



# **PRACTICE GUIDELINES FOR VIDEO-BASED ONLINE MENTAL HEALTH SERVICES**

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### **Practice Guidelines For Video-based Online Mental Health Services** (Alphabetical Order)

#### Practice Guidelines Work Group

Chair: **Carolyn Turvey, PhD**, Associate Professor, Department of Psychiatry, University of Iowa, ATA Telemental Health SIG Chair

#### Work Group Members

**Mirean Coleman, LICSW, CT**, Clinical Social Worker, National Association of Social Workers

**Oran Dennison**, Senior Software Architect, Alaska Native Tribal Health Consortium

**Kenneth Drude, PhD**, Psychologist, Board Member, Ohio Board of Psychology

**Mark Goldenson**, CEO, Breakthrough

**Phil Hirsch, PhD**, Chief Clinical Officer, HealthLinkNow

**Bob Jueneman**, Chief Scientist, SpyruS, Inc.

**Greg M. Kramer, JD, PhD**, Clinical Psychologist, National Center for Telehealth and Technology |T2|

**David D. Luxton, PhD**, Research Psychologist, Program Manager Research, Outcomes and Investigations |ROI|, National Center for Telehealth and Technology |T2|

**Marlene M. Maheu**, PhD, TeleMental Health Institute, Inc.

**Tania S. Malik, JD**, Founder and President of COPE Today

**Matt C. Mishkind, PhD**, Research Psychologist, Program Lead, Telehealth Program |THP|, National Center for Telehealth and Technology |T2|, Joint Base Lewis-McChord, Tacoma, WA

**Terry Rabinowitz, MD, DDS**, Professor, Departments of Psychiatry and Family Medicine, University of Vermont College of Medicine, Director, Division of Consultation Psychiatry and Psychosomatic Medicine and Director of Telemedicine, Fletcher Allen Health Care

**Lisa J. Roberts, PhD**, Global Clinical Innovations and Sales Manager, Viterion TeleHealthcare, a business of Bayer Healthcare

**Thomas Sheeran, PhD, ME**, Assistant Professor (Research), Rhode Island Hospital, The Warren Alpert Medical School of Brown University, Adjunct Assistant Professor, Institute of Geriatric Psychiatry, Weill Cornell Medical College

**Jay H. Shore, MD, MPH**, Associate Professor, Department of Psychiatry, School of Medicine, Community and Behavioral Health, Colorado School of Public HealthCenters for American Indian and Alaska Native Health, University of Colorado Anschutz Medical Campus

**Peter Shore, PsyD**, Assistant Professor of Psychiatry, Oregon Health & Science University, Director of Telehealth, VA NW Health Network (VISN 20), Department of Veterans Affairs, Adjunct Assistant Professor, Institute of Geriatric Psychiatry, Weill Cornell Medical College

**Frank van Heeswyk**, CTO & VP Technical Services, Ontario Telehealth Network

**Brian Wregglesworth**, Director of Product Development, Alaska Native Tribal Health Consortium

**Peter Yellowlees, MBBS, MD**, Professor of Psychiatry, UC Davis, Director of the Health, Informatics Graduate Program, UC Davis, Sacramento, CA

**Murray L. Zucker, MD**, Regional Medical Director, San Francisco, Optum

### Other Contributors

**David Kaplan, PhD**, Chief Professional Office, American Counseling Association

**Joel Yager, MD**, Chair, Steering Committee on Practice Guidelines, American Psychiatric Association

### ATA Standards and Guidelines Committee

Chair: **Elizabeth A. Krupinski, PhD**, Professor & Vice Chair of Research, Department of Medical Imaging, University of Arizona

### Standards and Guidelines Committee Members

**Nina Antoniotti, RN, MBA, PhD**, Director of Telehealth, Marshfield Clinic TeleHealth Network

**David Brennan, MSBE**, Director, Telehealth Initiatives, MedStar Health

**Anne Burdick, MD, MPH**, Associate Dean for Telemedicine and Clinical Outreach, Professor of Dermatology, Director, Leprosy Program, University of Miami Miller School of Medicine

**Jerry Cavallerano, PhD, OD**, Staff Optometrist, Assistant to the Director, Joslin Diabetes Center, Beetham Eye Institute

**Cindy K. Leenknecht, MS, APRN-CS, CCRP**, Telehealth Project Coordinator-Montana Pediatric Project, St. Vincent Healthcare/Partners in Health Telemedicine Network

**Helen K. Li, MD**, Adjunct Associate Professor, University of Texas Health Science Center

**Lou Theurer**, Grant Administrator, Burn Telemedicine Program, University of Utah Health Sciences Center

**Jill M. Winters, PhD, RN**, President and Dean, Columbia College of Nursing, Milwaukee, WI

#### **ATA Staff**

**Jordana Bernard, MBA**, Senior Director Program Services

**Gary Capistrant, MA**, Senior Director Public Policy

**Jonathan D. Linkous**, CEO

**Maureen McGrath, MA**, Director Program Services



# Practice Guidelines for Video-Based Online Mental Health Services

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## Preamble

The American Telemedicine Association (ATA), with members from throughout the United States and throughout the world, is the principal organization bringing together telemedicine practitioners, healthcare institutions, vendors and others involved in providing remote healthcare using telecommunications. ATA is a nonprofit organization that seeks to bring together diverse groups from traditional medicine, academia, technology and telecommunications companies, e-health, allied professional and nursing associations, medical societies, government and others to overcome barriers to the advancement of telemedicine through the professional, ethical and equitable improvement in healthcare delivery.

ATA has embarked on an effort to establish practice guidelines and technical standards for telemedicine to help advance the science and to assure the uniform quality of service to patients. These guidelines, based on clinical and empirical experience, are developed by work groups that include experts from the field and other strategic stakeholders and designed to serve as both an operational reference and an educational tool to aid in providing appropriate care for patients. The guidelines and standards generated by ATA undergo a thorough consensus and rigorous review, with final approval by the ATA Board of Directors. Existing products are reviewed and updated periodically.

The practice of medicine is an integration of both the science and art of preventing, diagnosing, and treating diseases. Accordingly, it should be recognized that compliance with these guidelines will not guarantee accurate diagnoses or successful outcomes with respect to the treatment of individual patients, and ATA disclaims any responsibility for such outcomes. These guidelines are provided for informational and educational purposes only and do not set a legal standard of medical or other health care. They are intended to assist practitioners in providing effective and safe medical care that is founded on current information, available resources, and patient needs. The practice guidelines and technical standards recognize that safe and effective practices require specific training, skills, and techniques, as described in each document, and are not a substitute for the independent medical judgment, training, and skill of treating or consulting practitioners.

If circumstances warrant, a practitioner may responsibly pursue a course of action different from the guidelines when, in the reasonable judgment of the practitioner, such action is indicated by the condition of the patient, restrictions or limits on available resources, or advances in information or technology subsequent to publication of the guidelines. Nonetheless, a practitioner who uses an approach that is significantly different from these guidelines is strongly advised to provide documentation, in the patient record, that is adequate to explain the approach pursued.

Likewise, the technical and administrative guidelines in this document do not purport to establish binding legal standards for carrying out telemedicine interactions. Rather, they are

result of the accumulated knowledge and expertise of the ATA work groups and intended to improve the technical quality and reliability of telemedicine encounters. The technical aspects of and administrative procedures for specific telemedicine arrangements may vary depending on the individual circumstances, including location of the parties, resources, and nature of the interaction.

This practice guidelines document focuses on telemental health services delivered in real-time using internet-based videoconferencing technologies through personal computers and mobile devices. These guidelines serve as a companion document to ATA's Practice Guidelines for Videoconferencing-based Telemental Health, a document adopted in 2009 that focuses on real-time videoconferencing-based telemental health services delivered using technologies other than the Internet.

## Scope

The scope of these guidelines covers the provision of mental health services provided by a licensed healthcare professional when using real-time videoconferencing services transmitted via the Internet. Other certified professionals may take guidance from these guidelines, but the current version targets the practice of behavioral health by licensed healthcare professionals. The guidelines pertain to telemental health conducted between two parties, and do not address concerns related to multipoint videoconferencing. These guidelines include telemental health services when the initiating, receiving, or both sites are using a personal computer with a webcam or a mobile communications device (e.g., "smart phone", laptop, or tablet) with two-way camera capability. These guidelines do not address communications between professionals and clients or patients via texting, e-mail, chatting, social network sites, online "coaching" or other non-mental health services.

This document contains requirements, recommendations, or actions that are identified by text containing the keywords "shall," "should," or "may." "Shall" indicates a required action whenever feasible and practical under local conditions. These indications are found in bold throughout the document. "Should" indicates an optimal recommended action that is particularly suitable, without mentioning or excluding others. "May" indicates additional points that may be considered to further optimize the telemental healthcare process.

## Introduction

Telemental health is one of the most active telemedicine applications rendered in the United States. Telemental health is an intentionally broad term referring to the provision of mental health and substance abuse services from a distance. Mental health is particularly suited to the use of advanced communication technologies and the Internet for delivery of care. By using advanced communication technologies, mental health professionals are able to widen their reach to patients in a cost-effective manner, ameliorating the mal-distribution of specialty care.

Establishing guidelines for telemental health improves clinical outcomes and promotes informed and reasonable patient expectations. ATA has developed core standards for telemedicine operations that provide overarching guidance for clinical, technical and administrative standards (<http://www.americantelemed.org/practice/standards/ata-standards-guidelines/core-standards-for-telemedicine-operations>). (1) This document provides further guidance on the clinical, technical, administrative as well as ethical issues as related to electronic communication between professionals and patients using advances in internet-based videoconferencing technologies and the resulting treatment models. These guidelines also serve as a companion document to ATA's Practice Guidelines for Videoconferencing-based Telemental Health, a document that focuses on real-time, videoconferencing-based telemental health services delivered using methods other than the Internet (2,3) and applies to the groups and services described therein.

Other professional organizations in the US and abroad have published guidelines for the provision of mental healthcare utilizing the desktop and mobile internet-based communication technologies. (4-7) When guidelines, position statements, or standards from any professional organization or society exist, mental health professionals should also review these documents and, as appropriate, incorporate them into practice.

### **Internet-based Telemental Health Models of Care Today**

Today, mental health professionals are using inexpensive technologies available through the proliferation of personal computers, the Internet, mobile devices and videoconferencing software to provide mental health services. For example, many mental health professionals are using widely available, commercial software downloaded from the Internet to provide care directly to a patient's home or other non-institutional setting. Internet-based web sites can serve as a conduit or portal for mental health professionals and patients seeking treatment online. Mental health professionals can sign up with one or more web-based companies and provide a professional profile that can be viewed online by prospective patients. Patients find such sites by searching online or through word of mouth. In both of these models of care, telemental health services are delivered directly to the patient. Thus, methods to ensure patient safety and privacy as well as identity verification of both professionals and patients can be implemented.

In other scenarios, mental health services are outsourced to companies who contract with hospitals or other institutions in need of such resources. In turn, some companies also contract with outside professionals to provide telemental healthcare using technology maintained and provided by the company.

This is a rapidly growing and evolving field and the risks and benefits of telemental health services delivered using videoconferencing technologies are not widely discussed or addressed in formal training of mental health practitioners. Therefore, thoughtful elucidation of the key

issues and the potential solutions are needed to better inform those who want to practice responsibly.

## **Practice Guidelines for Video-based Online Mental Health Services**

### **a. Clinical Guidelines**

#### **A. Professional and Patient Identity and Location**

At the beginning of a video-based mental health treatment (i.e., not at every subsequent encounter unless circumstances warrant re-verification) with a patient, the following essential information shall be verified:

##### **1. Provider and Patient Identity Verification**

The name and credentials of the professional and the name of the patient shall be verified. For services with the patient at a remote healthcare institution, the verification of both professional and patient may occur at the host clinic. When providing professional services to a patient in a setting without an immediately available mental health professional, the telehealth provider shall provide the patient (or legal representative) with his or her qualifications, licensure information, and, when applicable, registration number and where the patient can verify this information. Patients shall provide their full name. Professionals may ask patients to verify their identity more formally by showing a government issued photo ID on the video screen or by using a smart card.

##### **2. Provider and Patient Location Documentation**

The location(s) where the patient will be receiving services by videoconferencing shall be confirmed and documented by the provider. In addition, the location of the provider may need to be documented, especially in cases where such documentation is needed for the appropriate payment of services. However, it is not necessary for the mental health provider to reveal their specific location to the patient, especially if the provider is located at home at the time of the service.

Verification of provider and patient location is critical for four key reasons:

- a.** The professional shall comply with the relevant licensing laws in the jurisdiction where the provider is physically located when providing the care and where the patient is located when receiving care. Note, in the United States the jurisdictional

licensure requirement is usually tied to where the patient is physically located when he or she is receiving the care, not where the patient lives. (8)

- b. The emergency management protocol is entirely dependent upon where the patient receives services. Once again, where the patient resides is only relevant if that is also where he or she is receiving care.
- c. Mandatory reporting and related ethical requirements such as duty to notify are tied to the jurisdiction where the patient is receiving services.
- d. In some cases, provider payment amounts are tied to where the provider and patient are located.

When patients are receiving telemental health services at an accredited health center, the emergency management and reporting protocols shall be coordinated with the remote health center in accordance with applicable jurisdictional law and licensing requirements.

In instances where the mental health professional is providing services to patients in settings without clinical staff immediately available and/or to patients that change locations over the course of treatment, they should discuss the importance of consistency in where the patient chooses to receive care as it is tied to emergency management. Though patients who change locations may likely remain in the same state, they may change cities, which will impact emergency management protocols related to police intervention and location of local emergency rooms willing to evaluate potentially lethal psychiatric issues.

### **3. Contact Information Verification for Professional and Patient**

The contact information for both provider and patient shall be verified. This shall include gathering telephone and mail contact information for both the provider and patient and may also include contact information through electronic sources such as email.

### **4. Verification of Expectations Regarding Contact Between Sessions**

Reasonable expectations about contact between sessions shall be discussed and verified with the patient. At the start of the treatment, the patient and provider should discuss whether or not the provider will be available for phone or electronic contact between sessions and the conditions under which such contact is appropriate. The provider should provide a specific time frame for expected response between session contacts. This should also include a discussion of emergency management between sessions.

## **b. Patient Appropriateness for Videoconferencing-based Telemental Health**

To date, no studies have identified any patient subgroup that does not benefit from, or is harmed by, mental healthcare provided through remote videoconferencing. Recent large

randomized controlled trials demonstrate effectiveness of telemental health with many smaller trials also supporting this conclusion. (9-11) Regarding specific subgroups, such as patients with psychotic or phobic disorders, one review by Sharp et al. (12), found no evidence for inferiority of videoconferencing telemental health for patients with psychosis. Dongier et al. (13) compared in-person versus videoconferencing interviews in psychotic patients and concluded that even those with delusions pertaining to the TV, responded appropriately to videoconferencing and did not incorporate their experience into their delusional system. Bouchard et al. (14) found videoconferencing treatment effective for agoraphobia and panic disorder.

### **Appropriateness of Videoconferencing in Settings where Professional Staff are not Immediately Available**

Mental health professionals should consider the patients' expectations and level of comfort with home-based care to determine the appropriateness of using videoconferencing in this setting. (15) Provision of telemental health services in professionally unsupervised settings requires that the patient take a more active and cooperative role in the treatment process than in in-person settings. (15,16) Determining whether a patient can handle such demands may be more dependent on the patient's organizational and cognitive capacities, than on diagnosis.

When the patient is located outside an institutional location, the patient (guardian or caretaker) is responsible for setting up the videoconferencing system at his or her site, maintaining the appropriate computer settings, and establishing a private space. In addition, even with establishment of a community based emergency management protocol, such as that described in the Emergency Management section of this document, patient cooperation is critical for effective safety management in settings where a professional is not immediately available.

Determining patient appropriateness for videoconferencing-based telemental health services should, in addition to considering the patient's ability to potentially benefit from them, rely on the professional's assessment of the patient's ability to arrange an appropriate setting for receiving videoconferencing services and the patient's continued cooperativeness regarding managing safety issues. Professionals should also consider such things as patient's cognitive capacity, history regarding cooperativeness with treatment professionals, current and past difficulties with substance abuse, and history of violence or self-injurious behavior.

Professionals shall consider geographic distance to the nearest emergency medical facility, efficacy of patient's support system, current medical status, and patient's general level of competence around technology when determining patient appropriateness for videoconferencing.

Professionals should evaluate the potential for risk factors or problems at the start of providing videoconferencing services in settings where a professional is not immediately available. In addition, evaluation of appropriateness of videoconferencing care should continue throughout the treatment including monitoring of symptoms and patient cooperativeness in assuming the

responsibilities inherent in remote care. The consent process shall include discussion of conditions of participation around session management so that if a professional decides a patient can no longer be managed through distance technology, the patient is aware that services may be discontinued if no longer appropriate.

### **c. Informed Consent**

A thorough informed consent at the start of services shall be performed. The consent should be conducted with the patient in real-time. Local, regional 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.

The consent should include all information contained in the consent process for in-person care including discussion of the structure and timing of services, record keeping, scheduling, privacy, potential risks, confidentiality, mandatory reporting, and billing. In addition, the informed consent process should include information specific to the nature of videoconferencing as described below. The information shall be provided in language that can be easily understood by the patient. This is particularly important when discussing technical issues like encryption or the potential for technical failure.

Key topics that shall be reviewed include: confidentiality and the limits to confidentiality in electronic communication; an agreed upon emergency plan, particularly for patients in settings without clinical staff immediately available; process by which patient information will be documented and stored; the potential for technical failure, procedures for coordination of care with other professionals; a protocol for contact between sessions; and conditions under which telemental health services may be terminated and a referral made to in-person care.

### **d. Physical Environment**

Both the professional and the patient's room/environment should aim to provide comparable professional specifications of a standard services room. Efforts shall be made to ensure privacy so clinical discussion cannot be overheard by others outside of the room where the service is provided. If other people are in either the patient or the professional's room, both the professional and patient shall be made aware of the other person and agree to their presence. Seating and lighting should be tailored to allow maximum comfort to the participants. Both professional and patient should maximize clarity and visibility of the person at the other end of the video services. For example, patients receiving care in non-traditional settings should be informed of the importance of reducing light from windows or light emanating from behind them. Both provider and patient cameras should be on a secure, stable platform to avoid wobbling and shaking during the videoconferencing session. 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.

## **e. Communication and Collaboration with the Patient’s Treatment Team**

Professionals shall acknowledge that optimal clinical management of patients depends on coordination of care between a multidisciplinary treatment team. This shall be discussed with all patients. However, patients may have specific privacy concerns about release of information about mental health treatment even to other health professionals providing services to them and these concerns shall be respected.

For patients who agree to coordination of care, telemental health professionals should arrange for appropriate and regular private communication with other professionals involved in care for the patient. Moreover, professionals conducting telemental health to patients in settings without clinical staff immediately available are encouraged to develop collaborative relationships with local community professionals, such as a patient’s local primary care provider, as these professionals may be invaluable in case of emergencies.

## **f. Emergency Management**

Providing mental healthcare to patients using videoconferencing involves particular considerations regarding patient safety. There are also additional considerations when providing care to patients in settings without staff immediately available. (17) Below are issues that should be considered in both types of practice followed by separate sections for emergency management for supervised and unsupervised settings.

### **1. Education and Training**

Professionals should review their discipline's definitions of "competence" prior to initiating telemental health patient care to assure that they maintain both technical and clinical competence for the delivery of care in this manner. Professionals shall have completed basic education and training in suicide prevention. The depth of training and the definition of “basic” are solely at the professional’s discretion.

### **2. Jurisdictional Mental Health Involuntary Hospitalization Laws**

Each jurisdiction has its own involuntary hospitalization and duty-to-notify laws outlining criteria and detainment conditions. Professionals shall know and abide by the laws in the jurisdiction where the patient is receiving services.

### **3. Patient Safety when Providing Services in a Setting with Immediately Available Professionals**

When a professional sees a patient via personal computer and/or mobile device outside of the patient's home (e.g., local clinic, community-based outpatient clinic, school site, library) or other facility where dedicated staff may be present, it may be important that the professional become familiar with the facility's emergency procedures. In some cases, the facility will not have procedures in place. In such cases, the professional should coordinate with the distant site clinic to establish basic procedures. The basic procedures may include: 1) identifying local emergency resources and phone numbers; 2) becoming familiar with location of nearest hospital emergency room capable of managing psychiatric emergencies; and 3) having patient's family / support contact information. The professional may also learn the chosen emergency response system's average response time (30 minutes vs. 5 hours) and the contact information for other local professional associations, such as the city, county or state, provincial or other regional professional association(s) in case a local referral is needed to follow-up with a local professional.

#### **4. Patient Safety when providing Services in a Setting without Immediately Available Professional Staff**

For treatment occurring where the patient is in a setting without clinical staff, the professional may request the contact information of a family or community member who could be called upon for support in the case of an emergency. This person will be called "the Patient Support Person" an individual selected by the patient. In the case of an emergency, the professional may contact the Patient Support Person to request assistance in evaluating the nature of emergency and/or initiating 9-1-1 from the patient's home telephone. (17).

#### **5. Patient Support Person and Uncooperative Patients**

It is possible that a patient will not cooperate in his or her own emergency management, which underlies the practice of involuntary hospitalization in mental healthcare. Professionals should be prepared for this as well as the possibility that Patient Support Persons also may not cooperate if the patients themselves are adamant that they do not want to seek emergency care. Therefore, any emergency plan shall include local emergency personnel and knowledge of available resources in case of involuntary hospitalization.

#### **6. Transportation**

As videoconferencing-based telemental health has developed, in part, to increase access to patients in geographically remote areas, it is expected that there may be barriers to transportation to local mental health services. In light of this, the professional shall know any limitations the patient has in terms of self-transporting and/or access to transportation. Strategies to overcome these limitations in light of an emergency shall

be developed prior to starting treatment for patients in settings without staff immediately available.

In the event of a behavioral and/or medical emergency, the patient's Patient Support Person should discuss with emergency personnel whether they should transport the patient.

## **7. Local Emergency Personnel**

In providing care to patients in settings without professional staff immediately available, determining distance between local emergency personnel in the patient's community and the patient's location can shape the professional's decision process in determining appropriate actions.

Professionals shall acquire telephone numbers for local resources in the patient's community. At the beginning of each session, the professional shall have the patient's local emergency personnel telephone contact information readily available. Prior to each session, the provider shall also determine the patient's location and whether there have been any changes to the patient's personal support system or the emergency management protocol.

## **g. Medical Issues**

In case of medication side effects, elevation in symptoms, and/or issues related to medication non-compliance, the professional should be familiar with the patient's prescription and medication dispensation options.

Likewise, when prescribing, the clinician should be aware of the availability of specific medications in the geographic location of the patient and that should inform prescribing choices. Patients receiving treatment through telemental health services should have an active relationship with a prescribing professional in their physical vicinity.

If services are provided in a setting where a professional is not immediately available, the patient may be at risk if there is an acute change in his or her medical condition. The professional should be familiar with whom the patient is receiving medical services.

## **h. Referral Resources**

The professional shall be familiar with local in-person mental health resources should the professional exercise clinical judgment to make a referral for additional mental health or other appropriate services.

## **i. Community and Cultural Competency**

Professionals shall be culturally competent to deliver services to the populations that they serve. Examples of factors to consider include awareness of the client's language, ethnicity, race, age, gender, sexual orientation, geographical location, and socioeconomic and cultural backgrounds. Mental health professionals may use online resources to learn of the community where the patient resides including any recent significant events and cultural mores of that community.

## **b. Technical Guidelines**

Videoconferencing can be characterized by key features: the videoconferencing application, device characteristics including their mobility, network or connectivity features, and how privacy and security are maintained. The more recent use of desktop and mobile devices requires consideration of each of these.

### **A. Videoconferencing Application**

All efforts **shall** be taken to use video conferencing applications that have been vetted and have the appropriate verification, confidentiality, and security parameters necessary to be properly utilized for this purpose.

Video software platforms should not be used when they include social media functions that notify users when anyone on a contact list logs on. Many free video chat platforms include such functionality as a "default setting," which should be changed before providing video-based clinical services. These platforms may also include the capability to create a video chat "Room" that allows others to enter at will. This type of functionality should be disabled.

### **B. Device Characteristics**

When using a personal computer, both the professional device for video-transmission and the patient's site should, when feasible, use professional grade or high quality cameras and audio equipment now widely available for personal computers. Personal computers shall have up-to-date antivirus software and a personal firewall installed. Providers should ensure their personal computer or mobile device has the latest security patches and updates applied to the operating system and third party applications that may be utilized for this purpose.

Provider organizations should utilize mobile device management software to provide consistent oversight of applications, device and data configuration and security of the mobile devices used within the organization.

In the event of a technology breakdown, causing a disruption of the session, the professional shall have a backup plan in place. The plan shall be communicated to the patient prior to

commencement of treatment and may also be included in the general emergency management protocol. The professional may review the technology backup plan on a routine basis.

The plan may include calling the patient via telephone and attempting to troubleshoot the issue together. The plan may also include providing the patient with access to other mental healthcare. If the technical issue cannot be resolved, the professional may elect to complete the session via a voice-based telecommunication system.

Screen-in-screen options, also known as picture-in-a-picture or "PIP" may also be used when feasible and are widely available in professional grade desktop videoconferencing software packages. Professionals and patients may opt to use cameras that allow for pan, tilt, and zoom for maximal flexibility in viewing the remote room.

### **C. Connectivity**

Telemental healthcare services provided through personal computers or mobile devices that use internet-based videoconferencing software programs should provide such services at a bandwidth of 384 Kbps or higher in each of the downlink and uplink directions. Such services should provide a minimum of 640 X 360 resolution at 30 frames per second. Because different technologies provide different video quality results at the same bandwidth, each end point shall use bandwidth sufficient to achieve at least the minimum quality shown above during normal operation.

Where practical, providers may recommend preferred video conferencing software and/or video and audio hardware to the patient, as well as providing any relevant software and/or hardware configuration considerations.

The provider and/or patient may use link test tools (e.g., bandwidth test) to pre-test the connection before starting their session to ensure the link has sufficient quality to support the session.

Where possible, each party should use the most reliable connection method to access the Internet. Where wired connections are available (e.g., Ethernet), they should be used.

The videoconference software should be able to adapt to changing bandwidth environments without losing the connection.

### **D. Privacy**

The videoconference software should be capable of blocking the provider's caller ID at the request of the provider.

All efforts shall be taken to make audio and video transmission secure by using point-to-point encryption that meets recognized standards. Currently, FIPS 140-2, known as the Federal Information Processing Standard, is the US Government security standard used to accredit encryption standards of software and lists encryption such as AES (Advanced Encryption Standard) as providing acceptable levels of security. Providers should familiarize themselves with the technologies available regarding computer and mobile device security, and should help educate the patient.

When the patient and/or provider use a mobile device, special attention should be placed on the relative privacy of information being communicated over such technology.

Providers should ensure access to any patient contact information stored on mobile devices is adequately restricted.

Mobile devices shall require a passphrase or equivalent security feature before the device can be accessed. If multi-factor authentication is available, it should be used.

Mobile devices should be configured to utilize an inactivity timeout function that requires a passphrase or re-authentication to access the device after the timeout threshold has been exceeded. This timeout should not exceed 15 minutes.

Mobile devices should be kept in the possession of the provider when traveling or in an uncontrolled environment. Unauthorized persons shall not be allowed access to sensitive information stored on the device, or use the device to access sensitive applications or network resources.

Providers should have the capability to remotely disable or wipe their mobile device in the event it is lost or stolen.

Videoconference software shall not allow multiple concurrent sessions to be opened by a single user. Should a second session attempt to be opened, the system shall either log off the first session or block the second session from being opened.

Session logs stored in 3<sup>rd</sup> party locations (i.e., not on patients' or providers' access device) shall be secure. Access to these session logs shall only be granted to authorized users.

Protected health information and other confidential data shall only be backed up to or stored on secure data storage locations. Cloud services unable to achieve compliance shall not be used for PHI or confidential data.

Professionals may monitor whether any of the videoconference transmission data is intentionally or inadvertently stored on the patient or professional's computer hard drive. If so, the hard drive of the provider should use whole disk encryption to the FIPS standard to ensure security and privacy. Pre-boot authentication should also be used. Professionals should

educate patients about the potential for inadvertently stored data and patient information and provide guidance on how best to protect privacy.

Professionals and patients shall discuss any intention to record services and how this information is to be stored and how privacy will be protected. Recordings should be encrypted for maximum security. Access to the recordings shall only be granted to authorized users and should be streamed to protect from accidental or unauthorized file sharing and/or transfer. The professional may also want to discuss his or her policy with regards to the patient sharing portions of this information with the general public. Written agreements pertaining to this issue can protect both the patient and the professional.

If services are recorded, the recordings shall be stored in a secured location. Access to the recordings shall only be granted to authorized users.

## **c. Administrative Guidelines**

### **A. Qualifications and Training of Professionals**

In addition to clinical, legal, and ethical training required for licensure for in-person services, professionals shall make use of the widely available resources providing education of proper conduct of videoconferencing to both professionally supervised settings and those without readily available clinical staff. Mental health professionals shall also determine whether there are site-specific credentialing requirements where the patient is located.

Professionals shall conduct care consistent with the jurisdictional licensing laws and rules for their profession in both the jurisdiction in which they are practicing as well as the jurisdiction where the patient is receiving care.

Licensed mental health professionals should contact their licensing board to review their practice before starting any provision of telemental health services. The professional should also contact the licensing board relevant to the patient's location during treatment, to determine whether or not the services provided fall under their jurisdiction and what, if any, restrictions exist.

### **B. Documentation and Record Keeping**

Professionals shall maintain an electronic record for each patient for whom they provide remote services. Such a record should include an assessment, client identification information, contact information, history, treatment plan, informed consent, and information about fees and billing.

A treatment plan based upon an assessment of the patient's needs should be developed and documented. The plan should meet the professional's discipline standards and guidelines and include a description of what services are to be provided and the goals for services.

Services should be accurately documented as remote services and include dates, duration and type of service(s) provided.

Documentation shall comply with applicable jurisdictional and federal laws and regulations. Policies for record retention and disposal should be in place.

All communications with the patient (e.g., written, audiovisual, or verbal) shall be documented in the patient's unique record and all such records shall be stored in compliance with relevant government regulations, such as HIPAA and HI-TECH within the US. (15)

Requests for access to such records shall require written authorization from the patient with a clear indication of what types of data and which information is to be released. If professionals are storing the audiovisual data from the sessions, these cannot be released unless the patient authorization indicates specifically that this is to be released. Upon direction and written approval by the patient, the patient's record shall be made available to another provider that is caring for the patient.

All billing and administrative data related to the patient shall be secured to protect confidentiality. Specifically, all records are confidential; HIPAA regulations regarding psychotherapy notes are adhered to; and only relevant information is released for reimbursement purposes as outlined by HIPAA in the US.

### **C. Payment and Billing**

Prior to the commencement of initial services, the patient shall be made aware of any and all financial charges that may arise from the services to be provided. Arrangement for payment should be completed prior to the commencement of services.

## **Appendix**

### **References**

1. Core Standards for Telemedicine Operations. Washington DC: American Telemedicine Association, 2007. <http://www.americantelemed.org/docs/default-source/standards/core-standards-for-telemedicine-operations.pdf?sfvrsn=4>
2. Grady B, Myers KM, Nelson EL, Belz N, Bennett L, Carnahan L, et al. Evidence-based practice for telemental health. *Telemed J E Health*. 2011;17(2):131-48.

3. Yellowlees P, Shore J, Roberts L. Practice guidelines for videoconferencing-based telemental health - October 2009. *Telemed J E Health*. 2010;16(10):1074-89.
4. APA Statement on Services by Telephone, Teleconferencing, and Internet: A statement by the Ethics Committee of the American Psychological Association 1997 December 30, 2004: Available from: <http://www.apa.org/ethics/education/telephone-statement.aspx>.
5. Australian Psychological Society. Guidelines for providing psychological services and products using the internet and telecommunications technologies. 2011: Available from: <http://aaswsocialmedia.wikispaces.com/file/view/EG-Internet.pdf>
6. Standards for Technology and Social Work Practice. National Association of Social Workers and ASWB Standards for Technology and Social Work Practice, 2005. <http://www.socialworkers.org/practice/standards/naswtechnologystandards.pdf>
7. Ohio Psychological Association. Telepsychology Guidelines, 2010: Available from: <http://www.ohpsych.org/psychologists/files/2011/06/OPATelepsychologyGuidelines41710.pdf>.
8. Hyler SE, Gangure DP. Legal and ethical challenges in telepsychiatry. *J Psychiatr Pract*. 2004;10(4):272-6.
9. Day SX, Schneider PL. Psychotherapy using distance technology: A comparison of face-to-face, video, and audio treatment. *J Couns Psychol*. 2002;49(4):499-503.
10. O'Reilly R, Bishop J, Maddox K, Hutchinson L, Fisman M, Takhar J. Is telepsychiatry equivalent to face-to-face psychiatry? Results from a randomized controlled equivalence trial. *Psychiatr Serv*. 2007;58(6):836-43.
11. Ruskin PE, Silver-Aylaian M, Kling MA, Reed SA, Bradham DD, Hebel JR, et al. Treatment outcomes in depression: comparison of remote treatment through telepsychiatry to in-person treatment. *The American journal of psychiatry*. 2004;161(8):1471-6.
12. Sharp IR, Kobak KA, Osman DA. The use of videoconferencing with patients with psychosis: a review of the literature. *Annals of general psychiatry*. 2011;10(1):14.
13. Dongier M, Tempier R, Lalinec-Michaud M, Meunier D. Telepsychiatry: psychiatric consultation through two-way television. A controlled study. *Can J Psychiatry*. 1986;31(1):32-4.
14. Bouchard S, Paquin B, Payeur R, Allard M, Rivard V, Fournier T, et al. Delivering cognitive-behavior therapy for panic disorder with agoraphobia in videoconference. *Telemed J E Health*. 2004;10(1):13-25.
15. Luxton DD, O'Brien K, McCann RA, Mishkind MC. Home-based telemental healthcare safety planning: what you need to know. *Telemed J E Health*. 2012;18(8):629-33.
16. Luxton DD, Sirotnin AP, Mishkind MC. Safety of telemental healthcare delivered to clinically unsupervised settings: a systematic review. *Telemed J E Health*. 2010;16(6):705-11.
17. Shore P. Home-Based Telemental Health (HBTMH) Standard Operating Procedures Manual. 2011.