Föderation der Schweizer Psychologinnen und Psychologen FSP
Fédération Suisse des Psychologues FSP
Federazione Svizzera delle Psicologhe e degli Psicologi FSP

For psychotherapy practitioners

Quality standards Online interventions

Psychologists and psychiatrists providing online interventions must present and apply the following quality standards.

PREAMBLE

This document has been compiled with the FSP working group for online interventions in collaboration with academic experts and experts in psychotherapy and psychotherapeutic counselling. The work this group has been carrying out draws on preliminary carried conducted from 2003 and 2006, which is when the first quality criteria were drawn up.

The aim of this document is to establish quality standards for psychological and psychiatric online interventions.

The aim of these standards is as follows:

- To give specialists clear and specific reference points, both on a therapy level, a technical level and on a legal level.
- To make the general public, especially patients, aware of specialist treatments available.

Once the quality standards have been outlined, information on the following areas will be provided: the definition of as well as different types of online interventions, uses, effects, prospects and risks and lastly specific skills that are of benefit to individuals providing online interventions.

These quality standards were compiled by the FSP in collaboration with the FMPP, the Swiss Association of psychotherapeutic Psychiatrists.

QUALITY STANDARDS

Psychologists and psychiatrists providing online interventions should present and apply the following quality standards.

Quality Standards refer to everything that comes under the headings of “Transparency”, “Barriers, Indications and Contraindications of Online Therapy”, “Confidentiality and Data Protection” and “Professional Ethics”. The points in the text boxes are additional references.

1. Transparency

Identification of the provider

- Name, address, telephone number, e-mail address of the provider are known.
- The provider must disclose what qualifications, training/education, skills or qualifications they have.
- The professional organisations the provider belongs to are clearly stated.

Transparency of the service

- The service is described clearly.
- Realistic objectives are given that can be reached using this service.
- The areas the provider specialises in are stated.

Transparency of costs

- The costs of the treatment and potential payment types are stated.

- The fees should be the same as they are in the consulting room given that the services in question are the same.
- The decision regarding payment options is left to the discretion of the specialists. Some require an advance payment, especially if they are conducting online interventions.

Scheduling

- Clear on scheduling (when will sessions take place?) and on answering questions (if communication is asynchronous): The patient ought to know when he/she can expect to receive a response.

General Terms and Conditions

- The GTC that apply to the service are appropriately stated.
- It is of course possible to draw up a customised contract as opposed to GTC.

General Terms and Conditions are contractual terms that are compiled in advanced by a contracting party in order to conclude numerous contracts. This means they are not negotiated separately for specific contracts, but rather they are adopted in their entirety. According to Swiss law, only the standard clauses apply. Unusual, i.e. non-standard, clauses do not apply unless the customer was made explicitly aware of them (known as the “unusual clause rule”).

2. Barriers, indication and contraindication

Patient information

- For online therapy, patients may essentially remain anonymous, but some information is vital depending on the case.

It is recommended that the provider acquires the information they definitely require using a form.

Suicidal tendencies

- If the therapist suspects the patient is suicidal, they must attempt to contact the individual in person to investigate.

Contraindication

- Online therapy is generally not indicated in an acute crisis, especially if patients have attempted suicide, or if they are experiencing dissociation or acute psychosis.
- It is the therapist›s responsibility to decide when and for which disorders online therapy is an option.

Diagnosis and assessment

- "Distance diagnoses" are avoided. The risk of liability is particularly high in cases where the therapist overlooks objective findings in their diagnosis because they have not had direct contact with the patient, meaning therapy has already started poorly for the patient.
- If they cannot meet face to face, the patients are informed that a distance diagnosis cannot be made. Initial interventions that provide contact and support can be conducted without a diagnosis. However, without a diagnosis, therapy cannot begin.

Contingency plan

- The therapist must compile a contingency plan based on the diagnosis, and must inform the patient of this plan, including information regarding emergency numbers and addresses.

Exceptions to these rules can only be made if the therapist believes that the expected benefits to the patient of online therapy outweigh the potential risks. The therapist must give reasons as to why these benefits outweigh the risks in their documents.

3. Confidentiality and data protection

Information and encryption

- Patients are informed of the risk of confidentiality being compromised through the online storage and transfer of data. All the important information on data protection, security risks, the type, extent and period of data storage and the rights of patients is made appropriately available. The therapy may ask the patient to acknowledge the risks involved in writing.
- The therapist shall adhere to the highest standards of encryption: encrypted data transfer via Secure Sockets Layer (SSL) Encryption on websites, or Pretty Good Privacy (PGP) for e-mails; encrypted data storage; password-protected access to sessions with a secure password that regularly changes; virus protection; firewall, regular security updates and backups.

The patient›s responsibility

- The patient is informed that the therapist accepts no responsibility for the security of data stored by the patient on their own computer, or that they send via unencrypted e-mails.

Data storage

- At the end of the session, any e-mails, chats or videos are deleted from the server that was used during therapy. As is the case for face-to-face meetings, the therapy sessions must be recorded, and this data must be stored for ten years. The therapist accepts no responsibility for the security of data stored by the patient on their own computers, or which they send via unencrypted e-mails.

Responsibility of third parties

- Third parties who have access to the data (e.g. administrative staff, IT staff etc.) are also bound by confidentiality, and should sign an appropriate agreement with the psychologist or psychiatrist, that is unless a technical solution can be found that prevents them from viewing the data.

Consulting room sessions also require coordination or organisation via digital lines of communication. They leave a digital trace behind for which specific data protection provisions must also be observed and followed.

4. Professional code of ethics

Professional codes of ethics also apply online

- FSP members must comply with the code of ethics laid down in the FSP code of conduct.
- Complaints should be directed to the FSP Code of Ethics Panel or to the ombudsman of medical associations in each canton.
- Psychiatrists and psychologists are guided by the relevant professional standards (SAMV, FMH, FMPP).

Restriction on advertising

- Descriptions of online sessions shall not contain any advertising from third parties.

Reference to current quality standards

- Appropriate reference shall be made to the fact that the session complies with the current quality standards of the FSP and the FMPP.

INFORMATION ON ONLINE INTERVENTIONS

1. Definition and scope

Online interventions is the umbrella term.

- **Self-help interventions:** where the patient and the therapist do not meet
- **Online therapy: interventions** that involve active and beneficial interaction/relations between the patient and therapist. As is also true for face-to-face sessions, a distinction is made between counselling and psychotherapy.

If psychological disorders are being treated, the term is **online therapy**.

Online interventions have been researched and used to treat various different disorders: most frequently for social anxiety, panic disorder, generalised anxiety, post-traumatic stress disorder and depression, in addition to sleeping disorders, eating disorders and substance abuse (see also: Table 1 below).

This list is not exhaustive and needs constant updating to reflect the current situation.

The aim of an online intervention is to stimulate cognitive emotional processes in patients so they recover or improve their self-control and their capacity to act. The aim is to foster the positive development of patients.

The intervention can be supplemented by further treatments, e.g. medication.

Psychological and psychiatric online interventions are typical components of a professional helping relationship. They are based on academically-founded concepts of effective interventions, and on concepts of treatment and counselling tested in practice, as well as on fundamental ethical considerations.

They must comply with professional codes of ethics, the scope of which has been expanded to cover specific media (confidentiality, data protection, evidence of counselling expertise and so on).

Online therapy is not a new type of therapy per se, but rather a **new type of treatment access via the medium of the internet** that has certain characteristics.

2. Distinguishing features

2.1 Lines of communication

The interventions take place via various different lines of communication: e-mail, chat, videos and forums. This means there is e-mail therapy, chat therapy, video conferencing therapy as well as guided and non-guided self-help programmes (apps) or therapy combinations (known as "blended treatments").

2.2 Methods

Online interventions are carried out in different ways:

- for instance as therapy that relies only or nearly only on video conferences,
- guided/unguided self-help,
- or as a combined therapy: online interventions used to supplement consultation room meetings and to support traditional treatments ("blended treatments"),
- or using methods derived from writing therapy as is the case for e-mail counselling.

Patients undergoing conventional therapy can also benefit independently from unguided self-help modules, or draw on self-help tools. These tools can be used alone and/or in groups with or without psychological support.

Online therapy is often contrasted with "consulting room therapy". This can lead to confusion seeing as video conferencing does also offer participants the chance to sit face to face. Studies and literature on the subject, however, always equate "face-to-face therapy" with the conventional form of therapy (Botella, Garcia-Palacios, Banos & Quero, 2009).

2.3 Synchronous/asynchronous

Communication during online interventions can either be asynchronous or synchronous.

- asynchronous (at different times): by e-mail, on a moderated forum (consultation and moderation from open and closed forums) or
- synchronous (at the same time): video conferencing,
- one-to-one chat, moderated chat, expert chat (a group can ask experts questions live).

2.4 Phases

Internet-based interventions are used in various different phases and for various different target groups: universal, selective and indicated prevention, therapy (target group), preparing psychotherapy during the waiting period.

Various different types

Telephone	This therapy is conducted over the phone.
E-mail therapy	This type of therapy generally involves an exchange of e-mails, usually written, between the patient and the therapist. Thisinteraction should be encrypted.
Chat therapy	This type of therapy involves interaction between the patient and the therapist via chat. Chat refers to electronic, written communication in real time. It involves the patient and the therapist interacting in a protected, virtual chatroom. A virtual meeting point like this, where patients can open a user account for the duration of the therapy, is provided by the therapist.
Videoconferencing therapy	Video conferencing refers to interaction that takes place by phone between the patient and the therapist via a video screen. This means the participants are sat opposite each other in front of their screens, meaning they can see gestures, emotions and facial expressions on the screen. This type of therapy is undoubtedly closest to conventional therapy. The therapist provides an encrypted channel or an encrypted platform just as he/she would do if communicating via e-mail or chat. The patient can set up a user account for the duration of the therapy.

Unguided self-help	Unguided self-help is a type of internet-based psychological/psychiatric intervention that involves no contact in person. It is comparable to a printed self-help guide. Patients go through the information/help pages and are set tasks by the programme that they complete independently. Persevering with the programme until the very end requires a great deal of motivation from the patient. The patient normally has to create a user account in the beginning, and users do have to pay for certain services.
Guided self-help	In contrast to unguided self-help, guided self-help is characterised by regular interaction between the patient and the therapist. This interaction is generally limited to an initial diagnosis and regular, brief feedback from the therapist on what they have covered. This way, the patient›s motivation can be maintained and increased, and there is scope for minimising unforeseen developments.
Combinations (“blended treatments”)	Combinations or “blended treatments” refer to therapies that combine online therapy with face-to-face therapy. This means a patient undergoing conventional therapy can also be independently benefiting from unguided self-help modules at the same time.
Transdiagnostic programmes and modular programmes	Mental disorders are frequently comorbid, in other words it is very rare for there just to be one condition. The online therapy approaches mentioned above only address these disorders to some extent. Numerous studies (Berger, Boettcher & Caspar, 2014; Carlbring et al., 2011) have shown that tailored online interventions are effective. This involves splitting up an online therapy programme into parts (known as modules), and these are then grouped based on the symptoms of the patient in question. This makes customised online therapy a possibility, and it also offers the benefits that customised face-to-face therapy enjoys.

3. Are online interventions effective?

The first thing that must be said about the effectiveness of online interventions is that "the term 'online intervention' is often used as an umbrella term without specifying what clinical-psychological intervention method is actually involved. (...) Academic literature on the subject either distinguishes between online counselling and online psychotherapy to some degree, or not at all. (...) This is why results on the effectiveness and the mechanisms involved in online counselling come under the same section as online psychotherapy." (Eichenberg & Küsel 2016). It is also difficult to differentiate it from coaching seeing as the myriad studies there have been on guided self-help often use "coaches", whose main role is to motivate patients to actively engage with the self-help programmes themselves and to make the most of resources.

Even though research into internet-based interventions is still in its relative infancy, over 200 controlled trials and a number of systematic reviews and meta-analyses have already been conducted (e.g. Andersson, Cuijpers, Carlbring, Riper, & Hedman, 2014; Hedman, Ljotsson, & Lindefors, 2012). These studies cover a wide range of mental disorders and behavioural disorders/problems. It has not yet been comprehensively documented in academic literature that online therapy is effective for treating all disorders, but that does not preclude it from potentially working.

Most assessments have been of guided self-help for anxiety and depression (Andersson, 2016), which has now in fact now been assessed for a number of different disorders and problems. Table 1 provides an overview of the different types of disorders and problems for which randomised, controlled trials, complete with proof of efficacy, have already been conducted.

Table 1: Areas in which the efficacy of guided internet-based self-help has already been assessed with randomised, controlled trials (according to Andersson, 2016)

Psychiatric disorders	Somatic disorders / health problems	Other
► Depression (including post-partum depression) ► Bipolar disorder ► Panic disorder with/without Agoraphobia ► Social anxiety ► Specific phobia ► Generalised anxiety ► Hypochondria ► Mixture of anxiety and depression ► Obsessive-compulsive disorder ► Post-traumatic stress disorder ► Gambling disorder ► Various eating disorders ► Body dysmorphic disorder ► Various substance abuse disorders ► Attention deficit/hyperactivity disorder	► Headaches ► Tinnitus ► Diabetes ► Sleeping Disorders ► Chronic Pains ► Cancer ► Irritable Bowel Syndrome ► Encopresis ► Erectile Dysfunction ► Chronic Fatigue Syndrome ► Multiple Sclerosis ► Obesity ► Smoking	► Relationship therapy ► Parenting training ► Stress management training ► Perfectionism ► Self-compassion ► Burnout ► Procrastination ► Complicated grief ► Negative body image ► Unable to have children

A number of meta-analyses and systematic reviews have shown that guided self-help does on average provide treatment, the effect of which is comparable to that of conventional psychotherapies (Andersson, Cuijpers, Carlbring, Riper, & Hedman, 2014; Hedman, Ljotsson, & Lindefors, 2012). Given that therapists do not have to invest as much time in this treatment as they do with conventional psychotherapy (the average amount of time therapists invest is between 10 to 20 minutes per week and per patient), self-help has also proven to be more cost-effective than conventional psychotherapies (e.g. Hedman et al., 2012b). The long-term effects of treatment have also been shown to last up to five years post-intervention (z.B. Hedman et al., 2011). Furthermore, the results of the controlled trials could also be replicated in conventional clinics and with regular patients in countries such as Sweden and Australia, where guided self-help interventions are now offered in every clinic (Andersson & Hedman, 2013).

Whilst numerous trials have been conducted on guided self-help, very few trials yielding promising results have been conducted on e-mail, chat and video therapy (Kessler et al., 2009; Simpson & Reid, 2014; Vernmark et al., 2010). There are even fewer trials on blended treatments, i.e. the combination of face-to-face sessions with online interventions. Research is urgently needed in this area.

By contrast, it is well established that unguided self-help is also effective in comparison with passive control groups (e.g. waiting lists) for numerous problems, especially symptoms of depression (Cuijpers et al., 2011; Karyotaki et al., 2015; Karyotaki et al., 2017). However, unguided self-help has on average been shown to be less effective than guided self-help (Baumeister, Reichler, Munzinger, & Lin, 2014; Richards & Richardson, 2012; Spek et al., 2007). This is primarily due to lower levels of treatment adherence and higher rates of treatment dropout than with guided self-help. Where trials on unguided self-help solely analyse the results of participants who persevere with therapy until the very end, the treatments are generally found to be very effective (Meyer et al., 2009). Hence it appears that some participants are able to benefit a great deal from unguided self-help, whilst others drop out prematurely. Dropout rates are particularly high if it is very easy to get onto a self-help programme, and if there is no thorough assessment process. One example of this is the Australian depression programme MoodGym, which patients can use straight away, both anonymously and for free, as soon as they have entered a user name of their choosing and a password. The number of people who register for these open-access programmes is very high, yet the number of patients who drop out prematurely is also very high (Christensen, Griffiths, & Jorm, 2004). By contrast, unguided self-help programmes with a thorough assessment process and a diagnostic interview were found to have far lower rates of treatment dropout, and were shown to be far more effective (Berger et al., 2017; Johansson & Andersson, 2012).

4. Prospects and risks

Online interventions come with both prospects and risks. Berger (2015) points out that online interventions have specific characteristics that could prove both advantageous and disadvantageous. For instance, distance communication has the advantage of there being no need to travel, and patients who are unable to find help due to limited mobility or geographical location can also be reached. Another advantage is that communication takes place via the preferred media of young people. At the same time, however, this may compromise the confidentiality of the data shared (if no encryption techniques are used), the identify of providers and patients is not secured and it is only possible to respond appropriately to an acute crisis to a limited degree. Table 2 provides a summary of the pros and cons of internet-based interventions, though it is important to note that the pros and cons listed do not apply in equal measure to each type of internet-based intervention. As such, benefits such as ready availability and unlimited scope for duplication, lower intervention costs and consistent quality apply specifically to web-based self-help, not to e-mail therapy.

Table 2: Pros and cons of internet-based therapies (adapted from Berger & Caspar, 2011 and Berger, 2015)

Features of internet-based therapies	Pros	Cons / risks
Distance treatment	► Convenient as no travelling needed ► Possible to reach patients who cannot access help due to limited mobility or for geographical reasons	► Only possible to respond appropriately in a crisis (e.g. patient has suicidal tendencies) to a limited degree ► Confidentiality of data compromised by the sharing and storage of information ► Identity of therapists and patients not secured
Flexibility in terms of availability; can be used at any time	► No need to arrange appointments (only if communication is asynchronous. If communication is synchronous, an appointment has to be arranged) ► Can also be used outside normal working hours ► Material can be covered at a convenient time and at a flexible pace ► Several brief training modules and sessions can be good for learning ► Messages written by therapist can be checked before sending	► Not having a clear schedule can reduce compliance ► Limited scope for direct, ongoing interaction

No physical contact / written communication	► Fewer inhibitions about seeking help than in face-to-face therapy ► More openness and sincerity (no inhibitions: patients are able to express themselves faster) ► No social barriers (e.g. because of appearance) ► Chance to reflect upon what has been written ► More self-determination (the patients decide what they write about) ► Playing an active role in therapy is not a complicated process	► Lack of non-verbal/paraverbal communication ► Easier to gloss over difficult subjects ► More misunderstandings communicating ► Writing skills required ► Writing requires more effort and is more time-consuming than speaking
Self-help being readily available and easy to duplicate	► Low costs ► Consistent quality	► More dubious services can also easily become widespread

5. Specific skills

The prospects of treatment being effective are good if the patient is confident and enjoys communicating online. The therapist should be aware of the fact that, over the course of treatment, it may be possible or indeed necessary to either change from online therapy to consultation room therapy, or to change the line of communication.

5.1 Aptitude

Psychotherapy: a Swiss-recognised specialist qualification in psychotherapy obtained abroad, or one that is recognised by the Swiss body PsyKo (Psychology Professions Commission)

5.2 Skills

Psychotherapy skills and communication skills

- Indication and triage:
  - Ability to assess indications and contraindications for online therapy
  - Knowledge of other institutions, professional colleagues
- Ability to ensure a patient is compliant and that they build up confidence: prospects of effective treatment are good if the patient is confident.
- Symptom progression: change the medium/setting if need be
  - Change to another medium if it proves appropriate to do so
  - Change from online therapy to face-to-face therapy if it proves appropriate to do so
- Relationship: ability to develop a bond and empathy despite anonymity, and to keep the patient committed.
- Flexibility in terms of scheduling and objectives will contribute to the success of online therapy.
- Knowledge of the legal situation RE rights of notification

5.3 IT skills

- Up-to-date knowledge of the basics in IT software and hardware, user knowledge of the internet and current forms of communication (e-mail, chat, forums, text messages)
- The ability to type rapidly is a key technical skill for online therapy (e-mail, chat), especially if communication is synchronous

5.4 Date protection and security skills

Data protection and security skills: knowledge of data protection and security guidelines.

5.5 Concepts of media-based therapy

The therapists are familiar with theories and models of computer-mediated communication (theory of channel reduction, theory of social information processing, theories on imagination and simulation options, theories on media richness), and they are also capable of taking these theories and models into account in practice. These concepts are detailed in a work by R. Ott und C. Eichenberg (Ott, R. (Ed.), (2003), Klinische Psychologie und Internet, Potenziale für klinische Praxis, Intervention, Psychotherapie und Forschung, Hogrefe, Göttingen [Clinical Psychology and the Internet, Potential for Clinical Practice, Intervention, Psychotherapy and Rearch]) and summarised in a work by Thomas Berger (2015).

5.6 Reading and writing

- The ability to understand and correctly filter the content of messages and to read between the lines/spot gaps
- Text style: the number of words, the length of the text and the «smoothness» of the text play an important role in terms of the help a patient feels they are receiving. It is important that both patient and therapist are able to express themselves well in writing.
- Communicating what has been understood and what has not. Avoid irony
- Ask patients thought-provoking questions
- Orthography
- Knowledge of the main, most common emoticons and online abbreviations.

5.7 Quality development

- Willingness to perform supervision or consult with peers
- Ongoing training in online therapy

6. Creating a website

A number of things must be considered when creating and updating a website:

- Structure
- A clear, user-friendly page
- Updates possible and easy to make
- Smartphone/mobile-friendly
- Possible to communicate via an encrypted section of the website
- A contract that regulates each aspect of the treatment (therapy, data protection, risk acknowledgement, technology, fees) as well as GTC if there are fees.
- Legal information
- A clear definition of the website›s responsibilities and transparent communication with the patient

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