IACP Psychology Section TeleVideo Committee Report 10-7-15

This project began at the initiation of Drs. Heather McElroy and Steve Griffin. We were initially tasked with providing guidelines to members for the use of teleconferencing services for evaluation consultation and treatment. In the course of data collection, we discovered that relevant and appropriate guidelines exist from several organizations including the APA Guidelines on Telepsychology and the American Telemedicine Association.

These guidelines were seen as addressing the use of videoconferencing for evaluations, consulting and therapy. Our focus then shifted somewhat to what our members are actually doing in the field. As it turns out, this is an area of practice where our members are segmented. There are persons who have strong feelings both for and against the use of teleconferencing services in the practice of our profession. There appear to be a small number of our group who are utilizing such services in volume while most have not ventured into this area for practice. A very small number tried it on a limited basis and found that it was not for them.

We developed a survey to see what we can learn about the specific practices of our members in this area. Our sample size was limited in this first-round with a low response rate making it difficult to draw solid conclusions. It is our plan to present these initial findings at the 2015 annual meeting while at the same time hoping to solicit much more broad participation in an upcoming survey scheduled for early spring 2016. The results of that survey would be presented at the 2016 annual meeting and it is believed that we would not only be able to provide information as to how the membership utilizes teleconferencing services in their practice but also be able to make some statements about whether such use appears to be widely accepted among the membership. We also propose a panel discussion take place at the 2016 conference on this topic. We do not see this as a means by which to alter the existing guidelines at this point or a way for us to agree or disagree about the appropriateness of videoconferencing.  Rather, we view this as a good starting point of information gathering and sharing such that we can start to use it to facilitate further research studies to apply this technology to our field.

Certainly we are thankful to Heather K. McElroy, Ph.D., ABPP and Steve Griffin, PhD, ABPP for initiating the work of this committee and seeing this as an important area in the future development of our profession.

Our committee included the following members:

Bruce Michael Cappo, PhD, ABPP (Chair)

Stephen F. Curran, PhD, ABPP

Jeni McCutcheon, PsyD, MSCP, ABPP

Michael Cuttler, PhD, ABPP

Matthew Guller, JD, PhD, ABPP

Scott Stubenrauch, PsyD

Robert Tanenbaum, PhD

The committee also thanks Gary L. Fischler, PhD, ABPP for providing input and materials for review. Dave Corey, PhD, ABPP and Eric Ostrov, JD, PhD, ABPP are also recognized for their willingness to review drafts of this manuscript and provide input.

Summary of our findings:

There are 216 registered IACP-PPSS members.

The survey was sent out to all IACP-PPSS members via the email listserv as well as an estimated 20 COPPS members who were present at a conference.

So approximately 236 individuals were sent the survey

64 persons participated in the survey which is 27% of 236.

Not all members answered every question as certain sections were limited to those that do specific tasks.

* + - * 30% - 15/50 use video to conduct Police and Public Safety (PPS) Pre-Employment Screening
      * 10% - 5/50 use video to conduct PPS FFDEs
      * 12% - 6/50 use video to conduct PPS Promotions
      * 24% - 12/50 use it for evaluation interviews in non PPS sector
      * 59% - 29/50 None/Not Applicable

*Those numbers were further culled to yield 48 solid evaluation participants:*

15 have done some type of police and public safety evaluations via televideo (31%)

12 have done police and public safety PEPE evaluations via televideo

2 have done only police and public safety promotional evaluations ("1-5" & "6-10")) via televideo

1 has done only police and public safety FFDEs ("6-10') via televideo

2 have done no police and public safety, but have done other evaluations using televideo

Of 29 intervention / counseling participants:

10 have utilized televideo

6 have provided this service less than 10 times via televideo

2 more than 10 but less than 30 times

2 significantly higher, possibly into the hundreds

Most have utilized televideo technology less than 5 years

**IACP-PPSS TeleVideo Survey Summary**

**Televideo and Evaluation/Interviewing**

* + Q3: Video Technology (Evaluation Interviewing) 18 yes/43 no (about a 30%-70% ratio) 61 answered
    - Q5: 82% (50/61) do evaluation regardless of style/type
    - Q6: Evaluation Type - 49 of the 50 answered (20 individuals endorsing the first 4, so there is overlap)
      * 30% - 15/50 use video to conduct PS&S Pre-Employment Screening
      * 10% - 5/50 use video to conduct PS&S FFDEs
      * 12% - 6/50 use video to conduct PS&S Promotions
      * 24% - 12/50 use it for evaluation interviews in non PS&S sector
      * 59% - 29/50 None/Not Applicable
    - Q7: How many TelePsych Interviews have you ever conducted: 40 Respondents but the format skews results and anyone listing 0 drops the average. 18 endorsed use in Q3 so should total be divided by 18 instead?

* + - * 38/922 (avg. 24) PS&S Pre-Employment Screenings
      * 33/357 (avg. 11) PS&S FFDEs
      * 34/366 (avg 11) PS&S Promotional
      * 35/1524 (avg. 44) Non-PS&S Evals
    - Q8: How long been doing?

* + - * 30/47 (64%) None/NA
      * 1/47 (2%) 1 year or less
      * 7/47 (15%) 1-2 years
      * 4/47 (9%) 2-3 years
      * 2/47 (4%) 3-5 years
      * 3/47 (6%) 5+ years
    - Q9: Area of Importance

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Very Important | Somewhat Important | Somewhat Unimportant | Unimportant | Total |
| Client Request | 53%  8 | 33%  5 | 7%  1 | 7%  1 | 15 |
| Location Convenience (Examinee) | 53%  8 | 40%  6 | 0%  0 | 7%  1 | 15 |
| Location Convenience (Examiner): | 47%  7 | 27%  4 | 27%  4 | 0%  0 | 15 |
| Scheduling Flexibility (Examinee) | 33%  5 | 53%  8 | 0%  0 | 13%  2 | 15 |
| Scheduling Flexibility (Examiner) | 33%  5 | 47%  7 | 7%  1 | 13%  2 | 15 |
| Cost Effectiveness (Examinee) | 40%  6 | 20%  3 | 7%  1 | 33%  5 | 15 |
| Cost Effectiveness (Examiner) | 27%  4 | 47%  7 | 0%  0 | 27%  4 | 15 |
| Diversification/Expansion of Examiner’s Client Base | 13%  2 | 33%  5 | 7%  1 | 47%  7 | 15 |
| Alternative Qualified Examiner not nearby | 50%  7 | 29%  4 | 7%  1 | 14%  2 | 14 |
| Confidence video as good as in-person | 60%  9 | 33%  5 | 0%  0 | 7%  1 | 15 |
| Special Circumstances (Disability, etc.) | 40%  6 | 20%  3 | 13%  2 | 27%  4 | 15 |

* + - Q10: Other Factors contributing to decision to use Video in evaluation

* + - * Desire by agency to have all applicants seen by same examiner
      * Left off cost effectiveness for the referring agency
    - Q11: Concerns with using Video in Evaluation

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Serious Concerns | Moderate Concerns | Mild Concerns | No Concerns | Total |
| Concerns re: Process (Security/Confidentiality) | 37%  18 | 29%  14 | 27%  13 | 8%  4 | 49 |
| Technology always changing | 27%  13 | 45%  22 | 22%  11 | 6%  3 | 49 |
| Conform to Legal or Court Standards | 57%  28 | 22%  11 | 16%  8 | 4%  2 | 49 |
| Psych Licensing Requirements (State jurisdiction) | 55%  27 | 29%  14 | 10%  5 | 6%  3 | 49 |
| Loss of communication cues – rapport | 45%  22 | 20%  10 | 20%  10 | 14%  7 | 49 |
| Contextual Factors (Culture, language, recent negative life events) impacting quality of info obtained | 33%  16 | 27%  13 | 22%  11 | 18%  9 | 49 |

* + - Q12: Global Concerns

* + - * No subject interaction with support staff, limited body language info, subject in psychologist’s office where viewed for hours.
      * Harder to establish rapport
      * None (7)
      * Higher risk for litigation
      * Absence of research (2)
      * Observation from waiting room to interview, sense of smell, some body language below the belt
      * Reliability of Technology (2)
      * Licensing concerns across state lines
      * Don’t want to
      * Begun use in forensic practice not PS&S yet
      * Examinee’s internet connection
      * More serious when in person, live interpersonal data which is job relevant
      * In Person interaction is gold standard
      * Done over thousand PS&S interviews, do not think video would present appreciable problems for pre-employment. Interested in supporting the endeavor and would use if agency saw as acceptable method.

**Televideo and Counseling/Intervention**

* Q4: Video Technology (Counseling/Intervention) 7 yes/55 no (about a 11%-89% ratio) 62 answered
  + Q13: 47% (28/59) do intervention/counseling

(they may do evaluation/interviewing too)

* + Q14: Counseling Type: 29 responded (1 additional person than the 28 identified in Q13)

* + - * 23/29 (79%) None/Not Applicable
      * 4/29 (14%) PS&S Counseling
      * 6/29 (21%) Counseling other than PS&S
      * Q15: How many Televideo intervention/counseling session ever conducted (only 10 answered while 54 skipped; not sure why it is two more respondents that the 62 who answered in Q4) – (the way I read this is that 10 professionals that participated have done video counseling).

* + - * 6/10 (60%) have conducted 1-10 sessions
      * 2/10 (20%) have conducted 11-30 sessions
      * 1/10 (10%) have conducted 31-100 sessions
      * 0/10 (0%) have conducted 101-500 sessions
      * 1/10 (10%) have conducted 500+ sessions
    - Q16: How long been doing?

* + - * 22/27 (81%) None/NA
      * 1/27 (4%) 1 year or less
      * 1/27 (4%) 1-2 years
      * 1/27 (4%) 2-3 years
      * 1/27 (4%) 3-5 years
      * 1/27 (4%) 5+ years
    - Q17: Area of Importance (Only 4 respondents, not very useful data)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Very Important | Somewhat Important | Somewhat Unimportant | Unimportant | Total |
| Client Request | 50%  2 | 25%  1 | 0%  0 | 25%  1 | 4 |
| Location Convenience (Client) | 50%  2 | 50%  2 | 0%  0 | 0%  0 | 4 |
| Location Convenience (Counselor): | 75%  3 | 25%  1 | 0%  0 | 0%  0 | 4 |
| Scheduling Flexibility (Client) | 100%  4 | 0%  0 | 0%  0 | 0%  0 | 4 |
| Scheduling Flexibility (Counselor) | 75%  3 | 25%  1 | 0%  0 | 0%  0 | 4 |
| Cost Effectiveness (Client) | 25%  1 | 25%  1 | 0%  0 | 50%  2 | 4 |
| Cost Effectiveness (Counselor) | 25%  1 | 25%  1 | 0%  0 | 50%  2 | 4 |
| Diversification/Expansion of Counselor’s Client Base | 25%  1 | 25%  1 | 0%  0 | 50%  2 | 4 |
| Alternative Counselor not nearby | 50%  2 | 25%  1 | 0%  0 | 25%  1 | 4 |
| Confidence video as good as in-person | 50%  2 | 50%  2 | 0%  0 | 0%  0 | 4 |
| Special Circumstances (Disability, etc.) | 50%  2 | 25%  1 | 25%  1 | 0%  0 | 4 |

* + - Q18: Other Factors contributing to decision to use Video in counseling

* + - * Only required to have in-person for first session
      * Going to college, continuation of care
    - Q19: Concerns with using Video in Counseling

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Serious Concerns | Moderate Concerns | Mild Concerns | No Concerns | Total |
| Concerns re: Process (Security/Confidentiality) | 56%  14 | 28%  7 | 12%  3 | 4%  1 | 25 |
| Technology always changing | 40%  10 | 52%  13 | 8%  2 | 0%  0 | 25 |
| Psych Licensing Requirements (State jurisdiction) | 42%  10 | 38%  9 | 13%  3 | 8%  2 | 24  (1 skipped) |
| Loss of communication cues – rapport | 48%  12 | 24%  6 | 24%  6 | 4%  1 | 25 |

* + - Q20: Global Concerns

* + - * Restricted ability to observe nonverbal cues, rapport
      * Wants more education before considers
      * Does not want APA to dictate what can and can’t do
      * How to handle danger to self or others (2)
      * No concerns
      * Would only use for educational purposes only but not to treat
      * Gold standard is in person.

Question 12 of our survey asked, “Whether or not you have used TeleVideo technology in your practice, as a psychologist who provides Public Safety evaluation services in the ordinary course of their practice, I have any other concerns you would have that might weigh against your decision to use TeleVideo technology and Public Safety evaluation services?” The committee thought it helpful and important to include the specific comments listed by our members:

The TeleVideo experiences extremely limited and does not, for example, provide information about subjects interactions with staff. Further, the body language shown is limited in TeleVideo situations. The experience of having subjects in one’s office, where they may be observed over a period of hours is far more apt to reveal pertinent facts than a (perhaps) 30 minute or less pose before a camera.

I believe it is harder to establish rapport, which I count on to facilitate getting information.

We would not do it if we didn’t have to in order to keep the client. I believe the exposure to litigation is higher using TeleVideo than the traditional face-to-face because the cues are attenuated. Even if the technology improves and the guidelines are more clear it shouldn’t replace the standard interview if it can be done the traditional way.

Absence of research

There is a loss of introductory experiences from the waiting room to the start of the interview. There is a loss of smell, for things like very bad breath of overly anxious candidates, alcohol, marijuana, or overuse of perfume or cologne. Somebody language such as bouncing legs, eye contact, may be lost or misread. Detail of grooming may be lost such as stains on a shirt, open fly, dirty sneakers or sandals, wrinkles and clothing. Claims by an examinee of being misheard (even if false) can be persuasively made to an appeals panel. A lack of research establishing the equivalency to in person interviews in the police evaluation context.

Reliability of technology; what to do when your link breaks down in the middle of an evaluation.

Licensing concerns rate teleservices, particularly across state lines.

Unreliable technology interfering with flow of interview.

Although my experience was okay. I decided not to continue with TeleVideo evaluations.

While I’ve not used in my P PSP evaluations. I have begun to use in my civil forensic practice one) when I’m out of the country, and two) when the examinee is in my USA office attended by my associate.

Quality of connection on examinee’s end.

No scientific evidence to show the TeleVideo evaluations are comparable to face-to-face interview.

Face-to-face interviews in person appear to be more serious, more important and more professional. Moreover and personal interactions provide direct evidence of interpersonal skills mannerisms and how the applicant responses to face-to-face interactions. Public Safety officers have direct face-to-face interactions with contacts so it is important to assess how they conduct themselves in person to matter how sophisticated equipment it is not as personal and the individuals may react differently in person.

I consider in person, face-to-face interaction to be the gold standard.

I’ve conducted over 1000 pre-employment interviews for safety sensitive positions. I do not think TeleVideo technology would present any applicable problems or concerns in conducting pre-employment evaluations. I would be interested in supporting this endeavor, and would be interested in using this method if it were acceptable in the agency hiring me to do the evaluation.

An effort was made to build a committee representative of the varying opinions of our membership as well as in terms of committee members’ current experience with using TeleVideo services. Some found the discussion reminiscent of the early discussions regarding the use of computerized administration of psychological testing. Others asserted the uniqueness of work in the Public Safety sector and the need to have research focusing on this particular subpopulation and to not assume a more generalized applicability of research with other populations. Also, as reflected in the above comments, there appear to be varying differences both in terms of technology and comfort level in using technology. Certainly there appear to be individuals who have tried some form of teleconferencing and who either find it inadequate in comparison to face-to-face or simply find that it is not for them. Certainly some members have concerns about liability, state laws and the lack of an agreed-upon foundation and infrastructure in this still developing landscape of teleconferencing use.

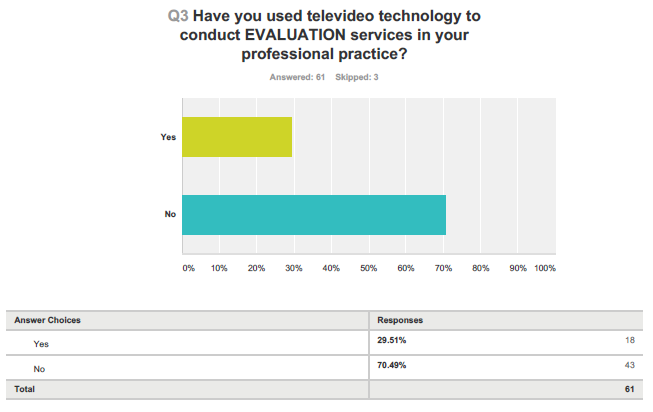
We encourage the membership to become familiar with the APA and ATA guidelines. We have also attached information from APA Legal and Regulatory Affairs as of October 2013 regarding the current status of any laws or limitations in each state regarding use of teleconferencing and providing psychological services.

The use of teleconferencing in medicine dates back more than 30 years, particularly in rural areas. Today, surgeries are performed using teleconferencing and robotics. However, it has been in the more recent years that such technology has been within the reach of everyday persons. The legal and licensing board infrastructure is more developed in some areas of practice than others. We see a need for further discussion and data collection as it pertains to use in the field of police and Public Safety psychology. As with many new technologies, is currently a small number of our members who are involved more significantly in this area although such members appear to represent a notable volume of services being delivered. We appreciate the purchase patient of those who completed our initial survey and we look forward to a more broad based participation in our 2016 survey. It is hoped that those results as well as a proposed panel discussion will continue to provide guidance and direction to our members in this developing field.

It is also noted that Association of State and Provincial Psychology Boards (ASPPB) has an E.Passport program called PSYPACT to facilitate the practice of practice telepsychology in PSYPACT states. ASPPB has hopes that at least seven states will enact PSYPACT in their 2016 legislative sessions. When seven states pass the legislation, PSYPACT becomes operational, and psychologists will be able to apply for and use E.Passport to practice telepsychology across member states. Those interested may contact Lisa Russo, PSYPACT Coordinator at [lrusso@asppb.org](mailto:lrusso@asppb.org) or call me at [678-216-1191](tel:678-216-1191).

Police Psychology Televideo Practice Survey

# July 20, 2015



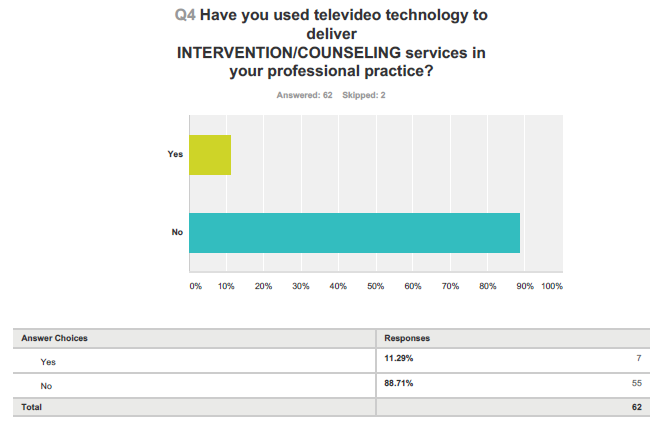
The number of participants who selected “yes” is 18

However, two participants answered “yes” to this but they then discontinued the survey entirely, leading to their exclusion.

1 of the participants skipped Q3, but said they do televideo pre-evaluations (in Q6). This leaves a total of 17 on Q3.

Code:

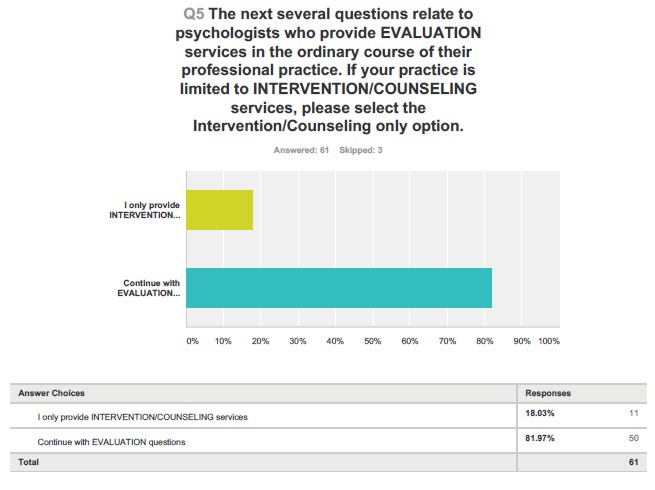
1. Yes
2. No



From Q13 and Q14, the researcher figured out that 29 people in the survey provided intervention/counseling services. Of those, 6 participants have used televideo in the delivery of those services.

Code:

1. Yes
2. No

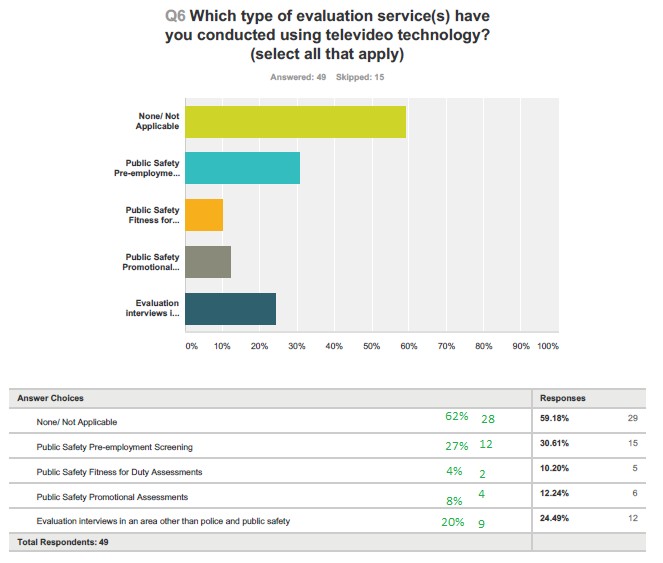


The number of participants who opted to “continue with the evaluation questions” is noted in the chart as 50. However, looking back at Q3 we are aware that one participant failed to answer Q3 and Q5 but indicated that they have performed pre-employment evaluations. The number then changes to 51 participants.

Nonetheless, three of the participants did not complete the survey in this group so we are left with a total of 48 participants are included in the results and the researcher concluded that they are evaluation psychologists.

Code:

1. Continue with evaluation
2. I only provide intervention/counseling services



49 participants answered this question.

29 selected “None/Not Applicable.” Of that 29, 1 individual discontinued the survey.

20 indicated a type of televideo service they provided; however, 3 of these participants indicated that they have not used televideo in response to Q3.

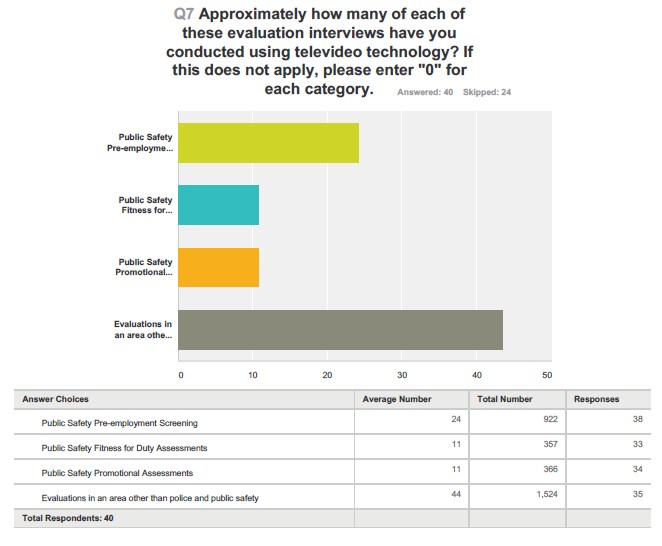
(28 selected “None/Not Applicable” and 17 selected services).

The 3 participants who the researcher is excluding are those who indicated that they do not use televideo technology in their evaluation services (Q3), but then selected to continue with evaluation questions in Q5.

The researcher’s numbers are noted in green on this chart.

(Note: participants selected all that apply) Code:

1. None/Not Applicable
2. Yes (If yes was selected for any service
3. No a 2 was marked in the “None/NA” section)



Code:

0- 0

1. 1-5 Evals.
2. 6-10 Evals.

3- 11-30 Evals.

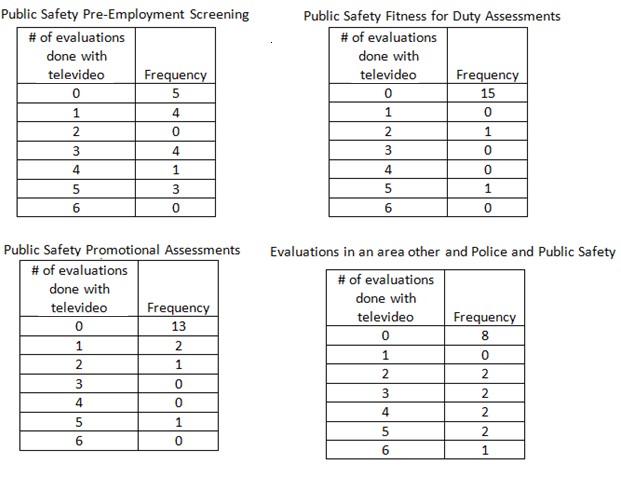
4- 31-100 Evals.

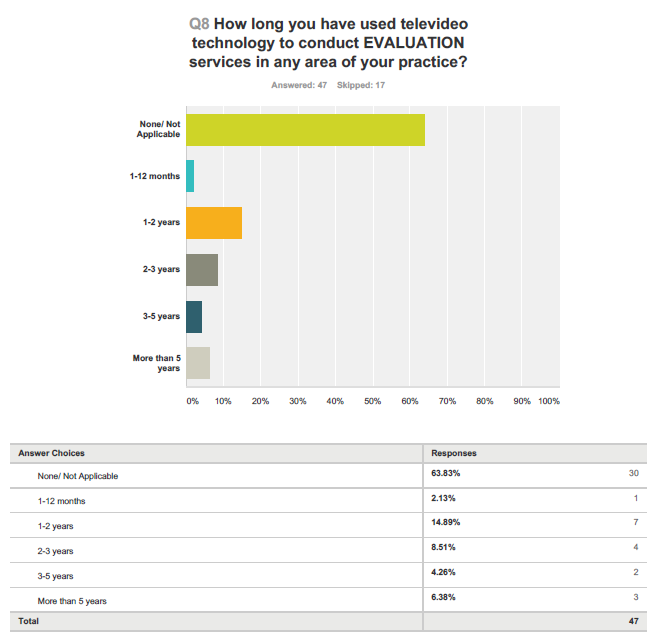
5- 101-500 Evals.

The 17 participants who perform evaluation services in their professional practices are represented here in these frequency distribution charts.

\*NOTE: “# of evaluations done (ever) with televideo” is coded:

0: 0 1: 1-5 2: 6-10 3: 11-30 4: 31-100 5: 101-500 6: 500+





The above numbers are consistent with the research’s conclusions noted for Q6.

Code:

0- 0

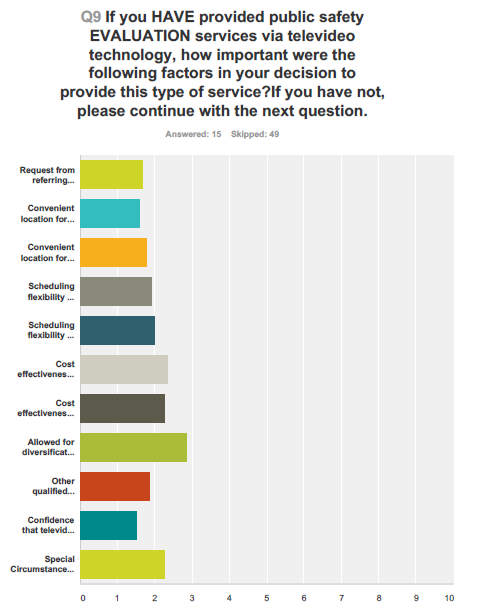
1- 1-12 Mo.

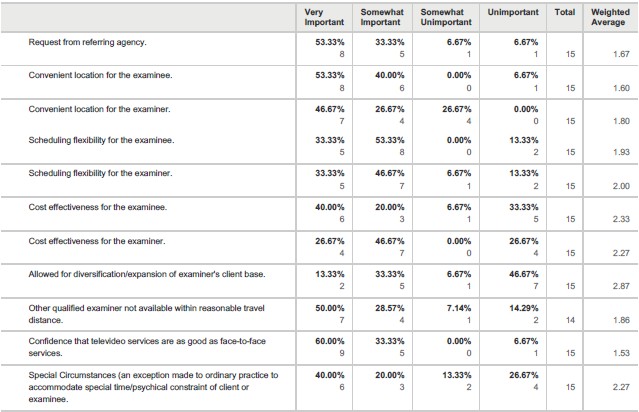
2- 1-2 Yrs.

3- 2-3 Yrs.

4- 3-5 Yrs.

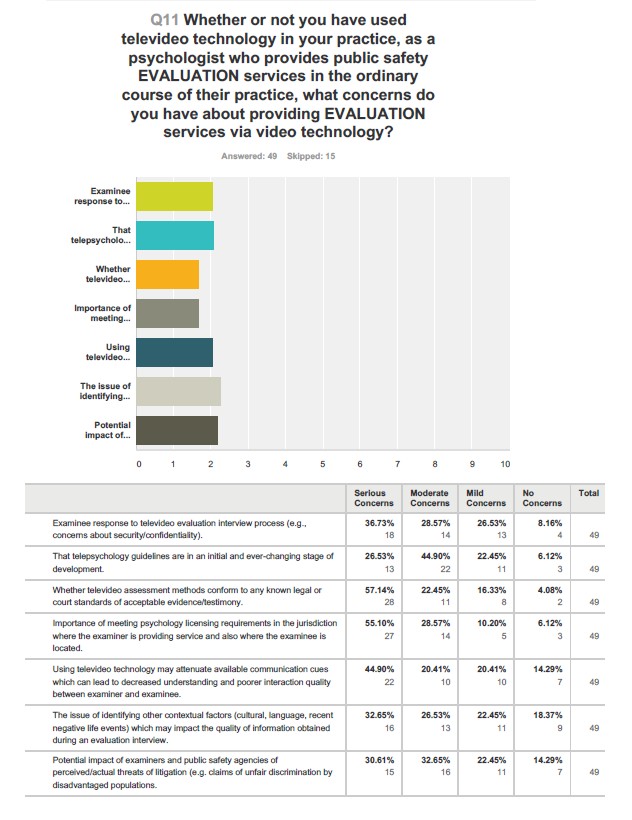
5- 5+ Yrs.





15 participants (of the 17 televideo using evaluation psychologists) answered questions regarding important factors in deciding to use televideo technology.

Not Coded.

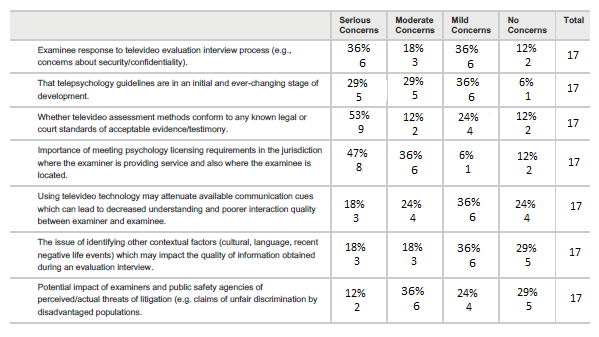


Of 48 participants who selected “continue with evaluation questions” 17 indicated what type of televideo evaluations they do (Doers). The other 31 did not, but gave their opinion of the technology (Non Doers).

Code:

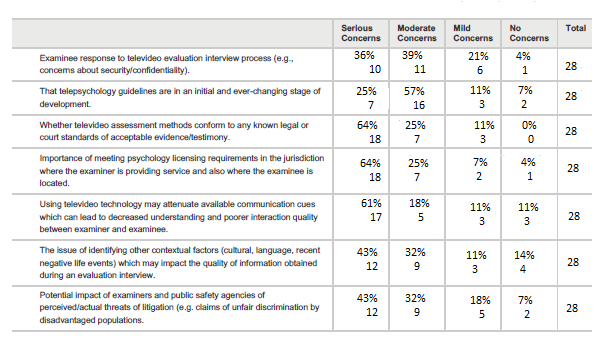
1. No Concerns
2. Mild Concerns
3. Moderate Concerns
4. Serious Concerns

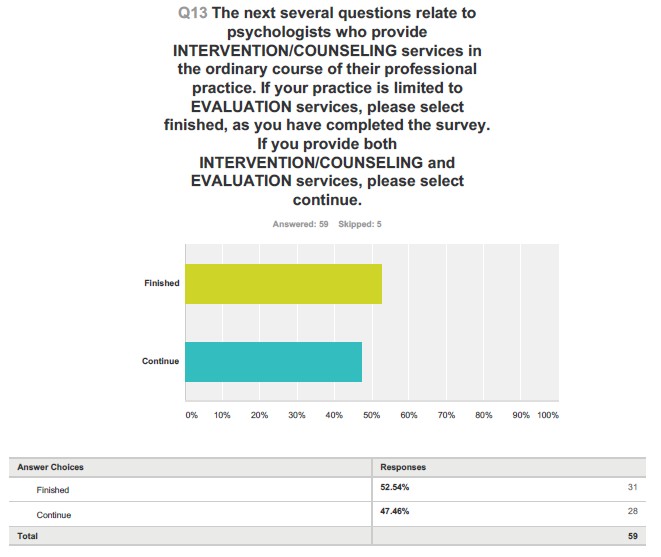
Opinion of Doers



Opinion of Non Doers

\*3 people skipped this section\*

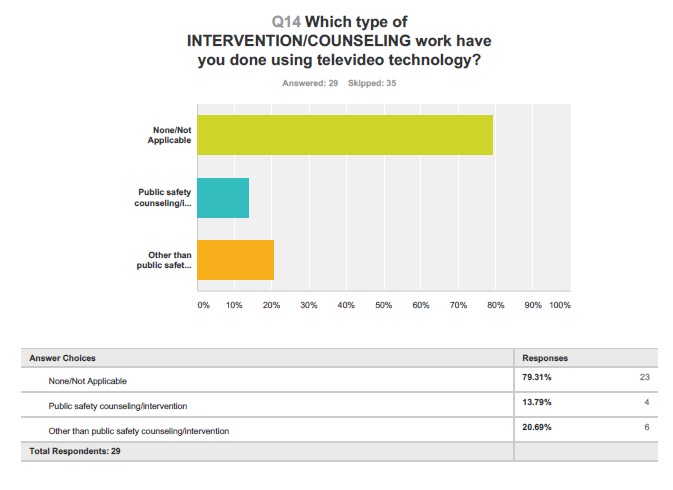




28 participants selected to “continue” with the survey, meaning that they either do intervention/counseling only or evaluation services and intervention/counseling. After reviewing the data the researcher found that 1 participant skipped Q13, but their responses on further questions indicate that they should have selected “continue” leading the researcher to conclusion that 29 participants are involved in providing intervention counseling service.

Code:

1. Continue
2. Finished



Of the 29 intervention/counseling people 6 indicated that they do Intervention/counseling using televideo (and the type of services they provide).

6 people selected “Other than public safety counseling/intervention” and 4 people selected “Public safety counseling/intervention.”

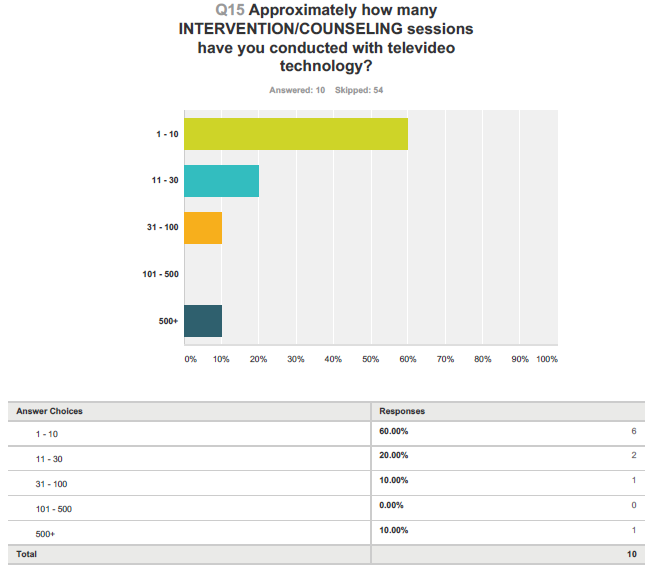
It is noted that in this question participants were able to select all that apply, which translates in the excel chart as:

2 participants selected “Other than public safety counseling/intervention” &

4 people selected both selected “Other than public safety counseling/intervention” and “Public safety counseling/intervention”

Code:

1. None
2. Public Safety
3. Other
4. Public Safety & Other

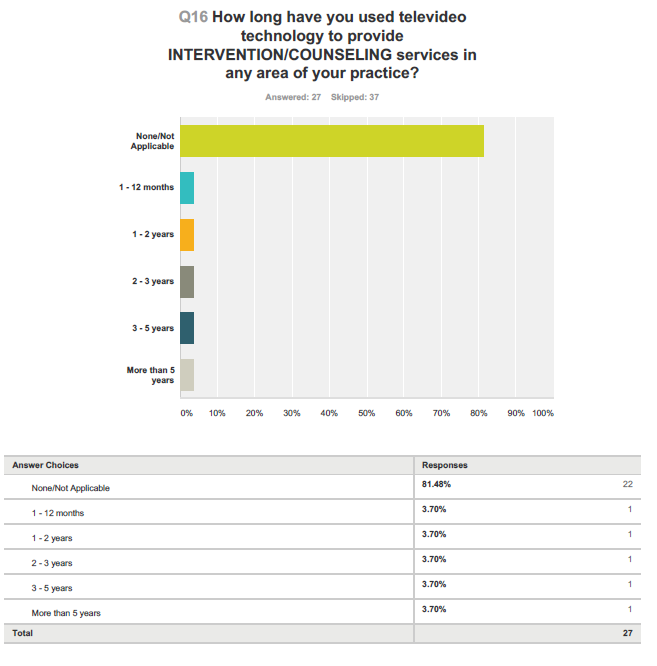


The 6 participants answered how many sessions they have done using televideo technology in their intervention/counseling services:

Code:

|  |  |
| --- | --- |
| Years | Frequency |
| 1. 1-10 | 2 |
| 2. 11-30 | 2 |
| 3. 31-100 | 1 |
| 4. 101-500 | 0 |
| 5. 500+ | 1 |

* 1. 1-10 Sessions
  2. 11-30 Sessions
  3. 31-100 Sessions
  4. 101-500 Sessions
  5. 500+ Sessions



The 6 participants were asked how long they have been using televideo technology in their intervention/counseling services:

3 participants skipped this question

2 participants selected “none/not applicable”

1 participant selected that he/she has been using the technology for 1-2 years

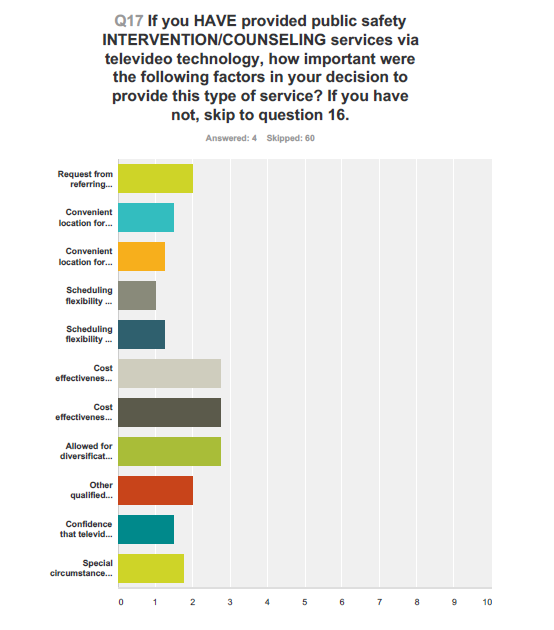
Code:

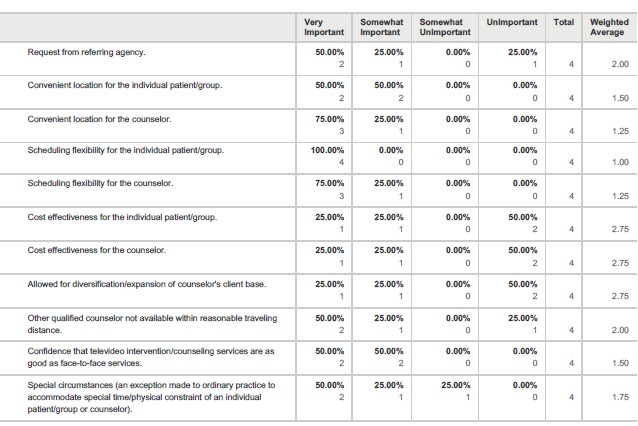
0- None 4- 3-5 Yrs.

1- 1-12 Mo. 5- 5+ Yrs.

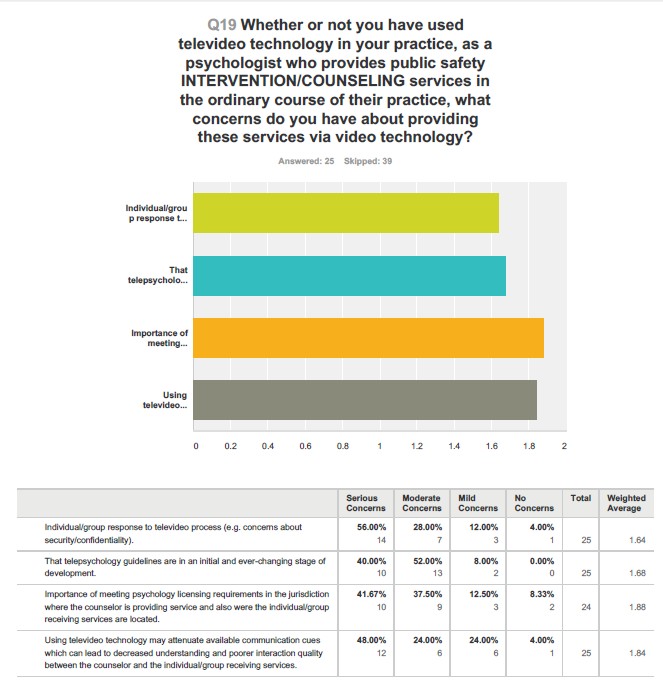
2- 1-2 Yrs.

3- 2-3 Yrs.





Of the 6 participants, 4 responded properly to these opinionated questions Not Coded.

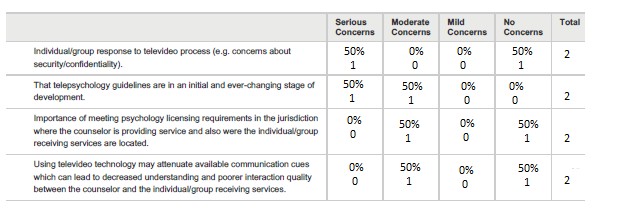


Of 29 participants who selected continue with intervention/counseling questions, 6 indicated what type of televideo evaluations they do (Doers). The other 23 did not, but gave their opinion of the technology (Non Doers).

Code:

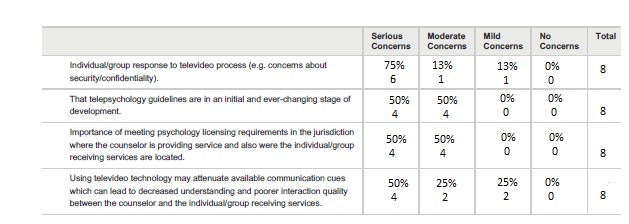
1. No Concerns
2. Mild Concerns
3. Moderate Concerns
4. Serious Concerns

# Opinion Doers



Opinion of Non Doer

\*15 participants skipped this section\*



NOTE:

* + Of the 64 participants 4 discontinued the survey after Q5 or before (#2, #33, #43, #58)
* Skipping questions was permitted in this survey

Insert APA Guidelines

Insert ATA Guidelines

Insert APA 50 state status document

Guidelines for the Practice of Telepsychology

Joint Task Force for the Development of Telepsychology Guidelines for Psychologists

These guidelines are designed to address the developing area of psychological service provision commonly known as telepsychology. *Telepsychology* is defined, for the purpose of these guidelines, as the provision of psychological services using telecommunication technologies, as expounded in the Definition of Telepsychology section of these guidelines. The expanding role of technology in the provision of psychological services and the continuous development of new technologies that may be useful in the practice of psychology present unique opportunities, considerations, and challenges to practice. With the advancement of technology and the increased number of psychologists using technology in their practices, these guidelines have been prepared to educate and guide them.

These guidelines are informed by relevant American Psychological Association (APA) standards and guidelines, including the “Ethical Principles of Psychologists and Code of Conduct” (“APA Ethics Code”; APA, 2002a, 2010) and the “Record Keeping Guidelines” (APA, 2007). In addition, the assumptions and principles that guide APA’s “Guidelines on Multicultural Training, Research, Practice, and Organizational Change for Psychologists” (APA, 2003) are infused throughout the *Rationale* and *Application* subsections describing each of the guidelines. Therefore, these guidelines are informed by professional theories, evidence-based practices, and definitions in an effort to offer the best guidance in the practice of telepsychology.

The use of the term *guidelines* within this document refers to statements that suggest or recommend specific professional behaviors, endeavors, or conduct for psychologists. Guidelines differ from standards in that standards are mandatory and may be accompanied by an enforcement mechanism. Thus, guidelines are aspirational in intent. They are intended to facilitate the continued systematic development of the profession and to help ensure a high level of professional practice by psychologists. “Guidelines are created to educate and to inform the practice of psychologists. They are also intended to stimulate debate and research. Guidelines are not to be promulgated as a means of establishing the identity of a particular group or specialty area of psychology; likewise, they are not to be created with the purpose of excluding any psychologist from practicing in a particular area” (APA, 2002b, p. 1048). “Guidelines are not intended to be mandatory or exhaustive and may not be applicable to every professional or clinical situation. They are not definitive and they are not intended to take precedence over the judgment of psychologists” (APA, 2002b, p. 1050). These guidelines are meant to assist psychologists as they apply current standards of professional practice when utilizing telecommunication technologies as a means of delivering their professional

ThisdocumentiscopyrightedbytheAmericanPsychologicalAssociationoroneofitsalliedpublishers.

Thisarticleisintendedsolelyforthepersonaluseoftheindividualuserandisnottobedisseminatedbroadly.

December 2013 ● American Psychologist

© 2013 American Psychological Association 0003-066X/13/$12.00

Vol. 68, No. 9, 791–800 DOI: [10.1037/a0035001](http://dx.doi.org/10.1037/a0035001)

services. They are not intended to change any scope of practice or define the practice of any group of psychologists.

The practice of telepsychology involves consideration of legal requirements, ethical standards, telecommunication technologies, intra- and interagency policies, and other external constraints, as well as the demands of the particular professional context. In some situations, one set of considerations may suggest a different course of action than another, and it is the responsibility of the psychologist to balance them appropriately. These guidelines aim to assist psychologists in making such decisions. In addition, it will be important for psychologists to be cognizant of and compliant with laws and regulations that govern independent practice within jurisdictions and across jurisdictional and international borders. This is particularly true when providing telepsychology services. Where a psychologist is providing services from one jurisdiction to a client/patient located in another jurisdiction, the law and regulations may differ between the two jurisdictions. Also, it is the responsibility of the psychologists who practice telepsychology to maintain and enhance their level of understanding of the concepts related to the delivery of services via telecommunication technologies. Nothing in these guidelines is intended to contravene any limitations set on psychologists’ activities based on ethical standards, federal or jurisdictional statutes or regulations, or for those psychologists who work in agencies and public settings. As in all other circumstances, psychologists must be aware of the stan-

The “Guidelines for the Practice of Telepsychology” were developed by the Joint Task Force for the Development of Telepsychology Guidelines for Psychologists established by the following three entities: the American Psychological Association (APA), the Association of State and Provincial Psychology Boards (ASPPB), and the APA Insurance Trust (APAIT). The “Guidelines for the Practice of Telepsychology” were approved as APA policy by the APA Council of Representatives on July 31, 2013. The co-chairs of the joint task force were Linda Campbell and Fred Millán. Additional members of the task force included the following psychologists: Margo Adams Larsen, Sara Smucker Barnwell, Bruce E. Crow, Terry S. Gock, Eric A. Harris, Jana N. Martin, Thomas W. Miller, and Joseph S. Rallo. APA staff (Ronald S. Palomares, Deborah Baker, Joan Freund, and Jessica Davis) and ASPPB staff (Stephen DeMers, Alex M. Siegel, and Janet Pippin Orwig) provided direct support to the joint task force.

These guidelines are scheduled to expire as APA policy 10 years from July 31, 2013 (the date of their adoption by the APA Council of Representatives). After this date, users are encouraged to contact the APA Practice Directorate to determine whether this document remains in effect.

Correspondence concerning these guidelines should be addressed to the Practice Directorate, American Psychological Association, 750 First Street, NE, Washington, DC 20002-4242.

dards of practice for the jurisdiction or setting in which they function and are expected to comply with those standards. Recommendations related to the guidelines are consistent with broad ethical principles (APA Ethics Code, APA, 2002a, 2010), and it continues to be the responsibility of the psychologist to apply all current legal and ethical standards of practice when providing telepsychology services.

It should be noted that APA policy generally requires substantial review of the relevant empirical literature as a basis for establishing the need for guidelines and for providing justification for the guidelines’ statements themselves (APA, 2002b, p. 1050). The literature supporting the work of the Joint Task Force on the Development of

Telepsychology Guidelines for Psychologists (i.e., the Telepsychology Task Force) and the guidelines statements themselves reflect seminal, relevant, and recent publications. The supporting references in the literature review emphasize studies from approximately the past 15 years plus classic studies that provide empirical support and relevant examples for the guidelines. The literature review, however, is not intended to be exhaustive or to serve as a comprehensive systematic review of the literature that is customary when developing professional practice guidelines for psychologists.

# Definition of Telepsychology

*Telepsychology* is defined, for the purpose of these guidelines, as the provision of psychological services using telecommunication technologies. Telecommunications is the preparation, transmission, communication, or related processing of information by electrical, electromagnetic, electromechanical, electro-optical, or electronic means (Committee on National Security Systems, 2010). Telecommunication technologies include but are not limited to telephone, mobile devices, interactive videoconferencing, e-mail, chat, text, and Internet (e.g., self-help websites, blogs, and social media). The information that is transmitted may be in writing or include images, sounds, or other data. These communications may be synchronous, with multiple parties communicating in real time (e.g., interactive videoconferencing, telephone), or asynchronous (e.g., e-mail, online bulletin boards, storing and forwarding of information). Technologies may augment traditional in-person services (e.g., psychoeducational materials posted online after an in-person therapy session) or be used as stand-alone services (e.g., therapy or leadership development provided over videoconferencing). Different technologies may be used in various combinations and for different purposes during the provision of telepsychology services. For example, videoconferencing and telephone may also be utilized for direct service, while e-mail and text are used for nondirect services (e.g., scheduling). Regardless of the purpose, psychologists strive to be aware of the potential benefits and limitations in their choices of technologies for particular clients in particular situations.

# Operational Definitions

ThisdocumentiscopyrightedbytheAmericanPsychologicalAssociationoroneofitsalliedpublishers.

Thisarticleisintendedsolelyforthepersonaluseoftheindividualuserandisnottobedisseminatedbroadly.

The Telepsychology Task Force has agreed upon the following operational definitions for terms used in this document. In addition, these and other terms used throughout the document have a basis in definitions developed by the following U.S. agencies: the Committee on National Security Systems (2010), the U.S. Department of Health and Human Services, Health Resources and Services Administration (2010), and the U. S. Department of Commerce, National Institute of Standards and Technology (2008, 2011). Last, the terminology and definitions that describe technologies and their uses are constantly evolving, and therefore psychologists are encouraged to consult glossaries and publications prepared by agencies such as the Committee on National Security Systems and the National Institute of Standards and Technology, which represent definitive sources responsible for developing terminology and definitions related to technology and its uses.

The term *client/patient* refers to the recipient of psychological services, whether psychological services are delivered in the context of health care, corporate, supervision, and/or consulting services. The term *in-person,* which is used in combination with the provision of services, refers to interactions in which the psychologist and the client/ patient are in the same physical space and does not include interactions that may occur through the use of technologies. The term *remote,* which is also used in combination with the provision of services utilizing telecommunication technologies, refers to the provision of a service that is received at a different site from where the psychologist is physically located. The term *remote* includes no consideration related to distance and may refer to a site in a location that is in the office next door to the psychologist or thousands of miles from the psychologist. The terms *jurisdictions* and *jurisdictional* are used when referring to the governing bodies at states, territories, and provincial governments.

Finally, there are terms within these guidelines related to confidentiality and security. *Confidentiality* means the principle that data or information is not made available or disclosed to unauthorized persons or processes. The terms *security* and *security measures* are terms that encompass all of the administrative, physical, and technical safeguards in an information system. The term *information system* is an interconnected set of information resources within a system and includes hardware, software, information, data, applications, communications, and people.

# Need for the Guidelines

The expanding role of telecommunication technologies in the provision of services and the continuous development of new technologies that may be useful in the practice of psychology support the need for the development of guidelines for practice in this area. Technology offers the opportunity to increase client/patient access to psychological services. Service recipients limited by geographic location, medical condition, psychiatric diagnosis, financial constraint, or other barriers may gain access to high-quality psychological services through the use of technology.

Technology also facilitates the delivery of psychological services by new methods (e.g., online psychoeducation, therapy delivered over interactive videoconferencing) and augments traditional in-person psychological services. The increased use of technology for the delivery of some types of services by psychologists who are health service providers is suggested by recent survey data collected by the APA Center for Workforce Studies (2008) and by the increasing discussion of telepsychology in the professional literature (Baker & Bufka, 2011). Together with the increasing use and payment for the provision of telehealth services by Medicare and private industry, the development of national guidelines for the practice of telepsychology is timely and needed. Furthermore, state and international psychological associations have developed or are beginning to develop guidelines for the provision of psychological services (Canadian Psychological Association, 2006; New Zealand Psychologists Board, 2011; Ohio Psychological Association, 2010).

# Development of the Guidelines

These guidelines were developed by the Joint Task Force for the Development of Telepsychology Guidelines for Psychologists (Telepsychology Task Force) established by the following three entities: the American Psychological Association (APA), the Association of State and Provincial Psychology Boards (ASPPB), and the APA Insurance Trust (APAIT). These entities provided input, expertise, and guidance to the Telepsychology Task Force on many aspects of the profession, including those related to its ethical, regulatory, and legal principles and practices. The Telepsychology Task Force members represented a diverse range of interests and expertise that are characteristic of the profession of psychology, including knowledge of the issues relevant to the use of technology, ethical considerations, licensure and mobility, and scope of practice, to name only a few.

The Telepsychology Task Force recognized that telecommunications technologies provide both opportunities and challenges for psychologists. Telepsychology not only enhances a psychologist’s ability to provide services to clients/patients but also greatly expands access to psychological services that, without telecommunication technologies, would not be available. Throughout the development of these guidelines, the Telepsychology Task Force devoted numerous hours to reflecting on and discussing the need for guidance for psychologists in this area of practice; the myriad, complex issues related to the practice of telepsychology; and the experiences that they and other practitioners address each day in the use of technology. There was a concerted focus on identifying the unique aspects that telecommunication technologies bring to the provision of psychological services, as distinct from those present during in-person provision of services. Two important components were identified:

1. the psychologist’s knowledge of and competence in the use of the telecommunication technologies being

utilized; and

1. the need to ensure that the client/patient has a full understanding of the increased risks for loss of security and confidentiality when using telecommunication technologies.

ThisdocumentiscopyrightedbytheAmericanPsychologicalAssociationoroneofitsalliedpublishers.

Thisarticleisintendedsolelyforthepersonaluseoftheindividualuserandisnottobedisseminatedbroadly.

Therefore, two of the most salient issues that the Telepsychology Task Force members focused on when creating this document were the psychologist’s own knowledge of and competence in the provision of telepsychology and the need to ensure that the client/patient has a full understanding of the potentially increased risks for loss of security and confidentiality when using technologies.

An additional key issue discussed by the task force members was interjurisdictional practice. The guidelines encourage psychologists to be familiar with and comply with all relevant laws and regulations when providing psychological services across jurisdictional and international borders. The guidelines do not promote a specific mechanism to guide the development and regulation of interjurisdictional practice. However, the Telepsychology Task Force noted that while the profession of psychology does not currently have a mechanism to regulate the delivery of psychological services across jurisdictional and international borders, it is anticipated that the profession will develop a mechanism to allow interjurisdictional practice given the rapidity with which technology is evolving and the increasing use of telepsychology by psychologists working in U.S. federal environments such as the U.S. Department of Defense and the Department of Veterans Affairs.

# Competence of the Psychologist

***Guideline 1. Psychologists who provide telepsychology services strive to take reasonable steps to ensure their competence with both the technologies used and the potential impact of the technologies on clients/patients, supervisees, or other professionals.***

***Rationale.*** Psychologists have a primary ethical obligation to provide professional services only within the boundaries of their competence based on their education, training, supervised experience, consultation, study, or professional experience. As with all new and emerging areas in which generally recognized standards for preparatory training do not yet exist, psychologists utilizing telepsychology aspire to apply the same standards in developing their competence in this area. Psychologists who use telepsychology in their practices assume the responsibility for assessing and continuously evaluating their competencies, training, consultation, experience, and risk management practices required for competent practice.

***Application.*** Psychologists assume responsibility to continually assess both their professional and technical competence when providing telepsychology services. Psychologists who utilize or intend to utilize telecommunication technologies when delivering services to clients/patients strive to obtain relevant professional training to develop their requisite knowledge and skills. Acquiring competence may require pursuing additional educational experiences and training, including but not limited to a review of the relevant literature, attendance at existing training programs (e.g., professional and technical), and continuing education specific to the delivery of services utilizing telecommunication technologies. Psychologists are encouraged to seek appropriate skilled consultation from colleagues and other resources.

Psychologists are encouraged to examine the available evidence to determine whether specific telecommunication technologies are suitable for a client/patient, based on the current literature available, current outcomes research, best practice guidance, and client/patient preference. Research may not be available in the use of some specific technologies, and clients/patients should be made aware of those telecommunication technologies that have no evidence of effectiveness. However, this, in and of itself, may not be grounds to deny providing the service to the client/patient. Lack of current available evidence in a new area of practice does not necessarily indicate that a service is ineffective. Additionally, psychologists are encouraged to document their consideration and choices regarding the use of telecommunication technologies used in service delivery.

Psychologists understand the need to consider their competence in utilizing telepsychology as well as their client’s/patient’s ability to engage in and fully understand the risks and benefits of the proposed intervention utilizing specific technologies. Psychologists make reasonable efforts to understand the manner in which cultural, linguistic, socioeconomic, and other individual characteristics (e.g., medical status, psychiatric stability, physical/cognitive disability, personal preferences), in addition to organizational cultures, may impact effective use of telecommunication technologies in service delivery.

Psychologists who are trained to handle emergency situations in providing traditional in-person clinical services are generally familiar with the resources available in their local community to assist clients/patients with crisis intervention. At the onset of the delivery of telepsychology services, psychologists make reasonable efforts to identify and learn how to access relevant and appropriate emergency resources in the client’s/patient’s local area, such as emergency response contacts (e.g., emergency telephone numbers, hospital admissions, local referral resources, clinical champion at a partner clinic where services are delivered, a support person in the client’s/patient’s life when available). Psychologists prepare a plan to address any lack of appropriate resources, particularly those necessary in an emergency, and other relevant factors that may impact the efficacy and safety of said service. Psychologists make reasonable efforts to discuss with and provide all clients/ patients with clear written instructions as to what to do in an emergency (e.g., where there is a suicide risk). As part of emergency planning, psychologists are encouraged to acquire knowledge of the laws and rules of the jurisdiction in which the client/patient resides and of the differences of those laws from those in the psychologist’s jurisdiction, as well as to document all their emergency planning efforts.

In addition, as applicable, psychologists are mindful of the array of potential discharge plans for clients/patients for whom telepsychology services are no longer necessary and/or desirable. If a client/patient recurrently experiences crises/emergencies, which suggests that in-person services may be appropriate, psychologists take reasonable steps to refer a client/patient to a local mental health resource or begin providing in-person services.

ThisdocumentiscopyrightedbytheAmericanPsychologicalAssociationoroneofitsalliedpublishers.

Thisarticleisintendedsolelyforthepersonaluseoftheindividualuserandisnottobedisseminatedbroadly.

Psychologists using telepsychology to provide supervision or consultation remotely to individuals or organizations are encouraged to consult others who are knowledgeable about the unique issues telecommunication technologies pose for supervision or consultation. Psychologists providing telepsychology services strive to be familiar with professional literature regarding the delivery of services via telecommunication technologies, as well as to be competent with the use of the technological modality itself. In providing supervision and/or consultation via telepsychology, psychologists make reasonable efforts to be proficient in the professional services being offered, the telecommunication modality via which the services are being offered by the supervisee/consultee, and the technology medium being used to provide the supervision or consultation. In addition, since the development of basic professional competencies for supervisees is often conducted in person, psychologists who use telepsychology for supervision are encouraged to consider and ensure that a sufficient amount of in-person supervision time is included so that the supervisees can attain the required competencies or supervised experiences.

# Standards of Care in the Delivery of Telepsychology Services

***Guideline 2. Psychologists make every effort to ensure that ethical and professional standards of care and practice are met at the outset and throughout the duration of the telepsychology services they provide.***

***Rationale.*** Psychologists delivering telepsychology services apply the same ethical and professional standards of care and professional practice that are required when providing in-person psychological services. The use of telecommunication technologies in the delivery of psychological services is a relatively new and rapidly evolving area, and therefore psychologists are encouraged to take particular care to evaluate and assess the appropriateness of utilizing these technologies prior to engaging in, and throughout the duration of, telepsychology practice to determine if the modality of service is appropriate, efficacious, and safe.

Telepsychology encompasses a breadth of different psychological services using a variety of technologies (e.g., interactive videoconferencing, telephone, text, e-mail, Web services, and mobile applications). The burgeoning research in telepsychology suggests that certain types of interactive telepsychological interventions are equal in effectiveness to their in-person counterparts (specific therapies delivered over videoteleconferencing and telephone).

Therefore, before psychologists engage in providing telepsychology services, they are urged to conduct an initial assessment to determine the appropriateness of the telepsychology service to be provided for the client/patient. Such an assessment may include the examination of the potential risks and benefits of providing telepsychology services for the client’s/patient’s particular needs, the multicultural and ethical issues that may arise, and a review of the most appropriate medium (video teleconference, text, e-mail, etc.) or best options available for the service delivery. It may also include considering whether comparable in-person services are available and why services delivered via telepsychology are equivalent or preferable to such services. In addition, it is incumbent on the psychologist to engage in a continual assessment of the appropriateness of providing telepsychology services throughout the duration of the service delivery.

***Application.*** When providing telepsychology services, considering client/patient preferences for such services is important. However, it may not be solely determinative in the assessment of their appropriateness. Psychologists are encouraged to carefully examine the unique benefits of delivering telepsychology services (e.g., access to care, access to consulting services, client convenience, accommodating client special needs, etc.) relative to the unique risks (e.g., information security, emergency management, etc.) when determining whether or not to offer telepsychology services. Moreover, psychologists are aware of such other factors as geographic location, organizational culture, technological competence (both that of the psychologist and that of the client/patient), and, as appropriate, medical conditions, mental status and stability, psychiatric diagnosis, current or historic use of substances, treatment history, and therapeutic needs that may be relevant to assessing the appropriateness of the telepsychology services being offered. Furthermore, psychologists are encouraged to communicate any risks and benefits of the telepsychology services to be offered to the client/patient and to document such communication. In addition, psychologists may consider some initial in-person contact with the client/patient to facilitate an active discussion on these issues and/or to conduct the initial assessment.

As in the provision of traditional services, psychologists endeavor to follow the best practice of service delivery described in the empirical literature and professional standards (including multicultural considerations) that are relevant to the telepsychological service modality being offered. In addition, they consider the client’s/patient’s familiarity with and competency for using the specific technologies involved in providing the particular telepsychology service. Moreover, psychologists are encouraged to reflect on multicultural considerations and how best to manage any emergency that may arise during the provision of telepsychology services.

Psychologists are encouraged to assess carefully the remote environment in which services will be provided to determine what impact, if any, there might be on the efficacy, privacy, and/or safety of the proposed intervention offered via telepsychology. Such an assessment of the remote environment may include a discussion of the client’s/patient’s situation within the home or within an organizational context, the availability of emergency or technical personnel or supports, the risk of distractions, the potential for privacy breaches, or any other impediments that may impact the effective delivery of telepsychology services. Along this line, psychologists are encouraged to discuss fully with the clients/patients their role in ensuring that sessions are not interrupted and that the setting is comfortable and conducive to making progress in order to maximize the impact of the service provided, since the psychologist will not be able to control those factors remotely.

ThisdocumentiscopyrightedbytheAmericanPsychologicalAssociationoroneofitsalliedpublishers.

Thisarticleisintendedsolelyforthepersonaluseoftheindividualuserandisnottobedisseminatedbroadly.

Psychologists are urged to monitor and assess regularly the progress of their client/patient when offering telepsychology services in order to determine if the provision of telepsychology services is still appropriate and beneficial to the client/patient. If there is a significant change in the client/patient or in the therapeutic interaction that causes concern, psychologists make reasonable efforts to take appropriate steps to adjust and reassess the appropriateness of the services delivered via telepsychology. Where it is believed that continuing to provide remote services is no longer beneficial or presents a risk to a client’s/patient’s emotional or physical well-being, psychologists are encouraged to thoroughly discuss these concerns with the client/patient, appropriately terminate their remote services with adequate notice, and refer or offer any needed alternative services to the client/patient.

# Informed Consent

***Guideline 3. Psychologists strive to obtain and document informed consent that specifically addresses the unique concerns related to the telepsychology services they provide. When doing so, psychologists are cognizant of the applicable laws and regulations, as well as organizational requirements, that govern informed consent in this area.***

***Rationale.*** The process of explaining and obtaining informed consent, by whatever means, sets the stage for the relationship between the psychologist and the client/ patient. Psychologists make reasonable efforts to offer a complete and clear description of the telepsychology services they provide, and they seek to obtain and document informed consent when providing professional services (APA Ethics Code, Standard 3.10). In addition, they attempt to develop and share the policies and procedures that will explain to their clients/patients how they will interact with them using the specific telecommunication technologies involved. It may be more difficult to obtain and document informed consent in situations where psychologists provide telepsychology services to their clients/patients who are not in the same physical location or with whom they do not have in-person interactions. Moreover, there may be differences with respect to informed consent between the laws and regulations in the jurisdictions where a psychologist who is providing telepsychology services is located and those in the jurisdiction in which this psychologist’s client/patient resides. Furthermore, psychologists may need to be aware of the manner in which cultural, linguistic, and socioeconomic characteristics and organizational considerations may impact a client’s/patient’s understanding of, and the special considerations required for, obtaining informed consent (such as when securing informed consent remotely from a parent/guardian when providing telepsychology services to a minor).

Telepsychology services may require different considerations for and safeguards against potential risks to confidentiality, information security, and comparability of traditional in-person services. Psychologists are thus encouraged to consider appropriate policies and procedures to address the potential threats to the security of client/ patient data and information when using specific telecommunication technologies and to appropriately inform their clients/patients about them. For example, psychologists who provide telepsychology services should consider addressing with their clients/patients what client/patient data and information will be stored, how the data and information will be stored, how it will be accessed, how secure the information communicated using a given technology is, and any technology-related vulnerability to their confidentiality and security that is incurred by creating and storing electronic client/patient data and information.

***Application.*** Prior to providing telepsychology services, psychologists are aware of the importance of obtaining and documenting written informed consent from their clients/patients that specifically addresses the unique concerns relevant to those services that will be offered. When developing such informed consent, psychologists make reasonable efforts to use language that is reasonably understandable by their clients/patients, in addition to evaluating the need to address cultural, linguistic, and organizational considerations and other issues that may have an impact on a client’s/patient’s understanding of the informed consent agreement. When considering for inclusion in informed consent those unique concerns that may be involved in providing telepsychology services, psychologists may include the manner in which they and their clients/patients will use the particular telecommunication technologies, the boundaries they will establish and observe, and the procedures for responding to electronic communications from clients/patients. Moreover, psychologists are cognizant of pertinent laws and regulations with respect to informed consent in both the jurisdiction where they offer their services and the jurisdiction where their clients/patients reside (see Guideline 8 on Interjurisdictional Practice for more detail).

Besides those unique concerns described above, psychologists are encouraged to discuss with their clients/ patients those issues surrounding confidentiality and the security conditions when particular modes of telecommunication technologies are utilized. Along this line, psychologists are cognizant of some of the inherent risks a given telecommunication technology may pose in both the equipment (hardware, software, other equipment components) and the processes used for providing telepsychology services, and they strive to provide their clients/patients with adequate information to give informed consent for proceeding with receiving the professional services offered via telepsychology. Some of these risks may include those associated with technological problems and those service limitations that may arise because the continuity, availability, and appropriateness of specific telepsychology services (e.g., testing, assessment, and therapy) may be hindered as a result of those services being offered remotely. In addition, psychologists may consider developing agreements with their clients/patients to assume some role in protecting the data and information they receive from them (e.g., by not forwarding e-mails from the psychologist to others).

ThisdocumentiscopyrightedbytheAmericanPsychologicalAssociationoroneofitsalliedpublishers.

Thisarticleisintendedsolelyforthepersonaluseoftheindividualuserandisnottobedisseminatedbroadly.

Another unique aspect of providing telepsychology services is that of billing documentation. As part of informed consent, psychologists are mindful of the need to discuss with their clients/patients prior to the onset of service provision what the billing documentation will include. Billing documentation may reflect the type of telecommunication technology used, the type of telepsychology services provided, and the fee structure for each relevant telepsychology service (e.g., video chat, texting fees, telephone services, chat room group fees, emergency scheduling, etc.). It may also include discussion about the charges incurred for any service interruptions or failures encountered, responsibility for overage charges on data plans, fee reductions for technology failures, and any other costs associated with the telepsychology services that will be provided.

# Confidentiality of Data and Information

***Guideline 4. Psychologists who provide telepsychology services make reasonable efforts to protect and maintain the confidentiality of the data and information relating to their clients/patients and inform them of the potentially increased risks of loss of confidentiality inherent in the use of the telecommunication technologies, if any. Rationale.*** The use of telecommunications technologies and the rapid advances in technology present unique challenges for psychologists in protecting the confidentiality of clients/patients. Psychologists who provide telepsychology learn about the potential risks to confidentiality before utilizing such technologies. When necessary, psychologists obtain the appropriate consultation with technology experts to augment their knowledge of telecommunication technologies in order to apply security measures in their practices that will protect and maintain the confidentiality of data and information related to their clients/patients.

Some of the potential risks to confidentiality include considerations related to uses of search engines and participation in social networking sites. Other challenges in this area may include protecting confidential data and information from inappropriate and/or inadvertent breaches to established security methods the psychologist has in place, as well as boundary issues that may arise as a result of a psychologist’s use of search engines and participation on social networking sites. In addition, any Internet participation by psychologists has the potential of being discovered by their clients/patients and others and thereby potentially compromising a professional relationship.

***Application.*** Psychologists both understand and inform their clients/patients of the limits to confidentiality and the risks of possible access to or disclosure of confidential data and information that may occur during service delivery, including the risks of others gaining access to electronic communications (e.g., telephone, e-mail) between the psychologist and client/patient. Also, psychologists are cognizant of the ethical and practical implications of proactively researching online personal information about their clients/patients. They carefully consider the advisability of discussing such research activities with their clients/patients and how information gained from such searches would be utilized and recorded, as documenting this information may introduce risks to the boundaries of appropriate conduct for a psychologist. In addition, psychologists are encouraged to weigh the risks and benefits of dual relationships that may develop with their clients/ patients, due to the use of telecommunication technologies, before engaging in such relationships (APA Practice Organization, 2012).

Psychologists who use social networking sites for both professional and personal purposes are encouraged to review and educate themselves about the potential risks to privacy and confidentiality and to consider utilizing all available privacy settings to reduce these risks. They are also mindful of the possibility that any electronic communication can have a high risk of public discovery. They therefore mitigate such risks by following the appropriate laws, regulations, and the APA Ethics Code (APA, 2002a, 2010) to avoid disclosing confidential data or information related to clients/patients.

# Security and Transmission of Data and Information

***Guideline 5. Psychologists who provide telepsychology services take reasonable steps to ensure that security measures are in place to protect data and information related to their clients/patients from unintended access or disclosure.***

***Rationale.*** The use of telecommunication technologies in the provision of psychological services presents unique potential threats to the security and transmission of client/patient data and information. These potential threats to the integrity of data and information may include computer viruses, hackers, theft of technology devices, damage to hard drives or portable drives, failure of security systems, flawed software, ease of accessibility to unsecured electronic files, and malfunctioning or outdated technology. Other threats may include policies and practices of technology companies and vendors, such as tailored marketing derived from e-mail communications. Psychologists are encouraged to be mindful of these potential threats and to take reasonable steps to ensure that security measures are in place for protecting and controlling access to client/ patient data within an information system. In addition, they are cognizant of relevant jurisdictional and federal laws and regulations that govern electronic storage and transmission of client/patient data and information, and they develop appropriate policies and procedures to comply with such directives. When developing policies and procedures to ensure the security of client/patient data and information, psychologists may include considering the unique concerns and impacts posed by both intended and unintended use of public and private technology devices, active and inactive therapeutic relationships, and the different safeguards required for different physical environments, different staffs (e.g., professional vs. administrative staff), and different telecommunication technologies.

ThisdocumentiscopyrightedbytheAmericanPsychologicalAssociationoroneofitsalliedpublishers.

Thisarticleisintendedsolelyforthepersonaluseoftheindividualuserandisnottobedisseminatedbroadly.

***Application.*** Psychologists are encouraged to conduct an analysis of the risks to their practice settings, telecommunication technologies, and administrative staff in order to ensure that client/patient data and information are accessible only to appropriate and authorized individuals. Psychologists strive to obtain appropriate training or consultation from relevant experts when additional knowledge is needed to conduct an analysis of the risks.

Psychologists strive to ensure that policies and procedures are in place to secure and control access to client/ patient information and data within information systems. Along this line, they may encrypt confidential client/patient data for storage or transmission and utilize such other secure methods as safe hardware and software and robust passwords to protect electronically stored or transmitted data and information. If there is a breach of unencrypted electronically communicated or maintained data, psychologists are urged to notify their clients/patients and other appropriate individuals/organizations as soon as possible. In addition, they are encouraged to make their best efforts to ensure that electronic data and information remain accessible despite problems with hardware, software, and/or storage devices by keeping a secure back-up version of such data.

When documenting the security measures to protect client/patient data and information from unintended access or disclosure, psychologists are encouraged to clearly address what types of telecommunication technologies are used (e.g., e-mail, telephone, video teleconferencing, text), how they are used, and whether the telepsychology services used are the primary method of contact or augment in-person contact. When keeping records of e-mail, online messaging, and other work using telecommunication technologies, psychologists are cognizant that preserving the actual communication may be preferable to summarization in some cases depending on the type of technology used.

# Disposal of Data and Information and Technologies

***Guideline 6. Psychologists who provide telepsychology services make reasonable efforts to dispose of data and information and the technologies used in a manner that facilitates protection from unauthorized access and accounts for safe and appropriate disposal.***

***Rationale.*** Consistent with the APA “Record Keeping Guidelines” (APA, 2007), psychologists are encouraged to create policies and procedures for the secure destruction of data and information and the technologies used to create, store, and transmit the data and information. The use of telecommunication technologies in the provision of psychological services poses new challenges for psychologists when they consider the disposal methods to utilize in order to maximally preserve client confidentiality and privacy. Psychologists are therefore urged to consider conducting an analysis of the risks to the information systems within their practices in an effort to ensure full and complete disposal of electronic data and information, plus the technologies that created, stored, and transmitted the data and information.

***Application.*** Psychologists are encouraged to develop policies and procedures for the destruction of data and information related to clients/patients. They also strive to securely dispose of software and hardware used in the provision of telepsychology services in a manner that ensures that the confidentiality and security of any patient/ client information is not compromised. When doing so, psychologists carefully clean all the data and images in the storage media before reuse or disposal, consistent with federal, state, provincial, territorial, and other organizational regulations and guidelines. Psychologists are aware of and understand the unique storage implications related to telecommunication technologies inherent in available systems.

Psychologists are encouraged to document the methods and procedures used when disposing of the data and information and the technologies used to create, store, or transmit the data and information, as well as any other technology utilized in the disposal of data and hardware. They also strive to be aware of malware, cookies, and so forth and to dispose of them routinely on an ongoing basis when telecommunication technologies are used.

# Testing and Assessment

***Guideline 7. Psychologists are encouraged to consider the unique issues that may arise with test instruments and assessment approaches designed for in-person implementation when providing telepsychology services.***

***Rationale.*** Psychological testing and other assessment procedures are an area of professional practice in which psychologists have been trained, and they are uniquely qualified to conduct such tests. While some symptom screening instruments are already frequently being administered online, most psychological test instruments and other assessment procedures currently in use were designed and developed originally for in-person administration. Psychologists are thus encouraged to be knowledgeable about, and account for, the unique impacts of such tests, their suitability for diverse populations, and the limitations on test administration and on test and other data interpretations when these psychological tests and other assessment procedures are considered for and conducted via telepsychology. Psychologists also strive to maintain the integrity of the application of the testing and assessment process and procedures when using telecommunication technologies. In addition, they are cognizant of the accommodations for diverse populations that may be required for test administration via telepsychology. These guidelines are consistent with the standards articulated in the most recent edition of *Standards for Educational and Psychological Testing* (American Educational Research Association, American Psychological Association, and the Council on Measurement in Education, 1999).

ThisdocumentiscopyrightedbytheAmericanPsychologicalAssociationoroneofitsalliedpublishers.

Thisarticleisintendedsolelyforthepersonaluseoftheindividualuserandisnottobedisseminatedbroadly.

***Application.*** When a psychological test or other assessment procedure is conducted via telepsychology, psychologists are encouraged to ensure that the integrity of the psychometric properties of the test or assessment procedure (e.g., reliability and validity) and the conditions of administration indicated in the test manual are preserved when adapted for use with such technologies. They are encouraged to consider whether modifications to the testing environment or conditions are necessary to accomplish this preservation. For example, a test taker’s access to a cell phone, the Internet, or other persons during an assessment could interfere with the reliability or validity of the instrument or its administration. Further, if the individual being assessed receives coaching or has access to such information as potential test responses or the scoring and interpretation of specific assessment instruments because they are available on the Internet, the test results may be compromised. Psychologists are also encouraged to consider other possible forms of distraction which could affect performance during an assessment and which may not be obvious or visible (e.g., sight, sound, and smell) when utilizing telecommunication technologies.

Psychologists are encouraged to be cognizant of the specific issues that may arise with diverse populations when providing telepsychology and to make appropriate arrangements to address those concerns (e.g., language or cultural issues, cognitive, physical, or sensory skills or impairments, or age may impact assessment). In addition, psychologists may consider the use of a trained assistant (e.g., a proctor) to be on the premises at the remote location in an effort to help verify the identity of the client/patient, provide needed on-site support to administer certain tests or subtests, and protect the security of the psychological testing and/or assessment process.

When administering psychological tests and other assessment procedures when providing telepsychology services, psychologists are encouraged to consider the quality of those technologies that are being used and the hardware requirements that are needed in order to conduct the specific psychological test or assessment. They also strive to account for and be prepared to explain the potential difference between the results obtained when a particular psychological test is conducted via telepsychology and when it is administered in person. In addition, when documenting findings from evaluation and assessment procedures, psychologists are encouraged to specify that a particular test or assessment procedure has been administered via telepsychology and to describe any accommodations or modifications that have been made.

Psychologists strive to use test norms derived from telecommunication technologies administration if such are available. Psychologists are encouraged to recognize the potential limitations of all assessment processes conducted via telepsychology and to be ready to address the limitations and potential impact of those procedures.

# Interjurisdictional Practice

***Guideline 8. Psychologists are encouraged to be familiar with and comply with all relevant laws and regulations when providing telepsychology services to clients/ patients across jurisdictional and international borders.***

***Rationale.*** With the rapid advances in telecommunication technologies, the intentional or unintentional provision of psychological services across jurisdictional and international borders is becoming more of a reality for psychologists. Such service provision may range from the psychologists or clients/patients being temporarily out of state (including split residence across states) to psychologists offering their services across jurisdictional borders as a practice modality to take advantage of new telecommunication technologies. Psychological service delivery systems within such institutions as the U.S. Department of Defense and the Department of Veterans Affairs have already established internal policies and procedures for providing services within their systems that cross jurisdictional and international borders. However, the laws and regulations that govern service delivery by psychologists outside of those systems vary by state, province, territory, and country (APA Practice Organization, 2010). Psychologists should make reasonable efforts to be familiar with and, as appropriate, to address the laws and regulations that govern telepsychology service delivery within the jurisdictions in which they are situated and the jurisdictions where their clients/patients are located.

***Application.*** It is important for psychologists to be aware of the relevant laws and regulations that specifically address the delivery of professional services by psychologists via telecommunication technologies within and between jurisdictions. Psychologists are encouraged to understand what services the laws and regulations of a jurisdiction consider as telehealth or telepsychology. In addition, psychologists are encouraged to review the relevant jurisdictions’ professional licensure requirements, the services and telecommunication modalities covered, and the information required to be included in providing informed consent. It is important to note that each jurisdiction may or may not have specific laws that impose special requirements for providing psychological services via telecommunication technologies. The APA Practice Organization (2010) has found that there are variations in whether psychologists are specified as a single type of provider or covered as part of a more diverse group of providers. In addition, there is wide diversity in the types of services and the telecommunication technologies that are covered by these laws.

ThisdocumentiscopyrightedbytheAmericanPsychologicalAssociationoroneofitsalliedpublishers.

Thisarticleisintendedsolelyforthepersonaluseoftheindividualuserandisnottobedisseminatedbroadly.

At the present time, there are a number of jurisdictions without specific laws that govern the provision of psychological services utilizing telecommunication technologies. When providing telepsychology services in these jurisdictions, psychologists are encouraged to be aware of any opinions or declaratory statements issued by the relevant regulatory bodies and/or other practitioner licensing boards that may help inform them of the legal and regulatory requirements involved when delivering telepsychology services within those jurisdictions.

Moreover, because of the rapid growth in the utilization of telecommunication technologies, psychologists strive to keep abreast of developments and changes in the licensure and other interjurisdictional practice requirements that may be pertinent to their delivery of telepsychology services across jurisdictional boundaries. Given the direction of various health professions, and current federal priorities to resolve problems created by requirements of multijurisdictional licensure (e.g., the Federal Communications Commission’s 2010 National Broadband Plan, the Canadian government’s 1995 Agreement on Internal Trade), the development of a telepsychology credential required by psychology boards for interjurisdictional practice is a probable outcome. For example, nursing has developed a credential that is accepted by many U.S. jurisdictions that allows nurses licensed in any participating jurisdiction to practice in person or remotely in all participating jurisdictions. In addition, an ASPPB task force has drafted a set of recommendations for such a credential.

# Conclusion

It is important to note that it is not the intent of these guidelines to prescribe specific actions, but rather, to offer the best guidance available at present when incorporating telecommunication technologies in the provision of psychological services. Because technology and its applicability to the profession of psychology constitute a dynamic area with many changes likely ahead, these guidelines also are not inclusive of all other considerations and are not intended to take precedence over the judgment of psychologists or applicable laws and regulations that guide the profession and practice of psychology. It is hoped that the framework presented will guide psychologists as the field evolves.

## REFERENCES

American Educational Research Association, American Psychological Association, & National Council on Measurement in Education. (1999). *Standards for educational and psychological testing*. Washington, DC: American Educational Research Association.

American Psychological Association. (2002a). Ethical principles of psychologists and code of conduct. *American Psychologist, 57,* 1060– 1073. [doi:10.1037/0003-066X.57.12.1060](http://dx.doi.org/10.1037/0003-066X.57.12.1060)

American Psychological Association. (2002b). Criteria for practice guideline development and evaluation. *American Psychologist, 57,* 1048– 1051. [doi:10.1037/0003-066X.57.12.1048](http://dx.doi.org/10.1037/0003-066X.57.12.1048)

American Psychological Association. (2003). Guidelines on multicultural education, training, research, practice, and organizational change for psychologists. *American Psychologist, 58,* 377–402. [doi:10.1037/0003066X.58.5.377](http://dx.doi.org/10.1037/0003-066X.58.5.377)

American Psychological Association. (2007). Record keeping guidelines.

*American Psychologist, 62,* 993–1004. [doi:10.1037/0003-066X.62.9.993](http://dx.doi.org/10.1037/0003-066X.62.9.993)

American Psychological Association. (2010). *Ethical principles of psychologists and code of conduct including 2010 amendments*. Retrieved from <http://www.apa.org/ethics/code/index.aspx>American Psychological Association Center for Workforce Studies. (2008). *2008 APA survey of psychology health service providers: Module D: Information on telepsychology, medication, and collaboration*. Retrieved from [http://www.apa.org/workforce/publications/08hsp/telepsychology/index.aspx](http://www.apa.org/workforce/publications/08-hsp/telepsychology/index.aspx)

American Psychological Association Practice Organization. (2010). Telehealth: Legal basics for psychologists. *Good Practice, 41,* 2–7.

AmericanPsychologicalAssociationPracticeOrganization. (2012, Spring/Summer). Social media: What’s your policy? *Good Practice,* pp. 10–18.

ThisdocumentiscopyrightedbytheAmericanPsychologicalAssociationoroneofitsalliedpublishers.

Thisarticleisintendedsolelyforthepersonaluseoftheindividualuserandisnottobedisseminatedbroadly.

Baker, D. C., & Bufka, L. F. (2011). Preparing for the telehealth world: Navigating legal, regulatory, reimbursement, and ethical issues in an electronic age. *Professional Psychology: Research and Practice, 42*(6), 405–411. [doi:10.1037/a0025037](http://dx.doi.org/10.1037/a0025037)

Canadian Psychological Association. (2006). *Ethical guidelines for psychologists providing psychological services via electronic media*. Retrieved from [http://www.cpa.ca/aboutcpa/committees/ethics/ psychserviceselectronically/.](http://www.cpa.ca/aboutcpa/committees/ethics/psychserviceselectronically/)

Committee on National Security Systems. (2010). *National information assurance (IA) glossary*. Retrieved from [https://www.cnss.gov/Assets/ pdf/cnssi\_4009.pdf](http://www.cnss.gov/Assets/pdf/cnssi_4009.pdf)

New Zealand Psychologists Board. (2011). *Draft guidelines: Psychology services delivered via the Internet and other electronic media*. Retrieved from http://psychologistsboard.org.nz/cms\_show\_download .php?id141

Ohio Psychological Association. (2010). *Telepsychology guidelines*. Retrieved from [http://www.ohpsych.org/psychologists/files/2011/06/ OPATelepsychologyGuidelines41710.pdf](http://www.ohpsych.org/psychologists/files/2011/06/OPATelepsychologyGuidelines41710.pdf)

U.S. Department of Commerce, National Institute of Standards and Technology. (2008). *An introductory resource guide for implementing the Health Insurance Portability and Accountability Act (HIPAA) Security Rule*. Gaithersburg, MD: Author.

U.S. Department of Commerce, National Institute of Standards and Technology. (2011). *Glossary of key information security terms*. Gaithersburg, MD: Author.

U.S. Department of Health and Human Services, Health Resources and Services Administration. (2010). *Special report to the Senate Appropriations Committee: Telehealth licensure report*. Retrieved from <http://www.hrsa.gov/healthit/telehealth/licenserpt10.pdf>





**AMERICAN TELEMEDICINE ASSOCIATION**

# Telemental Health Standards and Guidelines Working Group

**Co-Chairs:**

Brian Grady, MD

Kathleen Myers, MD, MPH

Eve-Lynn Nelson, PhD

**Writing Committees:**

**Evidence-Based Practice for Telemental Health**

Norbert Belz, MHSA RHIA, Leslie Bennett, LCSW, Lisa Carnahan, PhD, Veronica Decker, APRN, BC,

MBA, Brian Grady, MD, Dwight Holden, MD, Kathleen Myers, MD, MPH, Eve-Lynn Nelson, PhD,

Gregg Perry, MD, Lynne S. Rosenthal, PhD, Nancy Rowe, Ryan Spaulding, PhD, Carolyn Turvey, PhD, Debbie Voyles, Robert White, MA, LCPC

**Practice Guidelines for Videoconferencing-Based Telemental Health**

Peter Yellowlees, MD, Jay Shore, MD, Lisa Roberts, PhD

**Contributors:**

**Working Group Members [WG], Consultants [C], Reviewers [R], Telemental Health**

**Special Interest Group Chairs [MH], ATA Standards and Guidelines Committee Member [SG], ATA Staff [S]**

|  |  |  |
| --- | --- | --- |
| Nina Antoniotti, RN, MBA, PhD [Chair, SG] |  | Ron Mazik [R] |
| Richard S. Bakalar, MD [SG] |  | Dennis Mohatt [R] |
| Norbert Belz, MHSA RHIA [WG] |  | Kathleen Myers, MD, MPH [Co-Chair, WG] |
| Leslie Bennett, LCSW [WG] |  | Eve-Lynn Nelson, PhD [Co-Chair, WG] |
| Jordana Bernard, MBA [S] |  | Hon S. Pak, LTC MC USA [SG] |
| Anne Burdick, MD, MPH [Vice Chair, SG] |  | Gregg Perry, MD [WG] |
| David Brennan, MSBE [SG] |  | Antonio Pignatiello, MD [R] |
| Sharon Cain, MD [R] |  | Terry Rabinowitz, MD [C] |
| Lisa Carnahan, PhD [SG, WG] |  | Lisa Roberts, PhD [Chair, MH, C] |
| Jerry Cavallerano, PhD, OD [SG] |  | Lynne S. Rosenthal, PhD [SG, WG] |
| Robert Cuyler, PhD [R] |  | Nancy Rowe [WG] |
| Veronica Decker, APRN, BC, MBA [WG] |  | Jay H. Shore, MD, MPH [Vice Chair, MH, C] |
| Kenneth Drude, PhD [R] |  | Ryan Spaulding, PhD [WG] |
| Sara Gibson, MD [R] |  | Lou Theurer [SG] |
| Brian Grady, MD [Co-Chair, WG] |  | Christopher Thomas, MD [R] |
| Tom Hirota, DO [SG] |  | Carolyn Turvey, PhD [WG] |
| Dwight Holden, MD [WG] |  | Doug Urness, MD [R] |
| Barbara Johnston, MSN [C] |  | Debbie Voyles, MBA [WG] |
| Thomas J. Kim, MD, MPH [C] |  | Tannis Walc [R] |
| Mark Koltek, MD [R] |  | Robert K. White, MA, LCPC [WG] |
| Elizabeth Krupinski, PhD [SG, C] |  | Jill Winters, PhD, RN [SG] |
| Jonathan Linkous, MPA [S] Liz Loewen, RN, BFA, MN [R] |  | Peter Yellowlees, MD [C] |



**AMERICAN TELEMEDICINE ASSOCIATION**

## EVIDENCE-BASED PRACTICE FOR TELEMENTAL HEALTH

TABLE OF CONTENTS

1. PREAMBLE .................................................................................................................................4
2. SCOPE ..........................................................................................................................................5
3. GUIDELINE DEVELOPMENT PROCESS ................................................................................5
4. INTRODUCTION ........................................................................................................................6
5. CLINICAL CODING METHODOLOGY ...................................................................................7
6. EVIDENCE...................................................................................................................................8 a. Mental Health Evaluations .................................................................................................8

1. Setting. ..................................................................................................................8 a. Outpatient. .................................................................................................8

* + - 1. Inpatient ....................................................................................................8
      2. Physical Surroundings ...............................................................................9

2. Diagnostic Interview .............................................................................................9 a. Provider-Patient Relationship ...................................................................9

* + - 1. Diagnosis ..................................................................................................10
      2. Disposition ................................................................................................10
      3. Psychiatry Specific. ...................................................................................10
         1. Medication Management……………………………………..…10
         2. Medical Conditions. ......................................................................10
         3. Procedures and Laboratory Studies ..............................................11 e. Psychological Assessment ........................................................................11
         4. Diagnostic Instruments and Scales ...............................................11
         5. Personality Assessment .................................................................11
         6. Neuropsychological Assessment ..................................................12

f. Psychiatric Nurse Practitioner, Physician Assistant, and Psychiatric

Nursing Specific.........................................................................................12 g. Social Work/Counselor Specific ...............................................................12

b. Ongoing Mental Health Care .............................................................................................12

* 1. Psycho-Education .................................................................................................12
  2. Individual Psychotherapies ...................................................................................13
  3. Group Psychotherapies .........................................................................................13
  4. Marital and Family Psychotherapies .....................................................................14 c. Populations of Special Focus .............................................................................................14 1. Geriatrics ...............................................................................................................14 2. Children and Adolescent .......................................................................................15 a. Evaluations ................................................................................................15

1. Setting ...........................................................................................16 a. Physical Surroundings and Staff .......................................16

Outpatient ..........................................................................16

Inpatient.............................................................................16

Other Settings....................................................................17

2. Diagnostic Interview .....................................................................17 a. Provider-Patient Relationship ...........................................17

Assessment and Diagnosis ................................................17

Disposition and Continuity of Care...................................18

b. Treatment ..................................................................................................18

* + 1. Medication Management ..............................................................18
    2. Psychotherapy ...............................................................................18
    3. Seclusion and Restraint .........................................................................................19
    4. Emergency Assessments .......................................................................................19
    5. Involuntary Commitments ....................................................................................19
    6. Incarcerated ...........................................................................................................20

1. SUMMARY ..................................................................................................................................20
2. REFERENCES .............................................................................................................................21

**1. PREAMBLE**

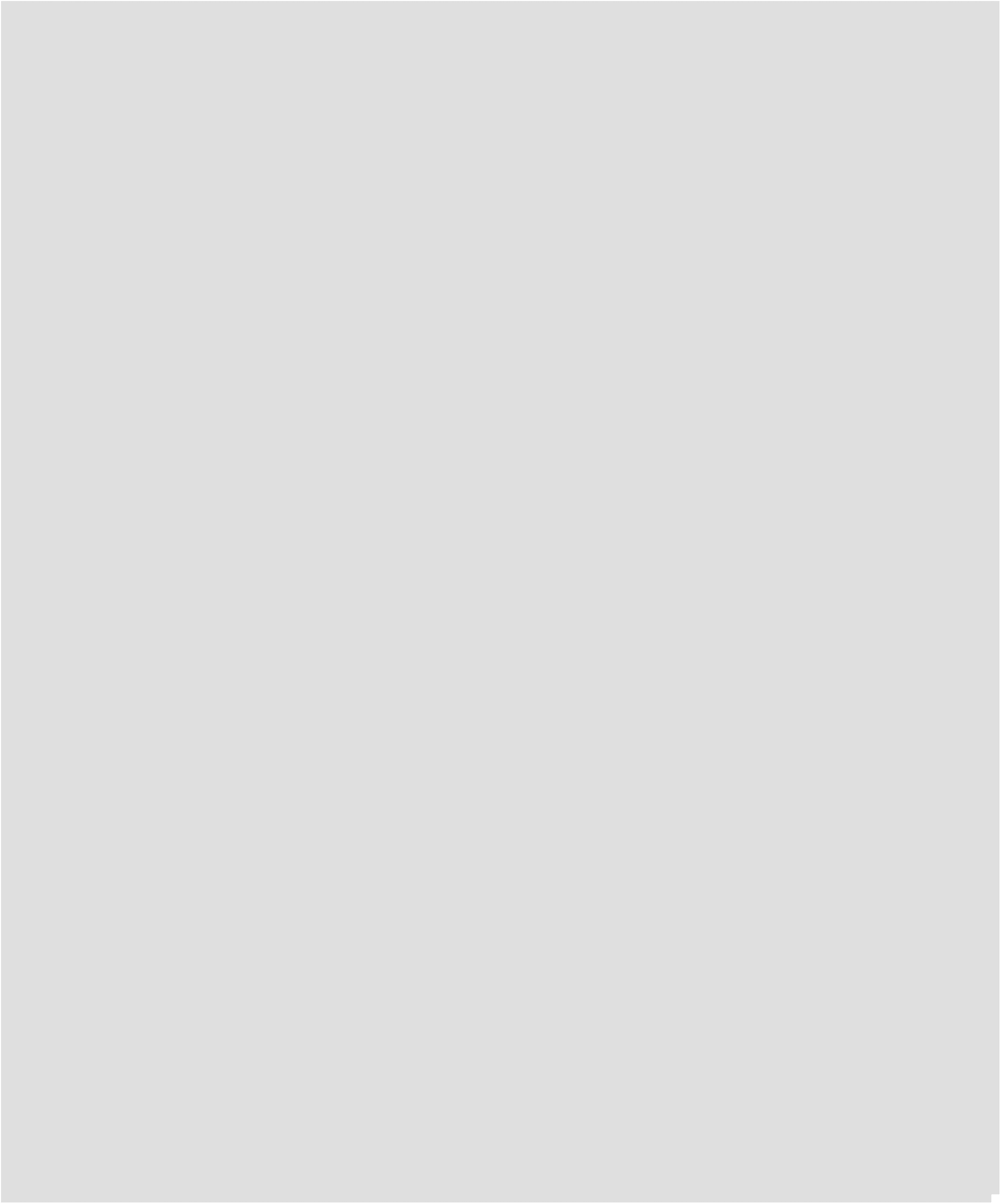
The American Telemedicine Association (ATA), with members from throughout the United States and throughout the world, is the principal organization bringing together telemedicine practitioners, healthcare institutions, vendors and others involved in providing remote healthcare using telecommunications. 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 health care 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. They are developed by panels 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 will undergo a thorough consensus and rigorous review, with final approval by the ATA Board of Directors. Existing products will be 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. The purpose of these standards is to assist practitioners in pursuing a sound course of action to provide 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. The resulting products are properties of ATA and any reproduction or modification of the published practice guideline and technical standards must receive prior approval by ATA.

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.

This document is an educational tool to aid practitioners in meeting the practice guidelines set forth in companion document, ATA’s Practice Guidelines for Videoconferencing-Based Telemental Health. The Evidence Based document provides the reader with an analysis of current published literature and documents qualitative and qualitative research focused on video-conferencing based mental health services and telemedicine/telehealth. The document does not serve the purpose of outlining what should or should not be done by a mental health practitioner, but, does provide reference and support for decision making in developing and providing telemental health services. Interested practitioners and/or telehealth organizations shall refer to ATA’s Practice Guidelines for Videoconferencing-Based Telemental Health for the specific methods with which to comply with the published standards and guidelines for telehealth and telemental health.



1. **SCOPE**

These guidelines are designed to serve as both a consensus operational best practice reference based on clinical empirical experience and an educational tool to aid practitioners in providing appropriate telehealth care for patients. The term telehealth indicates an inclusion of all health professionals, ranging from medicine to mental health, to educators, and to nurses. The use of telehealth also refers to the broader scope of e-health and distance education. Telemental health therefore, is the practice of mental health specialties at a distance. The practice of medicine is an integration of both the science and art of preventing, diagnosing, and treating diseases. It should be recognized that adherence to these guidelines will not guarantee accurate diagnoses or successful outcomes. The purpose of these guidelines is to assist practitioners in pursuing a sound course of action to provide effective and safe medical care that is founded on current information, available resources, and patient needs. The guidelines are not meant to be unbending requirements of practice and they are not designed to, nor should they be used to, establish a legal standard of care. The American Telemedicine Association advises against the use of these guidelines in litigation in which the clinical decisions of a practitioner are called into question.

The primary care or managing practitioner is responsible for the decision about the appropriateness of a specific procedure or course of action, considering all presenting circumstances. An approach that differs from the ATA guidelines does not necessarily imply that the approach varied from the standard of care. If circumstances warrant, a practitioner may responsibly pursue a course of action different from these 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 document in the patient record information adequate to explain the approach pursued.

1. **GUIDELINE DEVELOPMENT PROCESS**

The telemental health videoconferencing guideline project was initiated in 2006. A volunteer member of the Telemental Health (TMH) Special Interest Group (SIG) was appointed to chair the project at the 11th ATA Annual Meeting. A working group of clinicians, health care staff and health administration personnel was formed from the ATA membership. During the first year the group decided on limiting the scope of the project to interactive videoconferencing, addressing administrative, clinical and technical issues, deciding on the general format and beginning the literature search. Working group membership changed over the course of the guideline development. A literature search was conducted in November 2006 using PUBMED while committee members were also encouraged to search familiar literature, textbook and personal contacts for additional entries. Search terms used were:

telemedicine or interactive television or teleconferencing or teleconsultation or teleconsultations or video phone or videoconferencing or mental telehealth or telemental health or telepsychiatry or tele psychiatry or telepsychology or tele psychology or interactive videoconferencing or tele hypnosis or tele hypnosis or telepsychotherapy or tele psychotherapy or telecounseling or tele counseling or telenursing or tele nursing

Querying the broad terms led to approximately 9,300 listed articles. Approximately 5,300 articles were attributed to the word telemedicine alone and therefore most of the listed articles were non-telemental health in origin. Evidence tables were constructed according to the telemental health application, and consisted of setting, diagnostic interview, consultation-liaison, disposition, psycho-education, pharmacotherapy, individual psychotherapy, group psychotherapy, restraint/seclusion, incarceration, evaluation, family, substance abuse, geriatrics, child & adolescent, nursing, and psychology. Evidence tables for clinical applications included the headings of setting, bandwidth, interactive video technology used, outcome and sample size when available. Articles in the evidence table were classified according to the quality of the evidence; e.g. randomized clinical trial, longitudinal study, case report, etc. Members of the group wrote the initial sections of the guidelines based on their area of expertise. The sections were then consolidated into the first draft, which was sent to three consultants. An editorial committee was formed with the chair and co-chairs to review the consultant input and make initial changes to the document. A second draft was then sent to 12 expert reviewers (clinicians and other stakeholders in the field of telehealth or mental health). The editorial committee then reviewed, discussed and made changes to the draft based on reviewer feedback and the document was sent to a second set of 9 expert reviewers. The editorial committee again reviewed, discussed and made changes to the third draft document. The fourth draft document was forwarded to the ATA standards and guidelines committee for review. The editorial committee reviewed, discussed and made changes to the fourth draft document. A public comment period of 60 days was open for comments on the fifth draft document. Final revisions were made and the document was approved by ATA’s Standards and Guidelines Committee, and was forwarded to the ATA Board of Directors for final approval and publication.

1. **INTRODUCTION**

Telemental health, like telemedicine1, is an intentionally broad term referring to the provision of mental health care from a distance. The prefix “tele” can refer to geographical, time, or even circadian distance when providing care across time zones. Telemental health (TMH) includes mental health assessment, treatment, education, monitoring, and collaboration. Patients can be located in hospitals, clinics, schools, nursing facilities, prisons and homes. TMH providers and staff include psychiatrists, nurse practitioners, physician assistants, social workers, psychologists, counselors, primary care providers and nurses. Thousands of clients and patients have experienced access to mental health care via telemental health technologies. The goal of the telehealth provider is to eliminate disparities in patient access to quality, evidence-based, and emerging health care diagnostics and treatments. General information regarding telemental health can be found in review articles2,3,4,5,6 practice parameters7 and textbooks8,9.

Mental health professionals and practitioners continue to develop new ways to leverage technology to provide services to those needing expert care. This best practice recommendation document focuses on two-way, interactive videoconferencing as an alternative medium for clients and patients to directly engage with their mental health providers. The use of other modern technologies such as virtual reality, electronic mail, remote monitoring devices, chat rooms, and web-based clients were considered but these technologies are not currently included. There was little published literature on asynchronous methods for providing telemental health services at the time the document was written. The primary goal of the guideline is to distill the evidence from the published literature on interactive videoconferencing into a pragmatic reference for those engaged or about to engage in providing interactive TMH care. A secondary goal is to develop a clinical coding system for TMH clinical recommendations. Like other areas of telemedicine there is a growing, yet still limited amount of rigorous scientific research upon which to draw conclusions and set public policy for the use of telemental health. As the telemedicine field advances, researchers are striving to meet scientific standards and provide more guidance concerning evidence-based telemedicine practice in the future10,11 When guidelines, position statements, or standards exist from a professional organization or society such as (but not limited to) the American Psychiatric Association12, American Psychological Association13 or National Association of Social Workers14, the guidelines, position statements, or standards shall be reviewed and incorporated into practice.

In response to the needs and requests of providers, organizations and the ATA membership interested in or engaged in telemental health activities, the TMH SIG formed a committee to develop evidence based TMH guidelines. The broad nature of the mental health field along with an unlimited number of ways to use technology in mental health services led the committee to limit this guideline to interactive video conferencing applications.

Appreciating the broad range of providers and settings involved in TMH, a method for coding the literature upon which the practice recommendations in this document are based was developed. When feasible the relevant published data were organized by patient age, types of treatment, treatment setting and provider specialty. When reviewing the literature and formulating the recommendations, the following confidence ratings were used: considerable confidence, reasonable confidence, and limited confidence based on a specific application [for more detail see next section, clinical coding methodology]. The use of the rating scale is in line with the confidence rating structures used by other organizations (e.g., the American Psychiatric Association) and is familiar to mental health clinicians. However, in order to allow for the broad range of videoconferencing equipment used and disparities in bandwidth availability, the recommendations are subject to specific application situations. Thus a second coding variable was introduced to identify the technology used. The purpose of the second coding variable was to be inclusive and appreciative of the technical and social performance of all interactive videoconferencing technologies currently in use and to not exclude niche populations or applications. It is anticipated and hoped that the coding system will encourage more specific descriptions of the technology used for future TMH interactive videoconferencing research and methods publication.

**5. CLINICAL CODING METHODOLOGY**

Mental health clinicians refer to clinical guidelines when in need of evidence based recommendations and/or expert consensus regarding mental health diagnosis, medication and psychotherapy treatments, levels of appropriate care and social support information. TMH as a communication medium between provider and client/patient introduces an additional layer of variables into mental health care provision (e.g., effect of bandwidth, resolution and display size on the assessment and/or treatment interaction). The purpose of TMH evidence-based practice document is two-fold, 1) to provide evidence based recommendations and/or expert consensus regarding the effects of a particular video communication technology on the mental health diagnostic and treatment process, and 2) provide evidence based recommendations and/or expert consensus when TMH may be uniquely suited to enhance diagnostic clarification and/or treatment provision.

Three technological variables (bandwidth, resolution, and display size) are each believed to significantly influence the video interaction with mental health clients/patients. A TMH clinical recommendation coding scheme must be flexible enough to allow for a variety of video communication scenarios and yet be limited enough in classification to be readily understood. Bandwidth, using the H.264 video compression standard15, is be classified in this guideline as high (>256 kbps), medium (>128 kbps but <256 kbps) and low (<128 kbps). Display size is the diagonal measurement of the non-anamorphic picture. Video resolution will be referenced to High Definition (HD) and while Common Intermediate Format (CIF) and Source Input Format (SIF) will be considered equivalent standard definition (SD) formats. One-quarter CIF (QCIF) and one-quarter SIF (QSIF) are sometimes used on videophones.

The Evidence-Based Practice for Telemental Health utilizes a letter (A, B, C, D) and number (1, 2, 3) format. The letter indicates minimum requirements for bandwidth, display size, and resolution for a particular VTC (video tele-conference) application, and the number indicates the level of clinical confidence for that application. Bandwidth, display size, and resolution parameters must all be met for the particular video application code to apply. For example, sufficient research and expert consensus may provide a clinical confidence recommendation of 2 for cognitive therapy conducted at high bandwidth on a room-sized standard definition display, which would be coded as [B2], but may provide a clinical confidence recommendation of 3 if conducted via an analog videophone, and thus be coded as [D3]. This does not mean that a particular mental health application via analog videophone will always score lower, but rather that sufficient consensus or evidence-based data to support a higher clinical rating for the application was not supported in the literature. Clinicians are free to determine on a case by case basis, what evidence is relevant and how to proceed when little or no evidence exists. Ultimately, serving the patient safely and accurately is the goal of using any technology or method not well supported in the literature. The final decision rests with the clinician. The coding scheme is summarized below:

Video Application Coding:

1. - High Bandwidth; Resolution HD; Display >16"
2. - High Bandwidth; Resolution > SD; Display >26"
3. - Medium Bandwidth; Resolution > SD; Display >16"
4. - Low Bandwidth; Resolution >QCIF/QSIF to CIF/SIF; Display <16"

Clinical Confidence Recommendations:

1. - with considerable confidence
2. - with reasonable confidence
3. - may consider depending on the particular clinical objective and application used

**6. EVIDENCE**

1. **Mental Health Evaluations**

* 1. **Setting**

* + 1. **Outpatient.** The majority of telemental health has been conducted in the outpatient setting16,17,18,19,20. Access to care has been the driving force, both geographically for rural communities and for the underserved in urban environments. Community mental health centers and medical clinics frequently lack enough clinicians, including child services and psychiatrists. It has been demonstrated that patients can be reliably assessed, diagnosed, and treated with pharmacology and psychotherapy in outpatient clinics with a variety of videoconferencing equipment and communications protocols [B1, C2, D3]. School-based programs have been increasing in number as convenient locations for patients, parents, and school officials to participate in mental health-related prevention, assessment, and care21,22,23,24. These natural settings are ideal locations to reach children and adolescents with mental health, developmental, and behavioral issues [B/C2, D3]. Other natural or innovative settings not usually considered for mental health services can reach at-risk and needy adults, such as women in shelters. There has been minimal published literature regarding the usefulness of telepsychiatry assessment in the emergency room25, so more work describing how telemental health consultation can help emergency room clinicians is needed. Likewise, further published work is needed regarding assessments, pharmacotherapies, and psychotherapies delivered in the patient’s residence via home telehealth technologies.

* + 1. **Inpatient.** Reports of inpatient care in general psychiatric units have been are limited to consultative psychiatric services26 and experimental investigations of acceptance27 and diagnostic instrument accuracy28. One report of inpatient gero-psychiatric unit demonstrated patient and family satisfaction and perceived benefits with the telepsychiatry service29. While inpatient psychiatric care may be amenable to telehealth technologies, there has been little investigation describing the routine assessment or treatment on acute inpatient psychiatric units [B/C3] or for consultative psychiatry [B/C3]. One report indicated that inpatients with bipolar disorder, manic, had favorable opinions and engaged easily in videoconferencing assessments30. Uniqueness of assessment and treatment via videoconferencing has been considered to play a beneficial role. Whether uniqueness continues to have such a beneficial effect needs to be seen as telemental health becomes more commonplace. Despite many articles and activity involving geriatrics, there were limited evidence-based outcome data on the provision of psychiatric services to geriatric patients in nursing facilities.

* + 1. **Physical Surroundings.** Evidence is limited regarding the furnishing of either provider or patient offices31, although various program guidelines mention the importance of furnishings32. The literature states that as with in-person assessments, rooms used for telemental health should be safe, adequately lighted, and provide comfortable seating, with interruptions from electronic devices mitigated. Privacy, considered the ability to keep auditory and visual interactions from being seen or heard beyond the designated participants, is considered essential. VTC privacy features should be available to both the provider and patient. Privacy features should include audio muting, video muting, and the ability to easily change from public to private audio mode. Additionally, units should have features to improve the video clarity (e.g., brightness and contrast) and audio controls to adjust microphone and speaker volumes to reduce technology-based interruptions. All VTC-related features at the originating sites should also be controllable by the provider at the distant site. Providers should consider wearing pale solid colors such as blue, because patterned and striped clothing requires more bandwidth to update a more dynamic picture and may be distracting or disturbing to the patient.

* 1. **Diagnostic Interview**

* + 1. **Provider-Patient Relationship.** Establishing rapport and a therapeutic alliance is as important in interactive videoconferencing as it is in face-to-face (FTF) care. Rapport allows for the patient to be more forthcoming with past and current history, cognitive experience, emotional experience, and symptoms. Good rapport leads to a therapeutic working alliance where the patient and provider engage cooperatively in a treatment plan to cure, manage, or mitigate unhealthy symptoms, behaviors, and emotional states. There is significant evidence that patients quickly adapt and establish rapport with their teleprovider33,34 and are able to provide information via TMH as they would in person35,36. Clinicians should note that patients may present differently via telemental health, such as being more courteous or meticulous about their appearance37. It is also imperative for the clinician practicing mental health from a distance to have cultural competency in the population he or she is serving38,39. Adjusting to the medium may also require flexibility and creativity in conferring empathic gestures. Use of VTC appears to have minimal effect on the therapeutic working alliance [B/C2, D3]. There also is anecdotal evidence that for some disorders (e.g., post traumatic stress disorder, agoraphobia, and eating disorders), VTC may provide some “distance” that allows the patient to feel safer and in control of the therapeutic situation40,41. Another important consideration for video-based telemental health is gaze angle. Gaze angle is the angle between the participant’s local camera and where the participant looks at the distant onscreen participant (eye contact). The vertical location of the participant on the screen will affect gaze angle. Gaze angles of approximately 5 to 7 degrees are imperceptible to most people42,43.

* + 1. **Diagnosis**. Establishing rapport and rendering a good diagnostic assessment are paramount during the initial session(s) with clients/patients. Effective treatment planning begins with an accurate diagnosis. The diagnosis is what enables the provider to refer to evidence and expert consensus-based treatments for that particular culmination of unhealthy emotions, thoughts, and behaviors. There is a fair amount of literature regarding VTC diagnostic assessments demonstrating their acceptance, utility, and accuracy in clinical practice44,45,46,47,48,49,50. Limitations of VTC such as indirect eye contact due to cameramonitor placement need to be considered in assessing mental status. Adult diagnostic assessments conducted via VTC are comparable to FTF [B1, C2, D3]. While technical variables introduced by VTC assessment include bandwidth and display size, clinical VTC experience is another variable that should be appreciated. Providers who have significant experience using VTC for diagnostic assessments have little issue with the validity of diagnostics performed at medium bandwidth, while providers with less experience may encounter some difficulty (e.g., motion artifacts). This is an example where additional factors, in particular circumstances, may cause the recommended clinical confidence rating to increase or decrease. A wide range of patient diagnoses and settings lend to the generalization of accurate diagnostic assessments via VTC. There are limited data supporting diagnostic accuracy or utility at low bandwidth51,52.

* + 1. **Disposition.** Disposition planning, typically from an inpatient or day hospital mental health or substance abuse program, has been reported as part of program descriptions, both while reporting on other videoconferencing applications and as a particular focus of telemental provision53. One study, involving child and adolescent telepsychiatry indicated the importance of clear recommendations, involvement of local care providers, availability and stability of local agencies and cooperation of the client and guardian as key to successful implementation of teleprovider recommedations54. Coordination between levels of care may be a particularly beneficial application to improve continuity and adherence to care55, particularly for suicidal or potentially aggressive patients who may need emergent interventions including pharmacotherapy. Continuity of care was particularly effective between a rural long-term care facility for dementia and an urban academic acute psychiatric hospital56. VTC also has been used to screen and coordinate transfer of patients to and from general inpatient units to a high acuity inpatient unit57. The use of videoconferencing in patient disposition planning between levels of mental health care is beneficial [B/C2, D3]. The attendance of the patient, when practical, is strongly encouraged and may help with patients who have propensity to splitting behavior.

* + 1. **Psychiatry Specific.**

* + - 1. **Medication Management.** There are descriptions of telepsychiatry programs and collaboratives58, clinical trials, and case reports where medication management is an integral part of the care provision, outcome, and satisfaction of the VTC service59,60,61. There is little information regarding the effect of medication management via videoconferencing, although one retrospective study reported a trend toward prescribing more medications via videoconferencing62. Telepsychiatry, including medication management, has been the principle driving force of providing access to specialty care for remote and underserved populations. Access to psychiatric medication management, practiced in compliance with state regulations, in a timely manner and in keeping with local telemedicine protocols, is a particularly significant benefit of telemental health [B/C2, D3]. Most telepsychiatry programs use a combination of telephonic or facsimile ordering for remote sites and most are moving toward electronic prescribing. RCTs and case studies of VTC to increase adherence to mental health regimens have also been described63,64.

* + - 1. **Medical Conditions.** Psychiatry often does not require the hands-on physical assessment that other areas of medicine require. The lack of physical exam as a component of care has made videoconferencing particularly well suited for psychiatry. Provisions for routine or emergent local medical management, however, should be included in any local operating procedure or protocol. Consultations for inpatients should be reviewed by the telepsychiatrist via remote health record access or facsimile.

* + - 1. **Procedures and Laboratory Studies.** Ordering and receipt of results of pertinent laboratory studies *should* be outlined in any local operating procedure or protocol. Like medical consultations, laboratory or procedure results *should* be reviewed by the telepsychiatrist via remote health record access or facsimile. Telepsychiatry consultants need to have access to relevant clinical data as if they were seeing the patient in person.

* + 1. **Psychological Assessment.** The most common psychology-related evaluation is in relation to the diagnostic interview and the use of diagnostic rating scales as part of this process. Two other categories of psychological assessment are personality assessment and intelligence or cognitive assessment.

* + - 1. **Diagnostic Instruments and Scales.** A good deal of investigation has examined psychiatric assessments that are based on clinician interview, such as the Brief Psychiatric Rating Scale (BPRS)65,66 or psychiatric interviews based on the Structured Clinical Interview for the Diagnostic and Statistical Manual67. There is some support for the reliability and validity of VTC in the administration of the Brief Psychiatric Rating Scale, possibly depending on bandwidth68,69 [B2,C/D3]. Comparability between face-toface and VTC also is demonstrated for the Hamilton Depression Rating Scale for depression70,71 [B2].

One study demonstrated that BPRS ratings based on verbal report are more reliable than symptoms requiring visual observation72. Similarly, a largely positive study comparing teleconference to face-to-face found lesser reliability for the Scale for the Assessment of Negative symptoms using a bandwidth of 128 kbps73.

Remote diagnostic consultation has been widely applied as a way to provide expert opinion for patients in underserved areas. Most studies have demonstrated feasibility and satisfaction, but fewer reliability and validity studies have been conducted74. Two studies75,76 demonstrated high reliability in the administration of the Structured Clinical Interview for DSM-III-R.

* + - 1. **Personality Assessment.** To the best of our knowledge, there has not been any examination of the use of telemedicine in personality assessment. One reason for this may be challenges to using paper-and-pencil measures at remote sites, although adjunctive technologies such as web-based measures may assist with this in the future. There is no information about projective testing over VC, possibly because of the decreased use of such measures in traditional face-to-face practice.

* + - 1. **Neuropsychological Assessment**. Neuropsychological assessment is a subtype of psychological assessment. It is most commonly performed by asking patients to perform cognitively oriented tasks such as remembering a list of 20 words or counting backwards from 100 by 7s. Much of the research on remote neuropsychological assessment demonstrates feasibility77,78. Patients can understand the tasks they need to complete and then do so through video teleconferencing (VTC). Many studies also demonstrate comparability of scores between remote and face-to-face assessment79,80. However, some research also demonstrated differences on test scores81,82,83. Cognitive assessments examined and validated include the CAMCOG84, the MMSE85, The National Adult Reading Test, and the Adult Memory and Information Processing Battery86. One study found that scores were comparable for expressive word knowledge tasks but varied widely for tests of visual-spatial processing.

It appears that VTC neuropsychological assessment is possible and often valid [B/C/D3]. However, it is recommended that research begin to develop new norms so that the thresholds used for impairment are valid when compared with face-to-face administration87. Until this is accomplished, remote neuropsychological assessment will be able to provide a broad indication of areas of impairment, but may lack the same degree of resolution that face-to-face assessment provides. In addition, specific cognitive tests, such as those testing visual-spatial processing, may need to be modified for VTC administration.

* + 1. **Psychiatric Nurse Practitioner, Physician Assistant, and Psychiatric Nursing Specific.** Psychiatric Nurse Practitioners are educated and prepared to provide the full complement of psychiatric services, including primary mental health care services88. It is quite reasonable to assume that psychiatric mental health nurses working in clinical areas, both rural and urban, could benefit from telehealth care. However, a review of literature shows few published randomized clinical trials (RCTs) seeking answers to innovative care provided through videoconferencing, telephone and other telehealth technologies89,90,91,92,93,94,95,96,97,98,99.

* + 1. **Social Work/Counselor Specific.** The literature is limited regarding the use of interactive videoconferencing by social workers, although many articles may reference social workers in the broader term of therapists100. There are no clinical trials or research in the use of videoconferencing specifically by social workers. Often, rural sites have social workers providing therapy and working in concert with urban specialists, often psychiatrists, to provide treatment to their clients. Social workers, like other mental health providers, often have mixed levels of exposure, experience, perceptions, and attitudes about the use of telemedicine technologies, but realize the need to understand and participate in the use of such modalities for their client populations101,102.

Literature addressing substance abuse treatment by a telehealth addictions counselor was only represented by two original articles103,104, both of which demonstrated positive results. It is understood that many patients treated by telemental health for other mental disorders also have co-morbid substance abuse issues and illnesses. VTC cognitive assessments of persons with a history of alcohol use disorders were similar to face-to–face assessments; participants were satisfied with the videoconferencing examination105. More research data will be necessary to determine the risks and benefits of treating the substance abuse population before specific recommendations can be made.

1. **Ongoing Mental Health Care.**

* 1. **Psycho-Education.**

Providing psycho-education via video is a broad area. Grand rounds and case presentations to mental health and non-mental health providers has been a burgeoning area of educational benefit for years. This guideline will limit its focus to direct mental health teaching to patients106, education directly or indirectly to on-site providers as part of the clinical consultation107, and clinical supervision108,109,110. Teleconsultation to providers in rural practices is thought to help through specialist collegial support, bringing the latest information from academic centers and reducing the isolation of rural providers. Mental health knowledge and skills imparted to rural providers have been beneficial [B/C2,D3], with some limitations111. While imparting knowledge via VTC consultation was mentioned in a number of papers, there have been little forthcoming data on actual mental health patient outcomes. Supervision and training of mental health physicians, therapist trainees, and physician assistants has been demonstrated to be beneficial112,113,114,115,116.

* 1. **Individual Psychotherapies.**

As in the face-to-face setting, therapists using VTC come from a range of theoretical orientations and use a variety of psychotherapeutic strategies. Standard practice guidelines for therapy should guide psychotherapy services within the telemedicine setting. Guidelines concerning evidence-based practice and empirically supported treatments may be particularly relevant as therapies are adapted to new contexts such as VTC117,118,119,120. Even in the inperson environment, research into applications and outcomes of these psychotherapies is an ongoing challenge in today’s evidence-based and often managed mental health care environment. There are several publications describing case reports and clinical trials of individual psychotherapy conducted via VTC. Supportive121, exposure122, cognitive behavioral123,124,125,126, and hypnosis127 have all been reported. There were two case reports of Eye Movement Desensitization and Reprocessing therapy conducted via video128,129. Psychotherapy via VTC has included the treatment of bulimia nervosa, panic disorder, agoraphobia, obsessive compulsive disorder, depression, and post traumatic stress disorder, as well as ability to provide culturally sensitive expertise130,131,132,133,134,135,136. Therapist’s adherence and competence in the practice of manualized cognitive behavioral therapy via VTC has proven effective137. Psychotherapy appears to be amenable to the VTC communication medium [B/C2,D3], with the majority of the individual psychotherapy VTC literature describing cognitive behavioral therapy applications [B/C2, D3]. There are no specific recommendations to exclude types of psychotherapy to be utilized via telemental health VTC. As previously mentioned, some mental disorders, e.g., eating and trauma disorders, may benefit in their treatment from the geographic and/or interpersonal distance patients/clients may experience while engaged in psychotherapy via VTC138,139. Future research will provide guidance on the best person-setting-therapist matches for the various VTC contexts.

* 1. **Group Psychotherapies.**

Similar to individual psychotherapies, there are many different types and approaches to group psychotherapy in both inpatient and outpatient settings. Standard practice guidelines for group therapy should guide VTC services140,141,142,143. Multipoint videoconferencing offers the possibility to provide small numbers of patients in rural areas with the opportunity to attend outpatient groups that are more homogeneous and stable in nature. Witson mentioned in his earliest reports of video group therapy that the dynamics of the group depended more on the therapist and the makeup of the group than using VTC as the treatment medium144. Multipoint groups could be particularly advantageous for patients suffering trauma145, eating disorders, or other diagnoses or circumstances that are potentially isolating [B/C/D3]. While this may be a very powerful tool, there is limited published literature regarding videoconferencing group therapy. There were two clinical trials comparing

videoconferencing to in-person group therapy for veterans with PTSD. One study involved a coping skills group146 and the other a cognitive behavioral therapy group147. Satisfaction between group participants, level of retention of information, and attendance were similar. Future research will provide guidance about the best group therapy applications within the VTC context.

* 1. **Marital and Family Psychotherapy.**

Marital and family therapies could be considered specialized types of group therapy because sessions involve the interaction of two or more clients with a therapist(s). Like group therapy, the more members involved, the greater the likelihood that all members may not be physically co-located. Standard practice guidelines for marital and family therapy should be consistent with applications in the VTC context148. While there were no published research trials of family therapy conducted via VTC, there were a few articles describing unique applications, benefits, and limitations utilizing videoconferencing technologies. There is evidence that the use of TMH family therapy with inpatients may be particularly beneficial for the patient and may reduce the length of stay149. It was suggested that some patients may feel safer expressing themselves in session when communicating with family members via video150, while other families/members may experience extended family sessions as not “real”151. Two articles pointed out that the transmission delay they experienced was helpful to the therapy process as it made clear when family members talked over one another and were not demonstrating adequate listening skills152,153. Telemental health family therapy via a satellite connection proved helpful to this family in resolving their deeply held conflicts154. While there are limited data regarding family therapy via videoconferencing, early reports indicate excellent acceptance and primarily beneficial outcomes [B/C3].

There also are reports of medical teams using videoconferencing to communicate with the families of children recovering from or dealing with severe medical illness155,156,157,158. These sessions did not involve mental health therapists, but were mental health as well as somatic in nature. There also are reports of the benefit and support nursing home residents experienced through videoconferencing with their families159.

1. **Populations of Special Focus.**

* 1. **Geriatrics.**

The elderly population may benefit significantly from improved access to specialty mental health care that can be provided via videoconferencing160,161. Many elderly individuals have multiple health problems in addition to mental health problems; the medical problems may complicate or even precipitate mental health problems. Thus, the elderly often are high users of health services and often present complex issues.

For any elderly individual, accessing necessary care can present many challenges, from the frequency of visits for needed care to transportation for such care. For the rural geriatric patient, the challenges are greatly increased. The frequency of need for and the cost of transportation to the nearest urban area, which may be quite distant, can be prohibitive, even if the individual is insured for the actual care. For many, the cost and complexity of planning and locating such care in busy, traffic-intense urban centers are overwhelming. Many simply do without.

The trend toward accessing basic care in the home setting via simple videoconferences over video phones or computers is a welcome tool for increasing accessibility, especially for those who have mobility limitations or transportation limitations. Connecting local hospitals, health care clinics, nursing homes, and mental health facilities to remote specialists via high quality, secure videoconference connections is a technology that is now available and the number of such partnerships is increasing.

However, the literature on geriatric telemental health is quite sparse. There have been relatively few controlled studies of outcomes in the geriatric population162,163. There have been case studies and opinion essays164,165 while some literature involves psychometric instruments166, usually involving patients in long-term care facilities. There is some limited evidence-based support for the provision of psychiatric services to geriatric patients in nursing facilities [B/C/D3].

The concept of increasing accessibility of care via videoconferencing seems obvious and appealing. Further study must be done to provide reliable evidence. Such studies must also specifically address the challenges the elderly face in dealing with videoconferencing. Sensory deficits, especially visual and auditory, can impair their ability to successfully interact over a videoconference connection167. The patient end must have large monitors, good audio capabilities, and high bandwidth and video resolution to make sure there is a large and clear picture connecting the elderly patient/client to the care giver.

Another challenge for this age group is the prevalence of dementia, with deficits in cognitive capability and often accompanied by psychiatric symptoms such as depression and delusions. The elderly are the least likely to be familiar with new technology and, with dementia as an added factor, it can theoretically be a challenge to assure that the interaction with the service provider is understood to be real rather than just a figure on a television or a hallucinatory experience. An additional issue is that any videoconferencing approach must include all appropriate aspects of a full diagnostic evaluation. One article developed a protocol for diagnosing Alzheimer's disease utilizing videoconferencing168. The geriatric patient often has multiple medical problems, many of which affect their cognitive/behavioral state, and thus deserves a full workup, including all appropriate laboratories, radiologic, and other diagnostic procedures.

**2.** **Children and Adolescents.**

Recommendations for child and adolescent telemental health (CATMH) build on information and recommendations presented above for telemental health (TMH) with adults. Throughout this document the term “parents” refers to the youth’s primary caretakers, regardless of whether they are biological parents, adoptive parents, or legal guardians. The terms “youth” and “young people” refer to mixed samples of children and adolescents. When specific developmental groups are intended, the terms “toddlers,” “preschoolers,” “children,” and “adolescents” are used. The guidelines are applicable to the evaluation and treatment of youth from preschool to 18 years old and developmentally impaired young adults up to 21 years old with emotional and behavioral difficulties.

CATMH programs have been successfully implemented in multiple diverse settings such as pediatric clinics169, community mental health centers170, rural schools171,172 urban daycare173, corrections174, and private practice175. CATMH is applicable with youth of minority ethnicity, such as African-American176, Hispanic177, Hawaiian178, Native American,179,180 and Alaska Native181 youth.

**a. Evaluations.** VTC procedures for the evaluation and treatment of youth follow the same guidelines presented for adult with modifications to consider the developmental status of youth, such as motor functioning, speech and language capabilities, and relatedness. The following recommendations are in addition to the evidence listed for adults.

1. **Setting.**

* 1. **Physical Surroundings and Staffing.** Families should be informed during scheduling to prepare their children for a VTC appointment. The room is positioned and remote camera control is available so the practitioner is able to view and adequately observe children’s motor skills as they move about the room, play, and separate from their parents182,183. A table may provide a surface for the child to draw or play while the parent relates the history, but it should not interfere with communication or viewing the youth’s motor skills. Some simple toys should be provided both to occupy the child and to allow assessment of skills.

* 1. **Outpatient.** The literature on CATMH is sparse. Published work has predominantly described care in outpatient settings184,185,186,187,188. Most of these studies have measured parent and provider satisfaction189,190,191,192 and have found that parents and providers are very satisfied with CATMH care. Although satisfaction does not equate to efficacy, it does imply acceptability and informs directions for future work193. Other reports have described successes and challenges of program implementation194,195,196,197. One recent study described improvements in children’s affective states and oppositional behaviors after CATMH198.

No absolute inclusion or exclusion criteria for CATMH have been established. Applications of CATMH have been described across most developmental groups and diagnostic categories [B/C1]. School-aged children comprise the modal treatment group, similar to usual outpatient care199,200,201,202,203,204,205 but children as young as 3 years old have been evaluated and treated206,207,208. Thus, diagnosis is not a determining factor in deciding to treat a youth through CATMH. Rather, it is providing a system of care in the patient’s community that matches the services the telepsychiatrist will deliver and resources at the patient site to help manage challenging youth that best determines inclusion or exclusion for CATMH. Their care and the clinical procedures used in CATMH should follow the practice parameters developed by the American Academy of Child and Adolescent Psychiatry.

* 1. **Inpatient.** There are no reports of CATMH in inpatient settings, nor any indication as to whether any work is being done in this area. However, CATMH may be helpful to inpatient settings needing child and adolescent psychiatric consultation [B/C/D3]. Such units may be predominantly staffed by pediatricians or family physicians who then receive teleconsultation from a psychiatrist.

* 1. **Other Settings.** One advantage of CATMH is the ability to readily reach youth in rural naturalistic settings such as schools209,210 or in distant residential sites such as corrections211, and long term treatment centers212,213. VTC-mediated meetings can be especially helpful in bringing together youth at the residential setting with family and professionals in the youth’s home community for treatment planning214 [B/C2, D3]. One caveat is that adolescents in correctional settings may not be forthcoming if accompanied to the CATMH session by correctional staff. When afforded appropriate privacy and time alone with the telepsychiatrist, incarcerated youth express high satisfaction with their telepsychiatric care215 [B/C2].

1. **Diagnostic Interview.**

* 1. **Provider-Patient Relationship.** The teletherapist must establish a therapeutic alliance not just with the youth, but also with the parent and other participating adults, and must work within the parent-child relationship. Satisfaction data indicate that parents readily establish rapport with their teletherapist216,217,218, thereby suggesting that VTC does not interfere with the therapeutic alliance [B/C2, D3].

Emerging information from work with adults suggests that a more casual clinical style optimize rapport219,220,221 and this is likely true for youth as well [B/C2]. When working with youth with cognitive limitations222,223 or with youth of different cultural backgrounds, a more casual style could be problematic and the technological limitations might make it difficult to distinguish clinically relevant issues. Thus, it is important to adjust communication to patients’ needs [B/C2].

Because youth are evolving their interpersonal sensitivities and skills, but do not have access to the usual nuances of interpersonal relatedness, the teletherapist must devise ways to engage youth. Rapport-building can be facilitated by showing the youth how to use the remote control to obtain a close-up of the teletherapist or scan the teletherapist’s room to make it appear more real or to demonstrate the picture-inpicture box in the corner of the monitor to obtain a close-up view of himself/herself or his/her parents 224,225,226,227.

* 1. **Assessment and Diagnosis.** It seems intuitive that higher bandwidth should provide the most accurate clinical assessment, but there are no data to support this assumption. Bandwidth and resolution must be sufficient to detect subtle aspects of the mental status examination, such as tics, dysmorphia, or abnormalities in relatedness [B/C2].

Recent encouraging results suggest that diagnoses made in CATMH are reliable and valid 228,229. The accuracy and relevance of assessment conducted through VTC is further supported by the success of functional behavioral analysis of developmentally impaired young children in leading to effective classroom interventions230.

The American Academy of Child and Adolescent Psychiatry (AACAP) Practice Parameters for the Psychiatric Assessment of Children and Adolescents231 recommends that some time is spent interviewing the youth alone. In general, teens and older children with good impulse control, adequate verbal skills, and the ability to separate are amenable to interview alone [B/C2, D3]. Younger, developmentally impaired, or impulsive youth need a modified approach, likely including an adult in the room, e.g., a staff member at the clinic [B/C2]. Such decisions should be individualized to the youth.

The recommendation for a traditional play session with younger children232 may be challenging. One approach includes observing the child interacting with a staff member in either a free-form or structured play session. Some limited direct play with the child may be possible over the telemonitor. For example, while parents provide history, children often enjoy drawing pictures and sharing them with the teletherapist. The teletherapist also may receive the picture electronically, via fax or a document reader. Another possibility, although not yet explored, is that the child might draw on an electronic tablet that could be immediately transmitted via VTC.

The teletherapist can then build on the child’s actions by exploring the themes present in the pictures. Similarly, the teletherapist can develop a play scenario or story together with the child, or use puppets to facilitate play over the telemonitor. Sometimes the therapist may work with on-site personnel or parents to facilitate these interactions. Some time in a play session should be incorporated into the assessment and the treatment as indicated and tolerated [B/C3].

CATMH has been reported with preschoolers as young as 2.5 to 3 years old233,234,235,236. The AACAP Practice Parameter for the Psychiatric Assessment of Infants and Toddlers 237 recommends multidisciplinary sources of information regarding the child’s functioning in multiple settings. The parameter recommends direct observation of the child during his/her interactions with parents and preferably with an unfamiliar adult. Another recommendation is that the psychiatrist has direct interaction with the child. This interaction can be accomplished while the child remains in a room with a parent and/or a staff person [B/C2]. Some preschoolers can be directly engaged over the monitor, e.g., by asking them to point to body parts, to demonstrate skills such as counting, or to talk about his/her pets. However, it is helpful to have an adult present with the child to provide input regarding a very young child’s level of attunement, pleasure in the interaction, or spontaneity in play.

**c. Disposition and Continuity of Care.** The needs assessment conducted prior to the establishment of a CATMH practice identifies collaborating clinicians and system-of-care so that the teletherapist will have a clearly defined role within the youth’s treatment and know whose assistance to elicit as need arises238. The community should have the resources to follow up recommendations by the telepsychiatrist239. Ongoing treatment of unstable youth may only be possible in a community with a comprehensive system of care that can provide appropriate wraparound services240.

**b. Treatment.**

1. **Medication Management.** Expert pharmacotherapy is the most frequently requested CATMH service241,242. Various methods have been employed to provide medication management, including: a) the telepsychiatrist consults to the referring primary care physician (PCP) who prescribes; b) the telepsychiatrist works with a mid-level professional at the patient site who writes the prescriptions; and c) the telepsychiatrist directly prescribes. In this last scenario, clear procedures are established and communicated to all parties regarding the method for obtaining initial prescriptions and refills and reporting adverse effects. CATMH sites located in non-medical or non-mental health sites, such as schools or shelters, may not be able to provide medication service and/or will need considerable modifications to usual practice, particularly for controlled substances such as stimulants.

1. **Psychotherapy.** Standard of practice guidelines should be followed in psychotherapy evaluation and treatment with children243,244. As described with telepsychiatry, standard of care consultation with the child’s primary care provider or the child’s medical home is encouraged when possible. Ongoing psychotherapy requires time alone with the youth. How to accomplish ongoing individual therapy in CATMH has not been systematically

studied, but individual case reports of therapy with youth have been described245,246,247,248,249. The only therapy outcome study250 showed comparable improvements with cognitive behavioral therapy supporting a role for CATMH in psychotherapy with youth [B/C2]. A telepsychiatry counseling service to juvenile detention facilities suggested an improved rate of family and behavioral goals attainment251. In general, teletherapists may attempt to engage in therapy adolescents and older children with good verbal skills who are not aggressive, severely oppositional, or otherwise dysregulated [B/C2].

1. **Seclusion and Restraint.**

Reduction in the use of seclusion and restraint has been a priority of providers, facilities, and the Substance Abuse and Mental Health Services Administration. One clinical trial looked at the use of videoconferencing in place of in-person assessment following restraint and seclusion of pediatric patients at a private hospital252. Remote assessment was felt to be rapid and reliable.

1. **Emergency Assessments.**

Emergency evaluation of patients with mental health disorders may be an area of particular value to emergency departments, especially in remote geographic locations. Emergency evaluations are defined as evaluations that require assessment of patients where there are questions of imminent risk of harm to self or others or where acute psychosis is present. Useful VTC software features such as remote unit startups, auto answering, and camera power controls should be included when selecting a VTC unit for emergency assessment. Psychiatrists are often contacted by phone to consult on patients in the emergency room who have been seen by the emergency room physician, mental health professional, or paraprofessional and disposition is in question. The psychiatrist also may consult in person the following day when patients thought to need admission by the emergency room providers are still in the emergency room due to lack of inpatient beds. Consultation by psychiatrists via interactive video may provide the expertise to determine disposition, e.g., outpatient or day hospital treatment, more quickly and reduce the length of emergency room stays for patients with mental health issues. When patients are located in remote areas this also may eliminate the need to transfer patients to regional or urban hospital centers, disrupting their lives even more. There are a few papers discussing emergency telepsychiatry. Two papers describe outcomes for patients who received emergency telepsychiatric evaluations and remained as outpatients253,254. There also are descriptions of performing emergency evaluations or secondary opinions on patients already admitted255,256,257, providing medical clearance in the emergency room for psychiatric patients258, and a set of emergency management guidelines259. Special attention should be given to determining how assessment and disposition by videoconferencing can safely meet the needs of suicidal and aggressive patients260.

1. **Involuntary Commitments.**

Commitments involve both clinical and legal issues. Patients thought to be in imminent danger of harming themselves or others are assessed by providers according to State regulations and can be involuntarily admitted to a medical facility. These acute admissions are time-limited so that a legal hearing can be coordinated and a judge will render a decision whether to continue the involuntary admission or release the patient. Often legal hearings are avoided when patients change their decision and sign a voluntary admission request. While it is believed that involuntary commitments and legal hearings are being done in the United States via videoconferencing, little is mentioned in the literature. There is a case report of using videoconferencing to complete a psychiatric assessment under the mental health act in Australia for involuntary admission and use of depot antipsychotic medication261. Using VTC to interview patients for this combined clinical/legal proceeding would depend on local laws and the local administrative law judge.

1. **Incarcerated.**

Telemental health, like other applications of telemedicine, has been one of the earliest routine applications of telehealth. The main driving force behind this is access, especially of the pre-trial populations detained in the nation’s jails. Jails typically have high suicide rates due to their role in acute incarceration, risks of substance withdrawal, and social consequences. Additionally, onsite mental health care is usually only available at the larger jail complexes. Getting the patient transported to an appropriate provider is encumbered by costs, staffing levels, and safety concerns. Monies saved in escort costs are used to purchase VTC equipment, pay for administrative coordination, and provide on-site nursing or ancillary clinical staff attendance at videoconferencing appointments. Telepsychiatry treatment has been provided to both jails262,263,264 and prisons265. There has been limited discussion regarding the use of forensic telepsychiatry266. Two studies investigated the use of VTC for forensic evaluations; the resultant inter-rater reliabilities were good to excellent267,268. Several studies have proven acceptability269 and limited clinical evidence of effectiveness with the incarcerated population [B2,C/D3]. Because detained persons are a vulnerable population, teleproviders should be confident that incarcerated patients are referred for videoconferencing evaluation appropriately rather than solely to avoid costs.

1. **SUMMARY**

This document was prepared in response to the needs and requests of providers, organizations and the ATA membership interested in or engaged in telemental health activities, for the development of evidence based telemental health guidelines. The broad nature of the mental health field along with an unlimited number of ways to use technology in mental health services led the committee to limit this evidence based document to interactive video conferencing applications. Appreciating the broad range of providers and settings involved in TMH, recommendations are organized by patient age, types of treatment, treatment setting and provider specialty. The coding system was developed to encourage more specific descriptions of the technology being used in TMH interactive videoconferencing research and methods publication. It provides recommendations based on clinical confidence derived from the published literature, committee members and expert reviewers. The committee hopes the users of this document will benefit from the recommendations, literature references, and the development of a clinical/technical coding system. The document structure and headings were selected in anticipation that users will note the clinical applications that are in most need of additional evidence based research and perhaps select these areas as a focus of future research.

1. **REFERENCES**

1. Sood S, Mbarika V, Jugoo S, Dookhy R, Doarn CR, Prakash N, Merrell RC. What is telemedicine? A collection of 104 peer-reviewed perspectives and theoretical underpinnings. Telemed J E Health. 2007;13(5):573-590.
2. Hailey D, Roine R, Ohinmaa A. The effectiveness of telemental health applications: a review. Can J

Psychiatry. 2008 Nov;53(11):769-78

1. Antonacci DJ, Bloch RM, Saeed SA, Yildirim Y, Talley J. Empirical evidence on the use and effectiveness of telepsychiatry via videoconferencing: implications for forensic and correctional psychiatry. Behav Sci Law. 2008;26(3):253-69.
2. Norman S. The use of telemedicine in psychiatry. J Psychiatr Ment Health Nurs. 2006 Dec;13(6):771-7. 5 Hyler SE, Gangure DP, Batchelder ST. Can telepsychiatry replace in-person psychiatric assessments? A review and meta-analysis of comparison studies. CNS Spectr. 2005 May;10(5):403-13.
3. Monnier J, Knapp RG, Frueh BC. Recent advances in telepsychiatry: an updated review. Psychiatr Serv. 2003 Dec;54(12):1604-9.
4. Myers K, Cain S; Work Group on Quality Issues; American Academy of Child and Adolescent Psychiatry Staff. Practice parameter for telepsychiatry with children and adolescents. J Am Acad Child Adolesc Psychiatry. 2008 Dec;47(12):1468-83.
5. Grady BJ. Chapter 41: TelePsychiatry, in the American Psychiatric Press Textbook Of Consultation-Liaison Psychiatry: Psychiatry In The Medically Ill, Edited by Wise, MG, Rundell, JR, Washington DC, American Psychiatric Publishing. 2002.
6. Wooten R. Telepsychiatry and E-Mental Health. Royal Society of Medicine Press, 2003.
7. Whitten P, Johannessen LK, Soerensen T, Gammon D, Mackert M. A systematic Review of Research

Methodology in Telemedicine Studies. J Telemed Telecare, 2007;13(5):230-235

1. Hersch WR, Hickam D, Severance SM, Dana TL, Krages KP, Helfand M. Telemedicine for the Medicare Population—Update. Evidence Report/Technology Assessment: Number 131. AHRQ

Publication Number 06-E007. Agency for Healthcare Research and Quality, 2006, Rockville, MD 12 APA Resource Document On Telepsychiatry Via Videoconferencing, accessed December 15, 2007, http://www.psych.org/psych\_pract/tp\_paper.cfm

1. APA Statement on Services by Telephone, Teleconferencing, and Internet. Accessed December 15, 2007, http://www.apa.org/ethics/stmnt01.html
2. National Association of Social Workers and Association of Social Work Boards, Standards for Technology and Social Work Practice. Accessed December 15, 2007,

http://www.socialworkers.org/practice/standards/NASWTechnologyStandards.pdf

1. Wiegand T, Sullivan GJ, Bjøntegaard G, Luthra A. Overview of the H.264/AVC Video Coding Standard. IEEE Trans Circuits Systems Video Technol. 2003 Jul;13(7):560-76
2. Norman S. The use of telemedicine in psychiatry. J Psychiatr Ment Health Nurs. 2006 Dec;13(6):771-7 17 Broder E, Manson E, Boydell K, Teshima J. Use of Telepsychiatry for Child Psychiatric Issues: First 500 Cases. CPA Bulletin De l’APC June 2004 11-15.
3. Kennedy C, Yellowlees P. The effectiveness of telepsychiatry measured using the Health of the Nation

Outcome Scale and the Mental Health Inventory. J Telemed Telecare. 2003;9(1):12-6

1. Zaylor C. Clinical Outcomes in Telepsychiatry. J Telemed Telecare. 1999;5 Suppl 1:S59-60 20 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 Jun;58(6):836-43.
2. Nelson EL, Barnard M, Cain S. Treating childhood depression over videoconferencing Telemed J E Health. 2003 Spring;9(1):49-55
3. Miller TW, Kraus RF, Kaak O, Sprang R, Burton D. Telemedicine: a child psychiatry case report.

Telemed J E Health. 2002 Spring;8(1):139-41

1. Gallagher TE. Augmentation of special-needs services and information to students and teachers

"ASSIST"--a telehealth innovation providing school-based medical interventions. Hawaii Med J. 2004 Oct;63(10):300-9

1. Young TL, Ireson C. Effectiveness of school-based telehealth care in urban and rural elementary schools. Pediatrics. 2003 Nov;112(5):1088-94
2. Sorvaniemi M, Santamaki O: Telepsychiatry in emergency consultation. Journal of Telemedicine and Telecare 8: 183-184, 2002
3. Mielonen ML, Ohinmaa A, Moring J, Isohanni M. Psychiatric inpatient care planning via telemedicine. J Telemed Telecare. 2000;6(3):152-7
4. Pollard SE, LePage JP. Telepsychiatry in a rural inpatient setting. Psychiatr Serv. 2001 Dec;52(12):1659
5. Montani C, Billaud N, Tyrrell J, Fluchaire I, Malterre C, Lauvernay N, Couturier P, Franco A

Psychological impact of a remote psychometric consultation with hospitalized elderly people. J Telemed Telecare. 1997;3(3):140-5

1. Holden D, Dew E. Telemedicine in a rural gero-psychiatric inpatient unit: comparison of perception/satisfaction to onsite psychiatric care. Telemed J E Health. 2008 May;14(4):381-4. 30 Pollard SE, LePage JP. Telepsychiatry in a rural inpatient setting. Psychiatr Serv. 2001 Dec;52(12):1659
2. Major J. Telemedicine room design. J Telemed Telecare. 2005;11(1):10-4
3. Pineau G, Moqadem K, St-Hilaire C, Perreault R, Levac E, Hamel B, et al. Telehealth: Clinical Guidelines and Technical Standards for Telepsychiatry.

http://www.bibliotheque.assnat.qc.ca/01/mono/2006/09/912275.pdf accessed 17 July 2007. 33 Ghosh GJ, McLaren PM, Watson JP. Evaluating the alliance in videolink teletherapy. J Telemed Telecare. 1997;3 Suppl 1:33-5

1. Simpson S. The provision of a telepsychology service to Shetland: client and therapist satisfaction and the ability to develop a therapeutic alliance. J Telemed Telecare. 2001;7 Suppl 1:34-6.
2. Jerome LW, Zaylor C. Cyberspace: Creating a therapeutic environment for telehealth applications. Professional Psychology: Research and Practice. 2000;31(5):478-483
3. Urness, D., Wass, M., Gordon, A., Tian, E., Bulger, T. Client acceptability and quality of life - telepsychiatry compared to in-person consultation. J Telemed Telecare, 2006;12 (5):251-254 37 Ilan Modai, Mahmoud Jabarin, Rena Kurs, Peretz Barak, Ilan Hanan, Ludmila Kitain. Cost Effectiveness, Safety, and Satisfaction with Video Telepsychiatry versus Face-to-Face Care in Ambulatory Settings. Telemedicine and e-Health. 2006, 12(5): 515-520.
4. Shore JH, Savin DM, Novins D, Manson SM. Cultural aspects of telepsychiatry. J Telemed Telecare. 2006;12(3):116-21.
5. Nieves JE, Stack KM. Hispanics and telepsychiatry. Psychiatr Serv. 2007 Jun;58(6):877-8
6. Simpson S, Knox J, Mitchell D, Ferguson J, Brebner J, Brebner E. A multidisciplinary approach to the treatment of eating disorders via videoconferencing in north-east Scotland. J Telemed Telecare. 2003;9 Suppl 1:S37-8
7. Thomas CR, Miller G, Hartshorn JC, Speck NC, Walker G. Telepsychiatry program for rural victims of domestic violence. Telemed J E Health. 2005 Oct;11(5):567-73
8. Tam T, Cafazzo JA, Seto E, Salenieks ME, Rossos PG. Perception of eye contact in video teleconsultation. J Telemed Telecare. 2007;13(1):35-9.
9. Milton Chen Leveraging the asymmetric sensitivity of eye contact for videoconferencing. In: Proceedings of the SIGCHI conference on Human factors in computing systems 2002. Minneapolis, Minnesota: ACM Press: 49 – 56.
10. Baer L, Cukor P, Jenike MA, Leahy L, O'Laughlen J, Coyle JT. Pilot studies of telemedicine for patients with obsessive-compulsive disorder. Am J Psychiatry. 1995 Sep;152(9):1383-5. 45 Baigent MF, Lloyd CJ, Kavanagh SJ, Ben-Tovim DI, Yellowlees PM, Kalucy RS, Bond MJ.

Telepsychiatry: 'tele' yes, but what about the 'psychiatry'? J Telemed Telecare. 1997;3 Suppl 1:3-5

1. Ruskin PE, Reed S, Kumar R, Kling MA, Siegel E, Rosen M, Hauser P. Reliability and acceptability of psychiatric diagnosis via telecommunication and audiovisual technology. Psychiatr Serv. 1998 Aug;49(8):1086-8
2. Elford R, White H, Bowering R, Ghandi A, Maddiggan B, St John K, et al. A randomized, controlled trial of child psychiatric assessments conducted using videoconferencing. J Telemed Telecare 2000;6:7382
3. Hyler SE, Gangure DP, Batchelder ST. Can telepsychiatry replace in-person psychiatric assessments? A review and meta-analysis of comparison studies. CNS Spectr. 2005 May;10(5):403-13
4. Singh SP, Arya D, Peters T. Accuracy of telepsychiatric assessment of new routine outpatient referrals. BMC Psychiatry. 2007 Oct 5;7(1):55.
5. 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 Jun;58(6):836-43.
6. Zarate CA Jr, Weinstock L, Cukor P, Morabito C, Leahy L, Burns C, Baer L. Applicability of telemedicine for assessing patients with schizophrenia: acceptance and reliability. J Clin Psychiatry. 1997 Jan;58(1):22-5.
7. Shore JH, Savin D, Orton H, Beals J, Manson SM. Diagnostic reliability of telepsychiatry in American Indian veterans. Am J Psychiatry. 2007 Jan;164(1):115-8.
8. McLaren P, Jegan S, Ahlbom J, Gallo F, Gaughran F, Forni C. Controlled trial of discharge planning by video-link in a UK urban mental health service: responses of staff and service users. J Telemed Telecare. 2002 Dec;8 Suppl 3(6):44-46.
9. Boydell KM, Volpe T, Kertes A, Greenberg N. A review of the outcomes of the recommendations made during paediatric telepsychiatry consultations. J Telemed Telecare. 2007;13(6):277-81 55 D'Souza R Telemedicine for intensive support of psychiatric inpatients admitted to local hospitals J Telemed Telecare. 2000;6 Suppl 1:S26-8
10. Constantine G. Lyketsos, Carmel Roques, Linda Hovanec, and Beverly N. Jones, III Telemedicine Use and the Reduction of Psychiatric Admissions from a Long-Term Care Facility J Geriatr Psychiatry Neurol 2001 14: 76-79.
11. Haslam R, McLaren P. Interactive television for an urban adult mental health service: the Guy's

Psychiatric Intensive Care Unit Telepsychiatry Project. J Telemed Telecare. 2000;6 Suppl 1:S50-2 58 Fortney JC, Pyne JM, Edlund MJ, Williams DK, Robinson DE, Mittal D, Henderson KL. A randomized trial of telemedicine-based collaborative care for depression. J Gen Intern Med. 2007 Aug;22(8):1086-93. Epub 2007 May 10.

1. Zaylor C. Clinical Outcomes in Telepsychiatry. J Telemed Telecare. 1999;5 Suppl 1:S59-60
2. De Las Cuevas C, Arredondo MT, Cabrera MF, Sulzenbacher H, Meise U. Randomized clinical trial of telepsychiatry through videoconference versus face-to-face conventional psychiatric treatment. Telemed J E Health. 2006 Jun;12(3):341-50
3. Ruskin PE, Silver-Aylaian M, Kling MA, Reed SA, Bradham DD, Hebel JR, Barrett D, Knowles F 3rd, Hauser P. Treatment outcomes in depression: comparison of remote treatment through telepsychiatry to in-person treatment. Am J Psychiatry. 2004 Aug;161(8):1471-6
4. GradyBJ, MelcerT A Retrospective Evaluation of TeleMental Healthcare Services for Remote Military Populations Telemed J E Health. 2005 Oct;11(5):551-8.
5. Fortney JC, Pyne JM, Edlund MJ, Williams DK, Robinson DE, Mittal D, Henderson KL. A randomized trial of telemedicine-based collaborative care for depression. J Gen Intern Med. 2007;22(8):1086-93.
6. Frangou S, Sachpazidis I, Stassinakis A, Sakas G.Telemonitoring of medication adherence in patients with schizophrenia.Telemed J E Health. 200511(6):675-83.
7. Grob P, Weintraub D, Sayles D, Raskin A, Ruskin P. Psychiatric Assessment of a Nursing Home

Population Using Audiovisual Telecommunication J Geriatr Psychiatry Neurol. 2001 Summer;14(2):63-5

1. Ball CJ, McLaren PM. Comparability of face-to-face and videolink administration of the Brief Psychiatric Rating Scale. Am J Psychiatry. 1995 Jun;152(6):958-9
2. Shore JH, Savin D, Orton H, Beals J, Manson SM. Diagnostic reliability of telepsychiatry in American Indian veterans. Am J Psychiatry. 2007 Jan;164(1):115-8.
3. Matsuura S, Hosaka T, Yukiyama T, Ogushi Y, Okada Y, Haruki Y, Nakamura M. Application of telepsychiatry: a preliminary study Psychiatry Clin Neurosci. 2000 Feb;54(1):55-8
4. Yoshino A, Shigemura J, Kobayashi Y, Nomura S, Shishikura K, Den R, Wakisaka H, Kamata S, Ashida H. Telepsychiatry: assessment of televideo psychiatric interview reliability with present- and nextgeneration internet infrastructures. Acta Psychiatr Scand. 2001 Sep;104(3):223-6
5. Kobak KA A comparison of Face-to-Face and videoconference administration of the HDRS J Telemed Telecare. 2004;10(4):231-5.
6. Kobak KA, Williams JB, Engelhardt N. A comparison of face-to-face and remote assessment of inter-rater reliability on the Hamilton Depression Rating Scale via videoconferencing. Psychiatry Res. 2007 Oct 23; [Epub ahead of print]
7. Jones BN 3rd, Johnston D, Reboussin B, McCall WV. Reliability of telepsychiatry assessments: subjective versus observational ratings J Geriatr Psychiatry Neurol. 2001 Summer;14(2):66-71 73 Zarate CA Jr, Weinstock L, Cukor P, Morabito C, Leahy L, Burns C, Baer L. Applicability of telemedicine for assessing patients with schizophrenia: acceptance and reliability. J Clin Psychiatry. 1997 Jan;58(1):22-5.
8. Martin-Khan M, Varghese P, Wootton R, Gray L. Successes and failures in assessing cognitive function in older adults using video consultation. J Telemed Telecare. 2007;13 Suppl 3:60-62
9. Ruskin PE, Reed S, Kumar R, Kling MA, Siegel E, Rosen M, Hauser P. Reliability and acceptability of

psychiatric diagnosis via telecommunication and audiovisual technology. Psychiatr Serv. 1998 Aug;49(8):1086-8

1. Shore JH, Savin D, Orton H, Beals J, Manson SM. Diagnostic reliability of telepsychiatry in American Indian veterans. Am J Psychiatry. 2007 Jan;164(1):115-8.
2. Hildebrand R, Chow H, Williams C, Nelson M, Wass P. Feasibility of neuropsychological testing of older adults via videoconference: implications for assessing the capacity for independent living. J Telemed Telecare. 2004;10(3):130-4
3. Saligari J, Flicker L, Loh PK, Maher S, Ramesh P, Goldswain P. The clinical achievements of a geriatric telehealth project in its first year. J Telemed Telecare. 2002;8 Suppl 3:S3:53-5. 79 Cullum CM, Weiner MF, Gehrmann HR, Hynan LS. Feasibility of telecognitive assessment in dementia. Assessment. 2006 Dec;13(4):385-90
4. Loh PK, Donaldson M, Flicker L, Maher S, Goldswain P. Development of a telemedicine protocol for the diagnosis of Alzheimer's disease. J Telemed Telecare. 2007;13(2):90-4.
5. Loh PK, Ramesh P, Maher S, Saligari J, Flicker L, Goldswain P. Can patients with dementia be assessed at a distance? The use of Telehealth and standardised assessments. Intern Med J. 2004 May;34(5):239-42
6. Ball C, Tyrrel J, Long C Scoring written material from the Mini-Mental State Examination: a comparison of face-to-face, fax and video-linked scoring. J Telemed Telecare. 1999;5(4):253-6 83 Montani C, Billaud N, Couturier P, Fluchaire I, Lemaire R, Malterre C, Lauvernay N, Piquard JF, Frossard M, Franco A. Telepsychometry: a remote psychometry consultation in clinical gerontology: preliminary study. Telemed J. 1996 Summer;2(2):145-50
7. Ball C, Puffett A. The assessment of cognitive function in the elderly using videoconferencing. J Telemed Telecare. 1998;4 Suppl 1:36-8
8. Grob P, Weintraub D, Sayles D, Raskin A, Ruskin P. Psychiatric Assessment of a Nursing Home Population Using Audiovisual Telecommunication J Geriatr Psychiatry Neurol. 2001 Summer;14(2):63-5 86 Kirkwood KT, Peck DF, Bennie L The consistency of neuropsychological assessments performed via telecommunication and face-to-face J Telemed Telecare. 2000;6(3):147-51
9. Jacobsen SE, Sprenger T, Andersson S, Krogstad JM. Neuropsychological assessment and telemedicine: a preliminary study examining the reliability of neuropsychology services performed via telecommunication. J Int Neuropsychol Soc. 2003 Mar;9(3):472-8
10. Psychiatric-Mental Health Nurse Practitioner Competencies September 2003. National Organization of Nurse Practitioner Faculties, Washington, DC. accessed 2 January 2008.
11. Cook R. Introducing: telehealth and telecare. Br J Community Nurs. 2007 Jul;12(7):307. 90 Black S, Andersen K, Loane MA, Wootton R. The potential of telemedicine for home nursing in Queensland. J Telemed Telecare. 2001;7(4):199-205.
12. Guilfoyle C, Perry L, Lord B, Buckle K, Mathews J, Wootton R. Developing a protocol for the use of telenursing in community health in Australia. J Telemed Telecare. 2002;8 Suppl 2:33-6.
13. Pascoe SW, Neal RD.. Primary care: questionnaire survey of alternative forms of patient and nurse face-to-face consultations. J Clin Nurs. 2004 Mar;13(3):406-7
14. Rosina R, Starling J, Nunn K, Dossetor D, Bridgland K. Telenursing: clinical nurse consultancy for rural paediatric nurses. J Telemed Telecare. 2002;8 Suppl 3:S3:48-9.
15. Macduff C, West B, Harvey S. Telemedicine in rural care. Part 1: Developing and evaluating a nurse-led initiative. Nurs Stand. 2001 Apr 25-May 1;15(32):33-8.
16. Sävenstedt S, Bucht G, Norberg L, Sandman PO. Nurse-doctor interaction in teleconsultations between a hospital and a geriatric nursing home. J Telemed Telecare. 2002;8(1):11-8.
17. Arnaert A, Delesie L. Telenursing for the elderly. The case for care via video-telephony. J Telemed Telecare. 2001;7(6):311-6.
18. Tschirch P, Walker G, Calvacca LT. Nursing in tele-mental health. J Psychosoc Nurs Ment Health Serv. 2006 May;44(5):20-7.
19. Foster PH, Whitworth JM. The role of nurses in telemedicine and child abuse. Comput Inform Nurs. 2005 May-Jun;23(3):127-31.
20. Chahl Horton M. Identifying nursing roles, responsibilities, and practices in telehealth/telemedicine. Healthc Inf Manage. 1997 Summer;11(2):5-13.
21. Keilman P. Telepsychiatry with child welfare families referred to a family service agency. Telemed J E Health. 2005 Feb;11(1):98-101.
22. Parker-Oliver D, Demiris G. Social work informatics: a new specialty. Soc Work. 2006 Apr;51(2):127-34.
23. McCarty D, Clancy C. Telehealth: implications for social work practice. Soc Work. 2002 Apr;47(2):153-61.
24. Frueh BC, Henderson S, Myrick H Telehealth service delivery for persons with alcoholism. J Telemed Telecare. 2005;11(7):372-5.
25. Ikelheimer DM. Treatment of opioid dependence via home-based telepsychiatry. Psychiatr Serv. 2008 Oct;59(10):1218-9.
26. Kirkwood KT, Peck DF, Bennie L The consistency of neuropsychological assessments performed via telecommunication and face-to-face. J Telemed Telecare. 2000;6(3):147-51.
27. Faulkner K, McClelland L. Using videoconferencing to deliver a health education program to women health consumers in rural and remote Queensland: an early attempt and future plans. Aust J Rural Health. 2002 Feb;10(1):65-72.
28. Hilty DM, Yellowlees PM, Nesbitt TS. Evolution of telepsychiatry to rural sites: changes over time in types of referral and in primary care providers' knowledge, skills and satisfaction. Gen Hosp Psychiatry. 2006 Sep-Oct;28(5):367-73
29. Rees CS, Gillam D. Training in cognitive-behavioural therapy for mental health professionals: a pilot study of videoconferencing. J Telemed Telecare. 2001;7(5):300-3
30. Loera JA, Kuo YF, Rahr RR. Telehealth distance mentoring of students. Telemed J E Health. 2007 Feb;13(1):45-50
31. Rees CS, Gillam D. Training in cognitive-behavioural therapy for mental health professionals: a pilot study of videoconferencing. J Telemed Telecare. 2001;7(5):300-3.
32. MacFarlane A, Harrison R, Murray E, Berlin A, Wallace P. A qualitative study of the educational potential of joint teleconsultations at the primary-secondary care interface. J Telemed Telecare. 2006;12 Suppl 1:22-4
33. Fahey A, Day NA, Gelber H. Tele-education in child mental health for rural allied health workers. J Telemed Telecare. 2003;9(2):84-8
34. Gammon D, Sorlie T, Bergvik S, Hoifodt TS. Psychotherapy supervision conducted by videoconferencing: a qualitative study of users' experiences. J Telemed Telecare. 1998;4 Suppl 1:33-5 114 Loera JA, Kuo YF, Rahr RR Telehealth distance mentoring of students Telemed J E Health. 2007 Feb;13(1):45-50
35. Berg BW, Alverson D, McCarty T, Sinclair N, Hudson D, Vincent DS. Standardized patient interviewing with remote interactive technologies. J Telemed Telecare. 2007;13 Suppl 3:14-17
36. Frueh BC, Monnier J, Grubaugh AL, Elhai JD, Yim E, Knapp R. Therapist adherence and competence with manualized cognitive-behavioral therapy for PTSD delivered via videoconferencing technology. Behav Modif. 2007 Nov;31(6):856-66.
37. Barlow DH (Ed.). Clinical Handbook of Psychological Disorders. New York: Guilford Press, 2007. 118 Chambless DL, Baker MJ, Baucom, DH, Beutler LE, Calhoun KS, Crits-Christoph P, Daiuto A, DeRubeis R, Detweiler J, Haaga DAF, Johnson SB, McCurry S, Mueser KT, Pope KS, Sanderson WC, Shoham V, Stickle T, Williams DA, Woody SR. Update on Empirically Validated Therapies, II. The Clinical Psychologist. 1998; 51(1), 3-16.
38. Chambless DL, Sanderson WC, Shoham V, Bennett Johnson S, Pope KS, Crits-Cristoph P, Baker M, Johnson B, Woody SR, Sue S, Beutler L, Williams DA, McCurry S. An update on empirically validated therapies. The Clinical Psychologist, 1996: 49(2), 5-18.
39. Woody S, Sanderson WC. Manuals for Empirically Supported Treatments: A 1998 Update. Available at: http://www.apa.org/divisions/div12/est/manual60.pdf
40. Bose U, McLaren P, Riley A, Mohammedali A. The use of telepsychiatry in the brief counselling of non-psychotic patients from an inner-London general practice. J Telemed Telecare. 2001;7 Suppl 1:8-10 122 Oakes J, Battersby MW, Pols RG, Cromarty P. Exposure therapy for problem gambling via Videoconferencing: a case report. J Gambl Stud. 2008 Mar;24(1):107-18. Epub 2007 Sep 5.
41. Bouchard S, Paquin B, Payeur R, Allard M, Rivard V, Fournier T, Renaud P, Lapierre J. Delivering cognitive-behavior therapy for panic disorder with agoraphobia in videoconference. Telemed J E Health. 2004 Spring;10(1):13-25.
42. Griffiths L, Blignault I, Yellowlees P. Telemedicine as a means of delivering cognitive-behavioural therapy to rural and remote mental health clients. J Telemed Telecare. 2006;12(3):136-40
43. Day SX, Schneider PL, Psychotherapy using distance technology: a comparison of face to face, video and audio treatment. J Couns Psychol 2002 49:499-503.
44. Manchanda M, McLaren P. Cognitive behaviour therapy via interactive video. J Telemed Telecare. 1998;4 Suppl 1:53-5.
45. Simpson S, Morrow E, Jones M, Ferguson J, Brebner E. Video-hypnosis--the provision of specialized therapy via videoconferencing. J Telemed Telecare. 2002;8 Suppl 2:78-9
46. Doron Todder, Zeev Kaplan. Rapid Eye Movements for Acute Stress Disorder Using Video Conference Communication. Telemedicine and e-Health. 2007, 13(4): 461-464.
47. Todder D, Kaplan Z. Rapid eye movements for acute stress disorder using video conference communication. Telemed J E Health. 2007 Aug;13(4):461-3.
48. Shepherd L, Goldstein D, Whitford H, Thewes B, Brummell V, Hicks M. The Utility of

Videoconferencing to Provide Innovative Delivery of Psychological Treatment for Rural Cancer Patients: Results of a Pilot Study. J Pain Symptom Manage. 2006 Nov;32(5):453-461

1. Himle JA, Fischer DJ, Muroff JR, Van Etten ML, Lokers LM, Abelson JL, Hanna GL.

Videoconferencing-based cognitive-behavioral therapy for obsessive-compulsive disorder. Behav Res Ther. 2006 Dec;44(12):1821-9. Epub 2006 Feb 8

1. Cluver JS, Schuyler D, Frueh BC, Brescia F, Arana GW. Remote psychotherapy for terminally ill cancer patients. J Telemed Telecare. 2005;11(3):157-9
2. De Las Cuevas C, Arredondo MT, Cabrera MF, Sulzenbacher H, Meise U. Randomized clinical trial of telepsychiatry through videoconference versus face-to-face conventional psychiatric treatment. Telemed J E Health. 2006 Jun;12(3):341-50
3. Cowain T. Cognitive-behavioural therapy via videoconferencing to a rural area. Aust N Z J Psychiatry. 2001 Feb;35(1):62-4
4. Nelson EL, Barnard M, Cain S. Treating childhood depression over videoconferencing. Telemed J & ehealth 2003;9(1):49-55.
5. Mitchell JE, Crosby RD, Wonderlich SA, Crow S, Lancaster K, Simonich H, Swan-Kremeier L, Lysne C, Myers TC. A randomized trial comparing the efficacy of cognitive-behavioral therapy for bulimia nervosa delivered via telemedicine versus face-to-face. Behav Res Ther. 2008 May;46(5):581-92. Epub 2008 Mar 10.
6. Frueh BC, Monnier J, Grubaugh AL, Elhai JD, Yim E, Knapp R. Therapist adherence and competence with manualized cognitive-behavioral therapy for PTSD delivered via videoconferencing technology. Behav Modif. 2007 Nov;31(6):856-66.
7. Simpson S, Knox J, Mitchell D, Ferguson J, Brebner J, Brebner E. A multidisciplinary approach to the treatment of eating disorders via videoconferencing in north-east Scotland. J Telemed Telecare. 2003;9 Suppl 1:S37-8
8. Thomas CR, Miller G, Hartshorn JC, Speck NC, Walker G. Telepsychiatry program for rural victims of domestic violence. Telemed J E Health. 2005 Oct;11(5):567-73
9. Chambless DL, Baker MJ, Baucom, DH, Beutler LE, Calhoun KS, Crits-Christoph P, Daiuto A, DeRubeis R, Detweiler J, Haaga DAF, Johnson SB, McCurry S, Mueser KT, Pope KS, Sanderson WC, Shoham V, Stickle T, Williams DA, Woody SR. Update on Empirically Validated Therapies, II. The Clinical Psychologist. 1998; 51(1), 3-16.
10. Best Practices in Family Intervention for Serious Mental Illness. http://w3.ouhsc.edu/bpfamily/ Accessed March 2008
11. American Group Psychotherapy Association. Practice Guidelines for Group Psychotherapy. http://www.agpa.org/guidelines/index.html Accessed March 2008
12. Association for Specialists in Group Work. ASGW Best Practice Guidelines. Available at http://www.asgw.org/PDF/Best\_Practices.pdf
13. Wittson CL, Affleck DC, Johnson V. Two-way television in group therapy. Mental Hospitals 1961;

2:22-23

1. Deitsch SE, Frueh BC, Santos AB. Telepsychiatry for post-traumatic stress disorder. J Telemed Telecare. 2000;6(3):184-6
2. Morland LA, Pierce K, Wong MY. Telemedicine and coping skills groups for Pacific Island veterans with post-traumatic stress disorder: a pilot study. J Telemed Telecare. 2004;10(5):286-9 147 Frueh BC, Monnier J, Yim E, Grubaugh AL, Hamner MB, Knapp RG. A randomized trial of telepsychiatry for post-traumatic stress disorder. J Telemed Telecare. 2007;13(3):142-7.
3. Patterson JE, Miller RB, Carnes S, Wilson S. Evidence-based practice for marriage and family therapists. J Marital Fam Ther. 2004;30(2):183-95.
4. Hill JV, Allman LR, Ditzler TF. Utility of real-time video teleconferencing in conducting family mental health sessions: two case reports. Telemed J E Health. 2001 Spring;7(1):55-9.
5. Goldfield GS, Boachie A. Delivery of family therapy in the treatment of anorexia nervosa using telehealth. Telemed J E Health. 2003 Spring;9(1):111-4.
6. Kuulasmaa A, Wahlberg KE, Kuusimaki ML. Videoconferencing in family therapy: a review J Telemed Telecare. 2004;10(3):125-9.
7. Mielonen ML, Ohinmaa A, Moring J, Isohanni M. The use of videoconferencing for telepsychiatry in Finland. J Telemed Telecare. 1998;4(3):125-31.
8. Kuulasmaa A, Wahlberg KE, Kuusimaki ML. Videoconferencing in family therapy: a review J Telemed Telecare. 2004;10(3):125-9.
9. Paul NL. Telepsychiatry, the satellite system and family consultation. J Telemed Telecare. 1997;3 Suppl 1:52-3.
10. Morgan GJ, Grant B, Craig B, Sands A, Casey F. Supporting families of critically ill children at home using videoconferencing. J Telemed Telecare. 2005;11 Suppl 1:91-2
11. Bensink M, Wootton R, Irving H, Hallahan A, Theodoros D, Russell T, Scuffham P, Barnett AG. Investigating the cost-effectiveness of videotelephone based support for newly diagnosed paediatric oncology patients and their families: design of a randomised controlled trial. BMC Health Serv Res. 2007 Mar 5;7:38.
12. Young L, Siden H, Tredwell S. Post-surgical telehealth support for children and family care-givers. J Telemed Telecare. 2007;13(1):15-9.
13. Bensink, M, Shergold, J, Lockwood, L, Little, M, Irving, H, Russell, T, Wootton, R. Videophone support for an eight-year-old boy undergoing paediatric bone marrow transplantation. J Telemed Telecare. 2006;12(5):266-268
14. Hensel BK, Parker-Oliver D, Demiris G. Videophone communication between residents and family: a case study. J Am Med Dir Assoc. 2007 Feb;8(2):123-7. Epub 2006 Dec 14.
15. Jones BN 3rd, Johnston D, Reboussin B, McCall WV. Reliability of telepsychiatry assessments:

subjective versus observational ratings J Geriatr Psychiatry Neurol. 2001 Summer;14(2):66-71 161 Holden D, Dew E. Telemedicine in a rural gero-psychiatric inpatient unit: comparison of perception/satisfaction to onsite psychiatric care. Telemed J E Health. 2008 May;14(4):381-4.

1. Jones BN 3rd. Telepsychiatry and geriatric care. Curr Psychiatry Rep. 2001 Feb;3(1):29-36
2. Tang WK, Chiu H, Woo J, Hjelm M, Hui E. Telepsychiatry in psychogeriatric service: a pilot study. Int J Geriatr Psychiatry. 2001 Jan;16(1):88-93
3. Montani C, Billaud N, Tyrrell J, Fluchaire I, Malterre C, Lauvernay N, Couturier P, Franco A

Psychological impact of a remote psychometric consultation with hospitalized elderly people. J Telemed Telecare. 1997;3(3):140-5

1. Johnston D, Jones BN 3rd. Telepsychiatry consultations to a rural nursing facility: a 2-year experience. J Geriatr Psychiatry Neurol. 2001 Summer;14(2):72-5
2. Ball C, Puffett A. The assessment of cognitive function in the elderly using videoconferencing. J Telemed Telecare. 1998;4 Suppl 1:36-8
3. Montani C, Billaud N, Couturier P, Fluchaire I, Lemaire R, Malterre C, Lauvernay N, Piquard JF, Frossard M, Franco A. Telepsychometry: a remote psychometry consultation in clinical gerontology: preliminary study. Telemed J. 1996 Summer;2(2):145-50
4. Loh PK, Donaldson M, Flicker L, Maher S, Goldswain P. Development of a telemedicine protocol for the diagnosis of Alzheimer's disease. J Telemed Telecare. 2007;13(2):90-4.
5. Myers KM, Sulzbacher S, Melzer SM. Telepsychiatry with children and adolescents: are patients comparable to those evaluated in usual outpatient care? Telemed J E Health 2004 10:278-285
6. Cain S, Spaulding R Telepsychiatry: lessons from two models of care, Abstract 5172:1.17-2, Clinical Perspectives, presented at the 53rd Annual Meeting of the American Academy of Child and Adolescent Psychiatry, San Diego CA, October 2006
7. Alicata D, Saltman D, Ulrich D. Child and adolescent telepsychiatry in rural Hawaii. Abstract

5172:1.17-2, Clinical Perspectives, presented at the 53rd Annual Meeting of the American Academy of Child and Adolescent Psychiatry, San Diego CA, October 2006

1. Harper RA. Telepsychiatry consultation to schools and mobile clinics in rural Texas. Abstract 5172:1.17-2, Clinical Perspectives, presented at the 53rd Annual Meeting of the American Academy of Child and Adolescent Psychiatry, San Diego CA, October 2006.
2. Cain S, Spaulding R Telepsychiatry: lessons from two models of care, Abstract 5172:1.17-2, Clinical Perspectives, presented at the 53rd Annual Meeting of the American Academy of Child and Adolescent Psychiatry, San Diego CA, October 2006
3. Myers K, Valentine J, Melzer SM, Morganthaler R. Telepsychiatry with incarcerated youth. J Adolesc Health 2006 38:643-648
4. Glueck D (2006), Chief Executive Officer, Adapt Psychiatric Services, PLLC, 620 Eastern Bypass, Suite H, PMB 292, Richmond, KY 40475, 888-411-9745 ext 1500, www.adaptpsych.us
5. Cain S, Spaulding R Telepsychiatry: lessons from two models of care, Abstract 5172:1.17-2, Clinical Perspectives, presented at the 53rd Annual Meeting of the American Academy of Child and Adolescent Psychiatry, San Diego CA, October 2006
6. Harper RA. Telepsychiatry consultation to schools and mobile clinics in rural Texas. Abstract

5172:1.17-2, Clinical Perspectives, presented at the 53rd Annual Meeting of the American Academy of Child and Adolescent Psychiatry, San Diego CA, October 2006

1. Alicata D, Saltman D, Ulrich D. Child and adolescent telepsychiatry in rural Hawaii. Abstract

5172:1.17-2, Clinical Perspectives, presented at the 53rd Annual Meeting of the American Academy of

Child and Adolescent Psychiatry, San Diego CA, October 2006

1. Savin D, Garry MT, Zuccaro P, Novins D. Telepsychiatry for treating rural American Indian youth. J Am Acad Child Adolesc Psychiatry 2006 45:484-488
2. Adelsheim, Steven MD, personal communication, 2007
3. Lee, Tina MD, personal communication, October 2007
4. American Academy of Child and Adolescent Psychiatry. Practice parameters for the psychiatric assessment of children and adolescents. J Am Acad Child Adolesc Psychiatry 1997 36(10Suppl):4S-20S 183 American Academy of Child and Adolescent Psychiatry. Practice parameters for the psychiatric assessment of infants and toddlers (0-36 months). J Am Acad Child Adolesc Psychiatry 1997 36(10Suppl):21S-36S
5. Cain S, Spaulding R Telepsychiatry: lessons from two models of care, Abstract 5172:1.17-2, Clinical Perspectives, presented at the 53rd Annual Meeting of the American Academy of Child and Adolescent Psychiatry, San Diego CA, October 2006
6. Myers KM, Sulzbacher S, Melzer SM. Telepsychiatry with children and adolescents: are patients comparable to those evaluated in usual outpatient care? Telemed J E Health 2004 10:278-285
7. Myers KM, Valentine JM, Melzer SM. Feasibility, acceptability, and sustainability of telepsychiatry with children and adolescents. Psych Serv 2007 58:1493-1496
8. Myers KM, Valentine JM, Melzer SM. Telepsychiatry with children and adolescents: Utilization and Satisfaction. Telemed E-Health in press.
9. Pesamaa L, Ebeling H, Kuusimaki ML, Winblad I, Isohanni M, Moilanen I. Videoconferencing in child and adolescent telepsychiatry: a systematic review of the literature. J Telemed Telecare 2004 10:187-192
10. Dossetor DR, Nunn KP, Fairley M, Eggleton D. A child and adolescent psychiatric outreach service for rural New South Wales: a telemedicine pilot study. J Paediatrics Child Health 1999 35:525-529 190 Elford R, White H, Bowering R, et al. A randomized, controlled trial of child psychiatric assessments conducted using videoconferencing. J Telemed Telecare 2000 6:73-82
11. Elford R, White H, St John K, Maddigan B, Ghandi M, Bowering R. A prospective satisfaction study and cost analysis of a pilot child telepsychiatry service in Newfoundland. J Telemed Telecare 2001 7:7381
12. Kopel H, Nunn K, Dossetor D. Evaluating satisfaction with a child and adolescent psychological telemedicine outreach service. J Telemed Telecare 2001 7Suppl2:35-40
13. Williams TL, May CR, Esmail A. Limitations of patient satisfaction studies in telehealthcare: a systematic review of the literature. Telemed J E Health 2001 7:293-316
14. Broder E, Manson E, Boydell K, Teshima J. Use of telepsychiatry for child psychiatric issues: first 500 cases. CPA Bull 2004 36:11-15
15. Cruz M, Krupinski EA, Lopez AM, Weinstein RS. A review of the first five years of the University of Arizona telepsychiatry programme. J Telemed Telecare 2005 11:234-239
16. Gelber H. The experience in Victoria with telepsychiatry for the child and adolescent mental health service. J Telemed Telecare 2001 7, Suppl2:32-34
17. Hockey AD, Yellowlees PM, Murphy S. Evaluation of a pilot second-opinion child telepsychiatry service. J Telemed Telecare 2004 10Suppl1:48-50
18. Yellowlees PM, Hilty DM, Marks SL, Neufeld J, Bourgeois JA. A retrospective analysis of a child and adolescent eMental Health program J Am Acad Child Adolesc Psychiatry. 2008 Jan;47(1):103-7 199 Broder E, Manson E, Boydell K, Teshima J. Use of telepsychiatry for child psychiatric issues: first 500 cases. CPA Bull 2004 36:11-15
19. Hockey AD, Yellowlees PM, Murphy S. Evaluation of a pilot second-opinion child telepsychiatry service. J Telemed Telecare 2004 10Suppl1:48-50
20. Myers KM, Sulzbacher S, Melzer SM. Telepsychiatry with children and adolescents: are patients comparable to those evaluated in usual outpatient care? Telemed J E Health 2004 10:278-285
21. Myers KM, Valentine JM, Melzer SM. Feasibility, acceptability, and sustainability of telepsychiatry with children and adolescents. Psych Serv 2007 58:1493-1496
22. Myers KM, Valentine JM, Melzer SM. Telepsychiatry with children and adolescents: Utilization and Satisfaction. Telemed E-Health in press.
23. Nelson EL, Barnard M, Cain S. Treating childhood depression over videoconferencing. Telemed J E-Health 2003 9:49-55
24. Pesamaa L, Ebeling H, Kuusimaki ML, Winblad I, Isohanni M, Moilanen I. Videoconferencing in child and adolescent telepsychiatry: a systematic review of the literature. J Telemed Telecare 2004 10:187-192
25. Cain S, Spaulding R Telepsychiatry: lessons from two models of care, Abstract 5172:1.17-2, Clinical Perspectives, presented at the 53rd Annual Meeting of the American Academy of Child and Adolescent Psychiatry, San Diego CA, October 2006
26. Elford R, White H, Bowering R, et al. A randomized, controlled trial of child psychiatric assessments conducted using videoconferencing. J Telemed Telecare 2000 6:73-82
27. Myers KM, Sulzbacher S, Melzer SM. Telepsychiatry with children and adolescents: are patients comparable to those evaluated in usual outpatient care? Telemed J E Health 2004 10:278-285 209 Alicata D, Saltman D, Ulrich D. Child and adolescent telepsychiatry in rural Hawaii. Abstract

5172:1.17-2, Clinical Perspectives, presented at the 53rd Annual Meeting of the American Academy of

Child and Adolescent Psychiatry, San Diego CA, October 2006

1. Harper RA. Telepsychiatry consultation to schools and mobile clinics in rural Texas. Abstract

5172:1.17-2, Clinical Perspectives, presented at the 53rd Annual Meeting of the American Academy of

Child and Adolescent Psychiatry, San Diego CA, October 2006

1. Myers K, Valentine J, Melzer SM, Morganthaler R. Telepsychiatry with incarcerated youth. J Adolesc Health 2006 38:643-648
2. George R. A private practice model of telepsychiatry for residential treatment. Clinical Perspectives presentation at the 54th Annual Meeting of the American Academy of Child and Adolescent Psychiatry, Boston MA 2007.
3. Storck M. Bringing the community to the state hospital through teleconferencing. Clinical

Perspectives presentation at the 54th Annual Meeting of the American Academy of Child and Adolescent Psychiatry, Boston MA 2007.

1. Storck M. Bringing the community to the state hospital through teleconferencing. Clinical

Perspectives presentation at the 54th Annual Meeting of the American Academy of Child and Adolescent Psychiatry, Boston MA 2007.

1. Myers K, Valentine J, Melzer SM, Morganthaler R. Telepsychiatry with incarcerated youth. J Adolesc Health 2006 38:643-648
2. Elford R, White H, St John K, Maddigan B, Ghandi M, Bowering R. A prospective satisfaction study and cost analysis of a pilot child telepsychiatry service in Newfoundland. J Telemed Telecare 2001 7:7381
3. Myers KM, Sulzbacher S, Melzer SM. Telepsychiatry with children and adolescents: are patients comparable to those evaluated in usual outpatient care? Telemed J E Health 2004 10:278-285
4. Myers KM, Valentine JM, Melzer SM. Telepsychiatry with children and adolescents: Utilization and Satisfaction. Telemed E-Health in press.
5. Godleski L, Darkins A, Lehmann L. Telemental Health Toolkit. Field Work Group of the Veterans’ Health Administration 2003
6. Miller EA. Telepsychiatry and doctor-patient communication - an analysis of the empirical literature.

In: Telepsychiatry and E-Mental Health, Wootton R, Yellowlees P, McClaren P, eds. London: Royal Society of Medicine Press Ltd 2003

1. Onor MS, Misan MD. The clinical interview and the doctor-patient relationship in telemedicine. Telemed E-Health 2005 11:102-105
2. American Academy of Child and Adolescent Psychiatry. Practice parameters for the assessment and treatment of children, adolescents, and adults with mental retardation and comorbid mental disorders. J Am Acad Child Adolesc Psychiatry 1999 38(12Suppl):5S-31S
3. American Academy of Child and Adolescent Psychiatry. Practice parameter for the assessment and treatment of children and adolescents with autism and other pervasive developmental disorders. J Am Acad Child Adolesc Psychiatry in press.
4. American Academy of Child and Adolescent Psychiatry. Practice parameters for the assessment and treatment of children, adolescents, and adults with mental retardation and comorbid mental disorders. J Am Acad Child Adolesc Psychiatry 1999 38(12Suppl):5S-31S
5. American Academy of Child and Adolescent Psychiatry. Practice parameter for the assessment and treatment of children and adolescents with oppositional defiant disorder. J Am Acad Child Adolesc Psychiatry 2007 46:121-141
6. American Academy of Child and Adolescent Psychiatry. Practice parameter for the assessment and treatment of children and adolescents with attention deficit/hyperactivity disorder. J Am Acad Child Adolesc Psychiatry in press.
7. American Academy of Child and Adolescent Psychiatry. Practice parameter for the assessment and treatment of children and adolescents with autism and other pervasive developmental disorders. J Am Acad Child Adolesc Psychiatry in press.
8. Elford R, White H, Bowering R, et al. A randomized, controlled trial of child psychiatric assessments conducted using videoconferencing. J Telemed Telecare 2000 6:73-82
9. Elford R, White H, St John K, Maddigan B, Ghandi M, Bowering R. A prospective satisfaction study and cost analysis of a pilot child telepsychiatry service in Newfoundland. J Telemed Telecare 2001 7:7381
10. Barretto A, Wacker DP, Harding J, Lee J, Berg WK. Using telemedicine to conduct behavioral assessments. J Appl Behav Anal 2006 39:333-340
11. American Academy of Child and Adolescent Psychiatry. Practice parameters for the psychiatric assessment of children and adolescents. J Am Acad Child Adolesc Psychiatry 1997 36(10Suppl):4S-20S 232 American Academy of Child and Adolescent Psychiatry. Practice parameters for the psychiatric assessment of children and adolescents. J Am Acad Child Adolesc Psychiatry 1997 36(10Suppl):4S-20S 233 Elford R, White H, Bowering R, et al. A randomized, controlled trial of child psychiatric assessments conducted using videoconferencing. J Telemed Telecare 2000 6:73-82
12. Elford R, White H, St John K, Maddigan B, Ghandi M, Bowering R. A prospective satisfaction study and cost analysis of a pilot child telepsychiatry service in Newfoundland. J Telemed Telecare 2001 7:7381
13. Cain S, Spaulding R Telepsychiatry: lessons from two models of care, Abstract 5172:1.17-2, Clinical Perspectives, presented at the 53rd Annual Meeting of the American Academy of Child and Adolescent Psychiatry, San Diego CA, October 2006
14. Myers KM, Sulzbacher S, Melzer SM. Telepsychiatry with children and adolescents: are patients comparable to those evaluated in usual outpatient care? Telemed J E Health 2004 10:278-285
15. American Academy of Child and Adolescent Psychiatry. Practice parameters for the psychiatric assessment of infants and toddlers (0-36 months). J Am Acad Child Adolesc Psychiatry 1997 36(10Suppl):21S-36S
16. Godleski L, Darkins A, Lehmann L. Telemental Health Toolkit. Field Work Group of the Veterans’ Health Administration 2003
17. Greenberg N, Boydell KM, Volpe T. Pediatric telepsychiatry in Ontario: caregiver and service provider perspectives. J Behav Health Serv Res 2006 33:105-111
18. American Academy of Child and Adolescent Psychiatry. Practice parameter on child and adolescent mental health care in community systems of care. J Am Acad Child Adolesc Psychiatry 2007 46:284-299 241 Cain S, Spaulding R Telepsychiatry: lessons from two models of care, Abstract 5172:1.17-2, Clinical Perspectives, presented at the 53rd Annual Meeting of the American Academy of Child and Adolescent Psychiatry, San Diego CA, October 2006
19. Myers K, Valentine J, Melzer SM, Morganthaler R. Telepsychiatry with incarcerated youth. J Adolesc Health 2006 38:643-648
20. Brown RT, Antonuccio DO, DuPaul GJ, Fristad MA, King CA, Leslie LK, McCormick GS, Pelham WE, Piacentini JC, Vitello B. Childhood Mental Health Disorders: Evidence base and contextual factors for psychosocial, psychopharmacological, and combined interventions. Washington, DC: American Psychological Association, 2008.
21. Empirically supported treatments in pediatric psychology series. J. Pediatr. Psychol. 1999-2001; 24-26. 245 Alessi N. Telepsychiatric care of a depressed adolescent. J Am Acad Child Adolesc Psychiatry 2002 41:894-895
22. Cozza S, Prasanna S, Chun RS, Benedek DM. Tele-mental health: use of VTC and other computer-based applications at a MEDCEN. Presentation at the Behavioral Sciences Short Course, Bethesda MD, May 2001
23. Nelson EL, Barnard M, Cain S. Treating childhood depression over videoconferencing. Telemed J E-Health 2003 9:49-55
24. Goldfield GS, Boachie A. Delivery of family therapy in the treatment of anorexia nervosa using telehealth. Telemed J E Health. 2003 Spring;9(1):111-4.
25. Savin D, Garry MT, Zuccaro P, Novins D. Telepsychiatry for treating rural American Indian youth. J Am Acad Child Adolesc Psychiatry 2006 45:484-488
26. Nelson EL, Barnard M, Cain S. Treating childhood depression over videoconferencing. Telemed J EHealth 2003 9:49-55
27. Fox KC, Connor P, McCullers E, Waters T. Effect of a behavioural health and specialty care telemedicine programme on goal attainment for youths in juvenile detention. J Telemed Telecare. 2008;14(5):227-30.
28. Setterberg SR, Busseri MA, Fleissner RM, Kenney EM Jr, Flom JA, Fischer KJ. Remote assessment of the use of seclusion and restraint with paediatric psychiatric patients. J Telemed Telecare. 2003;9(3):176-9
29. Jong M. Managing suicides via videoconferencing in a remote northern community in Canada. Int J Circumpolar Health. 2004 Dec;63(4):422-8
30. Mannion L, Fahy TJ, Duffy C, Broderick M, Gethins E Telepsychiatry: an island pilot project. J

Telemed Telecare. 1998;4 Suppl 1:62-3

1. Sorvaniemi M, Santamaki O. Telepsychiatry in emergency consultations. J Telemed Telecare.

2002;8(3):183-4

1. Sorvaniemi M, Ojanen E, Santamäki O. Telepsychiatry in emergency consultations: a follow-up study of sixty patients. Telemed J E Health. 2005 Aug;11(4):439-41.
2. Harley J, McLaren P, Blackwood G, Tierney K, Everett M. The use of videoconferencing to enhance tertiary mental health service provision to the island of Jersey J Telemed Telecare. 2002;8 Suppl 2:36-8 258 Brennan JA, Kealy JA, Gerardi LH, Shih R, Allegra J, Sannipoli L, Lutz D. Telemedicine in the emergency department: a randomized controlled trial. J Telemed Telecare. 1999;5(1):18-22
3. Shore JH, Hilty DM, Yellowlees P. Emergency management guidelines for telepsychiatry. Gen Hosp Psychiatry. 2007 May-Jun;29(3):199-206.
4. Godleski L, Nieves JE, Darkins A, Lehmann L. VA telemental health: suicide assessment. Behav Sci Law. 2008;26(3):271-86.
5. Yellowlees P The use of telemedicine to perform psychiatric assessments under the Mental Health Act. J Telemed Telecare. 1997;3(4):224-6
6. Nelson EL, Zaylor C, Cook D A Comparison of Psychiatrist Evaluation and Patient Symptom Report in a Jail Telepsychiatry Clinic Telemed J E Health. 2004 Fall;10(suppl 2):S54-S59
7. Manfredi L, Shupe J, Batki SL. Rural jail telepsychiatry: a pilot feasibility study. Telemed J E Health.

2005 Oct;11(5):574-7

1. Brodey BB, Claypoole KH, Motto J, Arias RG, Goss R. Satisfaction of forensic psychiatric patients with remote telepsychiatric evaluation. Psychiatr Serv. 2000 Oct;51(10):1305-7
2. Zaylor C, Nelson EL, Cook DJ. Clinical outcomes in a prison telepsychiatry clinic. J Telemed Telecare. 2001;7 Suppl 1:47-9
3. Miller TW, Burton DC, Hill K, Luftman G, Veltkemp LJ, Swope M. Telepsychiatry: critical dimensions for forensic services. J Am Acad Psychiatry Law. 2005;33(4):539-46.
4. Lexcen FJ, Hawk GL, Herrick S, Blank MB. Use of video conferencing for psychiatric and forensic evaluations. Psychiatr Serv. 2006 Oct;57(5):713-5
5. Manguno-Mire GM, Thompson JW, Shore JH, Croy C, Artecona JF, Pickering JW. The Use of telemedicine to evaluate legal competence: a preliminary randomized controlled study. Journal of the American Academy of Psychiatry and Law. 2007; 35 (4), 481-489.
6. Morgan RD, Patrick AR, Magaletta PR. Does the use of telemental health alter the treatment experience? Inmates' perceptions of telemental health versus face-to-face treatment modalities. J Consult Clin Psychol. 2008 Feb;76(1):158-62.

**Telepsychology 50-State Review**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **STATE** | **Telehealth/**  **Telepsychology**  **Statutes and/or Regulations** | **Practice of**  **Psychology defined to include**  **specifically**  **telepsychology?** | **Licensing Board**  **Advisory**  **Opinions** | **Telehealth Coverage Mandate** | **Temporary / Guest**  **Practice Provision** | **Penalties for**  **Unauthorized practice of psychology without a**  **license** |
| **ALABAMA** | NO | NO | NO | NO | *Code of Ala. §* *34-26-41*    (f) f) An individual who possesses a valid license to practice psychology independently at the doctoral level, by any jurisdiction recognized by the Association of State and Provincial Psychology Boards, may practice psychology in Alabama for no more than 30 days each calendar year without applying for a license to practice psychology in Alabama, unless otherwise exempted pursuant to this chapter. This authority to practice does not apply to a psychologist who has been denied licensure in Alabama, is a legal resident of Alabama, or intends to practice full-time or a major portion of his or her time in Alabama. | *Code of Ala*. *§34-26-42*    Class B Misdemeanor: $500-5000 fine per occurrence plus court  costs |

*Disclaimer*: This document does not constitute legal advice and should not be relied upon, as it is not routinely updated and was prepared with information from other sources, whose accuracy was not independently verified by APA. APA strongly encourages the reader to independently verify the information contained herein and/or consult with independent legal counsel if the reader intends to use or otherwise rely on such information. Because the law and related information continually change and because APA relied on other sources to compile information contained herein, APA cannot guarantee the completeness, currency or accuracy of this document.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **STATE** | **Telehealth/**  **Telepsychology**  **Statutes and/or Regulations** | **Practice of**  **Psychology defined to include**  **specifically**  **telepsychology?** | **Licensing Board**  **Advisory**  **Opinions** | **Telehealth Coverage Mandate** | **Temporary / Guest**  **Practice Provision** | **Penalties for**  **Unauthorized practice of psychology without a**  **license** |
| **ALASKA** | NO | NO | NO | NO | *12 Alaska Admin. Code 60.035 - Courtesy*  *license*    (a) A courtesy license authorizes the licensee to practice psychology for no more than 30 days in a 12-month period. An applicant will only be issued one courtesy license in that person's lifetime. A courtesy licensee shall submit a report to the board each month during the period of courtesy licensure indicating the number of days practiced under the courtesy license during the month. A courtesy license does not authorize the licensee to conduct a general psychology practice or to perform services outside the scope of practice of psychology that is specified on the | *Alaska Stat. § 08.86.210*    Class B Misdemeanor: possible fine up to $2000 AND/OR possible imprisonment up to 90 days |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **STATE** | **Telehealth/**  **Telepsychology**  **Statutes and/or Regulations** | **Practice of**  **Psychology defined to include**  **specifically**  **telepsychology?** | **Licensing Board**  **Advisory**  **Opinions** | **Telehealth Coverage Mandate** | **Temporary / Guest**  **Practice Provision** | **Penalties for**  **Unauthorized practice of psychology without a**  **license** |
|  |  |  |  |  | courtesy license.    (b) The board or its designee will issue a one-time courtesy license to an applicant who meets the requirements of this section. |  |
| **ARIZONA** | *ARS § 36-3601 et seq.*    Psychologists are included under the definition of “health care providers” who may practice telemedicine in the state.    Telemedicine is the practice of health care delivery, diagnosis, consultation and treatment and the transfer of medical data through interactive audio, video or data communications that | NO | NO | SB 1353 enacted 4/8/13 codified as *ARS* *§20841.09, §20-1057.13,*  *§20-1376.05 & §201406.05*    For policies issued on or after Jan 1, 2015, private payers are required to provide coverage for live video consultations when treating specific conditions (mental health disorders & neurological diseases included) & originating site is in a rural area (area in a county < 900,000 population or area in county with > | *A.R.S. § 32-2075(4)*    Licensed out-of-state psychologist may provide services within his/her customary area of practice within the state up to 20 days per year.    The psychologist must inform the client or public of the limited nature of these activities and services & that the psychologist is not licensed in this state. | *A.R.S. § 32-2084*    Class 2 Misdemeanor: possible fine up to $750 AND/OR possible imprisonment up to 4 months |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **STATE** | **Telehealth/**  **Telepsychology**  **Statutes and/or Regulations** | **Practice of**  **Psychology defined to include**  **specifically**  **telepsychology?** | **Licensing Board**  **Advisory**  **Opinions** | **Telehealth Coverage Mandate** | **Temporary / Guest**  **Practice Provision** | **Penalties for**  **Unauthorized practice of psychology without a**  **license** |
|  | occur in the physical presence of the patient |  |  | 900,000 but proximity to nearest city of 500,00  is > 30 miles) |  |  |
| **ARKANSAS** | NO | NO | NO | NO | NO | *A.C.A. § 17-97-301*    Misdemeanor: fine of  $500-$1,000 |
| **CALIFORNIA** | *Cal. Bus. & Prof. Code*  *§§ 2904.5, 2290.5*    CA licensure is required to provide telehealth services to CA residents; telehealth includes live interactive and store & forward technologies; patient’s verbal consent must be obtained prior to delivery of telehealth services & documented in patient’s record.    Failure to obtain patient consent in advance constitutes | *Cal. Bus & Prof. Code § § 2904.5* – *Applicability of Telemedicine Provisions of Section*  *2290.5* | See CA Board of Psychology’s “Notice  to California  Consumers  Regarding the  Practice of  Psychology on the Internet” available online at  [http://www.psychb oard.ca.gov/consum](http://www.psychboard.ca.gov/consumers/internet-thrpy.shtml)  [ers/internetthrpy.shtml](http://www.psychboard.ca.gov/consumers/internet-thrpy.shtml) | *Cal. Health & Safety Code § 1374.13; Cal. Ins. Code § 10123.85; Cal.*  *Welfare & Institutions*  *Code §§ 14132.72,*  *14132.725*    Private payers cannot require in-person contact between a health care provider and patient or limit the type of setting where services are provided before payment is made for covered telehealth services, subject to coverage terms and conditions | *Cal. Bus & Prof Code*  *§2912* – *Out of State*  *Psychologists - Exemption*    Nothing in this chapter shall be construed to restrict or prevent a person who is licensed as a psychologist at the doctoral level in another state or territory of the United States or in Canada from offering psychological services in this state for a period not to exceed 30 days in any calendar year. | *Cal. Bus & Prof Code §2970*    Misdemeanor: fine not exceeding $2,000 AND/OR imprisonment in county  jail not exceeding 6  months |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **STATE** | **Telehealth/**  **Telepsychology**  **Statutes and/or Regulations** | **Practice of**  **Psychology defined to include**  **specifically**  **telepsychology?** | **Licensing Board**  **Advisory**  **Opinions** | **Telehealth Coverage Mandate** | **Temporary / Guest**  **Practice Provision** | **Penalties for**  **Unauthorized practice of psychology without a**  **license** |
|  | unprofessional conduct. |  |  |  |  |  |
| **COLORADO** | NO | NO but see *C.R.S. § 12-*  *36-106 (1) (g)* authorizing delivery of telemedicine by licensed providers within their scope of practice | *State Board of*  *Psychologist*  *Examiners Policies §*  *30-1*    Policy recommends  initial in-person visit prior to using telehealth & outlines issues that must be addressed by the psychologist & patient at the outset as well as the challenges posed by services provided remotely or electronically.    [http://cdn.colorado. gov/cs/Satellite/DO](http://cdn.colorado.gov/cs/Satellite/DORA-Reg/CBON/DORA/1251632089838)  [RA-](http://cdn.colorado.gov/cs/Satellite/DORA-Reg/CBON/DORA/1251632089838)  [Reg/CBON/DORA/1](http://cdn.colorado.gov/cs/Satellite/DORA-Reg/CBON/DORA/1251632089838)  [251632089838](http://cdn.colorado.gov/cs/Satellite/DORA-Reg/CBON/DORA/1251632089838) | YES but limited to rural areas – see *C.R.S. § 1016-123*    Face-to-face contact between the provider and patient is not required if the patient lives in a county with 150,000 or fewer  residents    References definition of telemedicine as found in C.R.S. 12-36-106(1)(g), meaning the use of advanced technology, including, but not limited to, interactive audio, interactive video, or interactive data communication. | *C.R.S. §* *12-43-215(9)*    Out-of-state  psychologists licensed in another state may perform certain activities or services without CO license if: (a) Performed within the scope of the person's license or certification;   1. Do not exceed 20 days per year in this state; 2. Are not otherwise in   violation of this article; and   1. Disclosed to the public that the person is not licensed or certified in this state. | *C.R.S. § 12-43-226*    Class 2 Misdemeanor (1st offense): Fine of $250-  1,000 &/OR imprisonment of 3-12 months    Class 6 Felony (subsequent offense) : Fine of $1,000-  100,000 &/OR imprisonment of 12-18  months |
| **CONNECTICUT** | NO | NO | NO | NO | NO | *Conn. Gen. Stat. § 20-193*  (amended by 2013 Ct. SB  983, Section 82) |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **STATE** | **Telehealth/**  **Telepsychology**  **Statutes and/or Regulations** | **Practice of**  **Psychology defined to include**  **specifically**  **telepsychology?** | **Licensing Board**  **Advisory**  **Opinions** | **Telehealth Coverage Mandate** | **Temporary / Guest**  **Practice Provision** | **Penalties for**  **Unauthorized practice of psychology without a**  **license** |
|  |  |  |  |  |  | Class D Felony: Fine not to exceed $5,000 &/OR possible imprisonment for a term not less than 1 year  nor more than 5 years |
| **DELAWARE** | *CDR 24-3500 --*  *Section 18.0*  *Telepsychology*    “Telepsychology” includes telephone, email, Internet-based communications, & videoconferencing.    Must be licensed to provide telepsychology services to DE residents. Obtain patient consent; use secure communications where feasible; document riskbenefit analysis; develop written emergency contingency plan | NO | NO | NO | *24 Del. C. §3510*    Out-of-state psychologists licensed in another jurisdiction may provide services without a DE license if they do not exceed an  “aggregate of 6 days of professional services as a psychologist, per calendar year.” | *24 Del. C. § 3520*    Misdemeanor:  For 1st offense, fine of $500-1,000 for each offense &/OR possible  imprisonment up to 1 year    2nd or subsequent offense:  fine of $1,000-2,000 for each offense &/OR possible imprisonment up to 1 year. |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **STATE** | **Telehealth/**  **Telepsychology**  **Statutes and/or Regulations** | **Practice of**  **Psychology defined to include**  **specifically**  **telepsychology?** | **Licensing Board**  **Advisory**  **Opinions** | **Telehealth Coverage Mandate** | **Temporary / Guest**  **Practice Provision** | **Penalties for**  **Unauthorized practice of psychology without a**  **license** |
|  |  |  |  |  |  |  |
| **DISTRICT OF**  **COLUMBIA** | NO | NO | See DC Board of Psychology newsletter (Spring 2013) available online at [http://doh.dc.gov/si tes/default/files/dc/ sites/doh/release\_c ontent/attachments /Psych%20newslette r%20Spring%202013](http://doh.dc.gov/sites/default/files/dc/sites/doh/release_content/attachments/Psych%20newsletter%20Spring%202013%20email%20post.pdf)  [%20email%20post.p](http://doh.dc.gov/sites/default/files/dc/sites/doh/release_content/attachments/Psych%20newsletter%20Spring%202013%20email%20post.pdf)  [df](http://doh.dc.gov/sites/default/files/dc/sites/doh/release_content/attachments/Psych%20newsletter%20Spring%202013%20email%20post.pdf) |  | *D.C. Code § 3-1205.02*    Health professionals authorized to practice in any state adjoining DC may treat patients in DC if: the health professional does not have an office or other regularly appointed place in DC to meet patients; Registers with the appropriate board and pays the registration fee prior to practicing DC; and The state in which the individual is licensed allows DC licensed health professionals to practice in that state under the conditions set forth in this section.    Health professionals practicing in the District pursuant to subsection (a)(4) of this section shall not see patients or clients in the office or | *D.C. Code § 3-1205.14*    Civil penalty: fine up to  $5,000 for each violation    Issuance of cease & desist order pursuant to D.C. Code § 3-1205.16 |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **STATE** | **Telehealth/**  **Telepsychology**  **Statutes and/or Regulations** | **Practice of**  **Psychology defined to include**  **specifically**  **telepsychology?** | **Licensing Board**  **Advisory**  **Opinions** | **Telehealth Coverage Mandate** | **Temporary / Guest**  **Practice Provision** | **Penalties for**  **Unauthorized practice of psychology without a**  **license** |
|  |  |  |  |  | other place of practice of a DC licensee, or otherwise circumvent the provisions of this chapter. |  |
| **FLORIDA** | NO | *Fla. Stat. §*  *490.003(4)(a)*    Psychological services may be rendered to individuals, couples, families, groups, and the public without regard to place of service.    (Cited by board in declaratory statement) | See Board’s opinion dated 06/05/06 stating that teletherapy constitutes practice of psychology requiring Florida licensure --  [http://www.doh.sta te.fl.us/mqa/psychol ogy/Petitions/DOH\_](http://www.doh.state.fl.us/mqa/psychology/Petitions/DOH_06-0976.pdf)  [06-0976.pdf](http://www.doh.state.fl.us/mqa/psychology/Petitions/DOH_06-0976.pdf)    See Board’s declaratory statement dated 02/16/12 stating that FL licensed psychologist in MI may provide telepsychology to FL patients -- [http://doh.state.fl.u s/mqa/declaratory/ psychology/DOH-12-](http://doh.state.fl.us/mqa/declaratory/psychology/DOH-12-0324-DS-MQA.pdf) | NO | *Fla. Stat. §*  *490.014(2)(e)*    Licensed out-of-state psychologist may practice no more than 5 days in any month and no more than 15 days in  any calendar year    Licensure requirements in the psychologist’s home state must be equivalent to or exceed FL’s licensing  requirements | *Fla. Stat. § 490.012(4)*    1st Degree Misdemeanor:  Possible fine up to $1,000  &/OR possible imprisonment not to exceed 1 year |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **STATE** | **Telehealth/**  **Telepsychology**  **Statutes and/or Regulations** | **Practice of**  **Psychology defined to include**  **specifically**  **telepsychology?** | **Licensing Board**  **Advisory**  **Opinions** | **Telehealth Coverage Mandate** | **Temporary / Guest**  **Practice Provision** | **Penalties for**  **Unauthorized practice of psychology without a**  **license** |
|  |  |  | [0324-DS-MQA.pdf](http://doh.state.fl.us/mqa/declaratory/psychology/DOH-12-0324-DS-MQA.pdf) |  |  |  |
| **GEORGIA** | *O.C.G.A. § 33-24-56.4*  -- *Georgia*  *Telemedicine Act*    Telemedicine is defined as the use of audio, video, or data communications for health care delivery, diagnosis, consultation, treatment, or transfer of medical data used or obtained during a medical visit with a patient    Standard telephone,  facsimile transmissions, unsecured e-mail, or a combination thereof are excluded | *Ga. Comp. R. & Regs. r.*  *510-5-.07(2) --*  *Representation of Services.*    Practicing via Electronic Transmission. The provision of psychological services by electronic transmission (e.g. internet, telephone, computer...) must meet the same legal and ethical standards as psychological services provided in person. This rule applies to both psychologists who are licensed in Georgia and to other psychologists residing elsewhere who are providing psychological services to clients/patients in Georgia who must meet the requirements of section 510-9-.03. The Georgia Board will | NO | *O.C.G.A. § 33-24-56.4* - *Payment for*  *telemedicine services*    Private payers cannot refuse to cover services provided via telehealth so long as provider followed generally accepted health care practices and standards prevailing in the applicable professional community at the time the services were provided | *O.C.G.A. § 43-39-7; Ga.*  *Comp. R. & Regs. r. 5109-.03*    (8) An individual licensed to practice psychology in another jurisdiction may practice psychology in Georgia without applying for a license, so long as the requirements for a license in the other jurisdiction are equal to  or exceed the requirements for licensure in Georgia, and the psychologist limits that person's practice in Georgia to no more than 30 days per year, as defined in the rules and regulations of the board.    Board rules require advance permission for limited practice – | *O.C.G.A. § 43-39-19*    Misdemeanor: Possible fine of $100-$1000 &/or imprisonment up to 12  months |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **STATE** | **Telehealth/**  **Telepsychology**  **Statutes and/or Regulations** | **Practice of**  **Psychology defined to include**  **specifically**  **telepsychology?** | **Licensing Board**  **Advisory**  **Opinions** | **Telehealth Coverage Mandate** | **Temporary / Guest**  **Practice Provision** | **Penalties for**  **Unauthorized practice of psychology without a**  **license** |
|  |  | report out of state psychologists to their respective licensing boards for practicing psychology via these means in the state of Georgia without a Georgia license. |  |  | submit at least 5 days before the intended practice either IPC attestation form issued by ASPPB, or verification form from the state licensing board indicating no history of  disciplinary action |  |
| **HAWAII** | NO | NO | NO | *HRS § 431:10A-116.3 – Coverage for telehealth*    “Telehealth” is defined as including but not limited to real-time video conferencingbased communication, secure interactive and non-interactive webbased communication, & secure asynchronous information exchange    Standard telephone contacts, facsimile transmissions, or email  text are excluded    Private payers cannot require face-to-face | *HRS § 465-9*    Licensed out-of-state psychologist may practice for a period not to exceed 90 days in any calendar year    Must petition the board for a temporary permit in advance    Licensure requirements in the psychologist’s home state must be equivalent to or exceed HI’s licensing  requirements | *HRS § 465-15 (b)*    Misdemeanor: Possible fine of $1,000 for each violation &/OR imprisonment not more than 1 year |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **STATE** | **Telehealth/**  **Telepsychology**  **Statutes and/or Regulations** | **Practice of**  **Psychology defined to include**  **specifically**  **telepsychology?** | **Licensing Board**  **Advisory**  **Opinions** | **Telehealth Coverage Mandate** | **Temporary / Guest**  **Practice Provision** | **Penalties for**  **Unauthorized practice of psychology without a**  **license** |
|  |  |  |  | contact as a prerequisite for payment for telehealth services subject to coverage terms & conditions    No reimbursement for a telehealth consultation between health care providers unless a provider-patient relationship exists between the patient and one of the health care providers involved in the telehealth  interaction |  |  |
| **IDAHO** | YES – *Idaho Code §*  *54-2305 (11)*    Authorizes the psychology licensing board to develop standards & requirements addressing the use of communication technology in the practice of | NO | NO | NO | *IDAPA 24.12.01.300*    Psychologists licensed in another state may practice in ID for a period not to exceed 30 days within a calendar year if they hold an interjurisdictional practice certificate (IPC) issued by ASPPB. | *Idaho Code § 54-2310*    Misdemeanor: Possible fine up to $1,000 &/or imprisonment up to 6  months |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **STATE** | **Telehealth/**  **Telepsychology**  **Statutes and/or Regulations** | **Practice of**  **Psychology defined to include**  **specifically**  **telepsychology?** | **Licensing Board**  **Advisory**  **Opinions** | **Telehealth Coverage Mandate** | **Temporary / Guest**  **Practice Provision** | **Penalties for**  **Unauthorized practice of psychology without a**  **license** |
|  | psychology, including supervision. |  |  |  | Those psychologists are required to notify the Board of their intent to practice and provide documentation of their status. |  |
| **ILLINOIS** | NO | NO | NO | NO | *225 ILCS 15/11.5*    Licensed out-of-state psychologists may obtain a temporary permit authorizing the rendering of clinical psychological services in IL for up to 10 calendar days per year, consecutively or in  aggregate | *225 ILCS 15/16.5*    Civil penalty up to $10,000 for each offense as determined by the Department of Financial and Professional  Regulation |
| **INDIANA** | NO    But there seems to be a collaborative effort between IPA & the state psychology board to develop telepsychology  policies    [http://www.in.gov/pl](http://www.in.gov/pla/files/Psychology_Newsletter_-_March_2012.pdf) | NO | NO | NO | *Burns Ind. Code Ann. §*  *25-33-1-4.5*    Licensed out-of-state psychologists may obtain a temporary psychology permit limited by terms and conditions considered appropriate by the board. | *Burns Ind. Code Ann*. *§2533-1-15; 35-50-3-2*    Class A misdemeanor:  Possible fine up to $5,000 &/or imprisonment up to 1  year |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **STATE** | **Telehealth/**  **Telepsychology**  **Statutes and/or Regulations** | **Practice of**  **Psychology defined to include**  **specifically**  **telepsychology?** | **Licensing Board**  **Advisory**  **Opinions** | **Telehealth Coverage Mandate** | **Temporary / Guest**  **Practice Provision** | **Penalties for**  **Unauthorized practice of psychology without a**  **license** |
|  | [a/files/Psychology\_N ewsletter\_-](http://www.in.gov/pla/files/Psychology_Newsletter_-_March_2012.pdf)  [\_March\_2012.pdf](http://www.in.gov/pla/files/Psychology_Newsletter_-_March_2012.pdf)    [http://www.indianap sychology.org/pdf/ne wsletters/newsletter](http://www.indianapsychology.org/pdf/newsletters/newsletter_sept_12.pdf)  [\_sept\_12.pdf](http://www.indianapsychology.org/pdf/newsletters/newsletter_sept_12.pdf) |  |  |  | A psychologist may practice under a limited scope psychology permit not more than 30 days every 2years. |  |
| **IOWA** | NO | NO | NO | NO    But Iowa has developed a state-based telecommunications network that may be used for telemedicine purposes  *See Iowa Code § 8D.1 et seq.; 751 IAC 7.1 ; 751*  *IAC 7.11* | *Iowa Code § 154B.3(5)*  *645 IAC 240.8*    Licensed out-of-state psychologists may practice for a period not to exceed 10 consecutive business days or 15 business days in any 90 day period    Must file a summary of intention to practice in IA & licensure verification in advance with the board    Licensure requirements in the psychologist’s home state must be equivalent to or exceed  IA’s licensing | *Iowa Code § 147.83 --*  *Permanent Injunction;*  *Iowa Code § 147.86; Iowa*  *Code § 903.1 (1)(b)*    Serious Misdemeanor:  Possible fine of $315$1,875 &/or imprisonment  up to 1 year |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **STATE** | **Telehealth/**  **Telepsychology**  **Statutes and/or Regulations** | **Practice of**  **Psychology defined to include**  **specifically**  **telepsychology?** | **Licensing Board**  **Advisory**  **Opinions** | **Telehealth Coverage Mandate** | **Temporary / Guest**  **Practice Provision** | **Penalties for**  **Unauthorized practice of psychology without a**  **license** |
|  |  |  |  |  | requirements |  |
| **KANSAS** | NO | *KAR 102-1-19 – Services rendered to individuals located in this state*    Each person, regardless of the person's location, who engages in either of the following activities shall be deemed to be engaged in the practice of psychology in this state and shall be required to have a license, issued by the board, to practice psychology as a licensed psychologist:   * If he/she engages in the practice of psychology, providing services to one or more individuals located in this state; or * Represents oneself to be a psychologist available to provide psychological | NO | NO | *K.S.A. § 74-5316a*    Licensed out-of-state psychologists must obtain a temporary permit from the licensing board in order to practice for no more than 15 days per year Must demonstrate good cause to Board for request to extend temporary permit for additional 15 days    Any psychology services rendered within any 24hour period shall count as one entire day of psychology services. | *K.S.A. § 74-5316a*    The licensing board may issue a cease and desist order &/OR assess a fine of up to $ 1,000 per day, for failure to obtain a temporary permit to  practice psychology in KS    *K.S.A. § 74-5341; K.S.A. §*  *21-6602; K.S.A. § 21-6611*    Class A Misdemeanor :  Possible fine up to $2,500  &/OR imprisonment up to  1 year |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **STATE** | **Telehealth/**  **Telepsychology**  **Statutes and/or Regulations** | **Practice of**  **Psychology defined to include**  **specifically**  **telepsychology?** | **Licensing Board**  **Advisory**  **Opinions** | **Telehealth Coverage Mandate** | **Temporary / Guest**  **Practice Provision** | **Penalties for**  **Unauthorized practice of psychology without a**  **license** |
|  |  | services to one or more individuals located in this state. |  |  |  |  |
| **KENTUCKY** | *Kentucky Rev. Stat. §*  *319.140; 201 KAR*  *26:310*    “Telehealth” is defined as the use of audio, video, or other electronic means to  deliver health care    Must obtain patient’s informed consent & maintain confidentiality of patient information, including electronic data | *201 KAR 26:310(3)*    “Telepsychology” is defined as the practice of psychology between a psychologist &  patient using electronic communication technology; or twoway, interactive, simultaneous audio and video | NO | *KRS § 304.17A-138*    A telehealth consultation shall not be reimbursable under this section if it is provided through the use of an audio-only telephone, facsimile machine, or electronic mail.    *806 KAR 17:270 -- Telehealth claim forms*  *& records* | *KRS § 319.015(8)*    Licensed out-of-state psychologists may practice for no more than 30 days every 2 years    Must register with the board prior to engaging in temporary practice or must hold a current, valid Interjurisdictional Practice Certificate issued by ASPPB    *201 KAR 26:215(6) –*  *Nonresident status*    A licensed out-of-state psychologist may engage in temporary practice of telepsychology if he/she receives prior board approval and complies with the above | *KRS § 319.990*    Misdemeanor: Possible fine up to $500 &/OR possible imprisonment up to 6 months for each  violation    Licensing board may also recover investigative expenses including reasonable attorney fees relating to the prosecution of those found guilty of violating of practicing psychology without a license |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **STATE** | **Telehealth/**  **Telepsychology**  **Statutes and/or Regulations** | **Practice of**  **Psychology defined to include**  **specifically**  **telepsychology?** | **Licensing Board**  **Advisory**  **Opinions** | **Telehealth Coverage Mandate** | **Temporary / Guest**  **Practice Provision** | **Penalties for**  **Unauthorized practice of psychology without a**  **license** |
|  |  |  |  |  | requirements for  temporary practice |  |
| **LOUISIANA** | NO | NO – not specified in statute or regulation but see licensing board opinion | YES    See Louisiana State Board of Examiners of Psychologists Opinion #013Telepsychology  Issued: March 29, 2012, available online at [http://www.lsbep.or g/pdfs/News\_vol25.](http://www.lsbep.org/pdfs/News_vol25.pdf)  [pdf](http://www.lsbep.org/pdfs/News_vol25.pdf) | *La. R.S. 22:1821(E)*    Appears to be limited to physicians only; reimbursement must be at least 75% of the “the reasonable and customary amount of payment, benefit, or reimbursement which that licensed physician receives for an intermediate office visit”    *La. R.S. 37:1262*    “Telemedicine” is defined as the practice of health care delivery, diagnosis, consultation, treatment, and transfer of medical data using interactive telecommunication technology that enables  a health care practitioner and a | *La. R.S. 37:2365(D);*  *LAC 46:LXIII.1001*    Licensed out-of-state psychologists may practice psychology in LA for a period not to exceed 30 days in any calendar year    However, he/she must be associated with a psychologist who is licensed in & a resident of Louisiana    The out-of-state psychologist’s state also must have a similar license exception privilege in place | *La. R.S. 37:2360*    Misdemeanor – Possible fine of $100-$500 &/OR possible imprisonment up to 6 months |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **STATE** | **Telehealth/**  **Telepsychology**  **Statutes and/or Regulations** | **Practice of**  **Psychology defined to include**  **specifically**  **telepsychology?** | **Licensing Board**  **Advisory**  **Opinions** | **Telehealth Coverage Mandate** | **Temporary / Guest**  **Practice Provision** | **Penalties for**  **Unauthorized practice of psychology without a**  **license** |
|  |  |  |  | patient at two locations separated by distance to interact via two-way video and audio transmissions  simultaneously.”    Phone calls or emails between a provider & patient are excluded as are consultations between providers. |  |  |
| **MAINE** | NO | NO | NO | *24-A M.R.S. § 4316 – Coverage for*  *telemedicine services*    “Telemedicine” is defined as the delivery of health care services, means the use of interactive audio, video or other electronic media for the purpose  of diagnosis, consultation or treatment. "    Audio-only telephone, facsimile machine or email excluded | *32 M.R.S. § 3812*    The “use of occasional services of qualified consultant psychologists from another state or jurisdiction or the use of the services of organizations from another state or jurisdiction employing qualified psychologists does not constitute the unlawful practice of psychology.”    *CMR 02-415-001 (13)* | *32 M.R.S. § 3814;*  *10 M.R.S. § 8003-C;*  *17-A M.R.S. § 1301;*  *17-A M.R.S. § 4-A*    Criminal penalty (Class E crime): Fine up to $1,000  &/OR imprisonment up to  1 year    Civil penalty: Fine of not less than $1,000 but not more than $5,000, each  violation    Permanent injunction (including costs of investigation & attorneys’ |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **STATE** | **Telehealth/**  **Telepsychology**  **Statutes and/or Regulations** | **Practice of**  **Psychology defined to include**  **specifically**  **telepsychology?** | **Licensing Board**  **Advisory**  **Opinions** | **Telehealth Coverage Mandate** | **Temporary / Guest**  **Practice Provision** | **Penalties for**  **Unauthorized practice of psychology without a**  **license** |
|  |  |  |  | Private payers must cover telehealth services, subject to coverage terms & conditions | "Occasional services" means consultation within Maine by a psychologist licensed in another state or jurisdiction but not licensed by the board, subject to the provisions of Chapter 9 of the board's rules.  "Occasional services" does not include psychotherapy.    *CMR 02-415-009(3)*    A psychologist not licensed by the board who provides  "occasional services" as defined above shall notify the board in writing each time the psychologist consults in Maine on a form provided by the board.    Such consultation may not occur more than 10 days in a calendar year. Consultation in Maine | fees) |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **STATE** | **Telehealth/**  **Telepsychology**  **Statutes and/or Regulations** | **Practice of**  **Psychology defined to include**  **specifically**  **telepsychology?** | **Licensing Board**  **Advisory**  **Opinions** | **Telehealth Coverage Mandate** | **Temporary / Guest**  **Practice Provision** | **Penalties for**  **Unauthorized practice of psychology without a**  **license** |
|  |  |  |  |  | beyond this 10-day period will only be permitted in exigent circumstances. |  |
| **MARYLAND** | NO | NO | NO    But see Spring 2011 newsletter of the Maryland Board of  Examiners of Psychologists for status of board’s work in this area    [http://dhmh.maryla nd.gov/psych/pdf/M archNewsletterSprin g2011.pdf](http://dhmh.maryland.gov/psych/pdf/MarchNewsletterSpring2011.pdf) | *Md. INSURANCE Code*  *Ann. § 15-139*    “Telemedicine” is defined as the delivery of health care services, the use of interactive audio, video, or other telecommunications or electronic technology by a licensed health care provider to the patient who is a different site.    Phone calls, faxes & email messages between the provider & patient are excluded.    Private payers must provide coverage for telehealth services subject to coverage terms & conditions | *Md. HEALTH*  *OCCUPATIONS Code*  *Ann. § 18-301(d);*  *COMAR 10.36.01.07(4)*    Board may authorize a non-resident to practice without a license if the Board finds that circumstances warrant & subject to any limitations the Board  imposes    In authorizing an exception, the Board: (a) Shall determine whether the circumstances warrant an exception to licensure, taking into account the:  (i) Qualifications of the  nonresident psychologist, (ii) Psychological services to be provided, | *Md. HEALTH*  *OCCUPATIONS Code Ann. § 18-401, § 18-404, § 18317.1.*    Criminal penalty  (misdemeanor): possible fine up to $10,000 &/OR imprisonment up to 1 year for each violation.    Civil penalty: possible fine up to $50,000 to be  assessed by the Board |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **STATE** | **Telehealth/**  **Telepsychology**  **Statutes and/or Regulations** | **Practice of**  **Psychology defined to include**  **specifically**  **telepsychology?** | **Licensing Board**  **Advisory**  **Opinions** | **Telehealth Coverage Mandate** | **Temporary / Guest**  **Practice Provision** | **Penalties for**  **Unauthorized practice of psychology without a**  **license** |
|  |  |  |  |  | and  (iii) Duration of the exception to licensure; and  (b) May impose any limitations on the psychologist's practice of psychology that the Board considers to be appropriate.    See FAQs on licensing board website:  [http://dhmh.maryland.g ov/psych/SitePages/FA](http://dhmh.maryland.gov/psych/SitePages/FAQ.aspx)  [Q.aspx](http://dhmh.maryland.gov/psych/SitePages/FAQ.aspx) |  |
| **MASSACHUSETTS** | NO | NO | See March 2006 policy of MA Board of Registration of Psychologists available online: [http://www.mass.g ov/?pageID=ocater minal&L=6&L0=Hom e&L1=Licensee&L2= Division+of+Professi onal+Licensure+Boa rds&L3=Board+of+R egistration+of+Psyc hologists&L4=Statut](http://www.mass.gov/?pageID=ocaterminal&L=6&L0=Home&L1=Licensee&L2=Division+of+Professional+Licensure+Boards&L3=Board+of+Registration+of+Psychologists&L4=Statutes+and+Regulations&L5=Board+Policies+and+Guidelines&sid=Eoca&b=terminalcontent&f=dpl_boards_py_policy_electronic_services&csid=Eoca) | *ALM GL ch. 175, § 47BB* ***--*** *Telemedicine.*    “Telemedicine” is defined as the delivery of health care services, using interactive audio, video or other electronic media for the purpose of diagnosis, consultation or treatment.    Audio-only phones, | *ALM GL ch. 112, § 123*  *(a) -- Activities Excluded*  *From Penalty Provisions*    The penalties in § 122shall not apply to: (a) persons eligible for licensure under §119 who provide  consultative services for a fee no more than 1  day/month | *ALM GL ch. 112, § 122*    Possible fine up to $500  &/OR imprisonment up to  3 months |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **STATE** | **Telehealth/**  **Telepsychology**  **Statutes and/or Regulations** | **Practice of**  **Psychology defined to include**  **specifically**  **telepsychology?** | **Licensing Board**  **Advisory**  **Opinions** | **Telehealth Coverage Mandate** | **Temporary / Guest**  **Practice Provision** | **Penalties for**  **Unauthorized practice of psychology without a**  **license** |
|  |  |  | [es+and+Regulations &L5=Board+Policies +and+Guidelines&si d=Eoca&b=terminal content&f=dpl\_boar ds\_py\_policy\_electr onic\_services&csid=](http://www.mass.gov/?pageID=ocaterminal&L=6&L0=Home&L1=Licensee&L2=Division+of+Professional+Licensure+Boards&L3=Board+of+Registration+of+Psychologists&L4=Statutes+and+Regulations&L5=Board+Policies+and+Guidelines&sid=Eoca&b=terminalcontent&f=dpl_boards_py_policy_electronic_services&csid=Eoca)  [Eoca](http://www.mass.gov/?pageID=ocaterminal&L=6&L0=Home&L1=Licensee&L2=Division+of+Professional+Licensure+Boards&L3=Board+of+Registration+of+Psychologists&L4=Statutes+and+Regulations&L5=Board+Policies+and+Guidelines&sid=Eoca&b=terminalcontent&f=dpl_boards_py_policy_electronic_services&csid=Eoca) | faxes or emails are excluded    Coverage of telemedicine services may be limited to those health care providers in a telemedicine network approved by the insurer. | *ALM GL ch. 112, § 124*    A nonresident psychologist may obtain a temporary license to practice in MA up to 1 year if he/she registers with the board & practices in consultation with, or under the supervision of, a licensed psychologist or possesses qualifications acceptable to the board. |  |
| **MICHIGAN** | NO | NO | NO | *MCLS § 500.3476;*  *MCLS § 550.1401k*    "Telemedicine" means the use a real-time, interactive audio or video, or both, telecommunications system for the health care professional to examine and interact with the patient at the time the services are provided.    Private payers cannot | Generally, NO but there is an exception for those who live in adjacent states    *MCLS § 333.16171(h) License for practice of health profession; exemptions*.    An individual residing adjacent to the land border between this state and an adjoining state who is authorized under the laws of that | *MCLS § 333.16294*    Practice without a license constitutes a felony    *MCLS § 750.503*    If a person is convicted of a felony for which no punishment is specially prescribed, felony punishable by imprisonment up to 4 years &/or a fine up to  $5,000 |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **STATE** | **Telehealth/**  **Telepsychology**  **Statutes and/or Regulations** | **Practice of**  **Psychology defined to include**  **specifically**  **telepsychology?** | **Licensing Board**  **Advisory**  **Opinions** | **Telehealth Coverage Mandate** | **Temporary / Guest**  **Practice Provision** | **Penalties for**  **Unauthorized practice of psychology without a**  **license** |
|  |  |  |  | require face-to-face contact between a health care professional & patient for services appropriately provided through telemedicine.    Telehealth services must be covered, subject to contract terms & conditions. | state to practice a health profession and whose practice may extend into this state, but who does not maintain an office or designate a place to meet patients or receive calls in this state. |  |
| **MINNESOTA** | NO | NO | NO | Only for Medicaid –  Minn. Stat. *§ 256B.0625* | *Minn. Stat. § 148.916(1)*    Licensed out-of-state psychologists may practice in the state for no more than 7 calendar days    But if more than 7 days, the psychologist must obtain approval from the Board for guest licensure.    Practice under guest licensure may not exceed 9 consecutive months per calendar year | *Minn. Stat. § 146.18;*  *Minn. Stat. § 609.02;*  *Minn. Stat. § 609.125;*  *Minn. Stat. § 609.033*    Misdemeanor: Possible fine up to $1,000 &/OR imprisonment up to 90 days |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **STATE** | **Telehealth/**  **Telepsychology**  **Statutes and/or Regulations** | **Practice of**  **Psychology defined to include**  **specifically**  **telepsychology?** | **Licensing Board**  **Advisory**  **Opinions** | **Telehealth Coverage Mandate** | **Temporary / Guest**  **Practice Provision** | **Penalties for**  **Unauthorized practice of psychology without a**  **license** |
|  |  |  |  |  | Approval for guest licensure must be received at least 30 days prior to anticipated  practice in MN |  |
| **MISSISSIPPI** | NO | *Miss. Code Ann. § 7331-3(d)(iii), § 73-31-*  *14(3)*    The practice of psychology shall be construed within the meaning of this definition without regard to whether payment is received for services rendered and without regard to the means of service provision (e.g., face-toface, telephone,  Internet, or telehealth).    Applicants awaiting licensure in Mississippi are prohibited from the practice of psychology without a temporary license issued by the | NO | *Miss. Code Ann. § 83-9351*    “Telemedicine” is defined as the delivery of health care services such as diagnosis, consultation, or treatment through the use of interactive audio, video, or other electronic media.    Must be "real-time" consultation    Use of audio-only telephone, fax or e-mail  excluded    Private payers must provide coverage for telehealth services to same extent as in- | *Miss. Code Ann. §73-3114(2); CMSR 50-0213201 – Rule 4.7(B)*    Out-of-state licensed psychologists may apply to the board for a temporary practice certificate to engage in practice on temporary basis in MS.    That practice must be limited in scope and duration, not exceeding 30 days during a consecutive 12-month period.    May be subject to a jurisprudence exam at the board’s discretion | *Miss. Code Ann. §73-3123; Miss. Code Ann. §7331-25*    Misdemeanor: Possible fine up to $300 &/OR possible imprisonment up to 60 days for each violation |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **STATE** | **Telehealth/**  **Telepsychology**  **Statutes and/or Regulations** | **Practice of**  **Psychology defined to include**  **specifically**  **telepsychology?** | **Licensing Board**  **Advisory**  **Opinions** | **Telehealth Coverage Mandate** | **Temporary / Guest**  **Practice Provision** | **Penalties for**  **Unauthorized practice of psychology without a**  **license** |
|  |  | board. For the purposes of this subsection, the practice of psychology shall be construed without regard to the means of service provision (e.g., face-toface, telephone, Internet, telehealth). |  | person services but may limit coverage to providers in a telemedicine network approved by the payer. |  |  |
| **MISSOURI** | NO | NO | NO | 2013 HB 986 to be codified as *§376.1900.1*  *R.S.Mo*, effective Jan 1,  2014    “Telehealth” has the same meaning as defined under *§208.670 R.S. Mo*. -- the “use of medical information exchanged from one site to another via electronic communications to improve the health  status of a patient.”    Private payers must provide coverage for telehealth services to same extent as in- | *§ 337.045(5) R.S.Mo*    Licensed out-of-state psychologist may practice for no more than 10 consecutive business days in any 90 day period, or in aggregate may not exceed 15 business days  in any 9-month period | *§ 337.065(1) R.S.Mo; §*  *560.011 R.S.Mo; § 560.016*  *R.S.Mo*    Class A Misdemeanor:  possible fine up to $1,000  &/OR possible  imprisonment up to 1 year |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **STATE** | **Telehealth/**  **Telepsychology**  **Statutes and/or Regulations** | **Practice of**  **Psychology defined to include**  **specifically**  **telepsychology?** | **Licensing Board**  **Advisory**  **Opinions** | **Telehealth Coverage Mandate** | **Temporary / Guest**  **Practice Provision** | **Penalties for**  **Unauthorized practice of psychology without a**  **license** |
|  |  |  |  | person services but may limit coverage to providers in a telemedicine network  approved by the payer |  |  |
| **MONTANA** | NO | *MONT. ADMIN. R.*  *24.189.301*    (1) "Defined professional relationship" means a relationship in which a licensee or license applicant provides diagnostic, assessment and/or therapeutic services to a client. A defined professional  relationship shall be  initially  established in a context where services are provided:   1. in person and faceto-face; or 2. transmitted via electronic or related methods. If provided under this subsection, the context must also | NO | SB 270 (2013).to be codified under Title 33, Chapter 22, Part 1,  effective 1/1/2014    “Telehealth” is defined the use of interactive audio, video, or other telecommunications technology to deliver health care services.    Includes real-time and store-&-forward technology; but excludes audio-only phone, fax or email    Must be delivered through secure communications  compliant with HIPAA    Private payers must provide coverage for | *Mont. Code Anno. § 3717-104 (1)(d); MONT.*  *ADMIN. R. 24.189.414*    Licensed out-of-state psychologists may render consulting psychological services not to exceed in the aggregate60 days during a calendar year.    If services exceed 10 days in a calendar year, the psychologist must submit a notarized form to the Dept. of Labor & Industry in advance as to the nature, extent & duration of the services to be provided in the state.  Notification shall be provided to the board | *Mont. Code Anno.* §37-17-  312    Misdemeanor: Possible fine up to $500 &/OR imprisonment in county  jail up to 6 months |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **STATE** | **Telehealth/**  **Telepsychology**  **Statutes and/or Regulations** | **Practice of**  **Psychology defined to include**  **specifically**  **telepsychology?** | **Licensing Board**  **Advisory**  **Opinions** | **Telehealth Coverage Mandate** | **Temporary / Guest**  **Practice Provision** | **Penalties for**  **Unauthorized practice of psychology without a**  **license** |
|  |  | be:   1. two-way; 2. interactive; 3. real-time; 4. simultaneous; 5. continuous; and (vi) providing for both audio and visual interaction.     *MONT. ADMIN. R.*  *24.189.607(4)(d)(ii)(A)* also allows for teleconferencing (twoway, interactive, real time, simultaneous, continuous, and provides audio &visual interaction) as substitute for face-toface postdoctoral supervision |  | telehealth services to same extent as inperson services | each year nonresident psychological services are rendered.    A letter verifying termination of said services shall be filed with the board at the time of termination. |  |
| **NEBRASKA** | NO | NO | NO | NO for private insurance but yes for NE Medicaid  (*see R.R.S. Neb. §71-*  *8501 et seq*.) | *R.R.S. Neb. § 38-3119;*  *172 NAC 155-004.03*    Licensed, out-of-state psychologists may provide services in NE so long as they do not provide more than an | *R.R.S. Neb. § 38-3130(2);*  *172 NAC 155-004.03; 172*  *NAC 155-012*    Class II misdemeanor:  possible fine up to $1,000  &/OR possible imprisonment up to 6 |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **STATE** | **Telehealth/**  **Telepsychology**  **Statutes and/or Regulations** | **Practice of**  **Psychology defined to include**  **specifically**  **telepsychology?** | **Licensing Board**  **Advisory**  **Opinions** | **Telehealth Coverage Mandate** | **Temporary / Guest**  **Practice Provision** | **Penalties for**  **Unauthorized practice of psychology without a**  **license** |
|  |  |  |  |  | aggregate of 30 days of professional services during the 12 month period beginning with the first date of issuance may be issued a letter to practice.    Requirements for a license in the other jurisdiction are equal to or exceed NE”s  licensure requirements    Must notify DHHS - Regulation & Licensure of the nature and location of their practice and provide evidence of their licensure in another jurisdiction to obtain a letter permitting temporary  practice | months    An individual who practices prior to issuance of a credential for temporary practice is subject to assessment of an Administrative Penalty, or such other action as provided in the statutes and regulations governing the credential.    Administrative penalty may be $10 per day, not to exceed a total of $ 1,000 for practice without a credential. |
| **NEVADA** | NO | NO | See FAQs on  State of Nevada  Board of  Psychological Examiners website: [http://psyexam.nv.g](http://psyexam.nv.gov/FAQs/) | NO | *Nev. Rev. Stat. Ann.*  *§641.410; NAC 641.180*    Licensed, out-of-state psychologists may practice in NV without a | *Nev. Rev. Stat. Ann.*  *§641.440; §193.140*    Gross misdemeanor: possible fine up to $2,000 &/OR imprisonment in |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **STATE** | **Telehealth/**  **Telepsychology**  **Statutes and/or Regulations** | **Practice of**  **Psychology defined to include**  **specifically**  **telepsychology?** | **Licensing Board**  **Advisory**  **Opinions** | **Telehealth Coverage Mandate** | **Temporary / Guest**  **Practice Provision** | **Penalties for**  **Unauthorized practice of psychology without a**  **license** |
|  |  |  | [ov/FAQs/](http://psyexam.nv.gov/FAQs/)    In Nevada, psychologists licensed in another state cannot provide services to residents without a license. This includes teletherapy of any type. |  | license so long as he/she does not practice more than 30 days in a calendar year **&** if the psychologist is invited as a consultant by a NV-licensed psychologist.    Licensure requirements for other jurisdiction must meet licensure requirements for NV.    The application for approval to practice as a consultant in NV must be submitted at least 30 days before the psychologist intends to begin practice in this State.    The application must be approved before practicing as a consultant in NV. | county jail up to 364 days |
| **NEW HAMPSHIRE** | *RSA 329-B:16*    Persons licensed by | *RSA 329-B:2(7)(h)*    Provision of any of | See Feb. 17, 2012 statement of interpretation by | *RSA 415-J: 1 et seq.—*  *New Hampshire*  *Telemedicine Act* | *RSA 329-B:20(I)*    Licensed, out-of-state | *RSA 329-B:17*    Class A Misdemeanor (for |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **STATE** | **Telehealth/**  **Telepsychology**  **Statutes and/or Regulations** | **Practice of**  **Psychology defined to include**  **specifically**  **telepsychology?** | **Licensing Board**  **Advisory**  **Opinions** | **Telehealth Coverage Mandate** | **Temporary / Guest**  **Practice Provision** | **Penalties for**  **Unauthorized practice of psychology without a**  **license** |
|  | the board who practice electronically shall be subject to standards of care for the practice of telemedicine and telehealth for psychology established by the board pursuant to rules adopted under RSA 541-A. | these services or activities by any means, including electronic or telephonic constitutes the practice of psychology | the NH Board of Mental Health Practice, which regulated psychologists prior  to July 1, 2013    [http://www.nh.gov/](http://www.nh.gov/mhpb/documents/out-of-statepractice.htm)  [mhpb/documents/o](http://www.nh.gov/mhpb/documents/out-of-statepractice.htm)  [ut-of-](http://www.nh.gov/mhpb/documents/out-of-statepractice.htm)  [statepractice.htm](http://www.nh.gov/mhpb/documents/out-of-statepractice.htm) | “Telemedicine” is defined as the use of audio, video, or other electronic media for the purpose of diagnosis, consultation, or treatment.    Audio-only telephone or fax excluded.    Private payers must provide coverage for telehealth services to same extent as inperson services. | psychologists may temporarily practice in NH if no more than 30 days per year.    Licensure requirements in the psychologist’s home state must be equal to or exceed NH’s requirements for licensure.    The out-of-state psychologist must hold one of the following credential: ASPPB’s CPQ or IPC; ABPP; NR’s HSP certification; or other equivalent qualifications determined by the board. | a natural person): possible fine up to $2,000 &/OR possible imprisonment up to 1 year, each violation    Felony if committed by any  other person (§330-A:23) |
| **NEW JERSEY** | NO | NO | NO | NO | *N.J. Stat. § 45:14B-6(d)*    Licensed out-of-state psychologists may practice in NJ without a license for not more than 10 consecutive business days or 15 | *N.J. Stat. § 45:1-11; N.J.*  *Stat. § 45:1‐18.2*    Possible civil penalty up to $10,000 for the first violation & up to $20,000 for the second and each subsequent violation |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **STATE** | **Telehealth/**  **Telepsychology**  **Statutes and/or Regulations** | **Practice of**  **Psychology defined to include**  **specifically**  **telepsychology?** | **Licensing Board**  **Advisory**  **Opinions** | **Telehealth Coverage Mandate** | **Temporary / Guest**  **Practice Provision** | **Penalties for**  **Unauthorized practice of psychology without a**  **license** |
|  |  |  |  |  | business days in any 90day period subject to following conditions:    Resides outside of NJ; major practice is outside of NJ: provides Board with summary of qualifications & minimum of 10 days' advance written notice of intention to practice; & home state’s licensing requirements must be equivalent to NJ’s  licensing requirements |  |
| **NEW MEXICO** | NO | NO | NO | 2013 N.M. Laws, Chap. 105 (SB 69) to be codified as *N.M. Stat. Ann. § 13-7-14, § 59A22-49.3, § 59A-23-7.12, § 59A-46-50.3, § 59A47-45.3*?    “Telemedicine” is defined as the use of interactive simultaneous audio & video or store & forward technology | *N.M. Stat. Ann. § 61-910.1(A); NMAC*  *16.22.5.13*    Licensed out-of-state psychologists may obtain a temporary license to practice for  up to 6 months in NM    Temporary license temporary license may be extended at the discretion of the board | *N.M. Stat. Ann. § 61-9-14*    Misdemeanor: Possible fine up to $1,000 &/or imprisonment up to 3 months for each violation |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **STATE** | **Telehealth/**  **Telepsychology**  **Statutes and/or Regulations** | **Practice of**  **Psychology defined to include**  **specifically**  **telepsychology?** | **Licensing Board**  **Advisory**  **Opinions** | **Telehealth Coverage Mandate** | **Temporary / Guest**  **Practice Provision** | **Penalties for**  **Unauthorized practice of psychology without a**  **license** |
|  |  |  |  | using information and telecommunications technologies by a health care provider to deliver health care services at a site other than the site where the patient is located    Telemedicine used to provide clinical services shall be encrypted and shall conform to state and federal privacy laws.    Private payers must provide coverage for telehealth services to same extent as inperson services. | with a written request 30 days prior to the expiration, stating the reason for extension. |  |
| **NEW YORK** | NO    But there is a provision governing  hospital credentialing/ privileging of health care practitioners providing | NO | Telepractice Guideline issued by the NYS Office of the Professions available online:  [http://www.op.nyse d.gov/prof/psych/ps ychtelepracticeguid e.htm](http://www.op.nysed.gov/prof/psych/psychtelepracticeguide.htm) | NO | *NY CLS Educ § 7605 (8);*  *8 NYCRR § 72.5*    Licensed out-of-state practitioner may practice may engage in temporary period up to 10 consecutive business days in any period of 90 | *NY CLS Educ § 6512; NY*  *CLS Penal § 70.00; CLS*  *Penal § 80.00*    Class E felony: possible fine up to $5,000 &/or imprisonment up to 4  years |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **STATE** | **Telehealth/**  **Telepsychology**  **Statutes and/or Regulations** | **Practice of**  **Psychology defined to include**  **specifically**  **telepsychology?** | **Licensing Board**  **Advisory**  **Opinions** | **Telehealth Coverage Mandate** | **Temporary / Guest**  **Practice Provision** | **Penalties for**  **Unauthorized practice of psychology without a**  **license** |
|  | telemedicine services  – *see* *NY CLS Pub*  *Health § 2805-u*    "Telemedicine" is defined as the delivery of clinical health care services through real-time two-way electronic audio-visual communications. The health care practitioner providing telemedicine must be licensed to practice in NY State. |  |  |  | consecutive days or in the aggregate no more than 15 business days in any such 90-day period.    They must file with the department before  practicing    This is a one-time practice exemption. |  |
| **NORTH CAROLINA** | NO | NO | See March 2005 opinion of NC Psychology Board available online:  [http://ncpsychology board.org/office/Ele ctronicServices.htm](http://ncpsychologyboard.org/office/ElectronicServices.htm) | NO | *N.C. Gen. Stat. § 90270.4(f); 21 N.C.A.C.*  *54.1610*    Licensed out-of-state psychologists may practice for up to 5 days in any calendar year.    Nonresident psychologists shall submit to the Board a | *N.C. Gen. Stat. §90-270.17;*  *N.C. Gen. Stat. § 14-3; N.C.*  *Gen. Stat. § 15A-1340.23*    Class 2 misdemeanor: possible fine up to $1,000 &/OR imprisonment of more than 30 days up to 6  months, each violation |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **STATE** | **Telehealth/**  **Telepsychology**  **Statutes and/or Regulations** | **Practice of**  **Psychology defined to include**  **specifically**  **telepsychology?** | **Licensing Board**  **Advisory**  **Opinions** | **Telehealth Coverage Mandate** | **Temporary / Guest**  **Practice Provision** | **Penalties for**  **Unauthorized practice of psychology without a**  **license** |
|  |  |  |  |  | written statement from their home state verifying licensure in good standing with a written description of their intended practice at least 5 working days prior to engaging in temporary practice in  NC |  |
| **NORTH DAKOTA** | NO | *N.D. Cent. Code § 4351-02 -Location of practice of an occupation or profession*    The provision of services to an individual in this state which fall within the standard of practice of a profession or occupation regulated by a board, regardless of the means by which the services are provided or the physical location of the person providing those services, constitutes the practice of that | NO | NO | *N.D. Cent. Code, §43-3230(2); N.D. Cent. Code, § 43-51-05; N.D. Admin.*  *Code 66-02-01-16*    Licensed out-of-state psychologists may practice temporarily in ND for up to 30 days in  any calendar year    The 1-year period commences on the date the written application is approved by the board.    The application must include verified documentation that the | *N.D. Cent. Code, §43-32-31*    Class B Misdemeanor: possible fine up to $1000 dollars &/OR imprisonment up to 30 days    Civil injunction remedy also available |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **STATE** | **Telehealth/**  **Telepsychology**  **Statutes and/or Regulations** | **Practice of**  **Psychology defined to include**  **specifically**  **telepsychology?** | **Licensing Board**  **Advisory**  **Opinions** | **Telehealth Coverage Mandate** | **Temporary / Guest**  **Practice Provision** | **Penalties for**  **Unauthorized practice of psychology without a**  **license** |
|  |  | occupation or profession in this state and is subject to regulation by the appropriate board in this state. |  |  | nonresident psychologist is licensed in good standing; the nature of the services to be provided; & explanation of when the services are to be provided. |  |
| **OHIO** | *OAC Ann. 4732-301(S); OAC Ann.*  *4732-13-03, 4732-13-*  *04 (supervision); &*  *OAC Ann. 4732-17-01*    “Telepsychology” is defined as the practice of psychology by distance communication technology such as but not necessarily limited to telephone, email, Internet-based communications, and videoconferencing.    In order to practice telepsychology in the state of Ohio one | See OAC Ann 4732-3-01 | NO | NO | *ORC Ann. 4732.22(B);*  *OAC Ann. 4732-5-*  *02(B)(2)*    Licensed out-of-state psychologists may practice temporarily in  OH for not more than  30 days a year    Must submit an application prior to practicing in Ohio indicating that home state’s licensure requirements are equal to or exceed OH’s licensing requirements    Holding an active interjurisdictional practice certificate (IPC) issued | *ORC Ann. 4732.99*    Possible fine of $100-500 &/OR imprisonment of 6 months up to 1 year, each  violation |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **STATE** | **Telehealth/**  **Telepsychology**  **Statutes and/or Regulations** | **Practice of**  **Psychology defined to include**  **specifically**  **telepsychology?** | **Licensing Board**  **Advisory**  **Opinions** | **Telehealth Coverage Mandate** | **Temporary / Guest**  **Practice Provision** | **Penalties for**  **Unauthorized practice of psychology without a**  **license** |
|  | must hold a current, valid license issued by the state board of psychology or shall be a registered supervisee of a licensee being delegated telepsychology practices. |  |  |  | by ASSPB shall be deemed to qualify for  permission to practice |  |
| **OKLAHOMA** | *36 Okl. St. § 6801 et seq -- Oklahoma Telemedicine Act*    “Telemedicine” is defined as the practice of health care delivery, diagnosis, consultation, treatment, including but not limited to, the treatment and prevention of strokes, transfer of medical data, or exchange of medical education information by means of audio, | NO but psychologists are included in the list of providers authorized to provide services under the Telemedicine  Act | See *Kennedy v.*  *Freeman,* 919 F.2d 126 (1990) (out-ofstate doctor had sufficient contacts with OK for OK court to assert personal jurisdiction in medical malpractice  action)    [http://www.leagle.c om/decision/19901 045919F2d126\_110](http://www.leagle.com/decision/19901045919F2d126_11003)  [03](http://www.leagle.com/decision/19901045919F2d126_11003)    See OK AG Opinion 00-041 addressing the ability of dental board to regulate | *36 Okl. St. § 6803*    Health care service plans, disability insurer programs, workers' compensation programs, or state Medicaid managed care program contracts shall provide coverage of telehealth services, subject to contract terms & conditions. | *59 Okl. St. § 1353(9* )    Licensed out-of-state psychologists may practice temporarily for no more than an aggregate 5 days during any year.    He/she must inform the Board prior to initiation of services. | 5*9 Okl. St. § 1374*    Misdemeanor: possible fine up to $500 &/OR imprisonment up to 6  months, each violation |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **STATE** | **Telehealth/**  **Telepsychology**  **Statutes and/or Regulations** | **Practice of**  **Psychology defined to include**  **specifically**  **telepsychology?** | **Licensing Board**  **Advisory**  **Opinions** | **Telehealth Coverage Mandate** | **Temporary / Guest**  **Practice Provision** | **Penalties for**  **Unauthorized practice of psychology without a**  **license** |
|  | video, or data communications.    Consultation by phone or fax is  excluded    Provider must obtain written patient consent prior to engaging in telehealth. See *36 Okl. St. § 6804* for what must be specifically included in the informed consent |  | dental services provided via  internet in OK    [http://www.oklegal. onenet.net/oklegalcgi/ifetch?okag+125](http://www.oklegal.onenet.net/oklegal-cgi/ifetch?okag+1256050667529+F)  [6050667529+F](http://www.oklegal.onenet.net/oklegal-cgi/ifetch?okag+1256050667529+F) |  |  |  |
| **OREGON** | NO | NO | NO | *ORS § 743A.058*    "Telemedical" means delivered through a two-way video communication that allows a health professional to interact with a patient who is at an originating site as defined in the statute.    Private payers must | *ORS § 675.063; Or.*  *Admin. R. 858-010-0055*    Licensed, out-of-state psychologists must obtain a limited (visitor’s) permit to engage in temporary practice in OR.    A visitor's permit shall be effective for no more than 30 days in a 12 | *ORS § 675.990; ORS §*  *161.615; ORS § 161.635*    Class C Misdemeanor:  possible fine up to $6,250  &/OR imprisonment up to  1 year      *ORS § 675.150 --* Injunction remedy |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **STATE** | **Telehealth/**  **Telepsychology**  **Statutes and/or Regulations** | **Practice of**  **Psychology defined to include**  **specifically**  **telepsychology?** | **Licensing Board**  **Advisory**  **Opinions** | **Telehealth Coverage Mandate** | **Temporary / Guest**  **Practice Provision** | **Penalties for**  **Unauthorized practice of psychology without a**  **license** |
|  |  |  |  | provide coverage for telehealth services, subject to contract terms & conditions. | month period.    The licensure requirements for the psychologist’s home state must be essentially equivalent to those required in OR. |  |
| **PENNSYLVANIA** | NO | NO | See *Guideline*  *Regarding*  *Requirements for*  *Provision of*  *Psychological Services Regardless of Delivery Method*, available on the State Board of Psychology’s website:  [http://www.portal.s tate.pa.us/portal/se rver.pt/community/ state\_board\_of\_psy chology/12521/licen sure\_information/5](http://www.portal.state.pa.us/portal/server.pt/community/state_board_of_psychology/12521/licensure_information/572083)  [72083](http://www.portal.state.pa.us/portal/server.pt/community/state_board_of_psychology/12521/licensure_information/572083) | NO | *63 P.S. § 1203(7); 49 Pa.*  *Code § 41.52(c)*    Licensed, out-of-state psychologists must obtain advance permission from the Board to practice on temporary assignment in PA.    Temporary practice is limited to up to 6 months.    Only 1 additional 6month extension may be granted. Requests for extension must be submitted in writing to the Board. | *63 P.S. § 1211*    Misdemeanor: Possible fine up to $ 1,000 &/or imprisonment up to 6  months    For additional violations, possible fine not less than $2,000 &/or imprisonment not less than 6 months up  to 1 year |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **STATE** | **Telehealth/**  **Telepsychology**  **Statutes and/or Regulations** | **Practice of**  **Psychology defined to include**  **specifically**  **telepsychology?** | **Licensing Board**  **Advisory**  **Opinions** | **Telehealth Coverage Mandate** | **Temporary / Guest**  **Practice Provision** | **Penalties for**  **Unauthorized practice of psychology without a**  **license** |
|  |  |  |  |  | Licensed, out-of-state psychologists on temporary assignment in PA for an aggregate of no more than 14 days are exempted from the  notification requirement. |  |
| **RHODE ISLAND** | NO | NO | Email communication from RI Board Administrator dated 4/20/10 indicates that the RI psychology board views provision of telemental health services as requiring  licensure in RI. It may also be possible to provide services under temporary licensure provision. It should be noted that the board equates 1 teletherapy session to 1 calendar day of the 10 calendar day limit. | NO | *R.I. Gen. Laws § 5-4423(h); CRIR 14-140036(2.9)*    Licensed out-of-state psychologists may practice temporarily up to 10 calendar days per calendar year with no more than 5 days of this activity occurring consecutively | *R.I. Gen. Laws § 5-44-21*    Misdemeanor: Possible fine up to $500, each offense |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **STATE** | **Telehealth/**  **Telepsychology**  **Statutes and/or Regulations** | **Practice of**  **Psychology defined to include**  **specifically**  **telepsychology?** | **Licensing Board**  **Advisory**  **Opinions** | **Telehealth Coverage Mandate** | **Temporary / Guest**  **Practice Provision** | **Penalties for**  **Unauthorized practice of psychology without a**  **license** |
|  |  |  |  |  |  |  |
| **SOUTH CAROLINA** | NO | *S.C. Code Ann. § 40-5550*    (C) A person is deemed to be practicing as a psychologist within the meaning of this chapter if the person engages in  any of the activities enumerated in subsection (A) electronically within this State including, but not limited to, by means of the internet, phone lines, and personal computer modems. | NO | NO | *S.C. Code Ann §40-55110*    Licensed, out-of-state psychologists must obtain a temporary permit from the Board to practice temporarily for a period not to exceed 60 days within a calendar year    Must demonstrate that the home state’s licensing requirements are equivalent to SC’s requirements. | *S.C. Code Ann* §40-55-170    Felony: possible fine up to  $50,000 &/or  imprisonment up to 1 year |
| **SOUTH DAKOTA** | NO | NO | NO | NO | *S.D. Codified Laws § 36-*  *27A-2 (4)*    Licensed out-of-state psychologists engage in temporary practice up to no more than an aggregate of 20 days during any 1 year.    If exceed 10 consecutive | *S.D. Codified Laws §36-2-2*;  *S.D. Codified Laws § 22-6-2*    Class 2 misdemeanor:  possible fine of $500 &/OR 30 days imprisonment in a county jail, each violation |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **STATE** | **Telehealth/**  **Telepsychology**  **Statutes and/or Regulations** | **Practice of**  **Psychology defined to include**  **specifically**  **telepsychology?** | **Licensing Board**  **Advisory**  **Opinions** | **Telehealth Coverage Mandate** | **Temporary / Guest**  **Practice Provision** | **Penalties for**  **Unauthorized practice of psychology without a**  **license** |
|  |  |  |  |  | days of practice in any year, then must report to the board in writing the nature and extent of practice in SD. |  |
| **TENNESSEE** | NO | NO | NO | NO | *Tenn. Code Ann. § 6311-211(b)(5)*    Licensed, out-of-state psychologists may practice up to 12 days per year for such purposes as special training or consultation, speciation evaluation or intervention, or serving  as an expert witness | *Tenn. Code Ann. § 63-11206(a); Tenn. Code Ann. §*  *40-35-111(e)(2)*    Class B misdemeanor: possible fine up to $500  &/OR imprisonment up to  6 months |
| **TEXAS** | *Tex. Ins. Code §1455.001 et seq.* (health care  coverage)    *Tex. Occ. Code §111.001 et seq.* (informed consent, patient  confidentiality)    *Tex. Occ. Code* | NO | See December 1999 telepractice policy statement of Texas  State Board of  Examiners of Psychologists available online:  [http://tsbep.texas.g ov/files/newsletters](http://tsbep.texas.gov/files/newsletters/1999Fall.pdf)  [/1999Fall.pdf](http://tsbep.texas.gov/files/newsletters/1999Fall.pdf) | *Tex. Ins. Code*  *§1455.004*    Private payers must provide coverage for telehealth services, subject to contract terms & conditions. | *Tex. Occ. Code §*  *501.263; 22 TAC §*  *463.27*    Licensed, out-of-state psychologists must obtain a temporary permit to practice in TX.    The home state’s licensing requirements must be substantially | *Tex. Occ. Code § 501.502;*  *Tex. Occ. Code § 501.503;*  *Tex. Penal Code § 12.21;*  *22 TAC § 470.22*    Civil penalty of $1,000 for  each day of violation    Class A Misdemeanor: possible fine up to $4,000  &/OR imprisonment up to  1 year |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **STATE** | **Telehealth/**  **Telepsychology**  **Statutes and/or Regulations** | **Practice of**  **Psychology defined to include**  **specifically**  **telepsychology?** | **Licensing Board**  **Advisory**  **Opinions** | **Telehealth Coverage Mandate** | **Temporary / Guest**  **Practice Provision** | **Penalties for**  **Unauthorized practice of psychology without a**  **license** |
|  | *§106.001*    The fact that an activity occurs through the use of the Internet does not affect a licensing authority's power to regulate an activity or person that would otherwise be regulated under this title.    *Tex. Gov't Code*  *§531.001(7)*    Telehealth service" means a health service, delivered by a licensed or certified health professional acting within the scope of their license or certification and that requires the use of advanced telecommunications technology, other than phone or fax, including: |  |  |  | equal to the licensing requirements in TX.    The temporary permit is valid only for a period up to 30 days as specified by the board and for the limited purpose approved by the board.    A person holding a temporary license issued under this chapter shall display a sign indicating that the license is temporary. The sign must be approved by the board and displayed in every room in which the person provides psychological services.    Yes (Tex. Occ. Code  §501.263; 22 TAC  §463.27) | Each day a violation continues or occurs is a separate violation |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **STATE** | **Telehealth/**  **Telepsychology**  **Statutes and/or Regulations** | **Practice of**  **Psychology defined to include**  **specifically**  **telepsychology?** | **Licensing Board**  **Advisory**  **Opinions** | **Telehealth Coverage Mandate** | **Temporary / Guest**  **Practice Provision** | **Penalties for**  **Unauthorized practice of psychology without a**  **license** |
|  | (A) compressed digital interactive video, audio, or data transmission; (B) clinical data transmission using computer imaging by way of still-image capture and store and forward; and (C) other technology that facilitates access to health care services or medical specialty expertise. |  |  |  |  |  |
| **UTAH** | NO | *Utah Code Ann. § 5861-102(10)*    “Remotely” is defined as communicating via Internet, telephone, or other electronic means that facilitate real-time audio or visual interaction between individuals when they are not physically present in the same room at the same time. | NO | NO | *Utah Code Ann. § 58-61307(2)(k)*    An individual who is licensed, in good standing, to practice mental health therapy elsewhere in the US outside of Utah may provide short term transitional mental health therapy remotely to a client in Utah only if:  (i) the individual is | *Utah Code Ann. § 58-61-*  *501; § 58-61-503; Utah*  *Code Ann. § 76-3-203; §*  *76-3-301*    3rd degree felony: possible fine up to $5,000 &/or imprisonment up to 5 years |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **STATE** | **Telehealth/**  **Telepsychology**  **Statutes and/or Regulations** | **Practice of**  **Psychology defined to include**  **specifically**  **telepsychology?** | **Licensing Board**  **Advisory**  **Opinions** | **Telehealth Coverage Mandate** | **Temporary / Guest**  **Practice Provision** | **Penalties for**  **Unauthorized practice of psychology without a**  **license** |
|  |  | *Utah Code Ann. § 5861-307(2)(k)*    Short-term telemental health services may be provided in UT from another state if the nonresident psychologist meets certain specified conditions (further  described in column #5) |  |  | present in the state or territory where the individual is licensed to practice mental health therapy;   1. the client relocates to Utah; 2. the client is a client of the individual immediately before the client relocates to Utah; (iv) the individual provides the short term transitional mental health therapy to the client only during the 45 day period beginning on the day on which the client relocates to Utah; (v) within 10 days after the day on which the client relocates to Utah, the individual provides written notice to the division of the individual's intent to provide short term transitional mental health therapy remotely to the client; and (vi) the individual does |  |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **STATE** | **Telehealth/**  **Telepsychology**  **Statutes and/or Regulations** | **Practice of**  **Psychology defined to include**  **specifically**  **telepsychology?** | **Licensing Board**  **Advisory**  **Opinions** | **Telehealth Coverage Mandate** | **Temporary / Guest**  **Practice Provision** | **Penalties for**  **Unauthorized practice of psychology without a**  **license** |
|  |  |  |  |  | not engage in unlawful conduct or unprofessional conduct. |  |
| **VERMONT** | *26 V.S.A. § 3018 –*  *Telepractice*    Licensees who provide services regulated under this chapter by means of the internet or any other electronic means are deemed to provide such services in this state, and are subject to the jurisdiction of the board. The board may take disciplinary or other action against such licensees. Action taken by the board does not preclude any other jurisdiction from also taking disciplinary or other action against such licensees. | *CVR 04-030-270(6.8) – Telepractice*     1. Telepractice is governed 26 V.S.A. § 3018. Professionals who provide service via the Internet or other electronic means should provide as much information as possible to individuals who access their services.      1. Psychologists from other jurisdictions providing telepractice   services to persons in Vermont are deemed to be practicing in  Vermont. They must be licensed by the Board and must comply with the disclosure requirements of Rule 6.8. | See board website for disclosures required for telepractice:  [http://vtprofessiona ls.org/opr1/psychol ogists/telepractice.a](http://vtprofessionals.org/opr1/psychologists/telepractice.asp)  [sp](http://vtprofessionals.org/opr1/psychologists/telepractice.asp) | *8 V.S.A. § 4100k - Coverage for*  *telemedicine services*    "Telemedicine" means the delivery of health care services such as diagnosis, consultation, or treatment through the use of live interactive audio & video over a secure connection that complies with HIPAA.    Audio-only telephone, e-mail, or fax excluded.    Coverage for telehealth services is required, subject to contract terms & conditions.    A health insurance plan may limit coverage to providers in the plan's network and may | *CVR 04-030-270(1.8)*    Licensed, out-of-state psychologists must obtain a temporary license to practice in VT.    Temporary practice is limited up to 10 days, or 80 hours in a 12-month period.    No applicant may be issued more than two temporary licenses. | *26 V.S.A. § 3002; 26 V.S.A.*  *§ 3003; 3 V.S.A. § 127*    Injunction & civil penalty  up to $1,000    Criminal penalty: possible fine up to $5,000 &/or  imprisonment up to 1 year |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **STATE** | **Telehealth/**  **Telepsychology**  **Statutes and/or Regulations** | **Practice of**  **Psychology defined to include**  **specifically**  **telepsychology?** | **Licensing Board**  **Advisory**  **Opinions** | **Telehealth Coverage Mandate** | **Temporary / Guest**  **Practice Provision** | **Penalties for**  **Unauthorized practice of psychology without a**  **license** |
|  |  | (c) Vermont licensed psychologists who provide telepractice services to clients outside of Vermont remain under the jurisdiction of the Board. They shall comply with the disclosure requirements of Rule  6.8 and shall specifically disclose:  (1) Name, location, and telephone number of the psychologist; (2) What the psychologist is licensed and trained to do; and (3) The limits and limitations of Internet practice and service delivery. |  | require originating site health care providers to document the reason the services are being provided by telemedicine rather than in-person. |  |  |
| **VIRGINIA** | NO | NO | Based on a communication with staff of the Virginia Board of  Psychology, see 115: 1.4 available online -- | *Va. Code Ann. § 38.23418.16*    “Telemedicine” is defined as the delivery of health care services, means the use of | *Va. Code Ann. § 54.13601(6), (7)*    Licensed, out-of-state psychologists may practice temporarily if consulting with VA | *Va. Code Ann. § 54.1-2401*    Civil penalty up to $5,000, each violation    *Va. Code Ann. § 54.1-111;*  *Va. Code Ann. § 18.2-10;* |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **STATE** | **Telehealth/**  **Telepsychology**  **Statutes and/or Regulations** | **Practice of**  **Psychology defined to include**  **specifically**  **telepsychology?** | **Licensing Board**  **Advisory**  **Opinions** | **Telehealth Coverage Mandate** | **Temporary / Guest**  **Practice Provision** | **Penalties for**  **Unauthorized practice of psychology without a**  **license** |
|  |  |  | [http://www.dhp.vir ginia.gov/counseling /counseling\_guideli nes.htm](http://www.dhp.virginia.gov/counseling/counseling_guidelines.htm) | interactive audio, video, or other electronic media used for the purpose of diagnosis, consultation, or treatment.    Audio-only telephone, electronic mail message, or facsimile  transmission is excluded    Coverage for telehealth services is required, subject to contract terms & conditions. | licensed psychologists, or when issued a temporary license by the Board to participate in continuing education programs or rendering psychological services without compensation  to any patient at clinics  for indigent/uninsured | *Va. Code Ann. § 18.2-11*    Class 1 misdemeanor:  possible fine up to $2,500  &/or imprisonment up to  12 months    Subsequent offense within  36-month period constitutes class 6 felony Possible fine up to $2,500 &/or imprisonment of 1-5 years or in court’s  discretion up to 12 months |
| **WASHINGTON** | NO | NO | NO | NO | *Rev. Code Wash*  *§18.83.082; WAC § 246-*  *924-480; WAC § 246-*  *924-483*    Licensed, out-of-state psychologists may petition the Board for a temporary permit to practice within the state for a period not to exceed 90 days in a calendar year. | *Rev. Code Wash. (ARCW) §*  *18.83.180; ARCW*  *§9.92.020*    Gross Misdemeanor:  Possible fine up to $5,000  &/or imprisonment up to  364 days |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **STATE** | **Telehealth/**  **Telepsychology**  **Statutes and/or Regulations** | **Practice of**  **Psychology defined to include**  **specifically**  **telepsychology?** | **Licensing Board**  **Advisory**  **Opinions** | **Telehealth Coverage Mandate** | **Temporary / Guest**  **Practice Provision** | **Penalties for**  **Unauthorized practice of psychology without a**  **license** |
|  |  |  |  |  | Licensure requirements in the psychologist’s home state must meet or exceed those requirements for licensure in WA.    A national background check may be required; however, the temporary practice permit may be issued while the check is completed if the psychologist meets certain conditions specified in WAC § 246924-483. |  |
| **WEST VIRGINIA** | NO | NO | See Board policy statement on Telepsychology – Skype, available online:    [http://www.wvpsyc hbd.org/policy\_stat ements.htm](http://www.wvpsychbd.org/policy_statements.htm) | NO | *W. Va. Code* §30-21-3    Licensed, out-of-state psychologists may practice for a period not to exceed 10 days in any calendar year    Must not establish a regular place of practice in the state | *W. Va. Code § 30-21-13*    Misdemeanor: Possible fine up to $500 &/OR imprisonment up to 6 months |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **STATE** | **Telehealth/**  **Telepsychology**  **Statutes and/or Regulations** | **Practice of**  **Psychology defined to include**  **specifically**  **telepsychology?** | **Licensing Board**  **Advisory**  **Opinions** | **Telehealth Coverage Mandate** | **Temporary / Guest**  **Practice Provision** | **Penalties for**  **Unauthorized practice of psychology without a**  **license** |
|  |  |  |  |  | Licensure requirements in the psychologist’s home state must meet or exceed the licensing  requirements in WV    Must petition the board in advance |  |
| **WISCONSIN** | NO | *Wis. Adm. Code Psy*  *2.14(2)*    A psychologist provides psychological services in this state whenever the patient or client is located in this state, regardless of whether the psychologist is temporarily located in this state or is providing services by electronic or telephonic means from the state where the psychologist is licensed. | NO | NO | *Wis. Stat. § 455.03; Wis.*  *Adm. Code Psy 2.14(1)*    Licensed, out-of-state psychologists may engage in temporary practice so long as he/she does not more than 60 working days in any year without holding a license.    The psychologist’s home state requirements for psychology licensure must be equivalent to or higher than the requirements for licensure in WI.    If temporary practice exceeds 20 working | *Wis. Stat*. *§ 455.11*    Possible fine up to $200  &/OR imprisonment up to  6 months |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **STATE** | **Telehealth/**  **Telepsychology**  **Statutes and/or Regulations** | **Practice of**  **Psychology defined to include**  **specifically**  **telepsychology?** | **Licensing Board**  **Advisory**  **Opinions** | **Telehealth Coverage Mandate** | **Temporary / Guest**  **Practice Provision** | **Penalties for**  **Unauthorized practice of psychology without a**  **license** |
|  |  |  |  |  | days within a year, the psychologist must report to the Board the nature & extent of practice. |  |
| **WYOMING** | NO | NO | See reference to  “telepsychology” in June 11, 2012 Board newsletter available online at:  [http://plboards.stat](http://plboards.state.wy.us/psychology/pdf/Newsletters/1stEditionNewsletterJune2011.pdf)  [e.wy.us/psychology/ pdf/Newsletters/1st EditionNewsletterJu ne2011.pdf](http://plboards.state.wy.us/psychology/pdf/Newsletters/1stEditionNewsletterJune2011.pdf) | NO | *Wyo. Stat. § 33-27-117*  *(e); WCWR 024-068003(1)(c)*    Licensed, out-of-state psychologists must obtain a temporary license, which allows practice up to 30 working days in 1 year.    Temporary license is available if the licensing requirements in the psychologist’s home state meets or exceeds WY’s licensing requirements.    If temporary practice exceeds 20 working days in 1 year, the psychologist must report the nature and extent of his/her | *Wyo. Stat. § 33-27-119*    Misdemeanor: possible fine up to $750 &/OR imprisonment up to 6 months, each violation |
| **STATE** | **Telehealth/**  **Telepsychology**  **Statutes and/or Regulations** | **Practice of**  **Psychology defined to include**  **specifically**  **telepsychology?** | **Licensing Board**  **Advisory**  **Opinions** | **Telehealth Coverage Mandate** | **Temporary / Guest**  **Practice Provision** | **Penalties for**  **Unauthorized practice of psychology without a**  **license** |
|  |  |  |  |  | practice in WY to the  board |  |