



The Current State of and Emerging Trends in Clinical Training for Telemental Health

A NEHI Report

November 2023

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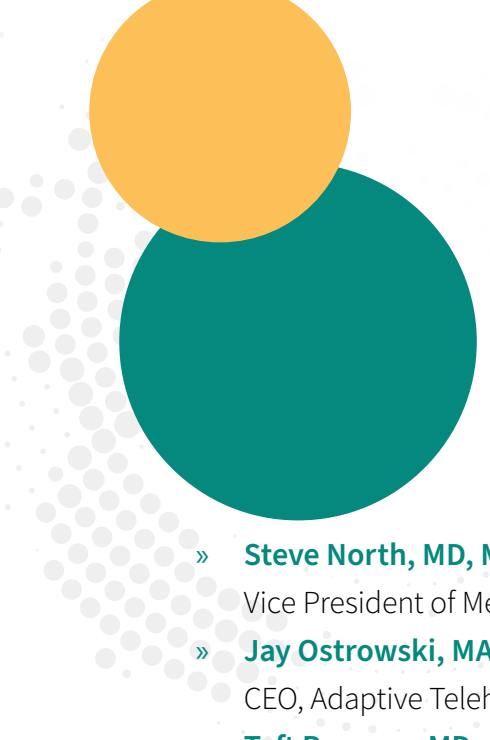
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About NEHI

NEHI is a non-profit, unbiased organization with members, including providers, hospitals and health systems, pharmaceutical and biotech companies, medical device, and technology providers, as well as associations and consultants. Through interdisciplinary collaboration and with our members' guidance, we research and examine tough and timely health care innovation issues from multiple, often divergent, perspectives. We then address policy and adoption challenges to promote the value of innovative products and processes.

Executive Summary

Use of telemental health (TMH) – defined here as delivery of behavioral and mental health services via synchronous or asynchronous telecommunications technology – has rapidly increased in recent years. As demand for virtual services increased during the COVID-19 pandemic, supply increased to respond. This trend, thus far, has endured. The American Psychological Association found in its 2021 COVID-19 Practitioner Survey that nearly all psychologists (96%) continued to provide virtual services to patients, even after COVID-19 restrictions began to ease.

The pandemic required a mindset shift—among both patients and clinicians. The need to avoid in-person contact drove significant changes in the way patients sought health care services—and the way that clinicians provided them. While clinicians responded by shifting more care to virtual platforms, the literature we reviewed and subject matter experts we spoke with indicate that many clinicians’ training in the transition to and use of TMH is lagging. As a result, greater attention is now being paid to how clinicians are trained and what support tools they need to effectively provide TMH services.

This project sought to examine the current state of and emerging trends in training for clinicians providing TMH services. This report brings together a review of existing literature on clinical training for TMH professionals along with takeaways from a moderated discussion between experts representing clinicians, providers, payers, academic researchers, certification institutions, and others. The report lays out key learnings from this research, chief among them being:

TMH competency frameworks exist, but the degree to which they are applied in practice is varied. Experts created competency frameworks to give clinicians guidelines for the skills required to provide high-quality TMH services. The first TMH competency frameworks were built upon leading general medical education frameworks. These competency frameworks have been integrated into some curricula and training modules, but with great variation across medical school, graduate, and continuing medical education training programs.

Patients are the ultimate beneficiaries of clinical training in telemental health.

This means that innovation must be accompanied by equal attention to safety and efficacy concerns. While the clinical toolbox is expanding and literature reveals a growing body of evidence supporting the use of TMH, at this stage, caution is still warranted. Future practice must be more informed by randomized clinical trials, comparative effectiveness research, and patient-centered outcomes research.

Support of clinicians needs to extend beyond the institutional walls. Experts generally agreed and research supports the need for practicing clinicians to receive additional training and ongoing support to facilitate their continued TMH practice. While some early adopters were ahead of the curve in seeking out training on their own, the consensus is that most practicing clinicians need to be encouraged to seek additional training. Peers and clinical supervisors play an important role here.

Clinicians don't know what they don't know. TMH is still new to many clinicians, and they need better ways to evaluate new technology and innovation. During our NEHI September 2023 convening, experts agreed that clinicians need stronger self-evaluation skills that enable their assessment of new digital health tools, treatment modalities, and how TMH might require different skillsets than in-person patient visits. Health plans and providers can play a key role in supporting or requiring TMH clinicians to seek additional training.

Background

Use of telemental health (TMH) – defined here as delivery of behavioral and mental health services using synchronous or asynchronous telecommunications technology – has rapidly increased in recent years. The initial period after the COVID-19 pandemic brought an unprecedented increase in TMH demand as both clinicians and patients sought to move visits away from in-person interactions. The increased use of virtual mental health services during this period was so large that it more than compensated for lower rates of in-person visits, resulting in an overall increase in utilization of mental health services.¹

As demand for TMH services increased, supply increased to respond. This trend, thus far, has endured. The American Psychological Association found in its 2021 COVID-19 Practitioner Survey that nearly all psychologists (96%) continued to provide virtual services to patients, even after COVID-19 restrictions began to ease. The large majority continued to use video conferencing (93%) and telephone (67%) to conduct visits with their patients.²

The pandemic required a mindset shift—among both patients and clinicians. The need to avoid in-person contact drove significant changes in the way patients sought health care services—and the way that clinicians provided them. Smith et al. (2022) observed that TMH was a “‘virtually perfect’ solution to the immediate crisis of a global pandemic” and “provided an effective way to deliver care while maintaining social (or, more accurately, physical) distancing.” The authors characterized this timeframe as an “almost overnight transition to video- and telephone-based assessments in mental health in many countries.”³

While these trends and data acknowledge the rapid adjustments that clinicians made to remain available for their patients, they do not reflect the changes in training required to adjust to practicing in the virtual setting. Indeed, there have been increased calls for greater support and training for clinicians conducting TMH services. This need was recognized prior to the COVID-19 pandemic but has become even more relevant as interest in and use of TMH continues to grow. For the stakeholders making these recommendations, there is a pressing need to ensure that TMH services and patient outcomes are high quality. As an example, Smith et al. stated that “programs to increase

digital literacy and competencies among both clinicians and patients are now critical to ensure all parties have the knowledge, confidence, and ability to equitably benefit from emerging innovations.”⁴

Many stakeholders are paying greater attention to how clinicians are trained and what clinical or technical support tools they need to effectively provide TMH services. This project sought to examine the current state of and emerging trends in training for clinicians offering TMH services. This report combines a summary of existing literature on clinical training for TMH professionals with takeaways from a moderated discussion between experts representing clinicians, providers, payers, academic researchers, certification institutions, and others. It lays out key learnings from this research and answers key questions such as: Why is clinical training specific to TMH needed? What gaps exist? Who is trying to close the gaps and how?

“One of the challenges that the pandemic presented was this proliferation of telemental health solutions and proliferation of asynchronous access and alternative modalities to providing care. There has been such variation in quality because many didn’t quite understand the medium in which they’re working. We’re trying to ensure that we provide a high element of quality to these interactions so patients can get the outcomes that they need when they’re using this modality.”
– Jason Parent, MSN, APRN, FNP-C, Director, Clinical Innovation, Point32Health

Methods and Approach

Our research approach included three phases:

Phase 1: Literature scan. We summarized literature on competency frameworks to support clinical training of telemental health professionals; curricula and training modules; and attitudes, experience, and identified needs of clinicians concerning training and the provision of telemental health. We covered peer-reviewed literature, as well as gray literature, in this scan.

Phase 2: Qualitative interviews. Guided by the literature scan, NEHI interviewed a number of key opinion leaders in related fields to gain further knowledge of this space and uncover more recent trends and insights that were not covered in the academic literature. During this phase, we also interviewed representatives from several NEHI member organizations to ensure the perspectives we included addressed multiple stakeholders across the health care environment.

Phase 3: Expert convening. We convened a set of TMH knowledge leaders from across many different fields to discuss the evolving landscape of training for TMH clinicians and its impact on patient care.*

A note about our use of artificial intelligence (AI) tools to complete this work: The research team used several AI-enabled tools throughout this project. We recorded the stakeholder convening and loaded the recording into an AI-transcription platform, Otter.ai. Using this AI-created transcript, we pulled out what we viewed as the key takeaways from the convening, while concurrently running the transcript through ChatGPT to summarize key takeaways from the convening. We then compared our key takeaways with the key takeaways generated by ChatGPT and combined them, along with key quotes captured in the Otter.ai transcript. We did not use any AI-enabled tools to help create this final report.

* NEHI members can access a recording of the members-only convening by visiting <https://www.nehi-us.org/events/roundtable-current-state-emerging-trends-in-clinical-training-for-telemental-health> and following the prompts.

Findings and Recommendations

Our summary centers on three key themes that emerged from the research and makes recommendations that aim to advance the practice of TMH and foster positive patient experiences and outcomes. Before we go into the findings, we briefly describe existing TMH competency models created to support TMH clinicians as well as curricula and training modules created to train clinicians based on those competencies.

TMH competency frameworks exist but the degree to which they are applied in practice is varied.

Competency frameworks for general medical education aim to ensure clinicians are adequately trained to provide services to patients and provide a foundation for more specific competencies, such as for TMH. TMH competency frameworks guide clinical training to emphasize a standardized set of skills required to conduct high-quality TMH services. To date, some curricula and training modules have been developed and implemented based on TMH competency frameworks, but with significant variation across medical schools, graduate training, and continuing education programs.

General medical competency frameworks provide a foundation upon which more topic-specific frameworks are often developed. The Royal College of Physicians and Surgeons of Canada CanMEDS Framework and the Accreditation Council for Graduate Medical Education (ACGME) Common Program Requirements are two leading general medical frameworks that have provided a foundation for TMH competency models. The Association of American Medical Colleges (AAMC) also created a Telehealth Competencies Framework, which describes a set of competencies that drive high-quality telehealth interactions between clinicians and patients. It is not, however, specific to TMH. These frameworks prescribe a set of competency areas with expertise levels within each area (e.g., novice or advanced beginner, competent/proficient, expert).

Two leading TMH competency frameworks are the Hilty et al. (2015) Framework for Telepsychiatric Training and eHealth and the Maheu et al. (2017) Interprofessional Framework for Telebehavioral Health Competencies, created through the Coalition for Technology in Behavioral Science (CTiBS).^{5,6} Both address core competencies

needed by TMH clinicians, though the Hilty framework focuses on psychiatry while the CTiBS framework is broader in nature. CTiBS covers eight behavioral health disciplines: addiction specialists, behavior analysts, counselors, marriage and family therapists, psychologists, psychiatric nurses, psychiatrists, and social workers. Another framework is the Canadian Psychological Association’s recently developed Guidelines on Telepsychology (2023). These guidelines provide an update to the Interim Ethical Guidelines for Psychologists Providing Psychological Services via Electronic Media that were approved in 2020. They expand beyond ethical considerations to “broadly-based guidelines that directly addressed a variety of practice areas, including ethical considerations.”⁷

While competency frameworks to support graduate and continuing education training in TMH exist, their application into practice is, at this point, varied. Indeed, several experts raised this point during a September 2023 NEHI convening on this topic, noting that graduate schools training new clinicians have not sufficiently integrated TMH training into their curricula. Dr. Kathy Wibberly noted that “telehealth training is still viewed as an extra class or course module” instead of a topic that must be integrated into all coursework.

As asynchronous care also grows in popularity, researchers are developing competency frameworks to support clinicians in their use of such tools, as well. Hilty et al. expanded their initial framework to include social media, mHealth, asynchronous technologies, sensors, and wearables.^{8,9,10,11} These frameworks, as with those created to support synchronous care, have been also adopted at varying rates across graduate and continuing education training programs.

The Veterans Administration (VA), which has a history with remote care that predates by decades most other payers and providers, features prominently in the training literature.¹² Other, more specific training programs have also been developed based on demand. For example, after Khan and Ramtekkar (2019) called for the development of an evidence-based pediatric telepsychiatry curriculum for trainees and practicing child and adolescent psychiatrists, DeJong et al. (2020) developed a national pediatric telepsychiatry curriculum based on content areas identified by the directors of Child and Adolescent Psychiatry (CAP) training programs. The goals and objectives of the training are built on the ACGME Competency Framework developed by Hilty et al. (2015).^{13,14}

There is consensus among the subject matter experts NEHI engaged that many TMH clinicians lack awareness of the core competencies for practicing in this field, especially concerning the risks associated with providing care through this avenue without proper training. Moreover, experts NEHI spoke to generally agree that the focus should be on ensuring that patients are receiving high quality care over requiring all clinicians to receive standardized training.

In the following sections, we discuss key findings from the literature and NEHI's September 2023 convening and elevate recommended actions that might advance future training for TMH clinicians.

Patients are the ultimate beneficiaries of clinical training in telemental health. Innovation must be balanced with safety and efficacy.

Most experts NEHI spoke with agreed that it is an exciting time for TMH and there is a great opportunity before behavioral and mental health clinicians: their clinical toolbox is expanding. The literature reveals a growing body of evidence supporting the use of both synchronous technologies in place of face-to-face care and digital asynchronous tools to support virtual and in-person care. However, at this stage, caution is warranted as the evidence base is still growing. Future practice must be more informed by randomized clinical trials, comparative effectiveness research, and patient-centered outcomes research.

"We're missing out on the potential of telehealth as a real tool that adds value to in person care. The status quo for telemental health training has been in person. You can do significantly more with digital tools that would not be feasible in in-person care and for which there is no in-person equivalent."

– Kathy Wibberly, PhD, Director, Mid-Atlantic Telehealth Resource Center

There continues to be significant growth in the development of tools meant to support synchronous and asynchronous telemental health services. According to Rock Health analysis, startups focused on mental health indications have been leaders in funding year over year from 2018 to 2022.¹⁵ For asynchronous technology such as mobile apps, one estimate suggests that there are anywhere between 10,000 and 20,000 apps meant to target mental health and treatment.¹⁶

TMH subject matter experts and literature support the notion that virtual, synchronous interactions for behavioral and mental health treatment can be as effective as in-person care.¹⁷ This is even true for some elements of treatment for serious mental illness (SMI). For example, a cohort study of Medicare beneficiaries with SMI found that while patients who received care from practices that offered more TMH care had more visits per year, their outcomes were comparable to patients who received care in practices with low TMH use.¹⁸ Additionally, in a systematic review, Lawes-Wickwar, McBain, & Mulligan (2018) found that telehealth can be an effective avenue for remote medication monitoring for individuals with SMI.¹⁹

The same can also be said of asynchronous technologies. As Srivastava et al (2020) noted, “the smartphone opens up an alternate pathway to effective mental health care for people who may not otherwise access face-to-face treatment.”²⁰ This raises an important distinction between using technology to deliver therapeutic interventions and digital health tools that are meant to supplement or even take the place of traditional therapeutic interventions. For example, there is a field of research that is comparing the effectiveness of administering cognitive behavioral therapy (CBT) via synchronous video or telephone sessions against CBT delivered through in-person visits.²¹ There is another field of research that is exploring how digital health tools can supplement in-person or virtual CBT sessions. Finally, there is yet another field of research exploring how effectively CBT can be delivered over digital health solutions like smartphone apps or through conversational AI platforms (e.g., chatbots).²²

Experts contributing to this NEHI research generally agreed that studies designed to gather strong evidence around which interventions can be delivered using synchronous or asynchronous technologies are just beginning. For example, Sugarman & Busch (2023) found that there are still gaps in the literature as to which combinations work best for different patient populations and treatment modalities. Moreover, the evidence on how to pair synchronous technologies with asynchronous technologies to best fit the needs of individual patients is still emerging.²³ For example, one review of apps focused on treatment and/or management of bipolar disorder found that most are not using features that are “in line with practice guidelines or established self-management principles.”²⁴

Moving forward, researchers and clinicians should rely on evidence-based studies to make treatment decisions and recommendations for their patients. With such rapid

proliferation of tools and resources also comes great responsibility to ensure that these interventions are not harmful to patients and are accessible to everyone who could benefit from them. User experience and evidence that tools can produce sustainable patient engagement must also be taken into consideration.²⁵ Randomized clinical trials, patient-centered outcomes research, and comparative effectiveness research will all play an important role in ensuring patients receive safe and effective behavioral and mental health care. Moreover, competency frameworks and curricula built upon them need to continue to evolve as TMH practices evolve.

Training needs to extend beyond the institutional walls. Clinicians need supervision and support to facilitate knowledge and awareness of competencies in practice.

NEHI's contributing experts generally agreed upon, and research supports, the notion that practicing clinicians need training and support to facilitate their continued TMH practice. While some clinicians were early adopters and sought training on their own, the general consensus is that most clinicians need to be encouraged to seek additional training. Peers and supervisors also play an important role in training clinicians.

In the September 2023 NEHI convening, participants shared their observation that groups who adopt innovation fall along a spectrum: early adopters (patients and new clinicians), mid-adopters (administrators and system and plan leadership), and late adopters (current providers). Each group has different motivators driving their adoption, which means they require different levels of training and support. This stresses the need for initial training (through graduate programs), ongoing continuing medical education opportunities, and public messaging to emphasize the importance of competencies in telehealth. It also underscores the importance of tailored training for different provider groups and the need for measurement and accountability in TMH. How clinicians can better assess their own deficiencies in clinical training to support telemental health? What tools and processes can clinicians use to make this kind of assessment? There was general consensus at NEHI's convening that more tools are needed to support clinicians who seek this kind of critical self-evaluation.

For practicing clinicians who believe they need additional training and/or credentialing, several methods exist. Clinicians may seek out their own education, certification, and/or credentials independently through the following resources (as examples):

- Telehealth.org (formerly known as the Telebehavioral Health Institute): The mission of Telehealth.org is to “deliver evidence-based professional development through telehealth training and consultation.” It offers the Board Certified Telehealth Professional (BCTP) certification at three different levels, all of which include training in theory and practice, telehealth law and ethics, video and phone best practices, and clinical best practice. Though recently Telehealth.org expanded into general telehealth, its roots are in TMH. More advanced topics covered in the highest certification level include trauma-informed child and pediatric care and telehealth autism assessment.²⁶
- Telehealth Certification Institute: The Institute was created in 2014 and has an online marketplace of more than 200 courses focused on ethical, legal, technological, and clinical competencies required to conduct telehealth. It also offers the TeleMental Health Training Certificate (THTC), which provides advanced training for TMH professionals.²⁷
- University of Washington Behavioral Health Institute Telebehavioral Health Training series: The University of Washington’s Behavioral Health Institute (BHI) used evidence-based implementation strategies to develop a progressive training series. See more in the case study below.²⁸
- Credentialing: Clinicians may seek additional credentials such as the Board Certified–TeleMental Health Provider (BC-TMH) credential, which was developed by the Center for Credentialing & Education (CCE).²⁹
- The National Consortium of Telehealth Resource Centers (NCTRC): TRCs and the National Consortium give clinicians a network with which they can build upon their current training and competencies. NCTRC has technical assistance, education, and resources, though not all of the content is tailored specifically to TMH.³⁰

“What’s really interesting about our duty to only practice within the boundaries of our competence, is that it takes awareness of what being competent looks like.”

*– Ray Barrett, LMHC, LPC,
Founder and CEO, Telehealth
Certification Institute*

Other NEHI contributing experts representing health systems, payers, and mental health startups agreed that communities of practice are also critical in supporting clinicians at the individual level. For clinicians who practice in a group setting, using tools such as Teams or Slack channels can provide an opportunity for clinicians at all levels to interact with one another and share best practices and guidelines, even if they are spread out geographically. The concept of virtual communities of practice is documented in the literature, though standards and best practices for such a concept are still emerging. As described by Shaw et al. (2022), “communities of practice (CoP) are networks of individuals who interact regularly to share their interests and develop their knowledge, skills, and capabilities concerning a particular issue. As internet and mobile device use has grown globally, virtual communities of practice (VCoPs) have become more prevalent in healthcare.” Researchers have begun to define standard practices around how to design, implement, and evaluate VCoPs in accordance with clinicians’ needs, though this research is early.³¹

“How can we learn from nonmedical spaces about how folks build good communities virtually? Can we look to social media apps or other online communities for how people do this and what makes participants feel supported?”

*– Emily Bernstein, PhD,
Massachusetts General Hospital*

“When the pandemic started, people were dispersed to their homes doing virtual visits. The informal learning we did during that time was indispensable to our staff. That’s the reason why people work here. They could have easily gone into private practice, but they liked the idea of being part of a team. I think there’s a tension with practicing virtually though. Despite all the benefits and convenience of [TMH], it can pull people apart. If we don’t figure out how to work through this tension, we will collectively default back to the idea that clinicians need to be onsite, shoulder to shoulder, in order to learn how to collaborate effectively.”

*– Oscar Bukstein, MD, MPH, Vice Chair of Psychiatry;
Director, Outpatient Psychiatry Service, Boston
Childrens Hospital, Professor of Psychiatry, Harvard
Medical School*

As competency models for TMH clinicians have begun to proliferate, so has the understanding that clinicians supervising trainees also need strong underpinnings in these core competencies. Most accrediting organizations that oversee counseling and therapy training programs require some level of supervision for all new trainees before they are deemed ready to practice independently. The quality of training is crucial and clinical supervisors may not have advanced competencies in this area themselves and, thus, may be ill-equipped to train new clinicians.

Importantly, surveys of clinicians indicate that those who have practiced TMH longer may need more training and reskilling than newer clinicians. Paige et al. (2023) surveyed TMH clinicians in early 2021 to understand their clinical and informational needs, finding that most felt they could benefit from more support in both areas. The researchers segmented their findings into two clinician populations: clinicians who provided TMH services before the pandemic and clinicians who were newer to the practice. Importantly, clinicians who practiced TMH prior to the COVID-19 pandemic “reported a greater need for services that help them cultivate relationships with patients, monitor health conditions, and to remain updated about reimbursement processes.”³²

Case study: University of Washington Behavioral Health Institute Telebehavioral Health Training series

Facing the urgency of COVID, clinicians and educators at the University of Washington's Behavioral Health Institute (BHI) used evidence-based implementation strategies ("PARiHS" -- Promoting Action on Research Implementation in Health Services) and a Plan-Do-Study-Act feedback loop to inform the development of a progressive training series.

The targets for the training are community clinics, providers, and administrators with limited telebehavioral health knowledge, experience, and skills. Invited instructors were asked to develop lectures tailored to beginners and practical for busy providers and administrators, grounded in evidence-based literature. The format of the training series, considered necessary for rapid training, is traditional didactic lecture, delivered via Zoom.

The six-part series includes 42 unique components, ranging from the "101" series (basic policies and techniques) to the "201" and "301" series of more specialized topics (telebehavioral health for special populations, digital tools, SUD, crisis management, safety and consent, supervision). The training is delivered via live webinar or can be accessed online. At the time of publication, 6,800 unique learners from 45 states had viewed over 3,000 webinars, earning 19,100 continuing education hours. Evaluations have been generally positive.³³

Clinicians don't know what they don't know. They need better ways to evaluate new technology and innovation.

This final section turns to the discussion of whether clinicians have the right tools in place to evaluate TMH interventions, whether synchronous or asynchronous. During the NEHI September 2023 convening, experts agreed that clinicians need strong self-evaluation skills that enable them to assess new digital health tools and treatment modalities. This is especially important as there continues to be rapid growth of

venture-backed digital health startups, some of which may not be employing “clinically robust” approaches in their practices.³⁴ Health plans and providers can play a key role in supporting or requiring TMH clinicians to seek additional training.

Researchers have begun to build evidence-based evaluation processes for TMH programs. In 2012, Kramer et al. “identified the need to advance the scientific knowledge base to better quantify success” in TMH, recognizing that one way to do this would be through the creation of a TMH evaluation model. In this seminal article, the authors laid out the initial elements of an evaluative framework and described a path for adoption of such a framework.³⁵ In 2014, Shore et al. went on to propose outcome measures for TMH, aiming to give clinicians “a lexicon of assessment” to “better unify the TMH field.”³⁶

Since this initial measurement framework was proposed, other researchers have continued to advance the field. More researchers are looking to evaluate TMH interventions and develop a solid set of metrics upon which to gauge their effectiveness. This includes developing new measurement areas. For example, Haidous, et al. (2021) found that evaluation approaches for telemental health programs vary, clinical and non-clinical outcomes are commonly used, and few studies look at technological feasibility, cost effectiveness, or patient satisfaction.³⁷ Researchers have also recognized the need to extend measurement beyond synchronous technologies to asynchronous TMH modalities such as apps, wearables, and other tools used for remote-patient monitoring. For example, Chan et al. (2015) proposed that “apps can be evaluated by their usefulness, usability, and integration and infrastructure” and “categorized by their usability in one or more stages of a mental health provider’s workflow.”³⁸

Importantly, these evaluative frameworks must be able to be easily integrated into a clinician’s everyday practice. Many professional medical societies and health care stakeholders recognize this and have responded with different solutions to

“Those of us who have gone through training, when a new modality of therapy comes out, we know how to evaluate that as it is it beneficial and has evidence to support it. When a new drug comes out, I know how to evaluate that and determine if I’m going to use it or not. Teaching that skill set on how to evaluate new digital therapeutics and new modalities of virtual care is critical.”
– Steve North, MD, MPH, FAAFP,
Eleanor Health

address this need. For example, the American Psychiatric Association created *App Advisor*, a tool that aims to give clinicians a methodical approach to assess mental health apps, accompanied by a rationale for why clinicians should consider evaluating any tool prior to its use, a model framework, sample evaluations, and resources clinicians can use to seek additional guidance or support in the evaluation process.³⁹ Other organizations such as Massachusetts General Hospital’s Center for Digital Mental Health (see case study below) and The Center for Technology and Behavioral Health at the Geisel School of Medicine at Dartmouth College have researchers and initiatives dedicated to advancing evidence and implementation science around the use of digital health tools to support behavioral and mental health treatment. Additional resources cited by experts we spoke with include University of California at Irvine’s One Mind PsyberGuide and Boston’s Beth Israel Deaconess Medical Center Division of Digital Psychiatry’s MindApps. Both are platforms that enable clinicians (or their patients) to sort through app features to identify appropriate tools matched to their specific needs.^{40, 41}

Clinicians must also be aware of tools that have been created to support patients’ self-navigation within mental health apps. Valentine, D’Alfonso, & Lederman (2022) laid out important ethical considerations that accompany such “recommender systems.” A recommender system is an “information filtering system that uses algorithms to predict content or information that the system deems relevant to the individual.” App developers often employ these tools to personalize content to the user, with the hope that more personalized content will drive sustained engagement among individuals. While the authors acknowledge there are advantages for patients to implementing such tools (e.g., reducing choice overload), they also warn of potential ethical challenges they present. For example, clinicians should educate themselves about the potential privacy issues and lack of “explainability” – or the “black box” issue around employing AI – that can accompany these applications.⁴²

Health plans and health care providers are increasingly employing digital health formularies to help clinicians navigate decisions around digital tools. Digital health formularies, similar in use to drug formularies, prioritize a list of apps from which clinicians can select and “prescribe” to their patients. Clinicians can also “search these formularies and know what was available for a specific diagnosis or purpose.”⁴³ Evernorth Health Services created a digital health formulary and, in 2022, expanded it to add five apps that provide mental health treatment for conditions such as anxiety

and substance use disorder.⁴⁴ Kaiser Permanente has also expanded its use of a platform called Xealth to allow its clinicians to prescribe digital mental health tools to their patients. Xealth is integrated with the Epic electronic health record system and mental health apps on the platform include mindfulness and meditation apps (e.g., Calm, Headspace, While) and CBT apps (myStrength, SilverCloud, and Thrive).⁴⁵

Case study: The Center for Digital Mental Health, Massachusetts General Hospital

Launched in 2019 as a think tank, the Center for Digital Mental Health sits within the Massachusetts General Hospital Department of Psychiatry. Its goal is to scale evidence-based technology solutions centered on advancing mental health and treatment for mental illness. The Center has a four-step process it follows to achieve this goal: developing and testing mental health technologies; collaborating with health care stakeholders and patients with lived experience to ensure solutions are informed by real-world perspectives and experiences; personalizing care to the needs of individuals; and implementing evidence-based, scalable solutions.⁴⁶ Core to its work is a process of continual evaluation. One recent innovation the Center developed and tested for effectiveness, through a randomized waitlist-controlled trial, is a coach-supported mobile app that provides CBT for body dysmorphic disorder. The British National Institute for Health and Care Excellence (NICE) has now recommended the app be scaled and deployed throughout the National Health Service (NHS).⁴⁷

Finally, health care stakeholders play a significant role in supporting TMH clinicians. Large providers who employ TMH clinicians, for example, can provide training, technological support, and peer-to-peer opportunities for learning and growth. Learning on best practices from early innovators in this space may help. As was mentioned earlier, the VA is a leading provider of TMH in the U.S., starting with clinical video telehealth services in 1959. Recent expansions of TMH required increased training, and the VA Telehealth Services' National Telehealth Training and Resource Center developed a curriculum, which is available to psychologists and other mental health professionals. The training consists of coursework, which covers the following areas:

- Historical and research overview of TMH
- Emergency management (safety planning, emergency contacts, hospitalization, technical emergencies)
- Technical operations
- Other clinical considerations (e.g., legal and ethical considerations, informed consent)

A skills assessment follows the coursework. Trainees are assessed on their ability to initiate a call, verbalize how to obtain and document informed consent, and articulate basic troubleshooting steps. Trainees also have an opportunity for hands-on experience, supervision, and consultation. Clinicians who complete the training may receive a certification in telemental health from the VA's Office of Academic Affiliations.⁴⁸

Health plans can also play a role in setting standards and protocols for clinicians whose services they reimburse. This can be done through site visits to understand what policies and procedures are already in place with various providers or by auditing patient charts to ensure that standard practices for safety and efficacy are being met. Health plans can provide key insights into patient outcomes, which can help clinicians understand how their patients respond (or don't) to TMH treatment. Health plans can also institute requirements on the clinicians

"[Payers] have teeth when it comes down to money and payments. We have found that in the virtual space, there's a real need to identify who has policies and procedures in place to address these issues and who can triage if a real risk or safety concern arises. That's where we come in and say, 'You can't provide this type of care; you're going on a performance plan because we're really concerned about patient safety.'"
– R. Dakota Carter, MD, EdD, Medical Director, Aetna

they place within their networks. For example, as recently as 2022, UnitedHealthcare's subsidiary, Optum, allowed all TMH clinicians to go through an attestation process to be listed in their provider directory as a telemental health provider. The attestation process requires clinicians to list their primary platform for providing services (e.g., Amwell, Adaptive Telehealth) and to attest that they will follow all applicable state and federal laws applicable to telemental health delivery.⁴⁹ Notably, this does not mean that clinicians are aware of all the legal and ethical issues that could arise in their TMH practice. Clinician surveys administered before COVID-19 indicated that many clinicians lacked familiarity with legal and ethical issues in TMH practice.⁵⁰ More recent anecdotal evidence suggests that there have been some improvements since the rapid scaling of TMH during the pandemic, but there are still strides to be made here.

Conclusion

Clinical training for TMH, as a field, is still growing and evolving. As training and credentialing programs increasingly adopt best practices for training TMH clinicians based on proven competency frameworks, more clinicians may be acquiring the basic skills and competencies required to achieve high-quality patient outcomes. However, more work is needed to integrate TMH training into graduate programs, convince currently practicing clinicians to seek continuing medical education, create opportunities for ongoing training and skills refreshment, and integrate new evidence-based approaches into everyday practice. This report outlined the key competency frameworks upon which these approaches can be built, emphasized new methods for training and upskilling TMH clinicians, and discussed important roles that health care stakeholders play in advancing this field.

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