How can psychologists stay ahead of the curve — and keep patients safe?

By Amy Novotney

June 2011, Vol 42, No. 6

On a typical day, military psychologist Ray Folen, PhD, might provide an hour of therapy to a patient struggling with anxiety in Guam, another hour to a client in Japan experiencing post-traumatic stress disorder and a third hour to a soldier in his home state of Hawaii who might be dealing with depression.

All of this therapy is provided from Folen’s office at Tripler Army Medical Center in Honolulu, but only one of the sessions is done face-to-face.

Folen, chief of Tripler’s psychology department, is one of a growing number of psychologists seeing patients via video teleconferencing. The practice has been in place for almost 20 years at the Department of Veterans Affairs and other government organizations that serve patients in rural areas. But over the last decade, more psychologists have begun offering “telepractice,” also often referred to as “telepsychology” or the newer term, “telemental health” and the older, more generic “telehealth.” The terms refer to providing psychological services remotely, via telephone, email or videoconferencing.

Those in the telehealth trenches say it improves access to care for people who live in remote areas or who, due to illness or mobility problems, can’t leave home. The practice also enhances psychological services by allowing psychologists to support clients between visits. Medicare, Medicaid and other third-party reimbursement is available for psychologists who deliver such services via videoconferencing and follow specific guidelines, experts say.

“By insisting that patients come to our offices, we’re excluding potentially millions of patients who need care,” says Carolyn Turvey, PhD, a professor of psychiatry at the University of Iowa and vice chair of the American Telemedicine Association’s Telemental Health special interest group.

Timely diagnoses by behavioral scientists via telehealth, for example, can help a child with autism in a rural community remain in school and improve socialization, she says. Or a quick check in via telehealth can help an older adult in a nursing home control her temper. “Being more open to telepsychology is really going to help many needy people who just can’t meet the requirements of current face-to-face practice,” she says.
APA’s Center for Workforce Studies has documented telehealth’s growth: Overall email use with clients for service delivery more than tripled among practicing psychologists from 2000 to 2008, with approximately 10 percent of those sampled using it weekly or more in 2008. Practitioners’ use of videoconferencing with clients, while still rare, increased from 2 percent to 10 percent among survey respondents during that same time period.

Turvey says much of telepsychology’s growth can be attributed to consumer demand — particularly from younger clients. As people become more accustomed to the convenience of online commerce and keeping up with friends and family via social networking websites, interacting with a therapist online may become just another convenience that’s expected.

And while some psychologists say it should have happened sooner, support for and guidance on telehealth from APA and other psychological organizations is growing, particularly under the leadership of APA President Melba J.T. Vasquez, PhD. In August, she spearheaded an effort to create a joint APA-Association of State and Provincial Psychology Boards task force that will develop national guidelines for telepsychology practice. APA’s Council of Representatives approved the creation of the task force in February.

One reason why APA has taken a cautious approach to developing these guidelines — and why more psychologists aren’t jumping on the telepsychology bandwagon — is that the practice still involves licensure concerns when it comes to treating patients across state lines, says Lynn Bufka, PhD, of APA’s Practice Directorate. Many practitioners also say providing therapy online continues to pose privacy risks and that reimbursement for these services has only recently begun. The practice of telehealth also requires significant training, and comes with several ethical and therapy effectiveness considerations, particularly with regard to email. Some say that while email is often the “easiest” technology, it has serious limitations as a clinical tool, including the absence of the ability to “see” non-verbal cues from a client.

“There’s just not a clear understanding of what’s acceptable and what’s not in telehealth,” Bufka says.

Why telepractice?

The expansion of telehealth would help address several hurdles to securing mental health services. Nearly 80 million Americans live in a mental health professional shortage area, according to the U.S. Health and Human Services Health Resources and Services Administration. Even in urban environments where psychologists abound, cost, transportation and time constraints often prevent people from seeking mental health services.

In addition to these structural barriers, a 2009 Substance Abuse and Mental Health Services Administration survey found that less than one-quarter of the estimated 45 million American adults who have a mental illness received treatment. One major reason for the low number: stigma and embarrassment about making contact with a therapist. Telehealth — be it by phone, email or video conferencing — can help solve many of these access problems, says Eve-Lynn Nelson, PhD, assistant director of research at the University of Kansas Center for Telemedicine and Telehealth.

“Technology really helps us get more bang for our buck and extend our service reach,” says Nelson, who has been researching and providing video-based mental and behavioral health services to children and adults for nearly a decade.
A 2008 meta-analysis of 92 studies, for example, found that the differences between Internet-based therapy and face-to-face were not statistically significant (Journal of Technology in Human Services, Vol. 26, No. 2). Similarly, a 2009 review of 148 peer-reviewed publications examining the use of videoconferencing to deliver patient interventions showed high patient satisfaction, moderate to high clinician satisfaction and positive clinical outcomes (Clinical Psychology: Science and Practice, Vol. 16, No. 3).

In addition, a 2010 study in the Journal of Clinical Psychiatry (Vol. 71, No. 7) found that videoconferencing can be successful in treating post-traumatic stress disorder. In that study, researchers compared the effectiveness of 12 sessions of anger management therapy delivered via video to in-person delivery of the same treatment to 125 rural combat veterans with PTSD. The researchers found that the video-based anger management therapy was just as effective as the face-to-face care.

“This is not a small statement to make when you’re trying to get buy-in from providers or clinics about how well this works,” says the study’s lead author, Leslie Morland, PsyD, a clinical psychologist with the National Center for PTSD, Pacific Islands Division.

But such findings don’t mean every mental and behavioral health intervention can or should be provided online, cautions Bufka. She says the research remains inconclusive about which treatments are suitable for telehealth and which are better done face-to-face.

**Jurisdictional restrictions**

Licensing is another major area of concern with telepsychology. Psychologists must be licensed to work with patients in another state. But what happens when a Georgia-based psychologist wants to offer telepsychology services to a client who has retired to Florida? Most clients prefer to continue therapy with their current provider by phone, email or video rather than find a new psychologist and begin a brand new relationship — and most psychologists don’t want to abandon their client in these situations. But current licensing laws don’t provide enough guidance as to whether they can continue to provide services, says ASPPB Executive Officer Stephen DeMers, EdD. This has become a problem for industrial-organizational psychologists, in particular, who work with clients nationwide and sometimes internationally, says Judith Blanton, PhD, a consulting psychologist with RHR International.

Research by APA’s Practice Directorate found that only three states — California, Kentucky and Vermont — have instituted specific licensing guidelines on psychologists’ use of telehealth. Most states continue to follow policies devised long before technology allowed provider and client to interact from separate states, DeMers says. “By making licensing laws so onerous and antiquated, it’s actually encouraging people to ignore them, so we need to come up with a better, more feasible system,” DeMers says.

**Online safety and security**

In addition to understanding the licensing barriers around telehealth, psychologists must also educate themselves on the ethical and legal challenges of providing telepsychology.

Calling telepsychology the “new wild west” for psychology, Marlene Maheu, PhD, executive director of the Telemental Health Institute, an online telemental training organization, warns that its use could have potential risks for both clinicians and patients. The convenient use of technology may not be as easy as it first appears, she says.
“Simply shifting one’s practice online can significantly veer away from evidence-based telehealth procedures, where nursing, administration and IT staff usually provide full patient support,” Maheu says. Clinician liability and reimbursement as well as patient safety are also critical issues.

For now, says Maheu, psychologists should manage their risk by adhering to their standard of care and only using well-documented protocols. This traditionally involves a thorough in-person intake and assessment, followed by research-based protocols of specific treatments with well-trained clinicians, but only if you can handle emergencies in far-away locations.

Successful telehealth programs traditionally follow an in-person assessment by a licensed health or mental health professional, such as a psychologist, physician or nurse, who then gives a referral to a telehealth practitioner. The in-person intake allows for thorough assessment, history taking, proper identification of the patient, including examination of a driver’s license, assessment of grooming and hygiene, substance abuse, movement and speech aberrations, general health and social skills. This model leads to a greater likelihood of adherence to evidence-based treatment as well as safety precautions.

To help ensure clients are aware of the risks, psychologists should add several other elements to their informed consent discussions, including the written authority to contact identified family and other treating professionals in the client’s local area in case the therapist needs emergency backup.

This is also a good place to consider setting limits with clients as to your rules around social networking — whether you are comfortable “friending” clients through Facebook, for example — and what they can expect when it comes to answering emails, texts and telephone calls.

“Greater use of online therapy is definitely realistic,” Maheu says, “but only with focus on research-based patient safety and other protocols.”

Training is essential

The key to successful telepractice, say Folen and others, is training in online therapy.

“You really can’t just take a provider who has been doing face-to-face work all their lives and put them in front of a camera and say, ‘go for it,’ because there are some very subtle, important things that need to be considered when you’re working with someone over an electronic connection,” he says.

For example, during face-to-face sessions, when a provider looks away from a patient to take notes, no real connection is typically lost. But for a client being treated over a computer screen, a provider looking away might indicate that the provider is distracted or not interested in what the client is saying, Folen says. “We now tell our providers to explain to the person on the other end that when they look away it’s simply to make a note about something,” he says.

Psychologists also need to adjust their cameras to eye level to ensure proper eye contact with the client, and to check in with the client at the beginning of each session to make sure the volume is at a comfortable level. “If the volume is too high, it may sound to the patient like the provider is extremely assertive or even possibly yelling at them,” Folen says.
Telehealth training also prepares practitioners in another way: It educates them on how tiring the practice can be. “You really have to concentrate and attend to what you see on the TV monitor, and I find that our providers — particularly those who are just starting to provide therapy this way — get pooped out very easily,” Folen says. “They have to do it enough to build up some resiliency.”

While training in how to provide these services — particularly at the predoctoral level — is almost nonexistent at this point, that is slowly changing. For the last several years, APA has offered continuing-education workshops on telehealth at its Annual Convention, and several APA divisions are beginning to provide training in telehealth as well. In addition, the American Telemedicine Association offers online courses and training for professionals at its annual meeting, including sessions on how to get started in telepsychology and how to be reimbursed. Still, more training is needed to help psychologists understand how the existing scientific literature as well as how current legal and ethical codes address such key issues as the specific requirements psychologists must follow for taking notes and the use of electronic health records. These issues and more are exactly what a joint APA-ASPPB telepsychology guideline task force could help clarify in more detail — providing guidance on what is and is not acceptable as psychologists struggle through the growing pains of working with new technologies, says Vasquez. The APA Insurance Trust will participate in the collaborative task force to represent issues related to risk management for psychologists.

“The tail is wagging the dog in some ways on this issue,” Vasquez says. “We need to make sure that our members understand the importance of informed consent, the limits of confidentiality, and the risks involved, and that they have information about the best uses of technology and what technologies are more facilitative of the provision of psychological services.” The research on this topic, particularly when it comes to the use of email for service delivery, is still lagging — and in need of greater attention, she says.

Yet, while many psychologists have their concerns about telepractice, most recognize that if psychologists don’t venture into this new area of consumer demand, less experienced mental health professionals will.

What’s more, as the technology evolves, so too may the opportunities to enhance current modes of face-to-face therapy, Folen says. For example, a client with agoraphobia could get feedback via text message from her psychologist as she ventures into a shopping mall.

“These kinds of things can be used to extend the effectiveness of our therapy,” Folen says. “If used correctly, I think technology can transform how we do care.”