Exposing the Risk, yet Moving Forward:
A Behavioral E-Health Model

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Abstract

The Internet is proving to be an emerging and promising area of practice for psychotherapists. Known as behavioral e-health, service delivery through the Internet is still in its infancy, however. Guidance for structuring these interactions can be found in the traditional telehealth research literature, where it has been shown that upholding the traditions and requirements of professional practice can be possible while using telecommunication technologies. Therefore, this article offers a telehealth-based model for behavioral e-health service delivery.

Introduction

Telecommunication technologies are developing more quickly than legal, regulatory and professional bodies can establish guidelines for their use in the practice of behavioral healthcare. Nonetheless, a flurry of attention by the popular press regarding the use of various Internet-based technologies for the delivery of psychotherapy has given it more credibility than warranted by research. The fact is that telecommunication requirements for positive outcomes in behavioral and mental health care are still largely unknown (Glueckauf, Whitton, & Nickelson, in press).

The term "e-health" has recently been coined to refer to the quickly expanding branch of telehealth being delivered through the Internet. Behavioral e-health services range from office management and educational programs offered to health-related businesses and clinicians to information, education and commercial
products offered directly to the consumer. More often than not, when referred to by the media, e-health conjures the image of direct service by the professional to the patient through e-counseling.

Indeed, a wide variety of behavioral healthcare Web sites are emerging as professionals and businesses attempt to move their services to the Internet. This new practice avenue is more formally referred to in this article as behavioral e-health services. Some of the most pressing concerns related to these innovations will be outlined, and a more conservative model for remote service delivery using the Internet and other technologies is offered in this article.

Concerns Related to Behavioral E-Health

Driven by commercial rather than practitioner interests (Reed, McLaughlin, & Milholland, 2000), telecommunication technologies have the potential for development into profitable but not necessarily better or more effective health care systems (Newman, 1998). More specifically, while many behavioral e-health Web sites offer information and community support, some have indiscriminately begun offering direct professional care to consumers despite a lack of research establishing the safety or efficacy of their approaches (Day & Schneider, 2001; Maheu & Gordon, 2000).

For example, some of the larger dot.com (Internet-based) businesses are soliciting practitioners to use their services with unknown, unseen, and undiagnosed consumers. While the technology exists to verify the identity of technology users and protect the confidentiality of their communications with a high degree of confidence through biometric measures as well as encryption of messages (Maheu, Whitten, & Allen, 2001), these protections have not yet been made widely available through the Internet.

Moreover, professionals are being encouraged by some dot.com companies to accept e-mail contact from
consumers. While attempts are made by some of these companies to screen consumers according to state of residence, these sites often lack a verification procedure to protect the practitioner by assuring that a consumer is indeed from any particular state. Users simply click on a field identifying a state of residence, are given the names of professionals within that state, and are free to send an e-mail or arrange for a chat-room session. Other sites offer anonymous services to consumers, and sidestep any obligation to report duty-to-warn situations because the identity of the consumer is unknown.

Practitioners are also readily invited by some of these companies to meet and treat new patients in text-only environments, as if they offer a new standard of care that is acceptable as safe for the public. Their services may appear credible because they have been developed using large amounts of venture capital funding. However, their well-developed Web sites fail to discuss how professional standards are followed by protocols for contact between patients and practitioners. They also fail to demonstrate any empirical evidence that their uses of technology are appropriate for serving people with social or emotional problems.

Nevertheless, service agreements with these companies clearly transfer all responsibility for patient care to the licensed professional. Along these same lines, it is also alarming to see that some solo practitioners and dot.com companies fail to obtain full written patient consent. Furthermore, they use technologies that are based in text alone. The practitioner, therefore, lacks capacity to conduct a mental status exam before initiation of treatment.

It seems odd that while boasting multi-million dollar budgets for television and radio advertising, some such companies fail to offer services in accord with telehealth practices that comply with some of the most rudimentary legal and ethical protections for practitioners. Examples of such protections include strict confidentiality of all patient contact, effective backup procedures for emergencies, and proper training of professionals in the complexities of using technology with people who struggle with social or emotional problems.
While prudent clinical approaches are not conducive to the rapid deployment of technology to the masses, they have been the hallmarks of clinical practice for decades. Their use in the dot.com world, however, seems to be replaced with a new model, which advocates the use of secured e-mail and chat-room services for obtaining new referrals and the treatment of unauthenticated, faceless and undiagnosed consumers from around the world. Some sites even offer videoconferencing with patients, but fail to promise that videoconferencing will remain confidential. The Internet is not yet able to deliver on the promise of complete confidentiality for the average consumer. These serious limitations do not stop some dot.com companies, however.

The proliferation of such loose practices by dot.com developers and practitioners may lead to innovative business models, but can put unwitting professionals at risk. Practitioners delivering healthcare services through such websites may be inappropriately relying upon the Internet business community to, in effect, define practice standards without the supporting research typically required before instituting innovative practice procedures.

Text-Based Environments

Several researchers have attempted to document the experience of working with patients via e-mail, but much of this literature is still anecdotal in nature (e.g., Brice, 1999; Childress, 1999; Collie, Mitchell, & Murphy, 2000). Many researchers have conducted pilot studies of Internet-based educational programs (e.g., DeGuzman & Ross, 1999; Helwig, Lovelle, Guse, & Gottlieb, 1999; Stroem, Pattersson, & Andersson, 2000; Winzelberg et. al., 2000). Many other professionals have outlined the pros and cons of delivering services in text-based environments (Baur, 2000; Bloom, 1998; Bloom & Walz, 2000; Mitchell & Murphy, 1998a; Mitchell & Murphy, 1998b; Murphy & Mitchell, 1998; Suler, 2000), yet empirical findings related to the direct and exclusive delivery of psychotherapy in text-based environments are difficult to locate (Cohen & Kerr, 1998, Gustafson et al., 1993, 1994; Jerome, 1997).
It is also noteworthy that many of the well-funded behavioral dot.com companies have not survived, despite their start with 10, 20 and 30 million dollar budgets. Like many other dot.com industries, they have shown an inability to sustain themselves without continued infusions of large-scale funding. Another noteworthy issue is that a while a large number of licensed professionals have Internet access (Psychotherapy Finances, 1997), fewer than one in a hundred of these professionals offers psychotherapy via e-mail or chat-rooms (Maheu and Gordon, 2000; VandenBos & Williams, 2000).

Perhaps text-based interactions with patients are best reserved for a limited and adjunctive role, much as telephones have been used to date. The reader is referred to the literature related to using telephones as a primary modality for psychotherapy for ethical considerations of potential relevance to e-mail and chat rooms (e.g., Haas, Benedict, & Kobos, 1996).

Implications of Telehealth

Protocols for Psychotherapy via E-Health

Interestingly enough, the professional literature for remote service healthcare has been accumulating for over 40 years (e.g., Baer, Cukor, Jenike, Leahy, O'Laughlen, & Coyle, 1995; Ball, Scott, McLaren, & Watson, 1993; Dwyer, 1973; Magaletta, Fagan, & Ax, 1998; Magaletta, Fagan, & Peyrot, 2000; Perednia & Allen, 1995; Reynolds, McNamara, Marion, & Tobin, 1985; Wittson, 1961; Zarr, 1994). This literature has effectively established many crucial precedents for the initiation of remote service delivery directly to behavioral healthcare recipients.

Developing an optimal e-health model for psychotherapeutic practice will undoubtedly take much more empirical research when applications move from the traditional telehealth use of secured telephone or data transmission connections to the public Internet. Given the volatile and vulnerable nature of a portion of
the population served by behavioral health professionals, it is imperative that risk management discussions begin now - especially given that dot.com companies seem to be offering services through the public Internet system, thereby disregardng standards that have sustained patient confidence for decades.

A Research-based Model for Remote Psychotherapy

For the practitioner contemplating treatment of patients through the Internet, reasonable inroads have been made, and practice-expanding opportunities do exist. However, treating patients who report duty-to-warn situations, including suicidal and homicidal ideations, as well as various types of physical, sexual and emotional abuse is cause for serious consideration. Traditional telehealth programs have accounted for these difficulties by establishing a protocol that maximizes face-to-face patient-therapist contact at the onset of treatment, and extends it to remote treatment thereafter. More specifically, typical protocols for psychotherapy in successful telehealth programs involve an initial face-to-face meeting between the patient and healthcare professional. Telehealthcare often involves evaluation of a patient by a local practitioner, with consultation or referral to a remote specialist using videoconferencing technologies (e.g., Baer et. al., 1995; Cukor et. al., 1998; Huston & Burton, 1997; Glueckauf et. al., 1998; Jerome, 1986, 1993; Sampson, Kolodinsky & Greeno, 1997; Stamm, 1998; Troster et al., 1995).

Local practitioners often reside in rural communities, and specialists often reside in urban areas, such as large teaching hospitals. Once the patient has been screened, consent forms are explained verbally and signed by the patient. Following an initial assessment by a healthcare professional, the appropriate technology for use is determined and explained to the patient. Videoconferencing is typically used (Maheu, Whitten, & Allen, 2001).

Lest the practitioner be disheartened, let it be understood that research is demonstrating a wide variety of uses for technology in psychotherapy. While e-mail
and chat rooms remain to be examined for direct clinical utility for one-to-one contact with individual patients, empirical evidence shows that other uses of technology augment face-to-face clinical practice (King, Engi, & Poulos, 1998; L'abate, 1999; Maheu, 1997). A host of software packages have also passed empirical testing and can be a notable asset to the toolkit used by the average clinician (Hester & Delaney, 1997; Kobak et. al., 1997; Newman, Kenardy, Herman, & Taylor, 1997; Wright & Bloom, 1997).

Practitioners are encouraged to look for existing guidelines for behavioral telehealth services when attempting to develop services through the Internet. The remainder of this article offers such a model for psychotherapy, as practiced in traditional behavioral telehealth programs.

**E-Health Risk Management Suggestions**

As with traditional healthcare, there are a wide range of guidelines to consider for Internet-based behavioral health services. In this section, I address guidelines related to training, legal and regulatory concerns, ethical issues, the wide range of specific challenges for delivering services online, and topics related to actually working with a dot.com firm.

**Training**

Before delivering services through technology, practitioners ought to obtain and document training for the use of specific technologies to mediate psychotherapy (Jerome & Zaylor, 2000). Until there is sound empirical evidence of the efficacy of the technology in question for the patient population and purpose intended, caution is suggested. Many aspects of working with technology require the practitioner to be aware of hidden factors that may positively or negatively influence communication with patients.

**Technical Proficiency**
Required training involves the influence of the specific technology upon the therapeutic relationship.

- E-mail can lead to a greater number of misunderstandings, and is dependent upon participants' written skills. People vary in their ability to communicate in written format. More importantly, text-based environments can be used to dupe the unwitting practitioner by disguising not only the identity but also the intent of the user (Maheu & Subotnik, in press). It can be used in innovative ways to taunt and harass the inexperienced practitioner. It also can be used by the inexperienced practitioner to do harm to the patient. Given the rapidity with which a thought can be composed and transmitted via e-mail without the typical restraints of business hours and the professional decorum taught to practitioners for telephone contact, mistakes are likely to occur. For example, professionals are not trained in the use of e-mail, and have been known to send e-mail in the wee hours of the morning to professional listservs, only to be embarrassed and retract their statements the following morning. Likewise, messages intended for private viewing have erroneously been sent to public listservs, for audiences of several hundred or thousands. If professionals are apt to make these mistakes with colleagues, it can be expected they will occasionally make similar mistakes with clients. More serious mistakes within the direct therapeutic relationship are imaginable. For example, if a battered client writes to ask for assistance with a batterer, and the therapist responds but neglects to remove the original wording of the request in the response, the message can be intercepted by the batterer, subjecting the patient to further harm.

- Chat rooms have not been adequately researched regarding their impact on the communication of people with social or emotional problems. Initial speculation revolves around their potential for eliciting incomplete or impulsive thoughts, due to the time pressure created by the delay in sending and receiving messages. While many dot.com companies offer chat rooms for professionals to use with patients, research showing the efficacy of such media for communicating with patients is nonexistent at present.

- Videoconferencing can be distracting, drawing attention
to factors in the peripheral movement, such as tapping, rocking or scratching one's face or hair. It can also draw attention to specific characteristics, while minimizing the presence of others. For instance, depending on camera location, videoconferencing can create a heightened or diminished sense of practitioner size. Such an effect can be beneficial or harmful, depending on the particular patient.

- Reliability of therapeutic contact is also crucial when establishing rapport and delivering services face-to-face. Given the particular patient and circumstance, it could be disconcerting and harmful to a patient to lose Internet contact with a therapist. Backup procedures and other informed consent issues must be thoroughly discussed before treatment.

Professional training to prevent problems in these areas is possible. For example, such training might consist of explaining potential risks and their remedies. For e-mail correspondence, the professional can send a neutral message to patients using the public e-mail system, and ask them to come to a password protected and encrypted Web site, where their request and the professional's response can be viewed securely. Professionals can role-play with each other in e-mail chat rooms designed for training, before delivering service to consumers. Such a service is available free (Telehealth.net, 2001).

Other technical training can be obtained for videoconferencing, where practitioners can experiment with the effect of various settings, environmental cues, lighting, camera distances and movement. Such technical proficiency is not difficult to obtain, and can have profound impacts upon the therapeutic relationship. A practitioner's participation in such training programs can not only avoid problems, but documentation of such training could help mitigate any problems that would arise if litigation were to occur as well.

**Legal Training**

Despite the lack of practice guidelines for psychotherapists, it is clear the Internet is the next large-scale vehicle for people to find relief from
behavioral health issues. It is hoped technology will bring professional services to many people who otherwise would not seek this aid.

Yet healthcare professionals are caught in a bind of having access to several technologies for practice, but not having legal protections for themselves or their patients. Case law is just being established in these areas, and much of that law is still new or unknown to the legal as well as healthcare communities (Cepelewicz, 1998; Koocher & Morray, 2000; Schanz, 1999a, b, c; Schanz & Cepelewicz, 1999). Laws vary from state to state, and profession to profession. Issues of licensure, privacy, confidentiality, and duty to warn will be examined in the next section.

**Legal/regulatory Issues**

*Licensure*

The Federation of State Medical Boards (1996) has published "A Model Act to Regulate the Practice of Medicine Across State Lines." Section II (Definitions) of the Model Act states: "It is important to view the practice of medicine as occurring in the location of the patient in order that the full resources of the state would be available for the protection of that patient. The same standard of care, already in existence in the patient's home state, would be required of all individuals practicing medicine within that jurisdiction..." (p. 2). On the other hand, members of the nursing profession are attempting to modify state restrictions on practicing across state lines by agreeing to adopt common state regulations (National Council of State Boards of Nursing, 1998).

Definitions of practice also need to be considered. Of the few practitioners who have ventured forth to offer professional services online, either through their own private Web sites or through dot.com companies, some suggest their services be used for giving advice, not psychotherapy, to people with social and emotional problems. However, existing licensing regulations may blur such semantic distinctions.
Lack of a clear definition of what constitutes psychotherapy raises serious questions. For example, how does a licensed professional deliver advice, while clearly avoiding the use of "psychological methods" leading to "greater human effectiveness?" Does refraining from rendering a diagnosis remove the obligation to discuss informed consent, or to offer confidential conditions for treatment? Such distinctions could be difficult to defend in a heated courtroom in a case involving, for example, a teenage suicide or homicide. Over time, case law will undoubtedly drive development of better defined distinctions between psychotherapy and mere advice.

Meanwhile, existing statutes govern licensed professionals (Reed, McLaughlin & Milholland, 2000). Training programs need to address legal risks assumed by professionals using evolving Internet-based technologies.

**Privacy & Confidentiality**

In response to the outcry for increased precautions for privacy and confidentiality of electronic healthcare records, noteworthy legislative actions are emerging (Goldman & Hudson, 2000). These include the Telehealth Improvement and Modernization Act of 2000 and the Health Insurance Portability and Accountability Act (HIPAA) (Health Insurance Portability and Accountability Act, 1996).

The Telehealth Improvement and Modernization Act of 2000 is also known as Senate Bill 2505. It was filed by Senator Jeffords (R-VT), and was designed to modify many of the provisions related to telehealth in the Balanced Budget Act of 1997. HIPAA attempts to provide transmission, privacy and security standards to reduce unauthorized access and alteration of confidential health records. Meanwhile, continued reports of unauthorized access to medical records continue to make headlines in the popular press (O’Harrow, 2000).

These two pieces of legislation will shape the development and use of technology by health care
professionals. Technologies are in flux and developing rapidly. Psychotherapists are well advised to obtain training in these changing legal issues, as well as to attempt to shape the future of this legislation by advocating for the protection of their patients.

*Duty to Warn*

While conducting psychotherapy with mental health patients exclusively through text-based environments is fraught with hazards, it might be reasonable to develop e-mail or chat room contact with properly prepared patients who have been screened and fully informed of how and when such contact is to be used. While laws regulate the reporting of child and elder abuse in most states, their application to Internet-based referrals is not addressed by many dot.com companies. Imagine receiving an e-mail referral from an unknown patient who describes an abuse situation and requests assistance.

As mentioned earlier, some such companies attempt to sidestep the dilemma of reporting patients by allowing consumers to contact professionals anonymously. Their reasoning is that if the identifying information is unknown to the professional, a duty-to-warn situation does not exist. Is such a practice in disregard of the intent of abuse-reporting laws, or does it simply allow patients to gain access when they otherwise would not step forward? These distinctions will undoubtedly be clarified by case law over the next decade.

*Ethical Considerations*

Ethical codes written for social workers are different from those written for counselors, for psychologists and psychiatrists. For professions in which specific guidelines have not yet been established, it may be important that guidelines set forth by other mental health professions be examined. For example, implications of recommendations set forth by the American Medical Association (1999) may be relevant for ethical training discussions with psychotherapists. More specifically, physicians are encouraged to obtain a complete medical history, see patients face-to-face before prescribing medication over the Internet, initiate other interventions
and arrange for follow-up care if prescribing medications with potentially serious side effects.

Based on the standards set forth by the AMA, questions to be examined in training sessions for psychotherapists might include: "If physicians are urged to see patients face-to-face before prescribing medication, it is reasonable for psychotherapists to require face-to-face contact with a patient to rule out potential sources of emotional instability (i.e., chemical dependency, medication reactions, neurological impairments)?"

Another question might be: "Even if consumer demand for such immediate and remote service without face-to-face contact is high, is it the duty of behavioral health care professionals to set limits on consumer demand if a patient cannot be adequately screened and diagnosed with a reliable level of certainty prior to remote treatment?"

When working in a secured e-mail or chat-room environment, practitioners may also easily forget the need for informed consent and mental status exams to rule out a variety of potential sources for a consumer's complaints. Training can help practitioners remember that use of technology does not alter the professional's need to adhere to established standards of care.

Other topics are of importance in ethical training for telehealth and e-health. Remote service delivery through technology can pose unprecedented problems. Training in telehealth and e-health ethics also can include discussion of how to overcome limitations to accessing local information and emergency backup systems when serving a community unlimited by national or continental boundaries. Ethical questions also arise with issues of competence for any aspect of new service delivery, but are particularly relevant in a milieu where cultural and linguistic differences are the nature of the community being served, such as with the Internet (American Psychological Association, 1992). Of equal relevance to ethical training are concerns related to attentiveness, distraction and privacy, and elements of the patient informed consent agreement.

Challenges of Delivering Services Online
Practitioners may find themselves at a serious informational deficit if unaware of local events that might influence the emotional state of consumers of Internet services. Such events can include natural disasters or celebrations that involve drug and alcohol use. Consumers cannot always be held responsible for what they do not share with a professional. Some issues may simply not seem important to them. They also might be distracted, tired, or simply unsophisticated regarding events that might influence their behavior or feeling state. It therefore behooves the therapist to be aware of such potential influences and screen for them appropriately.

It is also of importance to determine if the patient has been seen by other psychotherapists, and if those relationships are still active. A variety of ethical issues can arise with patients who are in treatment or seeking advice from one or more psychotherapists, either online or offline. Our most vulnerable patients, as well as some of our most dangerous patients, may do themselves and/or the practitioner undue harm. Questions include whether such other practitioners will be contacted to coordinate care, how such issues will be discussed with the consumer, and how proper releases of confidentiality will be obtained from the consumer. The question of which therapist will serve as a primary therapist in case of emergency is another issue for exploration.

Similarly, it is the responsibility of the treating behavioral healthcare practitioner to have adequate emergency backup systems in place before offering services to consumers, even if patients do not think such backup relevant or important (Maheu, Callan & Nagy, 1998; Maheu & Gordon, 2000; Reed, McLaughlin & Milholland, 2000).

It is sometimes the case that patients enter psychotherapy and decompensate in their ability to function. How Internet-based psychotherapists will conduct treatment of such patients is also a question. Of particular note are the services by professionals and dot.com companies who, in the fine print of their Web sites, decline to accept any responsibility for providing
emergency support services, encouraging suicidal or homicidal patients engaged in psychotherapy through their Web sites to dial 911 if an emergency arises. Clearly, by the very nature of their crises, patients who become suicidal or homicidal during treatment cannot reasonably be expected to avail themselves of assistance from their local police departments. By definition, suicidal and homicidal patients are intent upon hurting themselves or others, not upon calling the police.

*Linguistic and Cultural Competence*

The issue of linguistic competence on the part of the clinician is particularly relevant in the delivery of behavioral e-health services. With worldwide Internet access, consumers from remote areas of the planet can make contact with a clinician. Internet consumers include native English writers as well as people who write English as a second language. When working with mentally ill, suicidal or homicidal patients, the clinician's familiarity with colloquial expressions, idioms, and local variations of word usage will undoubtedly prove to be crucial. For a clinician to assume that all Internet consumers accessing Web-based services understand the same language (e.g., English) as the clinician can be a serious error.

Similarly, cultural competence is a fundamental issue of concern when working with a worldwide, Internet population. Cultural norms, local traditions, and religious rituals play important roles in the lives of many clients and patients. To offer behavioral and mental health care in the absence of such information about specific patients can easily be considered outside the standard of care.

*Attentiveness, Distraction and Privacy*

When using any form of technology, it is more difficult for the clinician to determine if a person is fully attentive or distracted during the therapeutic interaction. While this ability is increased with real-time technologies such as the telephone and videoconferencing, these technologies do not offer the same level of protection
from outside interference as found in a well-designed office environment.

When using technology, lapses in response may be due to a variety of different factors, including mental illness, medication reactions, or a child wandering into traffic. It is also easier for a practitioner to be distracted while on the telephone, reading or writing e-mail, or typing in a chat room. Each technology brings its own special demands from the patient and clinician.

All three means of communication are also subject to eavesdropping by people in the patient's locale. Eavesdroppers may have a stake in the details being communicated and may unduly influence future therapeutic interactions with the patient. Clinicians need to be aware of these attentiveness, distraction, and privacy issues and adjust for them throughout treatment.

Accepting Referrals

Acceptance of referrals to a traditional psychotherapy practice have been conducted primarily by telephone for several decades. E-health Web sites are changing this practice, offering e-mail and chat rooms as initial contact points between practitioners and potential patients or advice seekers. Regardless of what a consumer is called by a dot.com company or Web site, licensed practitioners in many states incur responsibility for establishing a professional relationship, with all the incumbent risks, upon the moment of contact with a consumer. Therefore, when working in a medium that is untested in case law, it is wise to proceed with caution.

- Obtain Patient Informed Consent Agreement
  Behavioral health care practitioners typically have an ethical obligation to obtain informed consent before delivery of service, including the practice of psychotherapeutic service through technology. Informed consent before treatment via technology is particularly critical, because patients and practitioners may not fully agree upon or understand how electronic transmissions might be recorded, intercepted, altered, or otherwise stored over time. Informed consent is optimally obtained in writing, and discussed verbally at the onset of
professional service delivery.

- **Patient Technical Proficiency**

  Patients cannot be expected to be proficient at using technology. Even if they claim to be proficient at using e-mail, they may not have fully anticipated how to handle the interception of their private e-mail messages by a family member, or may be surprised to receive a message from a practitioner's assistant rather than the practitioner. While professionals have been trained in how to manage family member receipt of phone calls and how to train staff members to leave messages for patients, the switch from telephone to e-mail may leave some patients and professionals unprepared for emotional reactions that may result. Patients can experience the delay, disruption or cancellation of an appointment as personal rejection, for example.

On the other hand, some patients may use the experience of a technical breakdown as an opportunity to have protracted discussions with the professional "off the clock," which can lead to unexpected emotional reactions in the practitioner. The use of chat rooms and videoconferencing technologies can lead to similar disruptions and expectations. These situations can interfere with the therapeutic relationship if not properly anticipated by the professional, and if the patient is not properly trained in the use of each technology mediating the therapeutic relationship.

Discussions of patient consent can serve as a forum for patient training in the risks and benefits of using technology, as well as about how to prevent complications that may inadvertently arise from using technology. Specific elements for topics to include in patient consent agreements are available in Maheu, Whitten and Allen (2001).

- **Initial Assessment**

  Given the current limitations of technology, it is wisest to conduct initial assessment and diagnosis in the office, face-to-face. When necessary, assessment can be conducted using technology, but only with an awareness that it may or may not be as efficient as conducting a face-to-face session. Should a problem arise, the practitioner will be at a disadvantage in defending
methods used to the extent they deviate from standards of care established in their communities of practice. When face-to-face assessment is not feasible, conduct full videoconferenced assessment of the patient with the presence and assistance of a local, non-specialist practitioner. Such a local practitioner should also agree to be available for ongoing backup support if necessary throughout treatment. Obtain patient and family signatures as required on release of information forms for contact between referring and consulting practitioners. If serving a frontier community and a local practitioner is not available, seek oversight and maintain contact with a local responsible party (i.e., community, religious, or tribal leader).

- Psychotherapy & Consultation
  Once a thorough intake and assessment have been completed, and the patient consent agreement is discussed and signed, practitioners have much leeway for determining how to conduct psychotherapy with patients optimally. Depending on the diagnosis and willingness of the patient to try new technologies, many combinations of technologies can be used (Smith & Allison, 1998).

Rather than limiting direct service delivery to use of the Internet, the reader is encouraged to consider use of software available through the Internet to augment standard face-to-face clinical practice. In fact, such auxiliary use might be the wisest use of Internet technologies, until secured videoconferencing capabilities become more widespread and traditional telehealth services can therefore be approximated. Examples of such Web-based auxiliary services include depression treatment, smoking cessation and stress management (Centre for Stress Management, 2001; CopeWithLife.com, 2000; Nicotine Freedom System, 2001). Software that may be downloaded from the Web can also be used as a research based adjunct to treatment (Hester & Delaney, 1997).

Other E-Health Risk Management Suggestions
Several groups are providing suggestions and leadership toward establishing e-health guidelines. These include the World Health Organization, the American Counseling Association, American Medical Association, American Medical Health Informatics Management Association, the American Medical Informatics Association, the National Council of State Boards of Nursing, and the National Board for Certified Counselors. URAC has proposed standards for health Web sites, and will be accrediting such sites (URAC, 2001) The American Psychological Association Ethics Committee issued a statement regarding services by telephone, teleconferencing, and the Internet (American Psychological Association Ethics Committee, 1998). They also have developed a consumer-oriented Web site to help the mental health community make appropriate decisions regarding healthcare websites (American Psychological Association, 2000). The Interdisciplinary Telehealth Standards Working Group has developed ten principles concerning new technologies and their implications for psychology (Reed, McLaughlin, & Milholland, 2000). Groups such as the Association of State and Provincial Psychology Boards have promoted use of certain technologies before state psychology licensing boards. Practical information regarding routine aspects of initiating psychotherapy with remote patients is also available from telehealth pilot programs across the United States, Canada and abroad. In addition to specific management issues related to providing care to patients, there are also important factors related to a provider actually working with a dot.com firm. It is to an examination of this topic that I now turn.

**Working with a Dot.com for Establishing or Maintaining Patient Contact**

If seriously considering the use of a dot.com Web service for making contact with new or established patients, practitioners and their employers are encouraged to examine the service agreements offered by behavioral health care dot.com companies thoroughly. It is further recommended that professionals send copies of these agreements to their attorneys, local, state and national ethics boards, state or provincial licensing boards, and malpractice carriers to clarify issues of
shared liability. It may also be wise to include for review specific treatment protocols intended for use, a description of the population to be served, and a copy of the informed consent agreement to be signed by such patients.

Professionals are also encouraged to read and understand their professional associations' codes of ethics and relevant state licensing laws to verify whether ethical service delivery can be offered through the specific technologies promoted by technology vendors. The best evidence of professionalism would be reports of properly conducted empirical studies showing conclusive efficacy of the technology to employed with the intended patient population to be serviced. Practitioners are also encouraged to obtain written assurances from dot.com companies that transmissions are secure, encrypted and confidential. It is prudent to obtain written assurances concerning whether records of communications with patients are kept in any form on the dot.com's server, and the disposition of those records over time.

Before joining dot.com provider panels, practitioners are also encouraged to examine the credentials of each of the principles of the dot.com company. Note which companies have clinicians in actual decision-making positions, and which have a list of well-known clinicians on advisory boards. Sometimes, these names are used as "window dressing," and professionals on such advisory boards are unsophisticated regarding the twists and turns that can arise when using technology to deliver psychotherapy. Practitioners should also verify the credentials of named associates. Ask if all advisory board members have been licensed, and if so, for how long. Similarly, ask if they practiced psychotherapy, and if so, for how long. After all, if a dot.com asks you to lend your reputation to them, you may want to be assured they have demonstrated minimal competency. Unlicensed and unpracticed 'professionals' may easily develop an online reputation, and lack of licensure and experience can be easily camouflaged with expensive Web sites and bogus titles. Other advisory board members may have dual affiliations with disreputable organizations (Posen, 2001).
The Failing Cot.com Direct Mental Health Service Industry

Having failed to complete the basic requirement of most granting institutions, that is, a feasibility study, many privately funded dot.com companies are not able to sustain themselves financially. It is no surprise that without any research to support the adequacy of e-mail or chat rooms to sustain therapeutic relationships, service models dependent upon these technologies are not proving successful. It is also noteworthy that as Internet usage skyrockets, the number of licensed professionals joining provider panels or dot.coms, or opening Web sites offering direct psychotherapy with unknown patients, has remained stable for several years. Despite dramatic estimates of the number of professionals using email with patients, it does not seem to have become a common practice. In fact, the audience response to professional presentations given by this author would indicate that while a number of practitioners have attempted to sustain contact with patients through e-mail, most have not used encrypted technologies, and discontinued such contact after experiencing undue anxiety and frustration with the experience.

Not only has the professional community approached e-mail and chat rooms with skepticism, so has the consumer market. If consumers trusted e-mail or chat rooms for establishing or maintaining contact with professionals, they certainly have had an golden opportunity in the last 12 months to support such an industry. Despite dozens of Web sites from which to choose, consumers have not availed themselves of such sites any more than using telephones to conduct psychotherapeutic relationships. Web-based services may have an adjunctive or supportive role. However, the failures of many telephone counseling services in the 1980’s, and more recently, of dot.com, e-mail and chat-room based psychotherapy services, testify to consumer preferences for traditional psychotherapy services.

At the time of this writing, several of the largest such services have folded, or are ceasing to offer services to the public. Some are targeting employer groups, who
they hope will respond more favorably to the economic incentives to offer services to anonymous patients through unproven and unsecured technologies. It is also of note that the few successful employer-focused companies attempt to sidestep duty-to-warn obligations by allowing the "employee" (rather than using referents such as client or patient) to remain anonymous. Such departures from duty-to-warn obligations, designed to protect the self-or-other injurious patient, have yet to be tested in court.

For now, it is reasonable to ask practitioners to obtain basic training in the form of technology they wish to use with their patients. This might encourage practitioners to follow protocols set forth in the telehealth research literature, i.e. have a licensed professional meet with patients first, complete a full mental-status exam, determine diagnosis, obtain a signed consent form, and decide how and when to use which specific form of technology. To ensure the chosen technology protects patient confidentiality, a treatment protocol which specifically addresses the technology is warranted, along with contingencies for continued use of the technology. It is also reasonable to ask practitioners to maintain the standard of care applicable to face-to-face delivery of psychotherapy, and to wait for the Internet to develop to the point where such a standard will more easily be upheld, i.e., when secured videoconferencing will be available.

Meanwhile, use of the Internet through secured Web sites has been shown feasible for adjunctive patient education, patient self-monitoring, patient messaging of limited types, patient self-help programs, and patient support. While these suggestions are not exhaustive or definitive, they are offered as a starting point for discussion of an appropriate e-health psychotherapy model.

**Conclusion**

The Internet offers innumerable growth opportunities for behavioral and mental-health practitioners. Practicing
psychotherapy through the Internet is the future, but several barriers are currently evident, despite the proliferation of dot.com companies offering psychotherapeutic services. Among the most pressing barriers are lack of case law, state regulations, professional guidelines, screening tools, treatment protocols, and security for patient interactions through the Internet. Professional attention to all these areas is warranted immediately. To quicken the removal of such barriers, practitioners working within professions with undefined legal, regulatory or ethical guidelines with respect to e-health are encouraged to contact their state licensing boards, malpractice carriers and professional associations with repeated requests for written, clearly defined definitions of acceptable practice.

Behavioral telehealth pilot projects have demonstrated it is possible for licensed psychotherapists to proceed cautiously, yet steadily, in deploying telecommunication technologies, while upholding the highest traditions and requirements of professional practice. After reviewing much of the related literature, this article offers a telehealth-based model for delivery of psychotherapeutic services through the Internet. Continued research will undoubtedly show the efficacy of various technologies for augmenting and managing the psychotherapeutic relationship. Meanwhile, by adhering to existing telehealth standards, properly trained psychotherapists will have the ability to deliver unprecedented service.

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