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Into the wild west : an exploratory study of videoconference telemental health in social work practice

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ABSTRACT

This qualitative study was undertaken to explore how social workers are integrating videoconference telemental health into practice, and what their experiences have been of using videoconference telemental health to provide services.

Twelve social workers with experience using videoconference telemental health participated in a semi-structured interview over Skype. The interview included questions about the clinicians' practices; how they started using videoconference telemental health to provide services; their attitudes' towards the use of the technology; and ethical dilemmas they have encountered while using videoconference telemental health. Ten of the clinicians interviewed were in private practice, and two worked in larger institutional settings.

The major findings were the agreement by all clinicians in the study that videoconference telemental health has the ability to expand access to services. A majority of clinicians also reported that it provided a unique treatment experience that was beneficial to their clients; that the technology is less than perfect and can be disruptive; and that there is a lack of clear ethical and legal guidelines regarding the use of this technology in practice.

INTO THE WILD WEST: AN EXPLORATORY STUDY OF VIDEOCONFERENCE TELEMENTAL HEALTH IN SOCIAL WORK PRACTICE

A project based upon an independent investigation,
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CHAPTER I

Introduction

The integration of videoconference technology into the mental health system gives mental health providers the opportunity to augment mental health service delivery to underserved populations and help break down some of the barriers to receiving treatment. Videoconference technology can also be used to supplement face-to-face therapy and build comfort and trust for certain individuals diagnosed with psychological disorders that make human contact, and thus long term face-to-face therapeutic relationships, difficult (Day & Schneider, 2002; Rees & Stone, 2005).

Using videoconference technology to provide mental health services is referred to as videoconference telemental health by the American Telemedicine Association (American Telemedicine Association, 2009a). In the US, telemental health is one of the most frequently used methods of telehealth. Videoconference telemental health is defined by the American Telemedicine Association (2009a) as:

> The provision of mental health services at a distance using Real-time, generally two way transmission of digitized video images between multiple locations; uses telecommunications to bring people at physically remote locations together and provide mental health services at a distance. Each individual location in a videoconferencing system requires a room equipped to send and receive video. (p. 3, 27)

This will be the definition used when referring to videoconference telemental health throughout this study.

In practice, videoconference telemental health has already been used around the world to reach those who might otherwise not receive the mental health services they need (Richardson, Frueh, Grubaugh, Egede, & Elhai, 2009). In April of 2002, the NASW released a practice

update entitled "Medicare Telehealth Provisions for the Clinical Social Worker" detailing the changes in the Benefits Improvement Protection Act that announced that clinical social workers can bill Medicare for videoconferencing services provided in designated shortage areas (Coleman, 2002). However, there is limited literature in the field of social work that addresses how this technology is being used in practice or that describes social workers' experiences of using this technology.

There is a need for more investigation of videoconference telemental health because it is important for social workers to understand whether videoconference telemental health is a viable way to deliver services to underserved and marginalized populations who may otherwise not receive mental health treatment. These populations include those who live in rural areas, prisoners, members of the military, those who are isolated due to disability or old age, those who are reluctant to attend traditional face to face psychotherapy due to the stigma attached to treatment and those who suffer from severe anxiety or social phobia (Rees & Stone, 2005).

These services are being integrated into the mental health system, and social workers should understand the implications that this treatment modality has for social work practice. Clinical social workers should be specifically interested in how this method of service delivery will affect vulnerable populations, and if social workers are missing from the conversation, this aspect might not receive as much attention.

There is very little research exploring how clinical social workers are using videoconference telemental health in their practices, and what their experiences of using this technology has been. This exploration will help to identify areas of further research and education needed for the field of social work around the implementation of this treatment modality in practice. In their article published in *Social Work,* a journal published by the

National Association of Social Workers, Parker-Oliver and Demiris (2006) challenge the profession of Social Work to become involved in researching and implementing new and existing technologies into practice:

> Already various informatics specialties are seeking, without social work expertise, to conquer the digital divide for numerous vulnerable populations; social work needs to join the team…. Social work practitioners must be trained on the use of these emerging technologies and on their possible benefits to practice settings. If tools are developed that improve the quality of life for clients, it is the responsibility of the profession to educate themselves on these tools and make them available to clients. (p. 131, 133)

Therefore, the research questions for this study are how are social workers integrating videoconferencing telemental health into practice, and what have the experiences of social workers been of using videoconference telemental health to provide services? The definition of mental health services will include all behavioral health services that clinical social workers are currently delivering in person including assessment, consultation, individual psychotherapy, group therapy, family therapy, substance abuse treatment, crisis services, case management and care coordination.

As previously noted, there is very little literature that discusses the use of videoconference telemental health in the field of social work. The results of this study may be relevant to clinicians who are currently using videoconferencing technology, clinicians who are curious about integrating this technology into practice, and leaders and policymakers in the field of social work who address current issues in social work practice.

CHAPTER II

Literature Review

The literature on videoconference telemental health strongly supports the idea that videoconference telemental health has the capacity to provide mental health services to populations who may otherwise not have access to needed mental health services. The majority of literature is from the field of medicine (primarily psychiatry when referring to telemental health, but there is also a large amount of related literature in the field of telemedicine) and psychology. There is very limited literature from the field of social work.

This review will address the following categories of videoconference telemental health literature: 1) a brief review of videoconference telemental health clinical effectiveness studies and; 2) client and clinician satisfaction with videoconference telemental health; 3) clinicians' experiences, attitudes and perceptions of videoconference telemental health; 4) the therapeutic alliance in videoconference telemental health; 5) information and communication technology in the field of social work; 6) ethical and legal issues with videoconference telemental health; 7) and a brief overview of current reimbursement policies for videoconference telemental health in the United States.

Clinical Effectiveness Studies of Videoconference Telemental Health

While clinical effectiveness is not the focus of this study, it is important to note that there are numerous empirical studies that provide evidence to support the use of videoconference telemental health in providing assessment, diagnosis, consultation, crisis intervention, individual psychotherapy, group therapy, family therapy, substance abuse treatment, and disposition planning (Antonacci, Bloch, Saeed, Yildirim & Talley, 2008; American Telemedicine

Association, 2009a; Hyler, Gangure & Batchelder, 2005; Richardson et al., 2009.) These studies cover a number of clinical settings with different populations including rural and remote populations, ethnic and racial minorities, children and adolescents, older adults, incarcerated individuals and veterans (American Telemedicine Association, 2009a; Antonacci et al., 2008; Hyler et al., 2005; Richardson et al., 2009). The literature shows that research has found videoconference telemental health to be effective, with many studies reporting clinical outcomes similar to face-to-face assessment, diagnosis and treatment (American Telemedicine Association, 2009a; Antonacci et al., 2008; Cullum, Weiner, Gehrmann, & Hynan, 2006; Frueh, Henderson & Myrick, 2005; Frueh, Monnier, Yim, Grubaugh, Hamner & Knapp, 2007; Griffiths, Blignault & Yellowlees, 2006; Hyler et al., 2005; Ilan, Mahmoud, Rena, Peretz, Ilan & Ludmila, 2006; Lexcen, Hawk, Herrick & Blank, 2006; Nelson, Barnard, & Cain, 2003; O'Reilly, Bishop, Maddox, Hutchinson, Fisman, & Takhar, 2007; Poon, Hui, Dai, Kwok, & Woo, 2005; Richardson et al., 2009; Ruskin, Silver-Aylaian, Kling, Reed, Bradham, Hebel, et al., 2004; Savin, Garry, Zuccaro, & Novins, 2006; Shepherd, Goldstein, Whitford, Thewes, Brummell, & Hicks, 2006; Shore & Manson, 2004b; Shore, Savin, Orton, Beals, & Manson, 2007; Richardson et al., 2009).

The majority of these effectiveness studies are case studies or measurements of client and clinician satisfaction with videoconference telemental health, and not necessarily measuring effectiveness in the sense of treatment outcomes. As Antonacci et al. (2008) note in their review of 35 effectiveness studies, only 5 of these studies addressed treatment outcomes and could be considered randomized clinical trials; and these five studies were methodologically flawed, "these studies used mixed diagnostic groups, mixed medication and psychotherapy interventions,

and a variety of outcome assessment measures to conclude that telepsychiatric intervention outcomes were equivalent to face-to-face outcomes" (p. 255).

Client and Clinician Satisfaction with VCTMH

Many effectiveness studies measured client satisfaction with services delivered via videoconference telemental health and found that clients were satisfied with the videoconference telemental health services they received, and there was no significant difference between client satisfaction with videoconference telemental health and face-to-face interactions (Brodey, Claypoole, Motto, Arias & Goss, 2000; Frueh et al., 2007; Frueh et al., 2005; Griffiths et al., 2006; Ilan et al., 2006; Morland, Pierce & Wong, 2004; Myers, Valentine, Morganthaler, Melzer, 2006; O'Reilly et al., 2007; Richardson et al., 2009; Savin et al., 2006; Shepherd et al., 2006; Shore & Mason, 2004b).

Himle, Fischer, Muroff, Van Etten, Lokers, Abelson et al. (2006) presented a series of three case studies of manualized cognitive behavioral therapy for obsessive-compulsive disorder delivered via videoconference telemental health. Participants felt less anxious about treatment and were more likely to compete their homework than in face-to-face interactions because they felt a greater sense of independence (Himle et al., 2006). Frueh et al. (2005) found that certain members of a substance abuse treatment group for adult male veterans felt more comfortable with videoconference telemental health group than with face-to-face, and that 82% of group members would recommend the service to a friend of family member. In a case study by Shore & Manson (2004a), an American Indian Veteran participating in weekly therapy and support groups using videoconference telemental health for treatment of post traumatic stress disorder (PTSD) found that videoconference telemental health provided him with a sense of safety and comfort that he was not able to find when he had used local face-to-face mental health services;

He also received a higher intensity of services than he could receive in his rural community. These findings were from studies with small sample sizes, which examined very specific populations and treatment interventions, so they are not necessarily generalizable.

While clients were satisfied overall with the services they received, there were reservations mentioned. In one study treating youth with a range of diagnoses, the youth reported being satisfied with videoconference telemental health, but they raised concerns about their privacy (Myers et al., 2006). One group of American Indian veterans receiving treatment for depression reported that, although they were satisfied with the treatment, felt comfortable with the technology, and would recommend it to others, they would have preferred face-to-face treatment over videoconference telemental health (Shore & Mason, 2004b).

Certain of these studies also measured clinician satisfaction, and found that clinicians were satisfied and felt able to deliver mental health services via videoconference telemental health, but did not offer any in depth explanation of the clinicians' experiences (Ilan et al., 2006; Griffiths et al., 2006; Morland et al., 2004; Myers et al., 2006; Savin et al., 2006; Shepherd et al., 2006).

Clinicians' experiences, attitudes and perceptions of VCTMH

Multiple studies have addressed clinician satisfaction as one component of multi-faceted effectiveness studies, and found that clinicians were satisfied (Ilan et al., 2006; Griffiths et al., 2006; Morland et al. 2004; Myers et al., 2006; Savin et al., 2006; Shepherd et al., 2006). However, these studies did not provide in depth information about clinicians' experiences of delivering services, or their attitudes and perceptions of the technology. The main focus of the literature presented in this section is the clinician, and their experiences, attitudes and perceptions of videoconference telemental health.

Damianakis, Climans & Marziali (2008) conducted a study that measured social workers' experiences of providing group psychotherapy to caregivers of individuals with Alzheimer's, Parkinson's, Stroke, Frontotemporal Dementia, and Traumatic Brain Injury. This descriptive study used an online survey with open-ended questions to explore therapists' experiences of transitioning from face-to-face groups to videoconference telemental health groups that took place one hour per week for ten weeks, with every member of the group in a remote site. Therapists perceived group interactions to be comparable to face-to-face groups, and that the online groups were a positive experience (Damianakis et al., 2008, p. 15). The sample included nine therapists; eight were masters' level social workers, and one was a registered nurse. They had an average of 12 years of post-masters experience. The therapists reported that the technology made interactions more difficult and time consuming at first, but once the group got used to the technology, it became much easier. The shared experience of learning about and dealing with the new technology contributed to positive group dynamics and group cohesion. They appreciated that they were able to provide these services to caregivers in the home. Therapists in this study also highlighted the importance of not underestimating an individual's ability to learn a new technology, as all therapists and group members in this study had limited to no experience with videoconferencing technology, but they were able to learn the technology and have a successful group experience. It should be noted that this study was funded by a grant, and that most current reimbursement policies would not allow for beneficiaries to be receiving services in their homes via videoconference telemental health. In order for this study to be replicated, a funding source may need to be identified or special arrangements may need to be made with third party payors.

Gibson, Simms, O'Donnell and Molyneaux, (2009) presented a study to the Canadian Research Council on Information Technology that explored clinicians' attitudes toward the use of communication technology (its "perceived usefulness, perceived ease of use, perceived appropriateness for certain mental health services, and perceived barriers" p. 4) and perceptions of using this technology to provide mental health services. This study included social workers, although it is unclear how many of the survey respondents were social workers. The authors make the important point that if clinicians do not perceive videoconference telemental health as useful and easy to use, it is unlikely they will engage in using videoconference telemental health.

There were two different sample populations and data collection methods: 1) an online survey, open to all mental health workers in Canada, 2) and interviews with mental health workers who provided services to first nations communities and veterans of the Canadian army in 4 different clinics in Canada. Two of the clinics were involved in telemental health at the time of the interviews, and two other clinics had received, but not yet set up, their telemental health equipment. The number of clinicians in the interview sample who had participated in videoconference telemental health was not given, but many had used the technology as they worked at clinics with telemental health equipment.

The preliminary results found that clinicians who had experience using the technology rated perceived usefulness and perceived ease of use higher on a scale of 1 to 5. The interview participants who had experience using the technology commented that before they used it, they were skeptical and viewed many barriers to using the technology, but now that they have used it, they see the possibilities it has for providing services. The majority of participants found that videoconference telemental health was a good way to increase access to services. Respondents also reported that distance between client and clinician, which is traditionally viewed as a barrier

in videoconference telemental health, can actually be an advantage for treatment with certain clients, helping them make faster connections with their therapists, such as clients with anxiety disorders who find more comfort with "interpersonal distance" (Gibson et al., 2009, p. 6). Some respondents noted that they were concerned that they would not be able to directly intervene if a client was in crisis. The respondents perceived the main challenges to be lack of adequate infrastructure, funding, client's access to and comfort with technology, and privacy concerns.

Overall, the authors conclude that these mental health workers perceive videoconference telemental health as an advantageous way to deliver services to this population. Also, the study found that the more experience the respondent had with telemental health, the more benefits they perceived with the use of telemental health. The study results are preliminary, and some of the participants have not used videoconferencing technology. This study was also conducted in Canada, where the structure of the healthcare system is different, and clinicians and hospitals do not rely on numerous third party payors for reimbursement.

Austen & McGrath (2006) surveyed mental health workers in three national centers in the United Kingdom that specialize in treating deaf individuals for the purpose of gathering information about their experiences of using videoconferencing. In this study, 134 participants completed and returned the surveys, 78 worked in deaf metal health services and 56 worked in general mental health services (12 were identified as social workers). Only 16 of the respondents had ever used videoconferencing, and 25 of the respondents were not familiar with the concept of videoconferencing. Of the 16 of the respondents who had used videoconferencing, only 1 had used it with a client. Other uses had been to communicate with staff, to give a presentation in court, to practice using the technology, and teaching. The survey found that the main reason

videoconferencing was not used was based on the clinicians' anticipatory anxiety of using the technology (Austen & McGrath, 2006).

As with Gibson et al. (2009), not all respondents had used videoconference telemental health, but it is important to understand the attitudes and perceptions of those who have not used the technology because certain perceptions of videoconference telemental health could be a barrier to its use and implementation. Again, this survey was conducted in the United Kingdom, where the structure of the health care system and reimbursement for service is different than in the United States.

In their review of peer reviewed telemental health literature published since 2003, Richardson et al. (2009) conclude that the current literature shows that clinicians who do not have experience using technology and have not received education regarding the use of videoconferencing as a treatment modality, are generally skeptical and hold negative views about the formation of a therapist-client relationship. Demiris, Parker, Fleming and Edison (2004) present a study that contradicts this view and concludes that hospice workers who had no previous experience using videoconference telemental health services had a positive attitude towards the use of videoconference telemental health by hospice staff and thought it would be a helpful tool for patients and clinicians (Demiris et al., 2004). This study is limited as it was only a focus group of 10 hospice staff and they did not actually participate in using the technology to provide services; it was simply discussed. The participants also stated that they would not want the technology to eliminate face-to-face interaction.

Therapeutic Alliance in Videoconference Telemental Health

It is widely accepted that the therapeutic alliance between client and clinician is a key factor to successful mental health service delivery. In a summary of literature regarding

videoconference telemental health, Jerome and Zaylor (2000) argue that the experience of the therapeutic relationship is different when using videoconference technology to provide mental health services than with face-to-face therapy, as the therapeutic interventions are experienced differently due to factors that are affected by videoconference technology. The authors conclude that the following factors create a different experience: communication (speech may be delayed or distorted), environmental factors (reality is perceived two dimensionally and nonverbal cues might be completely missed or distorted and not all of the senses are being used), human factors (there is no culturally established way of interacting in videoconferencing technology and there is not a shared reality as there is in face to face interactions) (Jerome & Zaylor, 2000). This article was a literature review and analyzed existing research in videoconference telemental health.

Despite these factors identified by Jerome & Zaylor (2000), current research has found that there is no significant difference found in the quality of the therapeutic relationship, as reported by both client and clinician in studies using both qualitative and quantitative instruments, between telemental health and face-to-face interactions. In an early study, Ghosh, McLaren and Watson (1997) presented a case study of an individual receiving 10 sessions of psychotherapy in which they measured the alliance from the perspective of both the clients and clinicians and concluded that the development of a therapeutic alliance was not affected by the use of videoconference psychotherapy (Ghosh et al., 1997). Magaletta, Morgan and Patrick (2008) conducted a naturalistic study of 186 male inmates located in a general population facility and a psychiatric prison (Magaletta et al., 2008). They did not find that there were any significant differences in the quality of the therapeutic relationship between telemental health and face-to-face treatment modalities, as reported by the inmates receiving services (Magaletta et al., 2008).

Day and Schneider (2002) conducted an analogue study (an analogue study attempts to replicate or simulate, under controlled conditions, a situation that occurs in real life) comparing the working alliance in psychotherapy between face-to-face and video and audio modalities and found that these modalities can be used to provide similar treatment, and there was an increase in communication by the client in the video and audio modes of treatment (Day & Schneider, 2002). They discussed the great limitations of the analogue study, such as the study sample not being representative of individuals from rural or home bound populations who currently use this treatment modality and treatment being limited to five sessions. The authors suggested conducting more studies in naturalistic settings (Day & Schneider, 2002). This study included videoconference telemental health, but also audio transmission with no video.

Germain, Marchand, Bouchard, Guay and Drouin (2010) conducted a study that assessed the quality of the therapeutic alliance when cognitive behavioral therapy for PTSD is delivered via videoconference telemental health as compared to face-to-face. Participants were adults age 18-65 who had been diagnosed with PTSD. The face-to-face control group had 29 participants, and the videoconference telemental health group had 17. The therapy was delivered by psychologists who had an average of 5 years experience with cognitive behavioral therapy (CBT), but no experience with videoconference telemental health. Treatment lasted for 16 to 25 weeks. Based on the assessments of the treatment sessions by both the participants and the therapists, the authors found that the therapeutic alliance that developed during the videoconference telemental health sessions was "completely comparable (Germain et al., 2010, p. 34)" to those that developed during face-to-face sessions. None of the therapists had any experience with videoconference telemental health prior to the study. They also found that

having a negative perception of videoconference telemental health prior to using the technology did not affect the development of the therapeutic alliance (Germain et al., 2010).

These studies suggest that the development of a therapeutic alliance in videoconference telemental health is not significantly different from face-to-face treatment. These studies were carried out on limited populations with small samples. All participants in these studies were required to be English speaking. Some participants had received mental health treatment before and some had not, which could be an important intervening variable in measuring their perception of the therapeutic relationship.

Social Work and Information and Communications Technology

The National Association of Social Work (NASW) and the Association of Social Work Boards (ASWB) published the *Standards for Technology and Social Work Practice* (2005), which includes 16 standards for social workers regarding the use of technology in practice: 1) Ethics and Values; 2) Access; 3) Cultural Competence and Vulnerable Populations; 4) Technical Competencies; 5) Regulatory Competencies; 6) Identification and Verification 7) Privacy, Confidentiality, Documentation, and Security; 8) Risk Management; 9) Practice Competencies; 10) Advocacy and Social Action; 11) Community Practice; 12) Administrative Practice; 13) Clinical Competencies; 14) Research; 15) Supervision; 16) Continuing Education

These standards cover all current and future technology used in social work practice. Technology is defined as "any electronically mediated activity used in the conduct of competent and ethical delivery of social work services" (p. 3).

> The past two decades have witnessed an immense expansion of the use of information technology in social work practice. This expansion has affected nearly every area of the profession: At the individual practitioner level, e-mail and the Web make Internet mediated direct practice possible on a global scale; social workers and clients can uncover vast Web-based sources for information that can enhance the likelihood of

> effective interventions; support groups for people at risk can be easily created and moderated. At the agency level, case management programs can generate reports, track personnel, automate billing, forecast budgets, and greatly assist service planning and delivery; global-level consultation and conference abilities are at hand; emerging geographic information systems can pinpoint community assets and needs. The future promises even more changes: automated interventions that do not require the direct involvement of the worker are emerging, and wireless technologies are facilitating social work in the field. These current and near-future technologies are changing the nature of professional social work practice in countless ways. As a result, the roles for social workers are changing and they may need to adjust to the new demands for practice in the information age. Social workers should acquire adequate skills that use technology appropriately, and adapt traditional practice protocols to ensure competent and ethical practice (p. 3-4).

The social work profession has not yet published a significant amount of literature that reflects the level of attention and interest to technology that is called for by these standards. The literature from the field of social work regarding telemental health is very general and reviews the implications of the work for the field and suggests that further study is needed (McCarty & Clancy, 2002; Parker-Oliver & Demiris, 2006; Damianakis et al., 2008,). The literature highlights social workers' resistance to adapting new technologies, such as videoconference telemental health, because of social workers' perceptions of technology as a medium that will depersonalize client interactions, and that "virtual" connection will lead to clients feeling further alienated, which is antithetical to the mission of social work (McCarty & Clancy, 2002; Parker-Oliver & Demiris, 2006; Parrott & Madoc-Jones, 2008). This resistance could possibly explain one of the reasons why this treatment modality is not widely used in social work practice or explored in social work research.

The literature on information and communications technology (ICT) in social work practice discusses how social work lags behind other professionals in adopting ICT and integrating ICT into practice and education (Perron, Taylor, Glass & Margerum, 2010; Parrott et al., 2008). Perron et al. (2010) argue that it would be unethical for the profession of social work

not to give more attention to ICT given their growth and presence in the health care delivery system and in the lives of clients. Parrott and Madoc-Jones (2008) present the argument that social work should embrace ICT and use it as a tool for empowerment of clients, although they believe that this will be difficult since they argue that the profession of social work has a "culture of indifference "(p.193) towards ICT. They argue for more training in the use of technology in social work education.

Ethical and Legal Implications

> Along with the application of modern technology in social work must come an equally enthusiastic reflection regarding the ethical use of technology. Clearly, technology itself is neither good nor bad, but depends for its virtue on the ethical choices of those who control it. In the careless hands of those who fail to grasp the nature of moral questions, the most benign form of technology can lead to unspeakable harm. In the cautious hands of conscientious professionals, it has the impressive capacity to enhance the lives of the people we aim to help. (Reamer, 1986, p. 471)

Reamer (1986) introduced certain ethical concerns about integrating technology into social work practice in his article "The Use of Modern Technology in Social Work: Ethical Dilemmas". He discussed a wide range of technologies from computers to health care technologies. The main ethical concern he raised regarding the use of computers in practice was how to maintain client privacy with the advent these new computer technologies. Privacy remains a central ethical dilemma concerning the use of technology in social work practice, as do the themes of cautiously and conscientiously embracing the benefits of technology.

Nearly two decades later, the NASW and ASWB Standards for Technology and Social Work Practice (2005) were published to address the expansion of the use of information technology in social work practice and cover a wide range of issues related to the implementation of technology into practice. The introduction to these standards nicely summarizes many of the unique risks regarding the use of technology in practice:

> Several critical issues need to be addressed: many technologies are powerful but fragile; crucial information can be lost or intercepted; not all Web sites providing information are reliable; service providers can easily misrepresent themselves and their credentials online; confidentiality in an electronic medium can quickly evaporate; jurisdiction, liability and malpractice issues blur when state lines and national boundaries are crossed electronically; numerous digital divides can thwart access and success; and clients and social workers alike may have unrealistic expectations for what a technology can actually provide (p. 4).

While the standards are comprehensive and bring up many important considerations for a social worker using or considering videoconference telemental health, they are very broad and do not specifically reference videoconference telemental health. It would be advisable that social workers who wish to use videoconference telemental health review this document as it discusses social workers' ethical obligations and how these interact with and are affected by using technologies to provide services.

The NASW Code of Ethics (2008) includes the following standards regarding electronic communication and technology that relate to the use of videoconference telemental health:

> -Social workers who provide services via electronic media (such as computer, telephone, radio, and television) should inform recipients of the limitations and risks associated with such services. (standard 1.03[e])
>
> -Social workers should take precautions to ensure and maintain the confidentiality of information transmitted to other parties through the use of computers, electronic mail, facsimile machines, telephones and telephone answering machines, and other electronic or computer technology. Disclosure of identifying information should be avoided whenever possible. (standard 1.07[m])

These standards are clear that precautions should be taken to protect the privacy and confidentiality of our clients when using certain technologies, and that clients should be informed of the risks of using electronic communications or other technologies.

The social work literature includes an examination of the ethical and legal implications of using technology in social work practice as it relates to the general field of telehealth and social

work (McCarty & Clancy, 2002), the practice of e-therapy (Kanani & Regehr, 2003), and issues that pertain to the use of videoconference technology (Pollack, 2008).

Although these articles do not all directly relate to the use of videoconference technology in social work practice, they relate to the integration of technology into service provision for clients and discuss the ability to integrate technology into practice in order to provide underserved population with otherwise unavailable services. These articles address the growing use of technology in treatment modalities. They also discuss the legal, ethical and policy gray areas with the use of technology in practice, such as the transmission of client data and therapeutic relationships that cross state and national boundaries, and the absence of any precedence or guidelines in social work practice to guide practitioners. McCarty & Clancy (2002) stress the importance of the informed consent process. The ambiguous nature of ethical and legal issues (for both clinician and client) regarding the use of technology in practice is noted (McCarty & Clancy, 2002; Kanani & Regehr, 2003).

All of the articles address the importance of obtaining informed consent from clients and notifying them of the unique risks of telemental health treatment modalities, and the unique complications these treatment modalities present in protecting patient confidentiality. McCarty and Clancy (2002) argue that the current policy trend is moving towards supporting telehealth, and (while it is not yet possible to fully know what the implications will be for the field of social work) if the current policy trend continues and ethical and legal issues are addressed, telehealth will become a method of choice for many health care services (McCarty & Clancy, 2002).

Kanani and Regehr's (2003) review of the legal and ethical implications of e-therapy for social work practice focuses specifically on non-videoconference forms of technology (email, chat, and Internet phone), but the ethical and legal considerations would be similar for

videoconference telemental health (Kanani & Regehr, 2003). They focus on the issues that would be complicated by distance, such as verification of licensure; establishing competence in clinicians; obtaining informed consent from clients; maintaining client confidentiality; duty to protect the client and third parties in the case of threat or harm to others or self (Kanani & Regehr, 2003). The issue of jurisdiction regarding practice over state lines and the inability to verify provider's credentials were presented, and both therapist and client are advised to be wary (Kanani & Regehr, 2003; McCarty & Clancy, 2002; Pollack, 2008). Pollack (2008) discusses the issues of ambiguity regarding jurisdiction by proposing a national licensing board to address this issue (Pollack, 2008). Pollack (2008) also calls for social workers to be educated and informed about the technology that they use so they can educate and inform their clients about the risks associated with using the treatment modality (Pollack, 2008).

Reimbursement for Telehealth Services

Reimbursement by third party payors is viewed as one of the barriers to the implementation and expansion of videoconference telemental health. As with other health care services, reimbursement for videoconference telemental health by Medicaid varies from state to state. In a survey completed in January 2011 by the Center for Telehealth and e-Health Law (results have not yet been published, but a summary is offered on The Center for Telehealth and e-Health Law's website http://www.ctel.org/expertise/reimbursement.), they found that 39 states now offer reimbursements for certain types of telemedicine (Center for Telehealth and e-Health Law, 2011). Each state's Medicaid statute will provide information as to which type of licensed professionals can be reimbursed, and the factors that govern reimbursement (such as location of providers, designated service areas, types of service, type of equipment, etc.).

Unlike Medicaid, Medicare is a federally administered program whose rules for reimbursement are generally the same across the country. Medicare does reimburse for telemental health services, and social workers can be reimbursed for these services, including individual psychotherapy (Coleman, 2002). However, Medicare's rules for the reimbursement of practitioners providing telemental health services limit reimbursement by requiring the provider and the client to be located at specific sites:

> An originating site is the location of an eligible Medicare beneficiary at the time the service being furnished via telecommunications system occurs. Medicare beneficiaries are eligible for telehealth services only if they are presented from an originating site located in a rural health professional shortage area or in a county outside of a Metropolitan Statistical Area. Entities that participate in a Federal telemedicine demonstration project approved by (or receiving funding from) the Secretary of the Department of Health and Human Services as of December 31, 2000 qualify as originating sites regardless of geographic location. The originating sites authorized by law are: The office of a physician or practitioner; Hospitals; Critical Access Hospitals (CAH); Rural Health Clinics (RHC); Federally Qualified Health Centers (FQHC); Hospital-based or CAH-based Renal Dialysis Centers (including satellites); Skilled Nursing Facilities (SNF); and Community Mental Health Centers (CMHC) (The Medicaid Learning Network, 2009, p.1).

The Center for Telehelth and e-Health Law (2010) has found that private insurers in 11 states reimburse for telehealth services. Whether or not these include telemental health is unclear.

A theme that was constant throughout all of the literature was the need for more research and exploration in this field. There was consensus that videoconference telemental health has the possibility of providing mental health services to otherwise underserved populations, but more education and training is needed so clinicians are prepared to deliver there services.

It should also be noted that these reimbursement standards, and other standards such as the American Telemedicine Association Practice Guidelines (2009) assume that services are being delivered by a professional in an organization that is using a more robust teleconferencing

system with a transmission speed of 384 kilobytes per second and security features (American Telemedicine Association, 2009b) that are not offered by currently available free videoconferencing systems, such as Skype.

CHAPTER III

Methodology

Problem Formulation

The purpose of this study was to explore how social workers are integrating videoconference telemental health into their practices, and what the experience has been of social workers using videoconference telemental health to provide mental health services. This study also attempted to identify areas of further research, education, and policy needed in the field of social work regarding the use of videoconference telemental health in social work practice.

There has been minimal research conducted on the use of videoconference telemental health in social work practice. Therefore, an exploratory study using flexible qualitative methods was chosen to better comprehend the phenomenon of videoconference telemental health in social work practice.

Sample

Participants in this sample were required to have experience using videoconference telemental health to provide mental health services, and to hold at least a master's degree in social work. For the purposes of recruitment, mental health services were defined as individual therapy; group therapy; family therapy; assessment & diagnosis; disposition planning; home visits; and any other way that videoconferencing technology was used by study participants to provide services to clients. This broad definition was used to be inclusive of multiple services, since there is little data on how this technology is used by social workers. Participants were required to read and write in English, and be able to participate in an interview over Skype.

There were no exclusions made for years of experience using videoconference telemental health or number of clinical contacts made using the technology.

The sample size for this study was 12. The sample for this study was a purposive, non-probability sample. An attempt was made to use the snowball technique by asking participants to identify other social workers who fit the selection criteria for participation, but no participants were identified using this technique. While using a purposive sampling technique does introduce a sampling bias into this study, it was the most feasible recruitment strategy given the minimal data available regarding social workers using videoconference telemental health and limited time and resources provided for this study.

Primarily, the sample was obtained by conducting online searches for social workers or institutions that use this technology. Once a possible participant was identified, they were sent a recruitment email (Appendix A). Eleven of the 12 participants were identified using this method. In addition, a call for research participants was posted online message boards, blogs, and networking groups. One participant was identified using this method.

Since the population of social workers using videoconference telemental health is unknown, it is hard to know if this sample is representative, and it raises the questions as to whether or not these results are generalizable.

Data Collection

This study was approved by the Smith College School for Social Work Human Subjects Review Committee (Appendix B). All participants were provided with an informed consent to sign and return prior to scheduling the interview (Appendix C).

Data was collected through a semi-structured interview over Skype that took between 25 minutes to one hour. Participants were asked to provide demographic data, including state of

residence, state of licensure, type of license, years of practice, years of experience using videoconference telemental health, type of technology used, and estimate of number of clients to whom services were provided using videoconference telemental health. Participants were then asked 12 open-ended questions (Appendix D) that aimed to gather data on how they were using videoconference telemental health and what their experiences of using videoconference telemental health have been. The interview guide included questions on how they started to use videoconference telemental health in practice, what their attitudes were before and after using the technology, differences they have noticed in the therapeutic relationship, and ethical issues encountered. The semi-structured format allowed for probing and follow-up questions in the event that unanticipated concepts or emerging themes arose during the course of the interview.

Since this study was based on the use of videoconferencing technology in social work practice, it seemed appropriate to conduct the interviews over Skype. This also provided greater flexibility in recruitment and interview scheduling.

The interviews were recorded using software designed to record Skype calls, which records both audio and video. The researcher then transcribed the interviews, and identifiable information was removed to ensure confidentiality. Given the nature of the study and of the data being collected, there were not great risks to study participants.

Data Analysis

The narrative data was analyzed thematically, and the demographic data was examined using descriptive statistic. Initially, data was grouped based on the questions from the interview guide, and then a thematic analysis was conducted. From this analysis, thematic categories emerged and the data was then grouped by relevant thematic category rather than response. Similarities and differences in the data were noted. Outlier data that did not fit into

main thematic categories, but seemed significant based on the nature of the narrative data or on its relation to important points in the literature review was noted. Relationships between specific thematic categories and demographic data were also noted.

CHAPTER IV

Findings

The study attempted to explore the following questions: How are social workers integrating videoconferencing telemental health into practice, and what have the experiences of social workers been of using videoconference telemental health to provide services? This chapter presents the findings of 12 interviews with social workers who are using or have used videoconference telemental health to provide mental health services.

Each interview began by gathering demographic data and information about licensure, years of practice, years of experience using videoconference telemental health, and an estimate of the number of clients with whom they had used videoconference telemental health. The interview then proceeded with 12 questions that were asked to gain a sense of how the clinician is using videoconference telemental health, and what their experiences have been.

Overall, respondents viewed videoconference telemental health as promising; it can provide continuity of care, access to care, a different therapeutic environment, and can provide the client and clinician with more flexibility. While the clinicians interviewed were generally optimistic about videoconference telemental health, there was a cautionary undertone to the interviews. The majority of these clinicians do not view videoconference telemental health to be preferable to face-to-face office visits, as the technology is less than perfect, limits body language, and does not always provide consistent quality. Clinicians also conveyed a sense of hesitancy, concern, and confusion when discussing ethical issues, such as privacy and confidentiality.

The findings are organized around the general themes mentioned above and are presented in the following categories: 1) Demographic Data; 2) Summary of Clinicians' Practices; 3) Benefits of Continuity and Access; 4) Clinicians' Preferences Towards the Use of Videoconferencing Telemental Health; 5) Different Type of Therapeutic Environment; 6) Technological Difficulties; 7) Ethical Concerns; 8) Connection Between Experience and Comfort Level.

Demographics of the Participants

Ten of the participants identified as female, and two as male. When asked to identify their race, all 12 identified as Caucasian/white. Eleven of the participants held a masters degree in social work. Of these 11, one was a current PhD candidate in a behavioral health field, and one held a JD. The one participant that did not hold an MSW was from Australia, and held the equivalent of a master's degree in social work. Ten were in private practice, two worked in larger institutional settings. The average age of participants was 48.2. The ages ranged from 31-62.

Summary of Clinicians' Practices

All 10 of the clinicians who were in private practice used the free Skype Video Calling; and one used Google Video Chat in addition to Skype. The two that worked in larger institutions used commercial videoconferencing systems such as Polycom or Tanberg. During the time that they were providing videoconferencing services, 11 of the 12 participants lived in urban or suburban areas, with only one residing in a rural area.

Years of Practice

The clinicians had an average of 17 years of practice, ranging from 5-36 years. The average years of experience using videoconference telemental health was 3.7, ranging from .5-11

years. The amount of client contact also varied, and did not necessarily correlate with years of experience. For example, one clinician with 1 year of experience had seen 10 clients, while another with 5 years experience had seen five clients. The amount of experience that each clinician had with videoconference telemental health varied greatly. *Table 1* displays the experience of each participant:

Table 1

Summary of Clinicians' Experience

	Total Yrs. Social Work Practice	Yrs. Experience with VCTMH	Estimated Number of Clients Seen/Client Contacts*	Type of practice/Notes
1	6	3	5 contacts per week for past 3 years	Private
2	36	7	6 clients	Institution. 20-30 sessions of supervision/consultation with rural clinicians per month
3	10	1	10 clients	Private
4	23	.5	1 client	Private
5	14	2.5	20 clients	Private. Certain clients are seen 3-4 times per week
6	14	2	3 clients	Private. Has not seen a client in over a year due to hesitance about videoconference telemental health
7	17	5	5 clients	Private
8	34	1	1 client	Private
9	12	7	Over 4000 clients contacts	Institution
10	18	2.5	1 session per week	Private
11	5	2	10 clients	Private
12	15	11	15 clients	Private
Avg.	17	3.7		

* Certain participants indicated total number of clients, while others indicated client contacts.

Type of Services Provided with Videoconference Telemental Health

Six of the respondents have done couples work, two have done family work, one has done group work, all 12 have seen individual clients. Using this technology for individual clients was most common. Of the six that have done couples work, one stopped using videoconference telemental health for couples because she found it too difficult to have two people in the frame, or one person in the office with her and one person at a remote location. The two that have done family work both worked in institutional settings. The one clinician that did group work works in an institutional setting.

Training and Education

Five of the clinicians reported that they had either received or sought out some sort of training or education before using videoconference telemental health. One respondent called the Board of Behavioral Sciences in her state and contacted a lawyer to educate herself on the legal implication prior to using the technology. One respondent had worked for a nonprofit that pioneered online support groups for individuals with cancer, so she felt like this training prepared her well to use videoconference telemental health. One private practice clinician stated: "I did attend a couple of workshops where this was not the sole focus, but it was part of the workshop." One of the clinicians who worked for an institution stated: "We have a manual and there are people here who know how to use the technology. The use of video had been going on for 8 years when I arrived here." Seven clinicians reported that they had received no training or education prior using videoconference telemental health. One clinician stated, "No, it had not crossed my mind." Another clinician stated, "I just jumped right in."

Comfort With Technology

Eight clinicians indicated that they were comfortable with technology or had previously used Skype prior to using VCTMH with clients. Four clinicians reported that they had not used video conferencing technology before it was introduced to them as a way to deliver services.

The Benefits of Continuity and Access

All participants either directly or indirectly mentioned that they viewed the ability of videoconference telemental health to provide continuity of care and/or access to care as the main benefit of videoconference telemental health, and the most promising aspect for the field of social work. All of the respondents reported that they began using videoconferencing for reasons of continuity of care and/or access to care. However, the specific impetus for beginning to use the technology varied from participant to participant. A number of participants (n=6) started offering videoconference telemental health on their own accord. Other clinicians reported that their clients asked them if they would provide videoconference telemental health (n=4), and others (n=2) were part of larger institutions that were using the technology to provide services to rural areas.

Over half (n=7) of the clinicians reported that they started working with a client in the office and then began providing videoconference telemental health services once the client was unable to come into the office. The reasons varied; certain clients moved away, some went on business trips or on vacation, and others were ill and could not make it into the office. One clinician stated:

> I have a client who started seeing me in the office and then took a job out in California and wanted to continue with me, so we did Skype while she was out in California, and now she is back in the office. I also see students at the nearby university, it is about 2 or 3 miles from my office, so I see them here and if they leave for the summer and want to keep working we will use Skype.

Another clinician stated:

> I currently see one student who comes from far away and one woman with major depression who gets physically ill frequently and has trouble making it in for sessions. I know they don't see it as a replacement. They are very happy to not have to come into the office certain days. It helps with continuity of care.

A majority of the clinicians (n=9) reported that for them, videoconference telemental health was a natural progression from phone therapy once Skype became available and that the visual component adds a lot to the experience. One clinician stated:

> I have a lot of people that travel for work and we were doing phone sessions, and it just was a natural expansion of that to start doing Skype because it became so easily available and makes for a more intimate conversation.

Another clinician stated, "I was excited because I had done a lot of phone work with a national counseling line, and being able to see someone's expression really adds to the experience." Yet another clinician stated, "It is like a phone call with full disclosure." Another clinician discusses the transition from phone to Skype, "She went to school and started to see another therapist, and it didn't work out. Then we started phone sessions, and she said can we try Skype, and I said lets go for it."

One clinician spoke of how she used videoconference telemental health instead of the phone (which she would have used previously) to support a client on an extended vacation:

> I had one woman who recently just took three weeks off with her partner and traveled around the country. She is in recovery for alcoholism and still struggling with her eating disorder, and she has found it extremely helpful to maintain the relationship long distance. Traveling there were all sorts of triggers that came up for her, so being able to see me and have the continuity of care, and for me to be able to notice facial gestures and movements of her mouth, physical movements, twitching, a sense of irritability that I wouldn't have picked up on if we had used the phone. And, I could tell that she was agitated and incredibly uncomfortable in her skin. These are some of those non-verbal cues that I would not have known about because she may not have communicated them in such detail. It enabled me to follow her on her trip and help guide her as she dealt with stressors and figure out how she could cope most effectively when she got home.

A number (n=8) of the clinicians also discussed how videoconference telemental health helped them to provide access to clients who might not otherwise receive services. One clinician

discussed how Skype allowed her to provide services to a woman who had difficulty finding services in her home country, "A woman who lives in a post-Soviet country found me online and contacted me and we started doing therapy over Skype. She was having issues of trust in her relationship, and I have written a book on the subject."

Another clinician discussed how videoconference telemental health helps provide access to clients who live far from her office:

> Distance is the first key component in assessing whether Skype is appropriate for me in my practice. If my patients are more than 40 miles away, then I will consider using Skype as a vehicle for communication. I believe that access to treatment is an important component, if people can't easily come to therapy and it may be a barrier, so I will offer it as a vehicle for therapy.

Three clinicians mentioned the access it provides for individuals who are chronically or terminally ill, the elderly, and those with certain disabilities. One clinician had worked for many years at an organization that provided counseling and support for individuals diagnosed with cancer, including a national hotline and online support groups, and now saw the benefits that Skype could provide to this population:

> When people are ill there is a sense of safety to be able to stay at home and feel connected, to feel like they are not as isolated. I think that for clinicians who do that kind of work it is an important piece to be able to bridge some of those barriers to service. I think for end of life care and delivery of service in end of life care it is such an important piece. When I worked with people with chronic illness many of them were not able to come into an office setting because many of them did not feel comfortable or well enough to come into public.

Another noted the access it could provide:

> I do hope that one day insurance companies will recognize the benefits of using Skype for therapy especially for those who are elderly, home bound, or have medical or physical problems that impair their ability to ambulate and travel.

One clinician specialized in working with adults with Asperger's syndrome, their significant others and their families. She did work locally with clients whom she also saw face-

to-face, but also did consulting nationally via Skype as she found there was a high demand for these services and few providers.

The two clinicians who worked within institutions discussed using videoconference telemental health to provide services to rural areas, and the potential of videoconference telemental health to expand access to services in underserved rural areas. They also both noted the struggle with high staff turnover in rural areas, or the absence or mental health clinicians in rural areas:

> I think it is great, and I think we need to be exploring more in terms of meeting people in their home. One of the things for us is that when people come to the hospital, sometimes people travel four hours by car to get to the hospital or to an appointment. It is just ridiculous…and the turnover of staff in rural areas makes access to mental health consultations really difficult.

Another clinician stated:

> I lived out in a very rural area, we had seven clinics on islands off the mainland, so if I wanted to do some outreach with clients sometimes it would take me two days to get to another island because you had to take four different plane trips to get to certain of the rural islands. We did not have televideo when I first started, so I did a lot of traveling. I started out trying to get to some of the places once every 8 weeks, which was very difficult, so I made it a quarterly visit. When we started using televideo for psychiatric consult, I would sit in the room with a patient and watched the psychiatrists do the evaluation with the patient, and immediately, I thought "oh my god." I watched the clinical experience between the two of them, and I watched how my clients responded. There were about two minutes of the client being uncomfortable and then it was as if the camera wasn't there and she was talking straight to him. After that experience I was excited to use this and started seeing clients by video for therapy. The next thing I did was to set up a support group because people in their small villages did not want to do support groups in the villages where they knew everyone, but were willing to do it with people they didn't know. It grew from 2-14 people. They would go down to their local clinic and join in the support group over televideo. When I realized the benefits, I started to promote televideo for behavioral healthcare at our medical clinics and encourage interaction for medical and behavioral healthcare. I made sure that all of the clinics had video. Some of these clinics had no behavioral health providers, so by adding video it increased the practice so much that we had to hire two new clinicians. At fist I saw no clinical value to videoconference telemental health. After gaining so much experience, my views changed.

Clinicians' Preferences Toward the Use of Videoconference Telemental Health

Eight respondents say they prefer face-to-face client interaction to videoconference telemental health, while at the same time realizing the benefits videoconference telemental health can provide. One clinician stated "face-to-face is always preferable; however, what we know is that for many families that is not an option." Another clinician stated, "It is not a perfect tool, it is still not a substitute to being seen in person." Yet another stated, "It (videoconference telemental health) is about the same. I mean I prefer to have people face-to-face, it is great to see them in person and have that personal contact." Another saw benefits to both, "I think that nothing can replace face to face, but it is beneficial to use both."

Over half (n=7) of the respondents said that having a face-to-face relationship first, prior to using videoconference telemental health was important. One clinician stated, "I think the best way to do it is to do in person first and then video after, that makes a lot of difference."

One clinician discussed an experience working with a woman she has already met face-to-face who then moved to a rural area, and how this added to the experience:

> There was one particular incident where the client actually knew me because they had gone from [the city] down to this other town and then they had taken an overdose, so another clinician picked up a client down there. And, I knew the [social] worker very well as well because I supervise her, so I think that is a case, it does depend on relationship and whether it is relationship developed over time by video or relationship because of other context. So, I taught this clinician in a previous life, so we managed. So it was actually very effective and we had a white board and we started to do goals, I was asking the questions, the clinician was writing them on the board. We just kind of used the machine as if it was not there, we did not see it as a barrier. I mean we used a sense of humor around it.

Five clinicians reported that they are comfortable providing services without having a face-to-face relationship, and they have provided services to certain clients solely through videoconference telemental health. All five report conducting screening interviews on the phone or over videoconference prior to agreeing to provide services solely over videoconference

telemental health. Some clinicians (n=3) stated that they did not notice any difference in the relationship between the clients they exclusively saw through videoconference telemental health and those who they saw in person:

> A fair number of the patients whom I work with via Skype are those whom I did originally work with in New York, although I have received referrals from patients in New York to friends of theirs, and have done work with people whom I have never met face-to-face and do not notice a difference in the relationships.

Another clinician who requires that all of her clients also be seen face-to-face, has started using Skype for an initial free consultation, but states "I would want the individuals to come into the office after the initial screening."

The majority (n=11) of clinicians would like their videoconference telemental health practice and the use of videoconference telemental health in social work practice to expand. One is curious about the use of the technology, and will use it if his clients want, but he is cautious and still prefers phone for distance counseling. Of the 11 respondents who would like videoconference telemental health to expand, eight stated that they prefer face-to-face, but hope use expands because of the continuity and access it provides. Of the remaining 3 of the 11 who would like practice to expand, one stated, "I guess I am just more comfortable with it. I just really enjoy it. I actually prefer it because it gives me and the client flexibility." One did not indicate a preference, and stated that she does not notice a difference between working with people face-to-face and working with people over videoconference telemental health. One said that she just looks at videoconference telemental health as another way to provide services: "It is just another way to do the same thing. It is another way to expand practice and make psychiatry and psychotherapy more available." Of the 11 respondents, five also noted personal reasons for wanting their telemental health practice to expand, such as the flexibility it would provide.

Attitudes Toward the Use of Videoconference Telemental Health in Practice

Clinicians were asked what their attitudes toward videoconference telemental health were before they started using it, and how their attitudes had changed since they started using videoconference telemental health. Three of the clinicians reported having positive attitudes before using videoconference telemental health and report that they are even more positive now that they have been using videoconference telemental health in practice. One clinician stated of his attitude prior to using in practice, "Oh, I wanted to do it, I used the technology in my personal life and thought, there is no reason why you couldn't do therapy this way." Regarding his attitude after, "I guess I am just more comfortable with it. I just really enjoy it; I actually prefer it." Another clinician stated, "Well given that I had been doing some phone therapy with people, I thought that it was an improvement in terms of the quality of care, attention focus, and understanding that I could provide." And her attitudes after, " Well, I am even more impressed, especially since I downloaded the newest version of Skype, the picture and streaming is much better."

Three clinicians reported that they had hesitancies about it prior to using videoconference telemental health, and since using videoconference telemental health have positive attitudes. One clinician stated, "I saw no clinical value before I started using it." She is now very positive about the technology and promotes its use. Another clinician stated, "My attitude has changed significantly. I am excited about using it and I think it is a viable means of communication for those who live far away."

Four clinicians reported that they had positive attitudes before and after using the technology. One stated, "I was excited, I thought it was a great idea. I am all for it. I would do

more if I could." One clinician who stated that she had positive attitudes before and after, but also now has more concerns about the technological difficulties.

Another clinician was hesitant prior to using videoconference telemental health, and remains hesitant about its use. He states, "I was hesitant because it was new for me to use; I knew it was not going to be perfect. I have not had a client in over a year. I am not opposed to using it if it is important to the client; it is not my first choice."

Clinicians' Perceptions of Client Satisfaction

Eight clinicians reported that they find their clients to be satisfied with videoconference telemental health. One clinician stated, "They have loved it, they have just been very excited about it." Another clinician stated:

> It wasn't even a deal. Just like what I had observed the first time when I saw the patient and the psychiatrist and the patient was a little uncomfortable for the first minute or two and then it was like it wasn't there. I never had a patient refuse. I think that people that keep the televideo from being a part of the practice are the practitioners themselves.

Two clinicians reported client satisfaction and appreciation of the flexibility it provides. One clinician stated, "Most of them love that I am comfortable with it because they feel that it is a nice option and easier for people to be in their homes when they want to be." Another clinician stated, "They seem great with it. I know they don't see it as a replacement, they are very happy not to have to come into the office certain days." Two clinicians reported client satisfaction, but also noted that there was a process of self-selection when being offered in a private practice setting. One clinician stated, "They like it, but you have to be careful with that because it is a filter. If you agree to do Skype with me, then you are probably comfortable enough and it is probably going to work." Another clinicians stated:

> They thought it was great. I have not had anyone say that they did not like it. People who stop don't come out and say they don't like it they just don't want to do it, sort of a self-selection.

Of the four that did not directly report client satisfaction, one clinician stated that his sense was that his clients felt "awkward." Another clinician said that her client seems satisfied, but told her "she would prefer face-to-face." Another clinician said, "It was fine. Some adolescents find it really difficult, and younger children do as well." Another clinician mentioned that she thinks her clients have found it to be better than they thought, and it is not interfering with their ability to heal.

Videoconference Telemental Health Provides a Different Therapeutic Environment

Half (n=6) of the respondents noted that videoconference telemental health provides a different therapeutic environment that is beneficial to certain clients. One clinician noted that she was able to provide group counseling to members of rural villages because the group could be composed of members from multiple rural villages, which provided for a certain level of confidentiality and safety for the members. Another therapist used it as a tool in couples work:

> I have done couples work with clients where they have been in separate rooms in their house using videoconferencing on their laptops. It was hard for them because they were sitting so close together to use Skype on the same computer they felt like it was weird so they tried sitting in separate rooms, so it was sort of like a videoconference call, but it was an interesting feature because I hadn't done that before. It was interesting because we were all together but in our own spaces and it felt more freeing in their couple work because they were not so worried about what the other person's reactions would be and they had the opportunity to be more honest. They did feel a little bit freer to express themselves. I think it does let people feel a little bit more open.

This same clinician also spoke about using videoconference telemental health with a young adult client, wondering if this had anything to do with younger generations being more comfortable with having an online presence and having developed with these technologies around them: "I noticed a huge difference in how she presented herself and how comfortable she

felt expressing her emotions more so than in my office I found her whole affect and her whole presence to be different when she was sing VC."

Another clinician speaks of a corrective emotional experience it provided for one of her clients:

> One of the patients whom I work with via Skype, their mother would often travel with her boyfriend when he was 12 and him and his brother would be left alone with no supervision, a little bit of money and his mother would go on a trip and they would be all alone and have no access to contacting her. The fact that he can reach out to me and see me while I am on vacation has been very profound for him.

Also, four of the clinicians noted that the technology helped them to be more objective in certain situations. One clinician notes that this makes it "easier to stay on task." Another clinician notes that "you have to focus on a different level to make the clinical connection happen, and I think videoconference telemental health has made me a better clinician because of this." Two clinicians specifically mentioned how countertransference plays out with videoconference telemental health:

> For the provider there are less countertransference issues because you are able to set better boundaries and for the client it is not as difficult to talk about the really hard issues because there is a little bit of distance and they don't get as nervous

Another clinician discussed countertransference with videoconference telemental health:

> I think that the primary difference that I have noticed face-to-face and videoconference has really been with the patients that I have seen more frequently in my work such as the gentleman whom I see 4 times per week or those whom I see three times per week as you can imagine the transference is at times very strong and my countertransference response has been fairly intense at times as well. I have found that if my patients have very strong loving, needy or even negative feelings for me, seeing them via Skype does somewhat dilute the experience, which in my mind has not been all together negative because it has provided me the opportunity to be a little bit more objective as a human being in those situations than I might otherwise. It has been fascinating.

Another discussed how some clients seem to feel more comfortable:

> Yeah, I have noticed a little bit of a difference. Some of my clients will say it feels more real to be in person. I think through that sense of having distance or anonymity and being

> in the comfort of their own home environment and not having to go back out into real work right after session, there is a comfort level of being able to share information that they might otherwise not or to be more emotive. Sometimes in sessions there is that sense that people need to put themselves together and go back to work or back out onto the street and you know when we do have video sessions there is more of a comfort that someone sitting in their own home might have a pet nearby and, you know, they feel safe.

Technological Difficulties

Eleven of the participants noted issues with the current available technology. The main issue that the respondents had with videoconference telemental health was the technology. Not being able to see the entire body limits the interpretation of non-verbal cues.

One clinician who prefers videoconference telemental health to face-to-face stated: "You don't get all of the body language and all of that. And, then you know I have to acknowledge, that there are limitations to it, but you know, for the most part you get 85-90% of what you would in the office." One clinician stated, "The biggest difference is I can't see body language."

> I cannot see all of the body language. Because I do some somatic experiencing work, so I scan the body and I will notice a foot twitching or the breathing being a little off, so I can't get as clear a picture of what is going on. I think that it is a good adjunct, even though I would like it to be more a part of my practice, but at this point I don't think the technology is clear enough. I can't see enough of you to see all of what your body is doing. You know probably eventually for this kind of treatment in the human services, they are probably going to have screens that are pretty much life size where you are actually sitting with the person and it is almost like being with them.

The visual quality and sound quality could also be an issue. Clinicians reported gaps in dialogue and distorted sound quality. Another clinician stated, "It varies from client to client; I think it depends on the Internet connection. I have one client where we have to have the speakerphones of our phones on set up as a backup because the sound quality is not consistent." Another clinician discussed the background noise from the technology, "Well sometimes technology is less than perfect. There is occasional background noise. It is like a fan going on or something. But I really think that it is certainly way better than nothing."

Another clinician, who prefers using phone to Skype, said some clients have found the technology too distracting, "I had one client who started on Skype and she decided she wanted to switch to phone after two sessions because it was too distracting." Another clinician discussed how she handled certain technological difficulties:

> At the beginning of every session, we had a back up plan. Technical issues that would come up sometimes were that there would be a delay and because of the rural connectivity there would be a telephone number that they would call or I would call. Even if it were delayed we would try and keep the video on and mute the volume to keep the presence. I became really good at not missing a beat and keeping people engaged.

Two clinicians mentioned the frustration of not being able to make direct eye contact with videoconference telemental health:

> I think one of the biggest things is just the eye contact. It does seem like you can make eye contact, but you really are not. And so it is a tricky thing in terms of therapy to be able to read somebody; you know you see his or her face, but you don't get to connect in the same way. The language is there, but the eye-to-eye is not, which a lot of people are uncomfortable with anyway. It's tricky because as you are talking you are trying to talk to the camera, but you want to see how the people are reacting.

Ethical Issues

Is this ethical? That seemed to be a question on a number of the respondents' minds. While they expressed that the ability to provide services to those who might not otherwise receive them was consistent with professional social work ethics, many expressed concern about managing risk and maintaining a client's safety, ensuring privacy and confidentiality, and managing their own liabilities. As one clinician stated, "This reaches people who would not otherwise be seen, it saves time, and it saves gas, but there needs to be a clearer sense of the legal and ethical implications."

Managing Risk and Safety

All of the private practice clinicians (n=10) would not see high-risk clients over videoconference telemental health because of their concerns about liabilities around risk and safety issues. Either they did not accept high-risk clients into their practice at all, or they would not see higher risk clients over videoconference telemental health. To further manage their liabilities one clinician called the service he offered online "Online Coaching" instead of counseling:

> When a person signs up for online coaching on my webpage, when you click on where it says online coaching on my website it talks about when online coaching might not be appropriate. If you are going to hurt yourself, or going to hurt someone else, if you need emergency services, no this service is not going to work for you. I do a pre interview; I always talk with the person for 15 minutes or so before we schedule an appointment. If it is on the lighter side, then Skype and phone is great, but if it involves medications, if it is court ordered I can't do it, if it is going to need emergency services, then that is the quick, "no you really need to come into my office," or I will look up a mental health center for someone in their area.

Another told the clients that she saw exclusively over videoconference telemental health, that she was not their primary clinician; she was acting as a consultant with regards to their Asperger's syndrome and how it impacted their relationships.

Conversely, the two respondents who worked in larger institutional setting reported that crisis intervention to rural areas was one of the benefits of videoconference telemental health.

> I had a situation where a small community had a traumatic incident where there were identified folks that had been abused and we could not get them out of the community because of foul weather; we did get the perpetrator out of the community. I did an emergency response by video. It was probably the best session I have even done face-to-face or on video. It was very intense. I don't think the outcome would have been different if it was face-to-face. I was present for this family during a time of crisis.

Privacy and Confidentiality

The majority of the clinicians (n=11) brought up the issue of privacy and confidentiality either to discuss how they managed these issues in their practice, or concerns that they have about these

issues. Two of the clinicians felt that a breach in privacy would not come from their end, but from the client end. One clinician stated, "The privacy is not the same. I say, 'are you somewhere private, can you talk right now?' and then they may say, 'well there is someone upstairs, but we are fine.' It is kind of their choice. It is private on my end." Another clinician stated:

> As far as Skype goes, it is more secure than the telephone, and more likely, nobody is going to see you in the waiting room. I just remind them to make sure they are in a private place. If there is going to be a breach of confidentiality it is going to be on the client's end most likely because of not doing it in a private place, leaving a chat window open. Often I email my clients as well, like email them handouts or quick little notes. You just have to make sure that they have their computers password protected and watch out for things like that.

One clinician spoke of concerns about her own privacy since she was providing the services from her home office.

Over half (n=7) mentioned the privacy in relation to the technology and concerns over whether or not the technology was secure. One clinician wondered if Skype was able to record calls or was taking information. Another wondered if it was HIPAA compliant. A few clinicians were concerned about whether or not people could eavesdrop on calls. One was concerned that clients could record sessions and send them to friends or post them online:

> I do talk to them about how they can't assume the same sort of privacy. I know that there has been discussion that Skype and Google capture information and you assume that it is for education or entertainment purposes, but I let people know that they can't assume the same sort of privacy. I definitely have concerns about it. Clients could share something with friends or record and put it on you tube. You can't promise privacy in the same way because we don't know what is going on. So I guess my concern is not knowing about how secure this is.

The two clinicians who worked in institutional settings noted that they were not allowed to use Skype for client contact because of privacy and confidentiality issues. One clinician stated, "We are not allowed to use Skype for clients because of confidentiality."

Another clinician stated:

> None of us would promote it because of the security aspects; we would lose credibility if we did. But I think if you did, from my perspective, you would have to be certain to have an informed consent that says there is no guarantee that people can't hear what we are saying.

These two clinicians use commercial videoconferencing systems such as Tanberg or Polycom, that had higher transmission speeds, tighter security, and the support of an IT department. They reported that these are closed systems, and you must be part of the network and/or have the videoconferencing equipment provided by these companies in order to engage in a videoconference interaction on these systems. These participants also reported that these videoconferencing systems are more secure, and they are not allowed to use Skype in their workplace. However, they both agreed that Skype provided better access and have used it in instances when their institutional videoconferencing system was not working or the person whom they were trying to reach did not have access to the network or equipment needed to communicate with those systems.

Informed Consent

Certain clinicians (n=5) specifically mentioned the informed consent process during the interview, and most of these clinicians (n=4) stated that they require a different informed consent for videoconference telemental health. Two of these clinicians worked for larger institutions, and they both discussed the informed consent process. One stated:

> There just is no 100% guarantee. Do I tell the client upfront? Do I want to scare them more than I need to? I had to really go back and forth with that. We came up with the

> consent that they are doing this by televideo, that I am not going to be taping them for any reason, and that I don't really think anyone would ever be able to see the session, but it is all about the possibility of it happening. I think if someone needed intensive sexual abuse treatment, I think I would have sent them off the island and brought them into town.

The other stated:

> We do have an information pamphlet that we give to families, before they have their service and technically they are supposed to consent. One of the dilemmas is can people consent to these services when they are acutely mentally ill?

A private practice clinician discussed her process:

> I really had to explore the legal implications of it before using it. I have a form that described it and people have to sign it if I am just going to be doing telemedicine with them. There are not a whole lot of rules and regulations around this yet; it was kind of the Wild West a little bit. I do this with people I have already seen and I think I will keep it that way. I will not do this with someone I have not seen before, they have to come in and I have to sit down with them.

Another clinician spoke of her uncertainty about whether or not her inability to control the environment was ethical:

> As a clinician I struggle with the appropriateness of having created the environment where we have a technical difficulty. I am not sure it is my responsibility to take for the technical difficulty; it would be like if in my office they have started drilling next door and there is noise, that is my responsibility.

Two clinicians were concerned about how the client could verify that the clinician providing services over videoconference telemental health was licensed and in good standing. They each brought up the idea of having a site that served as a clearinghouse for clinicians who were providing videoconference telemental health services.

Lack of Reimbursement as a Barrier

One clinician was able to bill Medicaid for videoconference telemental health services since she was in a designated rural service area and was using the appropriate technology, "It was mostly grant funded. We did have third party reimbursements. It was state to state for

Medicaid. In some states they consider televideo face-to-face for clinical supervision, practice and consultation. I billed directly for therapy."

Half of the clinicians (n=6) mentioned reimbursement as a negative issue. Most third party payors will not reimburse clinicians for videoconference telemental health, so clients have to pay out of pocket, and this limits access to these services for lower income clients. In certain states, Medicaid will reimburse social workers for videoconference telemental health, but there are many limitations. One clinician stated, "The insurance issue is the big issue." Another clinician stated, "I wish I could use this more, reimbursement is a huge obstacle."

Connection Between Experience and Comfort Level

There did seem to be a connection between amount of experience with videoconference telemental health and comfort with videoconference telemental health. The clinician with the most experience (7 years, over 4000 contacts), appeared to be much more comfortable using videoconference telemental health than those with less experience, and her perception of videoconference telemental health was very positive:

> I don't look at video as the modality, video helps to provide the service….This is not a new modality, it is just another way to do the same thing. It is another way to expand practice and make psychiatry and psychotherapy more available....I did an emergency response by video. It was probably the best session I have ever done face-to-face or on video.

The clinician that had not used the technology in the past year had the most negative response to the technology:

> It has been more than a year since I have had one [a client]. I was hesitant because it was new for me to use, I knew it was not going to be perfect. I am not opposed to using it if it is important to the client. I am willing to use it; it is not my first choice.

The clinicians with more experience spoke with much more confidence about videoconference telemental health, but certain clinicians with more experience had the same concerns as those with limited experience.

This chapter has examined the data from themes that emerged in the following areas: 1) Demographic Data; 2) Summary of Clinicians' Practices; 3) Benefits of Continuity and Access; 4) Clinicians' Preferences Towards the Use of Videoconferencing Telemental Health; 5) Different Type of Therapeutic Environment; 6) Technological Difficulties; 7) Ethical Concerns; 8) Connection Between Experience and Comfort Level.

CHAPTER V

Discussion

The purpose of this study was to explore the following questions: How are social workers integrating videoconferencing telemental health into practice, and what have the experiences of social workers been of using videoconference telemental health to provide services? This chapter will present a discussion on the findings of this study, which include 1) Demographic Data; 2) Clinicians' Practices 3) Client Satisfaction 3) Benefits of Continuity and Access; 4) Clinicians' Preferences Towards the Use of Videoconferencing Telemental Health; 5) Different Type of Therapeutic Environment; 6) Technological Difficulties; 7) Ethical Concerns; 8) Connection Between Experience and Comfort Level.

The findings will be analyzed and compared to current literature. Questions that arose from the findings will be addressed, and further areas of study will be identified. Strengths and limitations of the study will also be discussed.

Demographic Data

There is no existing demographic data on the population of social workers using videoconference telemental health; therefore no comparisons can be made between population and sample demographics. One surprising finding was the age of participants. As one participant himself stated, "I don't really think anyone over 40 would use this technology." The average age of participants was 48.2, and there was only one participant under the age of 40. There was no apparent association between age and comfort with technology.

Another surprising finding was the huge variance in years of experience in practice. This study found that participants with a range of years of experience from 5 – 36 years were using this technology. In addition, it was interesting to find that only 1 out of 12 respondents lived in a

rural area while providing videoconference telemental health services since the literature stresses the capacity of videoconference telemental health to provide rural service delivery.

Type of Services Provided

The literature notes that videoconference telemental health has been found effective in providing assessment, diagnosis, consultation, crisis intervention, individual psychotherapy, group therapy, family therapy, substance abuse treatment, and disposition planning (Antonacci et al., 2008; American Telemedicine Association, 2009a; Hyler et al., 2005; Richardson et al., 2009.) This literature did not directly address the use of videoconference telemental health by social workers.

While this study was not about effectiveness, these findings support that videoconference telemental health is being used by social workers for all of the above, except disposition planning. All of the respondents in this study used videoconference telemental health to provide therapy and consultation to individuals. Five respondents had used videoconference telemental health to provide couples therapy, two for family therapy, one for group therapy, and one for supervision and consultation to other professionals. While this study did not look to explore experiences of providing education and consultation to other professionals, this is noted, as it was a large part of this participant's practice.

It might also be noted that the majority of respondents in this study were in private practice (n=10), while the majority of studies presented in the literature were conducted with clients or clinicians who are part of large institutions, such as the veterans administration, large hospitals, rural mental health care organizations, or in countries that have national health systems, such as Canada and the United Kingdom.

Training and Education

The data from this study show that training and education for videoconference telemental health is not widespread. Five of the respondents received training: three received on the job training at their workplace and two sought out training, but it was not intensive. It is possible that one of the reasons that less than half of the respondents reported receiving any type of training or education is due to the fact that a majority of respondents view videoconference telemental health as a progression from providing phone therapy, which they already use in practice. As far as the technology itself is concerned, most clinicians reported being comfortable with videoconference technology prior to using Skype.

Benefits of Continuity and Access

The data from this study support the idea that videoconference telemental health has the ability to provide access to those who would not otherwise receive services. The findings also indicate that videoconference telemental health can enhance continuity of care for those who are not always able to participate in face-to-face sessions with their mental health provider. All participants (N=12) noted that the videoconference telemental health provided continuity of care and access to care, and this was viewed as the main benefit of videoconference telemental health. In their survey of mental health professionals in Canada, Gibson et al. (2009) found that the majority of participants perceived videoconference telemental health as a good way to increase access to services. Participants also mentioned the benefit of providing service to homebound individuals or meeting people in their home. Damianakis et al. (2008) presented a study of social workers that appreciated that they were able to provide these services to caregivers in the home with videoconference telemental health. The results of this study support the idea that videoconference telemental health increases access to services.

Continuity of care, as such, was not mentioned in the literature. However, providing continuity of care to individuals who are seen both face-to-face and over videoconference telemental health, as it was presented in the findings of this study, could also be considered contributing to access to care.

Client Satisfaction

Many studies measured client satisfaction with services delivered via videoconference telemental health and found that clients were satisfied with the videoconference telemental health services that they received, and there was no significant difference between client satisfaction with videoconference telemental health and face-to-face interactions (Brodey et al, 2000; Frueh et al., 2007; Frueh et al., 2005; Ilan et al., 2006; Griffiths et al., 2006; Morland et al., 2004; Myers et al., 2006; O'Reilly et al., 2007; Richardson et al., 2009; Ruskin et al., 2004; Savin et al., 2006; Shepherd et al., 2006; Shore & Mason, 2004b).

The data from this study showed that the majority of clinicians reported that their clients were satisfied receiving services over videoconference telemental health. The private practice clinicians noted that there was a self-selection process that happened when clients elected to receive services over videoconference telemental health. One of the clinicians who has served numerous clients and worked in an institutional setting serving rural clients never had a client refuse services over videoconference telemental health. However these rural residents most likely had no other access to mental health services. Clients would most likely not agree to videoconference telemental health in private practice if they were not comfortable. Certain clinicians noted that some clients did not like receiving distance services. Some studies presented in the literature directly measured clients satisfaction, while this study asks clinicians

of their perception of client satisfaction. This is not as reliable and introduces the clinicians' biases into the responses.

Clinicians' Preferences Towards the Use of Videoconference Telemental Health

Respondents discussed whether they offer services to individuals in conjunction with face-to-face treatment (n=7) or if they were comfortable offering videoconference telemental health to clients they had never met face-to-face (n=5). A number of clinicians still indicated a preference for face-to-face sessions. The majority of clinicians screened potential clients to make sure they were appropriate for videoconference telemental health.

Despite the majority of clinicians indicating a preference for face-to-face sessions, the majority of clinicians hoped that their videoconference telemental health practice would expand. There was no clear correlation between demographic characteristics of participants and their willingness to provide services.

Clinicians' Attitudes Toward VCTMH

The majority (n=11) of clinicians' attitudes towards videoconference telemental health either improved or remained positive after they gained more experience with VTMH. Only one clinician continued to state that he did not have a positive attitude towards videoconference telemental health after gaining experience. This clinician had not used videoconference telemental health in over a year, and this could be a variable affecting his attitude towards videoconference telemental health. One clinician's attitude remained positive, but her concerns about the technology had increased. The literature notes that clinicians who do not have experience with the technology and have not received education regarding the use of technology are generally skeptical. However, there was also one study that found that clinicians with no previous experience held positive attitudes towards the use of videoconference telemental health.

The data from this study seem to lend mild support to the notion that more experience produces more positive attitudes, but there are also clinicians who have little experience with videoconference telemental health who held positive attitudes. This could be affected by the fact that clinicians who start using this technology in practice most likely hold somewhat favorable views of it.

Different Therapeutic Experience

Six of the respondents noted that videoconference telemental health created a different therapeutic experience that they perceived as being beneficial to the client. This supports the literature, which indicated that, in certain instances, distance could be an advantage to treatment. Gibson et al. (2009) found that distance between client and clinician can actually be an advantage for treatment, while it is usually viewed as a barrier. Himle et al. (2006) found that participants felt less anxious about treatment and were more likely to complete their homework than in face-to-face interactions because they felt a greater sense of independence. Frueh et al. (2005) found that the majority of members of a male substance abuse group were less anxious. Shore & Manson (2004a) noted that a male American Indian veteran was more comfortable receiving services over videoconference telemental health than face-to-face. Jerome and Zaylor (2007) also note that there is a different therapeutic experience.

The data from this study support the literature in that certain clients seemingly felt less anxious and more comfortable receiving services via videoconference telemental health than face-to-face. This raises the possibility that for certain client populations who have severe anxiety, agoraphobia or PTSD, videoconference telemental health might be a more comfortable way to conduct treatment, at least initially. Also, as one clinician noted, providing a different environment for treatment is one reason why using both videoconference telemental health and

face-to-face can be beneficial. It might give certain clients an opportunity to feel more emotive, more comfortable and less anxious than they might be in face-to-face settings.

Technological Difficulties

The majority of participants (n=11) noted issues with technology that negatively affected the videoconference telemental health experience, such as inability to see body language and inconsistent sound and video quality, which could distort a client's image and voice. These findings are consistent with Jerome and Zaylor's (2000) argument that the videoconferencing technology creates a different therapeutic environment where speech can be delayed or distorted, not all senses are being used, reality is two-dimensional and there is no shared reality as with face to face interactions. Based on the findings, it is surprising that there was not more discussion in the literature of technical difficulties. It could be because most of the respondents to this study used Skype, and the majority of the literature consists of studies that use commercial videoconferencing equipment. However, two of the respondents who noted issues with technology used this commercial equipment, and they noted similar issues with technology as the private practice clinicians who used Skype.

Reimbursement

The literature notes that reimbursement is a barrier to the use of videoconference telemental health. Six of the study respondents noted reimbursement as a barrier to treatment since they could not be reimbursed by third party payors for the use of Skype for videoconference telemental health in private practice. It should be noted that this was not a question that was asked about directly, unless it came up in conversation. It would have been beneficial to ask all respondents about their views of reimbursement. If the use of videoconference telemental health is going to expand, commercial insurance will need to decide

whether or not they are going to consistently reimburse social workers for videoconference telemental health, in what settings, and what technologies are acceptable for use.

Ethical Issues

As one clinician put it, when referring to legal and ethical issues regarding the use of videoconference telemental health in practice, "This is kind of like the Wild West." The clinicians' concerns over ethical issues were similar to those concerns raised in the literature, which called for a more clear definition and investigation into these issues.

Risk and Safety

The majority of respondents (n=10) would not see clients that they considered to be high-risk over videoconference telemental health. Either they did not accept high-risk clients into their practice at all, or they would see high-risk clients only face-to-face. Gibson et al. (2009) noted clinicians' concern that videoconference telemental health would not provide adequate means for response if their client was in crisis. The data from this study support this concern. While the clinicians do not directly state that they are concerned about clients being in crisis, they refrain from using videoconference telemental health with the clients who are most vulnerable and most likely to go into crisis, in order to manage risk. However, it is interesting that the two clinicians who worked in institutional setting used videoconference telemental health technology to provide crisis intervention to clients in rural areas

Privacy and Confidentiality

Privacy and confidentiality were concerns for the majority of respondents. There was uncertainty regarding how secure Skype is and whether or not clinicians are compromising the privacy and confidentiality of their clients. The two clinicians who worked in institutions did note that they are not allowed to use Skype because it is viewed as not being secure enough to

protect privacy and maintain confidentiality. . They also noted that there are still security risks, even with commercial videoconferencing technology that has higher security protection.

Informed Consent

The literature addresses the importance of obtaining informed consent from clients and notifying them of the unique risks of telemental health treatment modalities, along with the unique complications that these treatment modalities present in protecting patient confidentiality. Five of the respondents mentioned the importance of informed consent.

The literature notes the ambiguous nature of the legal and ethical issues surrounding the use of this technology in practice and the need for more clarification around these issues. The findings of this study support the idea that these are grey areas that need to be addressed. The uncertainty about ethical issues stems from what is unknown about the technology, but a lack of education regarding the use of technology in practice could also be a contributing factor to this uncertainty.

Summary and Recommendations

It seems there is no question that videoconference telemental health has the ability to increase access to services for underserved populations and individuals who have difficulty finding providers. A large majority of the clinicians in this study indicated the desire for guidance from professional social work organizations (e.g. NASW) regarding the ethical and legal implications of integrating videoconference telemental health into practice. While social workers practicing within larger institutions have the benefit of institutional policy and information technology departments, social workers in private practice have access to readily available videoconferencing technology, but lack guidelines and specific technical support. Issues regarding videoconference telemental health must be addressed in order to effectively

implement ethical practice with videoconference telemental health into the field of social work. The following recommendations will be presented: 1) Continued research on effectiveness and the use of videoconference telemental health in social work practice; 2) Development of a national clearinghouse of licensed clinicians; 3) Education and training supported by the National Association of Social Workers and the Council on Social Work Education; 4) Implementation of guidelines for the use of videoconference telemental health in social work practice to supplement the NSAW Standards for Technology and Social Work Practice.

1. Recommendations for areas of further research:

a) The data from this study support the continuation of multidisciplinary effectiveness studies to indicate what types of therapy are effective with videoconference telemental health, including research into the use of face-to-face treatment in conjunction with videoconference telemental health, and the benefits and drawbacks of both.

b) The data from this study support the development of a quantitative study with a large sample size that focuses on how social workers are using this technology in practice. Such a study might examine on a larger scale the following variables: the type of technology being used; social workers' years of experience with videoconference telemental health; practice setting; type of services provided, and more specifically the type of therapy that they provided (i.e. cognitive behavioral therapy, psychodynamic, etc.); how social workers handle issues of risk and safety with videoconference telemental health; how they make their clients aware of risks to privacy and confidentiality; and how they handle the informed consent process and liability issues; and type of training and education that they receive.

2. National Clearinghouse:

The data from the study support the development of a national clearinghouse that certifies

licensure of clinicians practicing online and informs clients of risks associated with videoconference telemental health. Along the same vein, Pollack (2008) suggested a national licensing board to help address the issues of ambiguity regarding jurisdiction. A national clearinghouse seems like a goal that might be more attainable in the near future than a national licensing board as it will not require major policy changes.

3. Education and Training:

The data from this study support the inclusion of videoconference telemental health in Council on Social Work Education curriculum requirements and in NASW continuing education. Current social work students should discuss the integration of videoconference telemental health and other technologies in practice, be made aware of current guidelines available for the use of videoconference telemental health and other technologies, and be made aware of the risks associated with the use of videoconference telemental health and other technologies in practice.

4. Guidelines from the Profession:

While there are ethical standards for the use of technology in social work practice, these standards have not been specifically operationalized with regards to the use of videoconference telemental health in social work practice. The data from this study support the compilation of a set of practice guidelines for social workers that operationalize the following treatment issues:

a) Discussing the possibility of technical difficulties with a client and having a backup plan if the technology fails.

b) Informing clients of risks to their privacy and confidentiality due to security concerns with certain videoconferencing platforms.

c) Ensuring that clients are given a separate informed consent form in addition to the informed consent used in face-to-face interactions to emphasize unique risks associated with the use of videoconference telemental health.

d) Providing information for crisis planning with videoconference telemental health that ensures both clinicians and clients are informed of local resources at the client location to be used if there is a crisis.

e) Providing clear guidelines regarding which videoconferencing technologies can be used in practice.

Limitations

There are several limitations of this study:

1) The sample size was relatively small, racially homogeneous, and comprised almost solely of participants who were found through online searches for social workers using videoconference telemental health. It is unlikely that this sample is representative of the entire population of social workers using this technology. It would have been beneficial to have the sample represent more clinicians who were part of larger institutions using videoconference telemental health. It might also be worthwhile to obtain data from a random sample of social workers, both those who do and those who do not use technology in their practices.

2) The interview guide did not include specific questions regarding safety and risk, privacy and confidentiality, or informed consent. The assumption was made that asking questions regarding ethical issues that the clinicians had encountered would cover these topics. In hindsight, it would have been beneficial to ask these questions directly.

Technology is expanding quickly in almost all aspects of our daily life, and regulations, safeguards and sound ethics always seem to be one step behind the pace of technological

expansion. Certain videoconference systems have been used by providers in the medical and mental health field for years. Other videoconferencing software that is widely available to the public has been deemed too risky by many agencies and institutions for use in practice, but is used by clinicians in private practice. How should the social work profession strike a balance between the known and unknown risks of these technologies and investigating their use in social work practice? In a sense, are certain of these readily available technologies deemed so risky that they should not be used or can the risks be mitigated? Can the benefits of expanding access to services for underserved populations outweigh these risks? Videoconference telemental health has great potential to expand access to mental health services. As the use of technology expands, it is even more important for the social work profession to be involved in the conversation regarding videoconference telemental health to ensure that the needs of underserved and vulnerable populations are met in an ethically and culturally competent manner.

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Appendix A

Recruitment Email

My name is Charlotte Parker, and I am a graduate student at Smith College School for Social Work. I am conducting a research study that explores clinicians' experiences of using videoconferencing technology to provide mental health services. This research will be used for my master's thesis.

I am seeking social workers who would like to share their experiences of using videoconferencing technology in practice. Participants will take part in an interview over skype.

If you hold master degree or doctorate in social work and have used videoconferencing technology to provide services, you are eligible to participate. Services provided could include (but are not limited to):

-individual therapy;
-group therapy;
-family therapy;
-assessment & diagnosis;
-disposition planning;
-home visits;
-and any other way that you have used videoconferencing technology to provide services to clients.

If you have any questions, would like more information, or are interested in participating, please contact me via email. If you know of others who may be interested or able to help in this recruitment process, please pass along this information.

Thank you for your time.

Sincerely,

Charlotte Parker

Appendix B

HSR Approval Letter

SMITH COLLEGE
School for
Social Work

Smith College
Northampton, Massachusetts 01063
T (413) 585-7950
F (413) 585-7994

January 29, 2011

Charlotte Parker

Dear Charlotte,

Your revised materials have been reviewed and all is now in order. We are happy to give final approval to this most interesting study. Since these folks will all be very computer savvy, I would guess that recruiting over the net will go very well.

Please note the following requirements:

Consent Maintaining Data: You must retain all data and other documents for at least three (3) years past completion of the research activity.

In addition, these requirements may also be applicable:

Amendments: If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

Renewal: You are required to apply for renewal of approval every year for as long as the study is active.

Completion: You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Good luck with your project.

Sincerely,

Ann Hartman, D.S.W.
Chair, Human Subjects Review Committee

CC: Bruce Thompson, Research Advisor

Appendix C

Informed Consent

Dear Potential Research Participant,

My name is Charlotte Parker, and I am a graduate student at Smith College School for Social Work. I am writing to ask for your participation in my study, which will explore how clinical social workers are using videoconference technology to provide mental health services, and what their experiences have been of using this technology. Data obtained in this study will be used in my master's thesis and possible future presentations and publications.

As you may be aware, there is limited research or information available about how social workers are using videoconference technology in practice or the clinician's experience of providing services to their clients using videoconference technology. I hope that this study is able to highlight the importance of further research and education regarding the use of this technology in practice, which will help social workers to better serve underserved populations in need of mental health services.

If you are a master's level social worker, and you have used or are currently using videoconference technology to provide mental health services, your participation in this study is requested. If you are interested in participating in this study, you must understand and speak English, and be able to engage in a 45-75 minute interview using an Internet videoconferencing platform, such as Skype.

The interview will begin by collecting demographic data, information about your practice, and the number of years that you have used videoconference technology in practice.

The interview will then continue in a semi-structured format, asking questions about how your have used videoconference technology in practice, and what your experiences have been of using this technology. The Interviews will be recorded and transcribed. If a transcriber is used, he or she will sign a confidentiality pledge.

I do not foresee any risks of participating in this study. There will be no financial benefit to you for participating in this study. It will not be possible to participate in the study anonymously, but every measure will be taken to ensure your confidentiality. Research advisors will have access to the data only after identifying information has been removed. There will be no identifying information included in publications or presentations in such a way that it would compromise your confidentiality. In publications or presentations, the data will be presented as a whole and that when brief illustrative quotes or vignettes are used, they will be carefully disguised. Data will be stored on a flash drive in a locked filing cabinet for three years and may be kept past this time for as long as needed for inclusion in other research, publications and presentations. When no longer needed, data will be destroyed.

Your participation in this study is voluntary. You may withdraw from the study at any time during the interview, and you may refuse to answer any question. It is also possible for you to withdraw from the study after the interview is completed. To do this, you will need to contact me by April 15, 2011. All materials pertaining to you will be immediately destroyed should you chose to withdraw.

If you have any additional questions or if you wish to withdraw from the study after participating, you can contact me at the contact information listed below. Should you have any concerns about your rights or about any aspect of the study, you are encouraged to call me at the number listed below, or the Chair of the Smith College School for Social Work Human Subjects

Review Committee at (413) 585-7974.

Please sign and return this letter in the included self-addressed stamped envelope. Please keep a copy of this letter for your records. I know that your time is valuable, and I thank you in advance for your participation.

Sincerely,

Charlotte Parker

YOUR SIGNATURE INDICATES THAT YOU HAVE READ AND UNDERSTAND THE ABOVE INFORMATION AND THAT YOU HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS ABOUT THE STUDY, YOUR PARTICIPATION, AND YOUR RIGHTS AND THAT YOU AGREE TO PARTICIPATE IN THE STUDY.

_____

Signature of Participant Date

_____

Signature of Researcher Date

Appendix D

Interview Guide

Code #:

1. Demographic Information/Practice Information

Age:

Race/ethnicity:

Gender:

State of residence:

License:

Years of practice:

Years of experience using videoconference telemental health:

Type of videoconference technology used:

Estimate number of clients served using videoconference technology:

1. Can you begin by describing your practice?

2. How did you start using videoconference technology in your practice to provide services?

3. How do you decide when the use of this technology is appropriate?

4. How frequently do you use videoconference technology?

5.What type of training and/or supervision did you receive around the use of this technology in practice?

6.Do you use this technology in conjunction with face-to-face treatment? If yes, can you describe how this works?

7. What were your attitudes towards using this technology before you started using it?

8. How did your attitudes change after you began using this technology?

9. Do you notice differences in the client-therapist interaction when using this technology? If yes, can you describe them?

10. How have your clients reacted to receiving services via videoconference?

11. Have you ever encountered any ethical dilemmas with the use of videoconference technology?

12. I know we have covered a lot of information in this interview. Do you feel like there is anything that has been left out that you would like to share?