

FEASIBILITY OF IMPLEMENTING TECHNOLOGY-ASSISTED
INTERVENTION FOR THE TREATMENT OF MENTAL
HEALTH-RELATED PROBLEMS IN
RURAL COMMUNITIES

by

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ABSTRACT

Feasibility of Implementing Technology-Assisted Intervention for the Treatment of
Mental Health-Related Problems in Rural Communities

by

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In recent years advances in technology have begun to permeate the everyday lives of citizens in the United States. Technology has affected the way people send and receive information, communication, and entertainment. The world is more connected today than at any other time in history. However, despite this connectivity, there are still rural populations in the United States that remain underserved and disconnected in many areas, including mental health services. This study seeks to understand the feasibility of serving the mental health needs of rural residents through a method of delivery called technology-assisted intervention (TAI). This study polled referral sources, service providers, service facilities, state and professional organizations' rules and regulations, and insurance reimbursement as they pertain to the delivery of mental health services through TAI. The results of this study suggest that there would be a referral base from

the sources polled, interest from the service providers, and a willingness to provide space from service facilities. State laws and professional organizations that mental health professionals belong to did not identify any ethical issues that would be associated with TAI, and reimbursement from insurance companies was also discovered to be accessible. Suggestions and recommendations for further research into the establishment of rural mental health and TAI were also discussed.

(116 pages)

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CHAPTER I

INTRODUCTION

In the United States, mental health concerns are increasing across all ecosystemic levels, influencing the individual, couple, and family. While the increase has received attention in literature and in clinical settings, it appears that most consideration has focused specifically on urban or metropolitan mental health. Granted, there is literature addressing the stressors and strains in rural America (e.g., farm stress; Human & Wasern, 1991; Sawyer, Gale, & Lambert, 2006), as well as the even distribution of mental illness across urban and rural populations (U.S. Department of Health and Human Services, 2005); however, there is no active movement to bring mental health services into these communities so that services are available and accessible (U.S. Department of Health and Human Services). As such, although mental health needs are experienced in about equal amounts among urban and rural residents, services are not equally distributed (Human & Wasern).

To address the issue of there being a lack of mental health services in rural communities, this study examines three general factors that have been identified as barriers to the equitable distribution of mental health services, regardless of where one might reside. The identified factors are those of availability, accessibility, and acceptability. In the context of each of these identifiable barriers, research questions are posed. These research questions drawn from the identified barriers focus specifically on the issue of feasibility, examining feasibility from the perspective of those who would most likely be involved in bringing such services to rural America, namely, referring

physicians and clergy, community members who may participate in the services, therapists who would be needed to offer the services, and managers of locations and facilities where services would need to be housed.

The overarching question guiding this research is: Is it feasible to establish technology-assisted intervention (TAI) in rural communities as a primary mode to deliver interventions to residents who suffer from a variety of individual, couple, and family mental health issues?”

CHAPTER II

LITERATURE REVIEW

The U.S. Office of Management and Budget (OMB) define a rural community as an area or county that lies outside of a defined metropolitan area. A metropolitan area consists of counties that rely on the larger metro area for economic sustenance and growth (25% of the population commutes to a metro center for employment), and if that area has one or more urbanized areas (areas with at least 50,000 permanent residents; U.S. Department of Health and Human Services, 2005). According to the 2000 U.S. Census, 32% of the U.S. population resided in areas that had been defined as rural or non-urbanized areas. In 2000, the U.S. Department of Agriculture, Economic Research Service reported that the rural areas of the U.S. contained just over 80% of the land and about 20% of the population (Stamm et al., 2003). While this percentage of land to people ratio makes rural areas different from urban areas in many ways, of particular relevance to this research, are three barriers relating to the delivery and consumption of mental health services, namely, availability, accessibility, and acceptability (Sawyer et al., 2006). Though discussed separately these are not independent dimensions, rather they are intricately interwoven one with the other.

Availability of Mental Health Services in Rural Communities

Availability is defined as the likelihood that mental health services can be found in a community. Even though the data suggests that there is an equal distribution of mental illness as a whole across urban and rural populations, availability is not equally

distributed. In fact, the number of mental health practitioners and the availability of these practitioners in rural areas are severely inadequate (U.S. Department of Health and Human Services, 2005). In 1990, the census identified 3,075 counties in the United States. Of these identified counties more than half (55%) were without a practicing psychologist, psychiatrist, family therapist or clinically trained social worker (Hauenstein, Petterson, Merwin, Rovnyak, & Heise, 2006). For mental health services to be considered a shortage in any given community, a ratio of 1:30,000 must be exceeded. In the United States, 37% of the population resides in communities where there are less than 30,000 residents. According to this shortage ratio, it is likely that many communities will be without mental health experts and that there may not be a single mental health care provider within a 100 mile radius for nearly 20% of all U.S. counties (Hauenstein et al.).

This information becomes very disturbing when taking into account the fact that though services and service providers are scarcer in rural areas, the prevalence of mental health issues is not. Mental health issues, including substance abuse, vary little in incidence rates between rural and urban populations. In the case of substance abuse, the amount of abuse overall and the amount of the use of the various substances increases in rural areas versus urban areas. Suicide rates among adults and children/adolescents is markedly higher in rural areas versus urban areas (U.S. Department of Health and Human Services, 2005; D. Openshaw, personal communication, April 24, 2009). Finally, taking into account the variances among prevalence rates across age and gender levels and the fact that rural residents generally seek mental health services later than do urban residents

(U.S. Department of Health and Human Services), there becomes an obvious case for the need for more mental health professionals to service the needs of rural citizens.

Kimmel (1992) indicates that one of the major concerns of rural mental health is recruiting and retaining mental health professionals and practitioners. He points out that one significant contributor is that the earning potential is less in rural communities due to lower insurance reimbursement rates. A second factor that contributes to low recruitment of mental health professionals is what the community itself offers. Urban/metropolitan areas offer more resources to the therapist than rural communities, for example, larger communities can provide (a) a variety of services, entertainment possibilities, educational resources, (b) collegiality with other therapists for consultation purposes and coverage when one desires to leave town or just have a night off, and (c) greater heterogeneity and diversity of clientele which in turn challenges therapists to expand their knowledge and remain on the cutting edge (Kessler et al., 1994).

A third contributing factor associated with availability of services is embedded in the ethics of mental health professions, namely, dual relationships. Dual relationships refer to one's multiple associations in a community; for example, it is possible for a therapist and a client to worship at the same church. Dual relationships make it difficult for therapists to function without bias and can become a threat to confidentiality.

Erickson (2001) noted that a professional that is governed by strict ethics may have difficulty in providing services that require in-depth understanding of sensitive personal or family secrets, confronting the client about ineffective rules and meta-rules, and then associating with these clients in a social setting. In a recent research study (Morrow,

2008; D. Openshaw, personal communication, February 26, 2009) clients who had received therapy through TAI indicated that one of the reasons they preferred TAI over face-to-face therapy was the fact that there was a “distance” between them and the therapist; meaning that they did not “run into their therapist in the grocery store.” These clients reported they felt more at ease and were more likely to work collaboratively with the therapist through TAI.

Finally, there has been considerable support for evidence-based practices; however, minimal effort has been expended to help mental health providers in rural communities initiate such practices. This lack of effort is also evident in that the number of training programs addressing rural mental health services is few, and there are no known programs training therapists to provide such services via TAI. In this regard there has been a decline in professional training programs that focus on rural mental health (The President’s New Freedom Commission on Mental Health, 2004).

Accessibility of Mental Health Services in Rural Communities

Even though the data suggests that there is an equal distribution of mental illness as a whole across urban and rural populations, the issue becomes one of accessibility. Different from availability, accessibility refers to whether or not one can access the services. Three factors contribute to accessibility, namely, knowledge, transportation, and financing (The President’s New Freedom Commission on Mental Health, 2004). It is posited that one of the essential elements of accessibility is gathering the knowledge about when someone needs care, and where and what options are available to address those needs (U.S. Department of Health and Human Services, 2005). Mulder and

Lambert (2006) indicated that the perception of need is a critical factor in accessing services. According to the U.S. Department of Health and Human Services report in 2005, those residing in rural communities access mental health services later in time surrounding a mental health need than do those residing in urban communities. This appears to be associated with a perception that if you reside in rural communities your need for services are not as great as it is if you were residing in an urban/metropolitan area. A second factor contributing to access is transportation. Finding accessible and affordable transportation in rural communities is difficult, due to factors such as vehicle maintenance costs and the absence of mass transportation. This becomes a barrier especially for children, the elderly, and those with disabilities. Women may also be disadvantaged if their primary profession is homemaking, and income and travel are not in their control. Finally, the ability to pay for mental health services discriminates between those that have the income and those who do not. Employment-based health insurance may not be available to those who reside in rural areas due to the size of the company they may work for. Comer and Mueller (1995) indicated that, when compared with urban/metropolitan residents, those residing in rural communities go longer without insurance which affects their ability to receive mental health services, or if they cannot afford mental health services they may not seek them out. Further, rural residents may not seek out services due to personal pride as well as few chances to obtain free or reduced-fee clinical care where stigma is minimized (U.S. Department of Health and Human Services).

Acceptability of Mental Health Services

Acceptability refers to the willingness of those in need of mental health services to transcend the attitude and value of self-reliance. Although self-reliance is a positive resource, at its extreme it may interfere with wisdom associated with seeking help. Self-reliance is valuable and in association with resources outside of the self, the client with mental illness can make significant progress towards recovery as they learn to understand and cope effectively with their mental illness.

In addition to attitude and self-reliance, social stigma associated with mental illness, especially in rural communities, is a serious constraint for those desiring services. A common stigma about mental illness is that those in rural communities do not need mental health services. This, and other stigma are found when there has not been the educational efforts made to help communities understand the nature and course of mental illness. Educational efforts can be effectively provided through a variety of media (e.g., newspapers, Internet, community discussion, and TAI based psychoeducation).

The fact that availability, accessibility, and acceptability are common barriers to the delivery of mental health services to rural residents, coupled with the vast opportunity that technology can provide for mental health resources to these communities, as TAI has begun to demonstrate effectiveness (D. Openshaw, personal communication, February 26, 2009), it seems logical that an important question to ask is, "Is it feasible to provide TAI mental health services to rural communities?" This study addresses this issue of feasibility.

Technology-Assisted Intervention (TAI)

The use of technology to provide services in remote areas is not new.

Telemedicine research suggest that services such as distance learning, informatics training, medical consultations, and medical assessments can be effectively delivered via the Internet (Bashshur, 1995; Norris et al., 2002). While telemedicine is not teletherapy, there is some literature with a specific focus in this area. Most notable is telepsychiatry with its emphasis in providing consultation between the patient, their primary care physician, and the psychiatrist. Consultations are most often limited to medication consults and not providing psychotherapy. There is some literature, however, that has begun to emerge demonstrating the possibility, though feasibility remains a question, of reaching out to rural residents to provide them with a direct intervention opportunity.

The marriage and family therapy (MFT) program at the University of Nebraska-Lincoln has implemented teletherapy. The MFT program establishes a teletherapy connection between marriage therapists and clients in a rural part of Nebraska who report mental health concerns. What they found was a general attraction of those who attended therapy to the set-up of the telehealth project. Many of these clients had received treatment from mental health professionals in the past, but had discontinued the treatment due to the constraints that their isolated community placed on them.

One of the constraints reported had to do with the timing of the sessions. Attending a session during the day often required that clients take a full day off from work. This amount of time was necessary to allow the client sufficient time to drive to the appointment, which may be upwards of 3–4 hours, to attend a 50-minute session.

This makes weekly or regular visits almost impossible, if not from a transportation basis, certainly from a financial one. Bischoff and colleagues (2004) also found that attending sessions at discreet locations, such as a school or hospital, removed some of the stigma around receiving mental health services where you enter a clinician's office and all know why you are there—at least in terms of receiving therapy. Clients felt they were less likely to run into someone who knew the nature of their visit to one of these locations than if they were to visit a practicing therapist. In short, all participants in the study said that teletherapy was the most attractive of the options available to them to receive therapy. They also stated that the teletherapy was a much better option than receiving no treatment at all (Bischoff, Hollist, Smith, & Flack, 2004). These results have also been found in work of teletherapy (D. Openshaw, personal communication, February 26, 2009).

Though TAI is making its biggest impact in the world of face-to-face therapy over internet and satellite systems, there are also other outreach methods that have been implemented with success. One in particular was a CD-ROM based treatment for young girls with bulimia-nervosa (Bara-Carril, Williams, Pombo-Carril, Reid, & Murray, 2003). The CD contained eight modules that implemented Cognitive-Behavioral Therapy (CBT) based motivational and educational interventions to help the girls understand some of the consequences that the disorder had, ways to eat healthy, and began using initial treatment strategies such as addressing distorted thought processes. The most significant concern that researchers stated they had with the project was its participation rate. What they did find, however, was that the CD had a lower attrition rate than did in-room treatment with

a therapist. Of the 60 participants, 9.7% refused the CD treatment and participated in conventional therapy instead. These data are contrasted with 20% who generally refuse any form of treatment.

Another concern was that the girls would see the CD as the whole of treatment, rather than one part of an overall treatment package. Again researchers were surprised to find that 69% of the girls who used the CD made an appointment for conventional therapy, as opposed to 53.8% of individuals who made a second appointment after receiving one session of traditional therapy. At a 12-week follow-up, the success rate for bingeing cessation, vomiting, and laxative abuse was 40%, 40%, and 82%, respectively, as compared with 12.8%, 46%, and 68% from traditional treatments (Bara-Carril et al., 2003).

A type of internet based TAI has also been used for art therapy. A program designed by Collie, Cubranic, and Long (2002) consisted of using the Internet to send out audio files and text-only drawings into people's homes via their personal computers (PC). Results suggested that this type of therapy was cost effective and therapeutically effective.

In that there have been some data suggesting the use of teletherapy can be effectively used, at least in some contexts, the question of feasibility remains an important focus. The current research project will examine the feasibility of implementing TAI in rural communities.

Serious Concerns and Their Solutions

One of the most serious problems facing TAI, and specifically internet counseling

and teletherapy, is the question of whether this type of counseling can be done in an ethical manner that will allow the therapist to keep the session information confidential as well as prove to the client that not only the treatment is legitimate, but that the therapist is as well. Jencius and Sager (2001) addressed these problems with their research, finding that there were actually sanctioning bodies of therapists who had seen that teletherapy would one day surface and prepared their own ethical standards. For example, in 1997 the National Board for Certified Counselors (NBCC) provided an ethical code for its members that included a focus on teletherapy. Included at that time were confidentiality suggestions requiring that there be some type of encryption adopted by therapists using these types of media. Today, programs allowing contact with clients in virtually any location in the world can be purchased, many of which provide encryption of data or other forms of security to ensure confidentiality (e.g., Macromedia Breeze). In addition to confidentiality, NBCC made it mandatory for its counselors to verbally produce their credentials, namely the professional organizations that they belonged to, institution(s) where they received their degree(s), and websites, or other contact information, for these institutions.

Since this founding effort by NBCC, other organizations have followed suit with professional “webcounseling” guidelines of their own added to ethical codes, some of which are the American Psychological Association (APA), American Counseling Association (ACA), Association of Mental Health Counselors of America (AMHCA), and International Association for Marriage and Family Counselors (IAMFC). These organizations view teletherapy as imminent, and as a medium that will provide a variety

of mental health services that are not widely available. Aside from the obvious implications that teletherapy could have on treating populations in rural and isolated communities in the United States, it could become a global phenomenon, allowing experts from all around the world to counsel together on cases, see clients, and provide their services to an almost infinite number of people around the globe (Jencius & Sager, 2001).

Other problems foreseen with teletherapy are no different than problems that might arise in traditional therapy. Hardware and system malfunctions are proving to be no more common than problems with electricity, heating and cooling systems, and other utilities found in buildings where therapy takes place. Communication lines that carry voice, data, and video are becoming stronger and providing better and clearer data transfer than ever before. The chances of a miscommunication over the internet is no greater of a threat than is miscommunicating with someone mere feet from the therapist (Pollock, 2006).

In sum, it appears that the time has come for TAI to come of age in the world of mental health. An understanding of feasibility will provide a foundation for further implementation of TAI in rural communities by helping those desirous of implementing such services overcome the key barriers: availability, accessibility, and acceptability. To encourage more focus on rural mental health and recommend how these barriers can best be addressed, this study, which from a review of the literature appears to be the most comprehensive effort to understand feasibility of providing TAI to rural residents, will examine questions relating to availability, accessibility, and acceptability.

Feasibility of Implementing TAI in Rural America

Feasibility is defined as whether or not something can be accomplished given specific conditions and criteria. This definition, though simplistic in nature, is actually quite encompassing. Feasibility studies aim at investigating whether something that has never been done before can be effectively implemented, including the investigation of variables and other factors of a tangible or intangible nature that may inhibit the implementation or continuation of a particular program or therapy. Common variables suggestive of feasibility include economic cost, resources available in the area or community necessary to implement the program, therapy, and so forth; technical or organizational rules that may interfere in the implementation and carrying out of a given agenda, such as laws, ethics, and so forth; and receptivity of parallel, cooperative, or divergent agencies in the community necessary to sustain ongoing productivity of the new program or therapy (Bashshur, 1995; Nelson, Barnard, & Cain, 2006).

Feasibility implies that barriers to implementing and sustaining, in this case, a psychotherapeutic practice have been identified, conceptualized, and resolved. When considering the implementation of mental health services into rural communities, the literature suggest three significant barriers, namely, availability, accessibility, and acceptability (Bischoff et al., 2004; Human & Wasern, 1991; Kimmel, 1992).

Availability of Mental Health Services in Rural Utah Communities

In this study, the issue of availability has to do with recruiting a sufficient number of therapists who are trained in a variety of specialties and are willing to provide therapy

services in an outreach format to rural community residents. Research has suggested that if one relies solely on recruitment designed to have therapists move to rural communities, with or without stipends, it is unlikely that such recruitment will be successful (Kimmel, 1992). This study suggests that two critical factors must be considered if there is to be a shift towards the delivery of mental health services into rural communities; namely, increased specialty training focusing specifically on rural mental health delivery and best practices, and a method of providing services in an efficient and effective manner that allows therapists to remain in, for example, urban practices while extending themselves via teletherapy into rural communities.

Relative to soliciting clinicians practicing in urban settings, the study seeks to ascertain whether clinicians, if trained or could receive training, would be willing to provide their services to residents in rural counties. First it is important to ascertain if such training is available in academic settings, and if so, whether such training provided a way for those residing in urban communities to reach out, without leaving their urban office. A review of programs providing training in rural mental health is available and this study will identify the number of such programs; however, the most essential aspect is whether such programs offer training in an efficient and effective method of providing such services. Current research (D. Openshaw, personal communication, February 26, 2009) suggest that the use of TAI would allow therapists to remain in urban settings, with all of the benefits of their community, and, at the same time provide therapy to residents in rural communities. With this in mind, the more specific question of interest is: “If you were trained in rural mental health and how to deliver such services through TAI, would

you be willing to set aside some portion of your practice for the treatment of clients residing in rural communities?” As to the portion of time they would be willing to dedicate, since this also gets to the issue of availability, a follow-up question asks the clinicians what portion of time they would be willing to dedicate, and if not willing, what the rationale is for their desire not to provide such services.

A final and relevant issue concerning availability has to do with regulatory or licensure laws, both from the individual states and the professional organizations that mental health clinicians belong to. If state licensure or organization participation prohibits the delivery of mental health services via TAI, then regardless of whether clinicians are willing to offer these services, the issue is moot. Only in those states and with those organizations where regulatory boards have authorized such services would it be feasible to implement TAI if the community and referral sources were supportive. The question of interest is, “Which states permit teletherapy under their current licensure laws?” In examining this question, it is possible to understand how licensure laws support or restrict services to this disenfranchised population. How licensure laws promote or prohibit TAI has significant implications, not only for the delivery of services, but social policy as well.

Accessibility to Mental Health Services in Rural Utah Communities

When considering accessibility one must examine those factors that create opportunities for mental health services to be provided. One critical factor is the referral infrastructure that is most primarily composed of physicians and clergy; the front line persons involved with those with individual, couple, and family distress. It makes no

difference if services are available if there is unwillingness by primary service providers and clergy to refer those in need to providers of TAI. Due to the importance of understanding feasibility, as it pertains to referral sources, this study assesses the willingness of physicians and clergy to refer those in distress (individuals, couples, and families) to clinicians who are providing TAI services. It is also important to understand, if physicians and clergy are not willing to refer, what it would take for them to become comfortable with referring. It is understandable that, regardless of what one may do, there will be some who, for some reason or another, will not utilize these services for their patients or parishioners.

Referrals are critical, but are only as good as there is a location that offers a safe holding environment for those seeking services to receive their therapy. This location, in addition to providing an adequate degree of confidentiality must be accessible with minimal interference with daily activities and without significant cost. Previous research (D. Openshaw, personal communication, February 26, 2009) has demonstrated that one such location is the University Extension. Here, offices have been dedicated for the providing of therapy to those in the community or neighboring communities. Those receiving services come to the designated location, enter the office, receive services, and leave without undue recognition. For the most part clients have indicated that they cannot be recognized from students attending classes, thus increasing confidentiality and anonymity. Extension offices are located in all communities and it is possible that mental health services could be extended to county extension offices where space and equipment may be made available. Another potential location is hospitals in rural communities. It is

believed, based on current work (D. Openshaw, personal communication, February 26, 2009) that locations are available if one is willing to work cooperatively with those managing the facilities. Thus, feasibility will address whether there are locations in rural communities that are accessible to the general population; if so, can they offer a relative degree of confidentiality, and would administrators be willing to make space and equipment available to residents in their communities who want to receive mental health services at these locations. The overarching questions that emerge when considering location of services is, “Are there facilities available that offer confidentiality and the necessary equipment that administrators would be willing to make available to rural residents so that they can receive mental health services via TAI?”

The last accessibility factor deserving feasibility consideration pertains to cost. If costs for mental health services prove prohibitive, then even if services were available, those in need of mental health intervention would not be able to be recipients. Many of those residing in rural communities, like those in urban settings, have health insurance which provides payment for psychotherapeutic treatment, though some may limit the extent of their payments by diagnosis. Regardless of mental health limitations placed on those who have health insurance, what is unknown is whether health insurance carriers will reimburse therapists who provide mental health therapy through TAI, allowing clients to seek such services and pay only the co-pay required. In this regard, the question of concern is: Are insurance carriers willing to reimburse therapists for services to those residing in rural counties if rendered through TAI?

Acceptability and Rural Mental Health Treatment

Acceptability is a barrier that must be addressed if treatment offerings are going to be successful. It does not matter if mental health services are available and accessible if there are, for example, myths prohibiting those in need from reaching out (e.g., “Those residing in rural America do not experience sufficient stress so as to need mental health services” or “Our pristine family systems and community support should be sufficient to help those in need, regardless of what it is that ails them”). While there are those who understand that mental illness is biopsychosocial in nature, this may not be the case for those residing in rural communities where such services have not been readily accepted. Acceptability has to do with myths and stigmas associated with receiving therapy, or more specifically help outside of the close knit infrastructure of the rural community. Non-acceptance is not new, and historically one can trace the implementation and acceptance of mental health services on the East coast and its gradual movement, in terms of acceptability, across the nation; however, this trend has been most specific to urban or metropolitan areas (Kimmel, 1992; Samuels & Owen, 1998). Today in popular culture, it can be observed that therapy is almost a “status symbol” in some urban areas. However, in many rural communities the perceptions are of self-reliance with a fear of outsiders being “meddlers” in their business (Sawyer et al., 2006). When examining the issue of acceptability several factors are of relevance. One such factor associated with “reaching out for services” has to do with recognizing that one is in need of such services. While this specific factor is beyond the scope of this study, it is suggested that as services are made available and accessible, and those participating in them are satisfied, there will be

greater acceptability and understanding about mental illness. Also relating to this important factor is the need for a concerted educational effort to dispel stigma and myths associated with mental health services both for residents and referral sources, who sometimes directly or indirectly promote such stigma and myths.

It is the intent of this study to gain some understanding about how “accepting” are those residing in rural communities to seek such services if they were available and accessible. Questions in this study will assess what myths and stigma currently exist, what could be done to reduce these myths and stigma, and would residents be willing to involve themselves in TAI therapy.

Reaching Out via TAI: Making It Work

It is not that there has been no effort to reach out to those in rural counties of the United States; rather there is no consistent or effective method currently in place to provide mental health treatment, nor have best practices for rural America been established. While this may be true, there is modest extant research and some current research seeking to bridge the barriers of availability, accessibility, and acceptability. A project in the rural Australian bush is one of the many worldwide success stories that have been replicated in the United States. The idea of beginning a program in which the local health care center or hospital is used as a base and a cycle of professionals are rotated in to help treat clients in outlying areas has proven to be successful for a number of reasons. One of which is that it uses a center and staff that are already established and well known among the community. This helps to alleviate some of the “outsider” stigmata that are hard to overcome (Samuels & Owen, 1998).

In conclusion, this study seeks to gather information about the feasibility of setting up a TAI to supply mental health treatment to individuals suffering from mental health related issues and who reside in a rural community. Feasibility will be determined by ascertaining the variables in the areas of availability, accessibility, and acceptability, by answering the following questions: (1) If clinicians were trained in rural mental health and how to deliver such services through TAI, the practice of TAI was not prohibited by state or organizational factors, and a referral base was identified inside the community, would the clinicians be willing to set aside some portion of their practice for the treatment of clients residing in rural communities?, (2) Are insurance carriers willing to reimburse therapists for services to those residing in rural communities if rendered through TAI?, and (3) If mental health services were available and accessible to residents of rural communities through facilities already in place in the community, would they accept and make use of these services?

CHAPTER III

METHODS

Sample

This study focuses on investigating the feasibility of implementing TAI to residents of rural communities who are experiencing mental health related distress, individually, in a couple or relationship setting, or a family context. The sample is organized according to referral sources (i.e., physicians, clergy, community members) providers of services (mental health clinicians), service facilities (i.e., facility administrators), and other factors that support or inhibit the providing of TAI services (e.g., insurance providers, state licensing laws, and professional organizations).

Referral Sources

Three primary referral sources, physicians, clergy, and community members, were selected as part of this feasibility study (see Table 1). Three rural communities selected from which referral sources were invited to participate, namely, Vernal, Roosevelt, and Price, Utah. These locations were selected for two reasons: first, they are remote, rural locations with an adequate pool of physicians, clergy, and community members from which to draw a sample, and second, in two of the locations there are facilities established where TAI has been provided and the other where it may be possible to set up TAI in the near future, either at a USU extension site or UTN facility. The referral sources polled were all residents or housed their practice or place of business within one of these three communities.

A convenience sample of 10 practicing family, general, and gynecological physicians were selected by the researcher from a pool of approximately 21 such physicians residing in three rural communities, Vernal, Roosevelt, and Price, Utah. The responding physicians were asked to list their medical specialties. There were six respondents who stated that their specialty was as a family physician, two were gynecological physicians, and two general physicians. The average age of the physicians responding was 49.1, with 4 of 10 reporting that they were trained as rural physicians (see Table 1).

Forty-five clergy were selected and invited to participate in the study from these three rural counties. Thirty-two responded to the invitation that consisted of 26 LDS (Church of Jesus Christ of Latter-day Saints) clergy (81%) and 6 from other religions (19%), including two from the Baptist church (6%), one from the Catholic Church (3%), one from the Greek Orthodox Church (3%), and two non-denominational Christian (6%). Clergy were asked to respond to demographic questions asking about age and religious denomination. The average age of the combined respondents was 50.8 years (see Table

Table 1

Summary of Physician Response

	<i>N</i>	Age range	Mean age
Family physicians	6	35-60	45.5
General physicians	2	52-62	57
Gynecologists	2	47-57	52
Total	10	35-62	49.1

2).

The third referral source was drawn from the communities where 79 community members residing in these three rural communities were selected to participate. Fifty-seven individuals from the communities responded to the survey. Table 3 depicts the demographic data describing the community members who selected to participate in the study (see Table 3). Of the 57 participants there were 25 females (44%) and 32 males (56%). Seventy percent of the sample reported that they were married, 5% divorced, 9% widowed, and 16% single.

Providers of Services

Feasibility necessitates that if there is a referral base, that there be clinicians available and accessible to provide the services. The sample demographics of the 51 clinicians included in this study is illustrated in Table 4. Twenty-eight of the respondents reported a Master of Family Therapy (55%), 15 reported a Ph.D. in either family therapy or psychology (29%), and 8 reported a Master of Social Work (16%). These clinicians were found from the AAMFT, APA, and NASW national listserves in order to broaden the possible pool of respondents, though location information for residence, education, or practice location was not gathered.

Service Facilities

There were 23 facility administrators of university extension and telehealth network participating facilities located in rural Utah counties, with 17 responding. Participating facilities were selected from throughout the state of Utah. Administrators from two Utah based facilities (Utah State University Extension and Utah Telehealth

Table 2

Summary of Clergy Response

<u>Denomination</u>	<u>N</u>	<u>Percent of Sample</u>	<u>Age Range</u>	<u>Mean Age</u>
LDS	26	81	35-75	50.4
Baptist	2	6	52-65	58.5
Catholic	1	3	52	52
Greek Orthodox	1	3	57	57
Non-Denomina- tional Christian	2	6	35-53	44
<u>Total</u>	<u>32</u>	<u>100</u>	<u>35-75</u>	<u>50.8</u>

Table 3

Summary of Community Response

<u>Community</u>	<u>Female</u>	<u>Male</u>	<u>Mean age</u>	<u>Age range</u>	<u>Total</u>
Gender	25	32	48.9	22-82	57
Married	16	24	48	22-82	40
Divorced	2	1	48.8	41-55	3
Widowed	2	3	68.9	68-75	5
<u>Single</u>	<u>5</u>	<u>4</u>	<u>47.2</u>	<u>22-77</u>	<u>9</u>

Table 4

Summary of Clinician Response

<u>Clinicians response</u>	<u>N</u>	<u>%</u>	<u>Mean age</u>	<u>Age range</u>
MFT	28	55	36.4	25-59
MSW	8	16	37.2	33-49
PhD	15	29	45.9	39-60
Total	51	100	39.2	25-60

Network sites) were asked to respond to their willingness to provide space and equipment for TAI mental health services. The three selected communities also contained these polled facilities.

Factors That Support or Inhibit the Providing of TAI Services

With an understanding of referral sources and clinicians willing to provide services, it is important to examine other factors that may enhance or inhibit the feasibility of providing TAI. Three factors of sufficient import to feasibility were included in this study; namely, state licensure laws and regulations, code of ethics associated with clinical behavior and positions of national organizations (e.g., APA, AAMFT, NASW, and AMHCA), and reimbursement from health insurance companies.

Five insurance companies were included in this study, namely SelectHealth, Aetna, Educators Mutual, Public Employees Health Plan (PEHP), and Blue Cross and Blue Shield. SelectHealth, Educators Mutual, and PEHP were chosen based on the fact that this study uses Utah communities as its sampling pool. These three companies

insure more than 500,000 residents of the state, making them some of the largest health care insurance providers in the state. Aetna and Regence Blue Cross/Blue Shield were selected because they not only insure Utahans, but are prominent throughout the United States.

State laws and regulations of all 50 states were examined in this study. The purpose was to identify the presence of legal restrictions that may prohibit the practice of TAI in a particular state. The regulations were also examined to identify if there were possible licensing procedures that were different from regular licensing procedures that clinicians would need to go through in order to practice teletherapy. Only state laws were examined as states are the primary legal bodies that govern the practice of mental health therapy in the United States.

An examination of code of ethics for four national associations (APA, AAMFT, NASW, and AMCHA) was conducted to determine if the professional organizations that accredit graduate school programs across the nation, and to which many professional mental health providers belong, have addressed the topic of teletherapy and created any ethical guidelines that their members should adhere to. These organizations were also examined to determine if they have a stance, either for the practice of teletherapy by their members, or if they are against the practice.

Procedures

This section specifies the procedures used to collect the data from the various potential referral sources, service providers, facilities, and other factors that may contribute to feasibility. In order to facilitate a sufficient number of referrals to interest

clinicians in providing TAI, this study examined the willingness of three populations that are critical to providing referrals for mental health services, namely, physicians, clergy, and the general population.

Collecting Referral Source Data

Physicians as a referral source. The Physician Feasibility Survey (PFS) was delivered to the individual offices of the various selected physicians by the researcher. The researcher spoke with the receptionist or someone greeting people in the waiting room and asked them to deliver the envelope that contained the PFS to the physicians. Instructions and explanations were also given to the individual, including a time that the researcher would return to collect the survey.

Clergy as a referral source. The Clergy Feasibility Survey (CIFS) was hand delivered to the Greek Orthodox, Catholic, Baptist, and Non-Denominational Christian clergy during their prescribed office hours. The researcher met personally with the clergy and offered explanation and information requested. Each of these individuals then filled out the questionnaire and returned it, sealed in a provided envelope, to the researcher who returned the same day to collect the information.

The CIFS was delivered to the LDS clergy through mailing the information to, as well as face-to-face meetings with the selected bishops that were chosen randomly from the LDS congregations in the area. Those that resided in Roosevelt and Vernal were given pre-stamped return envelopes addressed to the researcher. The CIFS was delivered to those who resided in Price by a community volunteer. The volunteer returned one week after delivery and retrieved the sealed envelopes in which the completed surveys

were placed. The congregations were selected randomly from the existing congregations listed in the local phonebooks and the LDS Church's website.

Community as a referral source. The Community Feasibility Survey (CmFS) was delivered to the community via four individual community volunteers. These individuals delivered the surveys to the community on a Saturday morning and then returned to collect them the same evening. The community members were selected based on a convenience sample, with city streets randomly selected from the city map provided in the local phonebook and contact attempted at every house on the chosen streets. The volunteers continued this process throughout the same day until the sample size had been met. This provided a sample that contained male and female respondents across a wide array of ages. To protect confidentiality, each survey was distributed with an envelope in which the completed document was sealed by the respondents and then returned to the volunteers. The primary researchers provided the volunteers with an envelope where the sealed, completed surveys were kept until they were picked up by the researcher at the end of the polling day. Each volunteer also participated in a presentation dealing with confidentiality in research and signed a confidentiality agreement.

Clinical Service Providers

The Clinician Feasibility Survey (CFS) was distributed by e-mail to clinicians found on the AAMFT, APA, and NASW listserves. Clinicians first read the Letter of Informed Consent and if willing to participate, filled out the CFS. Survey data were downloaded, coded, and analyzed. All identifying information was destroyed to protect confidentiality.

One reminder was sent out three weeks after the initial mailing to insure all who were willing to participate had the opportunity to do so. However, a re-sampling of the listserv (25 more clinicians) was conducted one week after the reminder e-mail, and four weeks after the initial e-mail, due to an insufficient sample size. This re-sampling provided enough respondents (51) to reach the desired sample size of 50.

Service Facilities

Data for the AWFS was gathered by mailing the survey to the directors of university extension sites and those facilities who are a part of the Utah Telehealth Network of the Utah Educational Network. A pre-addressed, stamped envelope was included for the return of the survey to the primary researcher. All sites located in rural Utah counties were polled. Surveys sent to these administrators were coded for tracking and confidentiality purposes.

Factors Supporting or Inhibiting the Providing of TAI Services

Availability of insurance benefits. A total of five insurance carriers were selected based on their availability and prominence in the state of Utah. Two of these carriers were selected based on national prominence and accessibility. The researcher called the selected companies and spoke with carrier representatives. These representatives were asked the prepared questions from the ICFS. Additional e-mails were also sent to the Utah and U.S. Health and Human Services departments to gain further explanation about information gained from the insurance companies. All information obtained was considered public information.

Licensure information. Data for the questions asked about licensure laws were obtained primarily through browsing of individual state law found on individual state websites and querying e-mails sent to individuals designated as state contacts for questions regarding the interpreting of state law.

Professional ethics information. Data for the questions asked about professional ethics were gathered by browsing the websites of the APA, AAMFT, AMHCA, and NASW as well as responses to e-mails sent to each respective ethics board using information gathered from each website and published information such as ethical codes and their updates.

Measures

The measures in this study seek content-based information from respondents. Below is a description of the instruments that were used to gather the data. Copies of each instrument are available in the appendix.

Referral Sources

Physician Feasibility Survey (PFS). The PFS, consisting of seven items, assessed participants training as a rural physician and training in the use of telehealth and telemedicine techniques. The PFS also assessed whether physicians were presently making referrals to mental health providers and whether they would make referrals to TAI providers. The physicians were also asked to explain why or why not these referrals would be made or why they would not be made. If physicians were unwilling to provide such services, their rationale was assessed and the survey asked what it was that prevented them from making referrals to a TAI mental health provider. The PFS items

were content and quantitatively based, and contained open-ended items. Examples of these open-ended questions include describing the extent of the physicians training in rural medicine as well as asking the physicians to explain reasons why they would or would not be interested in providing referrals to rural mental health services through TAI. Demographic information such as age and practicing specialty was also gathered from the physicians.

Clergy Feasibility Survey (CIFS). The CIFS, comprised of four items, assessed the willingness of clergy and religious leaders in the community to refer their congregation members to TAI services for help with mental health issues. It assessed whether or not general referrals to mental health providers were currently being made, and if not, what would be needed to gain a referral from these leaders, both to mental health professionals already established in the community as well as to possible clinicians practicing through TAI. Some possible reasons for not referring were presented in list form that included statements such as needing more information about the credentials of the clinicians or more information about the process of TAI. Willingness of clergy to refer to TAI was assessed. Demographic information such as age and religion was also gathered from the clergy.

Community Feasibility Survey (CmFS). The CmFS assessed the perception of the community members about the present state of mental health services in their community. Four questions asked community members about the availability and accessibility of mental health services. The questions asked that if there were mental health services available through TAI, would they use them. If they replied they would

not use them, an open-ended question asked them to state reasons that would prevent them from using this service. Community members were also asked to provide their age, sex, marital status, and income.

Providers of Clinical Services

The Clinician Feasibility Survey (CFS) assessed clinical specialties and training in rural mental health. If not trained in rural mental health, clinicians were asked about the willingness to be trained and practice in this specialty. If they were unwilling to provide such services their rationale was assessed and the survey asked what it was that prevented them from wanting to be a rural mental health provider. On the other hand, if they were willing, what their specific needs were and what proportion of their business they would be willing to dedicate to the practice of rural mental health. There were five items that gathered this information. The questions were content based and contained open ended items, such as describing the extent of clinical training as well as explaining reasons why they would or would not be interested in providing rural mental health services through TAI.

Service Facilities

The Administrator Willingness and Feasibility Survey (AWFS) assessed the willingness of administrators in the identified facilities to open up their facilities to house TAI services. Through two questions, information was gathered about the amount of time that these facilities would be willing to dedicate to TAI services. The amount of compensation that the facilities would require was also asked. Finally, if the facility was not willing to open itself up, the facility was asked what would need to be done to make

them more willing to participate in TAI.

*Factors That Support or Inhibit
the Providing of TAI Services*

Insurance Carriers Feasibility Survey (ICFS). The ICFS assessed whether the identified insurance carriers would be willing to reimburse clinicians for the time spent practicing therapy using TAI. Through eight questions, information was gained about the present policy coverage, information about any discussion of reimbursing TAI therapists in the company, and, if no discussion has taken place, what would need to take place in order for discussion of the topic and possible policy change to take place.

Licensure Laws Feasibility Survey (LLFS). The LLFS assessed whether it was legal to practice teletherapy in each individual state. Through two questions, information was gathered about the legality of teletherapy, where in the state law it was spoken about, and the last update of that particular section of the law.

Professional Ethics Feasibility Survey (PEFS). The PEFS assessed whether there were any ethical codes of the professional associations of therapists that prohibited its members from practicing teletherapy. Through five questions, information was gathered about the presence of specific teletherapy guidelines, and, if there were no guidelines, what would need to be done in conjunction with ethics and other organizational bodies to begin creating guidelines (i.e., submission of research, petitions from organization members).

CHAPTER IV

RESULTS

Responses from Essential Groups

Results were based on responses from specific identified groups essential to understanding the feasibility of implementing technology-assisted intervention (TAI) in rural Utah communities. Results were organized according to potential referral sources, providers of services, service facilities, and factors that support or inhibit the providing of TAI services.

Referral Sources

Feasibility necessitated that primary referral sources be identified and encouraged to support the commencement of a new medium through which therapy is delivered, TAI, in their communities. Primary referral sources included physicians who were most likely to recognize the mental health needs of their patients; clergy who were not specifically trained in providing mental health services and thus rely on outside providers; and community members, which may have included previous clients, who recognized the need for a service such as this for themselves, family or friends.

Physician willingness to refer patients with mental health issues, couples distress, or family problems to TAI. Physicians were a vital source of referrals in that they were usually the first line of intervention for patients with mental health problems, couple distress, or family dissatisfaction. Because of the demands placed on them for medical assistance, they tend not to be in a position to provide mental health services. In addition,

Table 5

Summary of Physician Response

Physicians response	Willing to refer to TAI?	Trained as a rural physician?	Trained in telemedicine?	Average age of physicians
Interested in TAI	8	4	1	46.5
Not interested in TAI	2	6	9	59.5
Total	10	10	10	49.1

physicians, excluding psychiatrists, are not trained psychotherapists and as such would not be qualified to provide the therapy even if they did have the time. Table 5 depicts information provided by the physicians regarding their age, training in rural health, training in telemedicine, and their willingness to refer patients to TAI. Four of ten physicians reported that they were trained in rural healthcare but only one had experience with telemedicine. The trained physician in telemedicine indicated that s/he was, is, or will use email, instant messaging, and/or webcam to provide telemedicine services. Eight of ten indicated that they would be willing to refer patients for TAI, with the two who indicated they would not do so being, on average, older than those who reported willingness to use TAI.

Is it possible that older physicians saw no value in TAI because they felt that they could handle mental health, couple crises, or family distress effectively by themselves? Or does this perhaps reflect the stigma of some rural communities that may believe that these types of issues must remain “in house”? While more research will be needed to address age as a possible barrier for making referrals, it is important to point out that in

general, the use of teletherapy would be supported if such were available.

Although eight of ten indicated that they would be willing to make TAI referrals, none of the physicians queried reported that they had done so. When asked as to why they were not making TAI referrals, all of the physicians reported that they were unaware of such services. Even if there were TAI services available, two of ten stated that they did not know how to go about making such a referral. This does not reflect that the other eight physicians knew how to make a referral, but rather they did not respond to this question. Based on the literature, this response was anticipated (Sawyer et al., 2006; Stamm et al., 2003). Of the two physicians responding in the negative, one stated that s/he would not be willing to refer to TAI because the people in the community did not want these services. This is a surprising answer since the use of teletherapy is so new that it is most likely that this physician was responding from rural myth and lack of knowledge of the potential effectiveness of such services (D. Openshaw, personal communication, February 26, 2009).

Clergy members willingness to refer parishioners with mental health issues, couples distress, or family problems to TAI. Clergy are often sought out by parishioners for difficulties they are experiencing personally, as a couple or family. As such, clergy offer an early source of counsel and help to those in need. Unlike physicians, many seminary trained clergy are trained in some capacity to handle problems associated with general mental health problems, as well as marriage and/or family dissatisfaction, and also have time set aside to specifically deal with these problems. Lay clergy, like those found in the LDS religion, generally do not receive formal clinical training, but rely on

manuals provided by the First Presidency of the LDS church as well as formal and informal seminar type training, or resources offered through the LDS Social Services program. Regardless of the training received by clergy to address mental health issues, especially the training for lay clergy, it simply did not match the mental health services training received by individuals receiving an advanced degree in mental health therapy.

Presented in Table 6 are data acquired from the various clergy responding to the request to participate in the study. As noted, the majority of clergy responding ($N = 26$, 62.5%) represented the predominant religious orientation of the area. Data in Table 6 reflect sample size, mean age, age range, and willingness to make TAI referrals. Of the 26 LDS clergy, 20 (77%) responded that they would refer their parishioners to a therapist practicing TAI. The six LDS clergy that said they would not refer to TAI stated that they referred to LDS Family Services and have been happy with the results of that agency. However, the access to the services provided by the agency was difficult and somewhat

Table 6

Summary of Clergy Response

<u>Denomination</u>	<u>N</u>	<u>Mean age</u>	<u>Age range</u>	<u>Willing to refer to TAI?</u>
LDS	26	50.4	35-75	20
Baptist	2	51.2	52-65	0
Catholic	1	52	52	0
Greek Orthodox	1	57	57	0
Non-Denomina- tional Christian	2	44	35-53	0
<u>Total</u>	<u>32</u>	<u>50.8</u>	<u>35-75</u>	<u>20 (62.5%)</u>

inconsistent, with some communities being served by satellite agencies that are smaller branches of already small and understaffed offices. Information regarding the number of referrals that these clergymen provided for any agency was not gathered and would be useful information to gather for replication or expansion of this study. It is important to note that the majority of these clergy reported that they knew how to make referrals to mental health facilities.

Of the six respondents from the Baptist, Catholic, Non-denominational Christian, and Greek Orthodox churches, none were in favor of referring to TAI. All six stated that they held degrees from seminaries that allowed them to practice counseling and felt that was sufficient for their congregations and all that their parishioners wanted. It should also be noted that the counseling degrees that were held were from theological seminaries and were not specialized in mental health counseling or therapy. What would be important to know, that was not asked, was if these clergy held licenses to practice in the providing of mental health services. As was the case with some physician responses, it was surprising that these clergy would list that their parishioners did not want TAI, due to the fact that TAI is so new and is not presently offered.

There was not a great difference among the average age of the clergy respondents who were willing to refer to TAI versus those who were not willing. The average age of the combined respondents was 50.8 years, the average age for those willing to refer to TAI was 50.6, and the average age for those not willing to refer to TAI was 51.2. Overall, 62.5% of all clergy respondents stated that they would refer people to TAI which would be enough to begin a referral base for TAI, though it appears the base would be

homogeneous, at least in terms of religion (see Table 6).

Community members and their perception of mental health services in their community. As has been discussed above, primary referral sources were extremely important to assessing the feasibility of establishing a TAI in a rural community as well as making it feasible to implement a new method of therapy. Physicians and clergy have been identified as important and primary referral sources located in the community, but the community members themselves remain the ultimate source of referrals as the decision to seek mental health services largely rests with the individual in need of them. In this case, it would be the community members themselves. If community members did not feel that there was a need for further mental health services in their communities, or were not aware that such services even existed, then they would most likely not frequent or make use of TAI as a mental health resource.

The sample of respondents were asked if they felt that the mental health resources that were currently in place in their individual communities were sufficient to handle the mental health needs of the community. Fifty-four percent of the sample stated that they felt that the resources for mental health services in their community were sufficient to meet the community's needs. However, when asked if they felt that these resources were accessible to the community, an important step in deciphering feasibility, less than half (49%) felt that these services were accessible to the community (see Table 7).

When asked if they would be willing to refer themselves or someone they know to TAI for their mental health needs, 77% of the community sample stated that they would refer themselves or someone they knew to TAI. The community was also asked to

Table 7

Summary of Community Response

<u>Community</u>	<u>Female</u>	<u>Male</u>	<u>Total (%)</u>
Satisfied with community			
mental health resources	11	20	31 (54)
Mental health			
resources are accessible	9	19	28 (49)
Willing to			
refer to TAI?	23	21	44 (77)

explain why they would not refer themselves or an acquaintance to TAI. Common responses for not referring to TAI were: that the respondents sought help from religious leaders, they did not believe that the technology would work, and they could provide self-care of mental health problems.

The respondents were also asked what could be done to help them feel more comfortable with making a referral to TAI. Common responses that were selected from a prepared list on the questionnaire were: meeting with the clinician; possibly using the technology; making sure the clinician would listen to why they were there; and being able to view the credentials of the therapist they would be working with.

Service Providers

Finally, if all of the above factors were in favor of promoting the establishment of TAI, they would be negated if there were no mental health clinicians willing to offer their services to these communities and use the technology. To assess this, a sample of

Table 8

Summary of Clinician Response

Clinician responses

<i>(N = 51 Age = 39.2)</i>	<i>N</i>	<i>%</i>
Rural trained?	12	23.5
Teletherapy trained?	3	5.9
Practice with rural clients?	15	29
<u>Interested in TAI?</u>	20	39

clinicians (see Table 8) consisting of 51 clinicians from across the country and in varying therapy fields (psychology, family therapy, clinical social work) with varying degrees (Ph.D., MFT, MSW) was gathered.

The sample was asked whether or not they had been specifically trained to deal with the stigmas and special circumstances that pertain to rural mental health practices, either in their university training as students, or post graduation through various workshops or continuing education workshops. Twelve reported that they had been trained as rural clinicians (23.5%), but did not delineate where this training occurred (university or post graduation training). Fifteen (29%) of the clinicians were practicing with clients who either traveled to urban areas from rural communities for mental health services, or the clinicians resided in the rural area and were practicing in the community. When asked if their rural training extended into information about teletherapy, only three (5.9%) reported that they had been trained in teletherapy. As a whole, when the sample was asked if they would be interested in learning about TAI or would be willing to

dedicate a percentage of their practice to the use of TAI, only 20 (39%) reported that they would be interested in receiving training in and/or providing teletherapy to rural communities.

Service Facilities

If there were primary referral sources available that had a desire to make referrals to TAI and there were service providers ready to dedicate some of their professional time to the practice of TAI, without accessibility, or in other words, someplace for those desiring services to go to receive them, TAI would not be a viable alternative. It was determined that several possible clinical locations would be identified and useable if there were willingness on the part of the administrators to provide such for the community.

This study examined two of the most logical locations for setting up TAI because of accessibility in the broad sense, meaning not only a building and space, but the specific technology necessary along with adequate privacy and confidentiality, as well as convenience of location. These selected locations were sites associated with the Utah Telehealth Network (UTN) and university satellites or extensions associated with Utah State University (USU).

Administrative support for TAI services at their individual sites. An examination of the data suggested 16 of the 17 locations would allow their sites to be open to the community for clinical services offered through TAI. The only site that responded in the negative was the UTN site serving the Navajo nation. The respondent indicated that the reasoning had to do with the fact that such services would first need to be approved by the Tribal Council. Providing services to Native Americans residing on tribal

reservations, regardless of their location in America, must first be approved by governing councils, so this response was an expected finding.

Of the sites willing and able to provide space in their building for TAI, all indicated that they could make such space available some time during the hours of 9 AM and 5 PM or as late as 10 PM to accommodate those needing later hours. More specific was the number of hours the facilities would be available, regardless of the range of hours the facility could or would be open. Five of the administrators for the various facilities stated that they would offer from 1 to 5 hours of facility time per week dedicated to teletherapy, seven reported that they could offer 6 to 15 hours a week, and four indicated that they would allow as much time as was needed.

Relative to feasibility and facilities, to make such services available necessitated not only an agreement for physical space, but also for the monetary reimbursement such facilities would expect for providing a location to provide TAI. What was most extraordinary was that none of the administrators indicated that there would need to be any type of reimbursement for the use of the facilities or equipment. This would be most advantageous to availability and accessibility of services since cost is always a driving factor. For example, if therapy costs needed to be increased to cover the services of these facilities, there would be an impact on accessibility. This would be particularly impactful if the individuals, couples, or families were without insurance. In similar regard, if such increased costs were required they would also effect the reimbursement to clinicians for their time and availability, which would also affect accessibility. It would also need to be understood if these sites would require reimbursement from individuals who were not

affiliated with USU or UTN.

*Factors That Support or Inhibit
the Providing of TAI Services*

If referral sources and locations for offering teletherapy are available to rural communities, there still remain mitigating factors of consideration for such services to be feasible. These factors would need to be investigated and resolved in order to make TAI implementation as effective as possible. The mitigating factors examined in this study include factors associated with state laws, national clinical organizations, and insurance companies.

State laws would need to support this new form of technology in the delivery of mental health services in order to make sure that there were no licensing restrictions or other legal matters that would slow the progress of TAI. National clinical organizations would need to be willing to support their membership through training and development of ethical guidelines and standards of care specific to rural clientele and the use of TAI. Finally, insurance companies would need to offer reimbursement at a rate comparable to the rate for in-office therapy in order to attract therapists to participate, make it accessible for community members who wished to use insurance as payment, and add another level of quality monitoring and control of the services.

State licensing laws and the practice of teletherapy. The examination of the licensing laws of all 50 states for those providing psychotherapy did not directly suggest any restrictions in the practice of teletherapy via TAI. As is the case with all licensing laws and statutes, regardless of discipline, the only formal restriction would be the practice of therapy across state lines without having the necessary license to practice in

that state.

In a movement to address the issue of teletherapy, such as TAI, the state of Arkansas, which until 2001 prohibited teletherapy, now requires an additional endorsement on a license to practice teletherapy. Application for such certification can be obtained from the office of professional licensure in the state and requires an advanced degree in a therapy field (MFT, MSW, Ph.D.). There was no other state found to require anything other than regular licensing procedures.

Insurance reimbursement: A critical dimension to availability and accessibility.

The polling of the five insurance agencies revealed that at this time there would be no reimbursement for therapists wishing to practice TAI on their own. The five companies polled offered mental health coverage for their clients, but stated for them to recognize TAI as a reimbursable form of therapy there would need to be a practice code attached to it, which would be used for billing purposes. This code would need to be supplied by the U.S. Health and Human Services department and Medicare. However, contact with the U.S. Health and Human Services department resulted in a chain of responses that simply stated that when insurance companies requested a code for the practice they would then create one. Follow up with the insurance companies uncovered the response that they would request the code once services were established, empirically backed, and requested by their clients.

A code of Ethics, training, and standard of care: The role of national organizations. The polling of the APA, AAMFT, NASW, and AMHCA found that there were no limitations in their present codes of ethics and conduct for teletherapy. It was

found that all of these organizations have previously addressed the topic of teletherapy (Haug, 1995; O'Malley, 1995) and commissioned studies on its ethical considerations. These documents of warning are available to the respective members of each organization, but are not policy.

CHAPTER V

DISCUSSION

Making therapy available and accessible to rural residents necessitates an understanding as to how feasible it would be to implement a new mode of therapy into a community where acceptability may be much less than that expected in urban communities. There is often a false assumption that those in rural communities are not in need of mental health services; however, data suggests that even if there were a lesser need for such services when such a need is warranted the services are not available or accessible. The truth of the matter is, the need for mental health services, regardless of whether the client is an individual, couple, or family, is as great in rural communities as it is among urban residents. This discussion will address referral sources, possible locations for services to be rendered, involvement of clinicians in offering rural mental health services, and other factors that may promote availability and accessibility.

Referral Sources to Maximize TAI in Rural Communities

Making referrals to clinicians practicing rural mental health via TAI is essential to the viability of TAI. While there are a variety of referral sources, this study examined three of the most salient, namely; physicians, clergy and the general population.

Physicians as a Critical Dimension of Referral

Even though the sample was small, 8 of 10 clinicians reported willingness to refer patients to TAI if they had a better understanding of TAI, were trained in the referral

process, and could be assured of the credentials of those practicing therapy via TAI. This in mind, the first focus would be training physicians on what TAI is, how to make referrals effectively and with efficiency, and then provide them with means whereby they could ascertain the credibility of the credentials of the mental health service providers. Training would include a demonstration of the technology associated with TAI as well as a detailed description of the therapeutic process that clients would encounter. Use of a UTN or University extension site would provide a forum for the physicians to see exactly how the technology works and what the therapy experience could be like. Information about the differences between face-to-face teletherapy and face-to-face office therapy would be discussed in perhaps a lecture or PowerPoint presentation using TAI as the medium of communication with the physicians so that they could see the variety of possible technological resources. The hands-on use of the technology would be an important, if not a necessary point to put to rest any concerns about TAI that physicians may have. Seeing that the technology is user friendly as well as secure could squash possible fears and anxieties and increase the number of referrals both in number and in quality. At the conclusion of the training, using TAI, a question and answer period with the director of the TAI site and therapists knowledgeable about TAI would be offered.

How to access the clinician's credentials, such as degrees, licensure, and certifications would be important information for the referring physicians. Procedures used may include, though not necessarily have to be limited to the clinicians faxing a copy of their license to the referring physician along with a copy of transcripts showing training, national associations belonged to, and certifications from advance training

opportunities that would suggest credibility and competence in therapy and the providing of such therapy via TAI. In addition, it would be helpful for the clinician to provide the physician with the names of insurance companies that they work with since not all patients would be covered under the same insurance plan. For most physicians, it would seem logical that acquiring this information would be an essential factor in their decision-making process. Finally, physicians would also need to have accessible to them locations where patients would be able to go to receive therapy in as confidential and private manner as possible. In that their patients may not have access to this information; the physician's office manager could put together a listing of credible TAI therapists for patients to select from. Although up front this may take considerable time to initiate, the long-term benefits for the patient, physician, and clinician are significant.

As was expected, it appeared that many of the physicians were treating some of their patients for mental health related symptoms. However, 80% of the responding physicians were in favor of referring their patients in need of mental health care and were willing to allow a therapist practicing via TAI to be involved. Two reasons most likely underlie their willingness to refer, first may be the fact that they just do not have the time to set aside from their practice to treat mental health issues, and second they may feel they are not as adequately trained in psychiatric diagnosing to diagnose and treat as accurately in the short time they have in their practice and as such would rather refer the patient. The fact that these physicians were willing to make TAI referrals suggests their understanding of their own limitations, but also the fact that they would not see such as a threat to their current practice.

*Clergy as a Critical Dimension
of Referral*

The 32 responses from the individual clergy were varied, even among the leaders of the predominant religious organization that responded to the inquiry. The majority of the responses from clergy (81%) were members of The Church of Jesus Christ of Latter-day Saints (LDS), which is the predominant religion in each of the three communities. Although the majority of LDS clergy were largely in favor of referring to TAI, some felt that the church's social service agency provided adequate coverage for their parishioners and were not comfortable referring to TAI. Of the six clergy that were associated with the Baptist, Greek Orthodox, Catholic, and Non-denominational Christian churches none were in favor of referring their parishioners to any therapist, regardless of the method of delivery. The most notable comment was that they had received training and degrees from their various theological seminaries that allowed them to provide guidance to individuals of their congregation who needed help with mental health issues. One clergy stated that the advice he would give anyone coming to him for counseling would be to absolve themselves from the sins they are currently practicing because their torment was coming from a life of sin. The assumption of this clergy was that the answers to any and all questions would come from studying the Holy Bible; including relief from mental health and relational issues. Thus, relief from mental anguish was only obtained from a life of righteousness. This sentiment seemed to underlie most of those from these six religious organizations according to the comments provided on the CIFS. Due to the fact that there was such a disparity between the number of respondents from the Baptist, Greek Orthodox, Catholic, and Non-denominational Christian faiths as compared to those

from the LDS faith leaves a question about generalizing the information from the surveys. In other communities or states, where the religious population is more varied, it could be expected that there would be a possibly very different response from at least the non-LDS clergy, and possibly from both populations. These responses would affect the feasibility of establishing a TAI in those communities, either positively or negatively.

In considering religious organizations as a source of referral, the first place to focus energies would be with those that were supportive of referring to TAI. It would seem that building trust in those willing to make referrals to TAI would require steps being taken similar to that of the physicians, namely, providing training on what TAI was about, how to be effective in making referrals, and how to ascertain the credibility of those promoting themselves as rural clinicians with training in teletherapy. Offering broad based training may also be helpful in encouraging those who sit on the fence or may be opposed to making referrals to TAI.

For those opposed to making referrals, further research may need to ascertain if these clergy are trained clinically and licensed to practice psychotherapy. While this is not necessary for clergy since they can couch their behavior in the context of providing spiritual guidance, it would be helpful to understand training and rationale for their unwillingness to make such referrals. Finally, as the community becomes increasingly aware of services associated with mental illness, relationship problems, and family distress, it may be the community's response that encourages these clergy to offer opportunities for referral. Aside from the limitations of size of the sample, the population was not asked how they view the severely mentally ill and the resources that their

respective communities have to help these individuals versus helping the population who suffer from less noticeable distress such as family problems or depression.

*The Community as a Source of
Referral: The View of Rural Community
Residents Regarding Accessibility of Mental
Health Services and Acceptability of TAI*

Residents polled from the three communities gave an overall impression that they believed their individual communities had sufficient mental health services available to meet the needs of the residents, as well as ready access to these services. Based on the small number of mental health providers that are publicly listed in phone directories for these communities, this was contrary to what was expected. The largest provider of mental health services for these communities was LDS Family Services. In these communities, LDS Family Services is a satellite agency from a larger office based in Provo, Utah, which is at least 60 miles from the communities. It is possible that, in addition to LDS Family Services, rural residents perceive services as being available through other sources such as their physicians or clergy, though this was not formally assessed in this study. Of concern to this researcher was the fact that area hospitals may not have a sufficient pool of mental health providers to provide mental health services if the community were to experience what may be statistically possible in terms of the presentation of mental health, couple and relational issues, given the fact that 26.6% of the American population suffers from a mental health disorder (U.S. Department of Health and Human Services, 2005). In a population of 10,000 this would mean that approximately 2,500 people would be suffering from a diagnosable mental disorder. Thus, the fact that community members feel this confidence in their community resources

is commendable but may be naïve.

One of the major differences between urban and rural views of mental health is the difference between the experiences with individuals who have mental health issues. Often in urban areas, many community members have daily associations with individuals that they know suffer from mental health issues, and thusly develop a general familiarity with dialogue, symptoms, and even treatment of mental disorders. However, this contact in rural communities can be very rare, adding to the stigma surrounding mental health issues (U.S. Department of Health and Human Services, 2005). As such, it could be possible that some of the community responses were based on a lack of information about mental health issues in general.

It is also possible that the responses may be explained by the stereotypical feeling of self containment that rural communities often feel, and the dislike for outsiders of any sort to come to their aide. In that this study did not specifically seek to ascertain an in depth understanding of attitudes, beliefs and values associated with mental illness, relationship distress, and family issues, future research would be encouraged to seek to uncover stigma and myths that may interfere with the acceptability of psychotherapy in general, and TAI specifically. Using a quantitative and content based qualitative instrument would be beneficial to get at this and other issues associated with not only this portion of the study, but in other sections as well.

On the surface, responses that the community offered about TAI becoming a part of their community as a mental health resource may seem contradictory to the fact that they believe there are a sufficient number of resources available to them. Even though

the community believes that they have sufficient resources for mental health issues, they would be open to having more of them. Another finding that appears to be contrary was that 77% of those responding to the instrument indicated that they would be willing to use or refer someone to therapy offered through TAI. This finding does not support the myth or stigma of isolationism, and is again, a most promising finding. What is concluded is that community support of TAI will be as critical, if not more critical than referrals made by physicians and clergy since the community will be on the receiving end of the services.

These findings from community residents are encouraging. Education about mental illness, relationship problems, and family distress may be an essential factor to continue opening the eyes of communities to the disabilities associated with these difficulties, particularly if they are provided with resources to meet their needs in a way that increases their quality of life. Placing TAI as a therapeutic option could also be quite beneficial as many residents see already present community resources as only a refuge for the severely mentally ill, and not for people with “average” problems (D. Law, personal communication, April 24, 2009). Broadcasts using TAI, would be one way to educate rural communities about conditions affecting daily living and demonstrate the utility and viability of TAI as a method of reaching out to those who reside where services may be less available and accessible.

Providing Services to Rural Residents: Will Service Providers Be Willing to Assist?

Gaining a referral base is an important step to establishing TAI as a viable mental health delivery modality in a rural community. An equally important step is securing

mental health service providers to deliver interventions and therapy via TAI. The recruiting of trained mental health clinicians is vital to establishing the viability and credibility of TAI and serving the rural population. The results received from the sample of individual clinicians suggests that there would be varying degrees of support for TAI.

Before mental health services could be provided, it would be imperative that there be a trained group of clinicians who understand rural mental health and were willing to provide these services via TAI. This study sought responses from those professions where such services could be legally and ethically provided, namely marriage and family therapists, psychologists, and social workers. The majority of responses came from clinicians with a marriage and family therapy background, including master's and Ph.D. level training, with 15 indicating that they had training in rural mental health and 1 indicating some training in teletherapy. When asked about interest, the response for MFT's was 54%, indicating that they were interested in being involved in rural mental health that is delivered using TAI. While it is unclear as to why more are not interested, 54% is a good beginning considering that most are not trained as rural clinicians and the use of teletherapy (TAI). For the remaining who were not interested, it might be speculated that some who are not interested are already invested in their practices, and some may have academic positions. One finding for future study would also be age and gender. While gender was not considered in this study, age was. Initial impressions for the results provided by physicians and now MFTs is that there might be a correlation between age and desire to use the new technology, with the older the clinician the less likely they may be to show interest. Again the reasoning behind this is unknown.

Regardless, it would be interesting to better understand both why those who indicated interest were so, as well as the rationale for the lack of interest. Research of a quantitative and content specific qualitative nature would be one way to effectively ask and answer these questions.

The eight individuals responding with social work backgrounds, six of whom were trained in rural mental health and two with teletherapy background, were split evenly with four stating they were not interested in providing TAI and four responding they would be interested. Generally, social work programs train their students in a broad approach to therapy, focusing on the individual as well as society. The split is not dissimilar to that of MFT, 50% versus 54%, interested in practicing in rural communities via TAI. It is likely that those reasons for why MFTs were not interested in expanding their practices may be similar to the social workers had this question been asked. Again, future research could more effectively address this issue and would provide information that may be useful to encouraging more involvement in rural mental health.

Psychology was the third profession that is likely to be enlisted in providing rural mental health via TAI. Of the Ph.D. psychology respondents, four of whom were trained in rural mental health and two in teletherapy, the vast majority were not in favor of opening any of their practice to TAI, with only one of the eleven respondents stating they would be interested in being trained in TAI for the purpose of reaching out to rural residents. While it is not possible to say why this was the case, it is feasible to suggest that psychologists are less systemic in their approach to therapy than are either social workers or marriage and family therapists. Future research would prove beneficial in

better understanding this rationale, or at least understanding if this is consistent with a larger, more representative group of psychologists.

In summary, several reasons are suggested as to why clinicians may be less interested in rural mental health and providing these services via teletherapy or TAI. First, as with any profession, if you are not exposed to the information you may not develop a desire to move in that direction. Re-tooling takes time, money, and effort. After many years in school there are those who are focused in their clinical direction and not interested in change. However, sometime in the future this may not be the case and it is possible that some who stated they lacked interest may find it later. In this case it seems that there needs to be a concerted effort on the part of clinical programs to provide adequate training to meet rural mental health needs, and alternative methods to deliver the services. As research progresses in this area it is likely that there will be mounting interest.

Next, some of the clinicians may be situated in their profession such that they may not desire change. This may be associated with age, income, living circumstances, or a number of other factors. It is possible that these clinicians may not be aware that they can retain their current livelihood and lifestyle without moving to a rural community to provide these services. If such is the case, better education about rural mental health and possible delivery systems would be beneficial. Regardless, future research will need to ferret out some of the reasons for lack of interest.

It is possible that age may play a role in the decision of clinicians to be involved. Rural mental health delivery via TAI is relatively new and necessitates the ability to use

advanced technologies. Older clinicians may not want to learn to use the new technologies and are comfortable in their current practice. The use of the new technology not only necessitates the desire to learn how to use it, but there are start up costs that may act as an inhibiting factors. Desire to learn cannot not be externally motivated; however, it is possible that grants may be available for those desiring to provide services to these disenfranchised populations.

Finally, the fact that this study is a small “*n*” study may clearly have biased the findings; thus what has been found may merely be an artifact of the sample. Even if this is the case, it is interesting since this study is the first of its kind to address this most important issue, feasibility.

Availability and Accessibility of Clinical Locations

While having sufficient referral sources and clinicians who are willing to provide TAI based rural mental health are essential factors and necessary, the sufficient condition is having someplace where community members can go and receive these services; a place that is accessible, and allows for the level of confidentiality necessary to warrant being considered a “safe holding” environment. Thus, finding locations in the communities that not only contain the proper technology to host TAI, but also provide comfort for community members and help to establish the anonymity (i.e., having many possible reasons that an individual may be at the facility) was viewed as critical to understanding feasibility (U.S. Department of Health and Human Services, 2005). In each of the designated communities, as well in many other communities around the state of Utah, possible locations that fit this description include public health centers, hospitals,

educational settings (e.g., schools and universities), and other medical centers where T1internet links connect these locations with networks such as the Utah Educational Network or Utah Telehealth Network.

Utah State University Extension

Almost all communities, rural or urban, have access to community centers that either are equipped, or could easily be equipped, with the technology necessary to facilitate the set up of TAI. Land grant universities, such as Utah State University, not only have the equipment necessary, but this equipment is located in most all communities where there are extension services provided. One of the requirements for being a land grant institution is that campus satellites must be set up in every county in the state that the University serves. These centers will all have certain things in common, namely fast and reliable internet access, computer banks and labs, office space, and a pledge to serve the community. These sites are often set up in the county seat, which is a central location, based on geography as well as commerce, to the counties' residents and allows maximum access. In addition to availability, extension sites, where there are regional campuses, are open from early in the morning until later at night to accommodate for student courses and study. These extended hours of operation would fit well with a clinician looking to supplement their practice and for clients that need flexibility in their session scheduling. Lastly, regional campuses, with their number of students, provide a relative degree of anonymity in that it would be difficult to distinguish between a student and client in the building.

The extension sites and regional campuses of Utah State University that were

polled were very supportive of TAI being offered at their location, offering space, time, and equipment. One possible reason for their support could be that the primary researchers both had an active research and clinical affiliation with USU and perhaps they felt that as an extension site they should support projects from USU students and faculty. However, of greater importance was the willingness of these locations to open their doors to their community. This is most likely the greatest reason for their willingness to be involved; they are truly community oriented! In that the reasoning behind their willingness was not asked and as such, if such were desired, it would behoove other researchers to ask questions that would address their underlying motivation. Again, however, in that these facilities did not feel it necessary to be reimbursed and were willing to open their doors to TAI, it would seem that their motivation was clearly altruistic. For all intents and purposes extension sites would be excellent locations to set up TAI for a number of reasons. First, for the foreseeable future the establishment of TAI in the state of Utah would run through USU because of research and practice issues (i.e., knowledge of how to set up and run TAI, availability of practicum therapy students). Next, the space usage offered by the extension sites would be the most accessible as well as meeting all requirements of confidentiality. Finally, the costs involved would be negligible, not much different from seeing MFT students at the University clinic where fees are set on a sliding fee schedule.

*Public Locations Under the Umbrella
of the Utah Telehealth Network*

A second set of facilities that are available and accessible to communities across the state are those connected to the Utah Telehealth Network (UTN), namely hospitals

and public health department facilities. However, this study did not involve such facilities in its sample. Often, but not always, these UTN facilities are housed in the same town as university extensions and therefore available and provide easy access. Some of the facilities are public buildings, such as hospitals, clinics, and health departments, increasing their accessibility. As with the extension sites, the UTN sites were almost unanimously open to allowing TAI into the various facilities. In fact, UTN sites located on Native American lands already use telemedicine and teletherapy to provide services to their residents. The advantage of these facilities is that the technology needed to set up TAI is already present. In fact, many of the facilities have technology, such as Tandberg or Polycom systems, which are even more advanced than the basic technology needed to establish a TAI. Another potential positive would be that these facilities are often medically based and may “make sense” to potential clients to go to these sites that already have a medical or health related background rather than an educational facility. Those sites queried did not expect any reimbursement and offered a variety of hours that would be open to TAI, which would again provide maximum access for both clients and clinicians. There do remain questions about reimbursement for use of the facilities, such as whether or not the clinicians need to be associated with UTN.

Other Possible Locations

In addition to the locations noted above, other sites could be made available due to their unique connection with UEN. For example, Dr. Openshaw has made contact with Mr. Scott Wyatt, President of Snow College, and in discussing these projects and those to come has gained the support of President Wyatt to open Snow College to the

delivery of mental health services to the rural community. In addition, there is a possibility that other public sites could be used, such as public schools that are part of the Utah Education Network (UEN).

Delivering Rural Mental Health Services via TAI: What Do We Know?

Understanding the delivery of mental health services into rural communities via TAI, in this study, is based primarily on ascertaining willingness of referral sources to provide referrals, clinicians to offer the services, and the availability and accessibility of locations where TAI could be established. While physicians, for the most part, were supportive of TAI and making referrals, this population needs to be looked at more specifically and with a larger “*n*” to better ascertain their desires and willingness to be effectively involved. It is felt, however, that overall rural physicians would be willing to support this form of intervention as they become more aware of TAI, how to make referrals and ensure the credibility of those providing the services.

These results suggest that while there would not be an overwhelming amount of support from the clinicians polled (39% in the positive), this is clearly a beginning place since there are few, if any, clinicians providing the mental health services via TAI. Attention at this point would be to increase the credibility of TAI, develop an evidence base for rural mental health and continue educating clinical programs and clinicians in the necessity of providing services to this much neglected population. While factors such as degree, professional orientation, and age appeared to have some basis in the lack of desire to be involved, future research will need to more closely examine these factors and ferret out what factors are inhibitors through qualitatively based content questions.

Knowing this information will benefit future educational endeavors needed to recruit clinicians to rural mental health.

Relative to the community, while there was the opinion that there were a sufficient number of clinicians to provide mental health services, they would be willing to use and refer others to TAI as an additional community resource. As with the physicians, comments made from community members participating in the study suggested that they would need to feel that the clinician offering the services was credible, both in terms of competence and ethics, particularly since the TAI clinicians would be “outsiders.” One of the methods clinicians could use to enhance their credibility would be to make their credentials public to the community on a personal website that also provided their practice mission statement and information regarding their background in rural mental health. Clinicians could put information about mental health issues in local newspapers so that community members could be benefited by the information and come to know the clinician, or could possibly offer community workshops using TAI to instruct and answer questions. Finally, clinicians could demonstrate their understanding of the community by learning about its history, major industry, and residents. All in all, there is much that clinicians could do to promote the feasibility of TAI and themselves, to rural communities and enhance the desire on the part of the community to engage TAI services.

The final piece of knowledge acquired in this study, realizing the limitations, was that there are facilities that would open their doors with no or minimal cost and provide an environment that was conducive to confidentiality. This being the case, the barriers of

accessibility and availability would be undermined. It also appeared that those facility administrators responding to the survey were altruistic in their motivation to help mental health experts reach out to their communities. Most likely these facility administrators see and understand the needs of their community's residents.

Insurance Reimbursement

Although the facilities, at least those responding to the survey and for the present time, were not seeking reimbursement, it would be essential that there be reimbursement for clinicians in order for them to provide TAI services. The only two means of payment are personal payment and insurance reimbursement. What is unique about TAI is that the costs for mental health services would be no different for those in rural communities than are the costs for those residing in urban communities. Personal pay was not an issue in this study, though previous research found that clients would be willing to pay their co-payment and perhaps more for TAI services (D. Openshaw, personal communication, February 26, 2009). For purposes of this study, the focus was the willingness of a select number of well recognized insurance companies to pay for mental health services delivered through TAI.

The sample of insurance carriers revealed that at the present time and according to the individuals that responded to the IFS, there would be no reimbursement from insurance carriers to clinicians practicing TAI. The insurance company representatives that were contacted were not familiar with teletherapy in any form. One representative stated after a description of TAI was read to him that it appeared to be very similar to a regular office visit; however, he warned against using an office visit billing code until

further approval in writing could be obtained from the insurance agency.

It is suggested, based on conversation with Dr. Openshaw, that the individuals with whom this discussion took place were unaware of the movement of their companies towards providing mental health services. In fact, Blue Cross, Select Health, and Altius have recently been in discussion with the Utah Telehealth Network about providing services and reimbursement. Finally, it appears that the diagnostic codes typical for outpatient psychiatric services (90801, 90806, and 90804) are reimbursable without prior authorization for the use of TAI unless mental health benefits in general need prior authorization (e.g., United Behavioral Health; D. Openshaw, Clinical Subcommittee Co-Chair for UTN, personal communication, February 26, 2009).

In summary, it appears that according to the insurance carriers' customer representatives that were polled, the assumption that could be made would be that these companies would not be willing, at least presently, to reimburse therapists for services rendered through TAI. Possible solutions to this problem would need to include studies such as this that could spearhead a union between a research institution, interested clinicians, and interested rural communities that could come together to petition both private insurance companies and government bodies to change their current stance and create the things necessary to reimburse clinicians for using TAI.

However, through information obtained from those more familiar with insurance billing in general and teletherapy as well, it also appears that progress is being made with some companies' willingness to reimburse for TAI. Presently, regular office billing codes are being used to obtain reimbursement from insurance companies such as

SelectHealth, which was part of this study's insurance companies' sample, as well as Altius, which is an insurance company that was not polled in this study. Due to the fact that the customer service representatives that were spoken to by the researcher were not aware of this willingness and availability of reimbursement, it can be assumed that it is perhaps not widespread policy throughout the respective companies yet, but appears to be close. This is a limitation with this particular sample population that a more current re-sampling could overcome.

Maintaining a TAI Practice: Examining Rules and Regulations

All professionals in states of the U.S. are regulated by a Department of Professional Licensing, though in states outside of Utah it may be named differently. It is the responsibility of this organization to maintain and uphold the rules and regulations that have been enacted by state legislators relative to the practice of various professions. In the field of psychotherapy it would seem logical that in order to provide mental health services via TAI that the rules and regulations of the profession would, if such were possible, support this practice. If the rules and regulations were not supportive then regardless of whether there was a referral source, clinicians willing and able to provide services and a reimbursement process available, such services could not be provided. Thus, an important aspect of feasibility is to ascertain if the Rules and Regulations governing the practice of psychotherapy, by profession, were supportive of such a practice. In addition, National Organizations (AAMFT, APA, NASW, & AMHCA) with their professional ethics are an essential component to feasibility and as such, this study also sought to clarify the stand of the various psychotherapy organizations regarding the

practice of TAI as a means of reaching out to rural residents.

State-based Rules and Regulations

In reviewing the rules and regulations it was found that 49 of 50 states had laws supportive of the practice of rural mental health via teletherapy such as TAI, with the state of Arkansas not opposing the practice, but rather regulating it; more specifically, Arkansas requires an additional endorsement on an already current mental health service license. This endorsement does not require any further training, but is used more so the state can be aware of the therapists who are practicing teletherapy. The state does not make known publicly what they do with that information (i.e., special audits or interviews with the teletherapy clinicians) only that they collect it. Arkansas is a good example that technology is changing the practice of mental health therapy and state regulatory boards' views on therapy.

Before the year 2000, the state of Arkansas allowed only face-to-face therapy in an office. However, in 2001 as the push for telemedicine and teletherapy was growing nationwide, Arkansas reviewed its policy regarding telemedicine and therapy with a decision to alter its previous position in the best interest of its residents. In that Arkansas has considerable rural areas, this move was courageous and supportive of rural communities in general, demonstrating a desire to transcend the barriers of availability and accessibility (U.S. Department of Health and Human Services, 2005).

While the rules and regulations of the 49 states did not prohibit the practice of TAI, the one critical factor for consideration, which is also one faced by physicians who want to practice rural mental health, is that practice is limited to the states where the

individual is licensed. For example, a clinician licensed in Utah could not set up TAI with a client who is located in Idaho, unless the client traveled to a TAI site within the Utah borders or the clinician obtained a license for Idaho practice. While this may be perceived as an initial complication, organizations such as the Utah Telehealth Network are working diligently to facilitate cross-border opportunities. It may mean that for cross-border practices to reach out to more disenfranchised populations will still require licensing; however, reciprocity of licensures may be more likely and the process of licensing more easily navigated. Advocacy for this need is recommended by all who are interested parties, including but not limited to referral sources, community residents, and practitioners. Opening the borders for mental health services by qualified professionals is a wonderful opportunity to provide services to those in need.

An alternative to that just discussed, though most likely more difficult to enact, is the possibility of exceptions to the rule of practicing only in the state in which an individual is licensed. It is known that the government has been willing to make exceptions for other “political” ventures (e.g., establishment of time zones), and as such it is possible that a sufficient case could be made that the government, at a national level, could provide legislation to ensure that those needing services receive them and that those providing the services are qualified. This qualification, which may require some type of application and/or approval, may allow one to practice across borders with certain restrictions, for example to provide mental health services only to rural residents or the exception could mean that a smaller community (e.g, Franklin or Preston, Idaho) tied economically to a larger community (e.g., Logan, Utah) that lies across political state

lines could be given exceptions so that the community's mental health needs were met.

In summary, it appears that the practice of TAI is not prohibited in any of the 50 states of America; however, only one state, Arkansas, has actually taken steps to regulate the practice thereof. Maybe this means that Arkansas is more progressive with other states merely choosing to ignore and allow the current governing rules and regulations to serve as the guidelines. What this suggests is that the remaining 49 states may not have really taken the opportunity to articulate, for example, the differences between urban and rural needs and the practice of psychotherapy. It seems logical that states would want to be more assertive in the governance of TAI with rules and regulations devised to protect the client and to give practitioners guidelines to establish their practices.

It seems that at this point in time, governing rules and regulations do not inhibit the practice of teletherapy (TAI) and as such the feasibility of setting up a practice with TAI faces few if any barriers. It is plausible that as more studies that address teletherapy are published that states may move in the direction, as did Arkansas, to better articulate the practice of teletherapy. When this trend begins, it would behoove all involved to be "voice" in this process.

The Ethical Basis for Teletherapy

As critical as it is to have states provide rules and regulations for the practice of teletherapy (TAI), it is just as salient that professional organizations that monitor the practice of their members, provide the ethical guidelines for the practice of teletherapy. This study examined the Code of Ethics of four of the most prominent professional psychotherapeutic organizations, American Psychological Association (APA), American

Association for Marriage and Family Therapy (AAMFT), National Association of Social Workers (NASW), and Association of Mental Health Counselors of America (AMHCA). In addition to policing their members, these organizations often lobby legislators to improve the field of mental health in areas such as reimbursement equity, Medicare and Medicaid participation, and outreach to disenfranchised populations. Understanding these organizations perspectives on teletherapy and if their Code of Ethics supports such a practice is essential to promoting the viability of teletherapy in any form. Thus, this study not only talked with officers from these organizations regarding their view as to whether teletherapy was within the scope of the profession, but also reviewed documentation, most specifically the Code of Ethics, published by the organizations to ascertain if teletherapy would be contraindicated.

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An Examination of Feasibility by Profession*

Contact was made with the officers or staff associated with APA, AAMFT, NASW, and AMHCA to discuss their perceptions regarding the practice of teletherapy and if this form of therapy was within the scope of their profession. It was found that none of the professional organizations, at least with the information provided, felt that teletherapy was contraindicated. Although this was the case it was also found that APA, AAMFT and NASW were not as well versed on the practice of teletherapy as was AMHCA.

In regards to AAMFT, it was found that while they did not prohibit the practice of teletherapy they suggested that anybody interested in this type of therapy delivery be adequately prepared with an understanding of potential ethical problems that could arise.

Several articles were suggested as important reading, one dealing with phone therapy, another with e-mail therapy, and finally, one article addressed confidentiality in an age of electronics (Bashshur, 1995; Haug, 1995; O'Malley, 1995, respectively). Though these topics were about teletherapy, they were not about the latest movements in teletherapy and reflected that the organization may not be in touch with the latest research and foci relative to teletherapy. It may also reflect on their level of interest with teletherapy at this time; perhaps other matters are of greater relevance.

The APA and NASW code of ethics do not specifically address teletherapy or the use of technology in therapy practices. Personal contact with the ethics board of the APA (L. Greenwood, staff attorney, personal communication, June 17, 2008) stated that they were aware of the practice of teletherapy, specifically telepsychiatry, and asked any clinician wishing to participate to do so while keeping the ethical code in mind, specifically confidentiality and the storing of confidential information. According to the NASW website (www.socialworkers.org), NASW recognizes the practice of teletherapy, need for services in rural communities (Ginsberg, 2005), and practice of teletherapy. While this is the case, the website or code of ethics did not offer any current professional guidelines.

The AMHCA, unlike the other professional organizations polled, seemed very proactive in reference to establishing guidelines for its members who wish to practice teletherapy. They have included a section in their organization's Code of Ethics that deals exclusively with what they term "Internet On-Line Counseling." This portion of the document covers special aspects of confidentiality, counselor and client identification,

emergency information for the area where the client is living, and provides steps to help begin a successful on-line counseling relationship that is mutually beneficial. AMHCA sets the standard at this point in time for other psychotherapy organizations. Their detailed focus on teletherapy is more helpful than any readings, suggested Code of Ethics available, or State Rules and Regulations. It would be well worth the time of those wanting to practice teletherapy to read this section of their Code of Ethics (Principle 14: Internet On-line Counseling at <http://www.amhca.org/code/>).

In summary, it can be concluded that there has been little focus on teletherapy by most all professional organizations, with the exception of AMCHA. It is recommended that there be more focused consideration in the professions around the area of teletherapy; however, until such time, clinicians should self-monitor so that they are aware of those professional guidelines as they apply to the practice of teletherapy.

Implications for the Practice of Marriage and Family Therapy

The implications that TAI could have on the practice of marriage and family therapy are expansive and positive. As has been discussed above, the use of TAI was most popular with MFT clinicians, holding a master's degree, and between the ages of 20-35 years old. As the field and the degree of family therapy continues to grow, this age and education group will most likely become larger as more students seek out the degree earlier in their careers. The use of TAI will provide another outlet that these individuals can use to provide therapy and secure employment. The impact on educational programs that offer MFT degrees will also benefit from the presence of TAI by opening up further practicum and therapy training opportunities, which could help increase the number of

students that a program can house.

Further implications in the academic world also revolve around the use of supervision for students and professionals working toward licensure. The demand of live supervision hours has often mandated the use of video recording equipment during sessions. This equipment in the room could lead to a change in the comfort level of all involved in the session. However, the use of recording during TAI is often an unassuming process that requires nothing more than the click of a button. Also, the clients may tend to become acclimated with the presence of the equipment causing the recording of sessions to be easy on the clinician as well as the client. The ease in which supervisors could view these sessions is increased as well. With programs such as Macromedia Breeze, sessions can be viewed on any computer with an internet connection provided that the proper user account has been set up. This would make other tools, such as information from the internet, readily available during the supervision session, increasing its effectiveness for both student and supervisor.

Recommendations for Future Research

Some of the recommendations for future research have been previously mentioned within the individual sections above. Some of these recommendations include asking further questions of physicians to identify how many patients they are currently seeing that use their services for mental health treatment. This would allow for a greater assumption of the number of possible referrals that these physicians would supply to TAI. Finding a greater sample of clergy that were less homogenous regarding religion would also help to improve the generalization that could be applied to receiving referrals from

clergy.

It would be necessary to understand more about the idea of age surrounding favorability of TAI. It has been noted several times throughout this study that acceptance of TAI and technology seem to be greater with a younger population. Though this was discovered, there was no documented reason why this happened. Perhaps it has to do with a fear of change in an older generation or a familiarity with technology in the younger generation. Further research would be needed to clarify this finding.

Lastly, a follow up with insurance providers would be beneficial to further the research about the feasibility of establishing TAI. In the six months between when the IFS was presented to insurance companies and the completion of the study, great changes took place. This could be attributed to a lack of information that the individuals responding to the IFS had or could possibly be forwarding in policy in the various companies. A resampling using the information from this study would help in gaining correct information for the researcher as well as possibly informing the insurance companies themselves.

Limitations

Perhaps the greatest limitation to this study was the fact that a figurative “snapshot” was used to capture and understand a very rapidly growing subject that refuses to “stand still.” Though the turnaround time from sampling to completion of the study was relatively short (6 months), there is a possibility that the technology and the opinions surrounding it could have changed dramatically. For instance, the capability of personal digital assistants and personal cell phones has greatly increased over the last six

months, connecting people to the internet and communication through wireless technology at breakneck speeds.

A final limitation to this study was its small “*n*” design. The sample sizes of the various respondents were small in number. This severely limits the generalizability of the study, even based on its seminal nature. However, when dealing with the feasibility of TAI in rural communities, small numbers of physicians, clergy, and community members will always be an issue that needs overcoming.

Despite the limitations discussed above, feasibility of establishing a TAI has been given evidence. Referral bases from a variety of key areas in the community have been identified as generally supportive, possible locations for TAI have been found, ethical and legal questions have been addressed, and reimbursement possibilities are emerging and moving forward. A need has been identified within underserved communities for more available, accessible, and acceptable mental health options for community residents that TAI can provide.

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APPENDIX

CLINICIAN FEASIBILITY SURVEY (CFS)

Instructions: As a mental health professional we are interested in understanding your training and involvement in providing services to clients who reside in rural communities/counties. We are also interested in your knowledge and use of teletherapy in providing services in an outreach manner. Below are several definitions to refer to if necessary.

Definition of Terms

Rural Community: The U.S. Office of Management and Budget (OMB) define a rural community as an area or county that lies outside of a defined metropolitan area (areas with at least 50,000 permanent residents). A rural community is also set as an area in which the population density is less than 500 people per square mile.

Rural Mental Health: Mental health services that are offered to, and specifically designed for, individual, couples or families living in a rural community.

Teletherapy: Providing psychotherapy in a face-to-face format to clients using the Internet and webcam through such mediums as Macromedia Breeze or a Polycom/Tandberg system with a secure line such as that provided by the Utah Telehealth Network (UTN) or Utah Educational Network (UEN).

What is your: ____Age ____Degree ____Licensure

1. Have you been trained to offer mental health services specifically in rural communities?

____ Yes ____No (If no, please proceed to question 3)

If yes,

- a. Where did you receive your training?

____ Coursework

____ Workshops

____ Supervised consultation

____ Other (Please describe):

b. In that you indicated that you have been trained to provide rural mental health, please describe what your training consisted of:

c. Assuming you are providing rural mental health services, what percentage of time do you devote to the practice of rural mental health services? _____%

2. Did your training in rural mental health include how to provide therapy via teletherapy?

_____ Yes _____ No (If no, please proceed to question 3)

a. If yes, please check the areas you were trained in

_____ Email

_____ Instant messaging

_____ Web cam and audio services (e.g., Macromedia Breeze)

_____ Other (Please describe)

b. If you have received training in providing teletherapy, briefly describe what your training consisted of: -

3. Regardless of your training, are you currently providing mental health services to clients in rural counties?

_____ Yes _____ No (If no, proceed to question 4)

a. If yes, how are you offering your rural therapy services?

____ email

____ instant messaging

____ Web cam and audio services (e.g., Macromedia Breeze)

____ Other (Please describe)

b. If you are providing rural mental health services, which services are you providing?

____ Individual psychotherapy

____ Couples therapy

____ Family therapy

____ Psychoeducation

____ Other (Please describe)-

4. Assume that you were offered the opportunity to be trained in providing rural mental health services via teletherapy. Would you be willing to provide such services once you were trained?

_____ Yes _____ No

a. If you were trained, and willing to provide rural mental health services, what percentage of time would you be willing to allot to the practice of rural mental health? _____%

b. If you answered no, which reasons apply? (check as many as applicable):

_____ I have no interest in providing rural mental health services.

_____ There are too many ethical problems associated with providing rural mental health services.

_____ I do not have the equipment to provide teletherapy.

_____ There is not sufficient diversity in rural areas to keep my interest.

_____ Those residing in rural areas are not really seeking services so it would be difficult to build a practice.

_____ Referral sources would be difficult to establish.

_____ There is no standard of care or best practice principles to guide teletherapy interventions in rural communities.

_____ Other (Please describe)

c. Assuming you had interest in providing rural mental health services via teletherapy, list what you consider to be the three most important things you would need in order for you to believe you could effectively provide rural mental health services?

1. _____

2. _____

3. _____

d. If you are not interested in providing rural mental health services, please provide what you consider to be your three most significant reasons for not wanting to provide such services:

1. _____

2. _____

3. _____

PHYSICIAN FEASIBILITY SURVEY (PFS)

Instructions: As a practicing rural physician we are interested in understanding your willingness to refer patients you are seeing who are experiencing mental health issues (e.g., anxiety, depression, OCD, ADD, etc), couple problems (e.g., marital distress, communication problems, sexual difficulties), or family problems (e.g., conflict and anger management, parenting problems) to private practicing clinicians who can provide services in a face-to-face format using teletherapy. Below are several definitions to refer to if necessary.

Definition of Terms

Rural Community: The U.S. Office of Management and Budget (OMB) define a rural community as an area or county that lies outside of a defined metropolitan area (areas with at least 50,000 permanent residents). A rural community is also set as an area in which the population density is less than 500 people per square mile.

Rural Mental Health: Mental health services that are offered to, and specifically designed for, individual, couples or families living in a rural community.

Teletherapy: Providing psychotherapy in a face-to-face format to clients using the Internet and webcam through such mediums as Macromedia Breeze or a Polycom/Tandberg system with a secure line such as that provided by the Utah Telehealth Network (UTN) or Utah Educational Network (UEN).

What is your: _____Age _____Practice Specialty

1. Have you been specifically trained as a rural physician?
 _____ Yes _____No

2. Have you been trained in the use of telemedicine as a method of providing services to your patients?
 _____ Yes _____ No (If no, please proceed to question 3)

If yes,

- a. Which methods of telemedicine have you been trained in using (Check all that apply)?
 _____Email
 _____Instant messaging
 _____Web cam and audio services (e.g., Macromedia Breeze)
 _____Other (Please describe)
-

- b. If you have received training in providing medical services via teletherapy, briefly describe what your training consisted of:

3. Regardless of your training, are you currently providing telehealth services to patients?

Yes No (If no, please proceed to question 4)

- a. If yes, how are you offering your services?

Email
 Instant messaging
 Web cam and audio services (e.g., Macromedia Breeze)
 Other (Please describe)

4. Understanding the needs of patients you see on a daily basis, particularly those who present with individual, couple, or family problems, and recognizing the limited mental health resources available and accessible to those residing in rural communities, would you be willing to refer patients to clinicians who could meet with your patients in a face-to-face manner using teletherapy?

Yes No

5. Are you making such referrals?

Yes No

- a. If yes, approximately how many referrals, on a monthly basis, are you making to clinicians providing teletherapy?

1 – 10
 11 – 25
 26 – 50
 51 +

- b. I am not referring any patients at this time and I am desirous to make such referrals however, (check those that apply)

I do not know of any such mental health services being available.

___ I am not sure how to make such a referral.

6. If no, which of the following are the most likely reasons for not making such a referral? (Please rank order those items that best pertain to your situation):

___ There are no qualified clinicians who could provide such services.

___ I do not know any qualified clinicians who could provide such services.

___ These patients can usually resolve their problems in either a medical manner or through their own resources.

___ Patients do not want to be referred for teletherapy; they want face-to-face sessions with someone residing in the community.

___ There are ethical concerns about referring patients for teletherapy.

___ Visiting clinicians, those coming to our community from urban settings, are sufficient to meet the needs of our patients.

___ I can personally handle most of the problems that come to my office.

___ Mental health experts, especially if they reside elsewhere and provide teletherapy to our patients, do not work collaboratively with the physicians.

___ Other (Please specify) _____

7. If you are not presently comfortable with referring patients to clinicians who provide services via teletherapy to individuals, couples, and families, what would help you increase your willingness to make referrals? (Rank in order of importance.)

___ Be provided more information or training on teletherapy services.

- _____ Be provided information regarding the ethical and legal aspects of referring patients for teletherapy services.
- _____ Meet with the clinician, perhaps using the technology, to become familiar with them and the services they could provide.
- _____ Be provided the credentials of the clinician who is providing the teletherapy services.
- _____ Other (Please specify) _____
- _____ I would never feel comfortable about making such a referral because (Please specify reason(s))

CLERGY FEASIBILITY SURVEY (CIFS)

Instructions: As a clergy in the community we are interested in understanding your willingness to refer parishioners who come to you experiencing mental health issues (e.g., anxiety, depression, OCD, ADD, etc), couple problems (e.g., marital distress, communication problems, sexual difficulties), or family problems (e.g., conflict and anger management, parenting problems) to private practicing clinicians who can provide services in a face-to-face format using teletherapy. Below are several definitions to refer to if necessary.

Definition of Terms

Rural Community: The U.S. Office of Management and Budget (OMB) define a rural community as an area or county that lies outside of a defined metropolitan area (areas with at least 50,000 permanent residents). A rural community is also set as an area in which the population density is less than 500 people per square mile.

Rural Mental Health: Mental health services that are offered to, and specifically designed for, individual, couples or families living in a rural community.

Teletherapy: Providing psychotherapy in a face-to-face format to clients using the Internet and webcam through such mediums as Macromedia Breeze or a Polycom/Tandberg system with a secure line such as that provided by the Utah Telehealth Network (UTN) or Utah Educational Network (UEN).

What is your: _____Age _____Religion _____Ecclesiastical Position

1. Understanding the needs of parishioners you see on a weekly basis, particularly those who present with individual, couple, or family problems, and recognizing the limited resources available and accessible to those residing in rural communities, would you be willing to refer these parishioners to clinicians who could meet with your parishioners in a face-to-face manner using teletherapy?
 Yes No (If no, please proceed to question 3)

2. Are you making such referrals?
 Yes No
 - a. If yes, approximately how many referrals, on a monthly basis, are you making to clinicians providing teletherapy?
 1 – 10
 11 – 25
 26 – 50

_____ 51 +

- b. I am not referring any parishioners at this time and I am desirous to make such referrals however, (check those that apply)

_____ I do not know of any such services being available.

_____ I am not sure as to how to make such a referral.

3. If no, which of the following are the most likely reasons for not making such a referral? (Please rank in order of importance):

_____ There are no qualified clinicians who could provide such services.

_____ I do not know any qualified clinicians who could provide such services.

_____ These parishioners can usually resolve their problems in either a medical or spiritual manner or through their own resources without outside interference.

_____ Parishioners do not want to be referred for teletherapy; they want face-to-face sessions with someone residing in the community.

_____ There are ethical concerns with referring parishioners for teletherapy.

_____ Visiting clinicians, those coming to our community from urban settings, are sufficient to meet the needs of our parishioners.

_____ I can personally handle most of the problems that come to my office in a spiritual manner.

_____ Mental illness, as well as couple and family problems, are spiritually based and therefore do not require the help of mental health experts.

_____ Mental health experts undermine spiritual values.

_____ Other (Please specify) _____

4. If you are not presently comfortable with referring parishioners to clinicians who provide services via teletherapy to individuals, couples, and families, what would help you increase your willingness to make referrals (Rank in order of importance)?

_____ Be provided more information or training on teletherapy services.

_____ Be provided information regarding the ethical and legal aspects of referring patients for teletherapy services.

_____ Meet with the therapist, perhaps using the technology, to become familiar with them and the services they could provide.

_____ I would never feel comfortable about making such a referral because

_____ Be provided the credentials of the clinician who is providing the teletherapy services.

_____ Other (Please specify)

_____ I would never feel comfortable about making such a referral because

[Please specify

reason(s)] _____

COMMUNITY FEASIBILITY SURVEY (CmFS)

Instructions: As a member of a rural community, we are interested in understanding your willingness, if you were experiencing mental health issues (e.g., anxiety, depression, OCD, ADD, etc), couple problems (e.g., marital distress, communication problems, sexual difficulties), or family problems (e.g., conflict and anger management, parenting problems) to seek out services from a private practicing clinician who could provide you therapy, in a face-to-face format, using teletherapy. Below are several definitions to refer to if necessary.

Definition of Terms

Rural Community: The U.S. Office of Management and Budget (OMB) defines a rural community as an area or county that lies outside of a defined metropolitan area (areas with at least 50,000 permanent residents). A rural community is also set as an area in which the population density is less than 500 people per square mile.

Rural Mental Health: Mental health services that are offered to, and specifically designed for, individual, couples or families living in a rural community.

Teletherapy: Providing psychotherapy in a face-to-face format to clients using the Internet and webcam through such mediums as Macromedia Breeze or a Polycom/Tandberg system with a secure line such as that provided by the Utah Telehealth Network (UTN) or Utah Educational Network (UEN).

What is your: ____Age ____Sex ____Marital Status ____Income Level

1. Do you perceive there to be sufficient mental health services available in your community to meet the needs of individuals, couples, and families, regardless of age, race, religion or sexual orientation?
____ Yes ____ No
2. Do you perceive that mental health services in your community are readily accessible to individuals, couples, and families, regardless of age, race, religion or sexual orientation?
____ Yes ____ No
3. Recognizing that mental health services for those suffering from mental illness

(e.g., anxiety, depression, attention deficit disorder with or without hyperactivity), couples distress (e.g., marital distress, communication and conflict management problems, domestic violence), and family problems (e.g., parenting difficulties, coping with teenagers, juvenile delinquency) are limited, would you be willing to refer yourself, family member or a friend to a clinician who practices face-to-face therapy using teletherapy.

_____ Yes _____ No

- a. If no, what would you say would be your three most significant reasons for not using teletherapy to meet your mental health needs or those of a family member or friend?

1. _____

2. _____

3. _____

4. If the following were provided, which would be necessary in order for you to be willing to seek out teletherapy services? (Rank in order of importance)

_____ A location where there is as much confidentiality as possible.

_____ An opportunity to meet with the clinician either face-to-face or in the teletherapy setting before making a decision.

_____ Having the clinician listen to why I might be seeking services and to share with me what it is s/he could provide to help me, my marriage, or my family.

_____ Being able to view the credentials of the therapist before committing to therapy.

_____ Being educated on what teletherapy is and how it would be used to provide me, my marriage, or my family effective and efficient therapy services.

_____ Other (Please specify) _____

_____ I would not seek out teletherapy (Please specify)

INSURANCE CARRIERS FEASIBILITY SURVEY (ICFS)

Instructions: As insurance providers, we are interested in understanding your willingness to provide compensation for mental health services delivered to your cliental who reside in a rural community, and may be experiencing mental health issues (e.g., anxiety, depression, OCD, ADD, etc), couple problems (e.g., marital distress, communication problems, sexual difficulties), or family problems (e.g., conflict and anger management, parenting problems). Specifically, would you compensate mental health professionals whom are sought out by your cliental to provide therapy, in a face-to-face format, using teletherapy? Below are several definitions to refer to if necessary.

Definition of Terms

Rural Community: The U.S. Office of Management and Budget (OMB) define a rural community as an area or county that lies outside of a defined metropolitan area (areas with at least 50,000 permanent residents). A rural community is also set as an area in which the population density is less than 500 people per square mile.

Rural Mental Health: Mental health services that are offered to, and specifically designed for, individual, couples or families living in a rural community.

Teletherapy: Providing psychotherapy in a face-to-face format to clients using the Internet and webcam through such mediums as Macromedia Breeze or a Polycom/Tandberg system with a secure line such as that provided by the Utah Telehealth Network (UTN) or Utah Educational Network (UEN).

Name of Insurance Company: _____

Position of employee surveyed: _____

Data Gathering Instrument

1. Does the identified company have, or expect to have within the next year, mental health coverage?

_____ Yes _____ No (If no proceed to question 2)

If yes,

- a. What type of mental health disorders are covered under the policy?

(1) Clinical Syndromes

(2) Personality Disorders

(3) V codes

(4) Other DSM IV areas

b. How many sessions per year does the policy permit? _____

c. What type of clinicians can your clients obtain services from?

____ Psychiatrists

____ Psychologists

____ Family therapists

____ Licensed Clinical Social Workers

____ Licensed Professional Counselors

2. Must these clinicians be identified providers?

____ Yes ____ No

3. If they are not providers, and you cover mental health services, is there a difference in your payment schedule that is different from those who are providers?

____ Yes ____ No

If yes, please describe _____

4. Does the mental health portion of the policy cover treatment provided by a licensed mental health provider using teletherapy to reach out to rural communities?

Yes No

5. Whether or not specified in the policy, would you pay for serviced rendered by a licensed clinician who provides teletherapy?

Yes No

6. Assuming that your company does not currently cover teletherapy and recognizing the importance of providing coverage to those residing in rural communities where there is limited or no available mental health services, what would it take

for your

company to be willing to provide teletherapy coverage for such providers? (Check those that apply)

Our company provides such coverage.

We do not consider such services as valid because _____

- A new company policy would need to be adopted in order for such services to be considered.

The client would need a special rider to the policy for them to have teletherapy as a benefit.

To the best of my knowledge, this question has never been discussed in our company?

Other (Please specify) _____

7. If your company has addressed this issue but taken no action, what would need to be done to have it re-evaluated on behalf of those residing in rural communities?

8. If the current mental health coverage does not permit teletherapy, particularly for

those who reside in rural communities, would you be willing to be an advocate for such a change?

_____ Yes _____ No, because _____

LICENSURE LAW FEASIBILITY SURVEY (LLFS)

Instructions: As a lawmaking body affecting the licensing and practicing of the mental health field in your state, we are interested in understanding your willingness to accept teletherapy as a recognized form of delivering mental health services to individuals experiencing mental health issues (e.g., anxiety, depression, OCD, ADD, etc), couple problems (e.g., marital distress, communication problems, sexual difficulties), or family problems (e.g., conflict and anger management, parenting problems) by private practicing clinicians who can provide services in a face-to-face format using teletherapy. Below are several definitions to refer to if necessary.

Definition of Terms

Rural Community: The U.S. Office of Management and Budget (OMB) define a rural community as an area or county that lies outside of a defined metropolitan area (areas with at least 50,000 permanent residents). A rural community is also set as an area in which the population density is less than 500 people per square mile.

Rural Mental Health: Mental health services that are offered to, and specifically designed for, individual, couples or families living in a rural community.

Teletherapy: Providing psychotherapy in a face-to-face format to clients using the Internet and webcam through such mediums as Macromedia Breeze or a Polycom/Tandberg system with a secure line such as that provided by the Utah Telehealth Network (UTN) or Utah Educational Network (UEN).

State: _____

1. Does this state legally allow teletherapy?

____ Yes ____ No (If no proceed to question 2)

If yes,

- a. Where is this information located and when was it issued (e.g., Rules and Regulations, then note specifically where in the document it can be found and what it states)?

b. Assuming that licensure law permits the practice of teletherapy, does the licensure law limitations on practicing teletherapy that is different from regular mental health practicing laws?

____ Yes ____ No

If yes, please describe the limitations:

____ The licensure law does not allow for the practice of teletherapy.

2. If the licensure law does not permit the practice of teletherapy, when was it issued? _____

a. Has there been an update to the licensure law since its original implementation?

____ Yes ____ No

If yes, when and how does it now read?

PROFESSIONAL ETHICS FEASIBILITY SURVEY (PEFS)

Instructions: As a sanctioning body in the mental health field, we are interested in understanding your willingness to accept teletherapy as a recognized form of delivering mental health services to individuals experiencing mental health issues (e.g., anxiety, depression, OCD, ADD, etc), couple problems (e.g., marital distress, communication problems, sexual difficulties), or family problems (e.g., conflict and anger management, parenting problems) by private practicing clinicians who can provide services in a face-to-face format using teletherapy. Below are several definitions to refer to if necessary.

Definition of Terms

Rural Community: The U.S. Office of Management and Budget (OMB) define a rural community as an area or county that lies outside of a defined metropolitan area (areas with at least 50,000 permanent residents). A rural community is also set as an area in which the population density is less than 500 people per square mile.

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Teletherapy: Providing psychotherapy in a face-to-face format to clients using the Internet and webcam through such mediums as Macromedia Breeze or a Polycom/Tandberg system with a secure line such as that provided by the Utah Telehealth Network (UTN) or Utah Educational Network (UEN).

Name of Association: _____

1. Does your professional association have specific guidelines pertaining to teletherapy?

___ Yes ___ No

If yes, where is it found and what does it say?

- a. If no, do you expect to have specific guidelines for teletherapy within the next year?

___ Yes ___ No

2. Recognizing the importance of providing coverage to those residing in rural communities

where there is limited or no available mental health services, and if your association does not have guidelines for the practice of teletherapy, what would it take for the association to draft guidelines for the implementation of teletherapy? (Check that which best applies).

_____ We do not consider such services as valid because _____

_____ A new policy would need to be adopted by the association in order for such services to be considered.

_____ To the best of your knowledge, this question has never been discussed in your association?

3. If your association allows teletherapy services to be rendered by licensed clinicians, in order of importance, rank what you believe needs to be addressed in order to maximize effective and efficient rural mental health services via teletherapy.

_____ Identify rural mental health as a critical service area.

_____ Have a petition from those residing in rural communities for teletherapy.

_____ Have insurance carriers promote teletherapy in rural communities.

_____ Have clinicians who are members of the organization advocate on behalf of those residing in rural communities.

_____ Have licensure laws that specifically articulate teletherapy service guidelines.

_____Have our ethics committee draft ethical standards for the practice of teletherapy.

_____Have accredited programs provide curriculum that addresses rural mental health via teletherapy so that training is insured.

_____Have more research to determine what is meant by “best practice” when considering rural mental health and teletherapy.

_____Other (Please specify) _____

3. Regardless of whether your association has addressed the issue of teletherapy, particularly as it pertains to providing services to rural residents, if your association does not have teletherapy guidelines to foster best practice efforts in this area, what would need to be done in order for the association to make this a priority (Rank in order of importance)?

_____Identify rural mental health as a critical service area.

_____Have a petition from those residing in rural communities for teletherapy.

_____Have insurance carriers promote teletherapy in rural communities.

_____Have clinicians who are members of the organization advocate on behalf of those residing in rural communities.

_____Have licensure laws that specifically articulate teletherapy service guidelines.

_____ Have our ethics committee draft ethical standards for the practice of teletherapy.

_____ Have accredited programs provide curriculum that addresses rural mental health via teletherapy so that training is insured.

_____ Have more research to determine what is meant by “best practice” when considering rural mental health and teletherapy.

_____ Other (Please specify) _____

5. If your association does not have guidelines in place for the practice of teletherapy, specifically for those residing in rural communities, would you be willing to be an advocate to encourage and foster the development of such guidelines?

_____ Yes _____ No, because _____

ADMINISTRATOR WILLINGNESS AND FEASIBILITY SURVEY (AWFS)

Instructions: As the administrator of a facility in a rural community where access to televideo equipment such as Polycom or Tandberg is available, this survey assesses your interest and willingness to open your facility to those experiencing mental health issues (e.g., anxiety, depression, OCD, ADD, etc), couple problems (e.g., marital distress, communication problems, sexual difficulties), or family problems (e.g., conflict and anger management, parenting problems). Opening your facility would mean that you would provide access to the equipment, a room, and a block of time for such services to be provided by a private practicing clinician who could provide therapy in a face-to-face format, using teletherapy . Below are several definitions to refer to if necessary.

Definition of Terms

Rural Community: The U.S. Office of Management and Budget (OMB) define a rural community as an area or county that lies outside of a defined metropolitan area (areas with at least 50,000 permanent residents). A rural community is also set as an area in which the population density is less than 500 people per square mile.

Rural Mental Health: Mental health services that are offered to, and specifically designed for, individual, couples or families living in a rural community.

Teletherapy: Providing psychotherapy in a face-to-face format to clients using the Internet and webcam through such mediums as Macromedia Breeze or a Polycom/Tandberg system with a secure line such as that provided by the Utah Telehealth Network (UTN) or Utah Educational Network (UEN).

Facility_____

1. Recognizing the need in rural communities for mental health services to be offered, it is important that the services be accessible when made available. Your facility has been identified as a location where teletherapy services, due to the type of equipment necessary to provide teletherapy, could be provided. Would you be willing to dedicate time, space, and equipment so that teletherapy services could be offered to residents of your community?

____ Yes ____ No (If no, please proceed to question 2)

If yes,

- a. How much time, in hours per week, would you block out for use at your facility?

1 – 5 hours per week

6 – 15 hours per week

16 – 25 hours per week

As much as would be needed.

- b. Would you make your facility available?

9:00 AM to 5:00 PM

5:00 PM to 10:00 PM

- c. Would you anticipate compensation for the facility, equipment, and time?

Yes No

If yes,

- a. What form of compensation would you require?

1) Recognition in the form of _____.

2) Monetary compensation in the amount of _____ per client hour.

2. If you are not presently comfortable with opening your facility to clinicians who provide services via teletherapy to individuals, couples, and families, what would help you increase your willingness to open up your facility to teletherapy? (Check all that apply)

I would never feel comfortable about up my facility to teletherapy because

Be provided more information or training on teletherapy services.

Be provided information regarding the ethical and legal aspects of teletherapy services.

Meet with the clinician, perhaps using the technology, to become familiar with them and the services they could provide.

_____ Be provided the credentials of the clinician who is providing the teletherapy services.

_____ Other (Please specify) _____