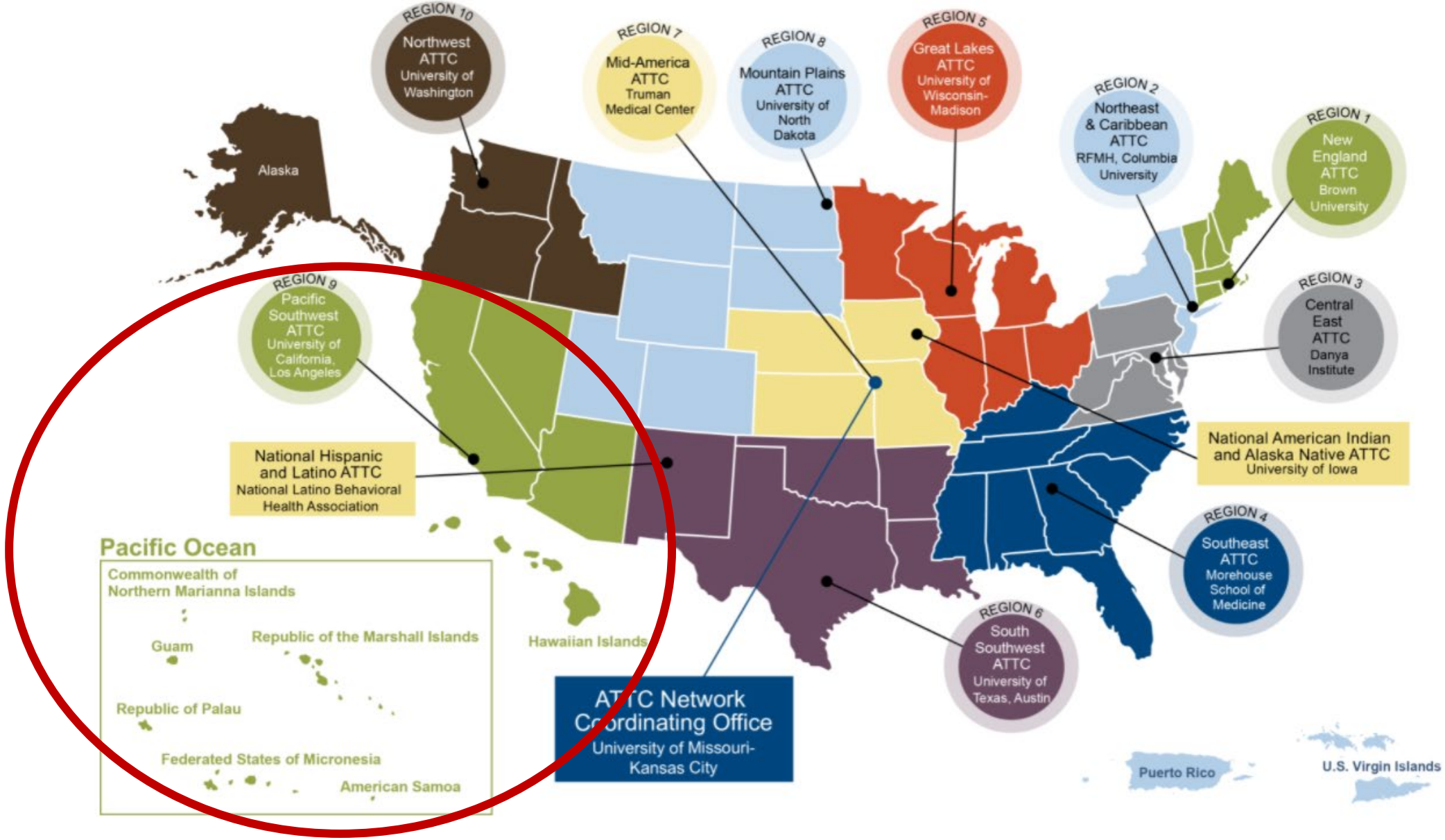
The Effectiveness and Utility of Telebehavioral (Telehealth) Services: The Future is Here

Nancy A. Roget, MS, MFT, LADC

Maryellen Evers, LCSW, CAADAC, CMFSW

ATTC Addiction Technology Transfer Center Network
Funded by Substance Abuse and Mental Health Services Administration

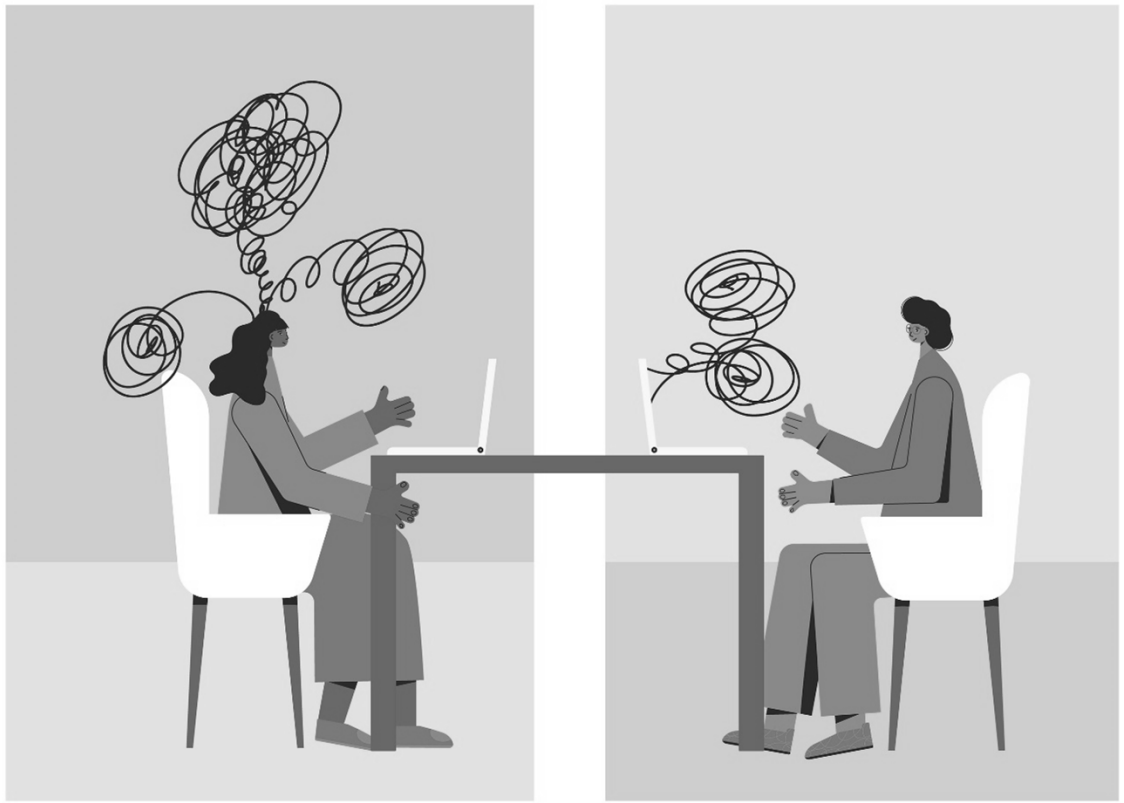
U.S.-based ATTC Network



Presentation Outline

- Definition/Uptake of Telebehavioral Health
- Research-base for Telebehavioral Health
  - History-Mental Health Services
  - Findings from Systematic Reviews
- Clients/Patients and Telebehavioral Health
- Clinicians and Telebehavioral Health
- Engagement, Therapeutic Alliance, Presence
- Telepresence
- Telehealth Tips
- Disinhibition Effects
- Guidelines for Telebehavioral Health
- Lessons Learned/Safety Issues
- Summary/Concluding Thoughts

Making the case…..



Telebehavioral health in the form of synchronous (LIVE) video and audio is effective, well received, and a standard way to practice.

Hilty et al., 2017

With the onset of the COVID-19 Pandemic

Rapid Virtualization of Behavioral Health Services

Shore, 2020

‘The research base for telebehavioral health-related interventions (videoconferencing) is more than 60 years old’

1959 – University of Nebraska began using videoconferencing for education, research, consultation, and treatment.

The telemedicine clinic at Boston’s Logan airport in the 1960s enabled health-care providers to share information on patients with providers at Massachusetts General Hospital.

Chakrabarti, 2015; https://irp.nih.gov/catalyst/v24i4/nlm-workshop-images-and-texts-in-medical-history

Delivering manualized treatments via telepsychology can be just as effective as FTF care

Shore, et al., 2018

Systematic Review of Videoconferencing Found:

Ease of Use

Improved Outcomes/ Communication

Medication Adherence

Missed Appointments

Wait-times

Re-admissions

Patient Travel-time

Kruse et al., 2017

High levels of patient satisfaction

are the most consistently reported finding

All patient populations (children, adolescents, seniors, minority populations, and individuals in the justice systems) report satisfaction

Chakrabarti, 2015

Virtual Group Counseling

- **A recent study found that patients participating in an online group reported feeling less connected than group members participating in in-person sessions.**
- **But most of these online group members believed:**
  - the convenience of attending group online offset any barriers or difficulties experienced
  - they probably wouldn't have been able to attend group sessions if they did not attend the online sessions
  - while an online group was not their first choice, it was preferred over no treatment

Lopez et al., 2020

Providers tended to express more concerns about the potentially adverse effects of videoconferencing on therapeutic rapport.

Reluctant providers… rather than Reluctant patients

"Hold my calls until I'm willing to listen."

Kruse, et al., 2017; Hubley et al., 2016

Clinician's Use of Telebehavioral Health

Concerns about:

- using new software programs or technologies
- confidentiality & privacy/security issues
- questions about telebehavioral's health efficacy
- regulatory concerns (e.g., uncertainty about laws governing telehealth or roadblocks)

McClellan et al., 2020; Jang-Jaccard et al., 2014; Scott Kruse, et al., 2018

However, many clinicians have concerns about services delivered via telehealth and being able to engage with patients and develop therapeutic alliances and therapeutic relationships

Cataldo et al., 2021

Check Your Attitude… Attitudes Towards Telehealth

Researchers Rees and Stone (2005) investigated therapeutic alliance in telehealth sessions versus in-person sessions; 30 psychologists were randomized into 2 groups:

- 15 psychologist viewed a video of an in-person session and rated the therapeutic alliance
- 15 psychologists viewed a video of a telehealth session and rates the therapeutic alliance

The telehealth session was rated lower in therapeutic alliance than the in-person session, even though the sessions were identical.

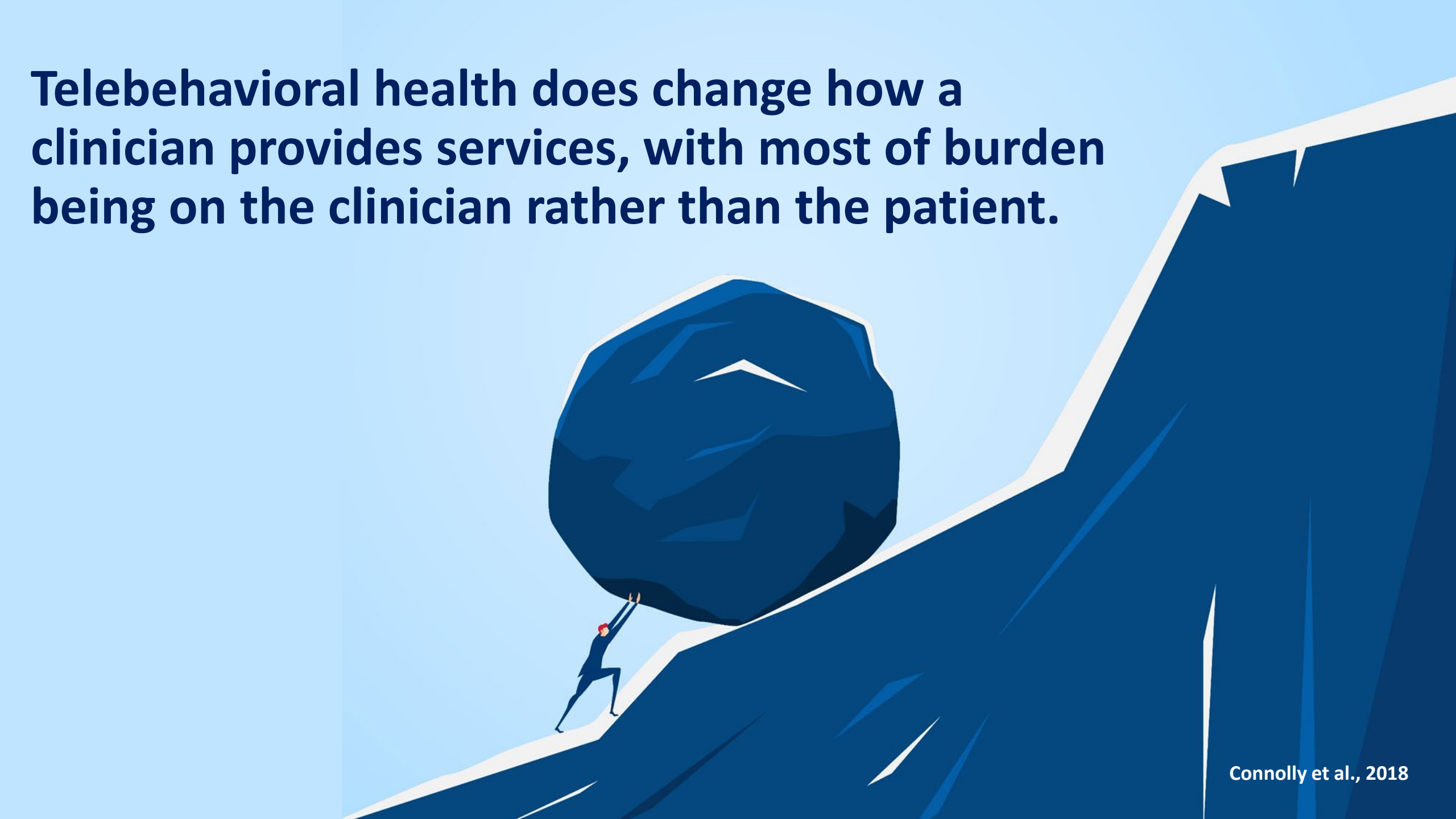
Rees & Stone, 2005

Study regarding clinician's attitudes about telebehavioral health found:

- Clinicians with more telebehavioral health knowledge and experience tended to have more favorable opinions
- Increasing knowledge and promoting skill proficiency may be the key to widespread adoption
- Practice with feedback, observing colleagues, & accessing experts helped to build competency

McClellan et al., 2020

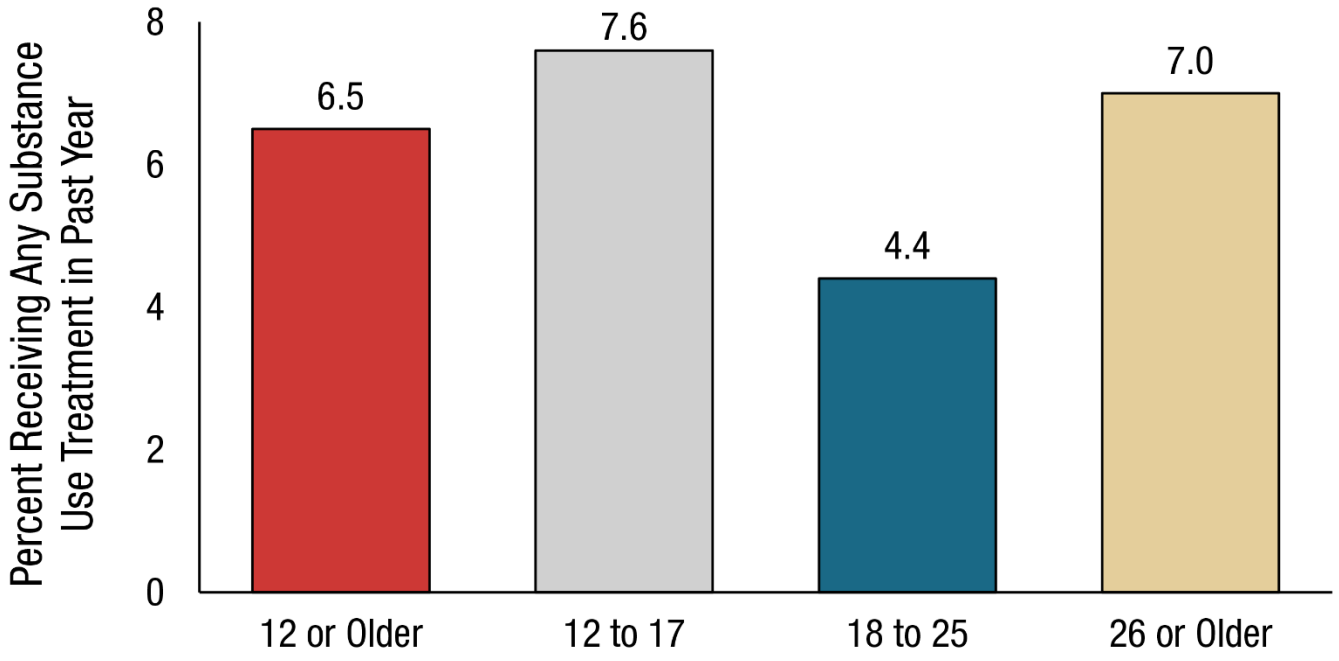
Telebehavioral health does change how a clinician provides services, with most of burden being on the clinician rather than the patient.



Connolly et al., 2018

Should Clinicians/Peer Support Specialists Deliver SUD Treatment Services Utilizing Telehealth?????

Received Any Substance Use Treatment in the Past Year: Among People Aged 12 or Older Who Had a Substance Use Disorder in the Past Year; 2020



SAMHSA
Substance Abuse and Mental Health Services Administration

85 % of Adults Own a Smartphone

35% in 2011 *to* 85% in 2021

- US smartphone users check their phones more than **344** times a day (every 4 minutes)

https://www.reviews.org/mobile/cell-phone-addiction/

https://www.pewresearch.org/internet/fact-sheet/mobile/

Pew Research Center, 2019

Engagement, Presence, Therapeutic Alliance

An important tenet of therapeutic relationship is engagement, which is key for effective treatment

Hilty, et al., 2019

Patient engagement is defined as the degree to which patients actively participate in care.

Engagement in Health Care

is defined as "the strengths-based process through which individuals with mental health conditions form a healing connection with people that support their recovery and wellness within the context of family, culture, and community…[part of the] therapeutic alliance".

NAMI, 2019



A clinician's highest calling is to comfort others in their suffering, a fundamental contribution to our own sense of purpose and meaning in our work. While there is no standard definition, we identify presence as undistracted healing engagement between clinician and patient.

Millstein & Chaiyachati, 2020

Presence in Counseling Sessions

- **Presence** enables therapists to be Physically, Emotionally, Cognitively, Spiritually, and Relationally in touch with themselves and their clients (Cooper et al., 2013).
- **Presence** itself becomes therapeutic and enables clients to experience neurophysiological safety, and consequently, their relationship is enhanced, and the healing process is favored (Geller & Porges, 2014).
- **Presence** is a crucial factor in therapy. It allows psychologists and clients to connect by experiencing the same moment, permits the development of empathy, and leads therapists to develop a therapeutic relationship (TR) with their clients (Rogers, 1951;1979;1980).
- An effective TR is also associated with the formation of good cooperation between clinician and clients defined as therapeutic alliance (TA) (Catty, 2004; Marshall & Serran, 2006).
- Therapeutic Alliance is a Good predictor of effective psychotherapy (Horvath et al., 2011).

Taken from article by Cataldo et al., 2021

Therapeutic alliance consists of 3 critical factors:

(1) the sharing of clear expectations and goals by both clients and psychologists;

(2) a clear definition of responsibilities, rules, and commitments;

(3) a relationship between psychologists and clients that involves their bonds, mutual trust, and respect.

Bordin, 1979; Taken from article by Cataldo, et al., 2021

The goal with technology is to simulate real-time experiences related to feelings, perception, images, and interaction.

Create an environment that facilitates therapeutic engagement and emotional wellbeing for all parties

Hilty et al., 2002; Hilty et al., 2019

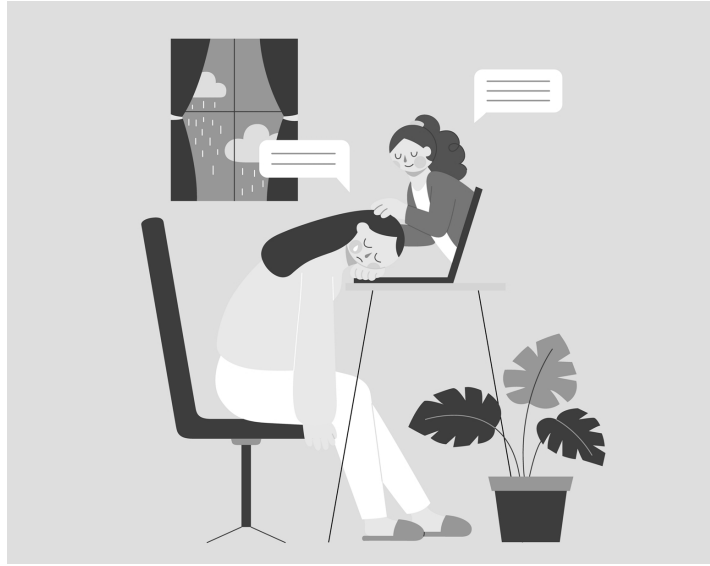
Technology may change the nature of interaction for participants and communication related to exchange of information, clarity, responsiveness, and comfort.

Liu et al. 2010

Translate clinical skills to provide services virtually (e.g., online engagement, support, pointing out discrepancies, employing EBPs and best practices, making referrals, etc.)

To

Telepresence Definition



Telepresence is broadly described as "a mental state in which a user feels physically present within the computer-mediated environment" (Draper, Kaber, & Usher, 1998, p. 356).

Telepresence is the patient's, caregiver's, and clinician's experienced realism during a telehealth session that is created through connection and collaboration, built on trust, support, and the clinician's skill at acting as the technology mediator… (Groom et al., 2021)

Telepresence

Groom et al., 2021

Connection

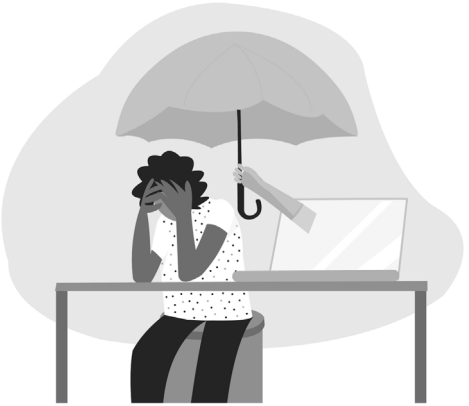
- If patients are unfamiliar with technology, clinicians should demonstrate patience and acceptance.
- If clinicians detect that the patient is uncomfortable, try purposefully altering the tempo and tone of their speech in order to put the patient at ease (Millstein & Chaiyachati, 2020).
- Observe client-reacting to statements or body language and **THEN** asking clarifying questions is a key component (Moyle et al., 2019; Narasimha et al., 2017).
- Beware that your attention may be **divided** between patients, family members, other caregivers, and computer controls which can make building connections more difficult (Lyerly et al., 2020).
- When clinicians are unable to use touch and/or gestures, heighten verbal interrelatedness through facial responses, active listening, reflection, and use of empathic statements- **Use MI Skills** (Millstein & Chaiyachati, 2020, p.286).

Trust

- Eye contact, while simulated through looking in the camera **(NOT the Screen)**, serves to increase trust- so maintain eye contact (Barrett, 2017).
- Other work describes the screen as a magnifier of trust vs. distrust.
- If a clinician is previously known and trusted by a patient, the experience of seeing that person in a telehealth session engenders an amplified feeling of trust (Pols, 2011).
- Meeting a new clinician over a telehealth session may magnify the sense of distrust for a patient, which the clinician may mitigate by increasing his or her supportive role behaviors.

Groom et al., 2021

Support



- Longer lengths of treatment allow the clinician to be supportive to patients across their treatment/recovery plan's trajectory (Sandelowski, 2020).
- Familiarity builds between patients and their treatment/recovery teams, and they in turn feel more supported.
- Researchers found that the video screen invites **intensive gazing**. While patients are speaking, observe and provide supportive statements to help with verbalization of issues (Pols, 2011; Sävenstedt et al., 2004).

Broom et al., 2021

Collaboration

- There is a need for a reciprocal flow of openness and plan for intentionally create a caring presence and shared space of togetherness (Grumme et al., 2016; Sandelowski, 2002; Tuxbury, 2013)
- This requires a more **deliberate attempt** when delivered over a telehealth medium.
- Collaboration is core to telepresence as both participants and providers must be **open**, **available**, and **knowable** to each other (Tuxbury, 2013)
- The clinician/peer support specialist may lead the interaction and create space in the conversation for collaboration.

Groom et al., 2021

Realism & Emotional Consequence

- To be fully present from a remote location and to have the **interaction be felt to be as strong as a face-to-face visit** are the ultimate goals.
- Researchers describe attributes as the feeling of entering into each other's homes and feeling as though you are together in those respective rooms (Barrett, 2017; Pols, 2011; Sävenstedt et al., 2004).
- Whether this experience has the emotional consequence of feeling safe and familiar or intrusive is dependent on other dimensions. However, the experienced reality is most immediately impacted by the dimensions of connection and collaboration.
- A failure to connect will inevitably negatively impact the experienced realism of an encounter, which will then impact the emotional consequences the patient and clinician experience.

Groom et al., 2021

Technological Mediation

- Technical quality of the telehealth session is of lower importance than the clinical usefulness of the session (Demiris, Speedie, & Finkelstein, 2001).
- During technical issues, the clinician may remain focused on providing clinical care and not allow technical issues to block the conversation
- When technology functions as a bad actor, the clinician should take control and ease associated discomfort. That may mean switching smoothly to a phone call, or it may require technical troubleshooting.

Groom et al., 2021

Ethical Duties – Telebehavioral Health

'*Demonstrating competency* with technology'

Minimally, clinicians using a videoconferencing platform for service delivery should be able to:

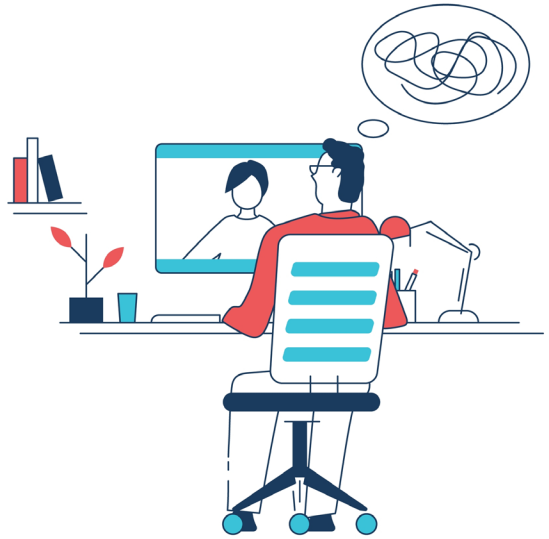
- **Show their capacity to use the technology with basic skills and to troubleshoot problems.**
- **Advise and help patients/clients with their use of the selected technology platform**
- **Explain the reasons for their choice of a technology platform (e.g., ease of use, affordability, functionality, privacy and security, federal confidentiality 42CFR Part 2 protections, etc.)**

Other Points About Use of Technology

- Some populations may be more comfortable with technology: children in general report novelty.
- Those clients with significant behavior/conduct/SUD issues report less stigmatization; and anxious patients report less anxiety with telehealth (Pakyurek, Yellowlees, & Hilty, 2010).
- A patient's perspective is best captured in her/his primary language (Hilty, 2016) or use of an interpreter (Maheu, 2017), (though research shows that communication with synchronous video is less problematic than asynchronous communication using English as a second language) (Sotillo,2016).

It’s the Little Things… Therapeutic Frame

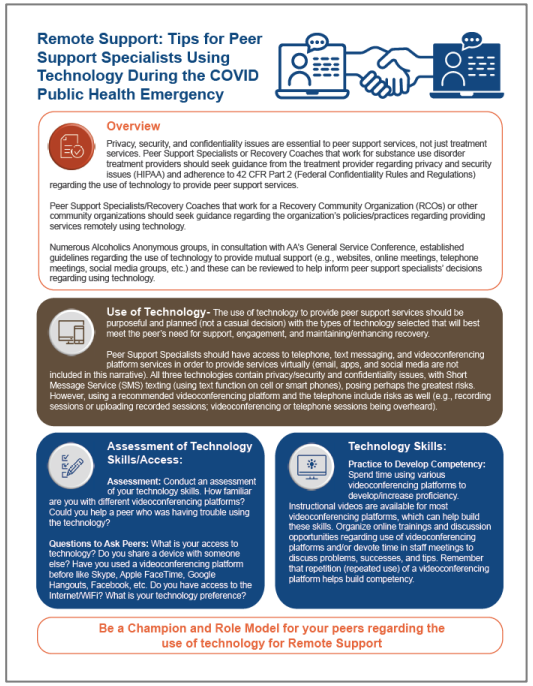
- The office, a typical appointment length, and a regular schedule of appointments are instrumental in creating a positive environment and the therapeutic frame
- The frame is the foundation or structure that promotes
  - Security
  - Trust
  - Confidentiality to explore and discuss anything



Hilty et al., 2013; Hilty, 2019; Greenberg, et al., 2002

Tips

- Establishing a Screen-side Manner
- Dos and Don’ts
- Setting Up Office Space
- Serving as a Role Model



Remote Support: Tips for Peer Support Specialists Using Technology During the COVID Public Health Emergency

Overview

Privacy, security, and confidentiality issues are essential to peer support services, not just treatment services. Peer Support Specialists or Recovery Coaches that work for substance use disorder treatment providers should seek guidance from the treatment provider regarding privacy and security issues (HIPAA) and adherence to 42 CFR Part 2 (Federal Confidentiality Rules and Regulations) regarding the use of technology to provide peer support services.

Peer Support Specialists/Recovery Coaches that work for a Recovery Community Organization (RCOs) or other community organizations should seek guidance regarding the organization’s policies/practices regarding providing services remotely using technology.

Numerous Alcoholics Anonymous groups, in consultation with AA’s General Service Conference, established guidelines regarding the use of technology to provide mutual support (e.g., websites, online meetings, telephone meetings, social media groups, etc.) and these can be reviewed to help inform peer support specialists’ decisions regarding using technology.

Use of Technology- The use of technology to provide peer support services should be purposeful and planned (not a casual decision) with the types of technology selected that will best meet the peer’s need for support, engagement, and maintaining/enhancing recovery.

Peer Support Specialists should have access to telephone, text messaging, and videoconferencing platform services in order to provide services virtually (email, apps, and social media are not included in this narrative). All three technologies contain privacy/security and confidentiality issues, with Short Message Service (SMS) texting (using text function on cell or smart phones), posing perhaps the greatest risks. However, using a recommended videoconferencing platform and the telephone include risks as well (e.g., recording sessions or uploading recorded sessions; videoconferencing or telephone sessions being overheard).

Assessment of Technology Skills/Access:

Assessment: Conduct an assessment of your technology skills. How familiar are you with different videoconferencing platforms? Could you help a peer who was having trouble using the technology?

Questions to Ask Peers: What is your access to technology? Do you share a device with someone else? Have you used a videoconferencing platform before like Skype, Apple FaceTime, Google Hangouts, Facebook, etc. Do you have access to the Internet/WiFi? What is your technology preference?

Technology Skills:

Practice to Develop Competency: Spend time using various videoconferencing platforms to develop/increase proficiency. Instructional videos are available for most videoconferencing platforms, which can help build these skills. Organize online trainings and discussion opportunities regarding use of videoconferencing platforms and/or devote time in staff meetings to discuss problems, successes, and tips. Remember that repetition (repeated use) of a videoconferencing platform helps build competency.

Be a Champion and Role Model for your peers regarding the use of technology for Remote Support

Tips for Clinicians/Counselors Providing Services Using Videoconferencing

Background

The use of technology through a web-based videoconferencing platform in a real-time manner (synchronous) is often called telehealth or telebehavioral health. Delivering assessment and treatment services using this type of technology has been shown as a way to increase patients’ access to behavioral health services. Recent research confirms high levels of satisfaction among patients/clients, along with positive treatment outcomes. Most importantly, services delivered through videoconferencing require specific skills and knowledge rather than simply turning on a webcam and chatting online. This document provides clinicians/counselors useful tips based on guidelines (https://www.liebertpub.com/doi/pdf/10.1089/tmj.2018.0237) for delivering services virtually.

Establishing Screenside Manner

Do…

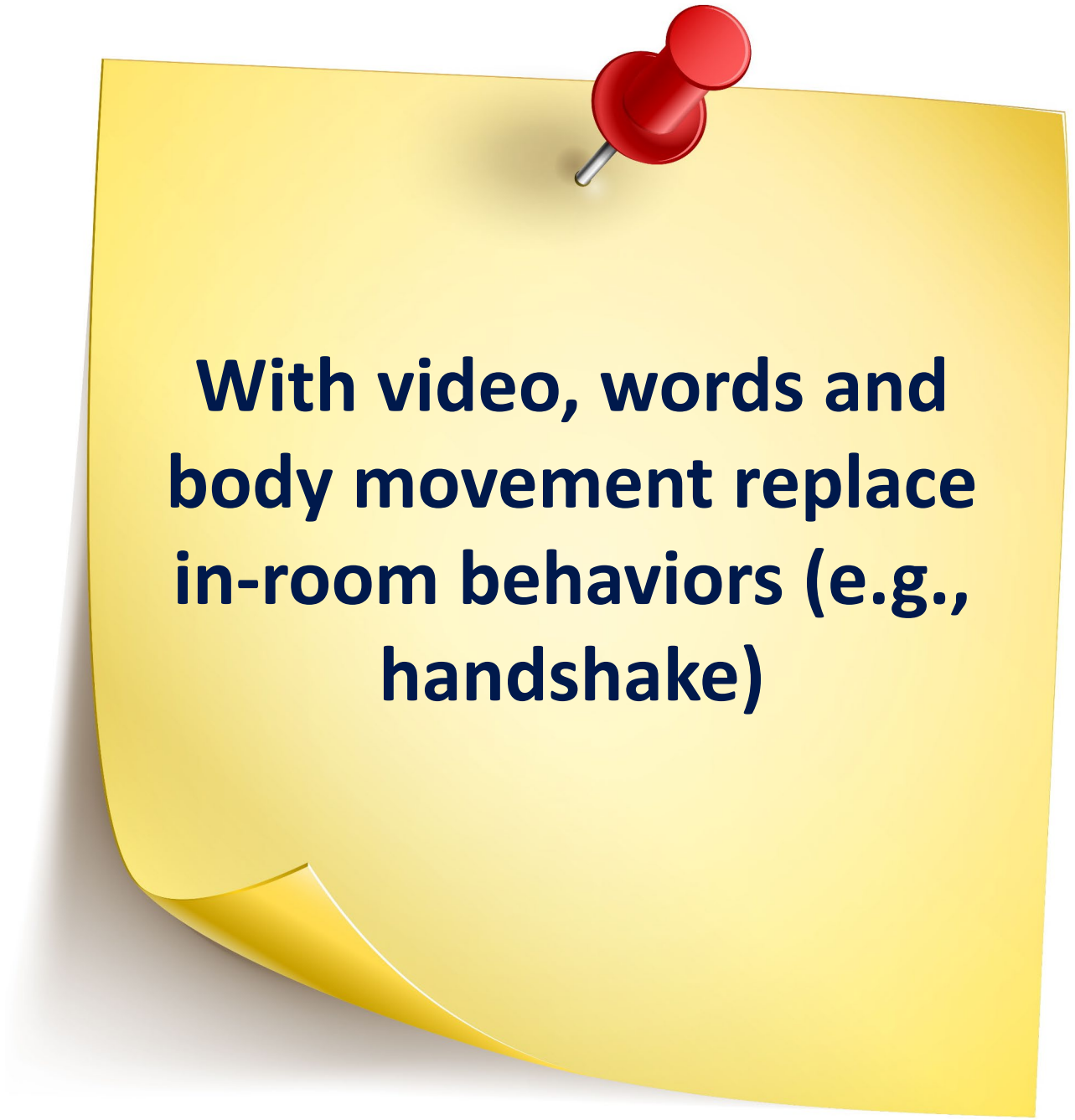
- Look directly into the camera rather than looking at the picture of the person on the screen (pseudo-eye contact)
- Balance facilitative and directive language (e.g., What are your thoughts about next steps you might take; It sounds like you have a lot of background noise going on. Can you move to a different spot for our session?)
- Wear solid colors and dress as if you are going to work in the clinic/office
- Nod your head and lean forward
- Stay seated (don’t pace) and sit-up straight
- Adjust camera so your entire face is visible and facing forward

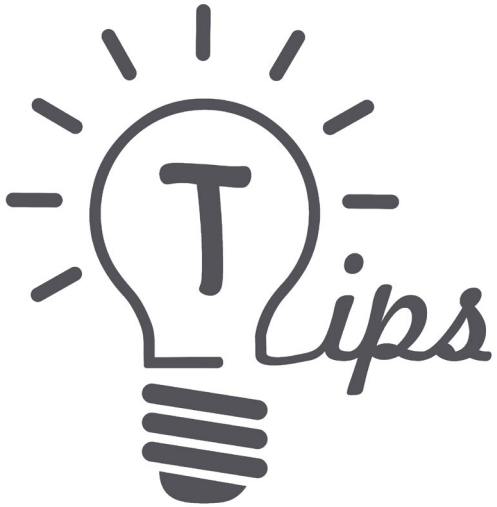
Avoid…

- Fidgeting, tapping, doodling, etc. (any kind of distracting behavior)
- Eating or drinking during sessions (if you need to take a sip of water, turn your head away from the camera)
- Video-camera shaming (demanding that a patient/client turn on their camera)
- Making exaggerated motions with hands

Setting Up Office Space…

- Remove all distractions (you don’t want patients/clients focused on trying to figure out what is on your bookshelf)
- Ensure there is good lighting (no shadowed face or halo effect)
- Provide a private and clean looking space
- Aim for a neutral backdrop like a plain wall or bookshelf
- Don’t sit with a window behind you that can cast shadows
- Ensure good placement of camera, microphone, and speakers
- Remove any Alexa-type devices
- Put a Do Not Disturb sign on the door





Hilty et al., 2019

Establishing Screenside Manner - DO

- Balance facilitative and directive language (e.g., What are your thoughts about next steps you might take; It sounds like you have a lot of background noise going on. Can you move to a different spot for our session?)
- Wear solid colors dress as if you are going to work in the clinic/office
- Nod your head and lean forward; make sure your face takes up 2/3 of the screen
- Act slightly more animated
- Stay seated (don’t pace) and sit-up straight
- Adjust camera so your entire face is visible and facing forward

Establishing a Screenside Manner - AVOID

- Fidgeting, tapping, rocking your chair, doodling, etc. (any kind of distracting behavior)
- Being too close or too far away from the camera
- Noise from jangly earrings or other hanging jewelry
- Noises from cars, buses, trains or activities off camera
- Eating or drinking during sessions (if you need to take a sip of water, turn your head away from the camera)
- Ice or gum chewing
- Ambient music or television sound – these may be greatly amplified to the listener/viewer, particularly with sensitive microphones and high-resolution screens
- Video-camera shaming (demanding that a patient/client turn on their camera)
- Making exaggerated motions with hands

Establishing a Screenside Manner

Be aware of:

- Grooming issues may also need attention:
  - such as covering any facial lesions
  - trimming nose and ear hairs
  - cleaning one's glasses

Depending on lighting...

- glare from eyeglasses
- shiny bald heads
- reflective glass from artwork may also be a serious distraction

Additional portable devices:

- should be turned off and put away unless one of the parties has courteously informed the other that an interruption may occur
- If an urgent call occurs, clinicians need to know how to check into whether their microphone/camera are on or off, lest they erroneously assume they are not being heard/seen, when actually they are.

Hilty et al., 2019

Setting Up Office Space…

- Remove all distractions (you don't want patients/clients focused on trying to figure out what is on your bookshelf)
- Provide a private and clean looking space
- Aim for a neutral backdrop like a plain wall or bookshelf
- Don't sit with a window behind you that can cast shadows
- Ensure good placement of camera, microphone, and speakers
- Remove any Alexa-type devices
- Put a Do Not Disturb sign on the door
- If the office located in the home is used for other purposes, plan ahead to ensure it is clinically conducive (e.g., others not using it, professional-looking)

It is the Little Things…

- In-person and TBH sessions require a clinical environment that is:
  - private
  - professional and warm – this includes:
    - good seating (e.g., ergonomic support)
    - adequate lighting (e.g., for facial illumination)
    - secure/private entries and soundproofing
- If a clinician uses more than one office site (e.g., main, home and/or part-time offices), the rooms should be professionally similar in design and technical layout.

Serving as a Role Model

- Turn off phone, email, and chat (avoid distractions)
- Use a virtual waiting room but be on time
- Dress as if you are going to work in the clinic/office
- Being online can cause people to act more casually (called disinhibition effect)
- Avoid self-disclosures or chatting (follow the 90/10 rule: listen, reflect, support, identify discrepancies, roll with resistance 90% of the time; self-disclose/chat 10% of the time at the beginning/end of the session)

Disinhibition Effect

‘It is well known that people say and do things in cyberspace that they ordinarily would not say or do in the face-to-face world. They loosen up, feel more uninhibited, and express themselves more openly. Researchers call this the *online disinhibition effect* (Suler, 2004a, Suler, 2004b)’ (Barak, Boniel-Nissim, & Suler, 2008, p. 1870)

Two specific factors in the practice of telepsychology have the potential to lead to an increased likelihood of harmful boundary crossings and violations for therapists:

(a) the potential for the flexibility of service delivery to prompt more frequent and more casual interactions and behaviors

(b) the assumption that physical distance provides protection from and/or makes the relationship immune to boundary crossings and violations.

Drum & Littleton, 2015

Disinhibition Effect

Flexibility can be taken to extremes with virtual service delivery:

- **Ability** to work from anywhere (working on vacation)
- **Ability** to work at anytime (sessions delivered outside of business hours)
- **Ability** to work from public locations (working from a coffee house)
- **Ability** to dress more casually

for example…

Clinicians working from public locations or being highly casual/informal in interactions can greatly jeopardize the professionalism of the relationship.

RISK: perceived as taking on the "buddy" role and may be seen as just another friend with whom the client talks to online

(Andersen, Van Raalte, & Brewer, 2001)

Drum & Littleton, 2015

Boundary Recommendations

- Maintain Professional Hours and Respect Timing of Sessions
- Ensure Timely and Consistent Feedback; Manage Excessive Communications
- Ensure a Private, Consistent, Professional, and Culturally Sensitive Setting
- Ensure Privacy of Non-Clients and Prevent Unintentional Self-Disclosures
- Ensure that Telecommunication Technologies Used Convey Professionalism
- Model Appropriate Self-boundaries
- Ensure Privacy of the Therapist's Work
- Use Professional Language and Consider Alternative Interpretations
- Ensure Competence in the Practice of Telepsychology

Drum & Littleton, 2015

Steps to Take to Improve/Enhance Telehealth Skills

- Since clinicians lose some connection through touch and gesture, we must: heighten our verbal engagement skills through active listening, reflection, and use of empathic statements-

Focus on Improving these skills through MI Training

- Be more purposeful in the tempo of our speech and tone because those are the most receptive senses to patients in the virtual environment-

Conduct Practice Sessions and Work on tempo & tone

- Be on the lookout for disinhibition effect….

Structure sessions as they are structured for in-person service delivery- Structure/Boundaries

Build Trust and increase Engagement/Therapeutic Alliance

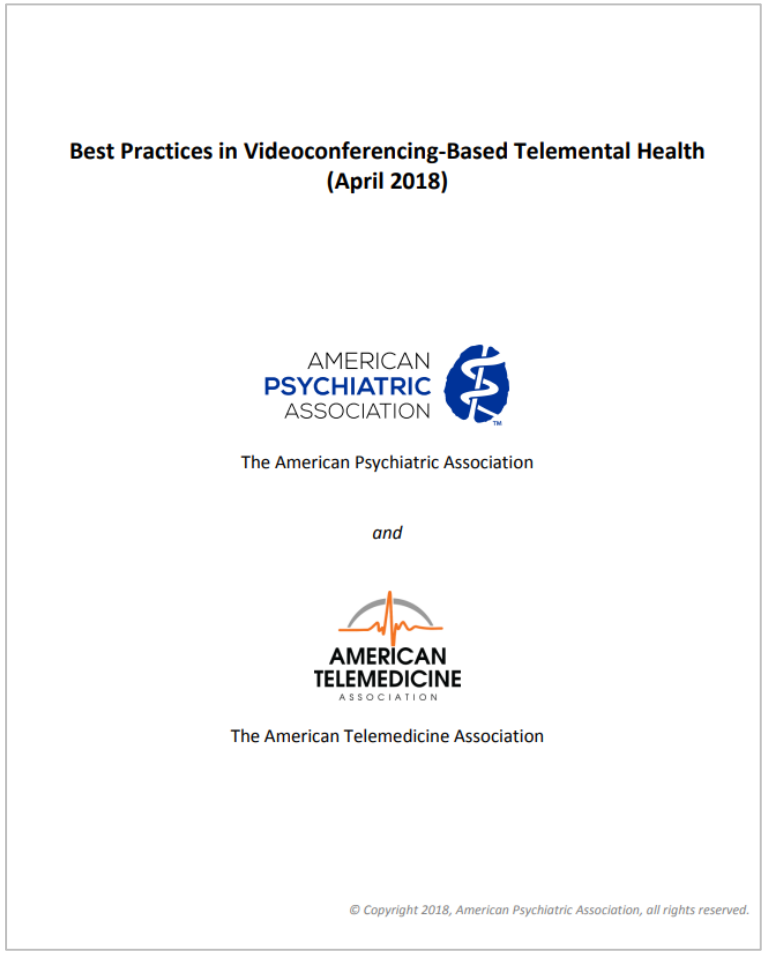
- If a Clinical Supervisor check with supervisee(s) regarding disinhibition effect (being too casual with clients- scheduling appointments outside of typical business hours or while on vacation or in public areas)

Review structure of sessions in supervision sessions

Telebehavioral Health Guidelines

Best Practices Guide in Clinical Videoconferencing in Mental Health

https://www.psychiatry.org/psychiatrists/practice/telepsychiatry/blog/apa-and-ata-release-new-telemental-health-guide



Best Practices in Videoconferencing-Based Telemental Health (April 2018)

AMERICAN PSYCHIATRIC ASSOCIATION

The American Psychiatric Association

and

AMERICAN TELEMEDICINE ASSOCIATION

The American Telemedicine Association

Best Practices in Videoconferencing-Based Telemental Health April 2018

Jay H. Shore, MD, MPH,[1,2] Peter Yellowlees MD, MBBS,[3] Robert Caudill, MD,[4] Barbara Johnston, MSN,[5] Carolyn Turvey, PhD,[6] Matthew Mishkind, PhD,[1] Elizabeth Krupinski, PhD,[7] Kathleen Myers, MD, MPH,[8] Peter Shore, PsyD,[9] Edward Kaftarian, MD,[10] and Donald Hilty, MD[11]

[1]Helen and Arthur E. Johnson Depression Center, the University of Colorado Anschutz Medical Campus, Aurora, Colorado.
[2]Department of Psychiatry, the University of Colorado Anschutz Medical Campus, Aurora, Colorado.
[3]Department of Psychiatry, University of California, Davis, Sacramento, California.
[4]Department of Psychiatry, The University of Louisville School of Medicine, Louisville, Kentucky.
[5]HealthLinkNow, Sacramento, California.
[6]Department of Psychiatry, Carver College of Medicine, The University of Iowa, Iowa City, Iowa.
[7]Department of Radiology and Imaging Sciences, Emory University School of Medicine, Atlanta, Georgia.
[8]Center for Child Health, Behavior, and Development, Seattle Children's Hospital, Seattle, Washington.
[9]Portland Veterans Affairs Health Care System, Portland, Oregon.
[10]Orbit Health Telepsychiatry, Encino, California.
[11]Northern California Veterans Affairs Health Care System, Sacramento, California.

Abstract

Telemental health, in the form of interactive videoconferencing, has become a critical tool in the delivery of mental health care. It has demonstrated the ability to increase access to and quality of care, and in some settings to do so more effectively than treatment delivered in-person. This article updates and consolidates previous guidance developed by The American Telemedicine Association (ATA) and The American Psychiatric Association (APA) on the development, implementation, administration, and provision of telemental health services. The guidance included in this article is intended to assist in the development and delivery of effective and safe telemental health services founded on expert consensus, research evidence, available resources, and patient needs. It is recommended that the material reviewed be contemplated in conjunction with APA and ATA resources, as well as the pertinent literature, for additional details on the topics covered.

Keywords: *telemedicine, telehealth, telemental health, policy*

Introduction

This document represents a collaboration between the American Psychiatric Association (APA) and the American Telemedicine Association (ATA) to create a consolidated update of the previous APA and ATA official documents and resources in telemental health to provide a single guide on best practices in clinical videoconferencing in mental health. The APA is the main professional organization of psychiatrists and trainee psychiatrists in the United States, and the largest psychiatric organization in the world. The ATA, with members from throughout the United States and the world, is the principal organization bringing together telemedicine practitioners, health care institutions, government agencies, vendors, and others involved in providing remote health care using telecommunications.

Telemental health in the form of interactive videoconferencing has become a critical tool in the delivery of mental health care. It has demonstrated its ability to increase access and quality of care, and in some settings to do so more effectively than treatment delivered in-person.

The APA and the ATA have recognized the importance of telemental health with each individual association undertaking efforts to educate and provide guidance to their members in the development, implementation, administration, and provision of telemental health services. It is recommended that this guide be read in conjunction with the other APA and ATA resources that provide more detail.[1–7]

OFFICIAL APA AND ATA GUIDELINES, RESOURCES, AND TELEMENTAL HEALTH TRAININGS

APA	ATA
(1) APA Web-based Telepsychiatry Toolkit (2016)[1]	(4) Practice Guidelines for Telemental Health with Children and Adolescents (2017)[4]
(2) Resource Document on Telepsychiatry and Related Technologies in Clinical Psychiatry, Council on Law and Psychiatry (2014)[8]	(5) Telemental Health Resource Toolbox (2017)[9]
(3) American Psychiatric Association. Telepsychiatry via Videoconferencing. (1998)[3]	(6) Delivering Online Video Based Mental Health Services (2014)[6]
	(7) A Lexicon of Assessment and Outcome Measures for Telemental Health (2013)[10]
	(8) Practice Guidelines for Video-Based Online Mental Health Service (2013)[6]
	(9) Practice Guidelines for Videoconferencing-Based Telemental Health (2009)[7]
	(10) Evidence-Based Practice for Telemental Health (2009)[11]

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Sections in Guide

- legal and regulatory issues
- standard operating procedures
- technical considerations
- clinical considerations

APA & ATA, 2018; Shore et al., 2018

How to do group therapy using telehealth

Group therapists are responding to COVID-19 by rapidly transitioning from in-person to online therapies.

By Martyn Whittingham, PhD, and Jennifer Martin, PhD Date created: April 10, 2020

Related Resources

- Telemental Health Laws App
- Group Circle: Couch to Screen, Online Group Therapy
- American Group Psychotherapy Association

CONTACT APA SERVICES

https://www.apaservices.org/practice/legal/technology/group-therapy-telehealth-covid-19

Session Safety Checklist

- ✓ Orientation
- ✓ Technology Check
- ✓ Phone Number
- ✓ Location
- ✓ ICE

Administrative assistants do safety check-ins for group sessions the day before group

Telebehavioral Health:

- Is equivalent to in-person care
- Research base on mental health services is extensive
- Research base for SUD treatment is growing-OUD treatment
- Patients express satisfaction with it – they like it
- Clinicians may be initially reluctant
- Engagement, Therapeutic Alliance, Presence
- Telepresence
- Telehealth tips can inform practice
- Disinhibition Effect/Boundary Recommendations
- National Guidelines exist
- Resources for training/TA and products are available

Concluding Thoughts…

- If therapists choose not to participate in the new and emerging field of telehealth because of concerns about the therapeutic relationship or their own technology skills, unqualified individuals might emerge to meet the ever-growing demand (Rummel & Joyce, 2010).

  Who do we want doing the work?

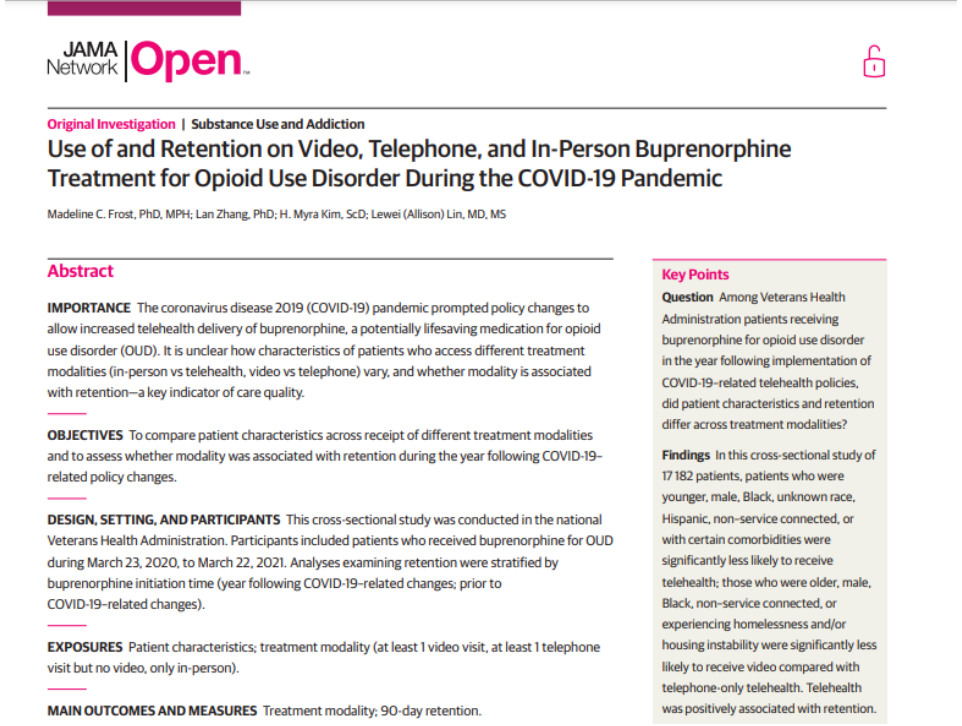
- Even if therapists decide not to offer telehealth services, they need to be equipped to provide information about telehealth services that enables patients to make a well-considered decision about using such services.

  How do I talk with clients who ask about telehealth?

  Do I have a licensed professional to refer them to?

Stoll et al., 2020

Concluding Thoughts…



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Original Investigation | Substance Use and Addiction

Use of and Retention on Video, Telephone, and In-Person Buprenorphine Treatment for Opioid Use Disorder During the COVID-19 Pandemic

Madeline C. Frost, PhD, MPH; Lan Zhang, PhD; H. Myra Kim, ScD; Lewei (Allison) Lin, MD, MS

Abstract

IMPORTANCE The coronavirus disease 2019 (COVID-19) pandemic prompted policy changes to allow increased telehealth delivery of buprenorphine, a potentially lifesaving medication for opioid use disorder (OUD). It is unclear how characteristics of patients who access different treatment modalities (in-person vs telehealth, video vs telephone) vary, and whether modality is associated with retention—a key indicator of care quality.

OBJECTIVES To compare patient characteristics across receipt of different treatment modalities and to assess whether modality was associated with retention during the year following COVID-19–related policy changes.

DESIGN, SETTING, AND PARTICIPANTS This cross-sectional study was conducted in the national Veterans Health Administration. Participants included patients who received buprenorphine for OUD during March 23, 2020, to March 22, 2021. Analyses examining retention were stratified by buprenorphine initiation time (year following COVID-19–related changes; prior to COVID-19–related changes).

EXPOSURES Patient characteristics; treatment modality (at least 1 video visit, at least 1 telephone visit but no video, only in-person).

MAIN OUTCOMES AND MEASURES Treatment modality; 90-day retention.

Key Points

Question Among Veterans Health Administration patients receiving buprenorphine for opioid use disorder in the year following implementation of COVID-19–related telehealth policies, did patient characteristics and retention differ across treatment modalities?

Findings In this cross-sectional study of 17 182 patients, patients who were younger, male, Black, unknown race, Hispanic, non–service connected, or with certain comorbidities were significantly less likely to receive telehealth; those who were older, male, Black, non–service connected, or experiencing homelessness and/or housing instability were significantly less likely to receive video compared with telephone-only telehealth. Telehealth was positively associated with retention.

- VA Study- 17,182 VHA patients Access to BUP video and telephone and patient retention
- Discontinuation or reduction of telehealth availability may disrupt treatment for many patients
- Discontinuation or reduction of telephone-only access may have a negative impact on groups who have had difficulty accessing buprenorphine
- Maintaining video and telephone telehealth modalities and improving access to video telehealth may contribute to improved retention.

Nancy A. Roget, MS, MFT

Maryellen Evers, LCSW

University of Nevada, Reno

CASAT
Center for the Application of Substance Abuse Technologies
UNIVERSITY OF NEVADA, RENO

nroget@casat.org

For additional information, contact

Pacific Southwest ATTC

The Pacific Southwest ATTC, which covers Arizona, California, Hawaii, Nevada, American Samoa, Commonwealth of the Northern Mariana Islands, Federated States of Micronesia, Guam, Republic of the Marshall Islands, and Republic of Palau, is designed to enhance knowledge of and expertise in providing effective substance use disorder treatment and recovery services by disseminating evidence-based clinical and research information. The Pacific Southwest ATTC develops, revises, and distributes curricula and other resources and products on a variety of SUD topics, and forms partnerships with local and regional stakeholders to ensure that the training and technical assistance needs of the Region are identified and met.

The overarching goals of the Pacific Southwest ATTC are to:

- Develop an infrastructure to assess the diverse needs of the Region and promote technology transfer of proven treatment and recovery practices
- Upgrade the standards of professional SUD practice to increase the number, quality, and cultural humility of substance use disorder treatment and recovery practitioners
- Provide stand-alone and sequenced learning events to help practitioners build their skills to promote systems change and accelerate the adoption and implementation of evidence-based practices
- Develop scientifically based substance use disorder curricula and encourage academic institutions to train and educate pre-service students and practitioners.

Pacific Southwest ATTC
UCLA Integrated Substance Abuse Programs
11075 Santa Monica Blvd, Suite 200
Los Angeles, CA 90025
United States

310-267-5408
pacificsouthwest@attcnetwork.org

Pacific Southwest ATTC

Tom Freese

Beth Rutkowski

https://attcnetwork.org/centers/pacific-southwest-attc/home