ATTITUDES OF THE MENTALLY ILL ABOUT

UTILIZING TELEMENTAL SERVICES

IN FRONTIER STATES

by

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ABSTRACT

The purpose of this qualitative research study was to explore the feelings, opinions and attitudes of mentally ill people living in frontier states about telemental health service to access their mental health care. The current study explores the feelings of people diagnosed with a variety of mental illnesses.

Participants in this study were chosen in a purposive criterion sample, and snowball sampling. This study included nine participants aged from 36 years of age to 68 years of age, diagnosed with a mental illness including, Paranoid Schizophrenia, Bipolar Disorder, Major Depressive Disorder, Obsessive Compulsive Disorder and Post Traumatic Stress Disorder.

This study was limited by the numbers of willing participants with a mental illness living within the frontier areas of the state the study was conducted in. This limitation is overcome by utilizing the snowball effect for recruitment of willing participants.

Eight of the nine participants of this study were willing to use telemental health for their mental health care. Others commented that they were acceptant and willing to utilize telemental health services for their mental health care needs after a period of time to build rapport with their provider. The major themes developed from the participant interviews were; savings, convenience, privacy and anonymity, rapport, crisis intervention and technology. The participants voiced an opinion that the general savings of time, money, travel and hours of work saved was a part of their acceptance of telemental health. The themes of acceptance can be developed in to methods to improve future models of telemental health. By understanding what would make this treatment modality more acceptable future providers can tailor a telemental health program that is fully acceptable to the clients who will utilize it.

CHAPTER 1

<u>Introduction</u>

In frontier areas of the western United States people diagnosed with a mental illness not only struggle with the illness, but also with limited access to specialized treatment. Mental health professionals strive to develop new ways to reach the underserved rural populations, which includes telemental health. "Telemedicine, and in particular, telemental health networks, have the potential to diminish the disparity of mental health care based on population density characteristics. Rural and frontier communities, compared to urban and metropolitan ones, typically are the last areas to receive advances in mental health care, such as newer antipsychotic medications or specialized treatment programs"(Smith & Allison, 1998, p. 1).

The use of telemental health is inexpensive, easily accessible, and even billable by Medicare and Medicaid. Studies have shown that the patients who use internet-based services view themselves as part of a larger community of online persons (Barnes, 2007). Participants of telemental health also may have improved feelings of acceptance and decreased depression. Additionally, Barnes purported that internet-based treatments may be used more by persons who have been somehow distanced by more traditional treatment for various reasons. In contrast to the Barnes study, this current study looks at how willing mentally ill people living in frontier areas are to use and access treatment services for mental illness via telemental health services.

With current innovations in computer technology and video communications the concept of telemental health has become more understood and accepted by providers and clients alike. Telemental health may be accessible from a client home, medical facility, school, or even medical clinic with modern technology. The common means for access to telemental health is internet service, which is rapidly becoming more accessible. One telephone company, in the region of the study, offers high speed internet to a large frontier area for a fee of $50.00 per month (Nemont, 2011), while another one has a similar internet costs, with an additional cost for required land line phone service (3 Rivers, 2011) for in-home internet. In some future instances the client may be able to access telemental health from their home via the internet and a home computer with a video link to the internet. This method would allow for the maximum in client comfort of their home.

The Department of Health and Human Services (2011) lists telemental health services as billable in rural health professional shortage areas, which covers many frontier areas. The services must originate from places such as health care clinics, hospitals, and even practitioners' offices. The advantage is that the client and the provider do not need to be at the same geographic location. For example, the provider may be in their office at a mental health clinic and the client may be in a special room at a medical clinic near to their home which may be hundreds of miles away from the provider. The telemental health services may be delivered by a physician, nurse practitioner, counselor, therapist and other licensed health care professionals. Standard Healthcare Common Procedure Coding System (HCPCS) codes are used in this billing.

The ability to bill for services provides incentive for the mental health professional to reach out to frontier areas that are often underserved.

Telemental health services have been studied and shown to enable the provision of client consultation, care, and education to areas that have been previously inaccessible by traditional care due to their remote locations (Shore et al., 2008). With modern technology, internet services are accessible in most areas and therefore, telemental health could be readily available. Persons could access treatment from the comfort and safety of their own home at times that are more acceptable to their schedule by using their computer. The individual client may also maintain anonymity in more public settings by using special telemental health rooms at their local medical clinic.

Telemental health has advantages in areas of low populations, geographical isolation or with patients with transportation difficulties and in areas where there are no mental health professionals (McLaren, 2005). Although potential advantages of telemental health are known, the acceptability of this form of treatment has not been well assessed in the frontier western U. S. Furthermore, while studies have shown telemental health's ability to deliver patient care at a distance, there is limited research in the area of acceptability by clients (Shore et al., 2008).

Purpose of Study

The purpose of this study was to assess the feelings, opinions and attitudes of mentally ill people living in frontier states about telemental health service to access their mental health care. The findings of this study will lead to suggestions in providing

methods of care for making telemedicine more acceptable for clients dealing with mental illnesses in frontier areas. The research question for this study is: "How do mentally ill people living in frontier states feel about utilizing telemental health for therapeutic services?"

Significance of Study

There is a shortage of mental health and psychiatric providers in frontier states. The shortage of providers impacts how long a patient will have wait before they can see a provider. This in turn can have adverse effects on the well-being of the patient. Smith and Allison (1998) suggests the benefits of telemental health could be far reaching in serving clients in the remote regions that may not otherwise be able to access specialized mental health services. These adverse effects may include hospital admissions, missed days of work or school, and even suicide. The availability of telemental health may help to reduce the length of stay and readmission rates to mental health facilities, as well as offer an additional resource to clients struggling with thoughts of self-harm and who are unable or unwilling to seek traditional mental health care. Therefore developing telemental health services that are acceptable to the mentally ill is a potential outcome of this study that could benefit both the client and the provider.

In one area Psychiatrists and Psychiatric / Mental Health Nurse Practitioners were employed by The Center for Mental Health (C4MH). This area had five Psychiatrists and two Nurse Practitioners located in the urban area with none in rural or frontier areas. There was a small therapist outreach office in other frontier sites that

transported patients to see providers in the urban area at regular intervals. The C4MH

had 14 outreach offices in 13 counties of Montana's 56 counties servicing the mentally ill

with therapeutic services.   According to Ken Kelvin (2009), the former executive

director of the C4MH, they had 5,802 open cases (clients) in the 13 counties, with over

3,400 of them being served from the urban offices. The C4MH had 321 employees and

an operating budget of $17 million dollars a year. This makes a ratio of 645 patients to

each provider. The ratio of clients to providers was very large, in the largest mental

health center in the state, and it was reasonable to conclude that in the frontier areas of

the state the ratio of patient to provider is larger. The perceived reason for the large

patient to provider ratio was because of a general lack of mental health providers in rural

and frontier areas.

In 1994, a hospital in one western frontier state was awarded a grant by the

Federal Office of Rural Health Policy for a three year video link treatment system. This

system covered a "12 county area that encompassed a 28,509 square mile area with a

population of 190,000. The service area has a population to psychiatrist ratio of 30,000

to 1" (Smith &Allison, 1998, p. 6). While this number includes the entire population of

the region and not just the mentally ill, as the C4MH client to provider ratio does, it

remains significant.

<div align="center">Theoretical Framework</div>

Phil Barker's "Tidal Model of Mental Health Recovery" provided the conceptual

framework for this study. The Tidal Model "emphasizes the central importance of:

developing understanding of the person's needs through collaborative working,

developing a therapeutic relationship through discrete methods of active empowerment,

establishing nursing as an educative element at the heart of interdisciplinary intervention"

(Brookes, 2006, p. 697). Furthermore, through the Tidal Model the story of the client

becomes the central focus of care along with a partnership between the client and the

provider. There are ten commitments that provide basis for the Tidal Model that consist

of; value the voice, respect the language, develop genuine curiosity, become the

apprentice, reveal personal wisdom, be transparent, use the available toolkit, craft the step

beyond, give the gift of time and know that change is constant (Brookes, Murata &

Tansey, 2008).

The concept of changing lives and ability to access care is easily transitioned and

blended with the overall flow of the Tidal Model. "In the model, tides are a metaphor for

lived experiences. Tides ebb and flow; they are constantly changing and full of

possibilities" (Brookes, Murata & Tansey, 2008). The Tidal Model was developed by

Phil Barker and launched in 1997 as a novel approach to mental health. It has since

become an internationally recognized model for mental health recovery, not merely

mental health treatment, as earlier models had been. The Tidal Model has been utilized

from outpatient settings, to high-security forensic ones alike. The central focus of the

Tidal Model is helping people face their problems while developing person-centered

approach to mental health care (Barker & Buchanan-Barker, 2008).

The Tidal Model is conceptualized as a holistic model to include the client as a

valued member of their recovery, and not just a recipient. Allowing for the flexibility of

the client to choose between face to face, or telemental health communication for their

care conformed to the idea of changing services in order to meet the client in the manner

that will be most beneficial for their mental health. Furthermore, telemental health has

been used as either a stand-alone style of therapy or in conjunction with more traditional

face to face therapy methods, which again offered a sense of flexibility to the care. Just

as the Tidal Model allows for less restrictions of location for therapeutic visits it respects

the wishes of the client, and encourages participation with mental health care.

Telemental health allowed for the client to further express themselves and participate in

their care rather than being a recipient only as with traditional face to face mental health

care.

Barker (2001) recalled that Florence Nightingale observed that nurses are like the

foot soldiers who carry out the orders of the generals against illness. The Tidal Model

gave a voice to the client along with their care provider. The concept of telemental

health, through its flexible approach and ability to reach beyond traditional mental health

treatment, blends with the Tidal Model. Specifically through the knowledge that change

is constant, as is the ability to use telemental health from a variety of locations, as well as

through the gift of time and crafting a new step in the clients mental health recovery

program.

<u>Definitions</u>

The following definitions are presented for use in this study and intended to assist the

reader.

1) Mental Illness: Mental illnesses are serious medical illnesses. They cannot be overcome through "will power" and are not related to a person's "character" or intelligence. Mental illness falls along a continuum of severity. It includes, yet is not limited to: Bipolar disorder, eating disorders, major depression, schizophrenia, seasonal affective disorder, depression, suicide, personality disorders, post traumatic distress syndrome and mood disorders (NAMI, 2011).

2) Frontier area: A frontier area consists of sparsely populated areas that are isolated from population centers and services. The recommended frontier area definition is: "ZIP code areas whose calculated population centers are more than 60 minutes or 60 miles along the fastest paved road trip to a short-term non-federal general hospital of 75 beds or more, and are not part of a large rural town with a concentration of over 20,000 population" (NRHA, 2008).

3) Telemental health: "Any type of professional therapeutic interaction that makes use of the internet to connect qualified mental health professionals and their clients" (Rochlen, Zack and Speyer, 2004, p. 270).

4) Counseling Services: "A professional relationship that empowers diverse individuals, families, and groups to accomplish mental health, wellness, education, and career goals" (American Counseling Association, 2012).

5) Face to Face: Meeting in person, in the same office setting between client and provider.

Limitations

This study was limited by the numbers of willing participants with a mental illness living within the frontier areas of the state the study was conducted in. This limitation was overcome by utilizing the snowball effect for recruitment of willing participants.

Assumptions

1) There is lack of services for people dealing with psychiatric or mental health illnesses in the frontier areas.
2) Telemental health treatment services will be a method to reach isolated people in frontier areas.
3) Persons living in frontier areas will be willing to access treatment for mental health by telemental health services.
4) Using telemental health based treatment will allow for more flexibility and personal comfort of the client during treatment.

Summary

Typically specialized mental health services are located in more urban areas of states, leaving people in frontier areas with a choice to travel to the urban area for care or forgo specialized care. Telemental health is a method that can be utilized by mental health professionals to reach these underserved persons living in frontier areas. Reaching the frontier patients who do not have the ability, funding, or means to travel to an urban

community for treatment is one area where telemental health treatment could save time,

money, and improve the recovery of mentally ill people. Telemental health services that

enable people to access treatment from home or a nearby location would make mental

health providers more accessible, and cold potentially decrease wait time for services.

This in turn may decrease relapses, hospitalizations, and improve the quality of life of the

mentally ill in frontier areas. However, if mentally ill clients have unfavorable attitudes

about telemental health, their utilization, and satisfaction with this form of delivery, will

likely impact the success of this form of therapy. This study explored the attitudes and

opinions of the mentally ill, who will most benefit from telemental health services.

Existing studies have only looked at the opinions of the providers and those with either

no mental health diagnosis, or only veterans with Post Traumatic Stress Disorder (PTSD).

CHAPTER 2

REVIEW OF LITERATURE

Introduction

The concepts for the search were derived from the research question in order to promote a more focused internet search. The areas of literature that were reviewed for this project were telemental health and the acceptability of telemental health. The area of telemental health included the structure of current programs, insurance reimbursement, and provider acceptance. There were far more literature results focused on the effectiveness of, and how to develop telemental health programs, then on acceptability of telemental health by the client. The area of acceptability of mental health care focused on client perceptions and reasons for acceptance; although not all the clients in these studies had a diagnosed mental illness, and some were children.

Two databases were used in this search using the search terms; telemental health, opinions, attitudes, acceptance, and frontier. The initial search was done using the Cumulative Index to Nursing and Allied Health Literature (CINAHL) accessed through the Montana State University library. The CINAHL database contained articles and literature from 1981 to 2012. Initially, the search was limited to a five year span (2006 – 2011), but due to the limited results, the search was broadened to cover a 10 year period (2001 – 2011). During the CINHAL database search a large number of results were obtained that were not related to the current research question. With the limited search parameters, and numerous terms, results that were not directly related to the current

research were obtained using the CINHAL database; therefore a second search was done using the PubMed database. The second database was found at www.PubMed.gov and was supported by the U.S. National Library of Medicine and the National Institute of Health. It was last revised in January of 2012. The articles that were discovered during these two searches were summarized in this chapter.

Evolution of Telemental Health

Telecommunication was initially utilized for distance health care in 1920 in Norway where radios were used to direct care to ships at sea. Over time this concept was transformed from a method for physical health to also include mental health. In 1956 the National Institute of Mental Health (NIMH) supported development of a two way radio link that connected the Nebraska Psychiatric Institute to seven hospitals in Nebraska, Iowa, and North and South Dakota for mental health consultations. Later the NIMH funded another project in 1968 that allowed for communication with the psychiatry department at Dartmouth Medical School and a rural hospital in Claremont, New Hampshire. The new project in telecommunication for mental health allowed for mental health consultations without the patients having to move from his or her home environment (Smith & Allison, 1998).

Acceptability of Telemental Health

Rohland, Saleh, Rohrer & Romitti (2000) conducted a study in a rural area in the Midwestern U.S. with a sample of 200 randomly selected participants. The participants were at least 18 years of age, and a stratified sampling scheme based on the percentage of the total population was used. Telephone surveys were used to determine seven topics: demographic information, access to health system, health status, mental health status, adaptive coping, and willingness to participate in telepsychiatry or to recommend it to a friend. This study did not specifically target those with a diagnosed mental illness.

Two thirds of the participants stated they were willing to use telemental health services if they needed mental health care, furthermore nearly three-quarters of the participants suggested they would recommend this treatment modality to their friends. Participants of this study who were physically healthy and had no mental illness were more likely to use and recommend these services then individuals who viewed themselves as having health concerns. The participants who were not willing to use or recommend telemental health cited reasons such as concerns of confidentiality, and a feeling of impersonal connection with the provider in their objections of this form of care.

The majority of the rural residents who participated in this study (57%) did not view themselves as having medical concerns and were accepting of telemental health for mental health services. Younger participants were more likely to be accepting of this form of mental healthcare then the older participants. One third of the participants who were not accepting of telemental health services cited reasons related to impaired hearing,

vision, and concerns of confidentiality. Also noted, was that the population of the participants who on Medicare or Medicaid were less accepting of telemental health care.

Grubaugh, Cain, Elhai, Patrick & Frueh (2008) discuss acceptance of both telemental health, and telemedicine for mental health, and medical care. Grubaugh suggested patients with posttraumatic stress disorder (PTSD) may be more likely to use telemental health than traditional face-to-face methods because of barriers associated with the illness, such as social isolation.

The purpose of this study was to examine the attitudes toward medical and mental health care delivered via telehealth. This study used a cross-sectional survey and included 194 participants who presented for appointments at two different primary care clinics at a medical school in the Midwestern U.S. The participants in this study were compensated $10 for their participation and completion of the survey tool that was utilized. After the data collection phase the results were separated into rural (58.8%) and urban (41.2%) populations. The results of this study showed that both the urban and rural participants were receptive and accepted the use of telemental health for their mental health care. Only a small percentage of the participants had concerns about the complexity of the technology utilized by telemental of health. Interestingly, over one half of the participants reported they would expect telemental health to be as helpful or even superior to traditional face-to-face care.

Shore., et al. (2008) conducted a study that investigated acceptability of telemental health in Native Americans with PTSD. This filled a gap in existing knowledge of telemental health acceptability, since cultural differences of Native

American participants exist, and there had not been any studies specifically focused on the acceptance of telemental health in this population. The study included 53 Native American veterans of the Vietnam War who were being treated for PTSD. The age range of the study population was 46 years old to 71 years old.

Results of the study showed that there was little difference in the acceptability in this population between telemental health and traditional face-to-face mental health care. Generally there was positive response to telemental health (94%) with only a small number finding the necessary technology difficult to use (15%). Ninety two percent of the participants of the study stated that they would be willing to use telemental health in the future.

Urness, Wass, Gordon, Tian & Bulger (2006) conducted a study on acceptability of telemental health as compared to face-to-face care. This study was conducted over one year, encompassed 11 sites across the Canadian province, and included participants from 18 to 60 years old.

Results from the study showed that the participants were generally positive about the time savings as well as travel savings associated with telemental health, as opposed to traditional face-to-face services. The researchers noted that all of the participants felt that their provider had listened to their concerns, felt supported and encouraged during their telemental health session. The majority of the participants in this study felt they were able to discuss the same information via telemental health as they were in person. Overall during the study participants expressed high levels of satisfaction with their session of telemental health compared to traditional face-to-face mental health.

Boydell, Volpe and Pignatiello (2010) studied the attitudes of children about utilizing telemental health care. This study took place in Canada and included 30 children who range from 7 to 18 years old. The goal of this study was to account for the experiences and acceptance of Canadian youth receiving telemental health services.

Four main themes were derived from this study and they included the actual visit with the provider, having other people in the room, helpfulness of the session, and a sense of personal choice. The initial cause of anxiety for the participants of the study was based upon complexity of the technology. Another concern was about having other people in the room during the visit, other than the mental health provider on the video system. The youth who participated in this study noted that they felt more empowered by utilizing telemental health as opposed to traditional face-to-face care. The participants viewed themselves in more control over the session via telemental health than they did in face-to-face sessions.

The participants were generally able to express a positive therapeutic relationship while using telemental health. They also were acceptant of the provider's expertise in mental health. An appreciation for expressing pent-up emotion to an attentive listener was also expressed as a positive point of telemental health. Some suggestions by the participants in the study included ways to make telemental health more acceptable to them. These included making the room less formal by making sure there are no obstructions between them and the video monitor. The youths who participated in this study noted most commonly that the most positive facet of telemental health was exposure to new technology.

Summary

Gaps identified in the current literature included a lack of input about acceptance from adult mentally ill persons other than those diagnosed with PTSD, as noted in two of the presented studies. Two of the reviewed articles noted the paucity of research about the opinions and attitudes of the consumer of telemental health. Much of the available research done examined the development and usefulness of telemental health programs without taking in to consideration the attitudes and opinions of the prospective clients.

The current research study differed from the previous research by looking at the acceptability of telemental health by adults, with a diagnosed mental illness, living in frontier areas of the western U.S. The study included research subjects with a variety of mental illnesses, such as; Paranoid Schizophrenia, Bipolar Disorder, Major Depressive Disorder, Obsessive Compulsive Disorder and Post Traumatic Stress Disorder. Educational levels of the participants from the eighth grade education to bachelor's degree were also included in this study. This research is valuable because it may help develop telemental health programs that are acceptable to the adult mentally ill population, with a variety of diagnosed mental illnesses. This research may also benefit the mentally ill who are geographically isolated in the frontier regions of the western U.S. This study may further the development of accepted telemental health programs that can help specialized providers in urban settings reach the geographically isolated populations of mentally ill, that have previously been underserved.

CHAPTER 3

METHODOLOGY

Introduction

This chapter describes the methodology of this study: the source of participants, selection of participants, the risks, and benefits to the participant, the consent, privacy, and ethical considerations of the participants, as well as the data collection and analysis. The purpose of this study was to determine the attitude of people living in frontier areas regarding the use of telemental health service to access their mental health care. The findings of this study will lead to suggestions in providing methods of care and suggestions for making telemedicine more acceptable for clients dealing with mental illnesses in frontier areas.

The research design was qualitative in nature, using one semi-structured interview with questions designed to elicit the participant's attitudes and opinions about using telemental health. The interviews were done to test the research question: How do mentally ill people living in frontier states feel about utilizing telemental health for therapeutic services?

Sample

The overall population consisted of people with any diagnosed mental illness or disorder. The target population was those with a diagnosed mental illness or disorder who lived in a particular frontier area of the western U. S. The sample size was based on

extant research. Luenburg and Irby (2008) suggest that, for qualitative research, from eight to 15 participants be included in the study. For this study, a sample size ranging from eight to 15 mentally ill people living the western U. S. were chosen in order to allow for time and full expression of opinion by participants the study. The intent was to continue with data collection until saturation was achieved.

Participants in this study were chosen in a purposive criterion sample, and snowball sampling. Purposive sampling included this researchers experience and knowledge with the group being sampled. Subjects were recruited by word of mouth, by posting of a flier, and snowball sampling. The flier was posted in areas that were likely to be seen by potential eligible participants for this study. These locations included near medical and mental health facilities as well as near offices of public assistance. The fliers listed the study topic, requirements for participation, a notice of being completely voluntary, non-payment for participation and contact information for this researcher. An example of the flier is located in Appendix A.

The word of mouth approach involved informing mental health workers, that were known to the researcher, about this study and the need for recruitment of participants, as well as the information that was provided on the flier. The mental health workers were asked to give a flier to prospective participants.

The inclusion criteria for prospective participants consisted of female and male mental health clients of at least 18 years of age. The participants had a diagnosed mental illness and lived in the frontier area of the western U. S. The participants may have been on prescribed mental health medications as part of their current treatment. The

participants were not suicidal, homicidal, or actively psychotic during their participation in the study. The participants may or may not have had experience or exposure to telemental health services prior to this study. The participants are residents of the region of the western U. S. where the study took place. The participants must have been able to read and speak English. It was preferable that the participants have had past experience with face to face therapeutic services for their illness. Exclusion criteria was included a participant not meeting the above criteria.

Design of the Study

Qualitative research and Phil Barker's Tidal Model were integrated together for this study. The Tidal Model takes in personal experience, stories and uses the person's own language to clarify questions by using essential values of the model. By incorporating the Tidal Model concept of allowing a person the freedom of personal expression, with semi-structured interview format, a free flowing, and expressive interview setting was created. Personal expression was easily attained by the combination of the Tidal Model ideas of allowing total expression of the client in their complete thoughts, even with poor grammar or personal sayings and ideas. With the open ended questions in the semi-structured interview format the participant was easily allowed to speak of their own and very individualized opinion about the study topic (Brookes, 2006).

The idea of qualitative research helped to emphasize understanding of the participant by their words, actions, and responses to the open ended questions

(Lunenburg & Irby, 2008). The idea of understanding a participant through qualitative

research, in which they are allowed opportunity to speak their opinions meshed well with

the theoretical basis, and methodology of this study. This combination of theory,

research design and methodology lent itself to the individualization of mental health care.

Instrumentation

The one instrument used in this study was a semi-structured interview with five

open-ended questions, and five clarification questions (Appendix B). This allowed

participants to respond freely, expressing themselves without constraints and allowing

respondents to answer in their own words. (Lunenburg & Irby, 2008; Meadows 2003).

This brief semi-structured interview had initial specific questions about the participant's

feelings and opinions of the use of telemental health services, in place of the traditional

face to face treatment. The questions were open-ended to probe the participants for

opinions, attitudes and life experiences about telemental health. Although the focus was

on the use of telemental health for therapeutic services a variety of questions about

mental health services were asked to obtain information and the participant's opinions.

They were also asked in follow up questions their opinions about using telemental health

in conjunction with traditional face to face treatment. Follow up questions for

clarification and more detail were asked during the interview.

Data Collection

Eight to fifteen participants were sought to participate in this study. Upon initial agreement to participate in the study this researcher contacted the participant by phone to set up an in-person visit to discuss and explain the study in detail, if desired by the participant. In some instances the participants made the initial contact with the researcher. At the initial meeting, the participant was asked to read the human subjects consent form if he or she was interested in participating. Upon agreement the participant scheduled a date and time for the interview if they were not able to do it at the same time. The interviews were recorded and field notes were taken. Audio files were transcribed and common themes were developed. No follow-up interviews needed to be scheduled. The interview location was a private place to provide for confidentiality and more open expression of ideas (Lunenburg & Irby, 2008).

Data Analysis

During the data analysis the interviews were analyzed as suggested by Meadows (2003) to help discern the resulting themes for categorization as were field notes take during the interview. Polit and Beck (2008) note the importance of verbatim transcription of the interview recordings to prepare the data for analysis. This step is to reflect the totality of the interview and strengthen the results. The transcripts of the interviews were read and categorized by the researcher. Common themes were identified. From these themes the key themes were identified as was the general answer to the research question.

Risks to the Participant

Written information about the study was given to participants during the selection phase as well as in a participation in human research consent form that was provided to the participants prior to their interview taking place. The participant is given time to read, comprehend and ask any questions they may have about the consent prior to signing it with their initials and the interview starting. A copy of the subject consent form is provided in Appendix C.

The potential risks for participants in this study included the minimal chance that asking for their opinion and attitudes of telemental health could precipitate a mental health crisis. This researcher is a psychiatric and mental health nurse with over 10 years of experience, and trained to recognize and assess a mental health crisis. This researcher also has a through awareness of community resources for referral in the event of a crisis. The potential for invasion of privacy was an additional risk as the participant was asked the nature of their mental illness and current treatment as inclusion or exclusion criteria. Coercion was avoided by allowing the participant to make the final decision on participation. If the participant had any reservations about meeting for the interview in their home they were offered alternatives such as private meeting rooms at locations that were comfortable for them.

Privacy and Confidentiality

The personal information from the study was protected as outlined by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This information

included names of participants, phone numbers of participants, any identifiers and

interview responses including the interview tapes and field notes. This information was

kept on a personal note pad that was kept in the locked personal office of this researcher.

The information was permanently destroyed after the data analysis process.

The researcher made every effort to protect the identity of the participants. All

information that was provided was kept confidential, with only the initials of the

participant used on the consent form and in the results of this study. The notes and

recordings were not included in any of the participants' medical or mental health records.

The notes and recordings were kept in a secure (locked) file in the personal office of the

researcher. Only initials were used in any communication or correspondence during this

study. Upon completion of the research the notes were shredded, the recordings and

computer files were permanently deleted. The information that was produced and

reported from this study does not contain any personal information from individuals,

rather only general data regarding attitudes about utilizing telemental health services.

Benefits to the Participants

The participant was advised that there would be no direct benefit to them for their

participation in the study. General potential benefits to the participants were obtaining

information that could improve current methods of mental health treatment that can reach

geographically isolated persons in the western U. S. This in turn may benefit the client

by a savings of their time and money as well as increasing their access to specialized

mental health care. Benefits further provide future researchers and telemental health care

givers assistance in developing an additional avenue of care for those with a mental

illness to add to their current method of treatment. The development of improved care

and access via telemental health could potentially save the client from hospitalizations

and perhaps unnecessary treatments or medications.

Ethical Considerations

Prior to the implementation of the study, institutional approval was obtained from

the Montana State University Institutional Review Board. This researcher completed the

Collaborative Institutional Training Initiative (CITI) basic course and the National

Institutes of Health (NIH) web-based training to assure the appropriate and ethical

treatment of human subjects in this research study. A copy of the certificate of

completion for each training is located in Appendix D.

Summary

This chapter showed the selection process for the participants along with the

manner in which their human rights were protected. The design and manner the study

was conducted was also discussed, as was the connection between these components and

the theoretical basis for the study. A participant sample size of eight to fifteen

participants was sought. The study was discussed with each participant and consent was

obtained prior to the interviews taking place. Each interview was of a semi-structured

nature and in a setting chosen by the participant. Data collection was in the form of

recorded answers to the semi-structured interview that were later transcribed. The data

analysis took place after transcription of the interviews, and included the categorizing of

the responses. The results of the study are presented in the following chapter.

CHAPTER 4

FINDINGS

<u>Introduction</u>

This chapter presents the findings of the study about the attitudes and opinions of the mentally ill, about utilizing telemental health for therapeutic services. This study included nine participants aged from 36 years of age to 68 years of age, diagnosed with a mental illness, not currently suicidal, homicidal, or experiencing psychotic symptoms of their illness. Six of the participants were male and three were female. Mental health diagnosis of the participants included Paranoid Schizophrenia, Bipolar Disorder, Major Depressive Disorder, Obsessive Compulsive Disorder and Post Traumatic Stress Disorder. Educational levels of the participants varied from the eighth grade to a bachelor's degree. Two of the participants had used telemental health through the Veterans Administration (V.A.) system. The participants were recruited by fliers, word of mouth, and snowball sampling in the western U.S.

Data collection: The interview lasted between 40 and 60 minutes, as guided by participant responses. The interviews took place in locations chosen by the participants that included a personal vehicle, homes, and available offices at mental health provider offices. The interviews were recorded with general field notes taken. Immediately following the conclusion of the interview, the interview was transcribed.

Data analysis: The interview transcripts were reviewed in detail, and common themes were identified. Six themes were developed from the opinions and attitudes of

the participants in this study: Savings, convenience, privacy and anonymity, rapport,

crisis intervention and technology.

<div align="center">Savings</div>

Many of the participants identified savings as a primary concept of acceptance of

telemental health. The concept of savings, as a part of acceptance by the participants,

encompasses; general savings of time, money, travel and hours of work. Participants

shared that they often felt that the time it took to drive to a specialized provider for face-

to-face care was not "worth" the time it took to drive to the appointment and then home,

therefore telemental health was a welcome tool in time savings. This was further clarified

by participants reporting that spending several hours away from home or work for a 30

minute appointment seemed to be an unnecessary use of their time. The following

comments were made about savings:

> They set up an appointment for me at my local V.A. center. When I get there they
>
> take me to the tele-communication room they have there and I talk to the
>
> psychiatrist who is at Fort Harrison. That saves me from having to drive all the
>
> way over there, depending on what the weather is like, I don't know if I'm gonna
>
> make it or not for a face-to-face visit. BR
>
> If there was something in a town close to me that wouldn't take a full day to see
>
> my doctor it would be great. I hate losing a whole day of work on the ranch to
>
> drop everything and drive to my doctor for a short visit about my meds. KA

You can still get things done at home without spending a whole day going to see

your provider. It is very cost effective for me to meet via telemental health. BR

Sometimes you don't really want to see the doctor but they want to see you and

this (telemental health) would be a great way to do it without wasting so much

time. RWR

If I had to go all the way to my doctor or therapist for a 15 to 20 minutes

appointment my day would be pretty much done. KA

It's gonna save me money, time. KM

One participant who was not willing to use telemental health did recognize that

there was a savings of time associated with that treatment modality. Although this

participant denied any desire to use telemental health they were willing to make

suggestions to improve its acceptability from his standpoint

I guess there was a time savings of not having to drive to the Fort Harrison, but

my wife gets to shop when I go there, so she prefers in person too. DB

Convenience

The convenience of utilizing telemental health is noted by participants with their

comments particularly focused on either been able to see their provider from the

convenience of their own home or from a location in a community near to them. By far

the biggest convenience for most people was related to not having to travel to a distant

community to receive specialized care.

Even if this was brand new and offered to me I would jump on it because of the convenience. BR

On the ranch it is hard to get time off, and when I first got sick my mom or dad would have to take time off to bring me to the doctor. Having a way to see the doctor from home or even a closer town by telemental health would be great. KA

If we had something in my local town that would only take like an hour rather than the whole day it would be great. KM

Local access sites would be better than regional ones for locations to access telemental health. KS

I would like it because if I was at home on the reservation with my mom there are no places for me to go and no one to talk to. It would work for me to go somewhere, like an office, to do telemental health. RWR

I would like to see it in winter months where people like me that are too scared to walk because they are afraid of falling don't want to go out of their homes. RWR

People who are apprehensive about groups would be better off using telemental health. It would be good to reduce anxiety in group or public situations. PS

One participant noted that the ability to communicate with their mental health provider from home would be a valuable tool for their provider to be able to see their actual living environment. This is further clarified by the participant stating that mental health consumers occasionally will not recognize a disorganized or unclean living environment as a symptom of their illness, therefore the provider being able to see this environment could give insight into the consumers' present mental status.

If I could do it from home it would be even better. My provider could even see my home, which may not always be a good thing. TM

<u>Privacy and Anonymity</u>

Privacy and anonymity are a common theme amongst the participants of the study. The typical response by the participants of the study was that they had improved privacy and anonymity while using telemental health. It is interesting to note that none of the participants were concerned about breaches of privacy or confidentiality while utilizing telemental health.

> With telemental health there is just me and the person who takes me back to the room even knowing where I am going in the building. I just go in and tell them I have an appointment and they take me back to put me in the room, close the door and I can have my appointment. If I go to Helena I sit in the waiting room with everybody else, they call my name and when they take me back everybody can see that I'm there for a mental health appointment. BR

> I'm not really comfortable with new people so I would rather stay at home or where I know the people. That is pretty much how I see going somewhere like that (a mental health center in a different town). I would rather be in a known environment and use telemental health to talk to my doctor or therapist than go somewhere new. If I'm somewhere I feel comfortable I can open up more. RWR

> I'm so used to being in my appointments with someone else, like my case manager, I'm not bothered by having someone else there. AC

Rapport

All but one of the participants of the study stated that they felt it was important to develop rapport prior to the initiation of telemental health. One participant preferred complete and anonymity and a slow progression to actual telemental health followed by face-to-face meetings with their provider.

I think a person should see their provider in person for a while first to get to know them and establish a relationship before using telemental health. Once you know each other it is no different than meeting in person. TM

I think that it is easier to talk about embarrassing topics via telemental health than in person. Like asking about a personal problem or asking what my diagnosis really means. BR

I think it would be good because you never know if we are gonna have a center or a place to go and this is where telemental health will come in to place. With budget cuts we don't know what will be in the future for mental health care so this is a good thing to get started. It won't help with companionship although it will with seeing my doctor or therapist. RWR

I would be more comfortable (using telemental health) than going somewhere else where I'm not really comfortable and with people I don't know. PS

The one participant of the study who was opposed to utilization of telemental health stated lack of rapport and lack of personal interactions with their provider as their primary dislike of the modality of treatment. This participant comments on this topic are listed below:

Seeing the whole person is important and you can't do that on telemental health.

DB

Crisis Intervention

The topic of crisis intervention was brought up by three different participants. Their primary concern was that provider is not in the room with them may not pick up on subtle nonverbal cues that they were experiencing a crisis or difficult time. One of the participants further was concerned that if there was a suicidal crisis there would be little a provider could do via telemental health.

There is no way to deal with a crisis except for to contact a peer support person or tell the consumer to go to the nearest medical center. PS

My provider could tell that I was not feeling well one time when I was on video and she asked me about it, and we were able to talk about it until I was better. BR

If I wasn't doing well I don't think they would know, even if they knew me. I could be telling them one thing that they can see and below the desk my legs could be doing the rabbit dance. Without my doctor or therapist sitting right there they wouldn't know. RWR

Technology

The final theme that is common amongst the participants of this study is the use of new technology. Several of the participants suggested that the current technology makes telemental health as close to being face-to-face with your provider as could be

imagined. There were concerns of learning new technology although it is suggested by

the participants that an initial orientation to the equipment necessary for total mental

health could be done and should be done by the provider during a face-to-face session

prior to beginning with telemental health treatment.

> The clarity must be great because my provider could tell something was bothering
>
> me just from seeing me on the V.A.'s system. I think it is a very good and
>
> positive thing to have. My provider has my information on her computer, fills out
>
> my new information and even can do my prescriptions and they just show up at
>
> the door. BR
>
> I think there is less distractions for the provider on telemental health and they can
>
> focus just on you, which makes is more personal. AC
>
> The way it is presented makes a difference in how a person will feel about it. If
>
> you just say here is the room and you are gonna use this to talk to your provider it
>
> makes it difficult to accept. You also need to show the person how to use the
>
> equipment beforehand. KM
>
> It would cost too much to have the equipment at home so I think it would be
>
> better to have the equipment provided in a local place that consumers could go to.
>
> KA
>
> Learning about new things would be hard. RWR

One participant noted that the technology utilized by telemental health help was no

substitution for actual human contact during a face-to-face visit. This same participant

also noted that he would be hesitant with the new technology due to his age.

You see the person but you never get the one on one, it is like watching a person

on T.V. It would be like taking to my grandson on my Kinect. I could just talk to

him and never have to see him; it's just not like being there. DB

If there was a way to make it more real, that is the only way it could be better, you

just don't get the physical interaction. I like the personal contact. TM

I'm an older person and electronics and I don't get along that good. DB

<div align="center">Summary</div>

Eight of the nine participants of this study were willing to use telemental health

for their mental health care. One was clearly opposed to it based on his desire for

personal face-to-face communication with his provider. The others commented that they

were acceptant and willing to utilize telemental health services for their mental health

care needs after a period of time to build rapport with their provider. Comments ranged

from complete acceptance to a slow transition to telemental health from traditional face-

to-face treatment.

CHAPTER 5

DISCUSSION

Introduction

This chapter consists of a summary of the study, discussion of the findings, implications, recommendations for further research, and conclusions of research. The purpose of this chapter is to further expand upon the themes that were developed by interviews during the study. This will increase the understanding of the acceptability of telemental health among mentally ill persons in the Western U.S., which will in turn provide information to develop telemental health programs that are appealing and acceptable to the mentally ill.

Summary of the Study

The purpose of this study was to understand how mentally ill people living in frontier states feel about utilizing telemedicine for counseling services. This is significant because in frontier areas of the western United States people diagnosed with a mental illness not only struggle with the illness, but also with limited access to specialized treatment. Mental health professionals strive to develop new ways to reach the underserved rural populations, which includes telemental health. The attitudes and opinions of the participants of this study lend understanding to develop telemental health programs that would be acceptable to the mentally ill.

The study uses Phil Barker's "Tidal Model of Mental Health Recovery" for the conceptual framework. The Tidal Model is conceptualized as a holistic model to include the client as a valued member of their recovery and not just a recipient. Allowing for the flexibility of the client to choose between face to face or telemental health communication with their mental health professional conformed to the idea of changing services in order to meet the client in the manner that will be most beneficial for their mental health. Furthermore, telemental health has been used as either a stand-alone style of therapy or in conjunction with more traditional face to face therapy methods, which again offered a sense of flexibility to the care.

This study included nine participants aged from 36 years of age to 68 years of age, diagnosed with a mental illness, not currently suicidal, homicidal, or experiencing psychotic symptoms of their illness. Six of the participants were male and three were female. Mental health diagnosis of the participants included Paranoid Schizophrenia, Bipolar Disorder, Major Depressive Disorder, Obsessive Compulsive Disorder and Post Traumatic Stress Disorder. Educational levels of the participants varied from the eighth grade to a bachelor's degree. The participants also must have lived in the area the study was conducted in during the research time period, speak English, and they may or may not have had experience with telemental health in their past. The participants were recruited by fliers, word of mouth, and snowball sampling in the Western U.S.

The design of the study was qualitative using semi-structured interviews that were designed to take 40 to 60 minutes to complete. The use of open-ended questions was employed to encourage free expression of attitudes and opinions of the participants.

Although the focus was on the use of telemental health for therapeutic services a variety of questions about mental health services were asked to obtain information and the participant's opinions.

Data analysis is done by transcribing the recordings from the participant interviews once all the interviews were complete. Common themes were developed from the transcriptions of the interviews. From these common themes the opinions and attitudes of the participants was categorized to assist in the discussion of the findings.

Recommendations for Further Clinical Practice

The findings of this study show the attitudes and opinions of the mentally ill participants. The participants expressed an overall acceptance for utilizing telemental health for their mental health care needs. Specifically eight of the participants were acceptant and willing to utilize telemental health while one was not. Attitudes range from complete acceptance of telemental health to acceptance with reservations.

Those who offered complete acceptance did so based on savings in their time that they would not have to spend to their distant appointments. The savings also included a financial savings in reduced travel, as well as less time away from work. The participants noted that an overall time savings was a significant influence on their acceptability.

Convenience was the second common opinion for acceptance by the participants. This was based on the ability to obtain specialized mental health treatment close to the homes of the participants. Several of the participants expressed a desire to be able to utilize telemental health services from their own homes. The participants expressed that

this would help to relive anxiety of new places and encourage therapeutic participation in their mental health care. Other aspects of convenience included using locations for car that are close to their home, such as a local clinic or facity.

The theme of privacy and anonymity was presented by the participants as an important aspect of their acceptability to telemental health. The participants reported that they felt more privacy and anonymity using this technology. The participants who cited this improved privacy and anonymity suggested that having the ability to go to an office or location that is not associated with mental health would make them more comfortable. They further suggested that this is due to the stigma associated with traditional mental health care. Several participants suggested that the ability to access their provider from places other than traditional mental health centers was preferable. One participant offered the suggestion that initial contact with the mental health provider be completely anonymous, even without video, although this presents problems in confidence in who is actually doing the communication.

Rapport between the mental health provider and the client is viewed as an important part of acceptance by all the participants, even the one who was opposed to telemental health in general. Participants agreed that establishing a rapport with the provider was paramount to the form of treatment being successful and accepted by the clients. Participants suggested that initial visits be face to face to establish trust and build rapport between them and the provider. The participants further suggested that telemental health be presented as an option to face to face care by the provider only after a therapeutic relationship had been established. The final suggestion from participants

was that the providers be the one to give an orientation to the telemental health

technology to the client prior to beginning this mode of treatment.

Crisis intervention was brought up by participants as a potential concern for

safety. The idea of a suicidal or homicidal client being seen by telemental health was

discussed. Participants offered suggestions for a method for crisis intervention that

includes recommending the client go to the nearest medical center, call 911, and / or

contact a local friend or peer support person for safety in their time of crisis. The

participants acknowledged an acceptance that the provider at a distanced via telemental

health are unable to provide direct intervention.

The final area which participants offered suggestions related to the common

themes was in the area of the technology needed for telemental health. Several of the

participants expressed concern that the technology needed used in telemental health

would be confusing and difficult to learn to utilize. Participants suggested that an

orientation be done by the provider on the proper use of the technology prior to initiating

this form of treatment. The participants offered acceptance to the technology of

telemental health as long as they had an introduction to it.

Implications

Implications to this researcher's future practice include developing a plan to offer

access to geographically isolated populations of mentally ill persons. It also includes

developing personal goals and methods for the achievement of this treatment method.

This research offered valuable lessons about the preference of the mentally ill in regards

to telemental health as a form of treatment. I hope to be able to develop a program of

telemental health to access the underserved.

The implications result from the review of literature and the findings from the

semi-structured interviews of the mentally ill participants of this study. Implications for

future practice include ways to develop telemental health programs that are acceptable to

the mentally ill population.   This is relevant to the future of mental health care because

there is a shortage of mental health providers in this frontier, which affects waiting

periods to see the specialized providers, and in turn may have an adverse effect on the

wellbeing of the client.

Much of the current literature about telemental health focuses on the development

and utilization of the technology, rather than the opinions and attitudes of the mentally ill

clients who use the technology to reach their specialized treatment providers. Improved

understanding of the opinions and attitudes of the mentally ill will help providers to

develop and present telemental health in a manner that is more acceptable to this

population of people.

Recommendations for Further Research

The goal of this study was to determine the attitudes and opinions of the mentally

ill about utilizing telemental health for their mental health care needs. Data and common

themes were developed from semi-structured interviews with the nine participants.

Although common themes were developed, the limited sample size of this study was a

limitation. Future research could benefit from a larger sample of mentally ill participants

in a similar rural or frontier living environments. A blending of participants who have

and have not been exposed to telemental health offered insight to the advantages of

telemental health as well as the disadvantages as viewed by participants.

Conclusions

This research was designed to determine the attitudes and opinions of the

mentally ill about utilizing telemental health for their mental health care needs. The

overall opinion of the participants was acceptance of this modality of treatment with one

participant who was opposed.

The major themes developed from the participant interviews were; Savings,

convenience, privacy and anonymity, rapport, crisis intervention and technology. The

participants voiced an opinion that the general savings of time, money, travel and hours

of work saved was a part to their acceptance of telemental health. The themes of

acceptance can be developed in to methods to improve future models of telemental

health. By understanding what would make this treatment modality more acceptable

future providers can tailor a telemental health program that is fully acceptable to the

clients who will utilize it.

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APPENDICES

APPENDIX A

FLIER

Make your opinion count.
Family Psychiatric Mental Health Nurse Practitioner Student needs your help on a survey about telemental health.

The survey will include a series of questions about your attitude and opinion about using telemental health for mental health care. This does not mean that you must use these services, it merely is asking for your opinion about it.

Completely voluntary
You may stop the survey at any time
Less than one hour of your time is needed
You decide where and when the survey takes place
There are no direct benefits to you for your participation
All information kept completely confidential
No names will be used
No payment for participation

If you are interested please
Contact: Russ Motschenbacher
406-788-6123
ramjsjc@msn.com

APPENDIX B

INTERVIEW QUESTIONS

Russell Motschenbacher

Research study on the acceptability of telemental health, semi-structured interview guide.

Please tell me about your opinion and feelings about using telemental health for

therapeutic care.

Please tell me more about…?

Continued clarifying questions…

Please tell me about your opinion of telemental health compared to traditional face to

face care.

Please tell me more about…?

Continued clarifying questions…

Please tell me about any reservations you have about using telemental health.

Please tell me more about…?

Continued clarifying questions…

Please tell me your opinion about what would make telemental health more acceptable.

Please tell me more about…?

Continued clarifying questions…

APPENDIX C

CONSENT FORM

SUBJECT CONSENT FORM
FOR
PARTICIPATION IN HUMAN RESEARCH AT
MONTANA STATE UNIVERSITY

Title: Attitudes of the mentally ill about utilizing telemental health services in frontier states.

What am I being asked to do? You are being asked to participate in a research project conducted by Russell Motschenbacher, a family psychiatric mental health nurse practitioner student. You are being asked to participate because you are receiving treatment for a mental illness. The research will examine and assess your attitude about utilizing telemental health services (online therapy).

Rationale of research: Sometimes, people with mental illness who live in rural areas have a difficult time getting access to specialized treatment. It may be possible to deliver psychiatric treatment through the internet, but first we need to better understand the feelings of people to see if this would be acceptable or not.

What procedures are involved? Participation is voluntary. If you agree to participate you will be asked a series of interview questions, which will take less than 60 minutes. If you are rushed for time, an appointment may be scheduled at your convenience. The interview will be conducted in private at a location agreed on by you. If you wish to be informed of the results of the study or participate in any further interview, a follow up appointment may be scheduled. Participation is voluntary and you can choose to not answer any questions you do not want to answer and / or you can stop at any time.

What are the potential risks and discomforts?   There are no known risks of participation in this study unless you find it uncomfortable to be interviewed. You may be inconvenienced due to the time required to complete the interview (less than 60 minutes).

What are the potential benefits to taking part in this research? There are no direct benefits to participating in this research.

What other options are there?   You may choose to not participate, or decide to not complete the interview by simply by not responding to the request or telling Russell. Your decision whether or not to participate in this research will not affect your current or future care at any medical center, mental health center, or future relations with Montana State University or this researcher. If you volunteer for this study, you may withdraw at any time without consequence.

What are the costs for participating in this study?   None.

What about privacy and confidentiality? I will make every effort to protect your identity. All information you provide will be kept confidential, with only the initials of your name on the consent form, and information on the interview notes or recordings that would reveal your identity. The notes or recordings will not be a part of your medical records at the any medical or mental health center. Notes or recordings will be kept in a secure locked file in the personal office of Russell Motschenbacher at the MSU College of nursing Great Falls campus. Upon completion of the research the notes will then be shredded, recordings and any computer files will be permanently deleted. Any communication between this researcher and his professor at MSU regarding this project

will be on computers accessible only to him and his MSU professor, and will be password protected.   The information that will be produced and reported from this project will not contain any personal information from individuals, but only general data regarding attitudes utilizing telemental health services.

Will I be paid for my participation in this research? No, there will not be any monetary compensation, or material compensation.

Injury and compensation statement. In the event your participation in this research directly results in injury to you, medical treatment consisting of referral to appropriate care will be available, but there is no compensation for such injury available. Further information about this treatment may be obtained by calling Russ Motschenbacher at (406) 788-6123.

Who should I contact if I have questions? The family psychiatric mental health nurse practitioner student researcher conducting this study is Russell Motschenbacher, BSN RN - BC. If you have questions regarding this research please contact Russ at (406)788-6123 or ramjsjc@msn.com . If you have additional questions regarding the rights of human subjects, contact the head of the Institutional Review Board, Mark Quinn, (406) 994-4707 mquinn@montana.edu .

AUTHORIZATION: I have read the above and understand the comforts, inconvenience and risk of this study. I,_____ (your initials only), agree to participate in this research. I understand that I may later refuse to participate, and that I may withdraw from the study at any time. I have received a copy of this consent form for my own records.

Signed: _____(your initials only)
Investigator: _____
Date: _____

Please keep the first two pages (YOUR COPY), and give this page to the student researcher (Russ). Thank you.

APPENDIX D

TRAINING

CITI Collaborative Institutional Training Initiative

**Social and Behavioral Research Investigators/
Faculty Curriculum Completion Report
Printed on 10/3/2011**

Learner: Russell Motschenbacher (username: motsrusc)
Institution: Montana State University
Contact Information   Phone: 406-788-6123
                                                       Email:
                                                       ramjsjc@msn.com

Social & Behavioral Research - Basic/Refresher: Choose this group to satisfy CITI training requirements for Investigators and staff involved primarily in Social/Behavioral Research with human subjects.

Stage 1. Basic Course Passed on 10/03/11 (Ref # 6815622)

Required Modules	Date Completed	
Belmont Report and CITI Course Introduction	10/03/11	3/3 (100%)
Students in Research	10/03/11	9/10 (90%)
History and Ethical Principles - SBR	10/03/11	4/4 (100%)
Defining Research with Human Subjects - SBR	10/03/11	5/5 (100%)
The Regulations and The Social and Behavioral Sciences - SBR	10/03/11	5/5 (100%)
Assessing Risk in Social and Behavioral Sciences - SBR	10/03/11	5/5 (100%)
Informed Consent - SBR	10/03/11	5/5 (100%)
Privacy and Confidentiality - SBR	10/03/11	5/5 (100%)
Conflicts of Interest in Research Involving Human Subjects	10/03/11	3/5 (60%)

For this Completion Report to be valid, the learner listed

above must be affiliated with a CITI participating institution. Falsified information and unauthorized use of the CITI course site is unethical, and may be considered scientific misconduct by your institution.

Paul Braunschweiger Ph.D.
Professor, University of Miami
Director Office of Research Education
CITI Course Coordinator

Certificate of Completion

The National Institutes of Health (NIH) Office of Extramural Research certifies that **Russell Motschenbacher** successfully completed the NIH Web-based training course "Protecting Human Research Participants".

Date of completion: 10/27/2009

Certification Number: 328154