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Resource Document on Best Practices in Synchronous Videoconferencing-Based Telemental Health

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Abstract

Background: *This document represents an updated 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 clinical best practices for providing mental health services through synchronous videoconference.*
Methods: *A joint writing committee drawn from the APA Committee on Telepsychiatry and the ATA TMH Special Interest Group (TMH SIG). was convened to draft and finalize the guidelines. This document draws directly from the 2018 APA/ATA guide and the ATA s previous guidelines, selecting from key statements/guidelines, consolidating them across documents, and then updating them where indicated. Guideline approval was provided following internal review by the APA, the ATA, the Board of Directors of the ATA, and the Joint Reference Committee of the APA.*
Results: *The guidelines contain requirements, recommendations, and actions that are identified by text containing the keywords "shall," "should," or "may."*
Conclusions: *Compliance with these recommendations will not guarantee accurate diagnoses or successful outcomes. The purpose of this guide is to assist providers in providing effective and safe medical care founded on expert consensus, research evidence, available resources, and patient needs.*

Keywords: *mental health, best practices, synchronous telehealth*

Introduction

This document represents an updated 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 (TMH), to provide a single guide on clinical best practices for providing mental health services through synchronous videoconference. 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 represents a broad and inclusive member network of leading health care delivery systems, academic institutions, and technology solution providers and payers, as well as partner organizations and alliances, working to advance industry adoption of telehealth, promote responsible policy, advocate

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for government and market normalization, and provide education and resources to help integrate virtual care into emerging value-based delivery models.

TMH in the form of interactive synchronous videoconferencing has long been 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. COVID-19 triggered vast and immediate changes in health care. Since TMH was already an identified standard of care with incorporated best practices, it was well positioned to maintain delivery and/or continuity of care, while other sectors saw significant drops in patient encounters. For many, the rapid transition to all virtual care and the gradual move to hybrid TMH and same-location services allowed the continued delivery of mental health care that is both patient and provider centric. The 2018 guide was critical to the ongoing development of TMH.[1]

Health care, consumer, and technology trends have consistently promoted and supported increased flexibility in how, when, and where mental health care is delivered. As a seminal event, COVID-19 highlighted and forced a rapid response to accelerate these trends. The APA and ATA have monitored and recognized the dramatic shifts in how mental health care has been delivered and the increased importance of TMH within each individual association undertaking efforts to educate and provide guidance to their members in the development, implementation, administration, and provision of TMH services. It is recommended that this guide be read in conjunction with other APA and ATA resources, some examples of which are listed below in Table 1. It is important to note, however, that the resources listed in this study were published before the COVID-19 public health emergency (PHE) and, as such, may not reflect current trends in TMH practice.

Table 1. American Psychiatric Association and American Telemedicine Association Guidelines, Resources, and Telemental Health Trainings (See Appendix A1 for Citations)

APA	ATA
1. APA Web-Based Telepsychiatry Toolkit (2016) 2. Resource Document on Telepsychiatry and Related Technologies in Clinical Psychiatry, Council on Law and Psychiatry (2014)	3. Practice Guidelines for Telemental Health with Children and Adolescents (2017) 4. Practice Guidelines for Video-Based Online Mental Health Services (2013) 5. Practice Guidelines for Videoconferencing-Based Telemental Health (2009) 6. Evidence-Based Practice for Telemental Health (2009)
7. Best Practices in Videoconferencing-Based Telemental Health (2018)	

APA, American Psychiatric Association; ATA, American Telemedicine Association.

These guidelines focus on TMH, defined as interactive, synchronous, videoconferencing-based mental health services, as well as hybrid care, which uses TMH in concert with clinically appropriate in-person services. The use of other technologies, such as virtual reality, electronic mail, electronic health records, telephony, remote monitoring devices, chat rooms, or social networks, is not a focus of this document, except where these technologies interface with videoconferencing services. Traditionally, these guidelines have aimed to help members with clinical, technical, and administrative issues related to patient care, but now that technology plays a more central role, attending to professional development and well-being is key—in line with the shift from the triple to quadruple aim.

The document was created by a joint writing committee drawn from the APA Committee on Telepsychiatry and the ATA TMH Special Interest Group (TMH SIG). This document draws directly from the 2018 APA/ATA[1] guide and the ATA's previous guidelines,[2–4] selecting from key statements/guidelines, consolidating them across documents, and then updating them where indicated. Approval of this publication has been given, following internal review by the APA, the ATA, the Board of Directors of the ATA, and the Joint Reference Committee of the APA.

The reference list includes several detailed reviews providing justification and documentation of the scientific evidence supporting TMH (see Appendices 1, 2, and 3). Following ATA guideline writing convention, this document contains requirements, recommendations, and actions that are identified by text containing the keywords "shall," "should," or "may." "Shall" indicates that it is required whenever feasible and practical under local conditions. "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 TMH care process.

It should be recognized that compliance with these recommendations will not guarantee accurate diagnoses or successful outcomes. The purpose of this guide is to assist providers and administrators in providing effective and safe medical care founded on expert consensus, research evidence, available resources, and patient needs.

This document is not meant to establish a legal standard of care nor is it meant to guide legislative or regulatory policy discussions.

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Administrative Considerations

PROGRAM DEVELOPMENT

Providers or organizations delivering mental health services *should* conduct a telehealth needs assessment before initiating these 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. Given recent experiences with TMH care, including modifications to lists of reimbursable services and providers, allowable technologies, geographical restrictions, and licensure limitations, a needs assessment *should* also include an understanding of patient and staff experiences and preferences for TMH, in-person care, or a hybrid of both types of care. A needs assessment is part of broader implementation science and effectiveness approaches in which research and evaluation focus on outcomes based on acceptability, adoption, appropriateness, feasibility, fidelity, cost, penetration, and sustainability.

LEGAL AND REGULATORY ISSUES

Local, state, and federal regulations around licensure and malpractice, scope of practice, prescribing, informed consent, and billing and reimbursement have been modified recently to allow additional flexibilities, to deliver TMH on a mass scale. Providers and administrators of TMH or hybrid care *shall* stay current on legal and regulatory issues, as at the end of the COVID-19 PHE, some may want to return to pre-pandemic enforcement, others will remain flexible, and still others will undergo additional permanent changes. TMH regulations are rapidly changing at both the federal and state levels and can lead to changes in practice management.

Licensure and malpractice. Health care services have been defined as delivered in the state where the patient is located. Providers of TMH 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 TMH session and *shall* have appropriate malpractice coverage.

Providers *shall* conduct their own due diligence to determine the type of licensure required and ensure they are compliant with state licensing board regulations. If providing care within a federal health care system (e.g., Department of Veterans Affairs, Department of Defense, Indian Health Service), providers *shall* follow the specific organization guidelines around licensure, which may allow for single-state licensure across multiple jurisdictions. In recent years, and as accelerated by the pandemic, there has been an increased focus on streamlining licensure for practice across state lines. Providers *may* utilize interstate licensure compacts or special telemedicine licensures offered by certain states, provided they comply with all individual state licensure and program requirements.

Providers issued a professional license from more than one state *shall* consider the regulations from each active license when providing mental health services. When practicing in any jurisdiction, providers *should* consider any other law and regulation that might pertain to services they are providing beyond licensure law.

Scope of practice. Providers or organizations offering TMH services *shall* ensure that the standard of care delivered through telemedicine is equivalent to in-person care. Persons engaged in TMH services *shall* be aware of their professional organization's positions on TMH and incorporate the professional association standards and clinical practice guidelines whenever possible. Providers in practice and trainees *should* stay current with evolving technologies, TMH research findings, and policies. Providers and administrators *should* be aware of requirements such as changes to scheduling, which are necessitated when providing hybrid care.

Prescribing. Providers *shall* be aware of both federal and state guidelines that address 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. Providers *should* anticipate future regulatory changes and ensure compliance.

Informed consent. Local, state, and national laws regarding verbal or written consent *shall* be followed. If written consent is required, then electronic signatures may be used, assuming they are allowed in the relevant jurisdiction. If the patient is unable to consent due to an emergency situation or to provide written consent due to technology limitations, providers and administrators *shall* follow applicable laws regarding implied consent. The provider *shall* document the provision of consent in the medical record. Providers and administrators *should* consider modifying informed consent for hybrid care.

Billing and reimbursement. The patient *shall* be made aware of any and all financial charges that may arise from the services to be provided before the commencement of initial services. Appropriate documentation and coding *shall* be

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undertaken, specifying when services are rendered through TMH. Providers and administrators *should* establish clear roles and boundaries for dealing with patient billing issues to include informing patients that the service provider may not be able to answer insurance coverage questions. Providers and administrators *should* stay current on reimbursement trends of government, commercial, and employer-sponsored insurers, as related to service codes, location of care, and type of technology, as well as any potential concern related to hybrid care. Administrators *should* consider tracking and sharing utilization and outcomes data to inform regulatory changes and ensure oversight against fraud, waste, and abuse.

Patient education. Administrators and providers *should* provide patients, and caregivers as necessary, with materials, including videos and fact sheets, to ensure proper understanding of TMH and related procedures. Patients *should* also be provided with the opportunity to participate in a "pre-session," as needed, to confirm proper bandwidth and setup and to be able to practice using technology before attending an initial clinical session.

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Standard Operating Procedures/Protocols

Ideally, conversations between provider and patient combined with clinical need *should* dictate the decision to pursue in-person, TMH, or hybrid services, with the understanding that the ability to alternate between modalities may add flexibility to the treatment course and may result in improved overall attendance at scheduled sessions.

Before initiating TMH 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:

- Roles, responsibilities (i.e., daytime and after-hours coverage), communication, and procedures around emergency issues.
- Agreements to ensure licensing, credentialing, training, and authentication of providers, as well as identity authentication of patients according to local, state, and federal requirements.
- A systematic quality improvement and performance management process that complies with any organizational, regulatory, or accrediting requirements for outcomes management.
- Procedures for identifying patients who may best be served by TMH, in-person, or hybrid care.
- Procedures and guidance for transitioning patients between TMH and in-person care.
- Procedures for technology selection.

PATIENT–PROVIDER IDENTIFICATION

All persons participating in the videoconference *shall* be identified to all participants at the beginning of a TMH session. This is especially important when all sessions, including intake and initiation of care, occur through videoconferencing.

At the beginning of a video-based mental health treatment with a patient, the following information *shall* be verified and documented:

- The name and credentials of the provider and the name of the patient.
- The location(s) of the patient during the session.
- Immediate contact information for both provider and patient (phone, text message, or e-mail) and contact information for other relevant support people, both professional and family.
- Expectations about contact between sessions shall be discussed and verified with the patient, including a discussion of emergency management between sessions.
- Expectations about procedures, identity verification, and presence of other individuals when providing hybrid or TMH-only care.

EMERGENCIES

General considerations. 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 TMH procedure or protocol. Providers *shall* be familiar with civil commitment regulations, patient handoff requirements, duty to warn and protect regulations, and the appropriate jurisdictional regulations of professional conduct, and they *should* have arrangements to work with local resources to initiate/assist with civil commitments or other emergencies in all geographic areas for the applicable patient populations.

Clinically supervised settings. Clinically supervised settings are patient locations where other medical or support staff are available in real time to support the TMH sessions. Emergency protocols *shall* be created with a clear explanation of roles and responsibilities in emergency situations. These include determination of emergency coverage outside clinic hours and guidelines for determining when other staff and resources should be brought in to help manage emergency situations. Providers *shall* be aware of safety issues with patients displaying strong affective or behavioral states upon conclusion of a session and how patients may then interact with remote site staff and establish an appropriate follow-up care plan.

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Clinically unsupervised settings. 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 in 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 include 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" (PSP), as clinically indicated. A PSP is a family member, friend, or community member selected by the patient, who could be called upon for support in case of an emergency. The provider *may* contact the PSP to request assistance in evaluating the nature of an emergency and/or initiating a 9-1-1 call from the patient's home.
- If a patient and/or PSP will not cooperate in emergency management, providers *shall* be prepared to work with local emergency personnel in case the patient needs emergency services and/or involuntary hospitalization.
- A provider who determines there is an emergency requiring local emergency services during a clinically unsupervised setting encounter *shall* make best efforts to contact and hand off care to emergency services, in accordance with the applicable standard of care, and any applicable written emergency care and handoff plan and *should* practice this before engaging in TMH care. Providers and administrators *should not* ask the patient or PSP to "hang up and call 9-1-1," and *should* make all reasonable efforts to coordinate care directly with emergency services professionals. The provider or administrator *should* make best efforts to,

  communicate standardized critical handoff information of the patient with emergency services in verbal and written form according to handoff requirements,
  send the provider's contact information to emergency services and be available during the emergency for additional questions, and
  remain connected to the patient until first responders have arrived on-site and are with the patient.
- A provider who reasonably believes an individual has a substantial probability of harm to himself or herself or to another person *shall*, as permitted or mandated by applicable regulations, contact emergency services regarding the individual and disclose knowledge of potential evidence of a substantial probability of harm or take any other action that a reasonable health care provider would consider as fulfilling the duty to warn and protect a person from substantial probability of harm.
- Organizations *shall* train all relevant personnel on the written emergency care and handoff plan, track and document emergencies, and monitor the success of interventions to improve emergency handoff communications to drive improvement.
- A patient's natural supports, including a PSP, are a critical part of their treatment and continued wellness and *may* be utilized with the patient's agreement. At a provider's clinical discretion, family and friends can be contacted in the event of an emergency or *may* be invited into a session, particularly if they are members of the patient's household and the patient is participating in sessions from their home. Utilizing household members can also be a tool for building rapport and increasing the patient's comfort with the TMH experience.

CARE COORDINATION

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

Technical Considerations

VIDEOCONFERENCING PLATFORM REQUIREMENTS

Providers and organizations *should* select videoconferencing applications that have the appropriate verification, confidentiality, and security parameters necessary to be properly utilized for this purpose. When conditions for a TMH session are compromised, consider other options. 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 access). TMH technologies *shall* provide services at a bandwidth with sufficient resolutions to ensure the quality of the image and/or audio received is appropriate to the services being delivered.

INTEGRATION OF VIDEOCONFERENCING INTO OTHER TECHNOLOGY AND SYSTEMS

Organizations *shall* ensure the technical readiness of the telehealth equipment and its arrangement within the clinical environment. They *shall* have policies and procedures in place

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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.

Privacy, security, Health Insurance Portability, and Accountability Act of 1996. For TMH services provided within the United States, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and state privacy requirements, duty to warn and protect, and warning of dangerousness *shall* be followed. Entities that are regulated by other, more stringent privacy laws *shall* follow the more stringent regulations. Privacy requirements in other countries *shall* be followed for TMH services provided in those countries.

Patients receiving mental health and substance use disorder services are afforded a higher degree of patients' rights, as well as organizational responsibilities (e.g., need for specific consent from patients to release information around substance use). TMH organizations, providers, and administrators *shall* be aware of these additional responsibilities and ensure that they are achieved. TMH organizations and providers *shall* determine processes for documentation, storage, and retrieval of TMH records.

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PHYSICAL LOCATION/ROOM REQUIREMENTS

During a TMH 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 for both *shall* be adjusted so the physical space, to the degree possible, maximizes lighting, safety, comfort, and ambiance.

With the rise of providers delivering services from their own homes or other nontraditional offices, providers *should* clearly identify their type of location and the privacy and safety standards being followed. Similarly, patients are now able to connect to care from a variety of locations. Administrators and providers *shall* ensure that patient locations are safe and appropriate as a health care setting. Providers *shall* also ensure that professional standards are maintained, regardless of location.

Clinical Considerations

PATIENT AND SETTING SELECTION

The use of TMH with any individual patient is at the discretion of the provider. For clinically unsupervised settings (e.g., home, office) where support staff is not immediately available, providers *shall* consider appropriateness of fit for an individual patient. Provision of TMH services in professionally unsupervised settings requires that the patient take a more active and cooperative role in the treatment process than would be the case for in-person locales. Patients need to be able to set up the videoconferencing system, maintain the appropriate computer/device settings, establish a private space, and cooperate for effective safety management. The rise in hybrid services allows for patients to be seen both in the same location and by TMH. Providers *should* consider patient selection as it pertains to TMH, same-location, or hybrid services and *should* have clear and direct conversations with patients about the options. Factors to consider include the following:

- Providers *should* consider a patient's cognitive ability, history regarding cooperativeness with treatment professionals, current and past difficulties with substance use, and history of violence or self-injurious behavior.
- Providers *shall* consider geographic distance to the nearest emergency medical facility, efficacy of the patient's support system, and current medical status.
- The consent process *shall* include discussion of circumstances around session management so that if a patient can no longer be safely managed through distance technology, the patient is aware that services may be discontinued.
- Providers *should* consider whether there is any medical aspect of care that would require in-person examination, including physical examinations. An understanding of the person's physical functioning, such as if a person uses a cane, walker, or service animal, to facilitate mobility can be included in the assessment. If the provider cannot manage the medical aspects for the patient without being able to conduct initial or recurrent physical examinations, this *shall* be documented in the record and arrangements *shall* be made to perform physical examinations on-site, as clinically indicated.
- Providers *should* consider patient desires about location, patient outcome goals, and patient likelihood to attend sessions.

MANAGEMENT OF HYBRID PATIENT–PROVIDER RELATIONSHIPS

Interviews can be conducted as part of a wider in-person and online clinical relationship using multiple technologies by providers working individually or in teams. The TMH interview can be an adjunct to periodic face-to-face, in-person contact or can be the only contact. It is typically supported by additional communication technologies, such as faxed or

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e-mailed consultation information, patient portals, telephones, mobile devices, and electronic health records.

Providers *should* have clear policies pertaining to communications with patients. These *should* describe the boundaries around ways in which patients can communicate with a provider and which content is appropriate to share over different technology platforms, anticipated response times, and how and when to contact a provider. Providers *should* identify clearly which platforms are acceptable for communication of an emergency and expected response times. Providers *should* be attentive of the impact of different technology platforms on patient rapport and communication. All modes of communication of personal health history *shall* be HIPAA compliant. Providers *should* have direct and clear communications with patients when recommending one modality over another or when suggesting a change in modality.

ETHICAL CONSIDERATIONS

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 TMH, as well as additional TMH-related concerns such as consent processes, patient autonomy, and privacy.

CULTURAL ISSUES

TMH providers *should* be culturally competent to deliver services to the populations they serve. Providers *should* become familiar 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 TMH interactions. Providers *should* conduct ongoing assessments of the patient's level of comfort with technology over the course of treatment, and the community voice directly impacted by the TMH service *should* be included in the initial needs assessment and ongoing assessments. Other considerations include ensuring that programmatic funding is available, especially if a TMH service has specific technology or communication requirements, and determining solutions for language and other cultural barriers.

Providers *should* seek to understand that the groups with which people either self-identify or are judged by others to belong to can contribute to mental health milieu and attitudes toward health care, with an awareness of ways in which membership to a named group interact with an individual person's experience. Due to the potential for TMH providers to be geographically and culturally remote from the context of the communities they serve, extra effort *may* be required to understand this interaction. These considerations *should* be addressed when working with any population.

SPECIFIC POPULATIONS AND SETTINGS

Child/adolescent populations. The transition to virtual and hybrid care has placed specific pressures on services to child, adolescent, and family populations. Providers *should* stay current on best practices for delivering TMH services to these populations, as they have undergone the most recent change. Providers *should* also remain vigilant about implementing best practices and understanding when to use TMH and/or in-person services.

TMH procedures for the evaluation and treatment of youth *shall* follow the same guidelines presented for adults with modifications to consider the developmental status of youth, such as motor functioning, speech and language capabilities, relatedness, and relevant regulatory issues. When working with younger children, the environment *should* facilitate the assessment by providing adequate room size, furniture arrangement, toys, and activities that allow the youth to engage with the accompanying parent, presenter, and provider and demonstrate age-appropriate skills.

Extended participation of family members or other relevant adults is typical of mental health treatment of children and adolescents. Providers *should* adhere to usual in-person practices for including relevant adults, with appropriate modifications for delivering service through videoconferencing in the context of resources at the patient site. Extended participation *may* include a "presenter" who *may* facilitate sessions (e.g., vital signs, assistance with rating scales, managing active children, assisting with any urgent interventions). Providers *should* consider how the presenter's involvement can affect service delivery (e.g., social familiarity with the family, perceived confidentiality, sharing information with other team members).

When TMH services are delivered outside of traditional clinic settings (e.g., schools), providers *should* work with staff to ensure safety, privacy, appropriate setting, and accommodations. This is particularly true if multiple staff participate in sessions.

Appropriateness for TMH care *shall* consider the safety of the youth, the availability of supportive adults, the mental health status of those adults, and the ability of the site to respond to any urgent or emergent situation. Providers *shall* ensure compliance with all relevant safety laws and regulations and follow standards and practices when engaging with children. Boundary setting is extremely important when engaging adolescents or children with trauma and their families. Boundary setting *should* include (but is not limited to)

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professional role clarification, prompt redirection upon recognition of violation, therapist self-awareness and avoiding disclosing personal information, avoiding nonemergency calls between sessions and/or outside regular office hours, avoiding extending session time (unless clinically indicated), avoiding making special allowances (unless clinically indicated), and setting appropriate communication rules.

Forensic and correctional. Providers *shall* be aware of systems issues when working in forensic and correctional settings and follow applicable standard consent around both treatment and evaluation in terms of a patient's legal status and rights. Providers *shall* have clear site-specific protocols regarding working with patients and staff in forensic and correctional settings.

Geriatric. The geriatric patient often has multiple medical problems, and the inclusion of family members *should* be undertaken as clinically appropriate and with the permission of the patient. Interviewing techniques *shall* be adapted for patients who may be cognitively impaired, find it difficult to adapt to the technology, or have visual or auditory impairment. Cognitive testing may be provided through videoconferencing, but might need to be modified for use by video.

Organizations administering cognitive testing through videoconferencing *shall* be aware of the properties of the individual test instrument, how it may be impacted by videoconferencing, and any potentially needed modification.

Military, veteran, and other federal populations. Providers *shall* be familiar with the federal and specific organizational structures and guidelines for patients related to the location of care. Providers *should* familiarize themselves with the culture of the patients (e.g., military cultural competency) and the organizational systems in which they practice.

Substance use disorder treatment. Providers *shall* be aware of and comply with federal, state, and local regulations around the prescription of controlled substances involved in substance use disorder treatment. Providers *shall* coordinate with on-site staff to provide appropriate standards of care, including care coordination and monitoring of physiological parameters for monitoring of ongoing treatment, as clinically indicated.

Inpatient and residential settings. Providers *should* work to integrate themselves into inpatient and residential care settings where they practice through virtual participation in administrative and organizational meetings, including clinical case staffing on a routine/regular basis. Remote providers *should* optimize use of patient-site staff for help with TMH consultations and case coordination, as clinically indicated. Inpatient units *should* provide the TMH provider with adequate access to patients, members of the interdisciplinary treatment team, and primary medical providers and nursing support, when appropriate.

Primary care settings. Providers *should* be aware of best practices in leveraging TMH to support integrated care across a continuum of models, including direct patient assessment, consultative models (e.g., asynchronous), and team-based models of care. Providers practicing integrated care telepsychiatry should attend to the impact of virtual interactions on team processes, dynamics, and patient outcomes in the delivery of integrated care.

Rural and other communities. Providers *should* be familiar with the impact of rural environments on treatment, including firearm and other lethal means ownership, kinship in small communities, local geographic barriers to care, and general availability of health care resources.

Black, indigenous, and people of color populations. Indigenous people experience higher rates of substance use and related disorders, post-traumatic stress disorder, and suicide, all of which are directly associated with intergenerational trauma on indigenous peoples. TMH providers *should* familiarize themselves with the culture, history, and best practices of serving indigenous populations. Black, indigenous, and people of color (BIPOC) individuals may experience interpersonal racism, vicarious racism, and intergenerational racism in their communities and within the health care system. Experiences of racism and discrimination can lead to racial trauma or race-based traumatic stress. This is compounded by the fact that accessing mental health services can be heavily stigmatized. TMH providers *should* familiarize themselves with the barriers, cultural nuances, and best practices of serving BIPOC populations.

Asian American and Pacific Islander Communities. Racism, microaggressions, and violence impact the mental health of Asian American and Pacific Islander Communities (AAPI), which is worsened by the stigma around seeking behavioral services within many Asian cultures. TMH providers *should* familiarize themselves with the barriers, cultural nuances, and best practices of serving AAPI populations.

Latinx/Hispanic. For many in the Latinx/Hispanic community, mental health and mental illness can be heavily stigmatized. This can result in prolonged suffering, which compounds other negative experiences of things such as immigration, acculturation, trauma, generational conflicts, and systemic discrimination. TMH providers *should* familiarize themselves with the barriers, cultural nuances, and best practices of serving Latinx and Hispanic populations.

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Lesbian, gay, bisexual, transgender, queer, questioning, intersex, asexual+. TMH creates the opportunity to bring needed mental health care to members of the LGBTQIA+ community. Providers *should* be familiar with the barriers LGBTQIA+ people face within health care, including discrimination, ignorance, and fear, and be aware of the specific mental health considerations this population experiences.

Hearing impaired. American Sign Language is an effective way of providing TMH services to the hearing impaired, as long as both parties have a strong, consistent internet connection and video feed. Providers *shall* ensure their internet is reliable before working with this population, and other tools, such as voice-to-speech or live caption, *should* be made available. There are different degrees of hearing impairment, so providers *should* also have a clear understanding of the patient's communication needs.

Visually impaired. TMH can decrease barriers to care for visually impaired patients by eliminating the need for them to commute to an in-person office. Because this group of patients may not be able to see and/or interpret nonverbal communication and gestures easily, providers *should* frequently confirm that the patient understands the provider's meaning and intent. Visually impaired patients also may not be able to easily utilize tools such as journaling, messaging, and documentation unless they have special software to assist them in accessing these tools, so providers *should* be aware of necessary accommodations.

Patients with developmental disabilities. Patients will vary in severity of symptoms. Providers *should* use their clinical judgment when determining a developmentally disabled patient's appropriateness for TMH. Special areas of consideration include how the patient presents and perceives nonverbal communication, triggers of agitation and aggression, sensitivity to sensory input, caregiver involvement in treatment, and the level of cognitive and emotional functioning.

Patients who experience intimate partner violence. TMH can provide important access to mental health and substance use treatment for patients who have experienced intimate partner violence. At the same time, providers *should* be aware of potential safety, security, and privacy risks for patients using services at home or in other settings when an abusive partner is present and/or monitoring their technology use. Treatment interference (e.g., preventing or disrupting participation, listening in on sessions), technology abuse (e.g., installing spyware or tracking devices, impersonation, location surveillance), and threats and retaliation may occur. Providers *should* be familiar with strategies to address safety and privacy issues and be knowledgeable about the wider resources that can support patients who are at risk from an abusive partner.

Disclaimer

The findings, opinions, and conclusions of this report do not necessarily represent the views of the officers, trustees, or all members of the American Psychiatric Association. Views expressed are those of the authors.—*APA Operations Manual.* This work was approved by the Joint Reference Committee, October 2022. This work was accomplished and approved by the American Psychiatric Association and American Telemedicine Association (ATA). Staff Support: ATA: Joe Kvedar, MD; Kyle Zebley. APA: Nate Tatro, MA; and Alexis Victor, MS. Reviewers: Telemental Health Special Interest Group (ATA), APA Committee on Telepsychiatry (APA), ATA Standards and Guidelines Committee Members [Dave Brennan, Bill Paschell, Iris Berman, Vanessa McLaughlin, James McElligott, and Christopher Brady], ATA Staff, and APA Staff.

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(*Appendix follows* →)

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Appendix

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Appendix A1. American Psychiatric Association and American Telemedicine Association Guidelines, Resources, and Telemental Health Trainings

A1. APA Web-Based Telepsychiatry Toolkit; 2016. Available from: https://psychiatry.org/psychiatrists/practice/telepsychiatry/toolkit [Last accessed: April 4, 2023].

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