TELEMENTAL HEALTH PRACTICE

Instructor Biography

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Course Objectives

Upon the completion of this learning material, the learner will be able to:

1. Describe the benefits of using telemental health services.
2. Define terminology basic to telemental health, computers, and technology.
3. Differentiate types of computer security measures.
4. List methods for video etiquette.
5. Explain legal and regulatory considerations and professional guidelines related to telemental health practice.
6. Explain the use of telemental health for risk assessments, safety protocols, and informed consent.
7. Identify the mental health conditions for which telemental health services can provide effective treatment.
8. Identify ethical considerations when providing telemental health services.
9. Summarize considerations for multicultural telemental health practice.

INTRODUCTION

Telehealth technologies provide mobility and enhanced access to care by providing real-time, interactive video services, in-home and mobile health remote monitoring, and uses devices that gather and store health information. The United States Veteran Affairs is a long-time provider of telehealth services (Veteran Affairs [VA], 2020). Virtual health visits can include a variety of services (e.g., teleservices), such as remote patient monitoring, video appointments, teleprimary care, telemental health, store-and-forward telehealth, and numerous other specialty care, such as telecardiology, telechaplain, teledentistry, teledermatology, teleeyecare, telegenomics, telehepatology, telehematology, teleICU, teleinfectious disease, etc. Telemental health, including telepsychiatry, telepsychology, and teletherapy, is a communication and information system that allows clinicians to provide psychiatric and behavioral health services using the telephone, videoconferencing, and the Internet (Langarizadeh, et al., 2017). The terminology used to describe different types of services can be confusing. Teleservices are cost-effective solutions to providing health care to individuals and supervision or consultation to other clinicians who may not otherwise have access. Telehealth services for physical conditions are

rapidly integrating with telebehavioral health services in a variety of ways. Many clinical interventions and assessments delivered remotely are effective in treating a variety of conditions. Because technologies evolve quickly, practitioners may find it difficult to keep abreast of information. Some clinicians may not be familiar with the intricacies of providing telemental health services. When deciding whether to facilitate a new telemental health practice, clinicians should understand the benefits, risks, and protections that apply to clinical practice. Because of the COVID pandemic, many behavioral health services offered in such settings as private practice, community agencies, or schools shifted to telemental health quite rapidly. Some states require specific training in the provision of telemental health services and some insurance companies require a separate credentialing process before a licensed practitioner can provide telemental health services; however, again due to the pandemic, many of these requirements were waived so that practitioners could immediately continue to work with clients. This learning material will provide information for the practitioner who may be new to the use of technology to provide remote behavioral and mental health services.

Information and communication technologies are effective and efficient ways in which to provide behavioral health services to individuals who may not otherwise have access to services. Telehealth is defined by the Health Resources and Services Administration (HRSA) as "…the use of electronic information and telecommunication technologies to support long-distance clinical health care, patient and professional health-related education, public health, and health administration" (HRSA, 2020). Telehealth is a broad term and includes such technologies as landline and wireless telephone communications, video conferencing, use of the Internet, store and forward imaging, and streaming media. Telepsychiatry, telepsychology, and teletherapy are modern, efficient, and cost-effective ways to assess, diagnose, and treat clients who need mental health services (Langarizadeh, et al., 2017). Telemental health technology includes using telephone, video-conference, and Internet-based platforms and applications to provide certain mental health services. Some services include live, real-time contact with clients, such as telephone calls and video-conferencing. Other services include self-monitoring systems like health applications (i.e., apps), instructional videos, and mobile health (e.g., e-health) (Langarizadeh, et al., 2017). There are many advantages to incorporating new technologies in the provision of behavioral health services to clients, but it requires that clinicians understand its components, use them to maximize client benefits, and reduce potential risks. Understanding

this process involves a number of components; however, practitioners should be aware that information about technology development and uses are evolving and require continued learning to ensure that they follow best-practices and up-to-date recommendations. For continual updates on telemental health practice, these are resources that can be helpful:

1. American Telemedicine Association: https://www.americantelemed.org/
2. Centers for Medicare and Medicaid Services: https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet

Telemental services offer many benefits for the provision of clinical services. Langarizadeh, et al. (2017) discuss ways in which telemental health was used to benefit clients; telemental health applications can be used to:

- Improve efficiency and quality of therapy.
- Provide rapid mental health diagnoses.
- Provide patient feedback on tele-services and guide distant treatment.
- Enable distant assessment, diagnosis, and therapy of disorders influenced by emotion.
- Reduce emergency room crowding.
- Provide mental health care in rural areas.
- Provide greater access to care.
- Provide access to counseling during disasters and states of emergency.
- Provide independent platforms for easy connectivity and information exchange.
- Provide facial expression monitoring as an index of mental health status.
- Provide continuous medication monitoring, flexible management, and contextual awareness and adaptation.
- Promote adherence to treatment and medication schedules.
- Enable assessment, diagnosis, and treatment of patients with cultural and language issues in a variety of settings with special populations, like deaf clients and non-native English speakers.
- Integrate research findings from computer science, neuroscience, psychology, and psychiatry.
- Enable assessment of identified needs of mental services and the limited capacity of mental care resources.

- Bridge the need for mental health care and provide a variety of models to extend mental health services to various care settings.
- Satisfy the needs of patients and clinicians by providing comparable services to in-person care.
- Reliable service for a variety of conditions, including mental health disorders, dementia, and ADHD.
- Enhance clinical care, services, education, administration, and research.
- Improve clinical outcomes and predict patients' satisfaction.
- Reduce costs of treatment and other medical expenses.
- Foster professional and social networks for creating and exchanging mental health information.

(Langarizadeh et al., 2017)

In summary, telemental health services can be used in varied ways and settings. Advantages of teletherapy include:

1) improved access to services,
2) comparable quality of care to in-persons services,
3) social networks,
4) flexible online interactions,
5) potential for automated questions and answers,
6) reduced costs and enhanced profits, and
7) potential for future innovation.

(Langarizadeh et al., 2017)

There are also challenges associated with telemental health services. These challenges generally include:

a) costs of online services and platforms, and equipment,
b) reliable communication quality control,
c) training needs for professional skill development,
d) unique ethical and regulatory considerations, and
e) information privacy and reliability issues.

This learning material discusses in greater detail the benefits and challenges of using telemental health later in the course once the learner is exposed to some basic terminology.

Understanding the history of telehealth and its applications, successes, and failures is important for a practitioner to know. For the clinician who wants to embark on incorporating telemental health services into practice, there is a necessary knowledge base of basic information that must be acquired. One of the fundamental components of this knowledge base is familiarity with the different terms that are used and their meanings.

Spanish explorers sailed into the Chesapeake Bay during the mid-16th century, the first time the area appears on a map. At the time of the early European settlement, the primary Indian groups were the Algonquian tribes, the Piscataway tribes, and the Nanticoke tribes. In 1788, Maryland became the seventh state to ratify the U.S. Constitution and in 1791 ceded to the nation (The Eastern Shore Guide, 2020). The eastern shore's history is rich with cultural heritage, including American Indian, African American, rural farming, and waterman crabbing and oystering.

Maryland's eastern shore history is relevant because remnants of its history continue to be an important part of the lives of those who live there, generations of rural families from different cultural backgrounds who have strong cultural values.

I moved first to Bethlehem, Maryland, right across from the post office in 1994. The lines at this small wooden post office around the Christmas holiday run down the street with people awaiting the stamp on their Christmas cards from "Bethlehem, Maryland." The rancher in which I lived was on the outskirts of the small town.

I had come to the town in 1994 to work with the deaf and hard of hearing population and provide behavioral health services for a nonprofit agency whose headquarters were in the Maryland suburbs of Washington, DC. I had worked for a nonprofit in Washington, DC offering behavioral health services to deaf and hard of hearing individuals there and was accustomed to working with individuals in the metropolitan DMV (DC, Maryland, and Virginia), a combination of urban and suburban environments. When I moved to the eastern shore, the geography and landscape were so different from where I was accustomed to living and working.

To give you an idea about the size of the eastern shore, it is comprised of nine counties east of the Chesapeake Bay: Caroline, Cecil, Dorchester, Kent, Queen Anne's, Somerset, Talbot,

Wicomico, and Worcester. The area is contained within the Delmarva (Delaware, Maryland, Virginia) peninsula sandwiched between the Chesapeake Bay and the Atlantic Ocean. The peninsula is 180 miles long and up to 70 miles wide. It has three entryways: one around the narrow upper part of the Chesapeake and down the west side of the eastern shore, one across the Bay Bridge from Annapolis, and one through a long underground tunnel near Virginia Beach. As I learned when I moved into the area, access was not always easily available, which served to isolate the small communities that dot the eastern shore. Of particular interest to me in 1994 was that I was the only behavioral health provider on the shore who could use American Sign Language and was expected to serve the deaf and hard of hearing community in all nine counties. This was no small feat. I had three separate offices located approximately 50 miles apart at which I would work on particular days of the week.

I left the shore in 1997 to move to Baltimore to start my doctoral studies. To be fair, another colleague tried to make the long commute from the western to the eastern shore once a week. The trip was long and the area where services were offered was in excess of 130 miles at places. This arrangement did not last long, and soon after, the agency closed its doors for deaf and hard of hearing people on the eastern shore.

Fast forward to 2013. I had my doctorate and faculty position for 13 years at that point, tenure secured and academic responsibilities under control. To keep my foot in the direct services world, I also worked at a local nonprofit as a psychotherapist with deaf and hard of hearing clients near Annapolis. The years apart did not dull my experiences on the eastern shore. In fact, an idea shifted into focus as I thought more about how we could provide services to the deaf community on the shore. With only a vision of what could be and a persistence for social justice, I decided that I was going to see if someone would fund a grant for a telemental health program for deaf and hard of hearing individuals on the eastern shore. I was just an ordinary person with an idea and a vague plan. Throughout this learning material, I am going to tell you my story about how I set up a telemental health program. I will share with you my challenges (there were many) and successes (there were many of those too). I will also share the materials I developed and insights I gained.

TELEMENTAL HEALTH TERMINOLOGY BASICS

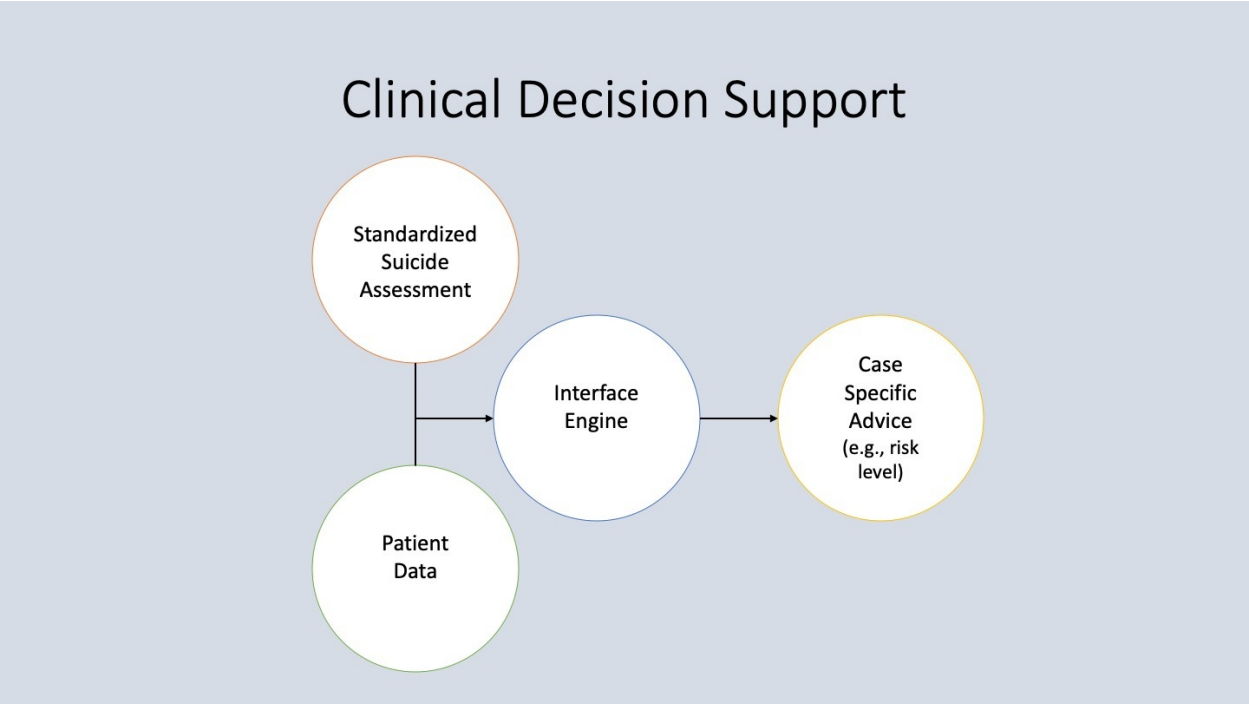
The first step to understanding telemental health service is to know the vocabulary. Unfortunately, different terms are used throughout the professional literature, licensing standards, and regulatory guidelines; so, for example, a clinician conducting an Internet search will miss important resources if only a limited number of terms are used. There is more than one term for telehealth, telemedicine, and telemental health. Organizations, professional agencies, state regulatory entities use different terms that have specific meanings. There is technical jargon for telehealth terms, which may be unfamiliar to many. Below is a list of common terms associated with telemental health and refers to the delivery of physical or psychological services using digital technologies. Explanations of terminology related to computer basics, computer security, and technology use are provided later in this learning material.

Asynchronous Communication

This term is synonymous with "store and forward" transmission of images and/or data. The data transfer takes place over a period of time that are typically separate, examples include e-mail or texts. The transmission does not take place simultaneously. Asynchronous is contrasted to "synchronous" (see below) (American Telemedicine Association, 2020; California Telemedicine & eHealth Center, 2020).

Clinical Decision Support System (CDSS)

The clinical decision support system is an interactive tool that helps clinicians with making decisions about their clients' treatments (California Telemedicine & eHealth Center, 2020). CDSS are generally used to facilitate diagnosis and treatment plans and to take into account patient history as well as the results of medical tests. CDSS may also have a database that includes drug interaction data, results of clinical trials, and other information.



Digital

The term digital means data technology using discrete values as opposed to continuous (analog) signals (American Telemedicine Association, 2020). Digital technologies are electronic tools, systems, devices, and resources that store or process electronic data. Examples of digital technologies are social medial, online games, multimedia, mobile phones, and applications.

Digital Camera Still Images

A digital camera is one that stores images digitally rather than recording them on film. Digital images can be downloaded to a computer or phone system and manipulated with a graphics program, printed, or transmitted electronically (American Telemedicine Association, 2020). Camera still images can be used by a patient to send images of physical symptoms, such as allergic reactions to medications, to a psychiatrist who is prescribing medication.

Digital Imaging and Communication in Medicine (DICOM)

This term refers to the international standard for medical images and related information, including protocols describing how images are identified, formatted, transmitted, and displayed. These standards were developed by the American College of Radiology and the National Electronic Manufacturers Association (American Telemedicine Association, 2020). This type of communication system is helpful to transmit images (e.g., x-rays, scans) for multiple providers to

use for clinical care coordination. This might be particularly relevant for behavioral health providers working in large systems of care.

Distance Learning

Distance learning systems are interactive tools that include video and/or audio technologies that allow individuals to attend virtual classes and training sessions. Distance learning is a familiar term for many academic studies, but in telemental health, distance learning can be incorporated as part of a psychoeducational approach for clients or training sessions for clinicians.

Distant Site

Sometimes telemental health services are provided to clients at remote clinics, called "originating sites" (see more below). The distant site is *where the practitioner or physician is located* while delivering remote services to clients in other physical locations (i.e., originating site).

E-Mental Health

The term e-Mental Health uses electronic disease management programs to facilitate mental health care (California Telemedicine & eHealth Center 2020). The term can refer to telepsychiatry, which involves real-time videoconferencing to evaluate or manage patient mental health care at a remote site. It can also include other means of electronic communication between practitioners and providers to facilitate the delivery of mental health care, consultation, or access to information.

E-Pharmacy/E-Prescribing

Psychiatrists can use e-pharmacy technology to transmit electronic information and communication remotely (American Telemedicine Association, 2020). An electronic prescription can be sent directly to a patient's nearby pharmacy. Another term used for e-pharmacy is e-prescribing.

E-Health

The term e-health refers to health care practice that is supported by electronic processes and communication (American Telemedicine Association, 2020).

Electronic Health Record

An electronic health record (EHR) is a digital collection of health information about individual patients that is recorded in electronic formats and is capable of being shared across health care settings across network-connected information systems (American Telemedicine Association,

2020). Electronic health records (EHRs) generally include client demographic information, intake forms, consent forms, medical history, medication, allergies, immunization status, laboratory results, medical test results, collateral client data, crisis plans, progress notes, intake assessments, treatment plans, and financial information. Other terms for EHR are electronic medical record (EMR), personal health record (PHR) and electronic patient record (EPR). EHRs in telemental health and their storage are a possible service provided by managed service providers (defined below) – these will be templates that clinicians or clients complete that are then stored in HIPAA compliant ways for the clinician's access and use.

HIPAA

The Health Information and Portability and Accountability Act (HIPAA) is a federal regulation that includes three parts: 1) Privacy Rule, 2) Security Rule, and 3) Patient Safety Rule (American Telemedicine Association, 2020). This regulation protects the privacy, security, and confidentiality of client information. More about this regulation will be addressed in another section.

Home Health Care and Remote Monitoring Systems

Home health care and remote monitoring systems can be tailored for client treatment in their homes. Remote monitoring and interactive devices allow the client to send in data or vital signs on a regular basis to a provider without the need for travel (American Telemedicine Association, 2020).

Interactive Video/Television

Video conferencing technologies allow for two-way synchronous (simultaneous), interactive video and audio signals for the purpose of delivering telehealth, telemedicine, telemental health services, or distant education services (American Telemedicine Association, 2020).

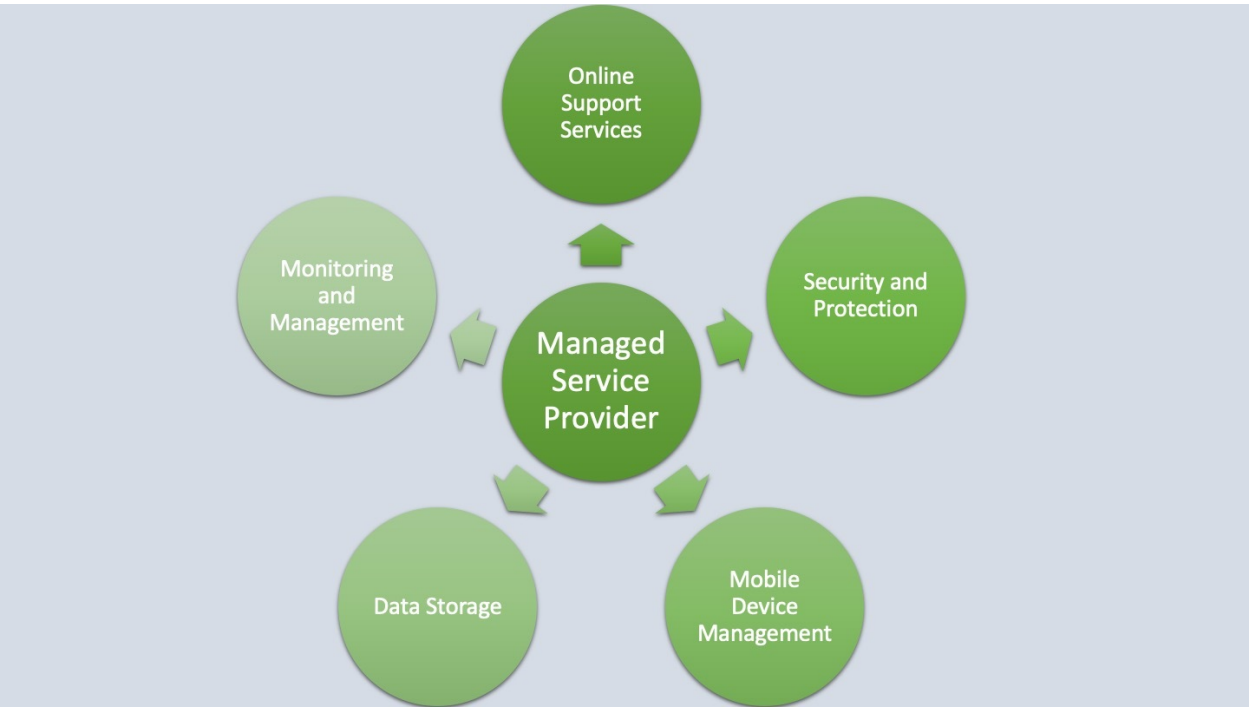
M-Health

The term m-Health is used with generally with health care services that are supported by mobile communication devices, such as mobile phones, tablet computers, smart watches, etc. (American Telemedicine Association, 2020).

Managed Service Provider

A managed service provider can offer various applications on a central server. Customers generally pay a fee to access the applications over secure Internet connections or a private network. Customers do not need to purchase, install, or maintain the software themselves.

Rather, they rent (e.g., monthly subscriptions) the applications from a managed service provider that they need. The managed service provider generally handles software upgrades and software fixes (American Telemedicine Association, 2020). Mental health practitioners may already access these types of services if they use on-line billing applications or interact with particular applications when working with insurance companies. Examples, which are discussed in greater detail later in section on platforms, include doxy.me, Simple Practice, and Theranest.



Originating Site

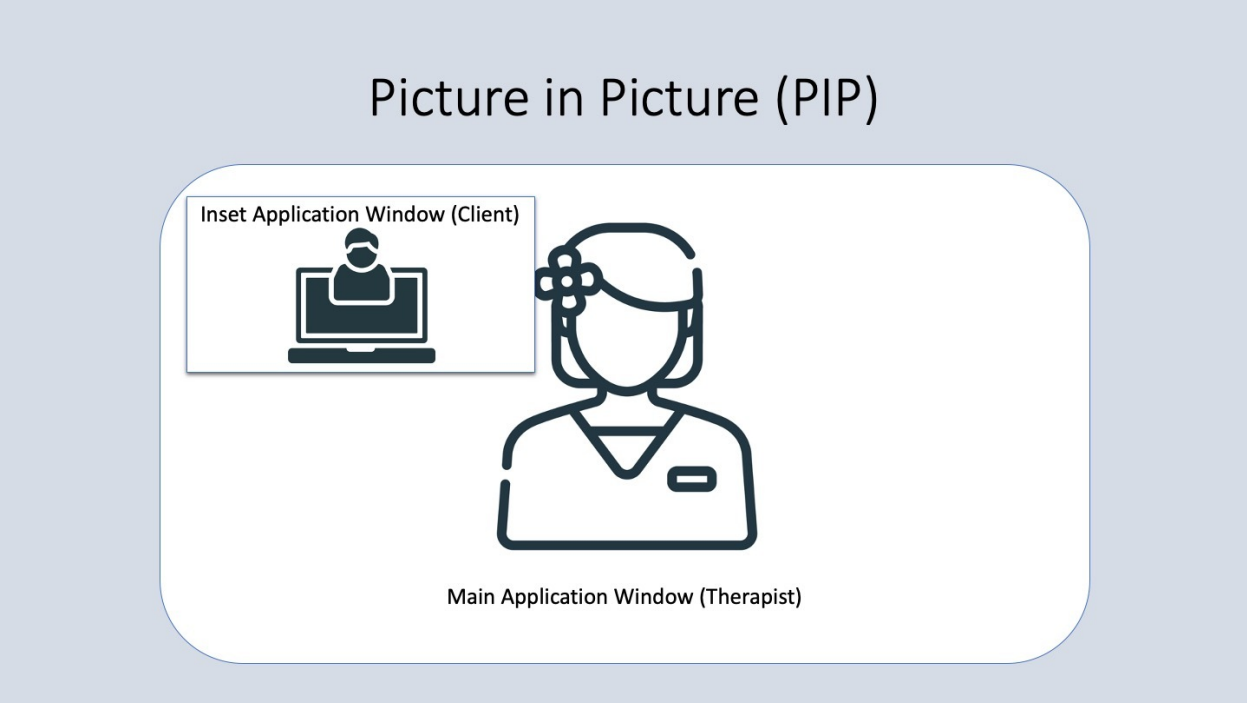
When receiving telemental health services, the originating site is where the client is located (as opposed to the *distant site*, where the practitioner is located) (American Telemedicine Association, 2020).

Peripheral Devices

A peripheral device is any component that is attached externally to a computer (American Telemedicine Association, 2020). Examples of peripheral devices are scanners, mouse pointers, printers, keyboards, and clinical monitors, such as blood pressure machines, weight scales, and cameras.

Picture-in-Picture (PIP)

A picture-in-picture is a feature of videoconferencing devices where an image is displayed on the full screen at the same time one or more other videos are pictured (American Telemedicine Association, 2020). An example of this is when a clinician makes a video call to a client, the images of the clinician and the client are often both on the same computer screen.



Protected Health Information (PHI)

Federally protected health information is individually identifiable health information that is held or transmitted by a covered entity, such as an outpatient mental health clinic, or its business associate, such as the video conferencing platform (American Telemedicine Association, 2020). Individually identifiable data includes patient demographic data, any medical records, diagnoses, treatment, conditions, or history. Common identifiers that include names, addresses, birth dates, and Social Security Numbers are considered PHI.

Store and Forward

Store and forward is a type of telehealth encounter that relies on asynchronous communication of still digital images and information that can be sent electronically (American Telemedicine Association, 2020). This is an asynchronous form of data transmission. Examples of store and forward data are e-mails, texts, blogs, discussion forum posts, and any imagery attached to these.

Synchronous

Synchronous connections are in-person, live interactions that transmit information in both directions as the same time (i.e., in real-time) (American Telemedicine Association, 2020). Examples of synchronous communication are speaking on the telephone or using video conferencing.

Telecommunications

This term refers to the transmission, emission, or reception of data or information, in the form of signs, signals, writings, texts, images, and sounds through wire, radio, video, or other electromagnetic systems (Zur, 2020).

Teleconferencing

Teleconferencing is an interactive, electronic communication between multiple users at two or more sites (American Telemedicine Association, 2020). These interactions can be video, voice, and/or data transmission systems, such as audio, graphic, computer, and video systems. Facetime, Googlemeet, and Zoom are commonly used teleconferencing platforms. When video is included this is also called *videoconferencing* or *videochat*.

Teleconsultation

Teleconsultation is an interactive consultation between two providers at a distance (American Telemedicine Association, 2020). Communications can be either store and forward or real-time teleconferencing.

Telehealth

Refers to the delivery of health care services or related health care activities through technology, such as telephones, computers, interactive video transmissions, direct links to health care instruments, transmission of images, and teleconferencing by telephone or video (Zur, 2020).

Telepresence

Telepresence refers to the methods providers use to establish rapport and facilitate treatment engagement with clients. Providers use a set of technologies and approaches that allow clients to feel as if the clinician were physically present in the session (American Telemedicine Association, 2020). These approaches can include the provider's body position, movements, actions, voice, and setting (e.g., background images).

Telemental Health

This is a general term that refers to providing psychological, counseling, or behavioral health services using digital technologies using the telephone, text, e-mail, or interactive video-

conferencing (Zur, 2020). Telemental health services can include: crisis intervention, assessment, treatment, interventions, psychotherapy, and prevention (Zur, 2020).

Telemedicine

This is a general term that refers to providing clinical services by using technology. Telemedicine services include videoconferencing, transmission of still images, e-health including patient portals, remote monitoring of vital signs, continuing medical education, and nursing call centers (Zur, 2020). Telemedicine also includes sub-specialties, such as teleradiology, teledermatology, telecardiology, telepsychiatry, and telehematology.

Telenursing

This term refers to a subset of services that focus on nurse practice using telecommunication technologies (Zur, 2020).

HISTORY OF TELEMENTAL HEALTH

The use of videoconferencing for psychiatric and psychotherapeutic purposes is not new. In 1948, the first radiological images were sent over the telephone (InTouch Health, 2020). Videoconferencing in psychiatry began in the 1950's (Caudill & Shore, 2019; Doarn, 2018; Von Hafften, 2020). In 1959, psychiatrists and medical students used videoconferencing to conduct group therapy, long-term therapy, consultation, and training to medical students at the Nebraska state hospital. This was the first case where health professionals used the telephone to send and receive medical documents across long distances (InTouch Health, 2020). During the next decade, Massachusetts General Hospital offered psychiatric consultations of adults and children in a clinic at the Logan International Airport (Caudill & Shore, 2019; Doarn, 2018; Von Hafften, 2020). In 1961, the U.S. Space Program used remote medical monitoring systems with animals that were sent into space (InTouch Health, 2020). This later evolved to the remote monitoring systems we use today.

The early use of teleconferencing incorporated a two-way closed-circuit microwave technology that allowed dialogue between different sites, a version of closed-circuit television (Doarn, 2018). This approach, which started in Nebraska, was further developed in Massachusetts and Arizona in the 1960's and 1970's.

The Internet was developed in the 1990's, which serves to be the lifeline to the globally-connected network practitioners use for telemental health today (InTouch Health, 2020). In 1993,

the American Telemedicine Association was formed with the purpose of promoting and expanding telehealth technology as a way of increasing patient access to care. This organization continues to provide information and resources to practitioners and patients about telehealth.

In 2009, legislation for the American Recovery and Reinvestment Act of 2009 directed money into the American health care system, including HITECH (Health Information for Economic and Clinical Health) (InTouch Health, 2020). This bill allocated more than $25 billion specifically to the development of health information technology. This evolved into health care digital connectivity.

In 2010, the Centers for Medicare and Medicaid Services (CMS) issued guidelines that outlined the meaningful use of electronic health records (InTouch Health, 2020). These guidelines were designed to clarify patient privacy and how it should be protected with the use of digital technologies. Meaningful use as defined by CMS included prescribing medications and improving the quality of health care for patients.

In 2016, the Health Resources and Services Administration (HRSA) received money to expand the use of telehealth specifically to rural areas. Individuals living in rural areas have limited access to services due to geographic distance from agency providers. The funds from HRSA helped to expand the telehealth network, thus allowing for many individuals to receive service who had not had access to them otherwise. HRSA (2020) identifies medically underserved areas (MUAs) and medically underserved populations (MUPs) that have an extreme shortage of healthcare providers and services. MUAs include: a whole county, a group of neighboring counties, a group of census tracts, or a group of county or civil divisions. MUPs include populations that are: homeless, low-income, Medicaid-eligible, Native American, and migrant farmworkers.

Currently, HRSA oversees the Office of Advancement of Telehealth (OAT) (HRSA, 2020). This office promotes the use of telehealth technologies for health care delivery, education, and health information services. It recognizes the critical need for health-related services in rural and remote areas that do not have sufficient health care services. Current programs managed by HRSA are:

- Telehealth Network Grant Program
- Substance Abuse Treatment Telehealth Network Grant Program
- Evidence-Based Tele-Behavioral Health Network Program

- Telehealth Resource Center Program
- Telehealth Centers of Excellence
- Flex Rural Veterans Health Access Program
- Licensure Portability Grant Program
- Telehealth Focused Rural Health Research Center Cooperative Agreement

According to the Rural Maryland Council, all of the eastern shore counties qualify as rural areas that are medically underserved in primary care, source: https://data.hrsa.gov/tools/shortage-area/mua-find. *The deaf and hard of hearing communities are not, in and of themselves, considered by HRSA to be a medically underserved population. However, given the needs for culturally and linguistically competent providers by deaf and hard of hearing individuals, they are an underserved community in practical terms.*

TYPES OF TELEMENTAL HEALTH PRACTICES AND SETTINGS

Behavioral health providers have options for telemental health services for their clients. Providers can choose from: direct videoconferencing (most common), telephone, mobile health, email, remote monitoring devices, and store and forward technologies (least common) (Mace, Boccanelli, & Dormond, 2018). The most frequent behavioral health providers who use telehealth technologies are psychiatrists (most frequent use), followed by mental health counselors, social workers, psychologists, addiction counselors, case managers, and peer workers (least frequent use) (Mace, Boccanelli, & Dormond, 2018). Types of services they most often provide are: medication management, individual counseling, assessment, consultations, crisis services, group counseling, clinical supervision, chronic disease management, peer specialist collaborations, individually targeted prevention services, and intake screenings.

There are many reasons that providers may decide to offer their clients services through telehealth technologies. Most often, providers want to improve the quality of care to their patients (Mace, Boccanelli, & Dormond, 2018). Telehealth technologies can provide access to an array of services that may otherwise not be accessible. For example, individuals who live in

rural areas often have a limited number of available services and sometimes must travel far distances to access them. Telehealth technologies can offer operational efficiency of services. It is easier to provide services via telehealth rather than driving to different sites and asking clients to drive to other sites as well. The technologies can potentially reach a lot of new clients. There may be many individuals who, for a variety of reasons, such as condition (e.g., anxiety) or location (e.g., rural) or language (e.g., deaf), may be more likely to receive treatment if it is provided via telehealth. In recent times, the coronavirus pandemic forced many behavioral health providers to offer services via telemental health so that they could continue to meet with clients who needed services while complying with state mandates for social distancing.

Behavioral health providers who have positive attitudes and beliefs about telehealth are more likely to use it (Mace, Boccanelli, & Dormond, 2018). There may be individual reasons for using telehealth, like saving the cost of rent for a designated private practice. In general, providers report that they use telehealth services because they:

- contribute to the success of the agency or organization
- increase ability to see a higher number of clients
- allow providers to offer services to consumers over greater geographical distances
- promote efficient workflow for seeing clients
- fill essential gaps in specialist providers Mace, Boccanelli, & Dormond, 2018).

Behavioral health providers identify a number of challenges associated with using telehealth technologies. Sometimes public and private insurance companies will not reimburse for services provided with telemental health (Mace, Boccanelli, & Dormond, 2018). Some insurance companies reimburse at lower rates for telemental health than they do for in-person office visits. Some types of services, such as substance use treatment and case management services, may not qualify for reimbursement. In addition, states oversee telehealth and telemental health services independently. There may be certain standards required by states in order to receive reimbursement.

Providers may be faced with additional costs, especially during start-up, when implementing a telemental health program. Start-up and maintenance costs can be substantial (Mace, Boccanelli, & Dormond, 2018). These costs can include equipment (computers, webcams, videoconference systems (i.e., Polycom)), services (e.g., server maintenance, platform membership fees, technology support), and Internet connections with sufficient speed and

reliability. Among agencies with limited resources, the costs associated with telemental health services should be compared with the potential revenue that can be generated.

In order for telemental health services to be implemented, there needs to be professionals who are trained and are able to assume leadership roles (Mace, Boccanelli, & Dormond, 2018). In addition to leadership, practitioners must be willing to provide services to clients using technology. For some, the use of technology may be a difficult challenge to overcome because types, uses, and availability are expanding at great rates, causing providers to be constantly learning and adapting to changing technology. Most providers are not aware of programs that support telehealth start-up and continued education (Mace, Boccanelli, & Dormond, 2018).

BENEFITS AND CHALLENGES OF TELESERVICES

Benefits

There are numerous benefits to providing mental health services through telehealth technologies. These types of technologies provide opportunities for individuals to receive treatment that may not otherwise arise if options were limited to agency-based care (Barnett & Kolmes, 2016; Howard, et al., 2018). One of the primary benefits, is that it enables providers to offer behavioral health care to populations who do not have access to services in their areas (Howard, et al., 2018; Langarizadeh, et al., 2017; Turvey, 2018). Individuals who live in remote geographical areas often have limited access to services because either they are not available in their areas or they have to travel long distances to service sites. Telemental health services allow clinicians to meet with clients either at home (i.e., home-based telemental health services) or at a clinic that is closer (i.e., clinic-based services). Clients from rural areas often have limited or no access to specialists. Telemental health is a way for specialists to either meet with clients directly or consult with local practitioners to enhance behavioral health treatment.

Telemental health services offer a cost-effective solution to the costs associated with traveling to agencies (Howard, et al., 2018; Langarizadeh, et al., 2017). This is especially important in rural areas where distances to service providers are great. For clients with limited financial means, transportation expenses can create financial strain that impede clients from seeking help and maintaining regular appointments. Costs associated with travel, child care, and taking time off from work are barriers that can be eliminated with the use of telemental health.

Some clients may have difficulty with mobility (e.g., elderly clients) that make traveling to agencies challenging. Others have unique needs for providers who are culturally and linguistically competent (e.g., deaf clients, individuals who speak in languages other than English). Telemental health services allow consumers to have access to a diverse range of providers with specialized skills.

Telemental health services can benefit individuals who have difficulty leaving their homes because of psychological conditions, such as anxiety and phobias (Lerman, et al., 2018). Those who have debilitating symptoms can receive treatment from their homes without having to face the anxiety of going somewhere for services. Telemental health can reduce the fear of stigma associated with being seen going into a facility that provides mental health services.

Clients who experience the effects of natural disasters, such as hurricanes, floods, and earthquakes, can use telehealth technologies to address physical health and mental health care needs (Lerman, et al., 2018). Disasters can cause individuals to experience trauma-related symptoms, such as depression and anxiety. They can use technology to access services during a time of upheaval and crisis. Telehealth technology allows greater access to a variety of professionals to address needs. Telemental health applications allowed for rapid transition from face-to-face services to videoconferencing during the recent coronavirus pandemic.

Telebehavioral health technology, such as mobile applications and web-based resources, can augment and enhance treatment (Barnett & Kolmes, 2016). Between sessions clients can access resources that help to keep them focused on treatment. These technologies can be used for clients who are experiencing crises and require referrals, follow-up, or support. It offers flexibility in receiving different types of therapeutic services as frequently as needed (Lerman, et al., 2018). Telehealth can reduce or eliminate barriers, such as stigma and fear, which can support those who would not ordinarily seek treatment.

For practitioners, offering telehealth services can boost provider access to more clients, thereby building their practices (Barnett & Kolmes, 2016). Advertising their services on the Internet allows more individuals to learn about the practitioner, the services provided, and different modalities from which to choose.

Telemental health technologies offer consumers convenience, confidentiality, and the ability for integration into daily life activities. Clients who receive telemental health services report higher satisfaction with services, greater adherence to treatment protocols, and mental health

outcomes comparable to face-to-face traditional therapy (Howard, et al., 2018). Telemental health services are effective in addressing a variety of behavioral health issues, unique needs of individuals from diverse cultural groups, and age groups. They offer the potential for diverse treatment approaches, such as videoconferencing for sessions and mobile applications between sessions, and increasing the frequency of interactions with providers (Lerman, et al., 2018; Petersen, Salazar, & Kertz, 2019). Clients who face particular barriers, such as physical limitations, anxiety, or fear of stigma, can now have more diverse treatment options and increase mental health care access. This can improve the quality of behavioral health care services and access to care.

Challenges

Despite the positive benefits associated with telemental health services, there are a number of challenges. A major challenge to telebehavioral health provision is the inconsistent, vague, and ambiguous regulatory environment in which telemental health providers work (Lerman, et al., 2018). At the federal and state levels, expanding coverage and reimbursement for telehealth services has been marginally successful. Though many professional organizations have incorporated telemental health guidelines, licensing requirements and regulatory issues are inconsistent, use different terminology, and often do not offer specific guidelines for telemental health delivery. States' laws vary in terms of coverage, reimbursement, and practitioner-client relationship definitions.

With varying guidelines, practitioners may be reluctant to begin a telemental health practice. Most states require providers other than physicians to have in-person assessments before providing telehealth services to clients (Lerman, et al., 2018). Changes to public insurance coverage, such as Medicare and Medicaid programs, require consistent monitoring by practitioners. The language regulating telehealth continues to broaden while the details of regulations become more specific (Lerman, et al., 2018). The changing environments of regulations about telehealth care delivery can be challenging for practitioners. Laws, guidelines, and regulatory parameters continue to evolve, which requires continuing vigilance.

Offering services using telemental health technologies requires technical competence from practitioners (Barnett & Kolmes, 2016). This can be a challenge for those who are unfamiliar with computers and their components, hardware, software, Internet connections, and privacy safeguards. During a session, a clinician should be able to adjust the auditory or visual quality of

the technology and address difficulties that may arise. Clients will look to their providers to assist when there are problems, such as Internet disconnection, hardware or software malfunctions, or other problems.

In addition, practitioners need to be aware of the differences between types of platforms and know which ones are appropriate for telemental health services (Barnett & Kolmes, 2016). For example, despite its popular use, Skype is not compliant with HIPAA (Health Insurance Portability and Accountability Act) standards. Products that are compliant will have written standards added to business associate agreements, which will be discussed in a later section.

Using telemental health systems requires a certain amount of general knowledge and competence. Because providers may often be responsible for choosing the most appropriate technology for a given situation, they need to be aware of the limitations of different types (Barnett & Kolmes, 2016). For example, practitioners may need to evaluate the need for client visual clues, which would incorporate a video technology. Another client may prefer to use email or text. Providers will need as much information from the client as possible in order to assess, diagnose, and treat. In doing so with telemental health technology, they will need to provide services using the most appropriate system. Similarly, clinicians will need to know when using technology is inappropriate with a particular client. Clients who display suicidal ideation or gestures, or those who have impulse control disorders, including violent behavior of homicidal tendencies may not be appropriate candidates for telemental health services (Barnett & Kolmes, 2016). Clinical safety assessment information is included later in this learning material.

Before developing and submitting a grant to provide the start-up money for the telemental health program, I needed to learn a lot about what was required. I did not have an exceptional knowledge of technology, security, or even the vocabulary to use when creating a plan for implementation. During this period of development, I discussed my ideas with many colleagues who had more experience in the area of information technology. I met with individuals from the university where I worked. I contacted acquaintances whom I thought could provide me with ideas about the best types of systems to use, the pros and cons of use.

Here are some of the things I learned during this time. During 2012, home-based telemental health services were not reimbursed

by Medicare or Medicaid. The terms used by the helpful people from whom I inquired were: encryption, secured server, Polycom systems. The IT manager at my university explained to me that they used the Polycom system, similar to what was used in the White House at the time. They gave me a tour of their videoconferencing board room. On the wall was a large monitor. It was wired to a box. The remote loaded the program onto the monitor. I had to enter an "IP address" of the Polycom system to which I wanted to connect. I entered each number by remote into the system and pressed the "ok" button. It "rang" with a box that popped up onto another screen. I could press the "answer" or "decline" buttons. When I pressed "answer," the image of the other person came on the screen. My own image was in a smaller box (picture-in-picture) on the same screen. Our conversation was conducted in American Sign Language. At the end of the conversation, we both pressed the "end" button.

I learned that telecommunication systems need to be compatible. So, for a Polycom system to be used, the site where the client was located needed to be a Polycom system as well. At the time, Polycom systems that we looked at were about $15,000 for one system. That meant that the other nonprofit organization would need to have an expensive Polycom system as well. This was an important piece of information because I would need to build in enough money in the grant for at least one system, maybe more depending upon how many sites I planned to use.

COMPUTER BASICS

Computers use a combination of hardware and software components. Computer hardware is any part that has a physical structure, such as the internal parts, keyboard, or mouse. Software is the set of instructions that is used to obtain and use the information wanted by an individual. Word processing programs, games, Internet browsers, PowerPoint, spreadsheet programs, and other programs are examples of software. Individuals rely on both hardware and software. Below is a list of terms that are helpful to know.

Many people think of a personal desktop or laptop when they think of computers. However, computers come in diverse shapes and sizes and perform many different functions in daily lives. Several examples of different types of computers are: ATM machines, automobile computer

chips, smartphones, personal digital assistants (PDAs), tablets, game consoles, smart televisions, and wearable technologies, such as fitness trackers and smart watches.

Computer Terminology Basics

The following discussion provided here is to help therapists interested in implementing a telemental health practice become familiar with commonly used terms and their meanings. These terms relate to computer and internet use (GCFGlobal, 2020; IBM, 2020).

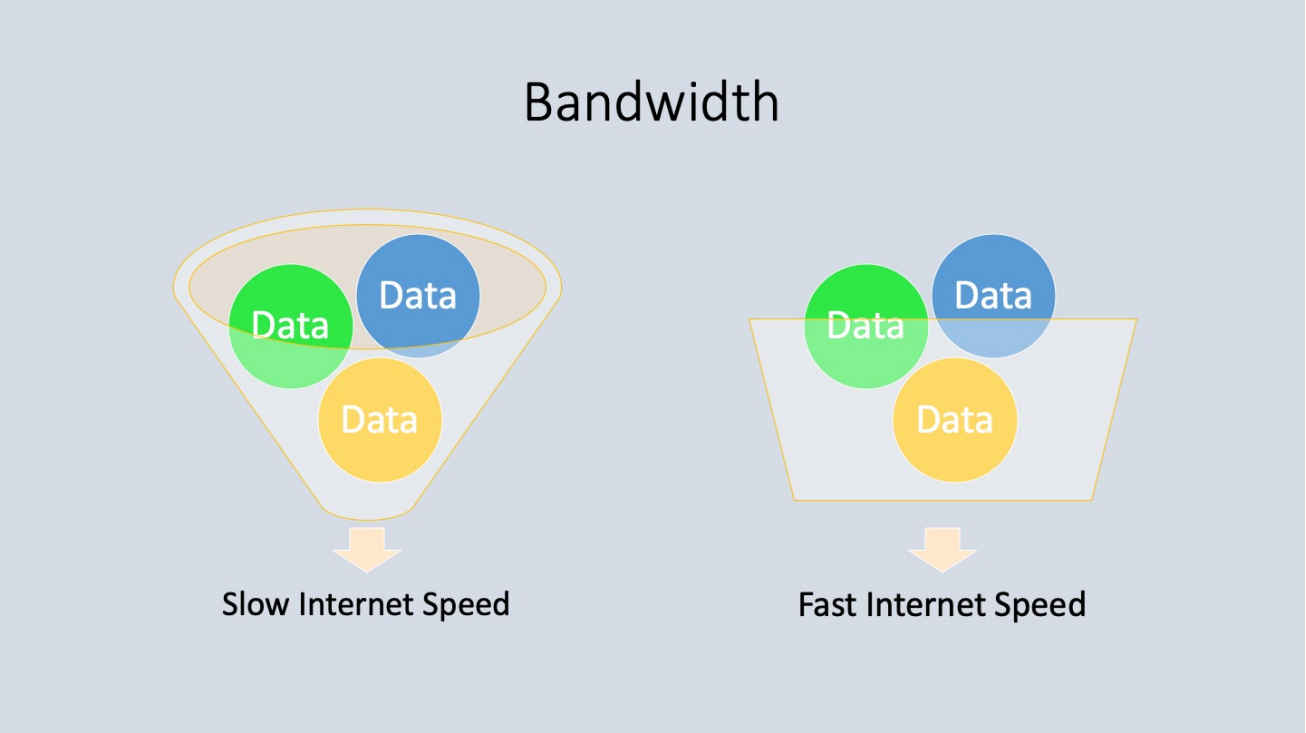
Application: An application, or app, is a type of software that allows a user to perform specific tasks. If an application is for a desktop or laptop computer, it's called a desktop application. If it's used for a mobile device, it's called a mobile app. An application program can be self-contained or embedded within a group of programs. It uses the computer's operating system and other supporting systems, such as database programs, word processors, web browsers, social media platforms, wikis (website that visitors can edit), and spreadsheets. There are also many desktop applications. Some offer a variety of features, such as word processing programs, like Microsoft Word, while others offer one to two features, such as a clock or a calendar app. Apps tend to be user friendly, unique, and focused.

***Authentication*:** Authentication is the process of verifying the identity of a person or a device sending or receiving information using passwords, keys, and other automated identifiers (ATA, 2020). Examples of authentication practices are entering in a four- or six-digit passcode to unlock a device, having a username and password for an account, verifying an email at another location in order to enter into an account, or having a code sent to a phone via text message to be entered into a field to gain access. Authentication is discussed in greater detail below in the discussion on computer security.

Bandwidth

Bandwidth is a measure of the information capacity of a communication channel (American Telemedicine Association, 2020). High bandwidth, which allows for fast internet speed (i.e. high-speed internet), is optimal for telemental health videoconferencing, whereas lower

bandwidths (e.g., slow internet speed) may result in quality issues like interrupted, slow, or "glitchy" video and audio.



***Bluetooth Card (or Adaptor*):** Bluetooth is a technology for wireless communication over short distances. It is used to communicate with wireless devices, such as keyboards, mobile phones, laptops, PCs, digital cameras, mice, printers, speakers, and headphones. The communication connection that Bluetooth facilitates is over a secure, globally unlicensed short-range radio frequency and most devices have Bluetooth technology built into the motherboard or included in a wireless network card.

Broadband

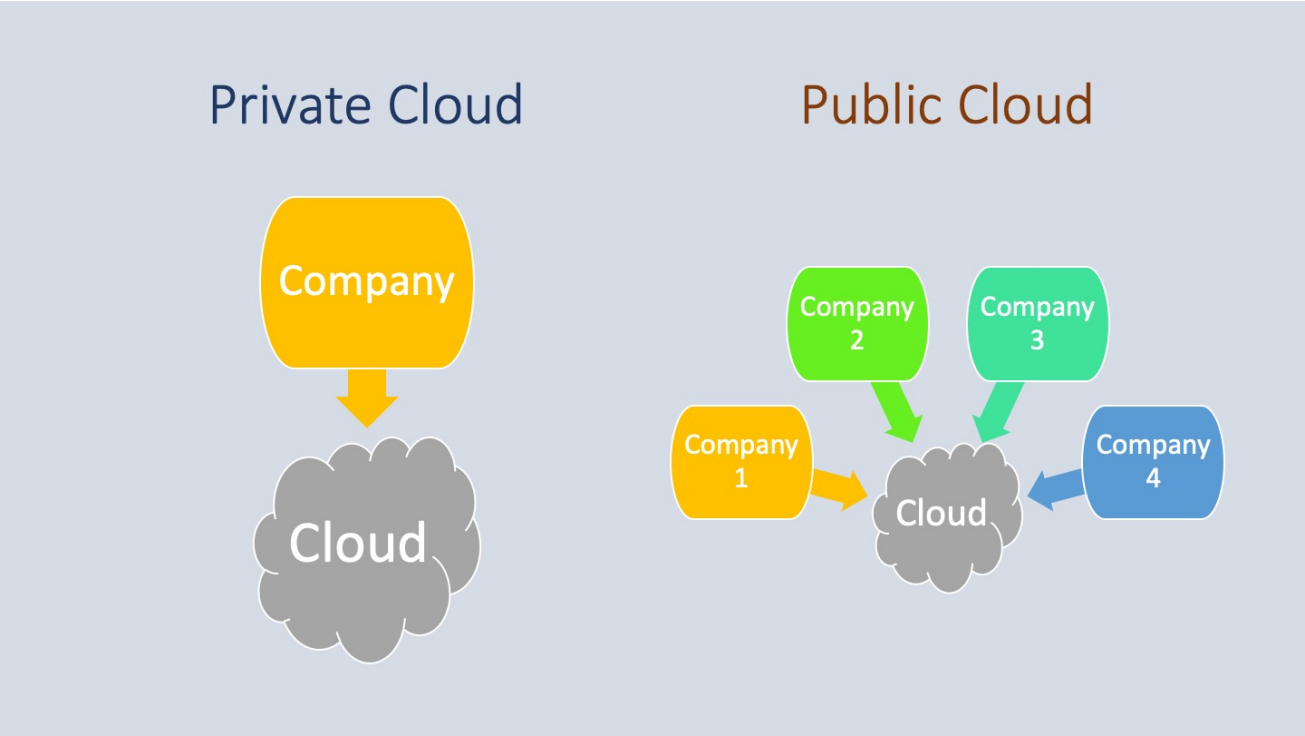
This term refers to a high-capacity transmission technique using a wide range of frequencies that allows a number of electronic messages to be communicated simultaneously. It refers to the transmission of signals in a frequency-modulated way over a segment of the total *bandwidth* (see above) that is available (American Telemedicine Association, 2020).

Cloud: The cloud, also called cloud computing or cloud storage, refers to the Internet. When something is stored in the cloud, it means that the data are saved onto an Internet server rather than the computer's hard drive. All email services are web-based, which are stored on an Internet

server rather than a personal computer. When data are stored on the cloud (i.e., the Internet), they can be retrieved from any computer with an Internet connection. Individuals commonly use the cloud for file storage, file sharing, and backing up (saving) data.

Cloud Computing

This term refers to computer hardware and software that are delivered as a service over the Internet (American Telemedicine Association, 2020). These computing services include servers, storage, databases, networking, software, analytics, and intelligence (Microsoft Azure, 2020). Typically, a customer pays only for the cloud services used, which helps to lower operating costs, run infrastructure more efficiently, and scales up or down as the business changes.

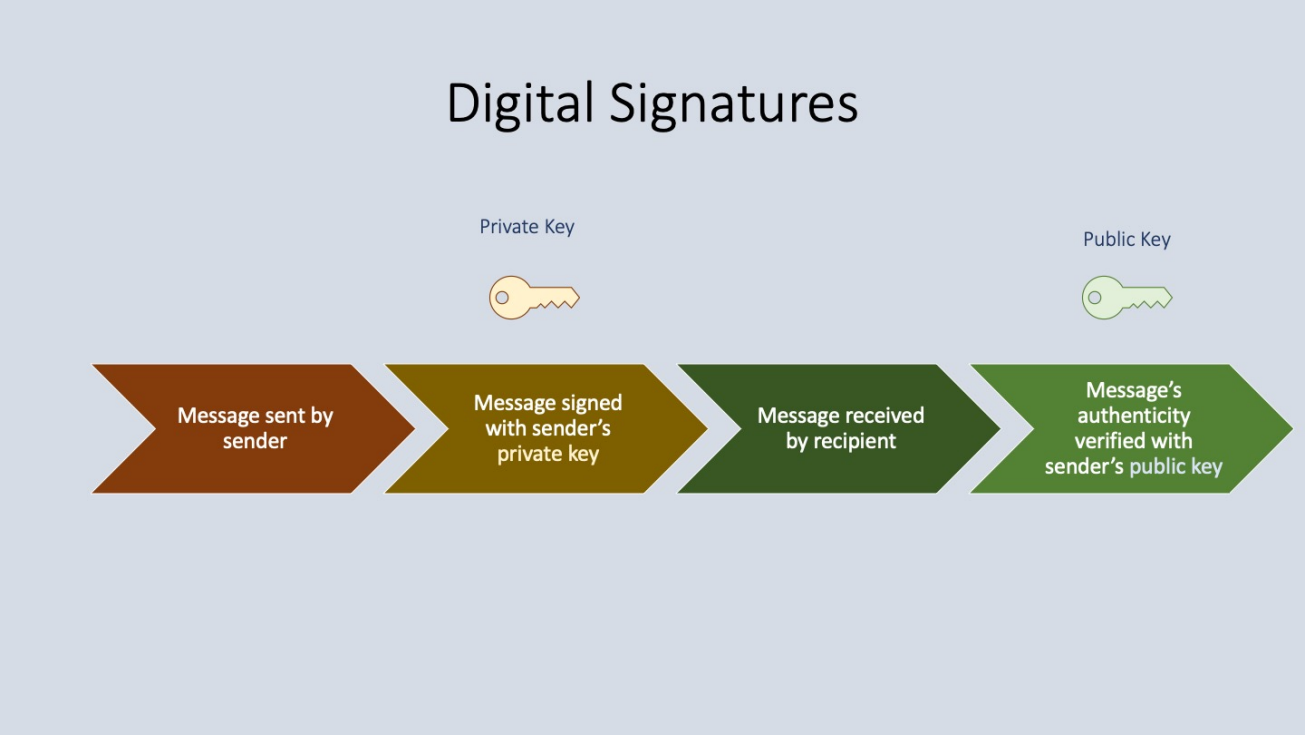


CPU (Central Processing Unit)/Processor: The central processing unit (CPU) is also known as the computer's processor. It is located internally and connected to the motherboard. The CPU is the brain of the computer and carries out the commands of the user. When a user presses a key or clicks the mouse, she is sending instructions to the CPU. The CPU is usually a two-inch ceramic square with a silicon chip embedded in it. A processor can be different speeds. A higher speed processor is desirable for videoconferencing.

Digital Camera: A digital camera allows an individual to capture pictures and videos in a digital format. When connected to a computer through a port, it can transfer images from the camera to the computer. These images can then be sent through e-mail to other individuals or saved and stored as part of an electronic health record. Related to this is the *depth of field* which refers to the degree to which an image remains in focus from front to back as the camera focuses on the main subject (California Telemedicine & eHealth Center, 2020).

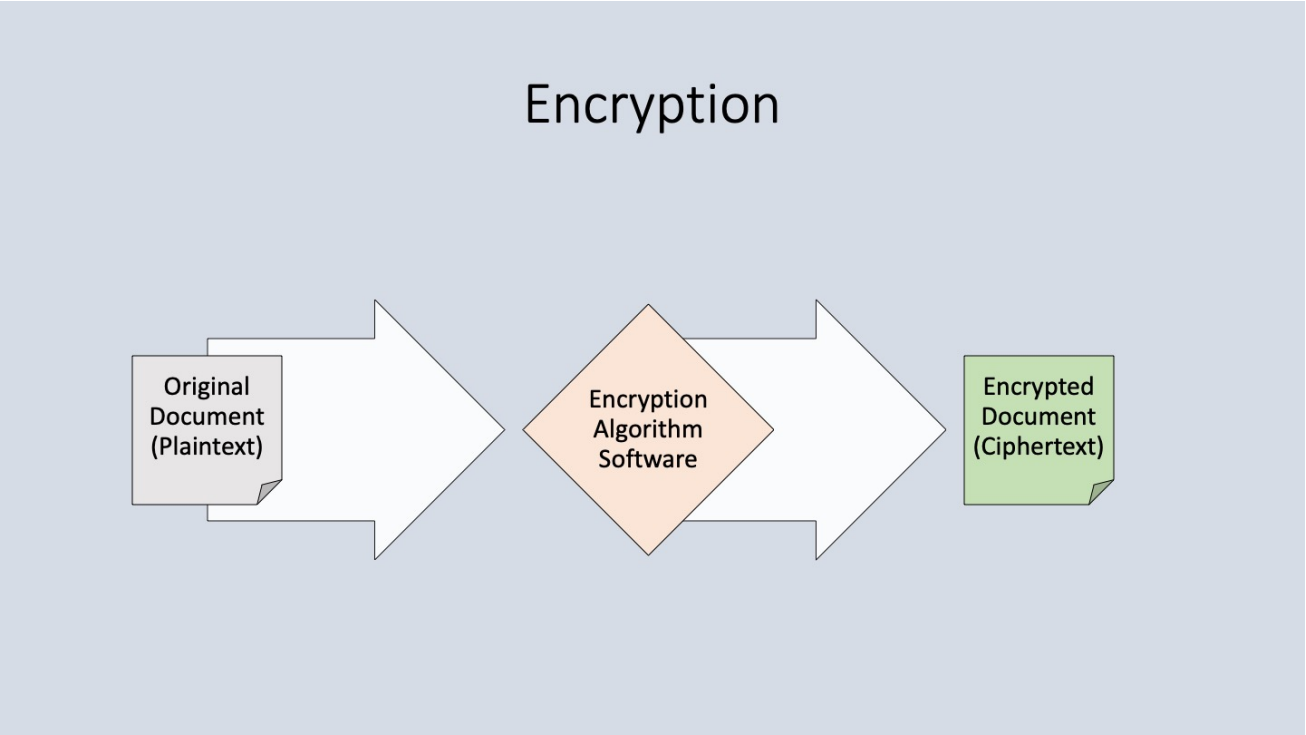
Digital Signature

A digital signature is a mathematical process for authenticating digital messages or documents (American Telemedicine Association, 2020). This digital signature gives the recipient of a document evidence that the message what created by a known sender and not altered in transit. In telemental health services, agency forms, such as consent for treatment, can be signed digitally by clients and then be entered into an electronic health record.



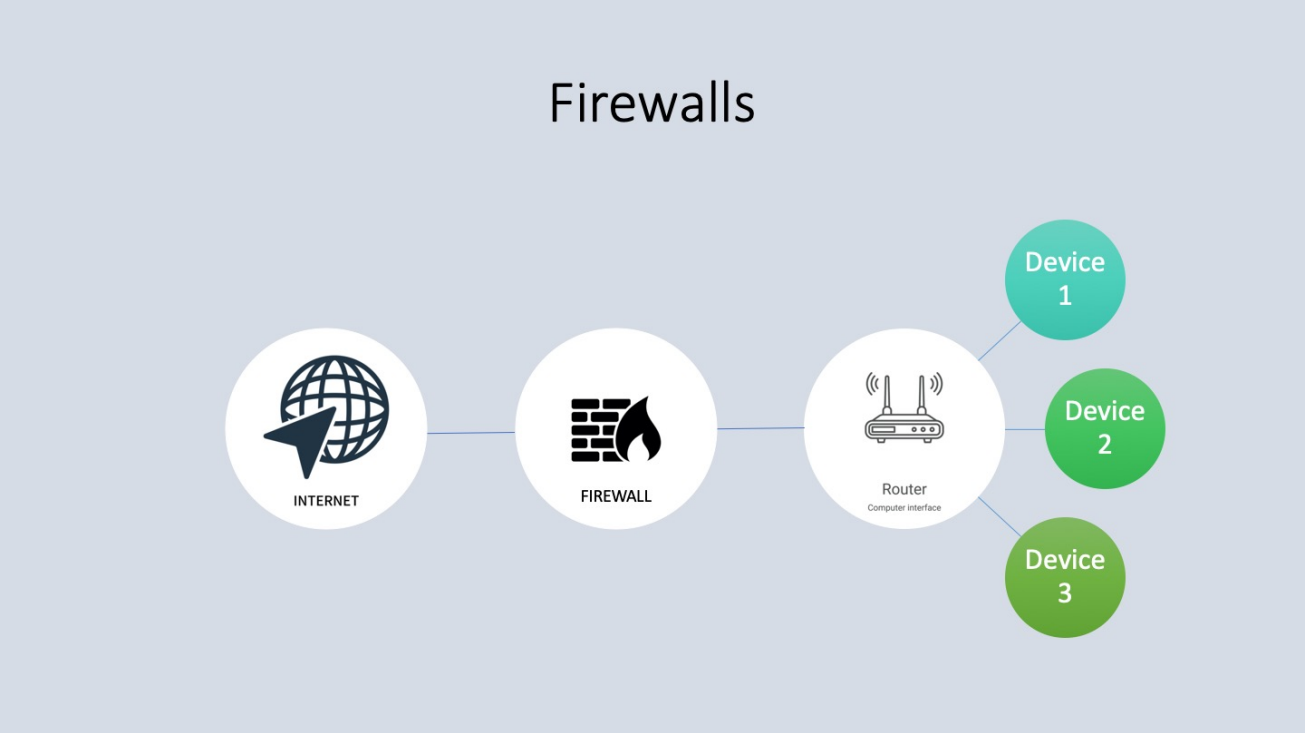
Encryption

Encryption is a process of encoding electronic data so the information cannot be retrieved or decoded by an unintended recipient (American Telemedicine Association, 2020). Only the person or computer system authorized can access encrypted data.



Firewall

A firewall is a computer hardware and software system that blocks unauthorized communications between a clinician's or agency's computer network and external networks.

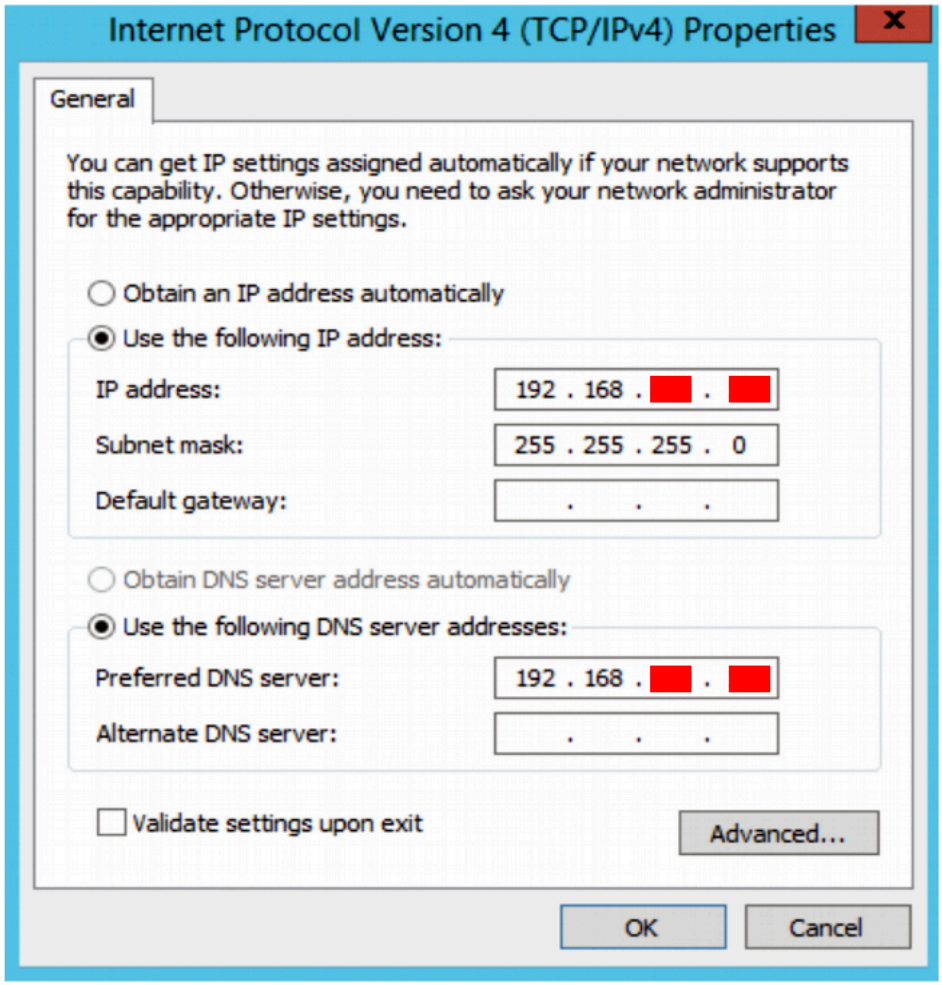


GPU (Graphics Processing Unit): A GPU is an electronic circuit device that controls what the user sees on the monitor. Most computer GPUs are already built into the motherboard of different devices, such as computers, cell phones, and game consoles. Some GPUs are stored on small video cards that can be plugged into a computer GPU slot. The GPU handles video images while a "sound card" manages audio.

Hard Drive: A hard drive is where software, documents, and other files are stored for long-term. When data on the hard drive are stored, they are saved even when the computer is turned off or unplugged.

Internet Protocol (IP)

An internet protocol is the computer's address that uniquely identifies it from other computers on the Internet (American Telemedicine Association, 2020). And IP address does not have an established connection between the end points that are communicating.



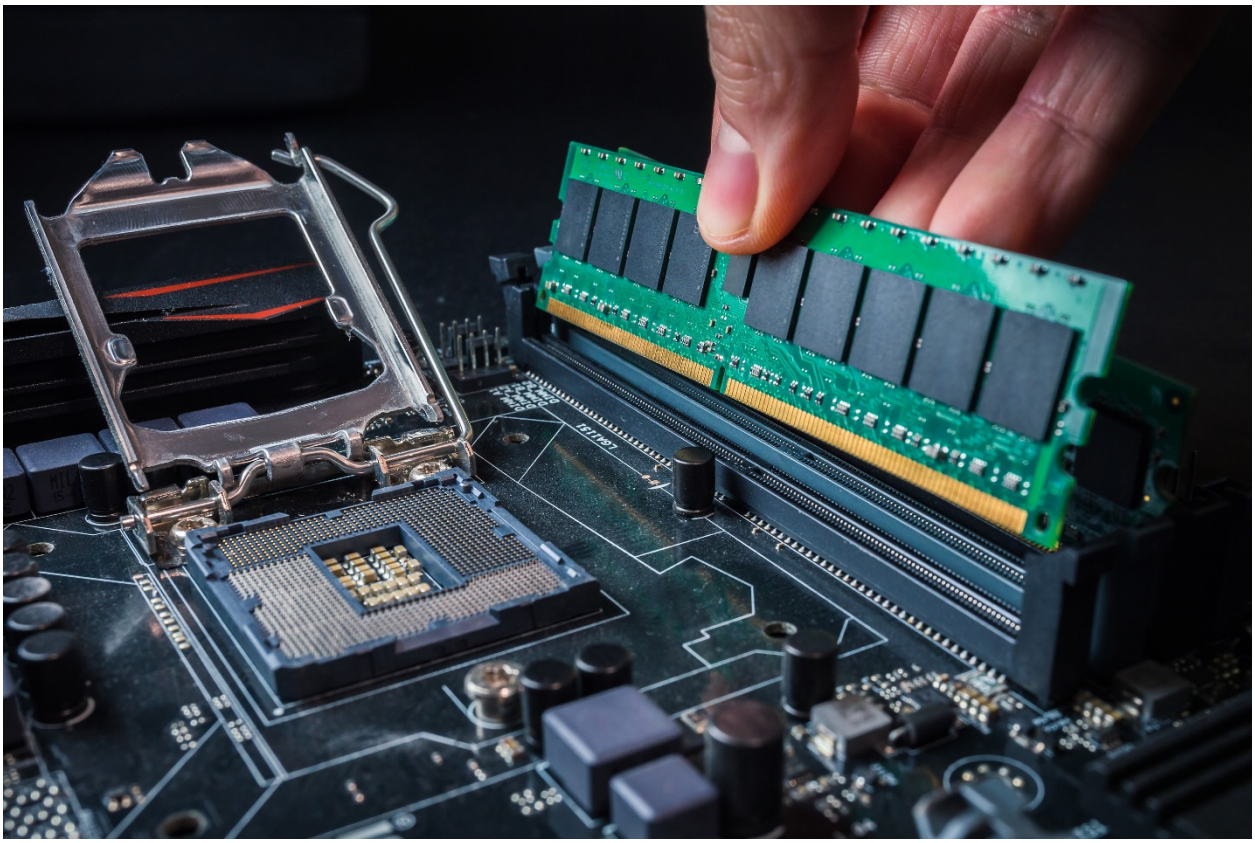
Malware/Malicious Software: Malware is a computer software that is designed to damage computers or steal computer files without the user's consent. It is a general term that can apply to specific types of threats, such as viruses, spyware, worms, trojans, and rootkits.

Microphone: A computer microphone is an integrated device that receives information from a user. This allows an individual to listen to sound or talk to someone using the Internet.

***Mobile Applications*:** Mobile applications are used for devices, such as smartphones and tablets. Examples of mobile apps are Gmail, and Instagram. There are thousands of mobile apps for different types of interests, such as travel, reading, games, navigation, and fitness. Mobile applications can include mental health-related programs, such as managing depression, anxiety, addiction, eating disorders, and post-traumatic stress disorder (PTSD). Some applications are free while others charge its users fees for using it.

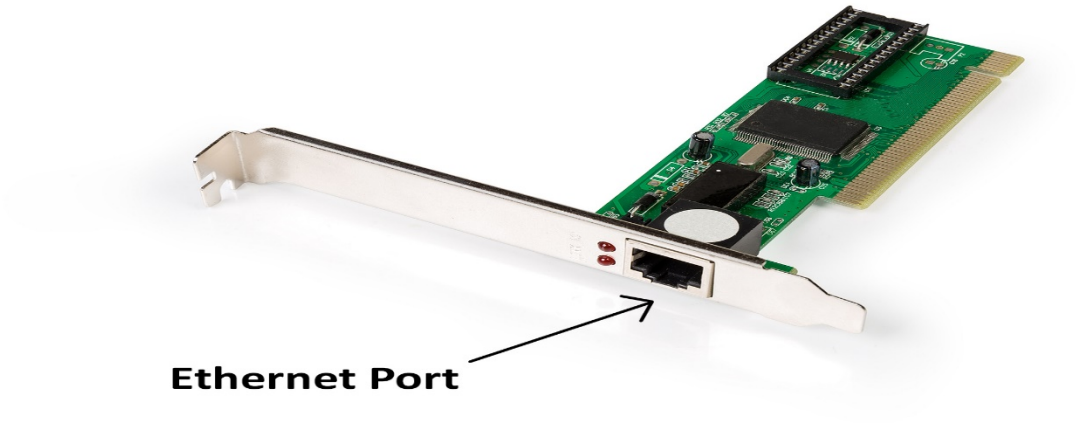
***Mobile Technology*:** Mobile technology is a device that goes where the user goes. It has portable two-way communication devices, computing components, and the ability to connect to Internet networks. Examples of mobile technology are smartphones, tablets, and watches.

***Motherboard**:* A motherboard is the computer's main circuit board. It is a thin metal plate that holds the connectors, memory, CPU, and other hardware to control the video, audio, and connections to the port. It contains the principal components of the device or computer and allows other connectors to other circuit boards.



Mouse: A mouse is a corded or wireless device that moves the computer cursor. Its name originated at the Stanford Research institute because earlier models had a cord that resembled a mouse tail.

Network Card: A network card allows the computer to communicate over an Internet network. It can either connect with an Ethernet cable, which is plugged into a computer port and into an Internet access point, or through a wireless connection (i.e., Wi-Fi). Network cards can also be expanded and used in a dedicated computer slot.



Operating System (OS): An operating system is the most important software that runs on a computer. This system manages the computer's memory, processes, software, and hardware. This system allows a user to communicate with the computer without having to use computer code language. It coordinates all of the computer components in order to allow the user to complete desired tasks. The three most common operating systems are Microsoft Windows, macOS, and Linux. Microsoft Windows 10, released in 2015, is one of the most popular operating systems; Microsoft Windows 11 is scheduled to be released August 29, 2020 and will be available to the general public. It often comes pre-loaded on most new personal computers. MacOS is an operating system created by Apple and is pre-loaded on all Macintosh computers, called Macs. Some of its newer specific versions are Mojave (released in 2018), High Sierra (released in 2017), and Sierra (released in 2016). Linux is an open-source operating system that is accessible to anyone in the world. Unlike Windows or macOS, Linux is free and has different versions from which to choose. Mobile devices, such as smartphones, tablets, wearables, and game players have different operating systems than computers or laptops. There are different operating systems for mobile devices. Two of the most popular ones are Google Android and Apple iOS.

Port: A computer port is a hole or connection on a computer that allows external devices, called peripherals, to be plugged in, such as a printer, an external drive, and a mouse.

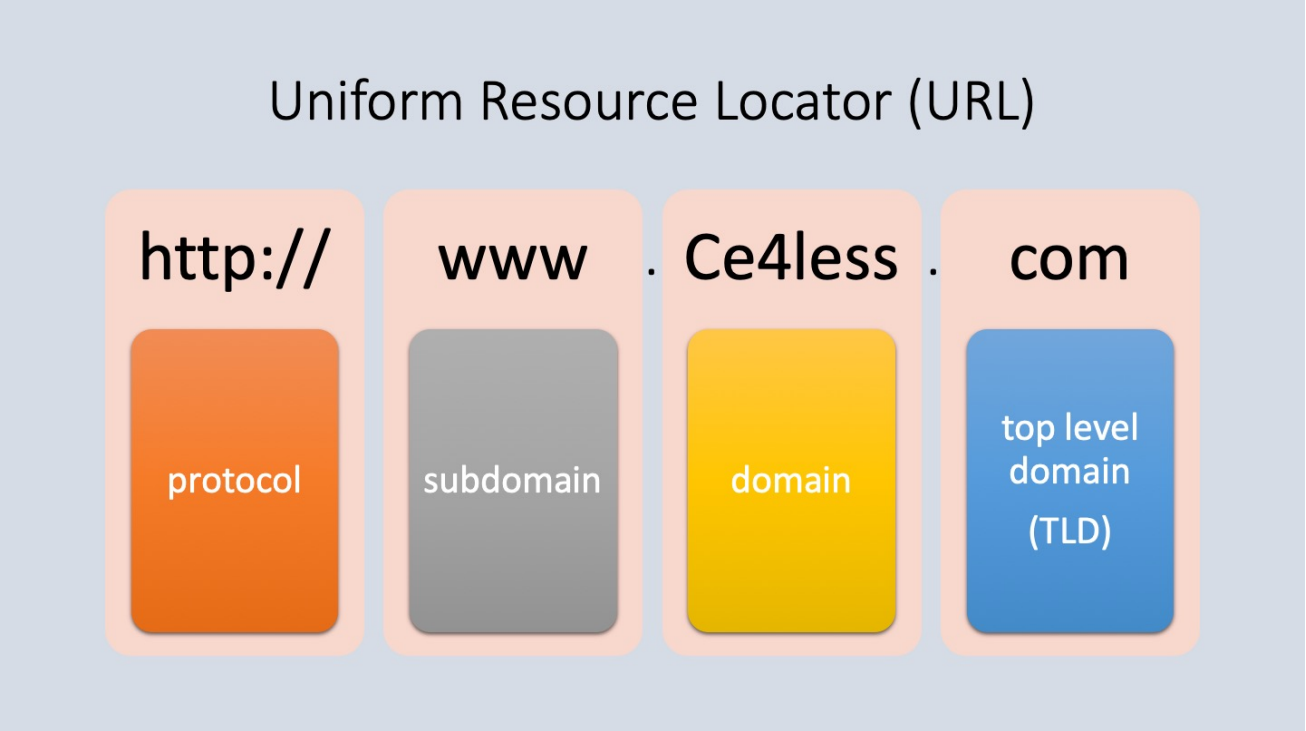
RAM (Random Access Memory): RAM is the computer's short-term memory. When the computer performs calculations, it stores the data in the RAM temporarily. When the computer is turned off, the short-term memory disappears unless the user saves the data on a document, spreadsheet, or other type of file. The more RAM a computer has, the more things can be done on a computer at the same time.

Sound Card/Audio Card: A sound card is responsible for the audio sounds in speakers or headphones. Most motherboards have integrated sound cards, but the user can install an additional card to upgrade to a higher quality sound.

Tablet: A tablet is a form of personal computer that is smaller and more portable than a desktop or laptop. It often includes a touch screen, microphone, and web cam. Tablets are compatible with wireless Internet connections and cellular data networks. They are lighter and easier to carry than laptops.

Uniform Resource Locator (URL)

A uniform resource locator (URL) is the address of a webpage on the Internet.



Web browser: A web browser is a type of computer application that allows user to access the Internet. Most computers have web browsers pre-installed, but others can be downloaded. Examples of web browser applications are Internet Explorer, Mozilla Firefox, Google Chrome, and Safari.

Web camera (aka webcam): A webcam is type of camera that is either integrated into a computer or is plugged into a computer as an external device. It can record videos, take pictures, and transmit audio or video across the Internet in real time. The webcam is a required component for videoconferencing.

Wi-Fi

Wi-Fi is a wireless networking protocol that allows devices to communicate without having direct cable connections (Pinola, 2020). When not connected via direct cable, devices need Wi-Fi (usually sourced by a router) to access the Internet – which is then how teleconferencing and other technologies are facilitated for telemental health. In some instances, users can connect to Wi-Fi using their smart phone as the Wi-Fi source (i.e., turning on the phone's "hotspot"). Wi-Fi allows for multiple devices (e.g. lap top, printer, tablet) to connect to the Internet, whereas broadband is a wired connection through a cable attached to a single device. The image below shows the Wi-Fi router as the source in the middle connecting the internet to a smart phone, lap top, desk top, and watch.

Computer Security

A computer that is attached to the Internet can potentially have many threats, including viruses, malware, and hard drive failure. Malware is a general term used to describe any type of software that can damage computers or files, steal files, or track key strokes without a user's

consent (GCFGlobal, 2020). Most malware is distributed over the Internet and is bundled with other software. Antivirus software helps to prevent malware from being installed and removes it from a computer.

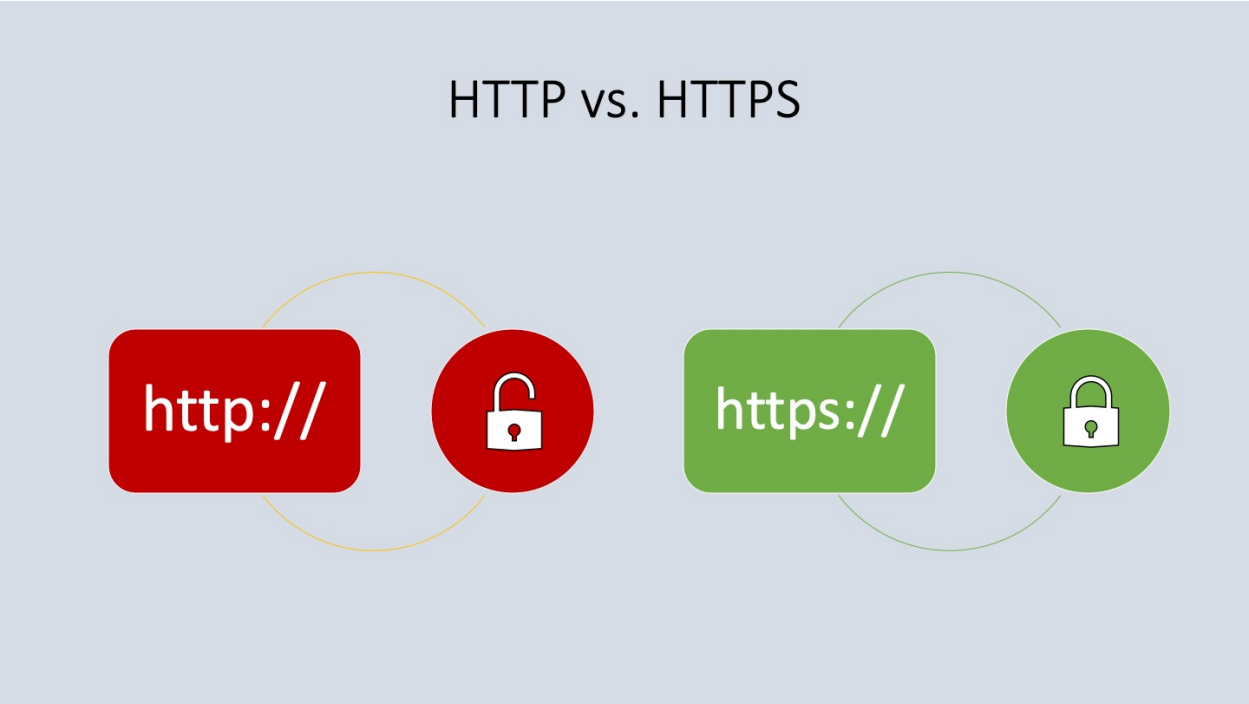
Many malware programs exploit the security flaws in other software programs (GCFGlobal, 2020). One way to help prevent this exploitation is to make sure your operating system, browser, and other programs are updated. These companies often send out "security patches," or updates in order to protect computers from these types of threats. Another way to avoid losing files because of malware, is back up computer files. When a user backs up files, it means she saves her data on an external hard drive that is connected to the computer or uses an online backup service. Then, if files are damaged or stolen, the user has them saved in another place.

Another way of preventing others from stealing or altering data is to create a strong password for files, programs, and applications (GCFGlobal, 2020). Passwords should be long, strong, and difficult for someone else to guess. Below are some tips for creating strong passwords (GCFGlobal, 2020).

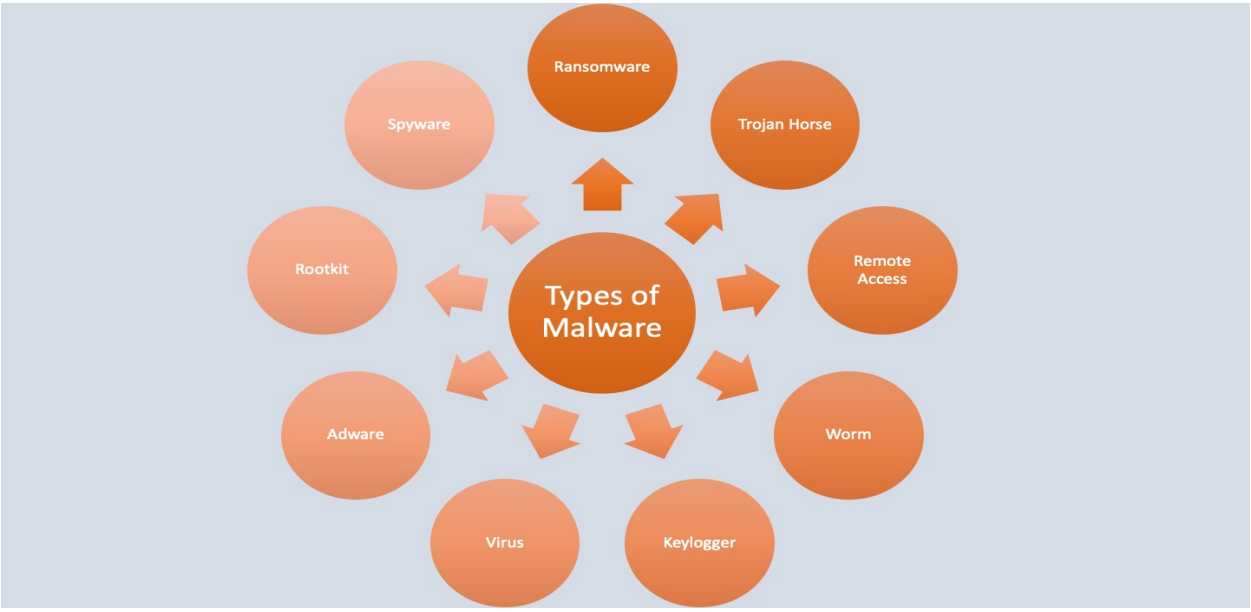
- Do not use personal information, such as your name, birthday, user name, or email address.
- Use a password that is at least six characters long, includes numbers and symbols, and uses both uppercase and lowercase letters.
- Use different passwords for different accounts.

Some common mistakes with passwords are using family names, the same password on multiple accounts, simple patterns, and short passwords.

Malware systems often use deceptive web addresses to trick users into allowing access to their files (GCFGlobal, 2020). Sometimes the web address link will look similar to legitimate web addresses. Double-check the web address (i.e., domain name) for any alterations. A lock symbol in the address bar, usually followed by https://, usually means the website is using a secure connection, which makes it safer to enter information. Not all websites have the symbol. Use caution when a website does not have the lock symbol or the https://.



Avoid suspicious links because often there are malware program hidden in them (GCFGlobal, 2020). Many malware programs require the user to click on a link or download and install a program that appears to be legitimate, but is not. Advertisements on websites that display boxes with "system messages" or "diagnostics" frequently contain malware. Other messages indicating that the user has won a prize or is being investigated often contain malware. Pop-up windows that attempt to lead the user to a different web site can sometimes be malware.



Using Wi-Fi can present a user with security risks. If a home Wi-Fi network is used, the user should make sure it is secure with strong passwords. The user should "disable SSID broadcasting" so that the home network name is not visible to others within the signal range (GCFGlobal, 2020). The user can "enable MAC (Media Access Control) address filtering" to prevent unauthorized wireless users to break into the home network. An SSID broadcast can be disabled by changing the settings on a router or on the web by typing the router's IP address. Directions can be found in the router instruction manual. She can make sure the network uses "WPA (Wi-Fi Protected Access)" or "WPA2." Public Wi-Fi is not as secure as a home network (GCFGlobal, 2020). Sometimes criminals on the Internet, called cybercriminals or hackers, can create seemingly legitimate network names like "Free Wi-Fi," but connect you to a malware network.

Authentication

Authentication is a security process of verifying a person's identity or device (Smith, Zhou, & Watzlaf, 2017). Authentication can occur through a variety of ways, such as:

- requiring a user name and password or PIN (personal identification number).
- signing into a website from a known device.
- using a four- or six-digit passcode to unlock a device.
- using a password to open a laptop or computer.
- using biometrics, such as fingerprints or eye scans, to unlock a device.
- enabling a two-factor authentication with requires two steps: a correct login and another verification check (Smith, Zhou, & Watzlaf, 2017).

Authentication allows a user to verify their digital identity. The American Psychiatric Association (2018) recommends that for teleconferencing, administrative and technical specifications should be followed to authenticate practitioners as well as the identity of patients. For telemental health services, the identities of persons at both sites (i.e., practitioners and clients) should be identified, verified, and documented. This documentation can include a) the name and credentials of the provider and the name of the client, b) the location of the client during the session, c) the immediate contact information for both the provider and the client (phone, text message, and/or email), and contact information for other relevant support people, including professional support and family members, and d) expectations about contact between sessions, including a discussion of emergency management between sessions.

The integration of mobile health applications (mHealth)with treatment has become widespread. Typically, these applications are used with smartphone devices and present unique challenges to security (Smith, Zhou, & Watzlaf, 2017). Small devices, such as smartphones and tablets, can be easily stolen or lost and if used for telemental health services can have sensitive information, such as passwords and usernames stored on them. Authentication capabilities for smartphones is a way to prevent unauthorized access to a device (Smith, Zhou, & Watzlaf, 2017).

Knowledge-based authentication, such as a username, password, or PIN, is an easy and convenient way for authentication. However, users must ensure that their passwords, PINs, and usernames have a high level of security (Smith, Zhou, & Watzlaf, 2017). Strong passwords that incorporate a number of features can help users avoid their information being stolen or hacked. Biometric authentication, such as fingerprints, eye scans, and facial scans, are simple to use and have a higher level of security compared to passwords (Smith, Zhou, & Watzlaf, 2017). The increased security of biometric authentication arises from the unique physiology of users. However, this type of authentication can be slow, socially awkward, and may require additional hardware. Behavioral biometric authentication uses a signature, voice, gait, or touch to secure information (Smith, Zhou, & Watzlaf, 2017). This type of authentication is convenient and utilizes a user's unique traits for secure information. There is a level of increased security because individual behaviors are difficult to replicate. However, some mobile devices have less computational capacity and require increased battery use.

There are currently no HIPAA requirements for specific authentication procedures (Smith, Zhou, & Watzlaf, 2017). A behavioral health provider is responsible for protecting the confidentiality, security, and privacy of client information. Authentication for device access is one way to strengthen protective measures. Single, two- and three-factor authentication measures can be used to increase security for private data.

TELEMENTAL HEALTH TECHNOLOGY BASICS

Telemental health technologies are mechanisms to provide behavioral health services remotely.

Types of Technology

Live videoconferencing

Live videoconferencing is a mechanism for providing synchronous services, meaning live interaction in real time (American Telemedicine Association, 2020). Videoconferencing is a way for a provider and client to see one another, interact, and engage on a live monitor or screen. Providers can use live videoconferencing to conduct screenings and assessments, render diagnoses, and provide treatment sessions.

Store and forward

Store and forward is an asynchronous mechanism that transmits information not in real time. It allows for information, resources, images, or video clips to be saved, forwarded, and used whenever convenient. Examples of store and forward technology are: patient data, video clips, photos, or other types of information that can be sent at a later time through texts or emails. These have benefit in behavioral health, for example clients engaged in cognitive behavioral therapy can use store and forward technology to track targeted behaviors.

Remote patient monitoring

Remote patient monitoring are devices that remotely collect and send data to providers at a remote location (American Telemedicine Association, 2020). Remote patient monitoring systems can help providers assess the health status of a client by collecting information, such as vital signs, weight, and blood pressure. Psychiatrists or prescribers may use remote patient monitoring to check health status before adding or changing medications.

Mobile health (mHealth)

Mobile health applications use the Internet and wireless devices, such as smartphones and tablets, for clients to obtain specialized health information, participate in online discussion groups, collect personal data, or receive peer support (American Telemedicine Association, 2020). There are a number of mHealth apps that can be used for behavioral health services for a range of ages and conditions. An example of an mHealth application is AnxietyCoach that is a self-help app that addresses fears and worries using cognitive-behavioral strategies. The app

instructs clients through a variety of exercises from making a list of feared activities to making a plan and tracking anxiety levels to viewing progress. The app is offered free of charge, but only though the iPhone store (https://apps.apple.com/us/developer/mayo-clinic/id350350016). Another mHealth app is the CPT Coach for individuals suffering from symptoms of PTSD who are in active treatment with a professional. This app is designed to be used by a client while in active treatment. The app provides education about PTSD symptoms and step-by-step approach to assessments that align with face-to-face sessions. The app utilizes a number of approaches, including prompts and reminders for appointments and homework assignments. This app is available from the Apple iPhone store and Google Play (https://www.mobile.va.gov/app/cpt-coach). Often behavioral health providers use a variety of approaches to optimize client engagement and participation in treatment.

In general, telemental health technology services are commonly delivered through HIPAA-compliant, cloud-based telehealth sites. These services can be delivered through a variety of devices, including desktop computers, laptops, tablets, smartphones, and smart watches. Telemental health platforms can allow providers to conduct online assessments, secure document storage, schedule appointments, offer online billing, provide secure messaging sites, and offer pdf forms and the ability to sign the forms electronically (eSign).

Telemental health services can be offered in a variety of settings, including private practice, agencies, and large consumer systems, such as hospitals. The types of technologies that are most effective may vary depending upon setting. Telemental Health Comparisons (2020) is an independent website that provides comparisons for telemental health software (https://telementalhealthcomparisons.com/). This site can be used when a provider registers for a free account.

Practitioners who would like to establish a telemental health practice should keep a few things in mind. One primary issue is being reimbursed for your services. It should be easy to use, HIPPA compliant, and include a variety of useful provider tools, such as e-prescribing, client custom folders, scheduling system, appointment alert, data export options, electronic health record integration, and automated workflows. Providers should understand whether the telemental health system is cloud-based, compatible with provider equipment, such as computers or tablets, and incorporates adequate video resolution, full screen video options, mobile access, and camera abilities, such as tilting, rotating, and zooming. Finally, the technology a provider

chooses should include, even if at an additional cost, technical support. Providers are responsible for maintaining their equipment and assisting clients when problems arise. Technical support is vital and should include a variety of mechanisms, such as phone support, email, chat, live video, and/or website support.

In the initial phases of establishing the plan for the telemental health program for the deaf, I included in the grant a cost for the Polycom system and for IT support at the agency. When the initial grant was funded, a partnering core service agency that oversees behavioral health services in part of the eastern shore offered to provide the money through an RFP (request for proposal) to an agency willing to allow me to use their office space for deaf and hard of hearing clients. Our partner agency, Arundle Lodge, won the grant and set up the Polycom system in their conference room. The plan was I would use their conference room for client sessions one day a week and the rest of the time the agency personnel could use the system for other telehealth functions, like staff meetings for multiple sites, trainings, and consultations.

By the time the first grant ended and I was looking for a second grant for the project, Medicare and Medicaid changed their requirements. In 2017, deaf and hard of hearing clients were no longer required to go to another site to receive telemental health services provided that the clinician had an advanced clinical license in social work or a medical degree. Maryland, though, has specific regulations for Medicaid coverage, which will be covered in the next section. Technology had evolved such that multiple service providers offered HIPAA-compliant, encrypted videoconferencing capabilities. This allowed clients to receive telemental health services, through a secure provider using any device with a camera, such as a tablet, iPad, laptop, or computer. The expensive, bulky Polycom systems were no longer needed to provide services remotely. This opened up an entirely new landscape for telemental health provisions. I had greater access to clients who were unable or unwilling to travel the distance to the local clinic, which was sometimes 50 miles away. Before writing the second grant, I reviewed many different telemental health application providers. We ultimately settled on one which provided encrypted, secured videoconferencing capability, technology support 24/7, and a signed business associate agreement (BAA).

Secured vs. Unsecured Technology

There are many advantages to using telemental health technologies, including ease of delivering services, access to services that many otherwise be inaccessible, ability to receive specialized care, obtain consultations, cost-effectiveness, and increased collaboration among professionals (Zhou, et al., 2019). However, clients and providers may be concerned about privacy and security of personal health information. Health data breaches and cyber-attacks targeting medical information has steadily increased with the more frequent reliance on technology. Breaches to protected health information (PHI) are costly for service providers. When breaches occur, the provider is responsible for conducting investigations, notifying clients, recovering data, subscribing to credit monitoring services for clients, hiring security personnel, and strengthening the security of the telemental health technology (Zhou, et al., 2019). In order to provide education to consumers and engage in practices that protect clients, clinicians should be familiar with the security of the technologies they use.

An unsecured network refers to an Internet connection that does not require a secure authentication process. Unsecured networks are generally public free wireless Wi-Fi connections (WhatIsMyIPAddress.com, 2020). Free Wi-Fi access allows anyone to use a network without a special authentication system. While a public network is easy and convenient to use, it is unsecured, so that someone could breach the connection and obtain personal data without consent of the user. Some public connections, also called hot spots, will have a user acknowledge terms and conditions. However, this does not secure the network site.

Most home wireless networks have built-in security features in their routers. There are typically passwords that allow access. However, in order for a home network to be secure, individuals need to take steps to set this up (WhatIsMyIPAddress, 2020). To secure a home network, the user needs to enable security settings and create a router password. There are different levels of encryption, such as WEP, WPA2, and WPA1. WPA2, but each offers a level of security (WhatIsMyIPAddress, 2020). Update and change passwords regularly.

A secured Wi-Fi network is one that uses passwords and security encryption methods to send wireless data (HealthIT.gov, 2020). WPA2 offers encryption that meets the IEEE 802.11i security standard of the Mobile Device Privacy and Security subsection of HealthIT.gov. Another way of providing a secure network is to use a Virtual Private Network (VPN). A VPN

provides encryption between a device and the servicer, so information that is sent or received is protected.

Platforms

A platform is a group of technologies that are used as a base for other applications, processes, or technologies and are commonly offered by a managed service provider (described earlier, examples are Theranest and Simple Practice) for use in telemental health (Techopedia, 2019). A platform uses the computer (hardware) and operating system (software) on which applications run. The platform has a set of standards and functions that are purchased by the user. There are a number of telemental health platforms from which providers can choose:

Doxy.me: is a cloud-based platform that does not require downloads. It is free to use and its website notes that it is compliant with several national standards. Website: https://doxy.me/

Secure Video: is a telemental health/telehealth platform that offers unlimited technology support, scheduling, branding, virtual waiting room, and a business associate agreement, which verifies that it complies with federal regulatory standards. Website: https://www.securevideo.com/

Thera-link: is a telemental health platform that includes several features, such as scheduling, billing, progress notes, virtual waiting room, multiple device capability, and a business associate agreement verifying that it meets federal regulatory standards. Website: https://www.thera-link.com/

Vidyo: is a video-based telemental health platform that offers low costs, but does not include hardware and maintenance costs. Website: https://www.vidyo.com

VSee: is a platform that includes telemental health, telehealth, and telemedicine kits. Medical device kits can be used with this platform. Website: https://vsee.com/

WeCounsel: is a telemental health platform that offers a variety of features, including scheduling, assessments, billing, eSign capabilities, and video- or text-based counseling. Website: https://www.wecounsel.com/telemental-health-platform/

LEGAL AND REGULATORY CONSIDERATIONS

Telemental health technologies developed initially as a way to provide services to individuals who could not access health care in their areas. The shortage of behavioral health providers further fueled the need to develop alternative ways of providing behavioral health services to

individuals. Telemental health technologies provided a way to provide services to individuals in remote locations and close a broadening gap between health care providers and clients. With the adoption of technologies and greater utilization of telemental health services, legal and regulatory guidelines are needed (Lerman, et al., 2018). Utilization of technologies has surpassed the rate of development for regulatory standards.

In the most recent 2019 update to the Telemental Health Laws survey of the 50 states, regulations about telemental health continue to change (Lerman & Ozinal, 2020). In all 50 states, including the District of Columbia, Medicaid services now provide some level of coverage for live video, synchronous telemental and telehealth services for consumers with Medical Assistance. Massachusetts approved coverage for telehealth services by Medicaid for psychiatrists, psychologists, social workers, behavioral health nurses, nurse practitioners, and professional counselors. Kentucky is one of 14 states that has approved legislation that allows home telehealth visits. Arizona expanded coverage to include substance use treatment through telehealth.

The coronavirus pandemic caused widespread disruption to behavioral health services. The Centers for Medicare and Medicaid Services relaxed the regulations for telemental health provision. Under the public health emergency declaration, providers were able to offer services using telehealth in order to mitigate the risk of spreading the virus (Centers for Medicare and Medicaid Services, 2020). The goals of relaxing the regulations was designed to: 1) expand the healthcare system workforce by removing barriers, 2) allow providers and agencies to have the capacity to handle a surge in patients, 3) increase access to services, 4) expand existing services, and 5) reduce the amount of paperwork, reporting, and auditing requirements. The implementation of some of these goals took the form of eliminating certain credentialing requirements and reimbursement rates matching in-person services.

In Maryland, Medicaid patients have to receive services at an originating site (e.g., another outpatient clinic). The following is a list of eligible sites:

College or university student health or counseling office

Community-based substance use disorder provider

Deaf or hard of hearing participant's home or any other secure location approved by the participant and provider

Elementary, middle, high, or technical school with supported nursing, counseling, or medical office

Local health department

Federally Qualified Hospital Center (FQHC)

Hospital, including emergency department

Nursing facility

Private office

Opioid treatment program

Outpatient Mental Health Center (OMHC)

Renal dialysis center

Residential services site

Effective October 1, 2015, Maryland Medicaid combined the telemedicine and telemental health programs and renamed them as the telehealth program. The telehealth program services Medicaid participants regardless of geographic location within Maryland.

Telehealth providers have to submit an application and enroll in the Maryland Medical Assistance Program and register as an originating or distant site.

In response to the coronavirus pandemic, the Behavioral Health Administration took several steps: 1) attained a blanket exemption to take-home medications, 2) allowed relaxing of Medicaid regulations to include telehealth and telephonic services, and 3) allows extensions of certificates and licenses to address the continuum of care.
Source: https://evisit.com/state-telemedicine-policy/maryland/

All states require health care professionals to hold valid licenses to practice in their fields (Lerman & Ozinal, 2020). A small number of states, including Alabama, Louisiana, Maine, Nevada, New Mexico, Ohio, Oregon, and Texas, require special telemedicine licenses for

qualified physicians who are located outside of the patients' states. All states allow licensed physicians to prescribe non-controlled drugs using telehealth and typically allow this without requiring a face-to-face examination.

Approximately 25 states have data privacy and confidentiality regulations and/or specific guidelines to the provision of telehealth services (Lerman & Ozinal, 2020). These guidelines go beyond the federal requirements. In addition, approximately 29 jurisdictions have informed consent requirements that must be met before offering services through telehealth.

In October 2018, President Trump signed the Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act that expands the geographic locations that will be covered by Medicare for substance use treatment (Lerman & Ozinal, 2020). Several states, including Indiana, Michigan, and Missouri have introduced and/or passed laws that expand remote prescribing of controlled substances for treatment of substance use disorders.

The Mental Health Telemedicine Expansion Act is pending in the current 116th Congress (Lerman & Ozinal, 2020). This bill provides exclusions for certain telemental health services from specified Medicare requirements, including those for originating sites. The Bipartisan Budget Act of 2018 lifted the geographic requirements previously required by Medicare. In addition, the federal government has encouraged states to incorporate telehealth technology through their state Medicaid programs.

In 2013, several states, including New York, expanded telehealth services to include public, private, and charter elementary and secondary schools, state-sanctioned care delivery sites, child care centers, and day care centers (Lerman & Ozinal, 2020). These laws allow children to have remote access to physicians, dentists, and mental health professionals. School-based telehealth care can include primary and acute medical care, behavioral health services, speech therapy, dental screenings, nutritional counseling, prevention, and health education.

Currently Medicare guidelines about the use of telehealth are stricter than Medicaid guidelines (Lerman & Ozinal, 2020). Many state Medicaid programs lifted the restriction of telehealth services only allowed in remote geographic areas. States may have restrictions on the types of providers who are eligible for reimbursement of telehealth services, but many include behavioral health providers in addition to physicians.

Legal and regulatory guidelines for telemental health services continue to vary among states (Lerman & Ozinal, 2020). Across public and private settings, insurance parameters for service delivery and reimbursement for services are significant barriers to the provision of services. In order to keep abreast of the changing environment for telehealth guidelines, clinicians need to continually monitor developments in federal and state laws, regulations, and policies.

In response to the COVID-19 pandemic in March 2020, a national emergency statement was issued that allowed the Secretary of Health and Human Services to exercise authority to temporarily waive or modify certain requirements of the Medicare, Medicaid, State Children's Health Insurance Programs, and HIPAA Privacy Rule throughout the duration of the pandemic (Lerman & Ozinal, 2020). This authority allowed temporary modifications or waivers to the "items and services furnished by a health care provider or classes of health care providers in any emergency area…" In addition, these waivers apply to the government health care programs.

An important part of telemental health care practice is to understanding federal, state, and licensing guidelines for practitioners. General federal laws provide broad guidance about telemental health mandates, such as privacy and security measures, but does not give specifics about how to accomplish them. States sometimes provide additional guidance about requirements, but these guidelines vary from state to state. Finally, licensing regulatory bodies do not allow all professionals to provide telemental health services. Again, the professionals who are authorized to provide those services vary, as does the ability for reimbursement.

In Maryland, certain licensed providers are allowed to provide telemental health services. The Maryland Code Regulations 10.21.30.02 describes them in detail.

Psychiatrists: *The Maryland Board of Physicians is the regulatory board with oversight. There are no specific licensing requirements specific to telemedicine/telehealth, but the physician must be licensed in the state where the psychiatrist practices and in the state where the client is located. Source:* http://onlinecounselling.com/resources/state-regulations/Maryland.pdf

Psychologists: *The Maryland Board of Psychology Examiners oversees practicing psychologists. There is no restriction on the scope of practice for psychologists, but in order to be a Maryland Medical Assistance provider, the psychologist shall:*

Except when the originating site is not a Medicaid payable provider, be enrolled as a Medical Assistance Program provider on the date of the service is rendered;
Except when the originating site is not a Medicaid payable provider, meet the requirements for participation in the Medical Assistance Program as set forth in: COMAR 10.09.36.02 and 10.09.36.03 and the COMAR chapter defining the covered service being rendered;

Register for participation in the program;

Engage in telehealth with a permitted telehealth provider registered with the Department, except when the originating site is not a Medicaid payable provider; and

If a behavioral health service provider, be registered as a provider through the ASO on the date the service is rendered.

An eligible and originating and distant site provider shall register with the Department before providing telehealth services. Source: http://onlinecounselling.com/resources/state-regulations/Maryland.pdf

Social workers: *According to the Maryland Department of Health, a social worker with an advanced clinical license (LCSWC) or an LMSW, under the supervision of an LCSWC, can provide teletherapy. The regulation also includes instructions for:*

Verifying the identification of the client receiving teletherapy services;

Obtaining informed consent specific to teletherapy services using appropriate language understandable to the client;

Preventing access to data by unauthorized persons through encryption or other means;

Notifying clients in the event of a data breach;

Ensuring that the teletherapy practitioners provides a secure and private teletherapy connection and complies with federal and State privacy laws;

Establishing safety protocols to be used in case of an emergency, including contact information for emergency services at the client's location;

Obtaining or confirming an alternative method for contacting the client in case of a technological failure;

Determining whether the client is in Maryland and identify the client's specific location;

For an initial teletherapy interaction only, disclosing the name, location, license number, and contact information of the LCSWC or LMSW;

Identifying all individuals present at each location and confirming they are permitted to hear the client's health information; and

Being held to the same standards of practice and documentation as those applicable for in-person sessions.

Further, an LCSWC or LMSW under the supervision of an LCSWC may not treat a client based solely on an online questionnaire.: https://health.maryland.gov/regs/Pages/10-42-10.aspx

Professional Counselors and Therapists: *According to Maryland regulations, the law applies specifically to: certified associate alcohol and drug counselors (CAC-AD); certified professional counselors (CPC); certified professional counselor – marriage and family therapist (CPC-MFT); certified supervised alcohol and drug counselor (CSC-AD); licensed clinical alcohol and drug counselors (LCADC); licensed clinical marriage and family therapists (LCMFT); licensed clinical professional art therapist (LCPAT); licensed clinical professional counselor (LCPC); licensed graduate alcohol and drug counselor (LGADC); licensed graduate marriage and family therapists (LGMFT); licensed graduate professional art therapist (LGPAT); and licensed graduate professional counselors (LGPC).*

A counselor or therapist licensed or certified in Maryland may provide counseling services using teletherapy if one or both of the following occurs: a) the individual practicing teletherapy is physically located in Maryland; or b) the client is in Maryland.

The criteria for standards of teletherapy practice are the same as those listed for social workers.
Source: https://health.maryland.gov/regs/Pages/10-58-06-01.aspx

Federal Regulations

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

HIPAA is a federal regulation that requires the protection of person health information (PHI) by implementing physical and technical safeguards to protect the information (Zhou, et al., 2019). The set of HIPAA Rules contains a Privacy Rule, Security Rule, Enforcement Rule, Breach Notification Rule, and a final Omnibus Rule (Health and Human Services (HHS), 2020).

HIPAA Privacy Rule

The Privacy Rule set national standards for the protection of individually identifiable health information by three types of covered entities: health insurance plans, health care clearinghouses, and health care providers who transmit health care data electronically. The goal of the Privacy Rule is to assure that individuals' health information is properly protected while allowing the flow of information that promotes quality health care to continue. "Business Associates" are a person or organization that perform certain duties on behalf of, or provides certain services to, a covered entity. Business associates are also required to comply with the Privacy Rule. Business associates can include claims processing, data analysis, utilization reviews, and billing. "Protected Health Information" includes all individually identifiable health information that is held or transmitted by a covered entity or its business associate. A template of a business associate agreement (BAA)that a provider of telemental health would enter into with a managed service provider platform is provided by US Department of Health and Human Services Department (https://www.hhs.gov/hipaa/for-professionals/covered-entities/sample-business-associate-agreement-provisions/index.html). Appendix A shows the BAA used by Arundle Lodge with their managed service provider who provided the telehealth platform and among other services.

HIPAA Security Rule

The HIPAA security rule sets national standards for protecting the confidentiality, integrity, and availability of electronic PHI. The Security Rule operationalizes the protections contained in the Privacy Rule by addressing the technical and non-technical safeguards that organizations must put into place to secure individuals' electronic PHI.

The HIPAA Privacy and Security Rules establishes national standards for security of confidentiality, integrity, and availability of electronic PHI (HealthIT.gov, 2020). Physical security under HIPAA includes protection over workstations, devices, media controls, and

facility access controls (Zhou, et al., 2019). HIPAA technical safeguards include unique user identification numbers, emergency access procedures, automatic provider log-off, encryption, and decryption. Covered entities that are required to follow these guidelines are health care professionals, including doctors, nurses, psychologists, counselors, therapists, and social workers. Individuals who transmit health information in electronic form are required to comply with the HIPAA Rules for privacy and security (HealthIT.gov, 2020).

HIPAA Enforcement Rule

The Enforcement Rule contains provisions the relate to the compliance and investigations of breaches. It also imposes civil money penalties for violations.

HIPAA Breach Notification Rule

The Breach Notification Rule requires HIPAA covered entities and their business associates to provide notification following a breach of unsecured PHI. Breach notifications apply to vendors of personal health records and their third-party service providers. According to HHS (2020), a breach is an impermissible use or disclosure under the Privacy Rule that compromises the security or privacy of an individual's PHI. There must be notifications to the affected individuals, through media outlets, and to the Secretary of HHS by submitting a breach report form. If a breach of PHI occurs by a business associate, the business associate must notify the covered entity when the breach is discovered.

Health Information Technology for Economic and Clinical Health (HITECH) Act: HIPAA Omnibus Rule

This HITECH Act is the final rule to modify the HIPAA Privacy, Security, Enforcement, and Breach Notification Rules in order to strengthen the privacy and security protection for individuals' health information. This Act removes loopholes in HIPAA by clarifying and narrowing its language to ensure that business associates comply with HIPAA Rules. In addition, this Act enacted tougher penalties for HIPAA compliance breaches to act as an incentive for compliance.

HIPAA Privacy Rule for Minors

The HIPAA Privacy Rule generally allows a parent to have access to the medical records about a minor child in accordance with state laws (HHS, 2020). There are three exceptions to this rule:

1. When the minor is the one who consents to the treatment and parental consent is not required under State or other applicable law;

2. When the minor obtains care at the direction of a court or a person appointment by the court; and

3. When, and to the extent that, the parent agrees that a minor and the health care provider may have a confidential relationship.

Even in these exceptional conditions, the parent may still have access to the minor's medical records when State or other applicable laws require or permit parental access (HHS, 2020). If State or other applicable laws do not specific right of access, a licensed health care provider may use professional judgment to the extent allowed by the law to grant or deny parental access to the child's medical information. There are unique considerations in using telemental health with families that will be discussed later in the learning material.

State Regulations

Lerman and Ozinal (2020) provide a comprehensive outline to telemental health laws and an update to the 2016 Epstein Becker Green survey. Their overview provides state-specific content relating to the regulatory requirements for professionals in behavioral health who want to provide telemental health services. Telemedicine is a term that is used widely and often refers to physicians providing telemedicine. However, the terms for other types of professionals who provide telemental health services are broadening.

States vary in their requirements for the provision of telemental health services (Lerman & Ozinal, 2020). The Telehealth Certification Institute (2020) also provides relevant links to States' Rules and Regulations for Telehealth. They have the contact information for the Licensing Board in each state. They provide links to each state's privacy laws, breach notification laws, Tarasoff Laws, and age of consent for treatment.

Many states have their own privacy laws for health care that complement the privacy laws at the federal level. The Health Information and Law Project (2020) provides information about state laws and regulations regarding the collection and disclosure of protected health information. Because state laws vary by state, practitioners should continually monitor state requirements, upcoming and passed legislation, and other regulations for providing telemental health services. Some state regulations may be stricter or have more narrow definitions than

other states about the types of practitioners that can provide telehealth services and how privacy and confidentiality of patient data are to be maintained. In addition, states establish standards for private health insurance companies when conducting health care business within the state.

The federal Medicaid program is a partnership between the federal government and states (Health Information and Law Project, 2020). Because of this collaborative effort, states can also impose their own requirements on participating providers. Medicaid program regulations can vary by state in terms of covered benefits, provider reporting requirements, and eligibility criteria. States may have their own requirements for reporting diseases and conditions to state health departments. They can require specific types of reporting by specific providers and health plans. Another reference to learn more about state telehealth laws and reimbursement policies is the Center for Connected Health Policy.

The Duty to Warn (e.g., Tarasoff Laws) vary by state as well (Telehealth Certification Institute, 2020). The National Conference of State Legislatures website is a good resource to understanding various laws related to health care on a state by state basis. Some states require that providers disclose information about clients who become violent (National Conference of State Legislatures, 2018). Some states have permissive reporting duties for clients who pose a danger to themselves or others while others have mandatory reporting laws. Some states require specific information to be included in the informed consent for telemental health treatment National Association of Social Workers (2020a) for a sample telemental health informed consent. This informed consent includes information specific to telemental health services, such as: the federal privacy and security laws, mandatory reporting laws, duty to warn responsibilities, potential for technical difficulties and the plan for abrupt disconnection, and emergency protocols.

Resources:

- Epstein Becker Green survey - https://www.ebglaw.com/telemental-health-laws-overview/
- The Telehealth Certification Institute - https://telementalhealthtraining.com/states-rules-and-regulations
- The Health Information and Law Project - http://www.healthinfolaw.org/state

- The Center for Connected Health Policy - https://www.cchpca.org
- The National Conference of State Legislatures - https://www.ncsl.org/research/health/mental-health-professionals-duty-to-warn.aspx
- NASW informed consent template - https://www.socialworkers.org/LinkClick.aspx?fileticket=fN67-dWQReM%3D&portalid=0

Licensing Boards and Regulations

State licensing boards determine the jurisdictions where a telemental health professional can practice. State licensing boards determine which practitioners are eligible to provide telemental health services and at what level of licensure. The National Association of Social Workers (2020b) recommends that social workers should check four sources of information before embarking on a telemental health practice. They should check with:

1. State licensing board where the social worker practices;
2. State licensing board where the client lives;
3. Malpractice insurance and professional liability insurances; and
4. Private or public payers.

In general, practitioners must meet the licensure requirements of the jurisdiction where they currently practice **and** the jurisdiction where the client resides. Clinicians should take these four steps to ensure they follow all guidelines before providing telemental health services.

IMPLEMENTATION BASICS

Become Familiar with Federal, State, Local, and Licensing Laws and Regulations

Establishing a telemental health practice requires some planning and preparation up front. Once a practitioner has investigated the federal, state, and local laws and licensing regulations, she can begin to create a telemental health practice.

Choose a Secure Platform

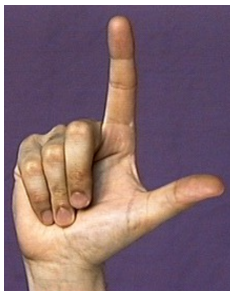
The next step is to choose a secure platform service, one that will provide a business associate agreement (BAA) to ensure that the service complies with HIPAA requirements. The

service you choose may also have a companion electronic health record service, virtual waiting rooms, and other types of options (Goodtherapy, 2020). Providers should ensure they have technology support either through the agency or through the telemental health platform (Crowe, 2017). This support is important, especially in cases when a client is in distress and/or there is an unexpected disruption in video transmission. Equipment, such as surge protectors, may be needed to minimize the chance that an equipment failure may occur. Telemental health platforms require certain amount of connectivity or broadband width in order to operate properly. Practitioners should ensure that both, the practitioner and the client have the capability for adequate connectivity strength.

Decide the Clinical Specialty and Client Population

The next step is to choose a specialty and client population with whom to work (Crowe, 2017; Goodtherapy, 2020). Clinicians, as with all professionals, must practice within the parameters of their competency. Offering a telemental health service does not change this best practice. Though telehealth is a flexible and practical way of delivering services to a larger number of clients, in and of itself it does not mean that telemental health practitioners can provide any service. Providers can offer effective services in the areas in which they are competent. Deciding whether or not to offer telemental health services to a particular client or client population is an important task. Providers should consider the client's safety and the circumstances under which an individual needs telemental health services. Below is a sample flyer advertising telemental health services.

EXAMPLE OF AN OUTREACH FLYER FOR TELEMENTAL HEALTH SERVICES


Arundel Lodge, Inc. offers home-based telemental health therapy and psychiatry to **Deaf and Hard of Hearing individuals** using video software. You can use your phone, laptop, computer, iPad, or tablet. If you have Medicare or Medicaid, your insurance covers this service.

What is home-based telemental health service?

Telemental health services are therapy sessions using video. You will use the software program called ABC Therapist on your smartphone, laptop, or computer to connect with your therapist during your appointment time. Arundel Lodge also has a psychiatrist (with an interpreter) who can meet with you on video. **Website**: **http://www.arundellodge.org/**

For More Information Contact:

Teresa Crowe, PhD, LCSWC (tcrowelcswc@xxxxxxxxxx.org) and (xxx-xxx-xxxx)

Begin Community Outreach and Engagement

Often clinicians must conduct some type of outreach and engagement in order to let individuals and organizations know that these services are available. Clinicians can contact other providers, potential clients, and advertise for services in order to explain the services provided and how telemental health is conducted (Crowe, 2017). With small, tight-knit communities, such as rural communities or the deaf community, practitioners can provide information sessions or meet individually with potential referral sources (e.g., health clinics) or individuals (e.g., contact sheets at a workshop) to describe and explain services. Communities and individuals who are unfamiliar with technology or telemental health services may be reluctant to try it.

When setting up the telemental health services for deaf and hard of hearing individuals on the eastern shore of Maryland, engagement and stakeholder investment was difficult for me. Not having been born on the eastern shore, I was at a distinct disadvantage. No one knew me; no one knew my family name. I was not a farmer and no familial connections to farmers. My original search for an originating site for the telemental health services was directed at the local departments of health. At that time, all of the sites had Polycom telemedicine equipment, and each county had a department of health. I thought this was an easy no-brainer. I was wrong. My requests to use the offices were declined, one after the other. Fortunately, the public mental health system on the shore was in the process of changing medical directors. I asked for a meeting with the incoming directors to discuss a potential collaboration that could benefit the deaf and hard of hearing community on the shore. I reviewed the plan with the directors, explained the inaccessibility of behavioral health services for this population, and outlined my strategy for addressing this need. The two psychiatrists with whom I met were innovators, bringing with them a wealth of knowledge about working with underserved, diverse, and marginalized populations. Though they did not have experience with deaf patients, they were open to expanding the public system to be inclusive and accessible. Their willingness to try something new and collaborate with me on creating a system of care for a specialized population made all of the difference.

Create a Specialized Telemental Health Consent Form That Includes Safety Protocols

Preparation is an important step to setting up a telehealth practice. Preparation for telemental health includes choosing a secure platform, learning how to use it, and also creating the necessary intake and informed consent paperwork. Receiving telemental health services is similar to face-to-face services in that treatment approaches, methods of engagement, setting goals, providing treatment, and monitoring outcomes may be similar. The context and environment in which these services are provided are different. There are aspects of telemental health about which clients should know. For example, there are potentials for different types of privacy breaches when technology is used. There may be unexpected disruptions or equipment failures. A client may decide to suddenly sign off of the technology without the clinician having a chance to discuss something further. Even the physical distance between the provider and client creates a need for planning and preparation in cases of emergency, like psychiatric hospitalization. The most important feature of informed consent for treatment that a client signs is that it includes written protocols and procedures, including emergency situations (Crowe, 2017). Providers should know the contact information for local clinics and hospitals in case the client needs emergency intervention. Clinicians may need to establish collaborative relationships with local agencies so that crises are handled efficiently. All of this information should be included in an informed consent form. Below is an example of a telemental health informed consent form. The National Association of Social Workers (2020b) offers a sample of an informed consent form as a template that is different from the one provided below and there are varied other professional templates available.

EXAMPLE OF A CONSENT FORM FOR TELEMENTAL HEALTH SERVICES THAT IS INCLUDED WITH OTHER INTAKE PAPERWWORK REQUIRED BY THE BEHAVIORAL HEALTH CARE PROVIDER

Client Name:

I, _____, agree to participate in teletherapy with a mental health provider at [Name of Agency].

This means that:

- I authorize information about my medical and mental health care to be transferred electronically through an interactive video connection between [Originating Site Agency Name, if applicable] and [Distant Site Agency or Provider].
- I understand that I will be informed of the identities of all people who are present during the teletherapy session and informed of their purpose for attending the session.
- My therapist/psychiatrist has explained how the teletherapy system works and how it will be used for my treatment.
- My therapist/psychiatrist has explained how this service will differ from face-to-face sessions, including emotional reactions that may arise due to technology use.
- I understand that my therapist will not be physically present during my teletherapy session. Instead, we will see each other electronically.
- I understand that teletherapy is an evolving modality for therapy. As such, there may be potential risks that may not yet be recognized.
- Potential risks include: a) at times the video image may be unclear or inadequate, b) a disruption in the connection may occur, or c) in rare circumstances, the information may be intercepted by unauthorized persons.
- I authorize the release of information pertaining to me determined by my mental health care providers or by my insurance company for the purpose of processing insurance claims.
- I understand that at any time, I may decide to discontinue teletherapy sessions with my provider. My therapist will refer me to a local mental health provider who can provide face-to-face services.

- I understand that, under the law, my mental health provider may be required to report to the authorities any information suggesting that I have engaged in behaviors that are dangerous to myself or others.
- My therapist/psychiatrist have explained the risks and benefits of receiving teletherapy. I understand that I still may need to see a specialist in person.
- I understand that information from my teletherapy sessions will be protected by HIPPA privacy laws. I may request a copy of my electronic record in writing.
- I understand that as part of receiving teletherapy, some information will be used for research purposes. No identifying information will be revealed to anyone other than those involved in my treatment at Arundel Lodge and Community Behavioral Health.

The contact information for my therapist/psychiatrist is:

- Name:
- Email:
- Phone:

These are the names and phone numbers of my local emergency contacts:

- Therapist:
- Psychiatrist:
- Primary care physician:
- Local hospital emergency room:

I voluntarily consent to participate in telemental health services using videoconferencing equipment for the care, treatment, and services deemed necessary and advisable under the terms set forth herein.

_____ _____

Name Date

_____ _____

Witness Date

_____ _____

Parent or Legal Guardian Date

Choose an Appropriate Setting for Services

Similar to face-to-face services when a clinician puts care and consciousness in the choices for office decor, so should a telemental health clinician choose similarly for a professional setting for telemental health services. Clinicians should give attention to details, such as room configuration, lighting, position of the telemental health equipment (e.g., cameras), background colors and items, clothing, and visual distractions (Crowe, 2017). There must be adequate lighting on the faces of both the clinician and client. There should be minimal "visual noise" such as people in the background, loud noises, such as barking animals, and too many visual distractions, such as a messy shelf or cluttered office space.

Offer Orientation to the Technology Before Beginning Treatment

Clinicians should first know how to operate the equipment and use the telemental health platform before beginning work with actual clients. Practitioners should provide an orientation to clients about what telemental health is and how it is to be provided. This orientation can include reviewing intake paperwork, obtaining informed consent, explaining emergency protocols, and teaching clients how to physically use the equipment and/or telemental health software platform (Crowe, 2017). If teleconferencing systems are used (e.g., Polycom), clinicians should know how to operate the equipment and assist clients if they are using a similar system at a remote location. Clinicians can experiment with video displays, video lag, eye contact, picture-in-picture display, and other elements before beginning a session (Crowe, 2017). Orientation to the technology can include walking clients through the use of links or sending screen shots about entering URLs or using links to access the virtual waiting room, enter the virtual session room, explain privacy precautions, emergency protocols, and explain about the importance of lighting, audio, and connectivity. For example, some systems will cut video in order to improve the audio by increasing bandwidth if connectivity is an issue. The platform the clinician or agency chooses to use will likely offer some type of client orientation.

VIDEO CONSIDERATIONS

Video Etiquette

Videoconferencing requires certain knowledge and skills that may be unfamiliar to practitioners who only provide face-to-face treatment. Being on camera may make providers and/or clients feel uncertain and uncomfortable seeing themselves in a picture-in-picture display. A client will rely on the clinician to know how to use the equipment and may need guidance about video etiquette as well. There are several basic rules for videoconferencing (George, 2020; Hart, 2020; Mendoza, 2020):

1. Mute yourself when not speaking. This minimizes background noise and feedback when someone is speaking.
2. Be on time or log-on a few minutes before the session is to begin.
3. Ensure that the technology works correctly. Practice beforehand to make sure you do not have any problems. Make sure the computer camera, speakers, and microphone work.
4. Choose the proper software and hardware for telemental health services. Have a back-up plan for contact if the software and/or hardware fails.
5. Wear work-appropriate professional clothing and expect the client to wear what they would to an office visit.
6. Frame the camera correctly. Ensure that your camera is positioned so that the client has the feel of direct eye contact during the session.
7. Have the right lightening. Make sure that you can see the client and the client can see the clinician clearly.
8. Pay attention during the session. This may seem like a basic idea, but in a telemental health environment there is the potential for a significant number of distractions during a session. For example, if dogs start barking that someone is at the front door, how does the practitioner handle this in the middle of a session? If a child enters the session room and waves on camera to the client, how does the clinician handle this?
9. Take into account there may be lag time in visual and audio transmission. Allow for sufficient time to receive and express information without overlap or interruption.

10. Use a direct, wired connection rather than Wi-Fi if available. This will reduce the risk for transmission disruption by an Internet glitch.
11. Have all the materials needed for the session downloaded prior. Many software platforms have a screen-sharing function that allows a practitioner to show the client what is on the computer screen. This could be a resource website for the client, a chart of progress throughout therapy, or an example of a visual reference. When clinicians use the screen-sharing function, it is important that they know the clients will be able to see everything on the screen, including tabs, website names, and other information that may be personal or otherwise inappropriate to share with clients.
12. Choose an appropriate virtual background. Some platforms allow for the individual users to change the background image for videos. A clinician may want to change the background if video conferencing is in a clutter room or office. Users can choose a blank background or one that has animation or images. Whatever background is chosen, it should not be distracting.

Video etiquette is an important part of conducting an effective session. Clients may not have the skills or experience with telemental health technology. So, it is important for the practitioner to have mastery in order to guide the client toward proper use. In addition to practical matters of communicating, seeing and hearing clearly, appropriate etiquette of video conferencing conveys to the client that this type of contact is professional and structured. Often practitioners need to practice their skills, especially when learning a new platform or platform features. During the session with the client is not the appropriate time to try different functions and features.

Video Space

When clinicians offer telemental health services, they should be cognizant of the nuances of the virtual office, the video space. The video space is the visual area in both the client's and practitioner's screen. Video space that is cluttered or interrupted by passersby can distract from the focus of the session. There are several components about video space about which clinicians should be aware. Preparation and planning are key tools in helping to make sure that video conferencing telehealth is a success.

A clinician should make sure that everyone is clearly seen in the video space (Campos, 2019). In order to do this, the equipment and office surroundings must work together to increase

compatibility and comfort for the client. This can mean choosing a particular space that is free from distractions or that has walls that are coated in soothing colors rather than stark white. A smaller room may help to make the client feel more secure from anyone looking at the camera; it may feel more like an actual therapy room. A clinician can evaluate the field of view, the view that is captured by the camera angle, to make sure that there is a wide enough visual space so that each person, or group of persons, is seen clearly (Campos, 2019). Some cameras have remote automatic focus functions that can track the movements of a person and keep the image clear. Some cameras can be configured to accommodate different amounts of people. If a clinician does a lot of group work, this type of camera could be helpful. This camera feature enables the clinician to easily adjust the angle and lens and with facial recognition features, can create the ideal zoom and focus.

Another aspect of video space is audio. Some microphones are better than others. Inexpensive or out-of-date microphones and speakers may have trouble filtering out ambient noise (Campos, 2019). Microphones and speakers can create an overlap effect when multiple people are talking at the same time. A quality sound system can filter or reduce noise while enhancing voice clarity. Microphone noise range can vary depending upon the product. The direction of the microphone is important as well. If you have clients seated in a group around a table, then a 360-degrees microphone may be more helpful than one that is unidirectional.

The space where the session takes place is an important consideration. Excess sunlight or sunlight facing into the camera can affect picture quality (Barr, 2020; Campos, 2019). A balance of natural lighting with ceiling light can reduce shadows that can create distractions during a session (Barr, 2020). Use curtains or soft lighting to help enhance picture quality. Uncovered or cement floors can create excessive echo and sound distortion (Campos, 2019; Barr, 2020). Softening floors and walls with rugs and wall-hangings can help reduce echo.

Lighting is a crucial element of video conferencing. Barr (2019) offers tips about how to improve lighting to enhance videoconferencing:

1. Avoid illuminating the surrounding walls too much; this makes faces appear darker on camera.
2. Try to keep the contrast less than 1:1.5. In other words, keep the brightness lower on the faces than on the table or surroundings.

3. Reduce sunlight to a comfortable level; excessive sunlight makes faces difficult to see and can be reflective in a camera.
4. Adjust the brightness to a lower intensity on faces; work towards illuminating faces that feel comfortable to the viewer.

The room where the session is held is an important factor, but in practical terms, a room may be used for more than one type of activity. If the clinician is providing services from home, the "therapy room" may also serve as a dining area or living room. If the therapy room is in an agency, it may also be used as a conference room. When a clinician uses a space for telemental health services, prior to beginning a session, she may want to create a therapeutic space. Furniture placement is an important part of video space (Barr, 2020). A comfortable chair or sofa will have a different effect than a metal office or fold-away chair. Comfortable surroundings can provide both the clinician and the client and enhance the therapeutic value of the space. Pay attention to the location of the door and the impact on the display. An opened door that impedes the camera view is less than ideal. Similarly, the camera view should not be angled where people can enter the visual space or see the face of the other person.

The size of the video screen can impact a session. If either the clinician uses a smaller screen, such as a cell phone screen, visual comfort may be difficult. A larger screen may be more comfortable; some video set-ups include multiple screens (Barr, 2020). However, client privacy and comfort are of key importance. Clinicians may want to avoid a larger screen if it is easily seen by people passing by.

Video Presentation Skills

Clinicians may be more comfortable with video conferencing than others. Prior experience with these technologies and an evolved skill set can help individuals feel more confident and competent. However, all individuals must go through the introductory development of skills in order to become comfortable and competent. Video communication skills are important because a clinician's comfort and competence with the technology can put a client at ease. Some clients (and clinicians) may feel uncertain or insecure with their communication skills or appearance on a screen.

Basic therapeutic communication skills transfer from the face-to-face environment to the video conferencing work environment. Active listening involves paying close attention to what

the other person is saying (Doyle, 2019). In face-to-face sessions, a clinician shows active listening by asking clarifying questions, maintaining eye contact, paraphrasing, and reflecting. In video sessions, the subtle movements that are seen in a face-to-face session may not be easily seen by the client. The clinician's eye contact may be focused on the screen, rather than the camera depending upon its location. If the practitioner's sight line is skewed from the camera, the view on the client's screen may convey distraction or disinterest. The camera should be positioned so that the clinician's line of sight appears as much as possible to align with the client's sight line. The clinician can use conscious body movements, such as head nodding, to show attention. She can ask clarifying questions while being careful not to talk over the client and being aware of lag time between video capture and voice.

Nonverbal language that is so essential in traditional services is also important in telemental health. Body language, such as eye contact, hand gestures, tone of voice, may be altered when using video conferencing technology (Doyle, 2019). Eye contact that is off-center with certain cameras can make either or both the clinician's and client's view appear slightly askew. If correcting the camera angle is difficult, other body language can be added, such as leaning forward and using facial expressions, which serves to convey the message that the clinician is listening closely.

Doyle (2019) offers specific suggestions for using body language and body position to enhance therapeutic presence. Clinicians should:

- Avoid slouching in the chair; rather, they can lean forward to encourage engagement
- Use hand animation and facial expressions to project presence and attention.
- Avoid drinking, eating, or looking at the phone during the session.
- Take care to eliminate fidgeting or trembling limbs, such as bobbing legs or repetitive hand movements, in order to create a "quiet" visual presence.
- Observe the client's reactions to your statement to detect understanding or misunderstanding.
- Ask clarifying questions, if needed.
- Encourage the client to ask questions and let the practitioner know when something is not understood.
- Avoid looking at the clock or phone during a session. The clinician can set a timer or glance at the clock on the computer screen.

Practitioners may recognize that video conferencing is not the ideal option for a particular session. If Internet connection is poor on either the clinician's or the client's end, a forced telesession may be frustrating and counterproductive. If a client seems distracted, for example if their children are home from school, it may be better to reschedule the session for a time when there are less distractions. Sometimes a client's body language will display disinterest or distraction, such as yawning, looking at a phone, or broken eye-contact. A practitioner can inquire about these nonverbal cues to see whether another time would be better.

Appearance is an important factor for video presentation. Both practitioners and clients should dress as they would for an in-person meeting, following the workplace's dress code (Chaudhry, 2020). When at home, one may be inclined to dress informally, but care and attention should be given to dress. If a client is dressed inappropriately for a video session, the clinician should address this as they would for an in-person session, perhaps asking the client to change or put on a sweater. Clothing patterns, such as stripes or polka dots, may be distracting in a video session (Chaudhry, 2020). The camera may or may not automatically adjust if the individual wears a bright white or black shirt, causing shadows or lack of lighting on the face. Plain, neutral colors may be a good choice for video.

During a video session, the clinician should be aware of the need to signal when she wants to talk. Typically, in face-to-face situations, there are small and subtle visual cues to let individuals know who wants to speak. These cues may be less obvious on a video call, especially when there is sound delay. A clinician can raise her hand or use a chat function to let an individual know that she has a question (Chaudhry, 2020). The speaker should speak clearly and at a normal volume; there is typically no need to raise the volume because the microphones are usually sensitive. A speaker may want to adjust the pace of speech, opting for a slightly slower rate since the interaction occurs across video and may have lag.

If the clinician wants to share her screen or pull up a document or email for reference, she should explain that to the client beforehand (Chaudhry, 2020). Long stretches of silence may indicate that the Internet connection has been lost. Communicating one's intentions and actions is important. In a video conference, it is difficult to differentiate when someone is looking at the video or looking at another screen on the computer.

CLIENT PREPARATION

A key to client preparation for telemental health sessions is for the practitioner to be prepared as well. There are several things a clinician can do to prepare for a telehealth session (TheraNest, 2020):

1. Test out the telehealth platform before the appointment.
2. Ensure that devices and connections are ready.
3. Inform the client about what to expect during the session.
4. Tell the client prior to the session what platform will be used. Send the link for the session or for download prior to the session. They may want to have a practice session just to make sure connectivity is achieved.
5. Help the client prepare for the session by telling them ahead of time the need for appropriate lighting, clothing, noise, and privacy. Light sources should be in front of clients, not behind them. Keep background and space clutter-free. Explain that background noise should be avoided (e.g., phones silenced). Explain the need for a private, confidential space for the sessions where no one can hear what is being discussed.
6. Avoid conducting sessions in public spaces.
7. Shut down other background applications on the computer, tablet, or phone to ensure the best Internet connection.
8. Use the latest version of Google Chrome, Mozilla Firefox, Safari, or another browser.
9. Provide clients with consent and intake documents prior to the session. Ensure that the practitioner knows where and how to access emergency services near the client in case of emergencies.
10. Ensure that clients are aware of the billing practices and whether telehealth services are covered under the insurance plan.

Clinicians can help their clients adjust to using telemental health services by providing information upfront and practicing before conducting a live session. Even in the best of circumstances, there will be disruptions, interruptions, and problems that need to be solved. Technical failures can occur and require rescheduling, rebooting computers, and problem-

solving. These failures can be frustrating, but it helps clients to know the possibilities in the beginning.

TREATMENT CONSIDERATIONS

There are a number of treatment consideration for telebehavioral health. As in much of behavioral health services, treatment approaches often involve a combination of providers and a collaboration to offer quality care to clients. Telepsychiatry, telepsychology, telehealth for primary care, teletherapy, and telepharmacy are the technology-delivered services that can be offered to clients are often combined in traditional face-to-face treatment.

When a practitioner decides to provide telemental health services, there are implementation considerations. A practitioner conducts a needs assessment of the target community to identify which health care services are not currently available to clients (SAMHSA, 2020). Once the types of services that are not provided locally assessed, telehealth activities that may be beneficial can be identified and prioritized. Knowing which services are available in the community can help the provider know which telehealth capacities need to be developed. Often this step involves developing partnerships, discussing plans, and engaging stakeholders from the local community.

Once a practitioner knows which telemental health services may be needed in a particular area, she or he needs to develop a program model for implementation (SAMHSA, 2020). When community stakeholders are engaged in the process, other collaborative partners can be used to create a continuum of services that address a variety of client needs. Often a beginning telepractice is not an all-at-once approach. Aspects of the practice can be phased in gradually, piloted to identify what works and what does not, or offered as a demonstration project (SAMHSA, 2020).

An important issue in the implementation of telemental health services is to have an understanding of the costs associated with start-up and operating (SAMHSA, 2020). As discussed in a previous section, reimbursement is not guaranteed and can be problematic in sustaining the service. Optimally, a telemental health practice has a mix of payers for services, perhaps seeing some clients face-to-face and others through telehealth for those whose insurances pay for telemental health.

A telebehavioral health practice may include a single practitioner or a team of clinicians. A team may include clinicians, technology support, schedulers, and prescribers. Each team member should have a specific role and responsibility that is outlined in a written handbook (SAMHSA, 2020). Leadership and organization of the team is very important. Policies and procedures specifically for telehealth should be in place. Team members should be trained in telehealth practice. By the time telebehavioral health services are to be offered, the leader will have: a suitable, dedicated space for video conferencing, a plan for scheduling appointments, referral mechanisms and guidelines, HIPAA-compliant hardware and software, service-level and support agreements with other agencies if appropriate, a list of existing organizational resources, and approvals or authorizations (SAMHSA, 2020). Approval and authorization of telemental health clinics, providers, and organizations may require state-level approval. In Maryland, the state's Behavioral Health Administration requires that outpatient mental health clinics (OMHCs) that provide telemental health service apply for telehealth approval and, if approved, are registered with the state.

Once a telemental health practice is implemented, the team leader should have an approach to measure, track, and achieve target goals (SAMHSA, 2020). This can include treatment or symptom progress, client satisfaction, practitioner satisfaction, and community feedback. Having defined project goals, objectives, and outcomes can provide valuable information about how well the practice is meeting the needs of clients. Telemental health practitioners need to not only monitor client progress, but also identify risks and plans for mitigation (SAMHSA, 2020). Especially in the beginning, a telehealth program may need modifications, adaptations, and changes as issues or needs arise.

The telemental heath project for the eastern shore was originally framed as a research project designed to pilot test the program, to see if it would actually work. When we secured funding for this part of the project, we approached the core service agency (CSA) that oversaw all of the public behavioral health services for the eastern shore. It was this initial grant that convinced the CSA to provide additional funding for the program. Below is a list of selected components from the original grant for the research study. Following this, there is an outline of the original scope of work with the CSA.

COMPONENTS OF THE PROPOSAL FOR THE ORIGINAL GRANT TO ESTABLISH THE TELEMENTAL HEALTH PROGRAM FOR DEAF AND

HARD OF HEARING INDIVIDUALS ON THE EASTERN SHORE OF MARYLAND

Purpose of the Project

The purpose of this project is for Arundel Lodge, Inc. to set up a telemental health service for deaf adults with chronic mental illness and test its effectiveness compared to traditional, in-person psychotherapy.

Overview of the Need

This section included a review of the literature to establish the need for the services with deaf and hard of hearing individuals.

Description of the Project

Participants:

Thirty deaf consumers receiving mental health treatment will comprise the sample for this pilot study. Fifteen consumers from Arundel Lodge already receiving traditional, face-to-face psychotherapy will act as the comparison group. Twenty new consumers from the eastern shore of Maryland will act as the experimental group, receiving telemental health services via videoconferencing. All participants will use American Sign Language as their primary mode of communication and have an axis I diagnosis of depression, bipolar disorder, schizophrenia (or schizoaffective disorder), or other major mental health diagnosis.

Intervention:

Telemental health sessions will be scheduled on a regular weekly or biweekly basis depending upon the client's individual treatment plan (ITP). Sessions will be either 30 minutes or 60 minutes as outlined in the ITP. The therapist will be based at Arundel Lodge in a private office with videoconferencing and/or videophone technology. Clients may either go to a "community-based outpatient clinic" (CBOC), use a videophone at a deaf services agency, or use a videophone from their homes for their sessions. After each session, the therapist will complete progress notes, including feedback about how the session progressed, any technological difficulties, or other information.

Procedures:

The design for this project is a pre- post-test, time series, group comparison design.

First, the principal investigators will receive approval from the Institutional Review Board at Gallaudet University, where one P.I. is employed full-time. After IRB approval, the researchers will recruit 20 deaf consumers in need of mental health services from the eastern shore of Maryland, a rural area of the state. This group will serve as the experimental group, receiving telemental health services.

The researchers will collect baseline data on the outcome variables. For consumers already receiving face-to-face psychotherapy from Arundel Lodge, the researchers will review

documents prior to receiving services from the mental health clinic in order to record baseline data. For new consumers, baseline data will be gathered prior to receiving services.
The outcome variables will be measured in a time series fashion at 6 months post-intervention, 1 year, 1 ½ years, and 3 years or when the client terminates therapy.

Outcome measures:
Maryland's Consumer Perception of Care Survey (2010) which includes: a) Demographic variables: Age, gender, race, education, living situation; b) benefits of mental health services received; and c) client satisfaction of services.

Number of psychiatric hospitalizations within the past 6 months, 1 year, 2, years, 3 years.

Treatment goals and progress toward each treatment goal over past 6 months as recorded in the electronic medical record (0 = no progress; 1 = minimal progress; 2 = moderate progress; 3 = significant progress).

Outcomes Measurement System (OMS) - Adult Questionnaire. This questionnaire is used by the Department of Health and Mental Hygiene as part of its state tracking system for individuals who receive mental health services. The questionnaire is a 49-item measure of progress in multiple life domains, including employment, housing, psychiatric symptoms and functioning, substance use, legal system involvement and general health.

Anticipated Results (Outcomes)
1. Telemental health services will be equally as effective as traditional face-to-face psychotherapy with deaf adults who have chronic mental illness.

2. Clients living in remote locations will report an improvement in accessibility to mental health services.

3. Clients who receive telemental health services will report a comparable level of satisfaction of services to those receiving traditional services.

4. The number of psychiatric hospitalizations for telemental health consumers will be similar to those who receive traditional services.

5. Treatment goals and progress toward each treatment goal for telemental health consumers will be similar to those who receive traditional services.

6. The number of deaf clients receiving mental health services, either face-to-face or through teletherapy, at Arundel Lodge will increase.

Anticipated Impacts
1. Increase the number of deaf adults living in rural areas of Maryland who receive psychotherapy services.

2. Medical Assistance of Maryland will allow reimbursement for telemental health services.

This is the scope of work developed with the CSA.

Deaf and Hard of Hearing Telemental Health Project Community Outreach and Service Provision Scope of Work by Arundel Lodge, Inc.

Type of Activity	Description of Tasks	Time/Resources needed
Outreach	Attend/Host at least one Deaf related event to market new service.	~ 190 miles round trip
		20 hours staff time
Outreach	Offer at least two open house telemental health orientation trainings to potential consumers.	~190 miles x 2 = 380 miles round trip
		40 hours staff time
Outreach	Contact Governor's Office for the Deaf and Hard of Hearing, Department of Rehabilitation Services, and other agencies to introduce service for prospective new consumers.	4 hours staff time
Outreach	Meet with eastern shore providers to discuss transition of prospective consumers.	~190 miles round trip
		8 hours staff time
Outreach	Mail marketing 200 postcards to eastern shore agencies.	4 hours staff time
		postage
Equipment Assessment	Assess equipment functionality between originating sites and distant site to ensure adequate accessibility.	~ 300 miles
		20 hours staff time
Training	Provide at least one training to originating sites staff (i.e., psychiatric team) about mental health services for deaf and HOH individuals.	~ 300 miles
		20 hours staff time
Training	Provide at least two trainings to local agency staff members about mental health issues of deaf and HOH individuals.	~ 190 miles x 2 = 380 miles
		40 hours staff time
Service Provision	Create new orientation packets for consumers to include: a. Directions for transferring services b. Letter for their current providers c. Release forms for transferring records	15 hours staff time
Service	Meet with at least 10 new consumers	~ 190 miles x 3 trips =

Provision	and collaborating agency staff, if needed, to provide individual orientation meetings.	570 miles
		30 hours staff time
Service Provision	Conduct intake assessments for mental health services. Make follow-up appointments for direct service delivery.	~ 190 miles x 3 trips = 570 miles
		40 hours staff time

Telepsychiatry

Telepsychiatry is a term that refers to providing psychiatric services using video-based conferencing (Hubley, et al., 2016). This service has been available for a long time and is used by large health care organizations, such as the United States Department of Veterans Affairs. Psychiatrist conduct evaluations, provide treatment, offer consultations, and prescribe medications through telehealth technologies (Yellowlees & Shore, 2018). Clients report high satisfaction with telepsychiatry services, especially among rural populations (Hubley, et al., 2016). Clients report several positive aspects of telepsychiatry: a) ease of use, b) convenience, and c) decreased burden for transportation. There are also some challenges: a) difficulty establishing a patient-doctor relationship, b) technical challenges, and c) discomfort in disclosure through a video.

Provider satisfaction with telepsychiatry services is mixed (Hubley, et al., 2016). Some psychiatrists and allied health providers report favorable experiences with telehealth and recognize the benefits to patients who may otherwise not have access to services. Others report concerns, such as lack of experience with technology and lack of therapeutic alliance with patients, that prohibit integration of telehealth technologies into their practices.

However, assessments made through telepsychiatry are comparable to face-to-face assessments (Hubley, et al., 2016). Overall, behavioral health interventions delivered through telepsychiatry have similar outcomes to face-to-face treatment (Hubley, et al., 2016). Telepsychiatry delivery of pharmacotherapy and psychotherapy are also similar to outcomes of face-to-face treatment.

Telepsychiatry is a cost-effective approach to providing treatment to large numbers of patients (Hubley, et al., 2016; Yellowlees & Shore, 2018). The direct costs associated with provider time, medical supplies, technology, and reimbursement are lower than in-office

services. The upfront costs of establishing a telepsychiatry practice may be higher initially, but over the length of a practice, reduce significantly. As the ease and confidence of providing telepsychiatry consultations improves, the more services are provided, which in turn, reduces costs.

Telepsychiatry has evolved over time, initially providing consultations and assessments to integration of psychotherapy, medication management, team care, and long-term follow-up (Johnston, et al., 2018). Telepsychiatry is offered in a variety of settings, including correctional facilities, emergency rooms, integrated inpatient health care systems, nursing homes, overseas embassies, ships at sea, oil platforms, and in patients' homes.

In addition, telepsychiatry, there are hybrid models of care where face-to-face sessions are combined with video conferencing sessions (Johnston, et al., 2018). Both children and adults can receive psychiatry services through video conferencing in a variety of settings, including in homes, schools, and counselor offices. Telepsychiatry is provided on an international scale to help address mental health problems in the developing world (Johnston, et al., 2018).

Johnston, et al. (2018) offer descriptions of specific models of psychiatric care that can be modified into a telepsychiatry approach:

1. **Direct psychiatric consultation and treatment:** In this model, the psychiatrist is the primary provider of mental health care. The psychiatrist examines the patient, develops the treatment plan, prescribes medications, and may provide psychotherapy.
2. **Consultation-liaison model:** In this model, the psychiatrist performs assessments for another primary care provider or other practitioner. Typically, the consulting psychiatrist will provide recommendations for treatment. In some cases, the telepsychiatrist will meet with the patient directly, conduct the assessment, and send the recommendations to the primary care provider. Sometimes the primary care practitioner who made the referral and the telepsychiatrist will meet with a patient together.
3. **Collaborative or integrated care model:** In this model, the psychiatrist is part of a team working with a population of patients. They may provide direct or indirect consultations. Direct consultations are used to assess or monitor patients periodically, or to assess certain patients for specific conditions or situations, such as a forensic psychiatric evaluation. An indirect consultation is used for case reviews, e-consultations, or in reference to patients with specific disorders.

From 2013 to 2019, Arundel Lodge offered telemental health services with a therapist fluent in American Sign Language. The teletherapist collaborated in regular meetings with local psychiatrists and stand-by therapists at local clinics where the clients resided. In 2019, Arundel Lodge added telepsychiatry to the deaf and hard of hearing telemental health program. The telepsychiatrist met with clients through the videoconferencing platform and had a certified ASL interpreter in the room with him. When the deaf clients signed in the video, the interpreter translated and vice versa.

In the years before Arundel Lodge offered psychiatric services remotely, we developed Memoranda of Understandings (MOUs) with local agencies whose psychiatrists provided services face-to-face with deaf clients. Appendix B is an example of an MOU we used when collaborating with local agencies during the first two years of implementation.

Telepsychotherapy

Telepsychotherapy is the provision of mental health therapy services using high-resolution, live video conferencing. There are other terms for telepsychotherapy, including e-therapy, video therapy, telemental health, and teletherapy (Mead, 2020). Teletherapy can be used by providers to offer one-to-one therapy sessions, group therapy, support groups, and psychoeducation. Teletherapy sessions, as with face-to-face sessions, are scheduled as appointments when both the provider and the client logs onto a secured video conferencing platform. The client and clinician interact in a virtual environment, but the approaches, activities, and techniques are the same as face-to-face therapy.

Telepsychotherapy allows individuals to have better access to therapy (Mead, 2020). For some, the anxiety of leaving one's home may inhibit seeking therapy in the community. For others, long distances and transportation costs are barriers to receiving treatment. Teletherapy is a flexible way to provide services because it can often be adapted to varying schedules that may not typically be available in a clinic office. Often teletherapy can be used to connect to a provider quickly compared to driving to an office. Because clients can participate in treatment from the comfort of their homes, this can help reduce the anxiety of walking into a clinic, signing in, and waiting to see a therapist. Telepsychotherapy for a private practitioner does not carry the overhead costs of maintaining offices and office personnel.

Teletherapy is as effective as face-to-face psychotherapy (Mead, 2020). It is effective with a variety of clinical applications, such as depression and other mood-related disorders (Edwards, 2018; Park, et al., 2016), PTSD and other trauma-related disorders, such as anxiety (Edwards, 2018), eating disorders (Sproch & Anderson, 2019), trichotillomania (Lee, 2018), marriage and

relational counseling (Pickens, et al., 2020; Springer, et al., 2020), chronic pain (Mariano, et al., 2019), and substance use disorders (Katzman et al., 2016). Telebehavioral health can be beneficial to clients, including children and adolescent to elderly individuals, suffering from many types of problems. Teletherapy is effective with many behavioral health conditions and can reduce medical and psychiatric hospitalizations by as much as 30% (Association for Behavioral Health and Wellness, 2020).

Recent legislative efforts focus on eliminating originating site and rural limit restrictions (e.g., mile restrictions for what is deemed "rural") for individuals with Medicare (Association for Behavioral Health and Wellness, 2020). Current issues include questions about state licensure, providing services across state lines, and broadening the scope for permissible groups of behavioral health care providers. Telemental health services are now recognized as a cost-effective, convenient, flexible, and efficient way to deliver mental health services (Ostrowski & Collins, 2016). It addresses challenges like lack of services in areas where there are health care professional shortages. Home-based telemental services address many challenges that often inhibit individuals from seeking behavioral health treatment.

Telepsychotherapy now allows clinicians and clients to connect in new ways that integrate technology into practice (Ostrowski & Collins, 2016). Providers can easily connect with clients without requiring in-office visits. Mental health outcomes for many clinical conditions can be addressed using teletherapy. Though telemental health practitioners may need to obtain competency in using video conferencing technology, once they do, their therapeutic reach grows.

Disaster Relief and Emergency Management

Telehealth services, including physical and mental health, can be advantageous in communities where disaster strikes because it can give patients direct and immediate access to health care providers. Some emergency response teams incorporate a collaborative model of care using local problems with consultations from specialists remotely. Large panels of physicians, psychiatrists, and mental health clinicians can be available worldwide during a disaster to provide assistance to those in need. While video conferencing may not be a front-line first-responder approach, telehealth practitioners can help to support bystander response, such as instructing untrained members of the general public in life-saving actions (Uscher-Pines, et al., 2016). Mobile phones with video can be used to augment dispatch assistance by showing

dispatchers real-time activities at the scene of the disaster. Videoconferencing with a trained responder can also provide the support to help a professional manage a particular situation.

Bystander use of video communication most often is through mobile phones (Uscher-Pines, et al., 2016). Unfortunately, 9-1-1 call centers in the United States cannot incorporate videoconferencing, which makes the use of mobile phones essential at times. Incorporating a video interface with emergency call centers could potentially add another layer of assistance, especially in times of disaster. Telehealth during disasters often involves primary care provided directly to patients with minor illnesses, including those who require medication refills (Uscher-Pines, et al., 2016). These functions can free the limited capacity of emergency room departments and allow them to address the most severe cases. Telehealth during disasters can be especially critical when victims are displaced from their homes or must remain in the disaster area.

Telebehavioral health services can assist local health resources and support an infrastructure that may be weakened by the disaster (Uscher-Pines, et al., 2016). Experiences of disaster often lead to symptoms of post-traumatic stress disorder (PTSD). Telemental health services may be especially suited to intervene directly with consumers immediately as well as long-term following an event. Teleproviders can also support local behavioral health clinicians who may be overwhelmed themselves.

The number of developing nations that provide worldwide mobile disaster relief is increasing (Kim & Zuckerman, 2019). Teleservices range from health call centers to disaster relief and emergency management. One of the reasons for its increased use is because international telecommunications systems globally provide wireless signal to over 90% of the world's population (Kim & Zuckerman, 2019). Telehealth applications improve health care systems as well as create an interconnected global health network that can respond at a moment's notice to humanitarian crises. These technologies are often inexpensive and dependable programs that can perform surveillance and monitoring of medical emergencies. They can generalize data to inform international disaster relief and health programs in real-time.

Digital technology allows providers to store and analyze large amounts of data collected by electronic devices (Mesmar, et al., 2016). The use of digital technology has been on the rise since the response to the earthquake in Haiti in 2010 in which social media, text messages, and satellite imagery provided real-time information. Digital technologies can perform important

functions during disaster relief and emergency management by collecting data, analyzing data, disseminating data, coordinating services, advocating for assistance, and fundraising (Mesmar, et al., 2016).

The complex nature of health and social well-being during times of crises are well known to behavioral health providers who are involved with these situations. Providers use digital technologies to perform various roles, such as preparedness, response to emergencies, recovery from disaster, and support for health assistance (Mesmar, et al., 2016). Digital health technologies in combination with geographical information systems can pinpoint areas of risk and vulnerability in areas of the world. These risks can range from earthquakes and hurricanes to the path of disease spread. Disease surveillance systems assess the risk for certain problems during natural disasters. They can help prepare individuals with specific health needs for incoming danger. Telehealth practitioners can help foster a continuum of care during a time of disaster when many health care systems may be overwhelmed.

Telehealth technology can be used in a variety of ways for disaster relief and emergency management both domestically and internationally. Mobile devices can quickly gather information about displaced individuals through surveys, identify those in need of help, and to capture data about conditions, such as food insecurity, disease, and mortality (Mesmar, et al., 2016). Telehealth assistance can be provided over the Internet and can incorporate technology, such as social media outlets and portable medical devices to facilitate communication and treatment. Cloud-based electronic health records allow for practitioners at multiple sites to record and monitor the health status of individuals affected by disasters over a period of time until regular sources of care are back to full-functioning.

During the COVID-19 pandemic, providers, agencies, and healthcare centers were faced with issues service availability, provision, and accessibility. Telehealth technologies became an integral part of health care worldwide. For those who had previously incorporated telehealth technologies into their practices, switching to a fully-remote service system may have been manageable. For those who had not incorporated technology, there was most likely a steep learning curve. There is no doubt that the pandemic has changed the face of health and behavioral health service provision. Had the pandemic occurred during a time when technology was not as advanced, many patients may have suffered with a disruption in services.

Telehealth technologies facilitate communication, care coordination, and data collection and analysis during times of disaster when timing is critical. These technologies allow practitioners to assess risk, identify the number and location of people with specific health concerns, maintain health records, and enable follow-up care (Mesmar, et al., 2016). They allow providers from different locations to offer consultation and assistance, which can be vitally important in hard to reach geographical locations where travel is hindered.

TELEMENTAL HEALTH BEST PRACTICES AND PROFESSIONAL GUIDELINES

A number of professional organizations have guidelines about best practices for practitioners using telemental health in service provision. These guidelines serve to help providers understand the training, ethics, and practices that underly competent service provision. The reader may want to read the guidelines from professional standards other than their own because each contributes unique knowledge to the overall practice of telemental health.

American Association for Marriage and Family Therapy (Caldwell, et al., 2017)

1. Compliance
    A. Marriage and family therapists (MFTs) engaging in online practice maintain awareness of, and follow, current applicable law and all other relevant standards surrounding online provision of psychotherapy where the client is physically located at the time of service, as well as where the therapist is licensed.
    B. MFTs engaging in online practice clarify with anyone participating in a service what the role and responsibility of that person is. Participants may include clients, family members, advocates, social service workers, probation officers, teachers, consultants, supervisors, and others. Documentation of therapy, including documentation to third-

party payers, accurately reflects the services provided and the roles of each participant.

C. MFTs engaging in online practice provide clients information on the MFT's licensure status, and with means to verify the MFT's licensure status.

2. Infrastructure

A. MFT's engaging in online practice have adequate, secure, and reliable network bandwidth to provide the services being offered. They regularly evaluate the adequacy, security, and reliability of the available bandwidth, and keep bandwidth updated to current standards. Broadband is a minimal standard for video-based services.

B. MFTs engaging in online practice ensure that their local network (such as wireless home or office network) is secure and reliable. Passwords are always required to access a local network. Network passwords are regularly changed.

C. MFTs engaging in online practice only use hardware that is functional and secure, and ensure that the MFT has adequate training and experience with the hardware to operate it comfortably. The therapist has a backup plan in place in the event of a hardware failure. Hardware systems are password-protected.

D. MFTs engaging in online practice regularly evaluate the adequacy, security, and reliability of the software used. They only use software that is functional, secure, and reliable, and for which they have adequate training and experience. Unless required by applicable law or policy, they do not require clients to purchase software to participate in online services.

E. MFTs engaging in online practice use end-to-end encryption when providing services via technology. Such encryption is available for phone-based, text-based, and video-based communication. Clients are specifically made aware of when encryption is not being used (such as for unsecured email communication between sessions). Client data is stored in encrypted formats.

F. MFTs engaging in online practice have current and adequate training and preparation for the provision of online service delivery. They seek regular consultation and retraining to maintain current knowledge and skills.

3. Advertising and Marketing
    A. To the degree to which it can be controlled, MFTs engaging in online practice only advertise their services to consumers the MFT can legally engage in treatment. The MFT's advertising either directly provides, or links to, a clear indication of the geographic locations in which the MFT is legally authorized to provide services.
    B. MFTs engaging in online practice separate their personal social media profiles from professional profiles or pages. When professional social medical profiles and pages are used, personal data is secured such that it is not publicly accessible. MFTs who utilize social media are cautious in their social media communications and inform clients about their policies surrounding social media communication.
    C. MFTs engaging in online practice clearly indicate on their websites and other materials: a) the geographic locations in which they provide online services, b) the specific services that can be accessed online, c) the hardware, software, and related requirements that clients must fulfill in order to be considered for online services, d) alternatives to online treatment, and e) their licensure or registration information in accordance with applicable law.
    D. MFTs engaging in online practice describe their online services and qualifications for providing those services in truthful and non-misleading language.

4. Informed consent
    A. MFTs engaging in online practice inform clients in writing the known risks and benefits of online therapy. Services and modes of service delivery that are experimental or innovative in nature are identified as such.
    B. MFTs engaging in online practice inform clients in writing of the plan for technological failure. This plan is provided in writing to the client as part of the informed consent process. It establishes such guidelines as who should first attempt to re-establish a connection, how long to wait before presuming that a connection cannot be re-established, when to attempt alternative technologies (such as phone), how fees for services are impacted by technological failure, and other elements as deemed appropriate by the therapist.

C. MFTs engaging in online practice must inform clients in writing of alternative treatment options, including in-person options. When in-person services are not accessible to the client, due to geographic, language, or other barriers, MFTs engaging in online practice document these barriers and inform clients of alternate treatment options that may be accessible via technology.

D. MFTs engaging in online practice recognize their responsibility for protecting client confidentiality and the security of data transfer and storage. They inform clients in writing of the steps they take to guard clients' privacy and security. They inform clients of how client information is gathered and retained, how treatment records are stored, procedures for requesting treatment records, and related privacy practices. They inform clients of the use of third-party systems for treatment, record-keeping, billing, or related professional services, and of the limits to the MFT's ability to ensure confidentiality and security.

E. MFTs engaging in online practice inform clients of their availability for additional communication between scheduled sessions, and for crisis intervention. They inform clients of the best means of between-session communications (phone, email, text messaging) and typical response time for such communications. They inform clients of typical office days and hours, and of times when the therapist is not expected to be available. They inform clients of the best way to notify the MFT that the client is in a crisis situation. They further inform clients of the MFT's ability to provide resources local to the client in the event of a crisis. MFTs using email or text messaging obtain specific written consent from clients to do so, and provide information on the risks and benefits of such communication technologies.

5. Initial Assessment

A. Prior to committing to the ongoing provision of online services, MFTs engaging in online practice assess whether online services are appropriate to client needs. This assessment includes consideration of: a) the type and severity of symptoms, b) the nature of the treatment being sought, c) client access to adequate, secure, and confidential means of online communication with the therapist, and d) client ability to effectively use the relevant technology. The MFT documents this assessment process and the criteria used to determine fit for online services.

B. MFTs engaging in online practice take reasonable steps to verify the identity and age of each client. This does not prohibit anonymous service provision when such anonymity is appropriate (for example, services performed for online crisis line). In such instances, MFTs should carefully consider their ability to meet all other legal and ethical requirements, and those best practices appropriate to the provision of anonymous services.

6. Ongoing Services
   A. MFTs engaging in online practice establish and utilize a procedure to reconfirm the identity of the client at each session. This can be done through the use of a password or code word, visual recognition, or other means that would not be obvious to anyone other than the client.
   B. MFTs engaging in online practice confirm and document the physical location of the client at each session.
   C. MFTs engaging in online practice regularly reassess the client to determine the appropriateness for online services. Such reassessment is documented. MFTs understand that clients may initially appear appropriate for online services and then, for a variety of reasons, become inappropriate for online care.
   D. MFTs engaging in online practice regularly evaluate client progress. When the MFT determines that alternative treatments are more likely to be effective than the current treatment, the therapist assists the client in identifying appropriate alternative services, including in-person services.
   E. MFTs engaging in online practice maintain clear professional boundaries when communicating with clients between sessions. They abide by stated policies regarding such communication.
   F. MFTs engaging in online practice have procedures in place to allow clients and others access to records in a manner consistent with applicable law. Third-party requests for records are fulfilled only after the MFT has taken reasonable steps to verify the identity of the party requesting records.

7. Crisis Management

A. MFTs engaging in online practice prepare a crisis management plan with every client as soon as practicable in therapy. This plan includes resources local to the client, such as local crisis lines, hospitals, or other emergency services, as appropriate. Both the MFT and the client retain copies of the plan.
B. MFTs engaging in online practice coordinate care with local crisis resources as appropriate when a client engages those resources. This ensures adequate continuity of care between providers.
C. MFTs engaging in online practice reassess the appropriateness of the client for online services as soon as practicable following a client crisis. This reassessment is appropriately documented.

8. Failures and Breaches
    A. In the event of a significant failure of technology that will impact the MFT's ability provide online services as scheduled. MFTs engaging in online practice contact clients to make alternative arrangements for continued care. Continued care may be in-person, via phone, online through reasonably equivalent alternative technology, or online through alternate providers, as appropriate to the needs of the client.
    B. MFTs engaging in online practice contact affected clients as soon as practicable upon becoming aware of a data loss or breach that could impact client data. They also contact regulatory and governmental bodies in accordance with applicable law to promptly report data breaches impacting client data.
    C. MFTs engaging in online practice are alert to possible breaches of security or confidentiality in their online communications with clients. Upon becoming aware of such a breach, the MFT promptly informs the client of the breach and any necessary steps to ensure improved confidentiality in the future. Depending on the nature of the breach, these steps may be the client's responsibility or the MFT's responsibility.
9. Accountability and Review
    A. MFTs engaging in online practice evaluate, at least once per calendar year, the adequacy and security of their technology infrastructure, updating hardware,

software, and related equipment as appropriate. For password-protected hardware and software, passwords are updated at least once per calendar year.

B. MFTs engaging in online practice regularly review their treatment outcomes. They seek out additional training and experience in the use of technology for online service delivery.

American Counseling Association

The American Counseling Association (2020) defines distance counseling as the use of a digital platform that provides secure, encrypted, audio-video conferencing to communicate with a client in real time. Their guidance for telebehavioral work includes all of the requirements for working with clients according to their professional codes of ethics and guidelines. Their website offers several considerations for telehealth work:

- The use of telebehavioral health services does not eliminate the requirement for licensure.
- Ensure informed consent documents and discussions with clients are updated to reflect how counseling services has changed.
- Contact the health insurance plan of each client to verify coverage and confirm the health insurance plan will reimburse claims (or that the client can be reimbursed).
- Note the physical location of each client, as well as local community resources which may need to be contacted in the event of an emergency or circumstances requiring a mandated report.
- Ensure professional liability insurance covers telehealth services.
- Ensure that the counselor is trained and competent to provide telebehavioral health services. This includes understanding the nuances of providing services in this delivery form, such as informed consent, HIPAA compliance, and ensuring that this service delivery is appropriate for the client.
- Ensure the client is appropriate to engage in counseling via telebehavioral health services, complete informed consent with the client, and ensure that he/she understands how to use the technology.
- If a client declines to use telebehavioral health services, respect client autonomy.

- Check state regulatory boards regarding scope of practice where the counselor is licensed and where professional services are delivered.
- Have a business associate agreement (BAA) to protect both the clinician and the client. A "business associate" is a person or entity that performs certain functions or activities that involve the use or disclosure of PHI on behalf of, or provides services to, a covered entity. Business associate agreements usually provide services provided by third party entities who handle PHI, such as technologies used to provide telebehavioral health.

American Psychiatric Association

The American Psychiatric Association (2018) lists best practice guidelines for those offering telepsychiatry services. Their guidelines in comparison to other professional organizations offers breadth and depth of practical recommendations for telepsychiatry work. Below is an abbreviated version of the guidelines.

1. Program Development

Providers or organizations delivering mental health services should conduct a telehealth needs assessment prior to initiating services. This needs assessment should include, at a minimum, the following components: program overview statement, services to be delivered, proposed patient population, provider resources, technology needs, staffing needs, quality and safety protocols, business and regulatory processes, space requirements, training needs, evaluation plan, and sustainability.

2. Legal and Regulatory Issues

   A. Providers of telemental health services shall comply with state licensure laws, which typically entail holding an active professional license issued by the state in which the patient is physically located during a telemental health session, and shall have appropriate malpractice coverage.

   B. Providers of organizations offering telemental health services shall ensure that the standard of care delivered via telemedicine is equivalent to in-person care. Persons engaged in telemental health services shall be aware of their professional organization's positions on telemental health and incorporate the professional association standards and clinical practice guidelines whenever possible. Providers in

practice and trainees should stay current with evolving technologies, telemental health research findings, and policies.

C. Providers shall be aware of both federal and state guidelines around the prescription of controlled substances, including the Ryan Haight Online Pharmacy Consumer Protection Act of 2008. Providers shall comply with federal and state regulations around the prescription of controlled substances based on the setting, model of care, scope of practice and locations in which they are practicing and where the patient is located at the time of treatment.

D. Local, state, and national laws regarding verbal or written consent shall be followed. If written consent is required, then electronic signatures, assuming these are allowed in the relevant jurisdiction, may be used. The provider shall document the provision of consent in the medical record.

E. The patient shall be made aware of any and all financial charges that may arise from the services to be provided prior to the commencement of initial services. Appropriate documentation and coding should be undertaken specifying when services are rendered via telemental health.

3. Standard Operating Procedures/Protocols

Prior to initiating telemental health services, any organization or provider shall have in place a set of Standard Operating Procedures or Protocols that should include (but are not limited to) the following administrative, clinical, and technical specifications:

A. Roles, responsibilities (i.e., daytime and after-hours coverage), communication, and procedures around emergency issues.

B. Agreements to assure licensing, credentialing, training, and authentication of practitioners as well as identity authentication of patients according to local, state, and national requirements.

C. A systematic quality improvement and performance management process that complies with any organizational, regulatory, or accrediting, requirements for outcome management.

D. All persons at both sites of the videoconference shall be identified to all participants at the beginning of a telemental health session. Permission from the patient should not

be required if safety concerns mandate the presence of another individual or if the patient is being legally detained.

E. At the beginning of a video-based mental health treatment with a patient, the following information shall be verified and documented:
   A. The name and credentials of the provider and the name of the patient
   B. The location(s) of the patient during the session
   C. The immediate contact information for both provider and patient (phone, text message, or email), and contact information for other relevant support people, both professional and family
   D. Expectations about contact between sessions shall be discussed and verified with the patient, including a discussion of emergency management between sessions.

F. Professionals shall maintain both technical and clinical competence in the management of mental health emergencies. Provisions for management of mental health emergencies shall be included in any telemental health procedure or protocol. Clinicians shall be familiar with local civil commitment regulations and should have arrangements to work with local staff to initiate/assist with civil commitments or other emergencies.

G. Clinically supervised settings are patient locations where other medical or support staff are available in real-time to support the telemental health sessions. Emergency protocols shall be created with clear explanation of roles and responsibilities in emergency situations.

H. In instances where the mental health provider is providing services to patients in settings without clinical staff immediately available: Providers should discuss the importance of having consistency where the patient is located for sessions and knowing a patient's location at the time of care, as it impacts emergency management and local available resources; as patients change locations, providers shall be aware of the impact of location on emergency management protocols. These emergency regulations, resources (e.g., police, emergency rooms, crisis teams), and contacts. These should be documented and available to providers. For treatment occurring in a setting where the patient is seen without access to clinical staff, the provider should consider the use of a "patient support person" as clinically indicated. A support

person is a family, friend, or community member selected by the patient who can be called upon for support in the case of an emergency; if a patient and/or a patient support person will not cooperate in his or her own emergency management, providers shall be prepared to work with local emergency personnel in case the patient needs emergency services and/or involuntary hospitalization.

I. With consent from the patient and in accordance with privacy guidelines, telemental health providers should arrange for appropriate and regular communication with other professionals and organizations involved in the care of the patient.

4. Technical Considerations
    A. Providers and organizations should select video conferencing applications that have the appropriate verification, confidentiality, and security parameters necessary to be properly utilized for this purpose. In the event of a technology breakdown, causing a disruption of the session, the professional shall have a backup plan in place (e.g., telephone or email access). Telemental health shall provide services at a bandwidth and with sufficient resolutions to ensure the quality of the image and/or audio received is appropriate to the services being delivered.
    B. Organizations shall ensure the technical readiness of the telehealth equipment and the clinical environment. They shall have policies and procedures in place to ensure the physical security of telehealth equipment and the electronic security of data. Organizations shall ensure compliance with all relevant safety laws, regulations, and codes for technology and technical safety (e.g., Privacy, Security, and HIPAA laws).
    C. During a telemental health session, both locations shall be considered a patient examination room regardless of a room's intended use. Providers shall ensure privacy so clinical discussion cannot be overheard by others outside of the room where the service is provided. To the extent possible, the patient and provider cameras should be placed at the same elevation as the eyes with the face clearly visible to the other person. The features of the physical environment both shall be adjusted so the physical space, to the degree possible, maximizes lighting, comfort, and ambiance.
5. Clinical Considerations
    A. There are no absolute contraindications to patients being assessed or treated using telemental health. The use of telemental health with any individual patient is at the

discretion of the provider. Factors to consider include: a) a patient's cognitive capacity, history of cooperativeness with treatment, current and past difficulties with substance abuse, and history of violence or self-injurious behavior, b)geographic distance to the nearest emergency medical facility, efficacy of patient's support system, and current medical status, c) a discussion of circumstances around session management during the consent process if the patient can no longer be safely treated through distance technology, d) whether there are any medical aspects of care that would require an in-person examination including physical exams.

B. Providers should have clear policies regarding the communication and management of hybrid patient-provider relationships. These policies should describe the boundaries in which patients can manage communication with providers.

6. Ethical Considerations

Telemental health professionals shall be responsible for maintaining the same level of professional and ethical discipline and clinical practice principles and guidelines as in person care in the delivery of care in telemental health, as well as additional telemental health-related concerns, such as consent processes, patient autonomy, and privacy.

7. Cultural Issues

Telemental health providers should be culturally competent to deliver services to the populations they serve. Providers should familiarize themselves with the cultures and environment where they are working and may use site visits and cultural facilitators to enhance their local knowledge when appropriate and practical. Providers should assess a patient's previous exposure, experience, and comfort with technology/videoconferencing. They shall be aware of how this might impact initial telemental health interactions. Providers should conduct ongoing assessment of the patient's level of comfort with technology over the course of treatment.

8. Specific Populations and Settings

The American Psychiatric Association (2018) guidelines offer specific advice for working with the following populations: children and adolescents, forensic and corrections, geriatric, military, veteran, and other federal populations, substance use disorder treatment, inpatient and residential settings, primary care settings, and rural areas.

National Association of Social Workers

The National Association of Social Workers (NASW; 2017) defines telemental health as the practice of delivering clinical health care services via technology-assisted media or other electronic means between a practitioner and a client who are located in two different locations. Treatment is considered to take place where the client is. The NASW (2017) and an article by Felton (2020), NASW's Office of General Counsel, offer guidelines for social workers practicing telemental health services. NASW (2017) outlines 43 standards related to the use of technology in telemental health care:

Provision of Information to the Public

- When communicating to the public using websites, blogs, social media, or other forms of electronic communication, social workers should make every effort to ensure that the information reflects the values, ethnics, and mission of the profession. They shall take reasonable steps to ensure that the information is accurate, respectful, and consistent with the NASW Code of Ethics.
- Social workers should post information from trustworthy sources, having ensured the accuracy and appropriateness of the material. They should advertise only those electronic services they are licensed or certified and trained to provide in their areas of competence. They should review information posted online to ensure that their professional credentials and other information are accurately portrayed.

Designing and Delivering Services

- When using technology to provide services, practitioner competence and the well-being of the client remain primary. Social workers who use technology to provide services should evaluate their ability to: a) assess the relative benefits and risks of providing social work services using technology (e.g., in-person services may be necessary when clients pose a significant risk of self-harm or injurious behavior, are cognitively impaired, require sustained support by a social worker with whom they have an ongoing relationship, or are in crisis), b) reasonably ensure that electronic social work services can be kept confidential (e.g., the information provided by the client should only be accessible by those who require access and that the host of the server used for electronic communication agrees to abide by the privacy policies of the social worker), c) reasonably ensure that they maintain clear professional boundaries, d) confirm the

identity of the client whom services are provided electronically at the onset of each contact with the client (e.g., confirming a client's online consent with a telephone call, providing the client with a password, passcode, or image that is specifically for the client's use when providing consent electronically), and e) assess individuals' familiarity and comfort with technology, access to the Internet, language translation software, and the use of technology to meet the needs of diverse populations, such as people with differing physical abilities.

- Social workers should be aware of all laws, regulations, and other rules that govern their work using technology, particularly licensure laws. Most jurisdictions have adopted the position that electronic social work practice takes place in the both the jurisdiction where the client is receiving the services, irrespective of the location of the practitioner, and in the jurisdiction where the social worker is licensed and located at the time of providing such electronic services, irrespective of the location of the client. If the social worker and client are in different jurisdictions, the social worker should be aware of and comply with the laws in both the jurisdiction where the social worker is located and where the client is located.
- In addition to professional regulation and licensure laws, there are many other jurisdictional laws that social workers need to understand, comply with, and inform clients of. It is the social worker's responsibility to comply with existing laws and keep apprised of new legislation. Specific obligations may include: mandatory reporting of suspected abuse or neglect, a practitioner's verbal or electronic sexual communication with a client, a practitioner's impairment in the ability to practice by reason of illness, use of alcohol or drugs, or as a result of mental or physical conditions, or a practitioner's improper or fraudulent billing practices. Social workers should be familiar with other laws governing social work practice, such as those related to mental health, addictions, duty to protect clients and third-parties, and social worker-client privilege.
- When providing social work services using technologies, social workers shall inform the client of relevant benefits and risks. Potential benefits include: 1) enhancing access to social work services, 2) real-time monitoring of clients' status, 3) being able to respond to clients rapidly, 4) enhancing flexibility to scheduling challenges, 5) providing cost-effective delivery of services, 6) communicating is flexible and easy ways, and 7)

reducing the frequency of client travel to obtain services. Potential risks include: 1) potential for technology failure and interruption of services, 2) potential for confidentiality breaches, 3) prevention of unauthorized use or unethical purposes, and 4) higher cost of technology.

- It is important for social workers to consider clients' relationship and comfort with technology.
- Social workers who provide electronic services should be competent in the use of technology and maintain competency through relevant continuing education, consultation, supervision, and training. Competence depends on the type of technology and how it is used, and can include: 1) communicating effectively while using the technology, 2) handling emergency situations from a remote location, 3) applying the laws of both the social worker's and client's location, 4) being sensitive to the client's culture, including the client's cultural community and linguistic, social, and economic environment, 5) attending to clients' unique needs and challenges, 6) ensuring that technology is in working order to avoid disruption, and 7) keeping abreast of the changing landscape of technology and adapt accordingly.
- Social workers who provide electronic services should develop protocols and policies to protect client confidentiality. They should use encryption software and firewalls and periodically assess confidentiality policies and procedures to ensure compliance with statutes, regulations, and social work standards.
- The processing of electronic claims and payments includes information about the client that should be protected.
- Social workers should take reasonable steps to prevent clients' access to the social worker's personal social networking sites and should not post personal information on professional websites, blogs, or other forms of social media, to avoid boundary confusion and inappropriate dual relationships. Social workers should distinguish between professional and personal communications. They should not post any identifying or confidential information about clients.
- Social workers should develop social media policies and share it with clients to enhance protection of private information and maintain clear boundaries.

- Ideally, an employer or organization should provide the devices and technology for social workers and have clear policies regarding clients' electronic access to the social worker. As a matter of fairness, employers should cover the costs of the devices and technology that are required for social workers to fulfill their work obligations. When social workers use personal mobile phone numbers with clients, it may limit the ability to maintain appropriate boundaries with clients and compromise client confidentiality. In situations where social workers use personal mobile phones or other electronic devices for work purposes, they should take reasonable steps to protect client confidentiality and maintain appropriate boundaries.
- Social workers should develop policies on how to manage technology failures and discuss them with clients at the beginning of their relationships. They should have backup plans to handle technological failures or interruptions in services during emergency or crisis situations.
- Social workers should take reasonable steps to identify the location of the client and emergency services in the jurisdiction. If the social worker believes that a client may be at risk, she should mobilize resources to defuse the risks and restore safety. They should develop policies on emergency situations that include an authorized contact person whom the social worker has permission to contact.
- Social workers should not solicit testimonial endorsements from current or former clients who, because of their particular circumstances, are vulnerable to undue influence.
- When technologies are used to organize communities and advocate, social workers should take reasonable steps to ensure that the information shared using technological tools is honest, accurate, and respectful. For example, social workers may use technology to communicate political messages and mobilize clients, colleagues, and citizens to engage in social action and monitor legislative activities. Use of technology should be done so in a manner that is consistent with professional, legal, and ethical standards.
- When social workers use technology for fundraising, they should take reasonable steps to ensure that information provided to potential donors clearly and accurately identifies the purposes of the fundraising and how the funds will be used.

- Social workers should prioritize the needs of the clients when administering, planning, and developing programs that incorporate technology.
- Social workers who conduct supervision or consultation, or facilitate other confidential meetings through the use of technology, should take appropriate precautions to protect the confidentiality of those communications. Precautions can include: 1) using passwords, firewalls, encryption, and antivirus software, 2) using electronic service providers that rely on standards of security for data that are transmitted and stored, or 3) ensuring a private setting when using electronic devices.
- Social workers who work with communities and organizations should ensure they maintain appropriate boundaries when using technology. Because social workers sometimes assume multiple roles and functions in their organizations and communities, they may not be able to avoid all dual or multiple relationships. Boundary issues may be particularly complicated when social workers participate in online discussions hosted on social networks and other forms of electronic communication that are intended to be available to the public. Social workers should be careful in determining what information or opinions they post, where they post the information or opinions, what language they use, and who might access the information or opinions they post. They should consider how members of their organizations and communities may react to information that is shared. They should apply the principles of honesty, respect, and social justice, whether their electronic communications are for personal or work-related purposes.
- Social workers who are engaged in policy or program development activities should consider how the use of technology may have different impacts on people given their unique biopsychosocial circumstances and should share these concerns with appropriate decision makers. They should ensure that the unique needs of individuals and groups are considered, including factors related to culture, ways of learning, abilities, educational levels, and economic circumstances.
- When appropriate, social workers shall advocate for access to technology and resources for individuals, families, groups, and communities that have difficulty accessing them because they are a member of a vulnerable population, such as people with disabilities, limited proficiency in English, limited financial means, lack of familiarity with technology, and other challenges.

- Social workers should keep apprised of the types of technologies that are available and research best practices, risks, ethical challenges, and ways of managing them. They should know how to use technology in an effective manner so that they perform functions required for work with communities, organizations, and policy practice.
- Social workers who use technology for community organizing and social advocacy should be aware that they may have limited or no control over how their electronic messages may be used, shared, revised, or distorted.
- Social work administrators should ensure that they plan and budget for the use of technology in a manner that promotes the organizations' mission and goals in a cost-effective manner.
- Social workers should evaluate the credibility and limitations of research obtained from online resources. This includes taking reasonable steps to assess authorship and sponsorship, the credentials and competencies of the researchers, the reliability, validity, currency, and limitations of the research, and the accuracy of the findings or results.
- Social work administrators and supervisors should consider developing social medial policies to guide employees and volunteers who work in their organizations.

Gathering, Managing, and Storing Information

- When social workers plan to use technology to gather, manage, and store client information, they should ensure that clients know how the information is being gathered, how it will be used, who will have access to it, how it will be stored, and how it will be retained. They should explain the potential benefits and risks of using a particular electronic method for gathering, managing, and storing data. Potential risks for electronic data include: 1) a hacker who gains access to data, 2) stolen equipment, such as computers, smartphones, flash drives, external hard drives, or other devices, 3) subpoenaed information for legal proceedings, 4) seizure of data by government or law enforcement organizations, and 5) unintentional transmission of electronic information sent to the wrong person.
- Social workers should clearly delineate between professional and personal information when using personal technology. This helps to maintain ethical boundaries, maintain proper client files, and protect the social worker's personal information.

- Social workers should take reasonable steps to ensure the privacy and confidentiality of protected health information according to federal and state statutes and regulations.
- Social workers should protect client confidentiality by developing and implementing policies that restrict access to colleagues who do not have a need for the client information. As part of the informed consent process, social workers should inform clients about which personnel in the workplace may have access to information in their records. Social workers should take special safeguards to ensure that clients' electronic records are stored in an accessible manner. They should update their software and technology, at least for any statutory record retention period.
- Social workers should develop and disclose policies and procedures concerning how they would notify clients of any breach of their confidential records.
- Because social workers may use online forms, websites, or other electronic sources to collect data, they should establish and verify the identity of the client.
- Before sharing information outside the organization, social workers should ensure they have informed consent from the client. They should ensure that they are sending information to the accurate e-mail address, website, or other electronic location. There are several ways that these risks can be minimized, including: 1) double-check that the e-mail address or other location is correct, 2) use secured servers and encrypted information, 3) limit the information that is sent electronically, and 4) ensure that the recipient of the information will maintain confidentiality without consent of the client.
- Social workers shall ensure that client access to electronic records is provided in a manner that takes client confidentiality, privacy, and the client's best interests into account.
- Social workers shall not gather information about clients from online sources, such as social media, without the client's consent unless there are compelling professional reasons, such as emergency situations. If they do so, they should take reasonable steps to verify the accuracy of the found information. This includes gathering online information about professional colleagues as well.
- Social workers should be aware of the digital footprint created by public postings, including the breadth of access and the period of time during which the information may be available. They should be aware of the potential uses and misuses of this material.

- Social workers should develop and follow appropriate policies regarding whether and how they can access electronic client records remotely and understand the risks to client privacy and confidentiality.
- When disposing of obsolete electronic devices, social worker should take the steps to prevent data leaks and unauthorized access to confidential information. Appropriate safeguards may require consultation with information technology experts.

Social Work Education and Supervision

- Social workers who teach students and practitioners about ways to use technology in social work practice should be knowledgeable about effective and ethical use of technology. They should adhere to best practices in social work, including whether and when technology is appropriate, evidence of effectiveness, assessment and outcome measures, and ways to accommodate individual needs and cultural diversity.
- Social work educators should keep current with developments related to the use of technology to teach, supervise, and practice social work.
- Social workers should provide the knowledge to students, trainees, or supervisees about the ethical use of technology, including potential risks and benefits.
- Social work educators and supervisors should keep current with relevant emerging knowledge about technology.
- Social work educators and supervisors should provide social media policies to provide students, trainees, and supervisees with guidance about ethical guidelines in using social media.
- Social work educators and supervisors should provide clear guidance on professional expectations and how online tests, discussions, and other assignments will be evaluated.
- Social work educators and supervisors should provide information about how to manage technological problems that may be caused by loss of power, viruses, hardware failures, lost or stolen devices, or other issues that disrupt the training process.
- When training practitioners, social work educators and supervisors should ensure they have sufficient understanding of the cultural, social, and legal contexts of the other locations where the practitioners or students are located.

- Social work educators and supervisors should ensure that students or trainees have sufficient access to technological support to assist with technological questions or problems that may arise during the training process.
- Social work educators and supervisors should take appropriate measures to promote academic and professional standards related to honesty, integrity, freedom of expression, and respect for the dignity and worth of all people.
- Social work educators and supervisors should take precautions to ensure and maintain appropriate personal and professional boundaries.
- Social work educators who provide field instruction to students should discuss the use of technology in organizational settings.
- Social work supervisors should ensure that they are able to assess students' and supervisees' learning and professional competence using technology.

NASW's Office of the General Counsel provides additional guidelines for telemental health practice that complements the technology standards (Felton, 2020). These guidelines encourage social workers to first: 1) check state licensing board requirements where the social worker is located, 2) check state licensing board requirements where the client is located, 3) ensure that malpractice insurance/professional liability insurance covers telemental health practice, and 4) check coverage by insurance payers, before providing telemental health services. Social workers should use a consent form that incorporates the unique aspects of telemental health. They should obtain business associate agreements with all video conferencing platforms to ensure compliance with regulatory guidelines.

SCREENINGS, INTAKES, AND ASSESSMENTS

Intake and assessment protocols are often a function of the location of the services. Telemental health services, because of their flexibility and remote capabilities, can be offered in various settings. These settings can be clinical, like in therapists' offices, or nonclinical, such as correctional facilities or client homes. Intake and assessment protocols in an emergency department are likely different than those in a nursing home. In some settings, a psychiatric nurse or psychiatrist complete assessments while in other settings, the intake coordinator may be a social worker. In some settings, telemental health care is arranged by a care navigator who is responsible for coordinating supporting specialists (Johnston, et al., 2018). In this capacity, care

navigators provide training, offer implementation assistances, and provide ongoing support for the telemental health technology system. They are typically the primary point of contact for clients and may even conduct initial assessment interviews. Routine assessments and screenings can help identify those who would benefit from telemental health services and connect them with the appropriate clinicians.

The VA offers clinical services in professional offices and directly in clients' homes (Johnston, et al., 2018). Conducting intake assessments and screens within clients' homes can often yield more detailed information about the individual's current circumstances, background, and interests in a way that may be more comfortable and aid in establishing a therapeutic rapport. Initial assessments often include evaluations for suicide risk, triage decisions, and contingency planning (Johnston, et al., 2018). Telemental health triage can conduct pre-screening assessments at a partner site, such as a law enforcement office, and make recommendations for next steps (Allen & Faris, 2017; Johnston, et al., 2018). Routine "teleprescreening" can assist practitioners in settings such as emergency rooms by conducting assessments before patient arrival to help decrease the high volume of evaluations across multiple sites. Contingency pre-screening can be used for after-hour evaluations, late at night, during poor weather conditions, or when evaluation services require lengthy security measures, such as in jails or on military bases, to plan for intervention.

There are several benefits to using telemental health technology for intake assessments and screenings. Telemental health evaluations, especially for emergencies, can decrease travel time to and from facilities, which in turn, decreases response time (Allen & Faris, 2017; Johnston, et al., 2018). They can address client safety concerns when they arise, especially during times after regular business hours or during bad weather. Telemental health screenings and assessments can offer benefits to the clients of fewer points of contact and less time spent in a facility, such as in police custody or hospital emergency room. It offers shorter wait times and frees up other personnel more quickly.

Telemental health services can help provide access to experienced personnel, such as psychiatrists to work with team members when challenging clinical decisions need to be made (Johnston, et al., 2018). In situations where there is chaos, such as natural or man-made disasters, having technologies to allow other professionals to intervene with telemental health services allows those on the ground more flexibility to do other things.

There are challenges to use of telemental health for screenings, intakes, and assessments. Agencies that offer these services must have ongoing IT support and be able to address issues immediately as they arise (Allen & Faris, 2017). They will need to regularly update their software and hardware and address disruptions when they occur. At times there may be clients who do not want to use teleconferencing systems and prefer face-to-face contact. Sometimes there are client conditions, such as acute psychosis, that may be better served with in-person interactions. Sometimes practitioners conducting screenings and intakes need to gather information about a client from multiple sources, such as family members, hospital staff, or law enforcement before recommending a course of action (Allen & Faris, 2017). This can take some time, especially if the client is not with someone who can provide collateral information.

Other challenges include establishing an infrastructure and network connections with partners. The local partner sites may not have the network capacity, equipment, or bandwidth to offer telemental health services (Allen & Faris, 2017). Technology software, such as electronic health record systems, may not be compatible from site to site. Staff, even from multiple sites, need to be trained in the screening, intake, and assessment protocols for telemental health services. This can involve mock interviews, workshops, and online training modules that require coordination among providers. Staff investment and "buy-in" is needed for telemental health systems to work (Allen & Faris, 2017). Providers who are reluctant to use technology for assessments may need training and practice until they feel competent to use the technology. Staff can be introduced to the system gradually and provide a multitude of training opportunities.

Risk Assessment

Risk assessment is a critical element in any behavioral health assessment. The focus of risk assessments generally falls into two types: risk of the person to themselves and risk of the person to other people (Coffey, et al., 2017). Typically, the risk to self occurs more often than the risk to others. However, clinicians assess individuals for both risks, whether the potential of those risks are high or low, whether there is a specific plan in place, and if there is accessibility to the means to enact the plan. Standardized assessment instruments can be used to assess suicide risk, but more reliable are in-person assessment practices with a clinician (Coffey, et al., 2017).

During intake assessments, often clinicians will conduct risk assessments for suicidal ideation. Conducting suicidal risk assessments through telemental health may raise clinical, ethical, and legal concerns for clinicians (Maheu, 2019; Tarlow, et al., 2019). Some types of

important client information, such as body mannerisms and postures, are not as easily assessed as they are in face-to-face encounters. Emergency interventions, such as involuntary hospitalizations, can be difficult if a practitioner is not physically present with a client who is suicidal. Practitioners may be concerned about liability for clients who are at risk if a technological disruption occurs and interferes with assessment and safety planning.

Assessment also includes evaluating a client's mental status, needs for level of care, social functioning, coping strategies, and others (Sheafor & Horejsi, 2015). Client information is typically gathered through direct verbal questioning through face-to-face interviews. Conducting assessments through video conferencing includes the same questions and types of interactions as face-to-face interactions, but practitioners needs to consider how therapeutic presence is established. Incorporating techniques for video etiquette, video space, video presentation skills, and client preparation help the clinician to focus on verbal and non-verbal cues to conduct accurate assessments.

Practitioners who use telehealth technology to conduct assessments need to be fully aware of the limitations of the technological environment (Maheu, 2019). During face-to-face interviews, the clinician is trained to use all senses, vision, sound, gait, olfactory, to evaluate a client's biopsychosocial status. For clients who have severe symptoms, such as psychosis or suicidal impulses, the practitioner may decide to refer the client for a face-to-face assessment at a local clinic. Having either of these symptoms does not automatically rule out candidacy for telemental health services and, in fact, there is some evidence suggesting that telemental health is as effective as in-person services for clients with suicidality or psychotic disorders.

If a clinician decides to use a formal testing instrument, such as the Beck Depression Inventory or more complex neuropsychological tests, there are several things to consider. Maheu (2019) recommends the following:

1. Ensure that the clinician's training and licensure support the legal authority to administer, interpret, and share results of a particular test.
2. Obtain supplemental information about the formal testing instrument prior to its administration. Evaluate whether the instrument is appropriate for telehealth administration.
3. Read individual studies of telemental health instruments and consider instruments that are developed specifically for digital use, validated with

telehealth populations, and meet the legal and ethical guidelines for administration.

Some assessments may be more difficult than others to administer over telehealth technologies. Not all clients' situations are appropriate for telemental health. Clinicians should follow evidence-based screening protocols and assessment processes and instruments in their treatment of clients (Maheu, 2019). Research on some instruments with telehealth may be stronger than others. Clinicians should check for tests and assessment procedures that have been validated with telehealth technologies.

Safety Protocols

As in direct face-to-face practice, telepractitioners needs to have established procedures for safety. When using telebehavioral health technologies, this becomes a critical part of practice because the therapist and the client are not at the same place. Special procedures for remote practice need to be in place and shared with the client during the intake session. These procedures should be written in the consent form and reviewed with the client at intake.

Emergency management procedures may differ depending upon the setting. For example, the procedures for telepractice with someone who is incarcerated may be different than with someone who is at a school. Clinicians should be familiar with agency-based protocols for emergencies. They can have a list of contacts for the practitioner to notify in case of an emergency as well as a list of local resources. Clinicians should be familiar with involuntary commitment regulations and have arrangements with local staff to either initiate or assist with commitments or other emergencies (Shore, et al., 2018).

Telepractitioners can establish specific emergency protocols that delegate particular roles and responsibilities to individuals in emergency situations (Shore, et al., 2018). Specific considerations include: emergency coverage outside of office hours, staff and resources used to assist, and under what conditions particular resources will be used. Clinicians may need to communicate particular issues with clients who have strong affective or behavioral states in order to help local staff address emergencies effectively and efficiently.

Clinicians should be aware of the client's location for each setting and confirm it at the start of each session in case emergency personnel need to be contacted (Shore, et al., 2018). They will need to know what resources, such as crisis teams, hospital emergency rooms, and police, are

local and have the contact information readily available. They can ask clients for the contact information of individuals who are able to provide support in emergency situations. Clinicians may need to work collaboratively with local professionals in order to coordinate the best care for the client in a given situation. Care coordination will need consent from the client and should be obtained during the intake session and as needed throughout the therapeutic process.

Informed Consent

Informed consent is typically obtained before or during the intake session that outlines in writing the client and clinician's plan and guidelines for treatment. Informed adult consent typically include treatment issues, such as: a) privacy and confidentiality (e.g., HIPAA), b) type of services that will be provided, c) client rights and responsibilities, d) clinician rights and responsibilities, e) potential risks and benefits of services, f) guidelines for appointments (e.g., scheduling and canceling), g) billing and fees associated with treatment, h)insurance coverage, i)record keeping, j) cases where disclosure is needed, k) how to contact the clinician, l) and other issues relevant to practice (The Center for Ethical Practice, 2020). Informed consent for telemental health services will contain all of the elements as a typical consent form, but with added information that relates specifically to telehealth technology.

Informed consent for telemental health services includes information that specifically relates to the risks, benefits, responsibilities, and roles of using technology (Person-Centered Tech, 2020). Included in a telemental health consent, clinicians may want to include: a) the name of the software, service, or tool that will be used, b) the benefits (e.g., convenience, flexibility) and risks of using telemental health services (e.g., potential for faulty Internet connections or disruptions), c) conditions under which telemental health may be inappropriate, d) rights of the client to decide not to use telemental health technology, e) telemental health setting and environment (e.g., etiquette, space, video skills), f) back-up communication plan, g) information about scheduling and canceling appointments (e.g., reminders of the time zones for the client and practitioner, especially if each is located in a different time zone), h) safety and emergency plan, i) security and privacy concerns, j) whether or not video or audio recordings are allowed, and k) any other telemental health-related issues specific to a given circumstance.

Telemental health consent adds a layer of considerations that is different than face-to-face sessions. Clinicians may need to practice first with a client before beginning regular therapy

sessions. Both the clinician and client may need time to become familiar with the nuances of a specific software or application. They will likely need to discuss potential problems and solutions in order to reduce reluctance or anxiety about using technology. Some telemental health technology providers offer electronic consent forms built-in to their platforms. Clinicians should review their consent forms and other documentation forms in order to ensure that they cover the scope of practice for telemental health.

TREATMENT INTERVENTIONS

Telemental health interventions are as effective as face-to-face treatment for many conditions. It is effective among different age groups, settings, and treatment modalities. The following section will address the treatment literature of different types of interventions and group populations with telemental health services. These sections are not designed to be exhaustive; rather, they highlight significant advances in teletreatment models.

Child- and Family-Based Treatment

Telemental health treatment of children and families is as effective as face-to-face treatment (Comer, et al., 2016; Rockhill, et al., 2016; Sibley, et al., 2017; Stephan, et al., 2016). Telemental health treatment offers flexibility in settings, convenience for families, and the ability to offer services in contexts that are directly relevant, such as homes and schools. They are effective in treating a variety of child mental health conditions and family issues. They improve appointment compliance, treatment coordination, and interdisciplinary communication. Telemental health eliminates barriers, such as the cost of transportation, removing a child from school, or driving long distances for services resulting in a loss of work for parents (Stephan, et al., 2016). It is important to note that there is no available research on the use of play therapy and telemental health, and statements about its efficacy cannot be made.

Research findings of telemental health interventions with children diagnosed with ADHD show that they are an effective strategy in treatment (Comer, et al., 2015; Crum & Comer, 2016; McCarty, et al., 2015; Rockhill, et al., 2016; Sibley, et al., 2017). In a study by McCarty, et al. (2015), a clinical treatment team of telepsychiatrists evaluated the effectiveness of a combined brief telemental health treatment protocol (six sessions) involving medication management, psychoeducation, and caregiver behavioral training. In this study, families reported high satisfaction and engagement with treatment.

In a study by Sibley et al. (2017), adolescents between the ages of 11 and 16 with ADHD located at 16 different schools participated in a telemental health treatment program. Adolescents and their families participated in the program using a range of devices in their homes, including tablets, laptops, desktops, and combinations of devices. Results of this study indicated that both families and adolescents reported a strong therapeutic alliance with their clinicians that continued to develop over time. The adolescents demonstrated high levels of readiness to achieve their therapy goals. ADHD symptomology decreased compared to baseline measures. Finally, both parents and adolescents reported high satisfaction with treatment.

In a study of internet-based delivery of Parent-Child Interaction Therapy (PCIT) in family homes, therapists provided real-time coaching to parents remotely (Crum & Comer, 2016; Crum, et al., 2015). The family treatment model worked particularly well in a videoconferencing environment and offered comparable quality to face-to-face sessions. The components of the treatment were identical to office-based treatment, but instead of using a one-way mirror, families used a webcam with therapists providing feedback through a Bluetooth ear-piece (Crum & Comer, 2016).

An Internet-based treatment of early-onset pediatric obsessive-compulsive disorder using exposure and response prevention showed similarly effective results (Crum & Comer, 2016). In this treatment approach, children and parents both interacted in real-time with a remote therapist. Family-based CBT telemental health approaches offered comparable quality and quantity of therapy to face-to-face visits. The ability to provide treatment in the family's natural environment can be particularly useful because therapists can give direct feedback to real-time observations.

Telemental health can be used with children and families in collaboration with primary care providers (Myers & Comer, 2016). Primary care providers are often involved with mental health treatment and can work with mental health clinicians to address the family's and child's needs. These types of services can be delivered to youth in a variety of settings, from remote rural areas to urban communities. Working with youth in their natural environments of home and schools, providers can work with their young clients directly in their own contexts. Naturalistic settings offer the opportunity for more relevant and deeper work that has a potential for direct application in the current environment (Myers & Comer, 2016).

School-based telemental health can offer children, adolescents, and their families treatment in greater efficiency while maintaining efficacy (Stephan, et al., 2016). Telemental health services in school also offers greater opportunities for a collaborative, multi-disciplinary team approach that includes various professionals, such as teachers, psychiatrists, nurses, and therapists. Parents may be more familiar with the school environment with teachers and staff, thereby promoting the therapeutic alliance. They do not have to worry about negotiating a child's schedule for appointments and may be able to participate more often with less stress and discomfort than if they needed to transport their child to a provider's office. School-based telemental health services can include feedback from multiple professionals simultaneously about the child's daily behavior, peer interactions, learning issues, and other concerns.

In a study by Wade, et al. (2019), researchers investigated the outcomes of teletherapy with pediatric rehabilitation populations, those with pediatric traumatic brain injury. Clinicians using telehealth technologies reported outcomes comparable to face-to-face treatment. They reported that therapeutic alliance, weekly progress, child and family engagement, and rapport were comparable. They reported greater ease of scheduling, increased understanding of the family and home environments, and less caregiver stigma for receiving behavioral health services. Clinicians reported that there was sometimes difficulty with reading nonverbal cues, technical issues, and disruptions during sessions.

Overall, telemental health with children and adolescents is effective and efficacious for treatment with a variety of psychological and psychiatric disorders (Nelson, et al., 2017). Both assessments and treatment of youth have been successful in using videoconferencing for telepharmacology and teletherapy. Telemental health technologies can be used to provide CBT, communication training, self-regulation and anger management, and problem-solving skills to children and adolescents and their families (Wade, et al., 2019). Telehealth technologies can be used to provide parent skill training in a convenient, feasible, and efficacious way. Parent and youth satisfaction and engagement of the technology are high among those who received telemental health treatment. These technologies have been used successfully with youth across different diagnoses, states of development, socioeconomic statuses, geographical location, and diverse cultures (Wade, et al., 2019). The setting of telemental health with children needs to be considered in particular as it relates to the child's privacy and safety from maltreatment within

the originating site (i.e., if the child is receiving services in their home compared to a school or other presumably private and safe setting).

Clinical Adult Treatment

There are a multitude of effective treatment approaches for anxiety, mood, and trauma disorders that are delivered via telemental health (Edwards, 2018; Parisi, 2020: Waltman, et al., 2019). Treatment models an include self-guided, clinician-guided, module-based, psychoeducational, and live therapist modules. Online psychoeducational models can provide information directly to clients to help educate them about symptomology and management. These online lessons can help clients learn about their symptoms (e.g., psychoeducation), develop coping skills, obtain support (e.g., chatrooms), and meet with clinicians. Telemental health online services can be educational (e.g., coping skills training), interactive (e.g., regularly scheduled homework assignments), and communicative (e.g., clinician feedback).

Telemental health approaches promote increased accessibility for effective behavioral health treatments. In particular, individuals from low socioeconomic statuses, remote geographic locations, and underserved populations can have better access to treatment, which has the potential to reduce mental health disparities (Parisi, 2020). Telemental health can be used to treat a range of disorders, including anxiety and mood, PTSD, schizophrenia, and substance abuse (Parisi, 2020; Waltman, et al., 2019). It is used to provide specific therapies, such as exposure and response prevention and cognitive behavioral therapy. CBT-approaches delivered via telemental health are effective with depression, panic disorders, obsessive-compulsive disorder, eating disorders, and trauma (Parisi, 2020).

Specialized clinical services can be delivered via telemental health technologies. Clients often have co-morbid mental health and physical health disorders, which can be addressed by use of telehealth (Saeed, et al., 207). Inpatient and outpatient services can utilize the specialized clinical skills of multiple clinicians, such as those who are skilled in working with individuals who have developmental disabilities, substance use disorders, psychiatric disorders, and medical problems. Telemental health services allow access to a broad spectrum of specialists without having to travel to multiple sites at different times.

Cognitive-processing therapy, prolonged exposure, and behavioral activation and therapeutic exposure for PTSD delivered telemental health have similar outcomes to those receiving face-to-face treatment (Waltman, et al., 2019). These treatments have been used effectively in treating

military personnel, especially those who have PTSD-related symptoms. The VA uses a manualized cognitive-behavioral treatment manual for PTSD that can be delivered using telemental health technologies. The manual is available electronically and allows veterans to access worksheets and handouts that are digitally shared with them during the session by the clinician. The therapist can use screen-sharing technology to share hard copies of handouts and worksheets or they can be sent directly to the client through encrypted e-mail. In addition, the VA offers an application called PTSD Coach which is used to provide veterans with psychoeducational materials (Waltman, et al., 2019). This smartphone application can be used as a supplement to telemental health sessions with a clinician providing CPT.

A clinician can also evaluate suicide risk using standardized instruments during the telesession. In one example, the VA used the Patient Health Questionnaire and the Columbia-Suicide Severity Rating Scale to evaluate the veteran for major depressive disorder and suicidal ideation (Waltman, et al., 2019). The Collaborative Assessment and Management of Suicidality (CAMS), an evidence-based clinical approach to assessing, treatment, and tracking suicidal risk, was used with veterans on an ongoing basis. The assessment tool, Suicide Status Form, is an instrument used to assess psychological pain, stress, agitation, hopelessness, self-hate, and overall suicide risk. This tool is traditionally used in face-to-face sessions, but has been used with veterans remotely.

Cognitive processing therapy (CPT) is a trauma-focused, evidenced-based cognitive behavioral therapy approach that is effective with trauma-related symptoms (Moring, et al., 2020). Studies using this approach via telehealth show that that outcomes are similar to face-to-face treatment (Moring, et al., 2020; Waltman, et al., 2020). In one study by Maieritsch (2015), results of a randomized clinical trial showed that CPT provided through office-based telehealth and face-to-face treatment to veterans serving in Iraq and Afghanistan had similar outcomes. The study showed a reduction in trauma symptoms and lower patient drop-out of treatment compared to in-person treatment. Similarly, Moring, et al. (2020) found similar results comparing veteran and civilian women exposed to various types of trauma. Their findings show that CPT can be delivered effectively through office- or home-based telemental health.

In a systematic literature review of studies of telemental health, the researchers found strong evidence of its effectiveness (Varker, et al., 2019). They found comparable outcomes for telemental health outcomes related to: anxiety disorders, depressive disorders, CBT group

interventions, web-based chat interventions, trauma-focused CBT, and PTSD interventions. Their review found significant reductions in symptomology in those with panic disorders, obsessive-compulsive disorder, social phobias, and mixed anxiety/depressive states. In their review, treatment satisfaction with telemental health interventions was high, rated an average of 95.3 points out of 100.

Telepsychiatry has been used effectively with forensic populations. In a literature review by Sales, et al. (2018), researchers found that forensic interviews through telemental health technologies provided the same information as face-to-face interviews. In cases of using telepsychiatry for competency to stand trial assessments, results were effective and reliable as compared to face-to-face assessments. In one case where videoconferencing was used for conducting a mental health competency, an individual appealed the use of telepsychiatry. However, the court ruled that videoconferencing did not violate due process and there was no legal basis for an appeal of the interview modality. In addition, telemental health users with this population report high satisfaction with its use.

Batastini et al. (2016) found similar results with telemental health services working with clients with substance use disorders in the criminal justice system. In their review of the literature, they reported that in juvenile detentions, youths attained goals in the areas of family, health, and social skills while receiving telemental health services. Among incarcerated adult populations, they reported overall symptom reduction and lower illness severity for those receiving telebehavioral health. Telemental health outcomes, specifically symptoms, therapeutic process, program performance, engagement, and service satisfaction, were similar to face-to-face treatment.

In summary, telemental health services are an efficient and efficacious way to provide behavioral health treatment to a variety of populations for certain diagnoses in a range of diverse settings. Research points to its effectiveness as comparable to face-to-face services. Telepractitioners may need to overcome the challenges of implementation and familiarization for themselves and their clients toward the use of technology for services. However, once implemented, treatments can be accessible, convenient, and flexible. The practice literature indicates that research studies of evolving technology are ongoing. Individual and group teletherapy processes and techniques can be similar to those practiced in sessions. Combined

approaches, using teletherapy, mental health applications, and online psychoeducational tools offer the benefit of multiple modalities with the ease and convenience of online access.

ETHICAL CONSIDERATIONS

When a practitioner decides to begin a telemental health practice, it is important to understand professional ethics codes (Barnett & Kolmes, 2016). Any code of ethics generally applies to practice regardless of type of service, such as assessment, treatment, consultation, supervisor or teaching. It also applies across a variety of settings and contexts, such as face-to-face, email, Internet, telephone, and other types of transmissions. Some professions offer specific guidelines for use of technology when providing services, such as NASW, American Psychological Association, and the American Psychiatric Association.

Competent practice refers to having the knowledge, values, and skills required to deliver service. For telemental health services, competency also includes having the technical knowledge and skills for telepractice (Barnett & Kolmes, 2016). The Telebehavioral Health Institute (2020) offers several documents for their telebehavioral health standards, guidelines, best practices and other statements. Telepractitioners should review relevant publications about best practices and guidelines from the Telebehavioral Health Institute (2020) along with guidelines from their own professional organizations.

In a telemental health practice framework, technological competence is an added component of clinical and ethical practice. Technological competence means that a clinician has the adequate knowledge of and familiarity with the various technologies being used in telemental health practice (Barnett & Kolmes, 2016). This can include knowledge about various components of telepractice, including hardware, software, type of Internet connection, privacy safeguards, and security precautions. Clinicians should be familiar with their systems and be able to make adjustments in the settings to provide optimal audio and visual quality. They should prepare themselves and their clients in the event of loss of sound or video or Internet connection during the sessions. They should be able to troubleshoot difficulties and have IT support at the ready.

Ethical telepractice includes familiarity with the strengths and weaknesses of the various software programs and applications that are commercially available (Barnett & Kolmes, 2016). Technological competence means being aware of the limitations of various hardware and

software components before offering telemental health services to clients. An example identified earlier in this learning material is that of Skype - a widely used video service for the general public, that is not compliant with HIPAA regulations (Barnett & Kolmes, 2016). Practitioners should only use products that comply with HIPAA standards.

Ethical telepractice includes notifying clients of the potential risks to using technologies, including disruptions, emergency protocols, and equipment failures (Barnett & Kolmes, 2016). These potential problems need to be in writing for the client so that consent can be given with full information. A client does not have to use telebehavioral health technology. Rather, the clinician should be able to provide alternate resources for face-to-face services.

Practitioners need to consider the appropriateness for particular technologies that meet unique client needs (Barnett & Kolmes, 2016). There are benefits and challenges with each type of technology (e.g., e-mail, online psychoeducation, mobile applications). These issues should be discussed with clients and appropriate resources chosen to fit needs.

Telepractitioners should check the literature to see whether there are validated protocols for particular types of treatment delivered with videoconferencing. The research literature is expanding rapidly; clinicians should make sure they keep abreast of new developments.

Clinicians who are not competent to provide particular assessments or treatments in-person should not provide them using telehealth either (Barnett & Kolmes, 2016). For example, if your profession does not allow a clinician to diagnose, treat, or advise on problems outside the scope of practice, the same applies with telemental health services. It is only in very rare and extreme circumstances that ethical practice guidelines would not apply to telepractice as well.

Informed consent is a particularly important component of ethical practice. In addition to the typical components of informed consent (e.g., services, fees, appointments), there are elements that are specific to telemental health practice (Barnett & Kolmes, 2016). Those specific elements were addressed in a previous section. The point of mentioning informed consent in this section is to highlight the importance of obtaining consent that is fully informed, especially with regard to the telepractice components. Clients need to fully understand what telepractice means in a practical sense before they can give consent for treatment. Telepractitioners can openly discuss the options and alternatives for treatment with their clients. They can discuss the strengths and weaknesses of specific approaches so both clinicians and clients can agree to a particular

modality for treatment. Telepractice can be combined with face-to-face sessions in order to create a hybrid version that meets client needs while maintaining flexibility and convenience.

Part of ethical practice includes adhering to the laws and regulations for licensing and practicing in particular jurisdictions (Barnett & Kolmes, 2016). Practicing outside of the scope of licensing and regulatory jurisdictions is not only an ethical concern, but also a legal liability. Professionals need to be aware of the scope of practice allowed by their licenses, including whether they can legally practice across state lines.

Another important ethical consideration is knowing the duty to report laws in each state where a clinician practices and where the client resides. Clinicians need to investigate a particular state's laws for mandatory reporting, especially in regard to the jurisdiction where the clinician is licensed and the jurisdiction where the client is located. When a clinician makes a report across state lines, the clinician may lose immunity unless an interstate licensure agreement is made (Barnett & Kolmes, 2016). Differences in reporting laws include the threshold for abuse and neglect, the age of majority in a particular state, and where and how a report should be filed. Practitioners should be knowledgeable about these laws in order to adhere to ethical practice guidelines.

Duty to warn laws may also differ from state to state (Barnett & Kolmes, 2016). Some jurisdictions outline different procedures and protocols for taking action if an imminent threat to do harm is disclosed. Some jurisdictions have duty to protect laws; some have duty to warn laws; some have neither. Telepractitioners providing services across state lines need to be aware of the differences in laws and regulations for practice as well. Issues regarding voluntary and involuntary hospitalization across state lines can be complex.

Barnett and Kolmes (2016) offer specific guidelines for ethical telemental health practice:

1. "Follow all requirements for ethical conduct from your profession's code of ethics regardless of the telemental health medium used.
2. Become familiar with and be guided by relevant telemental health practice guidelines.
3. Learn and follow the relevant telemental health laws in all jurisdictions in which you will be providing clinical services.
4. Assess each potential client's treatment needs to ensure the appropriateness of participating in telemental health, and that the most appropriate medium is

used. Make referrals to other competent professionals when in the client's best interest.

5. Use a comprehensive informed consent process that addresses all issues relevant to the practice of telemental health.
6. Take all reasonable actions and use all readily available technology to protect each client's confidentiality, such as the encryption of e-mail communications.
7. Only use HIPAA-compliant software programs to provide videoconferencing with clients.
8. Only provide clinical services that you are competent to provide based on your education, training, and relevant clinical experience.
9. Before providing telemental health services, develop competence regarding all hardware and software you will be utilizing to communicate with clients.
10. Ensure multicultural competence and attend to linguistic and other diversity issues in your online interactions with clients.
11. Learn about and follow all duty to warn and mandatory reporting requirements in the jurisdictions where you are providing telemental health services to clients.
12. Before providing telemental health services, learn about resources in each client's local area and make arrangements there for emergency and crisis situations.
13. Document all telemental health services provided just as you would document in-person mental health services, ensuring that all records are stored securely so that each client's confidentiality is preserved.
14. When unsure if a client should be treated via telemental health, utilize an ethical-decision making model and consult with experienced colleagues.
15. Maintain appropriate liability insurance coverage and confirm that your malpractice insurance policy covers the provision of telemental health services" (p. 64-65).

MULTICULTURAL CONSIDERATIONS

Cultural considerations are those practices that encompass beliefs, values, rituals, customs, and language from differing world views (Johnston et al., 2018). Culture is embedded in personal identity and defines group membership and behaviors. Many individuals have intersectional identities that are part of macro- and micro-cultures. These cultures include gender, sexuality, ethnicity, race, religion, and socioeconomic status. Practitioners become culturally competent through training and education about other cultures. They learn to interact with and provide care for clients who are part of different cultures.

Cultural humility is a term that addresses the challenges of becoming fully competent in a culture of which one is not a member (Johnston, et al., 2018). Because an individual who is not part of a particular culture cannot fully understand what it is like to be a member of a particular culture, she must assume a stance of openness and an acknowledgment of inherent personal biases. Cultural humility is process-oriented that contrasts with cultural competence that is destination-oriented. Clinicians who practice cultural humility know they can never be fully competent, but are willing to continue to learn and interact in ways that are respectful of another's culture.

Using technology to interact can be a complicated endeavor when working with clients who are members of different cultures. Technology presents greater risks for misunderstandings and miscommunication between providers and their clients (Johnston et al., 2018). To improve the chances of clear communication, a provider can take into consideration several issues. Johnston et al. (2018) provide several examples of ways that practitioners can convey cultural humility while using technology. A clinician can:

1. Adapt clinical style and process to accommodate different communication styles,
2. Wear proper attire and have an appropriate room set-up for direct in-home videoconferencing,
3. Be aware of different understandings and uses of voicemail, return calls, and texts,
4. Be cognizant that clients may not understand text message abbreviations, such as LOL (laughing out loud) or SMH (shaking my head).
5. Understand that there are different understandings and expectations regarding the immediacy of response to e-mails.

Telepractitioners who practice cultural humility are aware that they may be prone to specific assumptions about culture and environment based upon the clinical setting or client's home

(Johnston, et al., 2018). For example, they will refrain from particular assumptions, if a client who lives in a rural setting has hunting paraphernalia in the background. They incorporate contextual knowledge of a client's environment, culture, and resources into treatment approaches.

There are benefits to the cross-cultural service telehealth service provision. Telemental health services provide increased access to care and can be used to reach a wide range of diverse populations, such as Native Americans and Alaska Native communities, Latino populations, and international clients (Johnston et al., 2018). It allows providers to offer services to diverse age groups, settings, communities, and environments. Individuals from underserved and marginalized communities can have access to services that were previously inaccessible. Telebehavioral health practitioners can provide outreach, education, and community engagement in creative ways to address the needs of communities. They can target specific populations through an array of culturally-specific platforms. Also, because of limitations related to distance and availability clients using telehealth services will possibly have access to greater choices of clinicians and may choose to connect with a clinician from a similar cultural background (e.g. ethnicity, sexual orientation) if so desired or deliberately choose a clinician from a different background if so desired. Finally, technology now provides greater access to translation services. Videoconferencing platforms as well as text-based, mobile, and voice recognition services can help bridge language barriers that can inhibit service provision.

Telemental health technologies can be used to allow members of underserved populations and diverse cultural groups have greater access to services that meet their needs (Garney, et al., 2016). Communities that have difficulty with access to services due to geographic, economic, or medical limitations can be served in their homes by providers who practice cultural humility and are culturally competent and who may not be in the immediate area. However, there can be challenges as well. Communities whose members are underserved or remote may be reluctant to try services with unfamiliar technologies. There may be limited connectivity, such as in rural areas. In this case community members can invest in the process as peers or advocates to help others obtain needed services and resources.

While many technologies can have a far reach to multiple client populations, telepractitioners are still responsible for practicing with diverse populations within the parameters of their knowledge, values, and skills (Barnett & Kolmes, 2016). Some individuals may seek treatment

through the Internet because of limited access. When treating diverse individuals, it is not appropriate for teleclinicians to expect their clients to speak English fluently. Knowing one's own abilities and limits of working with specific populations is not only a part of regular clinical practice, but also telepractice. For example, it may not be appropriate for a telepractitioner to use the automatic closed-captioning with a deaf individual as a replacement for American Sign Language. A telepractitioner may need to make referrals to other providers who are better prepared to deal with specific needs of a particular individual.

SUMMARY AND RECOMMENDATIONS

Telemental health services are behavioral health services provided by licensed practitioners using technology. Telemental health technologies vary and can include services, such as videoconferencing, telephone communication, mobile applications, texts, and email among others. There are a number of issues that practitioners should keep in mind when implementing telehealth technologies into their practices. Practitioners should be familiar with telehealth, computer, and technology terminology. They should ensure that their services are offered through secure platforms that are HIPAA compliant. State, federal, and professional regulatory bodies often provide guidelines for telemental health practice and requirements for professionals. Telemental health services require special considerations, such as video presence, client preparation, and treatment considerations. Ethical considerations for professional behavior as well as client protection should be at the forefront of telemental health practice. Barnett and Kolmes (2016) offer specific recommendations for telemental health practitioners:

- Follow requirements for professional ethical practices (i.e., Codes of Ethics).
- Become familiar with federal and state laws and guidelines for telemental health practice.
- Conduct thorough assessments with clients to ensure that telemental health is appropriate for their particular circumstances.
- Include a comprehensive informed consent process that addresses specific telemental health-related issues as well as the overall treatment consideration.
- Use technologies that ensure clients' safety, security, and privacy, and comply with laws and regulations.
- Only use HIPAA-compliant software programs for videoconferences with clients.
- Provide only those clinical services for which the clinician is competent.

- Be familiar and competent with the hardware and software that will be used to provide telemental health services.
- Learn about and follow duty to warn and mandatory reporting requirements for the jurisdictions where services are provided and where the client resides.
- Know the resources in the areas where clients live in case emergency referrals are needed.
- Create safety and crisis plans for clients receiving telemental health services.
- Document telemental health services in accordance with federal, state, and organizational policies.
- Ensure that client records are secure, confidential, and private.
- Maintain appropriate liability insurance coverage for telemental health services.

APPENDIX A

EXAMPLE OF A BUSINESS ASSOCIATE TEMPLATE

BUSINESS ASSOCIATE AGREEMENT

This Business Associate Agreement (this "Agreement") is made effective as of _____ ("Effective Date") by and between_____("Covered Entity") and ABC Therapist Managed Service Provider ("Business Associate").

In consideration of the mutual covenants herein contained and intending to be legally bound hereby, the parties hereto agree as follows:

I. DEFINITIONS

A. In General. Terms used, but not otherwise defined, in this Agreement shall have the same meaning established for the purposes of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), ARRA (as defined below), the Privacy Rule (as defined below), the Security Rule (as defined below) and the Unsecured PHI Breach Rule (as defined below), as each is amended from time to time.

B. Specific Definitions.

1. "Applicable Law" shall mean any of the following items, including any amendments to any such item as such may become effective:

a. HIPAA;

b. the federal regulations regarding privacy and promulgated with respect to HIPAA, found at Title 45 CFR Parts 160 and 164 (the "Privacy Rule");

c. the federal regulations regarding electronic data interchange and promulgated with respect to HIPAA, found at Title 45 CFR Parts 160 and 162 (the "Transaction Rule");

d. the federal regulations regarding security and promulgated with respect to HIPAA, found at Title 45 CFR Parts 160 and 164 (the "Security Rule");

e. the federal regulations regarding notification in the case of breach of Unsecured PHI, found at Title 45 CFR Parts 160 and 164 (the "Unsecured PHI Breach Rule"); and

f. ARRA.

2. "ARRA" means Subtitle D of the Health Information Technology for Economic and Clinical Health Act provisions of the American Recovery and Reinvestment Act of 2009.

3. "ePHI" means electronic protected health information within the meaning of 45 CFR § 160.103, limited to the information created, received, maintained, or transmitted by Business Associate from or on behalf of Covered Entity.

4. "PHI" shall have the same meaning as the term "protected health information" in 45 CFR § 160.103, limited to the information created, received, maintained, or transmitted by Business Associate from or on behalf of Covered Entity.

5. "Underlying Agreement" shall mean any agreement between Covered Entity and Business Associate, under which Business Associate, on behalf of Covered Entity, provides a service or product, or performs or assists in the performance of a function or activity, which involves the disclosure, creation, receipt, maintenance, or transmission of PHI by Business Associate from or on behalf of Covered Entity.

6. "Unsecured PHI" shall have the same meaning as the term "unsecured protected health information" in 45 CFR § 164.402, limited to the information created, received, maintained, or transmitted by Business Associate from or on behalf of Covered Entity.

II. RIGHTS AND OBLIGATIONS OF BUSINESS ASSOCIATE

A. General Obligations and Activities.

1. Business Associate shall not use or disclose PHI except as permitted by this Agreement or as required by law.

2. Business Associate shall use appropriate safeguards, and comply with the Security Rule with respect to ePHI, to prevent use or disclosure of PHI other than as provided for in this Agreement. Business Associate shall encrypt (as that term is defined in 45 CFR § 164.304) its portable electronic devices that contain ePHI in a manner that is consistent with the "Guidance Specifying the Technologies and Methodologies That Render Protected Health Information Unusable, Unreadable, or Indecipherable to Unauthorized Individuals" issued by the Department of Health and Human Services as published in the Federal Register (74 FR 19006) on April 27, 2009.

3. To the extent the Business Associate is to carry out one or more of Covered Entity's obligations under the Privacy Rule, Business Associate will comply with the requirements of the Privacy Rule that apply to Covered Entity in the performance of such obligations.

4. Business Associate shall not receive remuneration, either directly or indirectly, in exchange for PHI, except as may be permitted by ARRA § 13405(d) and 45 CFR § 164.502(a)(5)(ii), as amended from time to time.

B. Reporting of Violations.

1. Business Associate shall report to Covered Entity within five (5) business days of it becoming aware of:

a. Any use or disclosure of PHI not provided for by this Agreement,

b. Any security incident, or

c. Any acquisition, access, use or disclosure of Unsecured PHI in a manner not permitted by the Privacy Rule.

2. The reports made to Covered Entity pursuant to paragraph 1 above shall include all relevant facts concerning the event and, with respect to reports of events set forth in paragraph 1.c. above, shall include the identity of each individual whose Unsecured PHI has been, or is reasonably believed by the Business Associate to have been, acquired, accessed, used or disclosed. As soon as possible thereafter, and to the

extent known, Business Associate shall also provide Covered Entity with a description of:

a. What happened, including the date of the acquisition, access, use or disclosure and the date of it becoming aware to Business Associate;

b. The types of Unsecured PHI involved in the acquisition, access, use or disclosure;

c. Any steps an individual should take to protect themselves from the acquisition, access, use or disclosure; and

d. What Business Associate is doing to investigate the acquisition, access use or disclosure, to mitigate harm to individuals and to protect against any further unpermitted acquisition, access, use or disclosure of Unsecured PHI.

3. Business Associate will cooperate with Covered Entity's investigation and/or risk assessment with respect to any report made by Business Associate pursuant to paragraph 1.c. above and will abide by Covered Entity's decision with respect to whether such acquisition, access, use or disclosure constitutes a breach of Unsecured PHI for purposes of the Unsecured PHI Breach Rule.

4. Business Associate agrees to follow the instructions of Covered Entity with respect to any event reported to Covered Entity under paragraph 1.c. above that Covered Entity determines to be a breach of Unsecured PHI. Business Associate acknowledges that this may include, but not be limited to, the actions set forth in paragraphs a. through d. below:

a. Providing written notice of the Unsecured PHI breach, on behalf of Covered Entity, without unreasonable delay, but no later than sixty
(60) calendar days following the date the breach is discovered or such later date as is authorized under 45 CFR § 164.412, to each individual whose Unsecured PHI has been, or is reasonably believed by Business Associate to have been, accessed, used, or disclosed as a result of the HIPAA Breach. The content, form, and delivery of such written notice shall comply in all respects with 45 CFR § 164.404(c)-(d). Business Associate and Covered Entity shall cooperate in all respects regarding the drafting and the content of the notice. To that end, before sending any notice to any individual, the Business Associate shall first provide a draft of the notice to the Covered Entity. Covered Entity shall have five
(5) business days (plus any reasonable extensions) to provide

comments on the Business Associate's draft of the notice.

b. Business Associate will provide written notice of the breach of Unsecured PHI, on behalf of the Covered Entity, to the media to the extent required under 45 CFR § 164.406. Business Associate and the Covered Entity shall cooperate in all respects regarding the drafting and the content of the notice. To that end, before sending any notice to the media, Business Associate shall first provide a draft of the notice to the Covered Entity. Covered Entity shall have five (5) business days (plus any reasonable extensions) to provide comments on the Business Associate's draft of the notice.

c. Business Associate will provide written notice of the breach of Unsecured PHI, on behalf of the Covered Entity, to the Secretary to the extent required under 45 CFR § 164.408. Business Associate and Covered Entity shall cooperate in all respects regarding the drafting and the content of the notice. To that end, before sending any notice to the Secretary, Business Associate shall first provide a draft of the notice to the Covered Entity. Covered Entity shall have five business days (plus any reasonable extensions) to provide comments on Business Associate's draft of the notice.

d. If the breach of Unsecured PHI involves fewer than five hundred
(500) individuals, Business Associate will maintain a log or other documentation of the breach of Unsecured PHI which contains such information as would be required to be included if the log were maintained by the Covered Entity pursuant to 45 CFR § 164.408, and provide such log to the Covered Entity within five (5) business days of the Covered Entity's written request.

C. Subcontractors.

1. In accordance with 45 C.F.R. § 164.308(b)(2), Business Associate shall ensure that any subcontractor that creates, receives, maintains or transmits ePHI on behalf of the Business Associate agrees to comply with the HIPAA Security Rule by entering into a contract or other arrangement that complies with 45 C.F.R. § 164.314.

2. In accordance with 45 C.F.R. § 164.502(e)(1)(ii), Business Associate shall ensure that any subcontractor that creates, receives, maintains or transmits PHI on behalf of the Business Associate agrees to the same restrictions and conditions that apply to the Business Associate with respect to the PHI by entering into a contract or other arrangement

that complies with 45 C.F.R. § 164.504(e)(1)(i).

D. **Access to Books and Records by Secretary**. Business Associate shall make its internal practices, books and records relating to the use and disclosure of PHI received from, or created or received by the Business Associate on behalf of the Covered Entity available to the Secretary for purposes of the Secretary determining Covered Entity's compliance with Applicable Law. Business Associate shall immediately notify Covered Entity upon receipt by Business Associate of any request for access by the Secretary, and shall provide Covered Entity with a copy thereof as well as a copy of all materials disclosed pursuant thereto.

E. **Mitigation**. Business Associate shall mitigate, to the extent practicable, any harmful effect that is known to Business Associate of any item reportable to Covered Entity under paragraph B.1. above.

F. **Obligations Relating to Individual Rights**.

1. **Restrictions on Disclosures**. Upon request by an individual, Covered Entity shall determine whether an individual shall be granted a restriction on disclosure of the PHI pursuant to 45 CFR § 164.522. Covered Entity will not agree to any such restriction, if such restriction would affect Business Associate's use or disclosure of PHI, without the prior consent of Business Associate, *provided, however,* that Business Associate's consent is not required for requests that must be granted under ARRA § 13405(a). Covered Entity will communicate any grant of a request, made consistent with the foregoing, to Business Associate. Business Associate will restrict its disclosures of the individual's PHI in the same manner as would be required for Covered Entity. If Business Associate receives an individual's request for restrictions, Business Associate shall forward such request to Covered Entity within five (5) business days.

2. **Access to PHI**. Upon request by an individual, Covered Entity shall determine whether an individual is entitled to access his or her PHI pursuant to 45 CFR § 164.524. If Covered Entity determines that an individual is entitled to such access, and that such PHI is under the control of Business Associate, Covered Entity will communicate the decision to Business Associate. Business Associate shall provide access to the PHI in the same manner as would be required for Covered Entity. If Business Associate receives an individual's request to access his or her PHI, Business Associate shall forward such request to Covered Entity within five (5) business days.

3. **Amendment of PHI**. Upon request by an individual, Covered Entity shall determine whether any individual is entitled to amend his or her PHI pursuant to 45 CFR § 164.526. If Covered Entity determines that

an individual is entitled to such an amendment, and that such PHI is both in a designated record set and under the control of Business Associate, Covered Entity will communicate the decision to Business Associate. Business Associate shall provide an opportunity to amend the PHI in the same manner as would be required for Covered Entity. If Business Associate receives an individual's request to amend his or her PHI, Business Associate shall forward such request to Covered Entity within five (5) business days.

4. **Accounting of Disclosures**. Upon request by an individual, Covered Entity shall determine whether any individual is entitled to an accounting pursuant to 45 CFR § 164.528. If Covered Entity determines that an Individual is entitled to an accounting, Covered Entity will communicate the decision to Business Associate. Business Associate will provide information to Covered Entity that will enable Covered Entity to meet its accounting obligations. If Business Associate receives an Individual's request for an accounting, Business Associate shall forward such request to Covered Entity within five (5) business days.

G. Permitted Uses and Disclosures by Business Associate.

Except as otherwise limited in this Agreement or by Applicable Law, Business Associate may:

1. Use or disclose PHI to perform functions, activities, or services for or on behalf of Covered Entity, as specified in any Underlying Agreement between the parties and in this Agreement, provided that such use or disclosure (i) is consistent with Covered Entity's notice of privacy practices and (ii) would not violate the Privacy Rule if done by Covered Entity, except for the specific uses and disclosures set forth in paragraphs 2 and 3 below;
2. Use PHI for the proper management and administration of Business Associate or to carry out the legal responsibilities of Business Associate;
3. Disclose PHI for the proper management and administration of Business Associate or to carry out the legal responsibilities of Business Associate, provided that (i) Business Associate obtains reasonable written assurances from the person to whom the information is disclosed that it will remain confidential and used or further disclosed only as required by law or for the purpose for which it was disclosed to the person, and the person notifies the Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached or (ii) the disclosures are required by law; and

4. Use PHI to provide data aggregation services to Covered Entity as permitted by 45 CFR § 164.504(e)(2)(i)(B).

III. RIGHTS AND OBLIGATIONS OF COVERED ENTITY

A. Privacy Practices and Restrictions.

1. Upon request, Covered Entity shall provide Business Associate with the notice of privacy practices that Covered Entity produces in accordance with 45 CFR § 164.520. If Covered Entity subsequently revises the notice, Covered Entity shall provide a copy of the revised notice to Business Associate.

2. Covered Entity shall notify Business Associate of any restriction to the use or disclosure of PHI that Covered Entity has agreed to in accordance with 45 CFR § 164.522. Covered Entity shall provide Business Associate with any changes in, or revocation of, permission by an Individual to use or disclose PHI, if such changes affect Business Associate's permitted or required uses and disclosures.

B. Permissible Requests by Covered Entity. Covered Entity shall not request Business Associate to use or disclose PHI in any manner that would not be permissible under the Privacy Rule if done by Covered Entity, provided that Covered Entity and Business Associate acknowledge that Business Associate may use or disclose PHI for the purposes and in accordance with the terms and conditions of paragraph II.G. of this Agreement.

IV. TERM AND TERMINATION

A. Term. The term of this Agreement shall begin on the Effective Date, and shall end: (i) upon termination or expiration of the last remaining Underlying Agreement, or if there is no Underlying Agreement in effect, when Covered Entity ceases disclosing PHI to Business Associate or allowing Business Associate access to or use of PHI, or (ii) upon termination for cause as set forth in the following Section IV.B, whichever is earlier, or (iii) when payment for `ABC Therapist Managed Service Provider` Pro or higher level subscription has stopped.

B. Termination for Cause. Upon either party's knowledge of a material breach of this Agreement by the other party, the nonbreaching party shall have the following rights:

1. If the breach is curable, the nonbreaching party may provide an opportunity for the other party to cure the breach or end the violation. Alternatively, or if the other party fails to cure the breach or end the

violation, the nonbreaching party may terminate this Agreement and any Underlying Agreement.

2. If the breach is not curable, the nonbreaching party may immediately terminate this Agreement and any Underlying Agreement.

3. If termination is not feasible, the nonbreaching party may report the problem to the Secretary.

C. Effect of Termination.

1. Except as provided in Section IV.C.2 of this Agreement, upon termination of this Agreement, for any reason, Business Associate shall return or destroy all PHI within its possession or control, and all PHI that is in the possession or control of Business Associate's subcontractors or agents. Business Associate shall retain no copies of the PHI.

2. If Business Associate determines that returning or destroying the PHI is infeasible, Business Associate shall provide to Covered Entity notification of the conditions that make return or destruction infeasible. Business Associate shall extend the protections of this Agreement to such PHI and limit further uses and disclosures of such PHI to those purposes that make the return or destruction infeasible, for so long as Business Associate maintains such PHI.

3. Except as otherwise expressly provided in this Agreement, all covenants, agreements, representations and warranties, express and implied, in this Agreement shall survive the expiration or termination of this Agreement, and shall remain in effect and binding upon the Parties until they have fulfilled all of their obligations hereunder and the statute of limitations shall not commence to run until the time such obligations have been fulfilled. Any terms of this Agreement that must survive the expiration or termination of this Agreement in order to have their intended effect, shall survive the expiration or termination of this Agreement whether or not expressly stated.

V. INDEMNIFICATION

Business Associate and Covered Entity shall indemnify and hold harmless the other party from and against all claims, liabilities, judgments, fines, assessments, penalties, awards or other expenses, of any kind or nature whatsoever, including, without limitation, attorney's fees, expert witness fees, and costs of investigation, litigation or dispute resolution, relating to or arising out of any breach of this Agreement by Business Associate. No provision concerning limitation of liability under any Underlying Agreement shall apply to Business Associate's and Covered Entity's obligations under this Agreement.

VI. MISCELLANEOUS

A. **Electronic Health Records.** The parties agree that Business Associate shall not maintain any "electronic health record" or "personal health record," as those terms are defined in ARRA, for or on behalf of Covered Entity. As such, Business Associate has no obligation to document disclosures that are exempt from the accounting requirement under 45 CFR § 164.528(1)(i)-(ix), and Covered Entity agrees not to include Business Associate on any list Covered Entity produces pursuant to ARRA § 13405(c)(3).

B. **Amendment**. To the extent that Applicable Law is amended in the future and to the extent that such amendments contain requirements and/or provisions not already contained in this Agreement that are required to be incorporated into this Agreement, the parties agree that either (i) this Agreement shall be deemed to be automatically amended to the extent necessary to incorporate such additional requirements and/or provisions, or (ii) if determined necessary by Covered Entity, they will enter into an amendment to this Agreement in order to incorporate any such additional requirements and/or provisions. All amendments to this Agreement, except those occurring by operation of law, shall be in writing and signed by both parties.

C. **Authority to Execute Agreement**. The individuals executing this Agreement on behalf of each party warrant and represent that they are authorized to execute this Agreement on behalf their respective party and have the power to bind their respective party to the terms set forth in this Agreement.

D. **Survival**. The respective rights and obligations of the parties under Sections II.D., IV.C, V and VI of this Agreement shall survive the term and termination of this Agreement.

E. **Interpretation**. Any ambiguity in this Agreement shall be resolved in favor of a meaning that permits Business Associates to comply with Applicable Law.

F. **Counterparts**. This Agreement may be executed in counterparts, each of which shall be deemed an original but all of which shall constitute one and the same instrument. An executed Agreement delivered by facsimile or other electronic transmission shall be treated as if an original.

IN WITNESS WHEREOF, the parties have executed this Business Associate Agreement as of the date first above written.

COVERED ENTITY	ABC Therapist Managed Service Provider - BUSINESS ASSOCIATE
Signature:_____	Signature:_____
Print Name: _____	Print Name: _____
Title: _____	Title: _____

APPENDIX B

MEMORANDUM OF UNDERSTANDINGS

Between

[Local Agency] and

Arundel Lodge, Inc. (ALI)

THIS AGREEMENT is made by and between [local agency] and Arundel Lodge, Inc. (ALI).

The purpose of this agreement is to:

1. increase the accessibility of mental health services for persons who are deaf by establishing an outpatient mental health services via teletherapy on the eastern shore; and

2. facilitate the referral and delivery of outpatient mental health services; coordinate these services with [LOCAL AGENCY] and to define responsibilities of ALI and [LOCAL AGENCY] for shared clients.

The provision of treatment and services in this agreement is conditioned on the receipt of authorization or preauthorization required by third party payers.

A. Mental Health Clinic Services

I. ALI agrees to provide mental health service to shared clients including but not limited to the following:
   1. Individual and/or group psychotherapy
   2. Intake evaluations and diagnostic assessments
   3. Development and monitoring of the Individual Treatment Plan (ITP)
   4. Referral to other services/professionals as deemed medically prudent by the psychiatrist and treatment team including targeted case management, psychiatric rehabilitation, residential rehabilitation, supported employment
   5. Collaboration with members of the service team
   6. Collaboration with other partners including, DILA and Departments of Health, in-patient psychiatric facilities, and other community agencies.
   7. Emergency and crisis intervention

   Clients may choose teletherapy services through Arundel Lodge and continue their psychiatric services and medication management services from [LOCAL AGENCY].

II. ALI agrees to provide teletherapy services to eligible clients weekly for psychotherapy. With a new client, the therapist will schedule an intake interview and make appropriate referrals to [LOCAL AGENCY] for psychiatric evaluations and medication management. If [LOCAL AGENCY] receives a new client referral, the psychiatrist will refer the deaf client to ALI for teletherapy services.

III. ALI shall accept and serve insurance eligible clients that are not presently covered but have current proof of eligibility.

IV. ALI agrees to make available to [LOCAL AGENCY] and other partners in the provision of services to the consumers information necessary for proper coordination of services in accordance with HIPAA standards. In instances when [LOCAL AGENCY] continues to provide medication management, [LOCAL AGENCY] will also send similar information to ALI for proper coordination of services.

V. ALI agrees that at least one therapist will complete training and certification in telemental health practice and act as a consultant if the need arises.

VI. [LOCAL AGENCY] agrees to provide mental health services to shared clients including but not limited to the following:
   1. Psychiatric evaluations and medication management
   2. Lab requisitions required for medication management
   3. Accessibility and assistance to clients using videoconferencing equipment
   4. Collaboration with members of the service team
   5. Collaboration with other partners including, DILA and Departments of Health, in-patient psychiatric facilities, and other community agencies.
   6. Management of emergencies and crisis interventions

VII. [LOCAL AGENCY] will collaborate with ALI to coordinate a plan of safety.
   1. In an emergency, a client will be assessed by an on-site [LOCAL AGENCY] provider. If the provider determines that the client is need of an acute psychiatric crisis services, due to safety, medical or time constraint issues, the client will be provided services in accordance with local standard operating procedures. Clients/patients will not be "tied over" or placed on "close observation", until they can see the TMH therapist.
   2. Either the client or therapist may require the presence of an attendant with the patient during the TMH session, based on their current understanding of the patient and the telemedicine consultation process. The selection of an appropriate attendant (physician, nurse, therapist, medical/psychiatric technician, other support staff), if required, will be mutually agreed upon before the start of the TMH session
   3. For TMH sessions where the client or provider have not required the presence of an attendant to be with the patient during the session, the following conditions must be met:

i. An attendant, who can respond immediately to assist the patient, will be available at [LOCAL AGENCY]
ii. An alternative communication medium (computer, phone, pager, etc.) must be available to notify the attendant at [LOCAL AGENCY]

4. Should an attendant be called, the session may continue or, either the client or therapist may elect to end the TMH session and refer the patient for an "in person" evaluation at [LOCAL AGENCY] or local emergency room, if necessary. This referral may be either voluntarily or involuntarily in accordance with local laws and standard operating procedures.

VIII. [LOCAL AGENCY] agrees to provide adequate and suitable space for clients to use videoconferencing equipment for teletherapy.

IX. In accordance with HIPAA standards, as well as all applicable state laws, ALI and [LOCAL AGENCY] will collaborate as needed to provide optimum outcome for mutual clients. With the permission of the client, ALI will send [LOCAL AGENCY] electronic copies of documentation of each service via secure email. In instances when [LOCAL AGENCY] continues to provide medication management, [LOCAL AGENCY] will also send documentation of each service provided to consumers.

X. ALI and [LOCAL AGENCY] shall maintain and provide certification of Professional Liability Insurance coverage in the minimum amount of one million dollars ($1,000,000) for each incident and three million dollars ($3,000,000) for annual aggregate coverage.

XI. Each party shall maintain and provide certification of General Liability Insurance coverage in the minimum amount of one million dollars ($1,000,000) for each incident and three million dollars ($3,000,000) for annual aggregate coverage. Such certification shall name the other party as Certificate Holder and shall include the following provision:

"It is agreed that this policy is not subject to cancellation of or reduction in coverage until 30 days prior written notice has been given to Certificate holder."

XII. Each party agrees to indemnify and save harmless the other and any and all of its board of directors, agents, servants, and employees from and against all claims, suits, judgments, and/or damages brought, recovered or exacted against one party, for or on account of the negligence (by act or omission) of the other party or the other party's employees, agents or independent contractors. In order to be entitled to indemnification, in the event one party receives notice of any claim or suit for which it may seek indemnification from the other party, within five calendar days, it must provide notice of the claim/suit to the other party; the other party may select counsel and participate in the defense of the claim/suit if it so chooses and exercises this option within ten calendar days of receipt of the notice from the party seeking indemnification.

XIII. This agreement shall remain in effect from the date of signing and continue as long as service is provided to shared clients unless terminated by either party in writing and in accordance with the following:

1) changes in policy that affect continued implementation of this agreement
2) failure to meet terms of the agreement

The individuals signing this agreement are authorized by the board of directors of their respective agency to do so on behalf of the agency.

For [LOCAL AGENCY]:

_____

Date:_____

Title:_____

Witness:_____

For Arundel Lodge, Inc.

_____

Date:_____

Title:_____

Witness:_____

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