Mental Healthcare Online

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Table of Contents

Tables

Executive Summary

The current world population of internet users, close to 349 million, is a growing industry, in and of itself with more web pages created each day. The virtual possibilities on the web include everything from shopping to managing finances, and keeping track of stocks (to name just a few). The internet is no longer limited to personal web-sites, listservs, newsgroups or performing research using search engines or traditional e-businesses such as, Amazon or Barnes & Noble. Pioneers on the internet are now moving towards making healthcare and more specifically mental healthcare, as a new potential for web business.

Is it possible to enforce mental health service ethics online? Will this new field be self-regulated? Who is qualified to provide online mental healthcare? What class of client/patient would benefit most from this method of delivery? There have been no completed studies to date to measure the usefulness of this burgeoning field. Until those studies are complete the debate will continue amongst the professionals as to whether mental health belongs online.

There are advantages and disadvantages for both the service provider and client alike within the mental healthcare online industry. Currently several ethical guidelines exist online for service providers but at this time there is no way of enforcing them thereby making them appear somewhat useless. Does self-regulation work? Looking at statistics for offline mental healthcare it doesn't appear so. There may be several catalysts for this, including but not limited to a difficult reporting process for the client, and governing boards that are more interested in rehabilitation than censure and reprimands.

Some of the debate within the professional online (and offline) communities centers on the exact definition of online mental healthcare. Is it really therapy? Is it counseling? Some critics argue that it is not.[1] Some professionals argue that there are no more disadvantages to mental healthcare online than there are disadvantages for therapy.

I have included statistics for two online studies, one completed in 1998 and one completed this year. These studies attempted to measure provider demographics and how many clients are using mental healthcare professionals practicing on-line.

Introduction

What exactly is mental healthcare online? Is it therapy, or counseling? What does it include? For the purposes of this paper, online mental healthcare will be defined as a licensed mental healthcare professional providing advice and/or counsel via e-mail, video conferencing, virtual reality technology or chat technology or any combination of those. It will not include self-help methods such as public bulletin boards or private listservs (whether they are run by a professional or not).

I have included a brief history of mental healthcare offline and some of the ethical issues surrounding the mental healthcare industry in regards to self-regulation. I will briefly discuss the reporting process for mental the American Psychological Association and the American Psychiatric Association (for traditional e.g. offline therapy only).

Further I will offer a brief history of mental healthcare online and include the advantages and disadvantages for both the service provider and the client. I will discuss ethics online and a few concerns on whether it can be regulated without so much an agreement on what to call the online services.

I have included statistics for two online studies, one completed in 1998 and one completed this year. These studies attempted to measure provider demographics and how many clients are using mental healthcare professionals practicing on-line. At the end of the studies (formatted so the reader can view corresponding results for both 1998 and 2000 on the same page) I discuss some of the problems with the methodology and the lack of participation amongst service providers.

Mental Healthcare Offline: A Brief History

Mental health care is not a new business. In fact it's quite old, dating back to the 1800s when the first almshouses (public mental health hospitals) were in existence.[2] The Mental Health Study Act of 1955 was introduced into legislation on July 28, 1955, resulting in the National Institute of Mental Health (NIMH) appointing the Joint Commission on Mental Illness and Health to "evaluate the needs of the mentally ill and to make recommendations to Congress for future programs." [3] Since then reports, including the most recent Surgeon Generals Report on Mental Health[4] and more studies have been mandated and carried out, so that more changes have come into effect to assess and govern the growth of mental healthcare as an industry. Throughout this growth accessibility has remained an issue. By accessibility I am referring to the limited availability of mental healthcare to people living in rural areas, lack of health insurance and physical disability issues. Psychiatry[5] and psychology[6] have made tremendous strides over the years, including but not limited to incorporating self-governing ethical standards. The question is: "are those ethical standards equally effective offline?"

Ethics Offline

The National Psychologist, an independent newspaper for practitioners ran a story about an Ohio newspaper The Plain Dealer. The Plain Dealer, located in Cleveland, held a six month investigation revealing that nearly 200 psychologists who "were found to have committed serious ethical violations in the last 18 years nationwide were allowed to continue their practice without ever serving any suspension."[7] The article went on to say,

> *"The nearly 200 psychologists who were not suspended for even a day were found to have engaged in sexual misconduct with patients, convicted of criminal offenses or committed other major ethical violations. The Plain Dealer looked at records from all 50 state licensing boards and created a data base containing the names of 2,218 psychologists who have been disciplined or denied licensure as a result of ethics violations. The study went back to 1971, although 80 percent, or 1,754, of the disciplinary actions were taken after Jan. 1, 1990 and reported that 27 states have revoked five or fewer licenses. West Virginia, Rhode Island, North Dakota and Montana, which license a total of 1,500 psychologists have taken a combined 15 disciplinary actions, but have never revoked a license. New York, the paper said, has about 14,000 psychologists, and has revoked 12 licenses. In Ohio, where there are 3,900 licensed psychologists, the Ohio Board of Psychology has revoked 16 licenses."*[8]

Perhaps part of the problem may be that many of the therapists responsible for overseeing ethical behaviors in their colleagues are more interested in rehabilitation than some form of censure or reprimand. This is a good argument on why self-regulation does not work. Another part of the problem may be that the reporting process is difficult.

Filing An Ethics Complaint with the American Psychological Association

The American Psychological Association will take complaints only if an APA Ethics Complaint form has been completed and mailed in. They do not act on anonymous complaints. Also, "a waiver must be signed by the complainant of any right to subpoena from APA or its agents for the purposes of private civil litigation any documents or information concerning the case."[9] That means if the APA chooses for whatever reason not to act on the complaint, you can not access the information they uncovered in the course of their investigation to privately pursue civil litigation.

Filing An Ethics Complaint with the American Psychiatric Association

In comparison the American Psychiatric Association requires all complaints to "be made in writing and signed by the complainant, and addressed to the accused member's district branch or, if addressed to the APA, shall be referred by the APA to the accused member's district branch for investigation."[10]

As you can see the process for reporting is not quite client friendly, particularly for a person who may have allegedly been "abused" by their therapist. Should an industry that is not successfully monitoring ethics offline move towards a market (or delivery system) where there is less ability to enforce guidelines, such as the internet? Continuing growth has allowed mental healthcare to expand in search for its place on the World Wide Web alongside other web-based businesses.

Mental Healthcare Online: A Brief History

The current world population of internet users is close to 349 million[11] and a growing industry in and of itself. More and more things have become possible on the web, as it's no longer limited to personal web-sites, listservs, or newsgroups. There have been many businesses and industries that have expanded their

service and products to the internet. Mental healthcare has not been different in that regard. At some point it became evident that both a need and a market for online mental healthcare should be explored.

Volunteer mental healthcare pioneers on the internet include "Dear Uncle Ezra" located at Cornell University, where anyone could ask a question anonymously and have it randomly answered on the web site on Tuesdays and Thursdays. Uncle Ezra has been operating since 1986.[12] Ivan Goldberg, MD, is another pioneer[13] who has been answering the public's questions about mood disorders and medications since 1993, possibly longer, as well John Grohol, PhD, who also has been running free weekly public chats since 1995. [14]

Paid mental healthcare pioneers date back to 1995 and include: David Sommers, PhD; Leonard Holmes, PhD; Gary Bresee, PhD; Ed Needham, MS; HelpNet; Shrink-Link; and the Pink Practice.[15] In 1996 the online practices grew to include Leya Aum, MFCC; David Safran, PhD & Aldo Tartaglini, PhD; Dan Mitchell, MA & Lawrence Murphy, MA; and The Institute of Transcendent Analysis.[16] Some of these web sites are still operating online, while others are available if only for historical review.

Many of us are familiar with the concept of distance learning now being offered through community college campuses. Distance learning allows a student to access learning materials and instruction with a professor from the privacy of their own home computer. Much of the work is self-paced and requires self-discipline. The same can be said about online mental health services. Online mental healthcare can be equated as a type of "distance" counseling. There are both advantages and disadvantages to the provision of mental healthcare services online for the client.

Advantages for Client

- Accessibility for those located in rural areas
- Accessibility for those physically disabled and unable to leave their homes
- Convenience – email at a time that is best for you
- Affordable (i.e. $100 a month versus $100 per session)
- Accurate records (copy of email) is kept of correspondence for review later

Disadvantages for Client

- Absence of non verbal cues (more chances for misunderstandings)
- No insurance reimbursement (unless you live in California)
- Confidentiality (may be overcome with encryption programs)
- Security (hackers)
- Unreliable technology (email server can go down)

- No immediate response to crisis
- New field, not as proven as traditional therapy
- Not appropriate for serious mental illness such as schizophrenia

To date, California is the only state to adopt and pass a Telemedicine Act (1996). This act states:[17]

- Third party carriers mandated to reimburse for telemedicine
- Third party carriers cannot require face-to-face contact as a condition for reimbursement
- California licensed practitioners limited to practicing in California
- Professionals can obtain reimbursement for consultation with out-of-state professionals if they are the primary healthcare provider for the patient

If other states were to adopt a similar Act, it may be a step in the right direction for regulating online mental health services.

There are also advantages and disadvantages for mental health online for the therapist.

Advantages for Therapist

- Convenience – email back at a time that is best for you (i.e. between sessions or evenings)
- No filing for reimbursement with insurance companies
- No managed care issues
- No overhead cost for an office, can be done from existing office or home
- Opportunity to participate in a new growing field
- Accurate records (copy of email) is kept of correspondence for review later (eliminating need for session notes)

Disadvantages for Therapist

- Absence of non verbal cues
- No liability coverage
- Reporting imminent danger, child abuse coupled with anonymity
- Conflicting state or country laws
- No formal regulations to date
- Unreliable technology (email server can go down)
- Ineffective method for responding to client crisis

Ethics Online

In 1997, The International Society for Mental Health Online (ISMHO) was formed to promote the understanding, use and development of online communication, information and technology for the international mental health community.[18] As an active participant on the general email list for the ISMHO, I have both watched and participated in meaningful dialogue amongst therapists, clients and laypersons. Discussions included but were not limited to issues of ethics, informed consent, fees, whether a therapist should include a picture of his/herself on their web site, confidentiality and more recently online research practices in terms of public message boards and private listservs.

Is it possible to enforce mental health service ethics online? Will this new field be self-regulated? Who is qualified to provide online mental healthcare? What class of client/patient would benefit most from this method of delivery? There have been no completed studies to date to measure the usefulness of this burgeoning field. Until those studies are complete the debate will continue amongst the professionals as to whether mental health belongs online. Some of the debate within the professional online (and offline) communities centers on the exact definition of “online mental healthcare.” Is it really therapy? Is it counseling? Some critics argue that it is not.[19] Some professionals argue that there are no more disadvantages to mental healthcare online than there are disadvantages for therapy.

In order to see this issue clearly we may need to drop our natural inclination to compare it to therapy and look at mental healthcare online as a unique method of delivery based entirely on its own merits. Only then can guidelines truly be set. In this authors opinion, without an agreement on the language (terminology, what to call it) how can there be true understanding that everyone is indeed talking about the same thing. In the current published standards one can note that there is no agreement on what the guidelines are covering. One published standard refers to it as WebCounseling and another refers to it as Online Counseling. However, if online mental healthcare is not counseling or therapy than how can guidelines even be proposed? More importantly what good are guidelines without some way of enforcing them? With this unique delivery option, there will continue to be questions. Online mental healthcare, even with concerns like confidentiality, anonymity, informed consent and liability coverage continues to be a growing practice online.

Published Standards

The sheer immensity of the internet makes it difficult to regulate. While guidelines and standards are necessary even in the infancy of mental healthcare online, none address what to do if something goes wrong. Where does a client turn when they receive bad distance "counseling?" By establishing standards, we define what behavior is acceptable and what isn't, but how can it be regulated and enforced online, and by whom? The following agencies have passed and published some form of standards for mental healthcare online:

1. International Society for Mental Health Online (ISMHO) and Psychiatric Society for Informatics (PSI) – "Suggested Principles for the Online Provision of Mental Health Services."[20]

2. National Board of Certified Counselors (NBCC) "Standards For The Ethical Practice of WebCounseling"[21]

3. American Counseling Association – "Ethical Standards for Internet Online Counseling"[22]

4. American Psychological Association (APA) "Services by Telephone, Teleconferencing, and Internet"[23]

5. American Medical Informatics Association (AMIA) "Guidelines for the Clinical Use of Electronic Mail with Patients"[24]

For myself, many questions arise from reading these standards including, what recourse does a client have when they encounter a "therapist" who does not hold the credentials they say they have? Online, without formal regulations in place, and even with, anyone can hang their virtual shields and call himself or herself a webcounselor. There are no laws preventing someone from lying. The law protects the client/consumer/patient only if the service provider has credentials and does something wrong and not if they don't have credentials.

Statistics

In 1998 Terri Powell, a student at the University of Kentucky, conducted a survey in an effort to measure the current online client/provider demographics. Powell used the professional listings on Metanoia "ABCs of Internet Therapy Guide," a comprehensive, non-profit, client information source for online mental health professionals.[25] Below are the published results from that survey.[26] Directly after each 1998 result is the corresponding 2000 survey result (that I performed).

1998 Overall Site Statistics

1998 Metanoia Site Category by Survey Stats, & Site Authenticity

Category	Surveys Sent	Respondents	Respondents Rate	Credentials	Average MHN
ongoing interaction	21	6	29%	2	2.2
one response, general topic	12	4	33%	3	3
one response, topical	12	3	25%	2	2.7
caveat	5	0	0	n/a	n/a
total	50	13	26%	7	2.5

Table 1.1 Terri Powell, <http://netpsych.com/Powell.htm> 1998 (10 Apr 2000)

- 50 surveys sent
- 23 responses came back (46% response rate)
- 10 respondents declined participation
- 13 survey responses (25% survey return rate)

2000 Overall Site Statistics

2000 Metanoia Site Category by Survey Stats, & Site Authenticity

Category	Surveys Sent	Respondents	Respondents Rate	Credentials	Average MHN
ongoing interaction	24	5	21%	4	2
one response, general topic	15	2	13%	1	3.5
one response, topical	12	2	17%	2	2
total	51	9	18%	7	2.5

Table 2.1 Pat Stubbs Mental Health Online Research (16 Apr 2000)

- 51 surveys sent
- 16 responses came back (31% response rate)
- 7 respondents declined participation
- 9 survey responses (18% survey return rate)

1998 Provider Demographics

Gender/Age

- more than ¾ (77%) of respondents were male
- average respondent age – 48 years
- youngest respondent age – 36 years
- 40% of respondents were over 50

Highest Degree Held

- most frequently occurring profession – psychologist
- 4 masters level psychologist
- 3 PhD's
- 2 doctorate level clinicians not reporting field degree
- 1 psychiatrist
- 1 registered therapist
- 1 social worker
- 1 master's level therapist (field unknown)

2000 Provider Demographics

Gender/Age

- 89% of respondents were male
- average respondent age – 50 years
- youngest respondent age – 39 years
- 67% of respondents were under 50

Highest Degree Held

- most frequent occurring profession – psychologist
- 3 PhD's
- 3 masters level psychologist
- 1 MSSW
- 1 ACSW
- 1 BA (hons)

1998 Client Information

1998 Online Client's Primary Problems by Counselor Occurrence Ranking

Primary Problem	Most Often	Often	Occasionally	Rarely	Never or No response
relationship issues	5	5	1	0	2
depression	3	4	3	1	2
other	3	0	1	1	8
family issues	1	4	2	3	3
substance abuse	1	0	0	5	7
anxiety	0	0	9	2	2

Table I.2 Terri Powell, <http://netpsych.com/Powell.htm> 1998 (10 Apr 2000)

- 1995 – 445 clients served (total respondents)
- 1996 – 947 clients served (total respondents)
- 1997 – 1344 clients served (total respondents)
- 1995 – average number of clients served 34
- 1996 – average number of clients served 72
- 1997 – average number of clients served 103

2000 Client Information

2000 Online Client's Primary Problems by Counselor Occurrence Ranking

Primary Problem	Most Often	Often	Occasionally	Rarely	Never or No response
relationship issues	4	4	0	0	1
depression	2	3	1	2	2
other	4	0	0	0	0
family issues	2	6	0	0	1
substance abuse	0	0	1	4	4
anxiety	0	4	2	1	0

Table 2.2 Pat Stubbs Mental Health Online Research (16 Apr 2000)

- 1997 – 578 clients served (total respondents)
- 1998 – 907 clients served (total respondents)
- 1999 – 1225 clients served (total respondents)
- 1997 – average number of clients served 64
- 1998 – average number of clients served 100
- 1999 – average number of clients served 136

1998 Client Information Continued

- most contacts reported for one client – 9
- most frequently occurring contact number – 6
- average number of contacts per client – 3

- 1997 – 30% reported increase in practice
- 1997 – 60% reported no change in practice
- 1997 – 10% reported decrease in practice

- 3 female clients for every 2 male clients received services
- 4 respondents (31%) had online practices composed of equal numbers of males and females

2000 Client Information Continued

- most contacts reported for one client – 30
- most frequently occurring contact number – 1
- average number of contacts per client – 7

- 1999 – 11% reported an increase in practice
- 1999 – 89% reported no change in practice
- 1999 – 0 reported a decrease in practice

- there were approximately 2 females for every male receiving services
- 2 respondents (22%) had online practices that only treated females

1998 Practice Information (part 1 of 4)

1998 Important Practice Issues By Counselor Ranking

Practice Issue	Mandatory	Critical	Very Important	Somewhat Important	Relatively Unimportant
Ethics	8	2	2	1	1
Confidentiality	6	3	2	1	1
Liability	3	5	2	0	3
Relationship	2	3	4	3	1
Licensure	2	2	1	1	7
Terminology	1	1	4	4	3

Table 1.3 Terri Powell. <http://netpsych.com/Powell.htm> 1998 (10 Apr 2000)

- average length of time face to face practice – 15 years
- average length of time online practice – 2 years

- 1995 - 7 of 13 practiced online
- 1996 – 8 of 13 practiced online
- 1997 – 13 of 13 practiced online

2000 Practice Information (part 1 of 4)

2000 Important Practice Issues By Counselor Ranking

Practice Issue	Mandatory	Critical	Very Important	Somewhat Important	Relatively Unimportant
Ethics	4	2	2	0	1
Confidentiality	5	2	1	1	0
Liability	3	3	1	0	2
Relationship	3	3	2	0	1
Licensure	1	1	1	2	3
Terminology	0	2	1	2	4

Table 2.3 Pat Stubbs. Mental Health Online Research (16 Apr 2000)

- average length of time face to face practice – 17 years
- average length of time online practice – 4 years

- 1997 – all respondents practiced online
- 1998 – all respondents practiced online
- 1999 – all respondents practiced online

1998 Practice Information Continued (part 2 of 4)

Terminology

- 2 respondents referred to online practice as “counseling”
- 2 respondents referred to online practice as “therapy”
- 4 respondents referred to online practice as “advice” (making it most common name)
- 1 respondent referred to online practice as “education/consultation”
- 5 respondents used the “other category”
- 3 used the term “e-mail counseling”
- 1 used the term “e-mail advice”
- 1 used the term “interactive consultation”

Services Offered

- 12 respondents offered services via e-mail
- 85% used primarily e-mail in their online service
- chat technology was available at 1/3 of the sites
- video conferencing was offered in the service array at one site
- none of the survey respondents provided service using virtual reality technology

2000 Practice Information Continued (part 2 of 4)

Terminology

- 4 respondents referred to online practice as “counseling” (making it the most common name)
- 2 respondents referred to online practice as “advice”
- 2 respondents referred to online practice as “therapy”
- 1 respondent referred to online practice as “consultation”

Services Offered

- 8 respondents offered services via e-mail
- 78% used primarily e-mail in their online service
- 22% offered telephone in their service array
- 44% offered chat technology on their sites
- video conferencing was offered in the service array at one site
- none of the survey respondents provided service using virtual reality technology

1998 Practice Information Continued (part 3 of 4)

Service Fees E-mail

- 3 respondents offered totally free services
- 2 respondents offered free e-mail to their face to face clients only
- 1 respondent charged $100 per month (unlimited e-mail)
- 1 respondent charged $35 for 3 e-mails
- 2 respondents charged per minute spent preparing responses ranging from $1 to $1.50 per minute
- average fees ranged $10 to $20 per e-mail exchange (provider spent 15 minutes preparing on average)

Service Fees Other

- 1 respondent charged $9.95 per service
- 3 responses were difficult to judge (it appeared they were providing their fees for face to face service)

2000 Practice Information Continued (part 3 of 4)

Service Fees E-mail

- 2 respondents charged per minute spent preparing responses ranging from $1 and $1.50 per minute
- 2 respondents charged $20 per e-mail
- 1 respondent charged $30 per e-mail
- 1 respondent charged $35 per 3 e-mails
- 1 respondent charged $100 per month (unlimited e-mail)

Service Fees – Other

- 1 respondent indicated a charge of $150 per chat hour
- 1 respondent indicated a charge of $59 per session
- 1 respondent indicated a charge of $1 per minute on telephone

1998 Practice Information Continued (part 4 of 4)

Strengths/Weaknesses of Mental Health Services Online

- 85% of respondents ranked two items as the strongest advantages to online mental health services
  1. the ability to provide services to disabled clients and those living in rural areas
  2. the increased flexibility of service delivery (services can take place more often without constraints caused by time, weather, and/or illness)
- 77% of respondents ranked decreased defensiveness due to partial anonymity as a major strength
- 70% of respondents ranked opportunity for discovery and research as least favorite strength but still considered it to be of major importance
- additional strengths practitioners identified were:
  - unconstrained time
  - the opportunity to obtain information and validation from many
  - increased use of journaling
  - reduced risk when seeking information about “embarrassing” issues
- all respondents requested a copy of the results

2000 Practice Information Continued (part 4 of 4)

Strengths/Weaknesses of Mental Health Services Online

- 56% of respondents ranked convenience as the largest strength
- 33% of respondents ranked increased access to service as a strength
- 33% of respondents ranked anonymity (in initial contact) as a strength
- 11% of respondents ranked spontaneity as a strength
- 33% of respondents ranked the inability to see client as the largest weakness
- 11% of respondents ranked trust as a weakness
- 11% of respondents ranked confidentiality as a weakness
- 11% of respondents indicated e-mails could be tedious and incomplete
- 11% of respondents indicated that there were no weaknesses or strengths online that did not also exist in offline practices
- all respondents requested a copy of the results

2000 Survey Additional Questions

The following information was not asked and therefore not available from the 1998 survey.

Percentage of Practice Conducted Online

- 50% was the largest percentage of practice conducted online
- 1% was the least percentage practice conducted online
- 10% was the most common percentage conducted online
- 15% was the average percentage of practice conducted online

Scheduled Services (time used to conduct online services)

- 33% of the respondents ranked free time (throughout the day) was the most convenient time to conduct their online service
- 22% of the respondents ranked morning as the time used to conduct their online service
- 22% of the respondents ranked evening as the time used to conduct their online service
- 22% of the respondents ranked anytime was convenient to conduct online service
- 1 respondent indicated chat sessions were only held in the evening time

Membership in International Society of Mental Health Online

- 33% of respondents were members of International Society of Mental Health Online

2000 Methodology

A directory of online mental health service providers is available at Metanoia. Mental Health Providers listed on Metanoia have had their credentials checked and been rated (not on service quality but on validity of the information given about the services) by Mental Health Net (MHN). Information is posted regarding the location of the provider, the services offered, payment structure, status of credentials checks, and more. MHN may give a rating of from one to four stars on the authenticity of the site. Credentials Check validates the authenticity of the provider's posted degrees, licenses, and/or certifications. For purposes of this

study (unlike the 1998 Survey) the caveat group was the only group not sent surveys. All other sites listed in the directory (regardless of rating) were sent an e-mail containing an URL to a website where the questionnaire could be filled out online (a copy of both the 1998 and 2000 surveys are located in the Appendix I, and Appendix II respectively). Participation was voluntary. Participants having difficulty completing the form could request a text copy of questions via e-mail. All participants who completed the questionnaire were assured that their specific practice information would not be identifiable in any way. Metanoia's directory divides the service providers into 3 categories:

1. **Ongoing Contacts** - therapists who work with you in an ongoing series of in-depth e-mails or chat sessions.

2. **One contact only** - therapists who answer a one-time inquiry about any mental-health related topic or concern.

3. **Specialty subjects** - therapists who specialize in a particular topic answer inquiries on specific subjects only: (medication & psychopharmacology, eating disorders, sex offenders and abusers, relationships, sexuality, alcohol & substance abuse, police stress, online relationships. Many of the therapists in categories 1 and 2 are qualified to help you with these issues also.)

Within the three categories there were a total of 64 sites listed at Metanoia. Of those 64, 6 were found to be inaccessible due to problems of bad addresses or error messages. Additionally on some sites I was unable to contact the provider without paying up front. Those providers were not sent an e-mail inviting participation. Therefore, a total of 51 initial e-mails went out to providers. A reminder was sent out two weeks later to the non respondents. Online Practice Groups were invited to return a survey for each service provider who practiced at that internet location. Only one member of a practice group completed the form.

Overall participation was poor in this continually growing field. Since I am a student I was unable to pay participants for their time. It is clear that some sort of financial compensation may have improved the participation numbers. I arrived at this conclusion when I initially only received 4 surveys and e-mailed John Grohol, PhD of the ISMHO mailing list for suggestions. He generously offered a $100 random drawing prize. A third e-mail was sent out and participation more than doubled, bring the final participation number to 9.

Conclusion

Mental healthcare online is more than likely here to stay. Based on the sheer size of the internet and the tremendous growth, can such a field be regulated and by whom? In this report I have discussed some of the ethics of mental healthcare online (certainly not all). There needs to be an understanding first amongst the professionals as what online mental healthcare actually is and, a defining of exactly who is qualified to be providing it and for which particular client it is most appropriate.

If all states were to pass similar legislature to California's Telemedicine Act, it may go a long way in resolving some of the issues, including limits of practice (California practitioners can only treat California patients).

In comparing the survey results it appears (number wise) that there has been little growth. However, I believe this is misleading since there were less participants than the first survey yet more providers were sent the survey. One need only go online and surf the web to see the increasing number of service providers popping up all over the place. I believe this study and others like it need to be done annually to measure growth. It would be nice to secure some kind of grant so service providers could be paid a small stipend for completing the survey each year. An important thing to remember is everyone's time is valuable, and is not limited to just the service provider.

Appendix I

1998 QUESTIONNAIRE

PROVIDER DEMOGRAPHICS

1. Gender _____M _____ F

2. Age _____

3. Please list highest degree held and any applicable certifications/specialties.

CLIENT INFORMATION

4. Approximately how many online clients did you serve?

_____1997
_____1996
_____1995

5. Please estimate the average number of contacts/sessions per client._____

Has this number
___increased
___decreased
___stayed the same in the past year?

1. Client Gender (estimated) _____# of Males _____#of Females

2. Please rate the frequency with which clients requested assistance for the following problems:

1. Most often 2. Often 3. Occasionally 4. Rarely 5 Never

_____relationship issues
_____family issues
_____depression
_____anxiety.
_____substance abuse
_____other - specify_____

PRACTICE INFORMATION

8. What are your fees per session or service provided? (If sliding fee, please give price range.)
_____Individual
_____Group
_____other - specify_____

9. What do you call the cyberservice you provide?

_____Counseling
_____Therapy
_____Advice/ information giving
_____Other - specify _____

10. How long have you been providing online services?

_____ years _____months

11. How long have you been in face to face practice (offline)?

_____ years _____months

12. Approximately what percent of your practice is conducted online?
(Note: this question was somehow omitted from the surveys that got sent!)

13. How do you provide online services? Check all that apply.

_____ Email
_____ real time (chat)
_____ video conferencing
_____ virtual reality
_____ other - specify_____

14. Which of the above technologies do you use most often? _____

15. Please rate from 1-5 the importance of each of the following issues related to online service

1.Mandatory 2.Critical 3.Very important 4.Somewhat important 5.Relatively unimportant

_____Client confidentiality on the internet (anonymity)
_____Licensure (practice beyond state lines)
_____Liability Issues (suicidality, reporting requirements)
_____Terminology (what to call services)
_____ethical issues (fraud, exploitation)
_____therapeutic relationship issues (changes in communication, control)
_____Other - _____

16. What do you see as the major strengths of online services? Check all that apply.

_____Serving disabled clients or those from remote areas.
_____increased flexibility of services (illness, inclement weather, time factors)
_____decreased client defensiveness due to partial anonymity
_____new opportunity for discovery & research
_____other - _____

17. Comments:

_____Yes, send me the results. Thank You!

Appendix II

2000 QUESTIONNAIRE

PROVIDER DEMOGRAPHICS

1. I am listed on Metanoia website as a therapist.

[ ] yes
[ ] no

2. I am a member of ISMHO and on mailing list.

[ ] yes
[ ] no

3. Gender

[ ] female
[ ] male

4. Age

5. Is your practice solely online?

[ ] yes
[ ] no

6. List highest degree held and any certifications/specialties:

CLIENT INFORMATION

7. Approximately how many online clients did you serve?

in 1999?
in 1998?
in 1997?

8. Estimate the average number of sessions per client

3. In the past year has this session number...

[ ] increased
[ ] decreased
[ ] stayed the same

10. Client Gender (estimated)

[ ] # males
[ ] # females

11. Rate the frequency clients requested assistance for (using the scale below):
1=most often, 2=often, 3=occasionally, 4=rarely, 5=never

[ ] relationship issues
[ ] family issues
[ ] depression
[ ] anxiety
[ ] substance abuse
[ ] other - specify [ ]

PRACTICE INFORMATION

12. What are your fees? (per session, or per email, indicate method for calculating fees, e.g. $1 a minute/responding to client email)

[ ] individual
[ ] group
[ ] other - specify [ ]

13. What do you call the cyber service you provide?

[ ] counseling
[ ] therapy
[ ] coaching
[ ] advice
[ ] education
[ ] other - specify [ ]

14. How long have you been providing online services?
[ ] years [ ] months

15. When do you schedule most of your therapy services:

[ ] anytime
[ ] mornings
[ ] afternoons
[ ] evenings
[ ] free time throughout day
[ ] other - specify [ ]

16. How long have you been in face to face practice (offline)?

[ ] years
[ ] months

17. Approximately what percent of your practice is conducted online?

[ ] percent

18. How do you provide online services? (check all that apply)

[ ] email
[ ] real time (chat)
[ ] video conferencing
[ ] virtual reality
[ ] other - specify [ ]

19. Which of the above technologies do you use most often?

20. Please rate from 1-5 the importance of the issues related to online service.

1=mandatory
2=critical
3=very important
4=somewhat important
5=relatively unimportant

[ ] client confidentiality (online anonymity)
[ ] licensure (practice beyond state lines)
[ ] liability issues (suicidality, reporting requirements)
[ ] terminology (what to call services)
[ ] ethical issues (fraud, exploitation)
[ ] therapeutic relationship (changes in communication, control)
[ ] other - specify [ ]

21. What do you see as the major strengths of online services?

22. What do you see as the major weaknesses of online services?

23. Please send me the results of this survey

[ ] yes
[ ] no

24. Comments -

Endnotes

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[14] John Grohol. PhD. <mailto:grohol@netscape.net> “Question.” 13 Apr 2000. Personal Correspondence. (13 Apr 2000).

[15] Martha Ainsworth. <mailto:ainsworth@metanoia.org> “History of Cybertherapy.” 7 Apr 2000. ISMHO General Email List. (7 Apr 2000).

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[20] International Society for Mental Health Online. "Suggested Principles for the Online Provision of Mental Health Services." <http://www.ismho.org/suggestions.html> 2000 (13 Apr 2000).

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