Mental Health Committee Members

TO TELEMENTAL HEALTH OR NOT? Using Technology to Bridge the Mental Health Services Gap

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Should I do Skype therapy? This has been a dilemma posed in social work forums, at trainings, and at dinner conversations, and it's one I once pondered. Information about this shiny new way of providing therapeutic services over video has been circulating in therapy circles for decades—according to several TeleMental Health researchers, psychiatrists started experimenting with services through technology as early as 1950 (Farris, 2013)—but TeleMental Health has achieved greater prominence over the past decade. With technology at our disposal and connectivity at its peak, TeleMental Health offers the opportunity to reach underserved communities who face access barriers to services.

First things first: Let's use the correct language. When people refer to Skype therapy, they are referring to TeleMental Health—that is, therapy provided over video or a technology-based platform. Skype is one of many platforms that professionals have used to provide services over video. Considerable debate continues over whether Skype is Health Insurance Portability and Accountability Act, (HIPAA) compliant; we will cover HIPAA-compliant platforms later. First, let's further explore TeleMental Health. TeleMental Health is a subset of Telemedicine or Telehealth, and both terms are often used interchangeably. According to the American TeleMedicine Association, TeleMedicine is the use of medical information exchanged from one site to another through electronic communications to improve patients' health status. The Health Resources and Services Administration defines Telehealth as the use of electronic information and telecommunications technologies to support distance clinical

health care, patient and professional health-related education, public health, and health administration (National Coordinator for Health Information Technology, 2017). The TeleBehavioral Health Institute TBHI Level I Professional Training Certification (2016) points out that there are at least 43 terms to describe TeleMental Health services, such as *telepsychology, telepsychiatry, telebehavioral health, video therapy, online therapy, distance counseling,* and *video conferencing*. TeleMental Health services can be provided in three main ways: text (e-mail or text message), video, and avatar (use of a digital character meant to represent a real person).

Much has changed since the 1950s, when the first experiments in TeleMental Health were taking place. TeleMental Health services have been slow to gain acceptance. As the Internet became available, text and then video therapy emerged. Initially, dial-up problems existed, equipment was expensive, little to no regulations were in place, and insurance companies offered no training and no reimbursement. Now, many organizations have adopted regulations to support TeleMental Health. The National Association of Social Workers (NASW) and the Association of Social Work Boards (ASWB) have created standards for technology in social work practice, and health insurance companies are not only reimbursing for services but prompting and recruiting providers to offer services through video. In addition, ASWB approved the TeleBehavioral Health Institute's online training program. Electronic medical records have even incorporated video platforms into their software to make it easier for therapists and clients to connect. Such headways have made it possible for more people to access mental health services.

STORY 1

Once a week, a young professional uses her lunch hour to connect with her therapist over video. She uses her private office, puts her headphones on, and turns on her white noise machine before she connects by computer with her therapist. She feels relieved that she doesn't have to ask for extra time to make it to and from therapy during work hours. Asking permission to leave work during the day would require her to fill out a disability form that she doesn't feel comfortable completing.

STORY 2

On a spring afternoon, a Maryland student finishes school and goes to her afterschool program at a nearby nonprofit organization. In between the nonprofit's programming, the student goes to the private counseling room at the agency, logs in to the computer, and connects to her mental health provider, who awaits her on the other side of the screen from her office in Washington, DC. This student's family had been looking for a therapist for her who speaks her language and understands the cultural nuances of her experience, but the family experienced transportation barriers accessing the therapist in DC.

These stories reflect the times in which we currently live—times of increased connectivity and services going right to the community. These stories also demonstrate two models of services: organizational-based partnership, or a spoke-and-hub model, in which a therapist partners with an agency to serve the agency's clients so they do not have to leave the primary place from which they obtain other services; and a model in which the intervention is going right to the client's preferred device and is both private and confidential.

Although my enthusiasm about TeleMental Health may be evident now, I wasn't always a fan. A few years ago, I interviewed for a mental health therapist job. At the interview, I learned that the job wasn't for one of the employer's "regular" therapist jobs; it was for a TeleMental Health job. When my interviewers asked me what I thought about TeleMental Health, I smiled and gave the diplomatic answer, but frankly I was thinking, "can this interview be over now? There is no way this works: You need to meet clients in person to build rapport and a therapeutic relationship. What about HIPAA? This can't be secure." After some reflection and checking in on my assumptions and strong negative feelings about a model of intervention I had never even tried and knew little about, I realized that my hesitation was grounded on the not-knowing stance. That night I turned to research and was blown away when I discovered that TeleHealth has been around for more than 30 years (Farris, 2013) and that plenty of evidence demonstrates its effectiveness to deliver health services.

In 2015, I decided to take the job to help implement a TeleMental Health program for primarily Spanish-speaking clients in the DC metro area. This program was the first of its kind. I worked with a team to evaluate the program to measure its effectiveness, and some of the findings suggest that TeleMental Health clients reduced their symptoms of distress at levels comparable to those of clients who receive therapy in person. Some major factors contributing to clients' satisfaction and rapport-building we found in our evaluation were the following: focus of therapist on client, the client's perception of being emotionally supported, and the client feeling safe and secure being alone in the counseling room while the therapist comes through video. Given the success of this pilot program, I continue to offer TeleMental Health to my clients in private practice.

What follows are some lessons I have learned since embarking on the TeleMental health journey.

Fear is real—but manageable—through education, preparation, protocols, and guidelines. Before starting to work as a TeleMental Health provider, I wondered about managing crises and building authentic therapeutic rapport over video. I also wondered about the effectiveness of this model with the population I mostly work with—Latinos and immigrants. This initial anxiety was similar to the beginner's anxiety I felt when I began practicing social work. As novice social workers, we hone our skills by practicing in the field, through supervision and mentoring, by attending trainings and conferences, and through turning to research. Following similar steps—training, supervision, and ongoing research—to address learning curves benefited my TeleMental Health endeavor. For every potential worst-case scenario, such as what would happen during a crisis, protocols and guidelines were created using templates and guidelines from existing organizations such as the American TeleMedicine Association, the Mid Atlantic

TeleHealth Resource Center (n.d.), NASW's standards for technology of social work practice, and consultations with others in the field who had already done this work. My supervisor, my program manager, and I developed protocols on how to manage a crisis, create a backup plan if technology fails, and exchange information through technology. NASW's standards for technology include guidance on these challenges, such as becoming familiar with emergency services in a client's jurisdiction.

Training is important. Initially, when I started my practice, I pursued three trainings: the TeleBehavioral Health Institute's online certificate training program, which now has continuing education units (CEUs) for social workers; a certificate program from the Southside Telehealth Training Academy and Resource Center that covers topics like TeleMental Health etiquette, presence, risks, and benefits of TeleMental Health; and a TeleMental Health workshop from the Ferentz Institute. In 2015, when I started providing TeleMental Health services, few trainings were available. However, now, a quick Google search of "telemental health trainings" will turn up a wide array of trainings in any geographic area or virtually. Competence is one of NASW's standards for technology in social work practice (NASW, 2019). Consider organizing dry runs to team up with other providers to test technology, video resolution, sound, and camera angle; this can help build the confidence.

Some clients are not a good fit for TeleMental Health. Before embarking on this journey, consider establishing an initial screening process—one similar to that used for clients seen in person—and determine criteria for selecting clients. For instance, consider whether clients with specific habits or distress could be assessed over video and whether an underserved population or a population with little access to technology could be a good fit. Think about whether seeing a client at a distance poses barrier to obtaining nonverbal clinical information. Some therapists conduct their assessment in person first to gauge whether clients may be a good fit for video; others may never meet the client in person first but may refer out to a more appropriate service if the client is not responding well to TeleMental Health.

TeleMental Health can be HIPAA complaint with the right platform. Some TeleMental Health practices are not HIPAA compliant—namely, using video or phone apps that are not encrypted or secure. However, the explosion of TeleHealth has also come with an emergence of health technologies designed specifically to secure privacy and confidentiality. When searching for such platforms, ask vendors if the platform is HIPAA secure and encrypted and whether they have a business associate agreement. Any person or company that is a business associate will be required to sign a contract with special language mandated by the HIPAA privacy rules (Snell, 2017). Business associate agreements assist in protecting clients' information when it is released to someone outside of a provider's organization (TeleHealth Certification Institute, n.d.). Many platforms are out there; I am most familiar with (and have used) VSEE, thera-LINK, Zoom.us, and Doxy.me.

Most Jurisdictions require providers to be licensed. Currently, no requirement exists for TeleMental Health certification, but the standards of care indicate familiarity and competence in technologies and laws about TeleMental Health. In addition, each jurisdiction may have specific local requirements. Most jurisdictions require providers to be licensed in the place from which they are offering services and in the area where client is located. For instance, a provider in Washington, DC, serving a client in Maryland must have licenses in both places. Contact the professional licensing boards of the states in which practice might occur. Professional boards may grant exceptions in certain situations, such as a regular in-person client going on vacation and wanting to temporarily access services through video. TeleMental Health is evolving; stay abreast of the latest updates.

Make your clients aware of informed consent. Clients who receive TeleMental Health services need to be made aware of the benefits and risks of receiving services over video, such as services interruption because of connectivity issues, among others. The most common areas of client dissatisfaction are associated with technical difficulties that interrupt sessions (Luxton, Pruitt, & Osenback, 2014). In a partner-to-partner model, the partner organization serves as an ally responsible for securing a room that is confidential and private; when providing services right to a client's device (e.g., computer, phone, iPAD), then the client becomes responsible for ensuring their privacy. Information such as benefits and risks, confidentiality and the use of client's devices can be reflected in informed consent.

It is critical to exchange information in a secure way. Research secure ways to exchange information with clients not met in person. Some practice management software have the capability to exchange information with clients through a secure hub where clients are required to enter a password to access information.

Focus on building a therapeutic rapport. One of the biggest concerns I hear about TeleMental Health is whether it's possible to develop therapeutic rapport through video. Research on TeleMental Health shows that therapists who provide services over video can build a therapeutic alliance when they continue to use the therapeutic skills they use during in-person sessions, including displaying empathic communications. Sadock, Sadock, Ruiz, and Kaplan (2009) remind us that rapport building includes the spontaneous, conscious feeling of harmonious responsiveness that promotes the development of a constructive therapeutic alliance. Hepworth, Rooney, Rooney, and Strom-Gottfried (2010) agree with this view. They note that "empathic communication involves ability to perceive accurately and sensitively the inner feelings of client."

The essence of what we do during in-person therapy and over video is the same, and those of us already practicing TeleMental Health strive to a quality of service identical to that achieved during in-person treatment—but with added precautions, more planning, and continued training, among other considerations.

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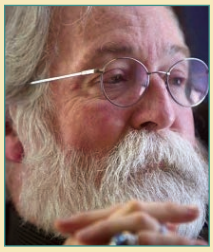
MEET THE COMMITTEE – Maurice S. Fisher Sr., PhD



Maurice S. Fisher Sr., PhD, has been in clinical practice for 37 years. He is currently in full-time clinical practice in Roanoke, Virginia. Dr. Fisher holds a master's degree in clinical social work and a doctoral degree in clinical social work and social policy. He is licensed in the Commonwealth of Virginia in mental health and substance abuse, and he is certified in Virginia as a sex offender treatment provider and a certified substance abuse counselor. Dr. Fisher holds numerous other national mental health and substance abuse treatment certifications.

WHAT IS YOUR AREA OF EXPERTISE?

The bulk of my private practice consists of forensic evaluations and risk assessments (such as sex offender evaluations, substance abuse evaluations, and risk evaluations of people who pose a lethal threat to others).

WHAT DO YOU ENJOY ABOUT YOUR WORK?

Mostly I enjoy the daily variety of the clients whom I treat.

WHAT DO YOU THINK ARE THE MAJOR CHALLENGES FOR SOCIAL WORKERS WITHIN YOUR PRACTICE AREA?

I would have to say that my daily challenge—and probably a challenge for many social workers in private practice—is dealing with health insurance companies.