Psychological Practice in a Post-Pandemic Era

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Published online: 17 August 2021

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The seismic shift to telepsychological service provision observed in the early weeks of the pandemic is evolving to a new, hybrid model of mental health service provision. Results of a survey conducted by Sammons et al. (2021) suggest that most psychologists will continue to use telepsychology to at least some extent in their practices, with approximately 20% of respondents indicating that they anticipate servicing the entirety of their caseload via telepsychology. Psychotherapy is rather uniquely suited for distance service provision, and anecdotal evidence suggests that many patients appreciate the convenience it affords. But not all forms of psychological service provision are so easily digitized, and many complex evaluations and mandated services will continue to require in-person care. Patient demographics, as well as patient choice, play a role. The survey results demonstrated that a significant minority of practitioners reported that patients lacked sufficient internet access to engage in distance service provision. Adopting an entirely digital service platform may, then, create a two-tiered patient system, and since those lacking internet access are more likely to have limited financial resources, perpetuate extant digital divides. Such divides may be based on factors not associated with income. For example, patients determined to be of lesser acuity may be shunted to a digital platform, with in-person services reserved only for those with more urgent problems (Tepper, 2021). Because many of the government emergency orders put in place during the pandemic may not be replaced by permanent legislation, the absence of enduring parity mandates may be another factor perpetuating a digital divide (Warren & Smalley, 2020).

It is an unfortunate reality that many individuals affected by the digital divide are people of color (Lewis, 2017). Numerous factors contribute to this divide, including rural status, age, cognitive ability, and overall health status, but BIPOC individuals do appear to be differentially affected. As

telehealth becomes more firmly embedded in the healthcare delivery system, some have argued that lack of broadband access should be considered as a social determinant affecting negative health outcomes (Clare, 2021). Mulchan et al. (2021) argue that implicit bias and potentially stigmatizing health conditions negatively affect access to health services in BIPOC youth. While effective interventions, such as motivational interviewing, may enhance participation, it is necessary to ensure that this population has adequate access to platforms providing these services. In the complex case that they present, they observe that racial and ethnic minority patients, as well as those of perceived lower economic status, may not be afforded the same treatment options as more affluent patients. Multidisciplinary treatment teams can mitigate the effects of bias expressed by a single practitioner. One can easily envision an online community as a key element in the treatment plan of an adolescent with multiple physical and psychological challenges.

Vujanovic and Tran (2021) emphasize the importance of understanding the culture of first responders—specifically firefighters. Since stigma regarding utilization of mental health services is a recognized barrier to care for this at-risk population, telepsychology may provide a more acceptable option for those with concerns about confidentiality. On the other hand, the authors note that substance abuse, domestic discord, and suicide risk may be more prevalent among firefighters, especially in volunteers, who comprise the majority of the firefighting force. These factors do not necessarily rule out distance service provision for firefighters but mandate that the telepsychology providers pay close attention to risk mitigation and have clearly articulated informed consent procedures for distance services. Safety plans that address access to emergency services at the patient's location must be a component of such informed consent.

As noted earlier, some psychological services cannot be conducted via distance technology. Steadman (2021) presents an instance involving intervention in the case of possible school gun violence, which clearly mandates interaction with multiple persons and entities. The psychologist's duty to protect cannot be executed without direct contact with potential victims, law enforcement authorities, and school personnel. Confidentiality may be abrogated in emergency situations, but in any ongoing treatment of a minor, assent issues, confidentiality, and parental involvement are bedrock therapeutic issues that complicate treatment, whether in-person or via telepsychology. In this context, it is worth noting that duty to warn standards differ between states, so in any instance involving inter-jurisdictional telepsychology services, knowledge of the duty to warn standards in both jurisdictions is essential. As Steadman cautions, the ethical responsibilities and mandated reporting requirements differ among the many professionals who may be involved in assessing potential school violence. It is incumbent upon the treating psychologist to make patients and guardians aware of the ramifications of these differing requirements on patient confidentiality.

Evaluation and management of the sequelae of enduring interpersonal violence is another situation where multiple persons and entities are likely to be involved. In the case presented by Van Buren and Liebman (2021), the evaluating psychologist will find it potentially necessary to interact with social service agencies, foster care agencies, and employers. Such evaluation is multifactorial. A complete evaluation may require prior treatment records, collateral interviews, and the administration of psychometrically valid instruments. Thus, while some components of an interpersonal violence assessment might take place via telepsychology, others, such as formal testing, are not amenable to this modality. Van Buren and Liebman note that a history of interpersonal violence can lead to varying diagnoses, including posttraumatic stress disorder or potentially to a complex trauma syndrome, the exact parameters of which are still being debated. Regardless of any ultimate diagnosis, interpersonal violence is likely more common than not, and a standardized approach to its assessment is a necessary component of effective treatment planning.

In sum, the papers in this issue of the *Journal of Health Service Psychology* emphasize the need for multimodal treatment approaches. Telepsychology may not be ideally suited for some patients due to the acuity or complexity of the presenting problem. Alongside other potentially limiting

factors such as broadband accessibility and living situations conducive to telepsychology, patient preference must be carefully assessed before the provider recommends this approach. Telepsychology is an effective tool that can be successfully incorporated into many treatment regimens. Still, those providers who opt to engage purely in telepsychological practice must recognize its limitations and be ready to make an appropriate referral.

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