Lyra Video Therapy Manual

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Purpose

At Lyra, we strive to provide the best possible evidenced-based mental health care for our clients. In order to do that, we also aim to provide support and guidance to our community of providers to help them be the best clinicians to our patients.

Given the complexity of providing psychological services over the internet, this manual seeks to highlight the ethical and legal challenges as well as provide best practices recommendations for the practical application of starting video therapy with clients. The information in this manual is not intended to be exhaustive, and the responsibility to provide good clinical and ethical care ultimately falls on you.

Getting Started

Research on video therapy has found it to be effective with a diverse client population and a number of mental health concerns (Backhaus et al., 2012). The benefits of video therapy include reducing barriers to accessing mental health care, reducing costs associated with the provision of psychological services, and increasing frequency of contact and engagement in therapy (Hilty et al., 2013).

As you get started, it is important to review the literature concerning the use of video therapy for the patient populations that you serve. The Telebehavioral Health Institute has an online list of 1000+ free articles related to video therapy for providers (click here to access). You should also take reasonable steps to ensure that you can competently provide video therapy using the indicated technology and consider how it might influence the therapeutic process (American Psychological Association, 2013).

A free webinar is available through Lyra to help you with getting started. Additionally, you may want to also view an online training by the Northwest Regional Telehealth Resource Center. The American Psychological Association (APA) Trust also has an inexpensive online training in telepsychology where you can earn CE hours.

Many mental health disciplines also provide guidelines for their practitioners. These are important to review prior to starting video therapy. Click here to see a comprehensive list of video therapy guidelines and best practices for a variety of mental health disciplines.

The Lyra clinical team will also be available for consultation should you have any additional questions that are not covered by this manual. Please feel free to contact us at education@lyraclinical.com.

HIPAA-Compliant Products

It is important that you use HIPAA-compliant products when you engage in video therapy with clients. At Lyra, we recommend doxy.me which is a free HIPAA-compliant videoconferencing platform. Please see our guide for signing up with doxy.me. You are welcome to use other HIPAA-compliant platforms in your work with Lyra clients. Please note, Skype, FaceTime, and WhatsApp are not HIPAA-compliant so should not be used for video therapy. If you use these services, your sessions could be recorded or released which would be in violation of HIPAA laws.

For any other services that you may use that contain protected health information (PHI), you should obtain a business associate agreement (BAA) with the service to ensure that client information remains confidential. Please check with your services to figure out the process for obtaining a BAA.

Practicing Across State Lines

Your Lyra clients should be located in the same state that you are licensed in. If not, please contact Lyra to make sure the information we have for you is correct and for help connecting the client to an appropriately licensed provider.

Before starting video therapy with clients, it is good to review the professional codes and laws for the state in which you are licensed. Most states require a license to practice in their state if the client is located in that state (e.g., you would need to get licensed in Utah if you see a client who lives in Utah and you currently carry only a California license). Some states will allow you to practice temporarily for a certain number of days (i.e., 30 days) before or during the application process for becoming licensed. This could be helpful if a client is temporarily in another state (i.e., for business travel) and still wants to continue their therapy.

Here is a list of state requirements for the provision of video therapy compiled and disseminated by the APA in 2013. As this document is a few years old, please also review any recent changes to state laws that may apply.

Here is another useful guide published in 2016 and a 2017 appendix update that details state-by-state the laws and regulations for a variety of mental health professionals providing video therapy. (Please allow a few minutes for the documents to load as the file sizes are big.)

You should also be familiar with the state laws and regulations regarding mandated reporting (i.e., child or adult abuse or neglect) and involuntary detainment or commitments in the state in which the client is located. These rules can vary quite substantially across states and certain states may have

specific provisions for clinicians providing therapy over video.

Setting Up the Environment

When conducting video therapy, it is important to be cognizant of communicating a sense of professionalism with the environment that the client views through video therapy. Efforts should be made to mimic the standard therapy room and try to conduct video therapy from the same location each time. Providing a view of the room at the start of treatment can also help demystify the clinical encounter.

Therapists should continue to adhere to all the appropriate standards of practice while conducting video therapy. That means that you should continue to dress (dark, solid professional clothing is best for video) and interact as you would for an in-person session.

For you and the client, pay special attention to ensure that you are both in a location that maintains privacy and confidentiality. Encourage clients to select a location and time in which they will not be disturbed. Additionally, turn off any on-screen notifications or computer sounds that will be distracting during the session. The webcam should be placed in a way such that the face and upper torso are clearly visible.

For clients, encourage them to be in a space that is comfortable but not too comfortable (i.e., lying in bed while participating in therapy is generally discouraged). Ask them to set up their webcam/computer on a hard, stable surface to reduce the movement of the video frame. (Because of the movement, discourage them from putting their laptop on their lap.) Typically, a desk or kitchen table works well. Swivel chairs can also impact video quality if there is excessive movement.

Generally, a background wall with a neutral solid color is best for video. Avoid walls that generate a glare in the video viewing screen. Light blue, grey, beige are good options for background colors. Try to avoid black or white as the contrast can cause a person to appear too light or too dark. Reducing the clutter behind the screen can also be helpful for minimizing distractions.

Efforts should be made to adjust any lighting behind, on the side, or in front of you or client in order to maximize clarity and visibility. For example, uneven lighting may cause shadows on the half the face making it hard to see facial expressions. (See examples below).

Example 1: Inadequate Lighting

Example 2: Uneven Lighting

Example 3: Excessive Direct Lighting

Example 4: Appropriate Lighting

Image source: DoD Telemental Health Guidebook, 2013

Try to position the camera in such a way that each of you is appearing to be eye-to-eye, straight-on, and centered in the monitors. When speaking to a client, look directly at the camera not the view screen so it appears that you are speaking to them. Otherwise, it may appear that you are gazing downward (in the case of a camera position that is too high) or upward (in the case the camera position is too low) at the client. (Encourage them to do the same as well.)

Audio Tips

Audio clarity is even more important than visual clarity when conducting video therapy. The audio should be set so that each person can hear the other well without being so loud that people in adjacent rooms can overhear. Keep in mind that people tend to speak louder than they normally would while engaging with video. Also, when the volume is high, the person on the other end can be perceived as being aggressive or overly assertive.

Equipment

Monitors: Make sure your monitor and your patient's monitor (if possible) are large enough. Small monitors can make it seem as if the person on the other end is gazing downward. The general recommendation is a minimum display of 16 inches diagonally. (See above for positioning recommendations for the webcam.)

Using two monitors can be helpful when wanting to view notes while talking with a patient and may be less distracting for you than toggling back and forth between notes/handouts and the client's on-screen image.

Webcam: It is suggested that your client use a webcam that has the ability to pan, tilt, and zoom to help with tracking movement (particularly when working with children).

Microphones: Utilizing a high quality microphone is essential to the video therapy process. Also, consider microphone placement in capturing the best sound quality possible. Microphones placed next to speakers may cause an echo and should be avoided if possible.

Internet connectivity: A high quality internet service provider with sufficient speed can significantly improve the quality of the video therapy interaction. It is generally recommended that speeds of above 384 kbps are best; however, a minimum speed of 128 kbps is generally adequate.

Phone: If the video conferencing software fails, you may need to rely on a phone to conduct the therapy session. Landlines are ideal, however, cell phones can also be used in the case of video failure.

Fax or Scanner: It can be helpful to have a fax or scanner handy on both sides to exchange documents between you and the client. For example, if you have the client fill out a clinical questionnaire, that document can be scanned and sent back to you. There are also several phone apps that are able to scan documents into electronic .pdfs. Just make sure they are HIPAA-compliant if you are transmitting any identifying information.

Technical Difficulties with Video

You should develop a backup plan in the event of technical difficulties. This should be communicated the to client prior to the start of treatment. You may first want to call the client by phone and attempt to troubleshoot the connection issue. If that fails, then you may need to complete the session by phone. If this continues to happen over the course of treatment with a particular client, then it may be appropriate to refer the client to an in-person therapist if the quality of treatment suffers due to the interruptions.

Informed Consent

In addition to the standard informed consent form, it is also recommended that you provide and discuss informed consent specific to video therapy.

Some suggestions for the video therapy consent include:

- Notify the client of your license/registration number and the type of license/registration you have
- Outline the services you provide by video therapy
- Provide a brief discussion of risks and benefits of using video therapy, including the limitations of the technology as it relates to confidentiality
- Include risks and benefits of not using video therapy, including not being able to access timely mental health services
- Have your client provide at least 1-2 emergency contacts in case of a crisis, as well as permission to contact other mental health providers to inform them of the emergency
- Outline security measures taken to ensure compliance with HIPAA and protect client privacy when information is shared between client and therapist
- Provide information regarding the policies and procedures in the event of technical failures
- Provide information regarding the policies and procedures for crisis situations requiring outside intervention
- Include information on policies and procedures for terminating therapy after several "no-shows"
- Inform the client that they have the option to terminate video therapy at any time and can be referred for in-person care

Additionally, if anyone else is present for the therapy session on either the therapist's or client's side, there should be an agreement made that both parties will inform the other of this person(s) prior to the start of the therapy session. Additionally, if you or the client wishes to tape the session, that should be clearly communicated and informed consent should be obtained from the client.

See the copy of the video therapy informed consent used by Lyra. Please note this informed consent is in addition to the standard consent for therapy.

Safety Concerns

Video therapy poses unique challenges for the management of concerns about suicidality, homicidality, or grave disability. It is important to be familiar with the local emergency contacts in the community in which the client is participating in the video therapy. If you are not located in the same

city, calling 911 will not help. You will need to locate the number of the local law enforcement department for the location of the client.

In general, the safety protocol should include:

1. The specific circumstances under which the protocol will be used. At a minimum, it must cover situations in which:
    a. The client is at imminent risk of suicide and cannot or will not participate in safety planning;
    b. The client is at imminent risk of harming others and cannot or will not participate in safety planning; or
    c. The client is gravely disabled.
2. A statement acknowledging that confidentiality must be maintained except for sharing the minimum amount of information necessary to manage the emergency.
3. Requirements for notifying law enforcement and/or an intended victim(s) if a client has made a credible threat of harming other(s).
4. Process for obtaining contact information for law enforcement in client's geographic area.
5. Process for communicating with local emergency contact(s) in case of emergencies.
6. Process for arranging both voluntary and involuntary hospitalizations.
7. Process for documenting emergency situations and notifying relevant parties.

For detailed information, see Lyra's sample Video Therapy Safety Protocol.

Pre-session Procedures

Before starting therapy with the client, there are a few things that are helpful to do:

- Have a direct phone number for the client in case of any problems with connecting to video therapy.
- Make sure you know what the emergency resources are in the patient's location.
- Have a plan in place for connection difficulties (e.g., therapist will contact the client by phone to help troubleshoot the connection difficulty. If unable to establish a good connection, will conduct the session over phone).
- Make sure the client has your contact information.

First Session

At the first session, be sure to review the standard informed consent plus any informed consent items specifically related to video therapy (see "Informed Consent" section for additional info). It is also good practice to

identify one or two local emergency contacts and/or other mental health providers as part of your safety discussion (see "Safety Concerns" section for additional info). If you haven't already done so, you can also go over your technical difficulties plan and how you might proceed if the video therapy interruptions persist. Be sure to also go over your "no-show" policy and eventual termination of services after repeated "no-shows".

It is also important to take make more effort to connect with your video therapy clients. Slow down your speech and take effortful pauses. Also be aware of audio lags which can sometimes happen due to connection challenges. Distinguish these from silences which are part of the therapeutic process. Also, don't forget to pay attention to non-verbals during the video therapy session as these can also be helpful for the therapeutic process. If you take notes during sessions, it may also be helpful to explain that you may look away from the camera at times to write things down and that should not be perceived as inattention or disengagement.

Each Time You Start

Each time you start video therapy with a client, get the current phone number and address of the location in which the client is currently located and document that in your notes. It is important to document this information at the start of the video therapy session just in case the session is abruptly terminated and you are concerned about safety.

Appointment Scheduling & "No Shows"

Be sure to review with the client how to schedule and cancel appointments with you. If you use email, let them know that it is not a secure form of communication (unless encrypted). If you use phone, make sure they have your number and encourage them to leave a message with options for rescheduling. Let them know how to access emergency resources if needed on your email or phone message.

If a client does not show up for a scheduled appointment, have a protocol in place for next steps. Generally, it is recommended to call the client ten minutes after the start of the session to make sure they are not encountering technical difficulties with connecting to video therapy. If they have "no-showed" the appointment, leave a message with a call back number and a plan for follow-up (i.e., "I will not schedule an additional session until I hear back from you"). If this is a repeated "no-show," it might be helpful to remind them of your termination policy.

Video Therapy with Children or

The room should be appropriately private and large enough to include both the child/adolescent and one or two other individuals (e.g., a parent or teacher). For younger children, it may be helpful to make sure the room is

Adolescents

large enough to include a table or play area in order to view the child's play ability, motor skills, and interaction with a parent. It is suggested that you use a webcam that has the ability to pan, tilt, and zoom to help with tracking the child's movement.

It is also important to be more deliberate about hand gestures, putting them at mid-chest level so they are viewable by the child/adolescent. They also should not be too rapid or they will reduce the pixilation of the image.

A focus on rapport when conducting video therapy with children or adolescents can also be helpful. Generally, a more casual clinical style is recommended for optimizing rapport when working with this population. Also, take the time to demystify the video therapy process if children/adolescents have questions.

Some instruction may be required if children/adolescents are not familiar with the technological equipment. For example, when a child is trying to share a drawing, it may be helpful to instruct the child to hold the picture up to the camera (rather than the monitor) to make it viewable. Similarly, props such as puppets are good video tools to use to help facilitate play interactions. Generally, it is helpful to have an adult present in the room to help with instruction and provide input on the child's behavior and interactive style.

Excluding Clients

There may be some clients for whom video therapy is not recommended. Clients who decline video therapy after the informed consent process should be referred to in-person therapy. Additionally, clients without good computer or internet access will likely find the quality of the video therapy unsatisfactory. Those clients who cannot or refuse to identify at least one local emergency contact should also be referred for in-person care.

Clients with an immediate need for hospitalization or crisis intervention generally are encouraged to seek in-person treatment. Also, refer clients to in-person therapy when there is acute risk of violence, instability, poor impulse control, active suicidal or homicidal plans or intent, or their mental status is severely impacted in any other way. Generally, refer clients with a diagnosis of dementia, cognitive decline, or in need of in-person medical monitoring to in-person care.

Research has indicated that clients with psychosis may benefit from video therapy (Sharp, Kobak, & Osman, 2011; Stain et al. 2011) and should not be automatically excluded. However, caution should be used when working with this patient population and the risks/benefits weighed appropriately.

Additional Resources

Here are some additional video therapy resources that may be helpful to review:

American Academy of Child & Adolescent Psychiatry (AACAP): Practice Parameter for Telepsychiatry With Children and Adolescents.

American Psychological Association: Guidelines for the Practice of Telepsychology.

American Telemedicine Association: http://www.americantelemed.org/home

Internet Delivered Psychological Treatments: https://www.ncbi.nlm.nih.gov/pubmed/26652054

Professional Guidelines & Articles on Telehealth: http://kspope.com/telepsychology.php

Telehealth Resource Centers: http://www.telehealthresourcecenter.org/

References

American Psychological Association: Guidelines for the practice of telepsychology. (2013). Retrieved from http://www.apapracticecentral.org/ce/guidelines/telepsychology-guidelines.pdf.

American Psychological Association: Telepsychology 50-State Review: Practice—Legal & Regulatory Affairs. (2013). Retrieved from http://www.apapracticecentral.org/advocacy/state/telehealth-slides.pdf.

Backhaus, A., Agha, Z., Maglione, M. L., Repp, A., Ross, B., Zuest, D., Rice-Thorp, N. M., Lohr, J., Thorp, S. R. (2012). Videoconferencing psychotherapy: A systematic review. *Psychological Services, 9*(2), 111-131. http://dx.doi.org/10.1037/a0027924

DoD Telemental Health Guidebook. (2013). Retrieved from http://t2health.dcoe.mil/sites/default/files/TMH-Guidebook-Dec2013.pdf.

Hilty, D. M., Ferrer, D. C., Parish, M. B., Johnston, B., Callahan, E. J., & Yellowlees, P. M. (2013). The effectiveness of telemental health: A 2013 Review. *Telemedicine and e-Health, 19*, 444–454. doi:10.1089/tmj.2013.0075

Sharp, I. R., Kobak, K. A., & Osman, D. A. (2011). The use of videoconferencing with patients with psychosis: A review of the literature. *Annals of General Psychiatry, 10*, 14. doi: 10.1186/1744-859X-10-14

Stain, H. J., Payne, K., Thienel, R., Michie, P., Carr, V., & Kelly, B. (2011). The feasibility of videoconferencing for neuropsychological assessments of rural youth experiencing early psychosis. *Journal of Telemedicine and Telecare, 17*, 328-331. doi: 10.1258/jtt.2011.101015

Questions

Please contact education@lyraclinical.com.

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