct categories for online mental health services: (1) online counseling and psychotherapy; (2) online support groups and blogs; (3) interactive, self-guided interventions; and (4) psycho-educational websites (Barak & Grohol, 2011). These categories vary in function, evidence-base, and degree of interpersonal interaction (most = online therapy, least = psycho-educational websites).

1. Online counseling and psychotherapy is the provision of mental health services by a mental health professional using ICTs. Online therapy can occur in real time (synchronously) using a webcam, via virtual reality (VR) environment, chat, or other technology; or in delayed time (asynchronously) using e-mail, texting, or video responses. Providers and consumers of online therapy consistently report that one of the most important reasons to use online therapy is "convenience" (K. S. Young, 2005). For providers, it minimizes or eliminates travel time to, and overhead costs for, office space. For consumers, online therapy can reduce structural barriers to treatment, such as transportation and access to providers (McCoyd & Kerson, 2006). For example, people who travel for business, such a truck drivers, or people who stay at work sites for extended periods of time, such as oil rig crew operators or active military, can access mental health services using VoIP programs like Skype, webcams, or even texting. In theory, clients have greater choice of therapists (e.g., characteristics, education), mode of therapy (e.g., chat, webcam), length of session, and time of day. Unlike F2F therapy, clients and providers increasingly have 24/7 online access. Consequently, online therapists are encouraged to establish boundaries regarding frequency and duration of online communications (Kanani & Regehr, 2003; Kolmes, 2010).

Online mental health providers range from those who provide online therapy exclusively (e.g., http://onlinetherapyinstitute.com/) to therapists who provide mostly F2F services, but use ICTs to provide services to one or two clients. Social workers who use technology such as e-mail or texting to confirm therapy appointments are not providing online therapy (Mishna et al., 2012). Providers of online mental health services must be aware of security concerns, HIPPA regulations, and other ethical and legal issues that arise when providing therapy online (see Reamer, 2013b for a comprehensive review). Therefore, many providers pay secure, HIPPA-compliant third party online therapy sites to host their online sessions, or join a network of online therapy providers (www.telementalhealthcomparisons.com). One of the earliest selling points of online therapy was that clients could be anonymous and anywhere in the world (Schopler, Abell, & Galinsky, 1998). Today, however, nearly all professional associations (e.g., NASW, APA) recommend verification of identify and emergency contact information prior to providing services. Some third-party sites require

clients to verify their identity prior to connecting them with a provider. Some therapists require at least one F2F meeting for clients who wish to meet online in order to verify the client's identify, get signatures (consent forms, treatment plan), and begin establishing a therapeutic alliance.

How Online Therapy Works: Clients register at the therapist's website with a user name and password, supply a working e-mail address, and perhaps read descriptions of participating therapists. Once the account has been verified, clients can book sessions through an online calendar and decide which type of online therapy they would like: e-mail, chat, phone (either traditional land line or Voice over Internet Protocol [VoIP]), or VR. Third-party therapy sites provide clients with verification of provider credentials, articles on treatment issues, professionally vetted links, and personalized logins where clients can access individualized content such as crisis plans and client-specific podcasts. These sites provide therapists with secure technology, HIPPA-compliant storage of documents, scheduling services, payment management, and confidential modes of communication. McCarty and Clancy (2002) suggested that the most important contribution of online therapy is in revolutionizing recordkeeping. Whereas traditional records (paper or electronic) are essentially a one-sided account of treatment, therapy conducted over e-mail, chat, and even text messaging creates a complete record of communication between client and clinician. Video therapy can be recorded and reviewed by clients either during session or in-between sessions. With either text or video, clients and clinicians can review past sessions to identify treatment progress and clinicians can use the transcripts in consultation. Currently there is no state licensing board that allows social workers to practice across state lines. As a result, clients need to be in-state in order to benefit from the protections afforded by the licensing board. Although getting licensed in all 50 states is impractical, therapists who live near state lines have the option of getting licensed in two states. Some therapists whose in-state clients are hours away develop treatment contracts and/or safety plans that include a local therapist who will be on-call for crises or any time a F2F therapy session is needed. However, given the long history of phone-based crisis intervention services, and more recently chat-based "hotlines," some argue that face-to-face services are not required, even for life and death situations (Barak, 2007).

2. Online support groups and blogs. "Online support groups" refers to peer-facilitated mutual aid groups where members meet online either using text-based ICTs such as chat, VR environments such as Second Life, or in webcam-mediated F2F settings with programs like Google Hangouts. Some research has found online support to be as effective in addressing mental health problems as psycho-educational websites and self-guided treatments (Freeman, Barker, & Pistrang, 2008; Griffiths et al., 2012). As with online therapy, the benefits of online support groups are similar to those of offline support groups. Participation leads to an increased sense of self-mastery, satisfaction, and well-being (van Uden-Kraan, Drossaert, Taal, Seydel, & van de Laar, 2009). The benefit of participation increases with interaction (Yalom, 2005). The absence of a professional means that group members can share potentially dangerous or damaging misinformation that will go unchecked. The one type of group that appears to be unique in the online environment are groups that explicitly encourage self-harm, such as "pro-suicide" and "pro-anorexia" groups.

Blogs are written by consumers or providers of mental health services. Bloggers gain social benefits through feedback from people who regularly follow the blog and provide feedback via comments. For consumers, this online community can counteract feelings of isolation, shame, or stigma associated with a mental illness. The act of writing a blog can itself be therapeutic (Pennebaker, J. W. & Chung, C. K., 2011). Therapist blogs can offer insights into the experience of providing mental health services, as well as create resources similar to psycho-education sites for consumers. Ironically, one benefit of blogging for consumers—interaction with other consumers—can become a liability for providers. For instance, if a client follows his therapist's blog or Twitter account and posts a publicly visible comment identifying himself as a client, he has breached his own confidentiality. If that client posts confidential or time-sensitive information, such as thoughts of suicide, with the intention that the provider will respond immediately, it puts the provider in a potentially liable situation if he or she does not. Online therapists are discouraged from engaging with clients in public forums like blogs, Facebook, Twitter, Pinterest, and Tumblr. Dr. Keely Kolmes, a psychotherapist in San Francisco, has developed a social media policy that clarifies her use of technology and social media and sets expectations for clients (Kolmes, 2010).

3. *Interactive, self-guided interventions.* These are typically computer-based, web or mobile app cognitive-behavioral interventions that are intended to be self-paced and self-directed. Although these programs are intended to be used without a therapist, they can be stand-alone or used as an adjunct to other mental health services including online or offline therapy (Carper, McHugh, & Barlow, 2011). They range in complexity from low (e.g., static modules that are offered to every user in the same order) to high (e.g., personalized programs that vary based on users' responses to baseline intake and are continuously modified based on user input).

The best-researched self-guided programs are computerized cognitive behavioral therapy (CCBT) programs, such as MoodGYM (Griffiths, Farrer, & Christensen, 2010; Lintvedt et al., 2013). These programs have been shown to be as effective at reducing depression and anxiety symptoms for people who complete the program as F2F therapy (Griffiths et al., 2010). Although they have been criticized for their high drop-out rates (So et al., 2013), some have argued that the completion rates for self-guided therapy are no lower than for F2F therapy (Andrews et al., 2010). Self-guided therapy programs have been consistently lauded for being cost-effective (Lintvedt et al., 2013; Powell et al., 2013); unlike F2F therapy, self-guided computer-based programs are often free to the user, cost very little to the provider (after recouping the cost of development and hosting), and are easily scaled so that one or one million people could use the program. Proponents of self-guided programs have long argued that the low cost and scalability of the programs could result in widespread adoption of psychotherapy (Bell, 2007). This proposition was recently tested by Powell et al. with the program MoodGYM (Powell et al., 2013). Although MoodGYM was developed to reduce anxiety and depression symptoms, it was hypothesized that the therapy modules would improve the mental health of those without anxiety or depression. Powell et al. recruited members of the general public to complete the modules in MoodGYM. After controlling for baseline depression and anxiety, they found that participants reported an overall improvement in well-being. This study provided the first evidence that computerized self-guided therapies could be used to improve well-being in the general population, and not just within a clinical population (Powell et al., 2013).

Interactive and self-guided interventions are increasingly being delivered over apps designed for mobile devices (e.g., mobile phones, smartphones, and tablets) (Proudfoot, 2013). The delivery of health and mental health services using mobile devices, called mHealth, has a number of advantages over other ICT-based interventions: Mobile devices travel with the client; they can be programmed to send alerts to take medication, call for an appointment, take a deep breath, or record an emotion or thought; or to deliver interventions at set times. GPS-enabled mobile devices can track exercise, or sound an alert when a person is in a pre-established "no-go-zone" such as a bar or casino. Despite their promise, apps are in their infancy, and the most capable developers (e.g., programmers) are not usually the content experts that consumers, providers, or health service organizations would be (HSOs) (Aguirre, McCoy, & Roan, 2013). Apps developed by social workers typically target other social workers, such as the ethics app, *Social Work Social Media* (Cooner, 2013).

4. *Psycho-educational websites* are online sources of information. They are analogous to offline bibliotherapy in that the purpose is to provide information, rather than contact with mental health professionals or personalized referrals. The value of websites has increased as people's access to the Internet through smartphones and tablets has increased. Examples include the *National Institute of Mental Health* (http://www.nimh.nih.gov), *Substance Abuse & Mental Health Services Administration* (http://samhsa.gov/), and *WebMD* (http://www.webmd.com/). Psycho-educational websites are only as good as the information they provide. Providers and consumers should evaluate web resources based on the *authority, accuracy,* and *objectivity* of the information (e.g., one person's opinion vs. results of a large-scale study), the comprehensiveness of the *coverage* and whether or not the site meets its stated purpose for its intended audience, how *current* the information is, and whether or not the *design* makes it easier or harder to find information on multiple platforms. Finally, consumers should know that even though they cannot find information on the Internet about a certain topic does not mean that there is no information available.

In sum, online mental health services have a growing evidence base for delivering a variety

of interventions to a variety of consumers using ICTs, including those who were traditionally excluded from treatment based on geographical or other barriers. Advances in self-directed interventions and mHealth point to a future when social workers are no longer providing some mental health and linkage functions. For example, Facebook and the iPhone are programmed to recognize when users make suicidal statements and refer them to the National Suicide Prevention Lifeline or local crisis centers. There continue to be significant limitations to ICTs in social work practice. ICTs do not bridge the "digital divide" by themselves. The benefits of online therapy cannot be realized by those who lack access to technology, the technical skills to participate in therapy online, or the financial resources to pay out of pocket (unlike F2F therapy, online therapy is not covered by insurance). These barriers can be considered economic, social, and electronic justice issues. Therefore, social workers have a professional responsibility to address the mezzo- and macro-level barriers to accessing and using ICT-based services, as well as using technology in mezzo- and macro-level practice and advocacy.

COMMUNITY ORGANIZING

Social work's community organizing roots emerged in the late 19th century, in part as a response to social problems that developed out of technological advances brought on by the industrial revolution. For much of the 20th century, social workers struggled with the ways that vulnerable and marginalized groups were adversely affected by technology (Hick & McNutt, 2002). In the 21st century, some problems, such as bullying and sex trafficking, have shifted from occurring primarily on the ground to primarily online. For some, lack of access to technology has itself become a social problem. For instance, those with access to Internet-connected computers have educational advantages related to information access, can enhance their marketable computer skills, and are better able to find and apply for jobs online than people without Internet access (Araque et al., 2013). And yet, between 25% and 50% of adults without high school degrees, older adults, and those who identify as a racial/ethnic minority do not have online access (Purcell, Brenner, & Rainie, 2012). Organizing efforts that do not acknowledge or address this "digital divide" may exclude the very groups that would most benefit from participation in advocacy efforts. And somewhat paradoxically, ICTs in the 21st century have made it possible for people who previously were marginalized because of age, geographical distance, physical or economic limitations, or social stigma, or a combination of all of these, to communicate and organize through virtual communities. Although the early days of the Internet included closed communities (e.g., CompuServ and AOL) and attempts at recreating physical communities online (e.g., Geocities.com), advances in virtual reality and 24/7 access to the Internet via smartphones and tablets has resulted in the creation of truly virtual communities with no offline counterparts. In these early days of the 21st century, social workers have to negotiate a paradox: the very technologies that marginalize and disenfranchise groups can also be used to ameliorate social problems.

In the 21st century social workers need to organize both physical and virtual communities. Technological tools that support community organizing and social work advocacy fall into two primary categories: (1) tools that mediate communication and message delivery, such as e-mail, listservs, social networks (e.g., Twitter, Facebook), and blogs; and (2) tools for data collection and visualization, such as GIS, donor management software, and automated subscription-based alert systems. Community organizers were early adopters of ICTs that mediated communication such as e-mail and listservs. These text-based technologies were inexpensive ways for organizers to communicate with and mobilize key stakeholders. The adoption of high-speed Internet and free video conferencing (via Google Hangouts or FreeVideoConference.com) simplifies and popularizes synchronous webcam-mediated F2F gatherings. Newer ICTs such as Twitter and Facebook combine text with images and videos, can be used synchronously or asynchronously, and, similar to self-guided therapy, have decreased the need for organizing efforts to be facilitated by a trained professional. The Occupy movement and the Arab Spring are examples of social movements that used Twitter and Facebook and were "marked by the absence of a clearly identified leader, a political party or figure, an association, or an organizing capacity" (Marzouki & Oullier, 2012).

Although online tools hold promise for organizing, they are often underutilized by nonprofits, especially in the realm of advocacy (Edwards & Hoefer, 2010). Despite the growing number of

nonprofits that use social media sites, there continues to be a gap between available ICTs and the knowledge and skills necessary to use them to engage stakeholders effectively (J. Young, 2012). Organizers should have a clear goal in mind when adopting a new technology, and consider utilizing multiple strategies (Dunlop & Fawcett, 2008). Social workers who want to increase their proficiency for online community organizing may join online groups such as COMM-ORG (comm-org.wisc.edu/), which offers numerous links to other community organizing resources.

The following is an example of how various ICTs can be used in concert to educate and mobilize key stakeholders around the issue of housing discrimination for same-sex couples:

- A social worker in North Dakota could (1) leverage face-to-face chats in Google Hangouts to organize stakeholders across the state who are interested in housing discrimination issues that affect same-sex couples; (2) use a Facebook group to collect comments about a related nondiscrimination policy proposal and to announce a public hearing; (3) start a statewide nondiscrimination petition on causes.com; and (4) direct people to tweetcongress.org, where they can tweet messages to their elected local representatives to advocate for a policy that bans housing discrimination based on sexual orientation.

Other examples of ICTs in community organizing and advocacy include:

- Geographical Information Systems (GIS) technologies can be used to analyze information about specific geographical regions, such as neighborhoods, zip codes, cities, or counties. Advocacy groups can analyze campaign demographics to improve voter participation on key social service issues. GIS can be used by consumer rights advocates to identify areas of need to improve service delivery.
- A number of websites allow nonprofits to meet a number of community organizing needs, including fundraising, volunteer recruitment, and legislative tracking, as well as collecting signatures, and conducting outreach. For example, anyone can start a petition or fundraising campaign on the website causes.com, and the site cqrollcall.com offers a paid service by which users can add legislative tracking to their websites.
- E-mail lists and social network sites are low-cost ways of distributing action alerts (e.g., "call your representative now!"), and targeted social media campaigns can be designed specifically to recruit certain disenfranchised groups (Vyas, Landry, Schnider, Rojas, & Wood, 2012). Social media users have higher levels of political participation and civic engagement (Valenzuela, Park, & Kee, 2009); thus, social media can be an ideal facilitator of collective action, political mobilization, and community building (Obar, Zube, & Lampe, 2011). Although a primary reason nonprofits begin using social media is to engage their current audiences (J. Young, 2012), websites like Facebook, YouTube, and Twitter make it easy and economical for agencies to develop an Internet presence, facilitate communication with new and existing stakeholders, and share information about their specific causes (Edwards & Hoefer, 2010).
- Online discussion lists, websites, and blogs, as well as issues-oriented and social change websites can organize people in one neighborhood or from around the world on a specific issue. For issues such as suicide, which has a relatively low base rate (12 per 100,000) and stigma-related silence, geography and social stigma have made it difficult to organize people to promote change. However, the Internet has made it possible for the friends, family, and loved ones of the nearly 38,000 people annually who die by suicide to come together as a community (Mohatt et al., 2013). For example, in July 2013 the advocacy work of American Foundation for Suicide Prevention (AFSP) (afsp.org) provided instrumental support for expanding a bill in the Senate Labor, Health, and Human Services Committee, including a $15 million budget increase for the National Violent Death Reporting system, which will provide more timely information about national suicide statistics. AFSP used its website to send legislative alerts, raise awareness among politicians, and encourage constituents to call their representatives. They provide tips on what to say when speaking to public officials about suicide.

POLICY ISSUES

Agency Policy

Agency-level policy may inform a social worker's participation in social media and online forums. Although many agencies lack specific social media policy (J. Young, 2012), agency employees who communicate via social media from home or work should understand company policies related to social media use. Additionally, they should know how they can represent their associations with their employers, understand the relative permanence of online postings, and consider how their public online identity might influence their interactions with consumers (Kimball & Kim, 2013). Although it is illegal for employers to limit an employee's private participation in workforce organizing online, online posts that broach professional ethics are not protected (Halpern & Gardner, 2012). Social workers who are government employees should also understand that the technology used at their agency, including web-browsing and e-mail, may be monitored by the agency or subject to public disclosure through freedom of information regulations (Dawes, 2010).

Social workers may be asked to help draft their agency's e-therapy or social media policy. Policy should educate workers, be realistic about the significance of the Internet and social media in the lives of social workers, be specific with examples of justifications and prohibitions for use, include consequences of policy violation, and consider the impacts of social media use, negative and positive, on clients (Reamer, 2013).

Licensing and Regulation of Online Therapy

As with other professions such as law, medicine, and nursing, licensing and regulation of social work occurs at the state level. Online therapy has no geographic boundaries and thus creates complex regulatory issues. For example, if a client resides in Idaho and a therapist works in Georgia and they meet online for therapy, in which state are they conducting therapy? Is the therapist going to the client or is the client coming to the therapist? Which state's consumer protections apply? These questions have yet to be settled by either regulatory or legal precedent. Although groups such as the American Telemedicine Association (ATA) are working toward best practices for telemedicine delivery across professional disciplines (americantelemed.org), and some state licensing boards offer policy guidance on Internet-mediated practice (Reamer, 2013b) unless explicitly allowed by your state's licensing regulations, interstate online therapy is a violation of your licensure.

Liability and Malpractice in Online Therapy

Social workers are increasingly seen as the primary providers of mental health services and consequently are named in more malpractice lawsuits than ever before. The largest provider of malpractice insurance for social workers, NASW Assurance Services, reports that liability coverage is offered worldwide for services including online therapy unless social workers provide services for which they are not licensed (e.g., practicing social work across state lines) (naswassurance.org). They offer specific caution about the importance of protecting client confidentiality. The onus of responsibility lies with social workers to understand the limits of state licensure. Case law suggests that a professional relationship can be established by responding to an e-mail. Reamer (2013b) notes that social workers are obligated morally and ethically to be familiar with the available research regarding the efficacy of online therapy and be proficient in the use of technology needed to carry out practice; practicing outside of one's scope is an ethical and liability concern. Informed consent requires that consumers are informed of the evidence available to support a course of treatment, and of the provider's qualifications and trainings in the proposed modality. Social work programs only started offering social work and technology courses in 2013 (UB Reporter, 2013). One approach to developing competency in online therapy is for clinicians to use technology in clinical supervision to both increase their comfort level and to receive consultation on online therapy issues (Singer, 2009).

Confidentiality, Security, and Informed Consent

There is currently no case law that clarifies the confidentiality of e-mails, webcam images, or text messages. However, online therapy is bound by specific HIPAA rules that address confidentiality and the security of electronic transmissions (Eack, Singer & Greeno, 2008), and the storage of

any personal health information and telehealth communications. Regulations regarding patient protection mandate the use of privacy safeguards including encryption, security passwords, and intrusion detection software (Scholl et al., 2008). Some states require specific language and signed consents for telemedicine activities (Baker & Bufka, 2011). Social workers should have clear policies related to the storage of online documentation (recordings, chats, e-mails, and records) and ensure that they are not violating any state regulations by practicing across state borders (Reamer, 2013a).

Reimbursement

Insurance reimbursement for clinical services from programs such as Medicaid, Medicare, or private insurance is organized at the state level and, therefore, varies by state. However, insurance companies typically require audio-video equipment to carry out "telemedicine" and exclude services offered via other methods such as e-mail or text (Baker & Bufka, 2011). Some insurance companies authorize e-therapy reimbursement on a case-by-case basis if a special need exists, while others, such as Magellan and Blue Shield, provide regular authorization of online therapy in California (Breakthrough Behavioral Health, n.d.). BlueCross authorizes telemedicine coverage in 21 states but can restrict the types of providers or services that are eligible, and 19 states have specific policies that mandate insurance companies pay for telemedicine services if they would be covered face-to-face (ATA, 2013; Baker & Bufka, 2011).

Online therapy groups require payment at the time of services and do not bill insurance for services. Although this arrangement is adequate for financially independent consumers, the economically disadvantaged consumers who make up social work's core service recipients will be unable to afford e-therapy. Ideally, social service organizations could develop Social Work 2.0 services, such as text-based technologies like e-mail or chat, telehealth using the phone or VoIP services, or video technologies such as webcams, to address the needs of clients for whom traditional face-to-face services are inadequate or difficult to access. However, this is unlikely until funding is available.

CONCLUSION

Advances in ICT have changed the way social workers think about and provide mental health services. Some of the advances have reduced the role of social workers in mental health treatment, community practice, and advocacy. Over the coming decades, it is likely that some social work services will be entirely computer-based, whereas others will have only minimal integration with technology. As today's youth become tomorrow's consumers, and they see fewer distinctions between their online and offline identity, social workers will have to demonstrate knowledge of and skill with ICTs to provide treatment in any environment. In an effort to address this need, social workers have taken to developing social work education apps (Cooner, 2013). But formal social work education in ICT-mediated social work is lacking; the first social work course to address the use of technology in clinical social work practice was taught as a summer elective in 2013 by Mike Langlois for the University at Buffalo School of Social Work (UB Reporter, 2013).

WEBSITES

International Society for Mental Health Online. http://www.ismho.org.

MoodGym, online cognitive behavioral therapy to prevent depression. https://moodgym.anu.edu.au/welcome.

NASW Standards for Technology and Social Work Practice. http://www.socialworkers.org/practice/standards/NASWTechnologyStandards.pdf.

References on Internet-assisted therapy and counseling. http://construct.haifa.ac.il/%7Eazy/refthrp.htm

The Social Work Podcast. http://socialworkpodcast.com.

Social Work and Technology—Google Plus Community https://plus.google.com/communities/115588985317830085141

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