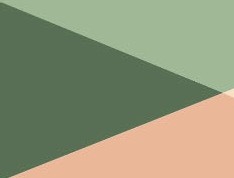


A TREATMENT IMPROVEMENT PROTOCOL

**Using Technology-Based Therapeutic Tools in Behavioral Health Services**





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**A TREATMENT IMPROVEMENT PROTOCOL**

**Using Technology-Based Therapeutic Tools in Behavioral Health Services**

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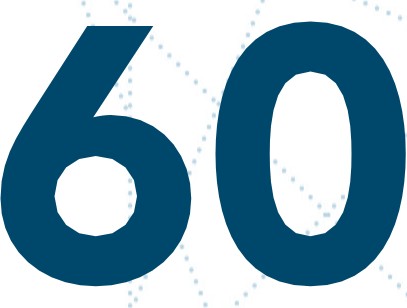
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-..\_ **U.S.DEPARTMENTOFHEALTHANDHUMANSERVICES**

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Acknowledgments

This publication was produced under the Knowledge Application Program (KAP) contract numbers 270-09-0307 and 270-14-0445 with the Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services (HHS).

Christina Currier and Suzanne Wise served as the Contracting Officer's Representatives, and Candi Byrne served as KAP Project Coordinator.

Disclaimer

The opinions expressed herein are the views of the consensus panel members and do not necessarily reflect the official position of SAMHSA or HHS. No official support of or endorsement by SAMHSA or HHS for these opinions or for the instruments or resources described is intended or should be inferred. The guidelines presented should not be considered substitutes for individualized client care and treatment decisions.

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Recommended Citation

Substance Abuse and Mental Health Services Administration. *Using Technology-Based Therapeutic Tools in Behavioral Health Services.* Treatment Improvement Protocol (TIP) Series

60. HHS Publication No. (SMA) 15-4924. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2015.

Originating Office

Qiality Improvement and Workforce Development Branch, Division of Services Improvement, Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, 1 Choke Cherry Road, Rockville, **MD** 20857.

HHS Publication No. (SMA) 15-4924 Printed 2015

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#### What Is a TlP?

Treatment Improvement Protocols (TIPs) are developed by the Substance Abuse and Mental Health Services Administration (SAMHSA) within the U.S. Department of Health and Human Services (HHS). Each TIP involves the development of topic-specific best-practice guidelines for the prevention and treatment of substance use and mental disorders. TIPs draw on the experience and knowledge of clinical, research, and administrative experts in various forms of treatment and prevention. TIPs are distributed to facilities and individuals across the country.

Published TIPs can be accessed via the Internet at [http://store.samhsa.gov.](http://store.samhsa.gov/)

Although each consensus-based TIP strives to include an evidence base for the practices it recommends, SAMHSA recognizes that behavioral health is continually evolving, and research frequently lags behind the innovations pioneered in the field. A major goal of each TIP is to convey "front-line" information quickly but responsibly. If research supports a particular approach, citations are provided. When no citation is provided, the information is based on the collective clinical knowledge and experience of the consensus panel.

### Foreword

The Substance Abuse and Mental Health Services Administration (SAMHSA) is the agency within the U.S. Department of Health and Human Services that leads public health efforts to advance the behavioral health of the nation. SAMHSA's mission is to reduce the impact of sub­ stance abuse and mental illness on America's communities.

The Treatment Improvement Protocol (TIP) series fulfills SAMHSA's mission by providing evidence-based and best practice guidance to clinicians, program administrators, and payers. TIPs are the result of careful consideration of all relevant clinical and health services research findings, demonstration experience, and implementation requirements. A panel of nonfederal clinical researchers, clinicians, program administrators, and patient advocates debates and dis­ cusses their particular area of expertise until they reach a consensus on best practices. Field re­ viewers then review and critique this panel's work.

The talent, dedication, and hard work that TIP panelists and reviewers bring to this highly par­ ticipatory process have helped bridge the gap between the promise of research and the needs of practicing clinicians and administrators to serve, in the most scientifically sound and effective ways, people in need of behavioral health services. We are grateful to all who have joined with us to contribute to advances in the behavioral health field.

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## How This TIP Is Organized

This Treatment Improvement Protocol (TIP) is divided into three main parts:

* Part 1: *A Practical Guide far the Provision of Behavioral Health Services*
* Part 2: *An Implementation Guide far Behavioral Health Program Administrators*
* Part 3: *A Review of the Literature*

Part 1 consists of two chapters and introduces behavioral health service providers to various tech­ nology-based treatment and prevention tools and interventions. It also explains how those tech­ nologies are applicable to various behavioral health services and settings. Part 1, Chapter 1, in­ troduces principles to guide technology-assisted care (TAC) in the behavioral health arena. This section addresses:

* The potential benefits and drawbacks of incorporating technology into treatment and pre­ vention, particularly for clients with unique service needs, as both stand-alone methods and as adjuncts to face-to-face services.
* Specific technologies with applicability to behavioral health, including emerging technologies and their potential applications in the context of behavioral health services.
* Ways to integrate technology into existing services.
* Issues of ethics and legality as well as cultural competence.
* Electronic health records.

Part 1, Chapter 2 consists of vignettes that demonstrate the application of TAC in behavioral health services. Designed for maximum latitude of use by supervisors and front-line profession­ als, the guidelines for TAC appear in the form of master clinician notes, how-to notes, and other teaching tools that demonstrate how a given technology can be applied clinically, how to identify potential pitfalls, and how to manage problems that might arise.

Part 2 of the TIP consists of two chapters and serves as an implementation guide for behavioral health program administrators and clinicians who wish to develop or expand the use of TAC by their programs. It covers:

* Programmatic considerations for the adoption and sustainability of TAC, including ap­ proaches administrators can use to involve staff members in the planning and implementa­ tion process.
* Technological capacity and budgeting considerations for technology-based treatment and prevention efforts.
* Methods for selecting technology-related vendors and consultants.
* Data management issues involved in TAC.

Using Technology-Based Therapeutic Tools in Behavioral Health Services

* Privacy, confidentiality, and regulatory concerns, including the establishment of relevant poli­ cies and procedures for ensuring confidentiality, managing client crises, and deciding when and how to apply electronic media in client care.
* TAC-related management of clinical supervision of counselors, TAC-related training and staff development, and the need for personnel trained in specific technologies and methods.
* Specific practical examples of how TAC has been incorporated into existing programs.

Part 3 of the TIP includes an analysis of the available literature on technology-based assessment and interventions targeting behavioral health, including journal articles, books, pamphlets, and electronic resources; links to select abstracts of the most cogent literature on the topic; and a comprehensive general bibliography of the relevant literature. The literature review is only avail­ able online at the Substance Abuse and Mental Health Services Administration (SAMHSA) Store (http://store.samhsa.gov).

Terminology

The following terms are broad in scope and denote concepts frequently referenced throughout the TIP. Detailed definitions of terms describing specific types of technology appear throughout Part **1,** Chapter 1, and are summarized in Exhibit 2.2-1.

**Behavioral health.** Throughout the TIP, the term "behavioral health" appears. Behavioral health refers to a state of mental/emotional being and/or choices and actions that affect wellness. Be­ havioral health problems include substance use disorders, serious psychological distress, suicidali­ ty, and mental illness. This includes a range of problems from unhealthy stress to diagnosable and treatable diseases like serious mental illness and substance use disorders, which are often chronic in nature but from which people can and do recover. The term is also used in this TIP to describe the service systems encompassing the promotion of emotional health, the prevention of mental and substance use disorders, substance use and related problems, treatments and services for mental and substance use disorders, and recovery support. Because behavioral health condi­ tions, taken together, are the leading causes of disability burden in North America, efforts to im­ prove their prevention and treatment will benefit society as a whole. Efforts to reduce the impact of mental and substance use disorders on America's communities, such as those described in this TIP, will help achieve nationwide improvements in health.

**Electronic media.** This term is used in the broadest sense, covering everything from technology­ based therapeutic tools to the use of social media for treatment or prevention.

**Prevention.** Technology can be used in prevention activities to foster the SAMHSA mission, which is "to reduce the impact of substance abuse and mental illness on America's communities" (SAMHSA, 20146, p. 4). The term "prevention'' covers a broad set of services, interventions, and supportive activities that promote resilience.

**Recovery.** This term reflects a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential (SAMHSA, 2012). Major dimensions that support a life in recovery, as defined by SAMHSA (2012), include:

* ***Health:*** overcoming or managing one's disease(s) or symptoms as well as making healthy, well-informed choices that facilitate physical and emotional well-being.
* ***Home:*** having a safe, stable place to live.

**XII**

How This TIP Is Organized

* ***Purpose:*** engaging in meaningful daily activities, such as a job, education, volunteer work, car­ ing for family members, or creative pursuits; having sufficient independence, income, and re­ sources to participate in society.
* ***Community:*** maintaining relationships and social networks that provide support, friendship, love, and hope.

Substance use disorders. Throughout the TIP, this term applies to substance use disorders of all varieties and levels of severity. Usage reflects current terminology as described in the *Diagnostic and Statistical Manual of Mental Disorders,* Fifth Edition **(DSM-5;** American Psychiatric Association, 2013). In general, the distinction between substance abuse and substance dependence in prior **DSM** editions related to the requirement of tolerance to or withdrawal from alcohol or other sub­ stances as a diagnostic criterion for substance dependence but not for substance abuse. If a particu­ lar drug (e.g., cocaine, amphetamines, marijuana) did not typically produce clear signs of tolerance or dependence, a diagnosis of substance dependence still indicated high severity or intense compul­ sivity, whereas a diagnosis of substance abuse denoted less severe symptoms (e.g., continued use de­ spite negative consequences and/or knowledge of detrimental social and health effects of use). The distinction between "abuse" and "dependence" thus carried a connotation of severity, which is now a

codified part of the diagnosis of substance use disorder in DSM-5.

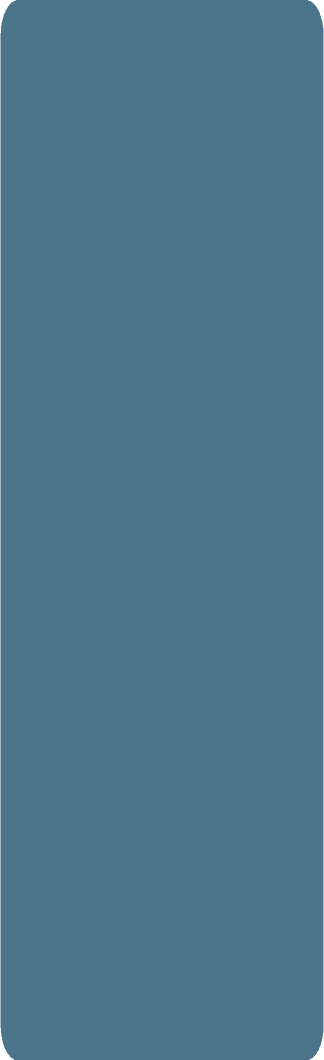
**Technology-assisted care.** This term and its abbreviation, TAC, are used throughout the TIP to refer to the broad range of interventions and enhancements to traditional care models possible through the use of technological tools and to the range of behavioral health service delivery settings within which technology can contribute to care delivery.

Part 1: A Practical Guide for the Provision of Behavioral Health

Services

# Part 1, Chapter 1

###### Introduction



**IN THIS CHAPTER**

* Introduction
* The Potential Utility of Technology-Based Therapeutic Tools
* An Overview of Behavioral Health Technologies
* Emerging Technologies and Future Opportunities
* Integrating Technology Into Existing Services
* Legal and Ethical Issues to Consider
* Electronic Health Records
* Concluding Comments

Digital media and resources, such as email, smartphone/tablet ap­ plications (apps), online forums, Web sites, DVDs, CD-ROMs, blogs, computer software, online social networks, telephone and televideo communication, and mobile devices are becoming univer­ sal in our culture. The use of electronic media and information technologies in behavioral health treatment, recovery support, and prevention programs is rapidly gaining acceptance. Technology­ based assessments and interventions are important therapeutic tools that clinicians can integrate into their work with clients. Ad­ ditionally, technology allows alternative models of care to be of­ fered to clients with specific needs that limit their ability to partici­ pate or interest in participating in more conventional interventions targeting behavioral health. Technology-assisted care (TAC) can transcend geographic boundaries to reach many people otherwise

unable to access services and is useful in a wide variety of settings, including Web-based interventions offered in the home, commu­ nity organizations, schools, emergency rooms, and healthcare providers' offices, as well as via mobile devices and online social networks. Furthermore, TAC is often accessible on demand at the user's convenience, thus reducing barriers to accessing care.

As of 2014, 87 percent of the population used the Internet (Pew Research Center [PRC], 2014), and only 7 percent of those who did not use the Internet lacked access to it (PRC, 2013). In 2012, 72 percent oflnternet users reported seeking health information online **(PRC,** 2013). This represents a substantial increase from 2009, when only 61 percent of adults reported looking for health in­ formation online Gones & Fox, 2009). Moreover, 90 percent of people now own a cell phone **(PRC,** 2014) and 64 percent own a smartphone (PRC, 2015); of those with a smartphone, 62 percent reported having used it to acquire some type of health-related in­ formation (PRC, 2015). The number of adults who have an

account with an online social network in­ creased from 8 percent in 2005 to 46 percent in 2009 (Lenhart, 2009c). Currently, 74 per­ cent of adults who use the Internet use a social networking site, with 89 percent of those ages 18 to 29 and 82 percent of those ages 30 to 49 reporting use (Duggan et al., 2015). As a re­ sult of these considerable increases in overall online access, TAC could potentially have a significant impact on public health. Major strides have already been made in the promo­ tion and use of telemedicine, including tele­ behavioral health.

The rapid growth of these resources requires a carefully planned response by treatment and prevention programs targeting behavioral health. In addition to relevant staff develop­ ment and training, this response needs to ad­ dress the specific electronic resources applica­ ble to each program, the contexts in which those resources will be most useful, the bene­ fits and risks of using them, the methods for preparing clients to accept and use these re­ sources, and an organizational commitment to evaluating the effectiveness and utility of spe­ cific technologies. New technologies represent new means of communication; messages must be tailored to the technology and the issues at hand. For example, an email message will most likely need to be different from a text message. Use of advanced technologies also requires consideration of a number of legal and ethical issues, such as confidentiality, scope of practice, state licensure regulations, privacy, data security, consent management, and the potential for misuse.

Goal and Scope of This TIP

This Treatment Improvement Protocol (TIP) provides an overview of current tech­ nology-based assessments and interventions (including treatment, recovery support, re­ lapse prevention, and prevention-focused in­ terventions) targeting behavioral health, and

it summarizes the evidence base supporting the effectiveness of such interventions. It also examines opportunities for TAC in the behav­ ioral health arena-particularly in improving early access to care, client engagement in and commitment to treatment and recovery, client education, specific treatment interventions, relapse prevention and recovery management, extended recovery, community engagement, mental health promotion, and substance use disorder prevention, among other areas. This TIP addresses how behavioral health service providers can use Web sites, telephone and televideo resources, smartphones, and other portable devices and electronic media for edu­ cation, outreach, and direct client services. It emphasizes use of TAC with clients who

might not otherwise receive treatment or whose treatment might be impeded by physical disabilities, rural or remote geographic loca­ tions, lack of transportation, employment con­ straints, or symptoms of mental illness. This TIP emphasizes the use of TAC with those who might not seek treatment in conventional settings and/or who have personal preferences that limit access to conventional services.

It is definitely not the intent of this TIP to suggest that electronic media should replace in-person client contact. Instead, this TIP fo­ cuses on how TAC, when incorporated into mental and substance use disorder treatment and prevention efforts, can supplement exist­ ing methods and also provide services to cli­ ents who might not otherwise receive this help. It is also not the intent of this TIP to promote any particular technology-based ther­ apeutic tools or any of the companies that de­ velop or host these tools, but rather, to broadly highlight the promise of TAC by providing specific examples. This TIP does not explicitly address how use ofT AC in behavioral health service delivery intersects with changing

healthcare laws in the United States, but it does

suggest that TAC may significantly increase

the quality of care delivered and the success of integrating behavioral healthcare with disease prevention and management.

In short, evidence-based TAC has the poten­ tial to reach more clients and help engage and retain them in services in a cost-effective manner. This TIP provides treatment and pre­ vention workers in the behavioral health arena with the resources they need to use various technologies in their practice and to recognize the limits and ethical considerations involved in using them. It also provides behavioral health program administrators with the information they need to integrate and expand the use of technologies in their systems of care.

Principles for Using Technology­ Based Therapeutic Tools

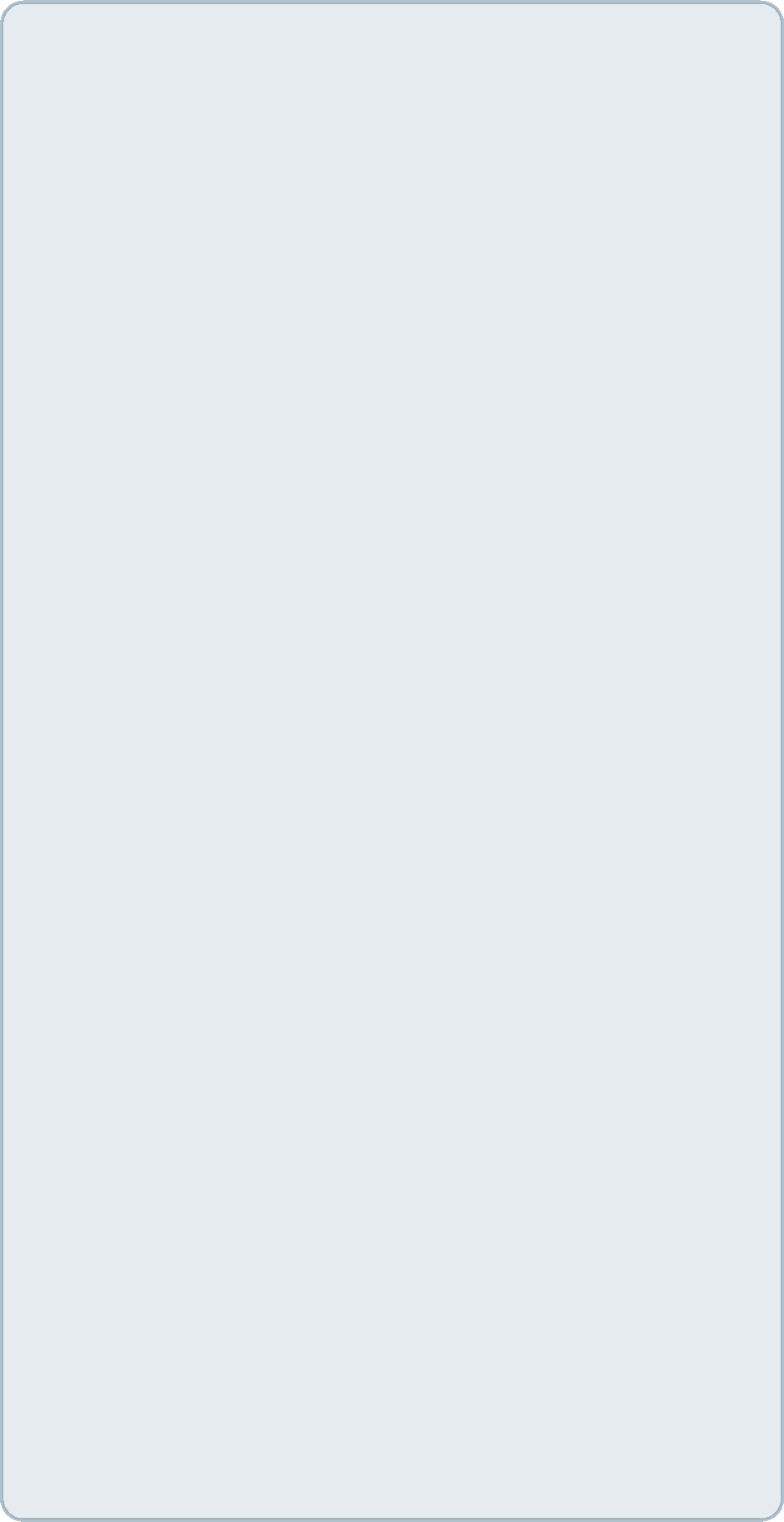
The content of this TIP was developed with continual input from a consensus panel of be­ havioral health clinicians, behavioral health program administrators, and federal agencies with significant experience, expertise, or inter­ est in the provision of TAC in the behavioral health arena. The panel identified several key principles to guide TAC in behavioral health services. These principles provide overall guidance for the use of any type of electronic media or information technology targeting behavioral health, and as such, all sections of this TIP align with these overarching princi­ ples (Exhibit 1.1-1).

##### The Potential Utility of Technology-Based Therapeutic Tools

Technology-based assessments and interven­ tions are of use in a variety of ways, and they may also be clinically meaningful along an en­ tire spectrum of behavioral health services, including screening, assessment, prevention, treatment, recovery management, and con-

tinuing care. The use of technology, such as a computer or a mobile device, in screening for and assessing individuals' behavioral health needs may allow for the efficient, standard­ ized, and cost-effective collection of clinically relevant client information in diverse settings. This can be particularly important in healthcare settings where clinicians trained in behavioral health assessment procedures are not readily available and where opportunities to identify individuals who may benefit from behavioral health interventions are missed.

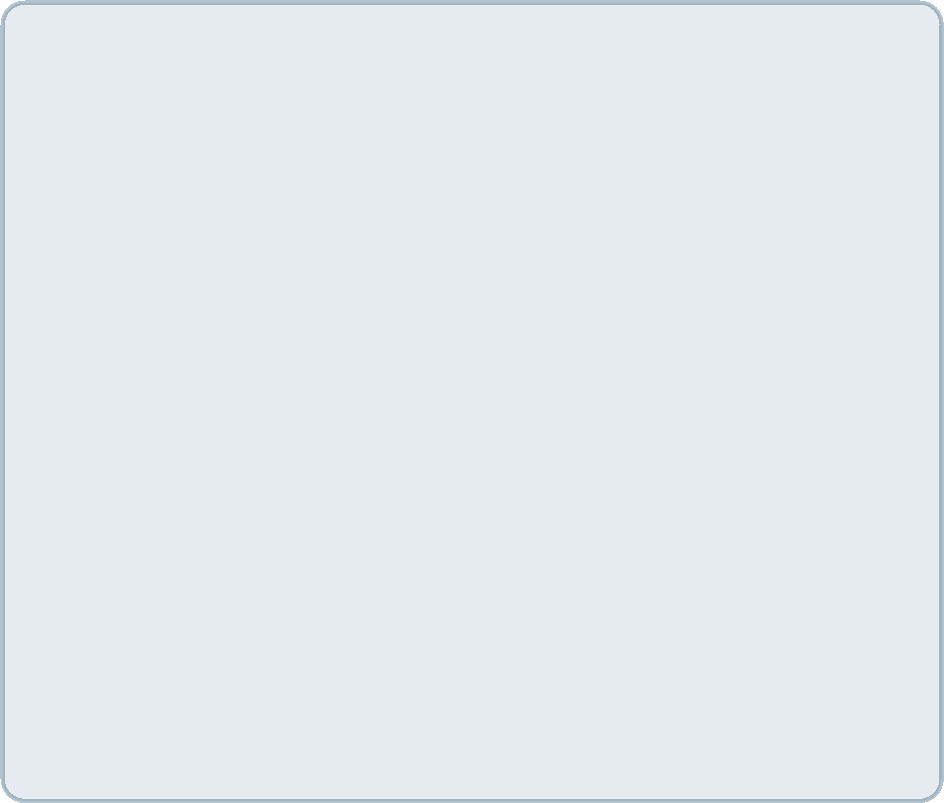
TAC gives clients access to screening, inter­ vention, and oversight by trained behavioral



**Exhibit 1.1-1: Principles To Guide TAC in the Behavioral Health Arena**

The following key principles guide TAC in the behavioral health arena. All sections of this TIP were developed to align with these principles:

* Clinical judgment is fundamental and should drive decisions regarding the use of technology. Clinical judgment, and not merely the existence of a given technology, should guide the application of said tech­ nology in clinical contexts.
* Practitioners should use technological solu­ tions only within their realm of professional competence and scope of practice.
* The way technology-based tools are used may differ across populations and settings.
* Clinicians and clients should thoughtfully consider and discuss the risks and benefits of technology-based tools as part of the therapeutic process.
* Technology can offer value for individuals and their families along the entire spec­ trum of behavioral health services. This may include screening, assessment, pre­ vention, treatment, recovery management, and continuing care.
* Maintaining security and confidentiality in TAC is the responsibility of all parties en­ gaged in such care.
* Clinicians, clients, and other stakeholders should continually work together to shape, maintain, and refine models for the adop­ tion and use of technology-based thera­ peutic tools in treatment.



**It's Not About the Technology**

New technologies, such as telehealth, help im­ prove healthcare services. For technology to succeed in doing so, it must work for the people it is meant to help; it must aid not only clients, but also the professionals providing their care. Telehealth helps ensure that clients who are vet­ erans get the right care in the right place at the right time. It aims to make the home the pre­ ferred place of care whenever possible.

*Source: U.S. Department of Veterans Affairs* ***(VA)*** *Telehealth Services (http://www.telehealth.va.gov)*

health staff members in remote locations. Brief computerized screenings can identify individuals with varying levels and types of behavioral health needs and can identify the differing resources and services that may be helpful to them. These brief screenings may also be useful as a less intensive therapeutic option for individuals not willing to seek pro­ fessional care actively at a given point in time.

TAC allows behavioral health service provid­ ers and their clients to communicate directly at the same time (synchronously) or at sepa­ rate times (asynchronously). For instance, dis­ tance counseling approaches in which clients and clinicians interact in real time online or by phone exemplify synchronous communication, whereas text-based communication (e.g., text messaging, emails) between a clinician and client may be asynchronous; one sends a mes­ sage, but the other may not reply until later.

This chapter discusses technology-based ther­ apeutic tools that fall in both general catego­ ries and may be integrated into treatment and prevention activities.

Technology-based interventions targeting be­ havioral health may be used as "clinician ex­ tenders," or additional tools used by clinicians that can also be made available to clients (Bickel, Marsch, & Budney, 2013; Carroll &

Rounsaville, 2010; Marsch, 20116). For ex­ ample, distance counseling approaches may fill a treatment gap for those who cannot readily access care in their local communities: indi­ viduals in rural or remote settings, people who are unable to commute to behavioral health service providers' offices, and/or people unin­ terested in traditional service delivery models. Additionally, by offering TAC to clients (e.g., encouraging clients to complete online skills training modules), clinicians may increase their time availability for clients with multiple challenges; focus more of their time on the delivery of services that require their clinical expertise and interaction with clients; and en­ able clients to review repetitive but clinically important content, such as psychoeducational material, without having to devote extensive time to such activities themselves.

E-therapeutic tools can also serve as clinician extenders by helping clinicians work with a larger number of clients and/or for longer pe­ riods of time (e.g., online counseling offered as relapse prevention after a more intensive treatment episode), which allows them to have a greater impact with their service delivery.

When used in this manner, TAC offers great potential for extending the benefits of treat­ ment as well as allowing clients to access care when they need it the most. Time flexibility is another potential benefit of TAC, particularly through incorporation of technologies that enable asynchronous communication between clinicians and clients-making services availa­ ble on demand at times that are convenient for clients. As a result, TAC allows widespread access to therapeutic support, thereby creating unprecedented models of intervention delivery and reducing barriers to accessing care.

The anonymity afforded by TAC (e.g., when conducted via online anonymous support groups) may be appealing to individuals when addressing sensitive topics such as substance

use and other risky behaviors (Des Jarlais et al., 1999; Ramo, Hall, &Prochaska, 2011). Anonymity, however, can also be a problem for behavioral health clinicians. It can create legal and ethical issues when there is no in­ formed consent, when reportable use issues arise, when clients potentially pose a danger to themselves or others, and when the counselor can't verify whether the client lives in a state or region where the counselor is licensed, among a variety of other circumstances.

When information technology is used to de­ liver behavioral health interventions, new in­ formation can be incorporated easily and ex­ ported quickly. This is particularly true for Web- or mobile-based TAC, because updates in program content can be incorporated cen­ trally and made available to all end users at the same time. Thus, TAC has the potential to offer the latest scientific advances in behavior­ al health services rapidly and continuously.

TAC facilitates linkages to services and sup­ port systems in the community through:

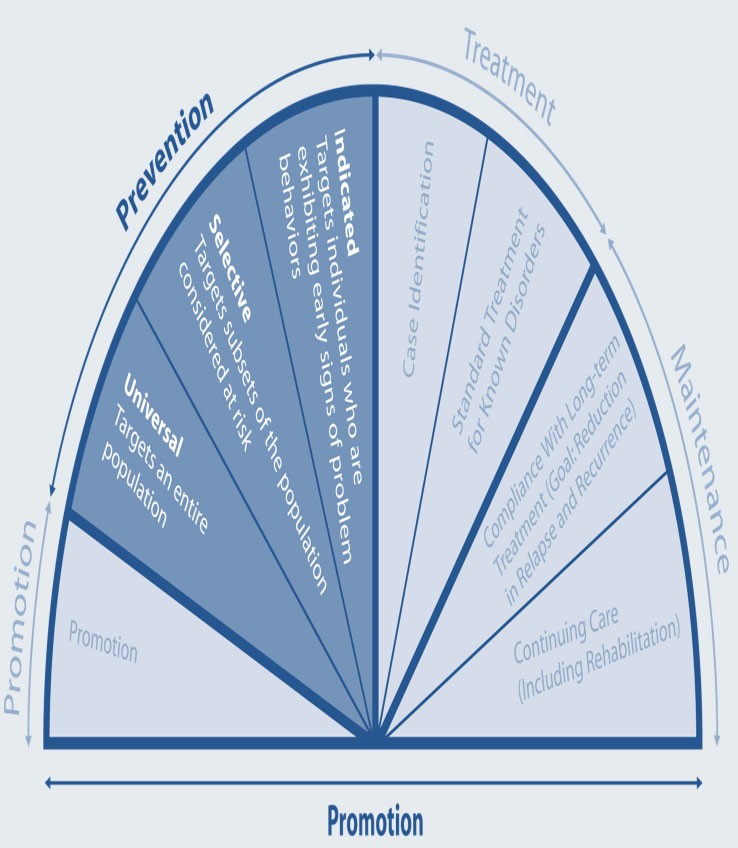
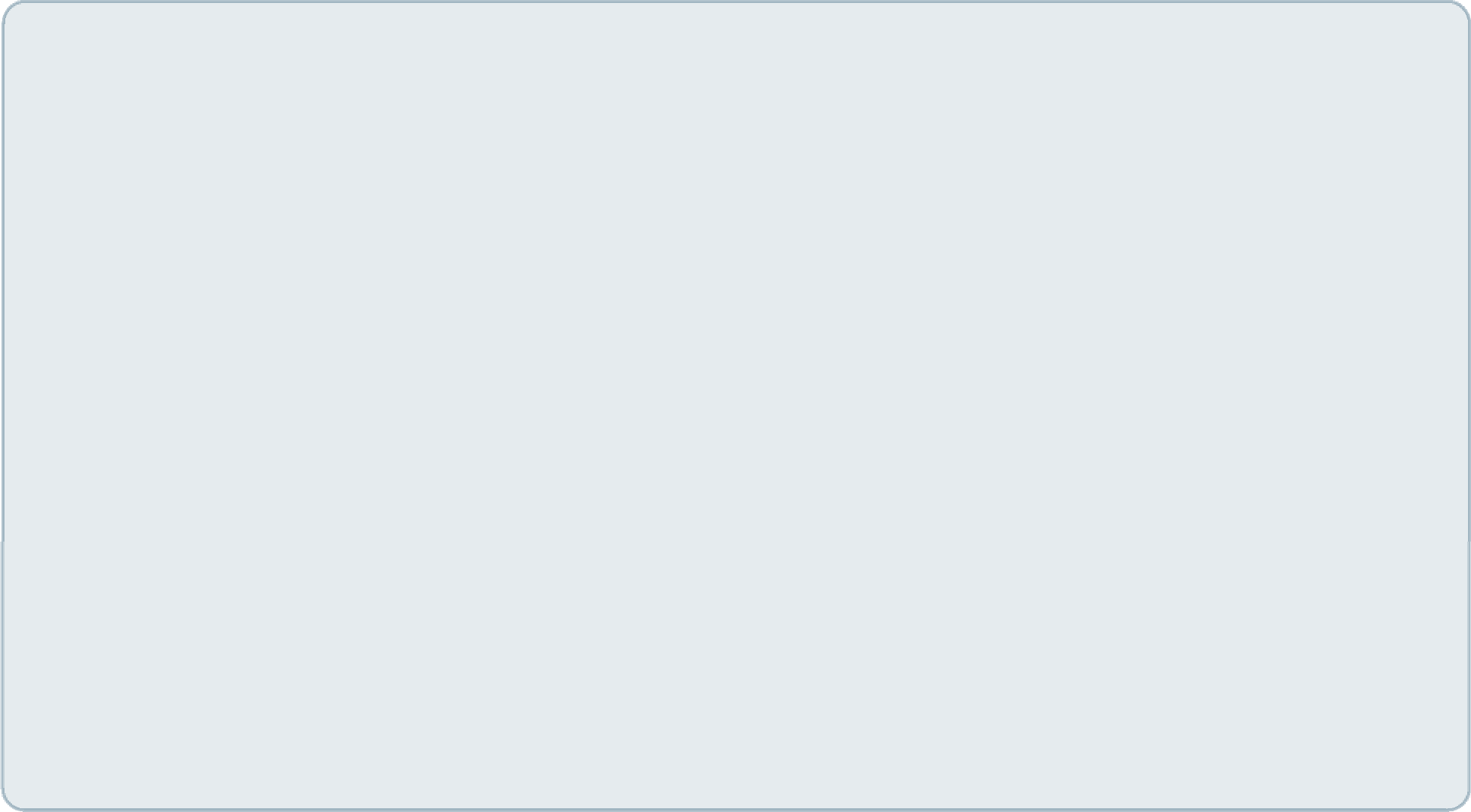
* Online resources or decision support systems to help individuals make choices about their own care.
* Online collaborative care/case manage­ ment models for clinicians, which enable coordination of services among a network of providers and their clients (and some­ times clients' extended networks of family members and/or significant others).
* The ability to reach large populations (es­ pecially when delivered in nonspecialty settings, such as universal prevention ef­ forts using online technologies).

Technology can play a role across the spec­ trum of prevention efforts (Exhibit 1.1-2).

The use of technology also offers individuals the opportunity for personalized recovery monitoring and management, including links to online or mobile recovery support groups (sometimes called virtual support groups).

This may allow for new models of care in which individuals can take ownership of monitoring their own care and recovery.

The main costs of technology-based therapeu­ tic tools are associated with completing initial development, keeping up with the latest research, training new staff members, and



**Exhibit 1.1-2: Types of Prevention as Described by the Institute of Medicine**

*Source: Institute of Medicine, 2009. Used with permission.*

evaluating effectiveness. Deployment costs are relatively limited and are associated with bandwidth for online access, technical sup­ port, licensing of the technology, and ongoing equipment maintenance and support. Thus, technology-based assessment and intervention tools may be cost effective and offer consider­ able utility for many resource-constrained ser­ vice settings. Overall, TAC, when appropri­ ately applied, holds great potential to have a significant impact on public health.

##### An Overview of Behavioral Health Technologies

This section provides an overview of specific technologies and their potential applications in behavioral health. This section is organized by types of technology, including telephone/ audio counseling and video/Web conferencing tools; self-directed, Web-based, and desktop computer-based therapeutic tools; Web-based text communication (e.g., email, chat, forums); and mobile technologies. There is considerable overlap across these categories. For example, online counseling can refer broadly to any be­ havioral health service delivered via the Inter­ net, even though delivery to clients can occur via a wide range of delivery platforms (e.g., computers, mobile devices). Nevertheless, the categories establish conceptual clarity and con­ sistency with the approach taken in the litera­ ture by Maheu, Pulier, Wilhelm, McMenamin, and Brown-Connolly (2004).

For each category of technology, you will find a brief description and a review of its applica­ tions in assessment, prevention, treatment, and recovery support efforts targeting behavioral health. Several examples of how each type of technology has been applied in behavioral health programs are also provided (see Part 2,

Chapter 2, for more real-world program examples).

Although this overview discusses technology and the many ways in which it can be used in detail, clinicians must be careful not to let the technology itself determine how it is integrat­ ed into clinical care. Technologies evolve rap­ idly, and new technologies are emerging all the time; clinicians should consider how a giv­ en tool will enhance clinical services and select only those technologies that are likely to be most beneficial to their clinical work and that they and their clients can use competently.

Technologies and information technology tools serve supportive roles that enable clini­ cians to provide enhanced care under particu­ lar circumstances; in no way can they replace traditional methods and service delivery. Clin­ ical need and clinical benefit should drive the use of technology-not the other way around!

Some e-therapeutic tools are more effective than others; among these are tools that inte­ grate evidence-based content and evidence­ based approaches for technology-dependent delivery (e.g., tools based on research into the optimal use of educational and informational technologies that allow for interactivity, mod­ ularity, and multimedia approaches in pro­ moting behavior change; Aronson, Plass, & Bania, 2012; Bickel, Marsch, Buchhalter, & Badger, 2008; Campbell et al., 2014; Consalvo, Landay, &McDonald, 2009; Dan­ aher, McKay, & Seeley, 2005; Gustafson et al., 2014; Ritterband & Tate, 2009; Webb, Joseph, Yardley, &Michie, 2010). Although TAC can mimic aspects of traditionally deliv­ ered, in-person behavioral health services, it differs in a number of ways. For example, self­ directed, technology-based interventions, such as online skills training programs, cannot optimally engage clients in role-play; however, they can help ensure that clients are active participants in the learning process and can

document what content clients have or have not mastered in a given program (Marsch et al., 2013). As a result, technology-based ap­ proaches to behavioral health assessment and intervention should not be held to the same standards as traditional models of care; rather, consider what technology can do well and what it can do less well when embracing a TAC approach. Technology-based approaches should still be evaluated with the same rigor as traditional approaches and need to show evi­ dence of empirical support before they are used in clinical settings (Kiluk et al., 2011).

The use of technology warrants the same types of considerations as traditional care, such as being sure the client is benefiting from its in­ corporation into treatment, considering how and when to terminate its use in the context of the client's best interests, and monitoring the treatment process to note whether any modifi­ cations to the technology will be necessary.

Telephone/ Audio Counseling and Video/Web Conferencing Tools

***Understanding these technologies*** Telephone or audio counseling allows for syn­ chronous communication and delivers behav­

ioral health services to clients via the telephone (the terms "te1eph one" and "aud.10 " are used interchangeably hereafter). Telephone-based

counseling services have existed for decades, so they no longer reflect use of a new technology, but this type of technology-dependent service delivery is still promising. Telephone counsel­ ing is distinct from interactive voice response

**(IVR)** and therapeutic interactive voice re­

sponse (TIVR) technologies, in that telephone counseling typically involves clients' verbal communication with a clinician by phone in real time, whereas IVR and TIVR approaches typically require clients to communicate ver­ bally with a computer database by phone (e.g., interacting vocally with a computerized menu

of options and receiving automated feedback based on their input).

Video or Web conferencing can be conducted in a number of ways, but it typically involves a behavioral health specialist evaluating and providing consultation or counseling to a client via live, two-way, interactive audio/video con­ nection. Synonymous terms include online counseling, Web therapy, distance counseling, telemental health, cybercounseling, and behav­ ioral telehealth. The Health Resources and Services Administration's Web site (<http://www.hrsa.gov/ruralhealth/about/telehe> alth) defines telehealth as "the use of electron­ ic information and telecommunications tech­ nologies to support long-distance clinical healthcare, patient and professional health­ related education, public health and health administration."

Telephone-based counseling is already a common practice, and video or Web confer­ encing as well as other types of telehealth ap­ proaches are rapidly growing in acceptability. The increasing availability and reduced cost of voice over Internet protocols (VOIPs), broad­ band connections, and video quality are making telehealth models more accessible to large numbers of individuals. The distinction be­ tween these approaches has diminished with the ever-growing availability of mobile phones and tablets, which often include video tech­ nology and thus allow for more efficient use of telephone- and video-based therapeutic interventions. Many states have, and some are developing, specific laws, rules, and regula­ tions regarding telehealth interventions.

***Applying these technologies* to**

***behavioral health***

Reviews of the scientific literature on tele­ phone-based counseling have underscored the utility of this approach in a number of areas, such as physical activity and dietary behavior

change (Eakin, Lawler, Vandelanotte, & Owen, 2007), smoking cessation (Meites & Thom, 2007), and improvement of mental status and quality oflife (Mohr, Carmody, Erickson, Jin, & Leader, 2011; Piette et al., 2011). This approach also increases follow-up capabilities in healthcare settings (Racine, Alderman, & Avner, 2009) via telephone­ based contacts or visits. Additionally, inter­ ventions via telephone can be clinically useful tools when addressing the behavioral health needs of clients in primary care settings (Glas­ gow, Bull, Piette, & Steiner, 2004; Jordan, Ray, Johnson, & Evans, 2011). Several studies have demonstrated the feasibility, acceptabil­ ity, and efficacy of using the telephone to ob­ tain data regarding their substance use from adolescents receiving treatment for substance use disorders and to provide telephone-based counseling interventions targeting substance use among youths (Burleson & Kaminer, 2007; Kaminer, Burleson, Goldston, & Burke, 2006; Kaminer & Napolitano, 2004). These studies highlight the efficacy of telephone­ based interventions and suggest that youths may prefer telephone-based interventions to

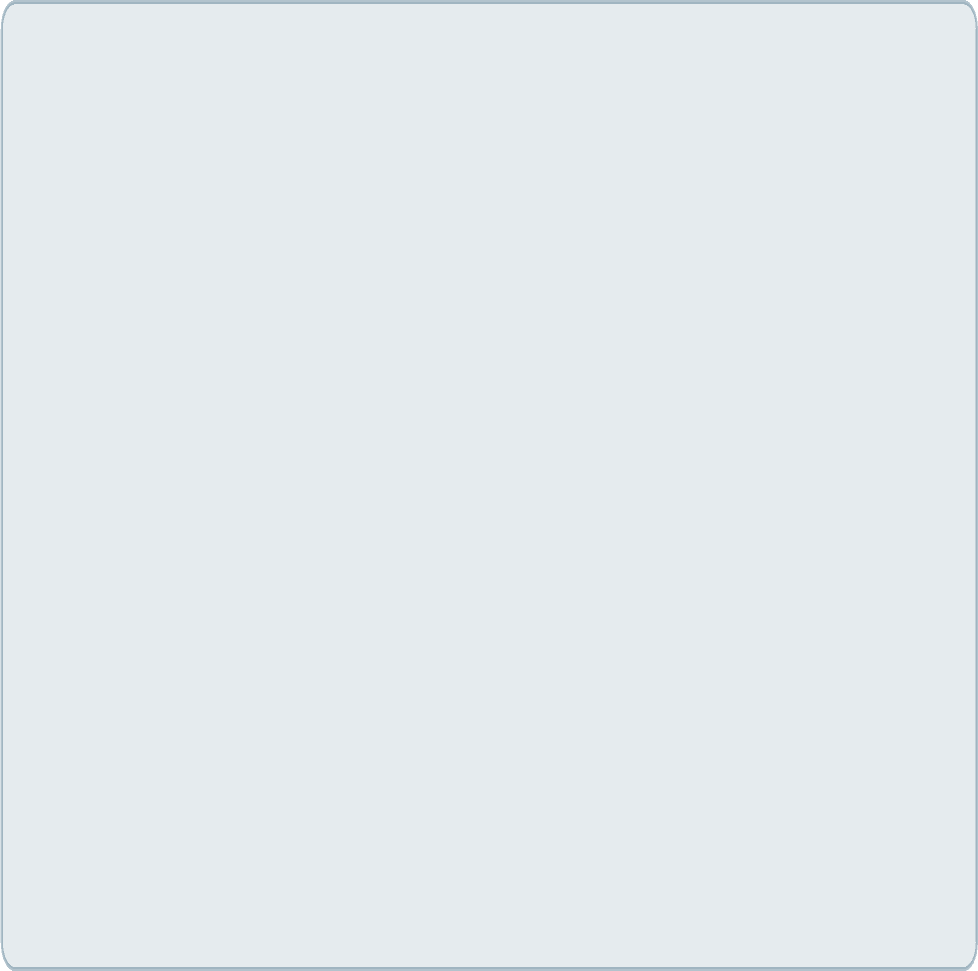
in-person counseling. Recent review papers

also support the use of telephone-delivered

behavioral counseling as a tool for improving health in people with chronic illness (Muller & Yardley, 2011).

Telephone-based **IVR** interventions have been shown to have considerable clinical utility in areas such as the behavioral management of chronic pain (Naylor, Keefe, Brigidi, Naud, & Helzer, 2008) and as part of posttreatment smoking cessation efforts (Regan, Reyen, Lockhart, Richards, & Rigotti, 2011). As tel­ ephones, including mobile phones, have been a routine part oflife for so long, research typi­ cally shows that both clinicians and clients are comfortable with telephone-based counseling. Indeed, many clients consider telephone coun­ seling a satisfying and helpful process (Reese, Conoley, & Brossart, 2002, 2006).

Video conferencing/telehealth approaches have been increasingly useful to a wide range of clients, including individuals in remote lo­ cations (e.g., Alaskan Native villages), the el­ derly, military personnel, individuals who are hearing impaired, and incarcerated individuals (Simpson & Morrow, 2010), as well as those with serious mental illness (SMI; Sharp, Kobak, & Osman, 2011). Although more re­ search is needed, data to date suggest that



**HealthCall and HealthCall-S**

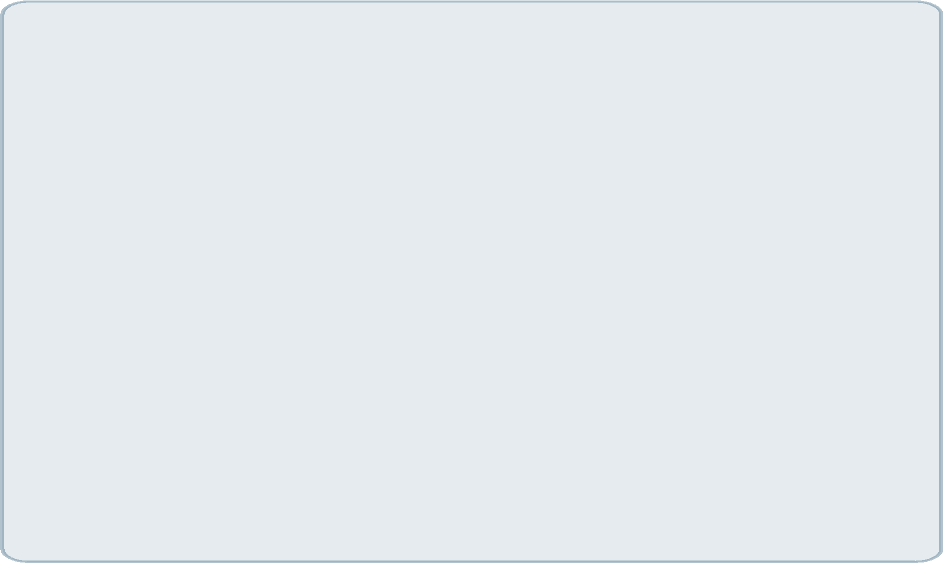
The growing use and affordability of smartphones continues to stimulate their use by researchers for gathering data and developing innovations in behavioral health clinical applications with IVR systems. For example, to monitor substance use, Hasin, Aharonovich, and Greenstein (2014) developed HealthCall-S as an adaptation of the HealthCall lVR programs that have been used in research and clinical practice for more than 5 years. HealthCall's self-monitoring component allows users to moni­ tor their drinking by answering questions about their behaviors; they "receive reinforcement for do­ ing so (e.g., 'We're glad you called')" (Hasin et al., 2014, p. 2). Clients also receive personalized feed­ back through in-person interactions with a staff member, as the contributors to the development of HealthCall found that participants preferred a combination of technology-based and interpersonal support interventions. HealthCall-S was specifically designed to take advantage of smartphone capa­ bilities and to do so with input from clients themselves; a pilot study showed its acceptability by cli­ ents and some limited evidence of its possible usefulness in promoting abstinence among individuals with both HIV and alcohol dependence. Another study that highlighted the role of smartphones in managing symptoms of mental illness was a pilot study of a smartphone intervention with clients who had schizophrenia; results showed acceptability and preliminary efficacy for reducing symptoms in clients over the course of the month-long study (Ben-Zeev et al., 2014).

video conference-based interventions produce outcomes comparable to more traditionally delivered in-person counseling and may pro­ vide a useful alternative when in-person coun­ seling is not possible (Garcia-Lizana & Munoz-Mayorga, 20106; Norman, 2006).

Additionally, some evidence suggests that cli­ ents may participate in counseling sessions more if they are offered in a distance telehealth environment as an alternative or an adjunct to in-person settings (Day & Schneider, 2002).

**Self-Directed, Web-Based, and Computer-Based Therapeutic Tools**

***Understanding these technologies*** Self-directed, technology-based therapeutic tools are typically assessments and interven­ tions provided as stand-alone programs via technology-based platforms. These programs are self-directed in the sense that clients can access and use them with or without assistance from a clinician. Often, these programs enable both clients and providers to access helpful



**Telehealth Video Session Produced by the National Frontier and Rural Addiction Technology Transfer Center**

The Substance Abuse and Mental Health Ser­ vices Administration (SAMHSA)-funded Addic­ tion Technology Transfer Center (ATTC) Net­ work has designated its National Frontier and Rural (NFAR) ATTC as the focus area lead for the delivery of addiction-related telehealth ser­ vices to frontier and rural communities. Tele­ mental health, addiction, and training services were first introduced into frontier and rural ar­ eas decades ago (LaMendola, 1997). NFAR provides free resources and ongoing "Tele­ health Tuesdays," including an easily accessible 15-minute counseling session video with a cli­ ent in continuing care, all of which are available online (<http://www.attcnetwork.org/nationa1-> focus-a reas/content.aspx?rc-frontierrural&con tent=STCUSTOM 1).

information. For example, clinicians may re­ ceive updates about client activity from the program, and clients may access help in de­ termining how to use and benefit optimally from the program.

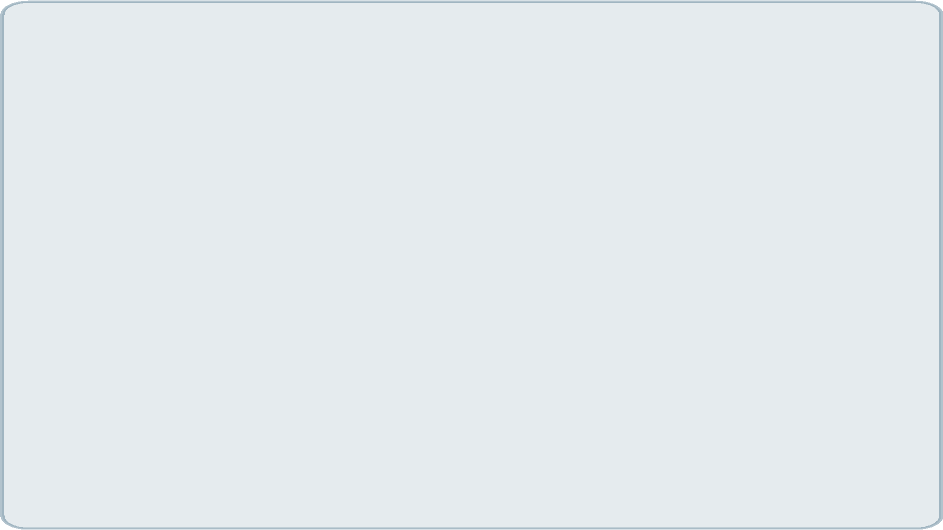
These therapeutic tools are accessible online (e.g., interactive, Web-based coping skills training programs; Web-based behavioral management software) or as computer-based programs run from a DVD or a flash drive on a local machine. Computer-based programs that are not Web based may have utility in specific settings where Internet access is lim­ ited, such as in criminal justice settings and certain residential treatment programs. How­ ever, Web-based, self-directed therapeutic tools offer a number of advantages, including the ability to update centrally and deploy con­ tent within a given program as needed (e.g., when new information becomes available that is important for an entire population to re­ ceive), the ability to track user activity within a program over time via unique login infor­ mation, and aggregation of user activity data across client groups (e.g., to allow a provider to review summary information of all of his or her clients). Although the Internet and online assessment and intervention tools are accessi­ ble via mobile devices (mobile phones, tablets, and other devices), this section focuses on therapeutic tools accessed primarily via desk­ top or laptop computers. Therapeutic tools accessible via mobile devices are described lat­ er in this chapter.

***Applying these technologies* to**

***behavioral health***

Interventions that incorporate computer­ based, self-directed interactive technology have been used to assess behavioral health, to provide services, and to promote health behav­ iors related to diabetes (Wise, Dowlatshahi, Farrant, Fromson, &Meadows, 1986), eating disorders (Tate, 2011), substance use disorder

prevention (Chiauzzi, Brevard, Thurn, Decembrele, & Lord, 2008; Chiauzzi, Green, Lord, Thum, & Goldstein, 2005; Hester & Delaney, 1997; Marsch, Bickel, & Badger, 2007; Schinke, Schwinn, & Cole, 2006; Schinke, Schwinn, Di Noia, & Cole, 2004; Schinke, Schwinn, & Ozanian, 2005), HIV/AIDS prevention (Marsch & Bickel, 2004; Marsch et al., 2011; Noar, Black, & Pierce, 2009), and methadone maintenance treatment (Marsch et al., 2013). Computer­ ized treatments for mental disorders have been most widely developed and extensively used for anxiety, traumatic stress, and depressive disorders (Barlow, Ellard, Hainsworth, Jones, & Fisher, 2005; Newman, Consoli, & Taylor, 1997; Newman, Kenardy, Herman, & Taylor, 1997; Selmi, Klein, Greist, Sorrell, & Erdman, 1991). Computer-based interventions to treat these disorders may, in part, reflect the manu­ als developed for cognitive-behavioral treat­ ments of these disorders. Treatments that have been broken down into discrete proce­ dures as part of the production of a treatment manual are easy to adapt for computer-based interventions. For example, computer



**Computer-Based Training for Cognitive-Behavioral Therapy**

Investigators are conducting a randomized clin­ ical trial (Clinical Trial NCT 01615497) of a

Web-based version of a computer-based train­ ing for a cognitive-behavioral therapy program called CBT4CBT, which was specifically de­ signed to address alcohol use. Clinical Trial NCT 01615497 is evaluating CBT4CBT's effec­ tiveness relative to standard outpatient coun­ seling in a substance use disorder treatment unit. CBT4CBT teaches basic coping skills, of­ fers video-based examples of effective use of coping skills in various realistic situations, and allows clients in substance use disorder treat­ ment to practice and review new skills.

*Source:* [*http://www.clinicaltrials.gov/show/nct01615497*](http://www.clinicaltrials.gov/show/nct01615497)

programs have successfully implemented such mental health techniques as cognitive restruc­ turing (Selmi, Klein, Greist, Sorrell, & Erdman, 1990), relaxation training (Buglione, DeVito, &Mulloy, 1990), systematic desensi­ tization (Chandler, Burck, Sampson, & Wray, 1988), and self-exposure (Carr, Ghosh, & Marks, 1988). Furthermore, an interactive, Web-based intervention called the Therapeu­ tic Education System (Bickel et al., 2008; Campbell et al., 2014) effectively delivers cognitive-behavioral therapy/community rein­ forcement approach treatment for individuals with substance use disorders and may be as effective as counseling delivered by highly trained clinicians. A computerized program for substance use disorders that is theoretically grounded in cognitive-behavioral therapy (the CBT4CBT program; Carroll et al., 2008; Carroll et al., 2014) can significantly enhance outcomes when provided as an adjunct to tra­ ditional treatment for substance use disorders, and other programs have effectively integrated motivational interviewing approaches (Hester, Squires, & Delaney, 2005; Ondersma, Chase, Svikis, & Schuster, 2005; Ondersma, Svikis,

& Schuster, 2007) that target alcohol and oth­ er substance use disorders.

An automated, Internet-based contingency management (abstinence reinforcement) inter­ vention called Motiv8, which obtains video­ based evidence of smoking behavior and rein­ forces evidence of behavior change (e.g., smoking reduction, abstinence), has produced outcomes that generally meet or exceed the effects produced by nicotine replacement ther­ apies (Dallery & Glenn, 2005; Dallery, Glenn, & Raiff, 2007). An interactive decision sup­ port system has shown great promise in help­ ing individuals with SMI initiate smoking ces­ sation treatment (Brunette et al., 2011).

The use of computers may help increase be­ havioral health counselors' awareness of

community-based resources for client referrals (Carise, Gurel, McLellan, Dugosh, & Kendig, 2005). Additionally, research evaluating com­ puterized tools for providing screening, brief intervention, and referral to treatment for be­ havioral health needs has generated promising results to date (Vaca, Winn, Anderson, Kim, & Arcila, 2011; see Part 3 of this TIP, the online literature review, for more infor­ mation). Interactive computer games targeting various areas of behavioral health have also shown promise (Foley &Maddison, 2010), including games that use virtual coaches (Watson, Bickmore, Cange, Kulshreshtha, & Kvedar, 2012). Overall, literature reviews on the use of computer-generated health behavior interventions underscore the effectiveness of such interventions in producing health behav­ ior change (Moore, Fazzino, Garnet, Cutter, &Barry, 2011; Revere &Dunbar, 2001; Tate & Zabinski, 2004; Taylor & Luce, 2003; Wantland, Portillo, Holzemer, Slaughter, & McGhee, 2004). Comparisons of computer­ delivered interventions with person-delivered interventions generally report comparable out­ comes (Marsch & Bickel, 2004; Marsch et al., 2007; White et al., 2010).

**Web-Based Text Communication: Email, Chat, Forums, Electronic Mailing Lists, and Social Networks**

***Understanding these technologies*** This section focuses on text-based communi­ cation that may be useful in the behavioral health arena, with a particular focus on email, chat rooms, electronic mailing lists, and fo­ rums. Text-based communication that most frequently occurs via mobile devices (e.g., text messaging) is described later in this chapter.

Chat rooms typically refer to open "rooms" online in which individuals can come and go as they wish and communicate synchronously with any or all participants in the chat room.

Many, but not all, chat rooms that focus on behavioral health are moderated by a clinician who posts comments, guides discussions, and sometimes screens comments written by oth­ ers before allowing them to post. Whether chat rooms are overseen by clinicians or by peers, they typically include guidelines for par­ ticipation, with designated moderators who monitor content to ensure that participants remain on topic and are appropriate and re­ spectful. Instant messaging typically refers to a private, real-time communication between

two or more people in a secure (not public) chat room. However, privacy issues can be­ come an issue in chat rooms, particularly those that are not monitored.

Online support forums are typically organized in a bulletin board format that allows users to post anonymous, text-based communications. Online support groups typically enable asyn­ chronous communication, as do electronic mailing lists (email lists that do not require logging in to a Web site to view postings). For example, the support forum Patients Like Me (http://www.patientslikeme.com) offers Web­ based exchanges of information among clients or interested parties related to numerous health conditions and disorders, including types of depression ranging from major de­ pressive disorder to postpartum depression.

Online social networks let members keep in contact with others and/or meet new people. These sites offer a number of elements, in­ cluding biogs, pictures, chat and private mes­ saging capabilities, and videos. At the time of this writing, Facebook is one of the most pop­ ular online social networks. As of March 31, 2015, Facebook reported **1.44** billion monthly users and 936 million daily users worldwide (Facebook, 2015). Facebook has collaborated with several suicide prevention efforts, includ­ ing those of SAMHSA, to offer unique forms of prevention through social media (for more

information, see <http://blog.samhsa.gov/2011/> 12/13/facebook-provides-first-of-a-kind­ service-to-help-prevent-suicides/). Although the online social network of the moment may change over time, online social networks will likely persist, offering considerable potential to function as platforms for behavioral health screenings, brief interventions, and referrals to care. Note that it is possible to set up semi­ private online social networks (often within larger online social networks) composed of individuals with common interests (e.g., smoking cessation). For more about social networks and introductory information, see "Emerging Technologies and Future Oppor­ tunities" later in this chapter and "Internet Security and Privacy Considerations for Clinicians and Clients" in Part 2, Chapter 2.

***Applying these technologies* to**

***behavioral health***

Text-based communication can be used in a number of ways in the behavioral health arena. Email can be used for routine contacts, such as setting appointments, or for therapeutic pur­ poses, such as following up on counseling ses­ sions (e.g., to send motivational messages en­ couraging clients to engage in specific therapeutic activities between scheduled coun­ seling sessions) or actually conducting some portion of counseling. Emails, encrypted or unencrypted, can be automated (e.g., system­ generated prompts to encourage clients to keep daily diaries) or generated by providers. Provid­ ers can choose to accept and monitor email re­ sponses from clients, allowing for dialog, or they can limit communication to one-sided messages sent from the clinician to the client.

Email has utility in addressing issues such as eating disorders, smoking cessation, work stress, and weight-loss counseling (Polosa et al., 2009). As with all forms of electronic communication, compliance with the Health Insurance Portability and Accountability Act

(HIPAA) and other federal and state regula­ tions regarding privileged communication is a primary concern.

Chat counseling in chat rooms or via instant messaging can achieve purposes similar to those of email but typically requires more ab­ breviated interactions (e.g., abbreviated words, emoticons; Derrig-Palumbo, 2010). Chat counseling can target an array of behavioral health issues, including problematic alcohol use (Blankers, Koeter, & Schippers, 2011), stress management (Hasson, Brown, & Hasson, 2010), and HIV prevention (Rhodes et al., 2010).

Online social networks can be an excellent forum for conducting online surveys and as­ sessments related to behavioral health (Lord, Brevard, & Budman, 2011). Research into optimal uses of online social networks for be­ havioral health interventions is still in its infan­ cy, but work to date underscores the potential utility of this platform in engaging hard-to­ reach populations (Levine et al., 2011) and promoting behavior change (Moreno et al., 2009), particularly when offered in the context of online communities or support groups that target specific behavioral health issues (Griffiths, Calear, & Banfield, 2009; Selby, van Mierlo, Voci, Parent, & Cunningham, 2010). However, online social networks can be problematic due to their general lack of

HIP AA compliance and because of the ten­ dency of clients to post private information in public forums. Additionally, providers who use such networks are faced with how to act on their legal and ethical duties in such ven­ ues. Many service delivery organizations, state governance groups, and funders use online survey instruments, either within social plat­ forms or as stand-alone tools, to assess target­ ed population needs for planning activities or to collect satisfaction data.

Mobile or Handheld Technologies

***Understanding these technologies***

The term "mobile devices" refers to a number of types ofhandheld and mobile computers, but it most frequently denotes mobile phones and includes both smartphones (handheld computers that can run a complete operating system and thus can function as a platform for app developers) and feature phones (mobile phones that have less computing capacity than smartphones). The popularity of mobile phones has increased dramatically in recent years. Global penetration of mobile cellular subscriptions has reached 87 percent and cur­ rently stands at 79 percent in the developing world, with about 6 billion mobile phone sub­ scriptions worldwide; mobile broadband sub­ scriptions have grown 45 percent annually over the past 4 years, and today, there are twice as many mobile broadband as fixed broadband subscriptions (ITU, 2011b). Given the widespread use, ease of use, portability, and high level of computing capacity of even basic feature phones, these technologies offer great potential for affecting public health and healthcare delivery.

***Applying these technologies* to**

***behavioral health***

Mobile devices can be used for a wide variety of therapeutic purposes, including:

* + Mobile data collection tools to obtain data about users' emotional states and behavior in real time (e.g., ecological momentary as­ sessment; Shiffman, 2009).
  + Short messaging services (SMS), also known as text messaging or texting, which typically allows a limited amount of data to be transmitted (usually between cell phones). SMS is easy to use and allows for data to be entered into a database and monitored in real time (Lim, Hocking, Hellard, &Aitken, 2008; Merz, 2010),

which in turn facilitates the sending of messages that encourage client/recipient engagement in health promotion and/or treatment-related activities.

* Applications embedded on mobile devices and/or accessed on servers via mobile de­ vices to provide in-the-moment interven­ tions designed to reduce health risk behav­ ior. Although many apps are accessed primarily on mobile phones, these software programs are often accessible on a wide ar­ ray of hardware, including tablets and oth­ er computer platforms.

The use of mobile devices for collecting data in real time has led to enormous advances in understanding the behavior states of individu­ als. Collection of real-time data via these de­ vices can provide data that are more accurate than data obtained via retrospective recall (Ben-Zeev, McHugo, Xie, Dobbins, & Young, 2012; Shiffman, 2009). Data collec­ tion via mobile devices in real time also offers the opportunity to provide in-the-moment interventions in response to participants' be­ havior state, addressing their mood, medica­ tion regimen compliance status, symptoms, or functioning (Granholm, Ben-Zeev, Link, Bradshaw, & Holden, 2012). Offering evidence-based interventions via mobile devic­ es and apps holds great promise for enabling access to behavioral health services outside of formal treatment settings and when individu­ als may be most likely to engage in risky be­ havior. Participation in therapeutic activities in one's natural environment and outside of formal systems of care may enhance outcomes (Carroll et al., 2008; Carroll, Nich, & Ball, 2005), enabling more generalization of skills as applied in real-world settings.

The scientific literature on mobile phone­ based interventions, although limited to date, suggests that they may hold great promise.

One-sided text messages, for instance, from

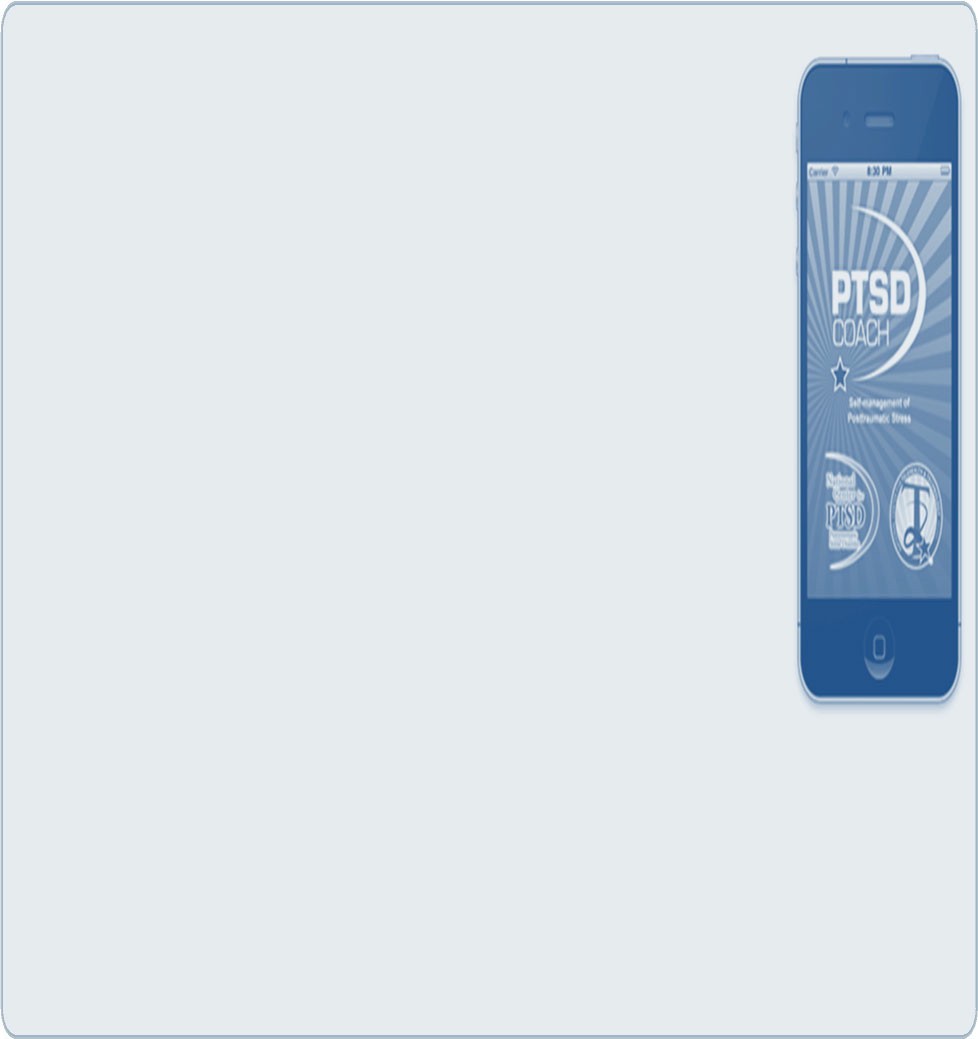
provider to consumer, have shown considera­ ble utility in promoting treatment compliance (e.g., for asthma, diabetes, medication man­ agement; Franklin, Waller, Pagliari, & Greene, 2003, 2006; Tasker, Gibson, Franklin, Gregor, & Greene, 2007) and self-monitoring of health behavior, such as healthy eating and exercise. Text message prompts can also sig­ nificantly improve attendance at medical ap­ pointments (Chen, Fang, Chen, & Dai, 2008; Downer, Meara, Da Costa, & Sethuraman, 2006; Leong et al., 2006) and compliance with vaccinations (Villela et al., 2004). Moreover, these prompts show promise in weight loss (Gerber, Stolley, Thompson, Sharp, & Fitzgibbon, 2009; Shapiro et al., 2008) and HIV risk reduction Guzang, Fortune, Black, Wright, & Bull, 2011).

More recent developments in mobile technol­ ogy enable the continuous tracking and moni­ toring of health information as well as interac­ tive programming on mobile phone platforms. Additionally, two-way text messaging may allow clients to input data that lead to in-the­ moment interventions delivered in real time, enabling clients to connect with behavioral

health service providers in many different set­ tings. This technology has facilitated the de­ velopment of more sophisticated mobile in­ terventions to promote behavior change, including weight loss Goo & Kim, 2007; Patrick et al., 2009) and diabetes management (Cho, Lee, Lim, Kwon, & Yoon, 2009; Kim & Kim, 2008; Qiinn et al., 2008). One exam­ ple of using advances in programming and adaptive algorithms to permit apps to select content based on an individual's characteristics and prior responses is a program that provided text messages and other information to em­ ployees with diabetes that enabled each employee to regulate the number of text mes­ sages that the employee would receive (Nundy et al., 2014). By being sensitive to how an em­ ployee felt about the number of text messages received, the researchers hoped to build en­ gagement with and acceptance of the program and its use. Evidence showed that their client­ centered efforts worked; many participants were happy to receive several messages a day, with one employee stating that the messages

made him feel that he did not have to handle

the complexities of his diabetic condition en­ tirely on his own.



**PTSD Coach**

PTSD Coach is an app created by the VA's National Center for PTSD and the U.S. Department of Defense's National Center for Telehealth and Technology. This app helps users learn about and manage symptoms that commonly occur after trauma. Features include:

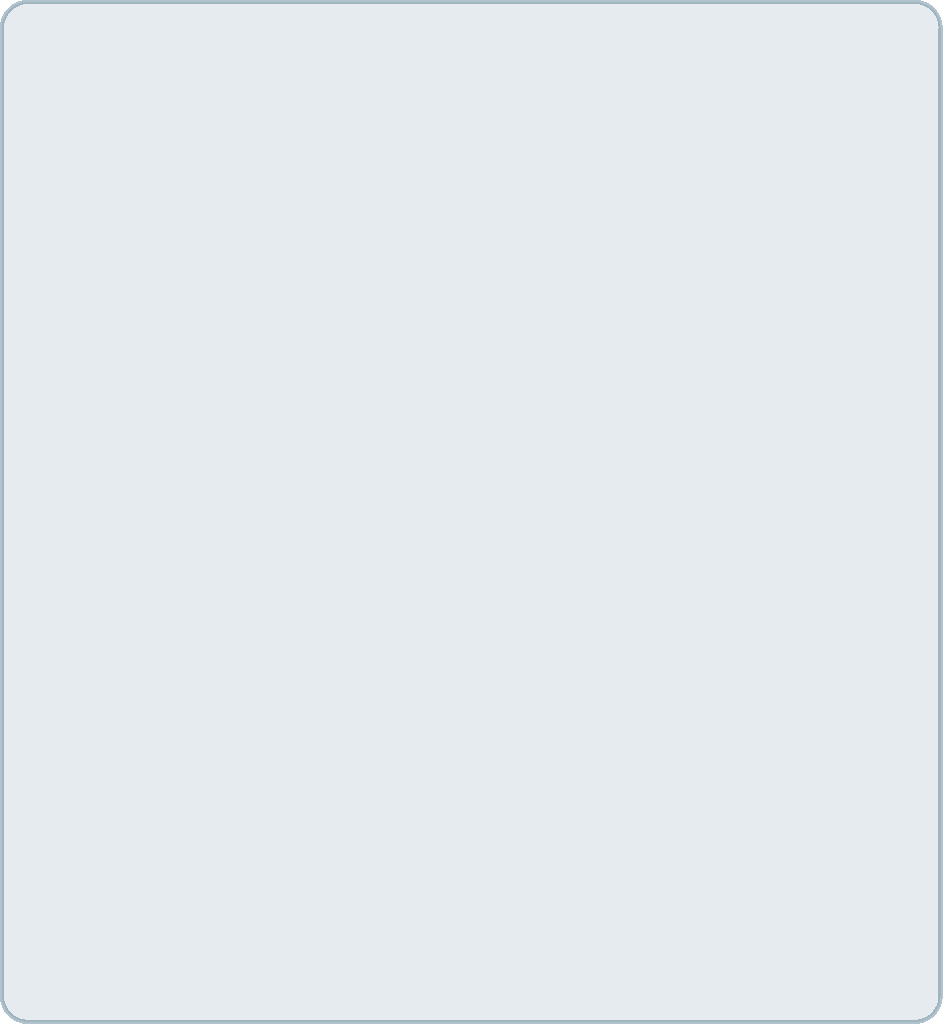
* Reliable information on posttraumatic stress disorder (PTSD) and treatments that work.
* Tools for screening and tracking symptoms.
* Convenient, easy-to-use skills to help clients handle stress symptoms.
* Direct links to support and help.
* Continuous accessibility; the app is available to clients whenever they need it, wherever they are, so long as they have an appropriate, enabled device.

Together with professional treatment, PTSD Coach provides clients who have or may have PTSD with dependable, trustworthy resources. Family and friends can also learn from this app. As of February 2014, PTSD Coach has been downloaded 138,000 times in 84 countries.

Source: [*http://www.ptsd.va.gov/public/pages/PTSDCoach.asp*](http://www.ptsd.va.gov/public/pages/PTSDCoach.asp)

Mobile phone-based interventions show promise in reducing smoking and alcohol use (Brendryen, Drozd, & Kraft, 2008; Brendryen & Kraft, 2008; Free et al., 2009; Haug et al., 2008; Lazev, Vidrine, Arduino, & Gritz, 2004; Obermayer, Riley, Asif, &Jean-Mary, 2004; Riley, Obermayer, &Jean-Mary, 2008; Rodgers et al., 2005; Weitzel, Bernhardt, Usdan, Mays, & Glanz, 2007; Whittaker et al., 2009). Mobile devices can also function as tools to prevent substance use disorder relapse (McTavish, Chih, Shah, & Gustafson, 2012). Embedding elements of cognitive-behavioral therapy on mobile devices can significantly increase treatment retention and improve ab­ stinence as part of outpatient substance use disorder treatment (Marsch, 2011a).

It is important to understand the empirical support for various mobile interventions before recommending their use in clinical contexts. In addition to reviewing published studies that evaluate various technology-based tools, in­ cluding studies covered in Part 3 of this TIP (available online), some centralized resources are available to help individuals evaluate the empirical support for many technology-based



**Text-Based Smoking Cessation**

Text messaging interventions provided via mo­ bile devices can increase smoking cessation, particularly among higher-income individuals. One such intervention, txt2stop, can more than double biochemically verified smoking cessa­ tion (Free et al., 2013). Compared with stand­ ard support, the txt2stop intervention, which delivered five text messages per day for the first 5 weeks and allowed users to text the words "crave" or "lapse" to receive an instant mes­ sage of support when a craving struck, pro­ duced 10.7 percent continued abstinence at 6- month follow-up, compared with just 4.9 per­ cent continued abstinence among participants who had received standard smoking cessation services (National Institute for Health Research Clinical Research Network, 2011).

behavioral health tools (e.g., [http://www.c4tbh.org/technology-in­](http://www.c4tbh.org/technology-in) action/program-reviews; Maheu, Pulier, & Roy, 2013; http://nrepp.samhsa.gov; [http://www.telementalhealthcomparisons.com.](http://www.telementalhealthcomparisons.com/)

Exhibit 1.1-3 provides examples of technology­ based therapeutic tools targeting differing are­ as of behavioral health and using various types of electronic media.

###### Emerging Technologies and Future Opportunities

Significant developments in technology con­ tinue to emerge and offer great promise for integration into behavioral health services.

Ubiquitous computing (sometimes called ubicomp or pervasive computing) and ambient intelligence are rapidly evolving fields in which human-computer interactions are em­ bedded into everyday objects and activities.

Ubiquitous or pervasive computing typically refers to technologies that "weave themselves into the fabric of everyday life until they are indistinguishable from it" (Weiser, 1991, p. 94). For example, ubiquitous computing tech­ nologies may include sensors to assess physio­ logical states. Such sensors are worn by indi­ viduals on their bodies or are embedded within mobile devices, allowing the unobtru­ sive and objective measurement of psycho­ physiological states, as well as biological and environmental variables, in real time (e.g., via interaction between the sensors and mobile computing devices). One example of this ap­ proach is a suite of wearable sensors that col­ lect and process cardiovascular, regulatory, and thermoregulatory measurements to infer stress as individuals move through their daily lives (Ertin et al., 2011). Other sensors infer physi­ cal activity, social interactions, and behavioral risk factors by capturing and interpreting a va­ riety of characteristics of speech via smartphone (Choudhury et al., 2008). Barnett, Tidey,

**Exhibit 1.1-3: Examples of Technology-Based Therapeutic Tools Across Technological Categories**

|  |  |
| --- | --- |
| **Telephone/audio conferencing** | **Telephone Monitoring and Brief Counseling Intervention:** 15- minute phone calls weekly between counselor and client; ac- companying client workbook targeting substance use (McKay  et al., 2004). |
| **Video/Web conferencing** | **VA National Telehealth Services:** Designed for counselors to treat numerous diagnoses in VA clients via multiple treatment modalities in a wide range of settings ([http://www.telehealth.va.gov/real-time/index.asp).](http://www.telehealth.va.gov/real-time/index.asp)) |
| **Self-directed, web-based tools** | **Online, Tailored Interventions Targeting Obesity and Eating Disorders:** Self-directed, Internet-based behavioral treatment (Tate, 2011). |
| **Email** | **Email-Based Psychotherapy:** Therapeutic intervention target- ing depression (Vern mark et al., 2010). |
| **Chat** | **Internet Chat as Aftercare:** An 8- to 10-session on line chat- based continuing care intervention to facilitate transfer from inpatient to outpatient psychiatric care (Golkaramnay, Bauer, Haug, Wolf, & Kordy, 2007). |
| **Text** | **txt2stop:** Mobile phone text messaging intervention to pro- mote smoking cessation (Free et al., 2011; see the Text-Based Smoking Cessation box in the "Mobile or Handheld Technolo- gies" section of this chapter). |
| **Forums** | **Schizophrenia Online Access to Resources:** Online therapeutic forum for individuals with SMI (and their supporters) that focus- es on helping individuals solve problems, achieve personal goals, and meet personal needs (Rotondi et al., 2010). |
| **Tools for mobile/handheld devices** | **Addiction Comprehensive Health Enhancement Support System:** Personalized monitoring/support for individuals in re- covery from substance use disorders; global positioning system to detect when users are nearing high-risk environments; per- sonalized stories of recovery experiences; links to support net- work (Gustafson et al., 2011).  **PTSD Coach:** See the "PTSD Coach" box in the "Mobile or Handheld Technologies" section of this chapter. |
| **Emerging technologies** | **National Center for Telehealth and Technology (T2):** Provides innovative solutions in health technologies for traumatic brain injuries and psychological health through such mobile apps as T2 Mood Tracker and Breathe2Relax, among other efforts ([http://t2health.dcoe.mil/apps/t2-mood-tracker).](http://t2health.dcoe.mil/apps/t2-mood-tracker))  **AutoSense:** Wearable sensor suite for inferring stress (Ertin et al., 2011 ). |

Murphy, Swift, and Colby (2011) conducted a pilot contingency management study using a transdermal alcohol sensor that measures the

very small amount of ingested alcohol that is excreted though the skin. The Secure Contin­ uous Remote Alcohol Monitoring bracelet

used in this pilot study is being used in veter­ ans' treatment courts, including the Center for Substance Abuse Treatment (CSAT)/Justice for Vets collaborative Mentor Court in Tulsa, **0 K** ([http://www.justiceforvets.org/veteran­](http://www.justiceforvets.org/veteran) mentor-courts).

Ambient intelligence refers to an intelligent environment or an intelligent service system that can anticipate, adapt to, and meet users' needs. Although these evolving technologies (such as smart homes) have only just started to be applied to behavioral health, they could have a marked impact on the field, incorporat­ ing many of the technologies already available and in use. These approaches could allow for real-time, unobtrusive psychophysiological measurement and on-demand, continuous ac­ cess to tailored support, education, and inter­ ventions targeting behavioral health. For ex­ ample, ubicomp tools can obtain real-time data on physiological and environmental fac­ tors that precede and follow risk behavior (or healthy behavior) and can provide in-the­ moment interventions that are responsive to these factors. These tools may enable unprec­ edented levels of tailoring for individuals over time. However, such efforts will, of course, require careful consideration of issues related to disclosure, consent, and privacy.

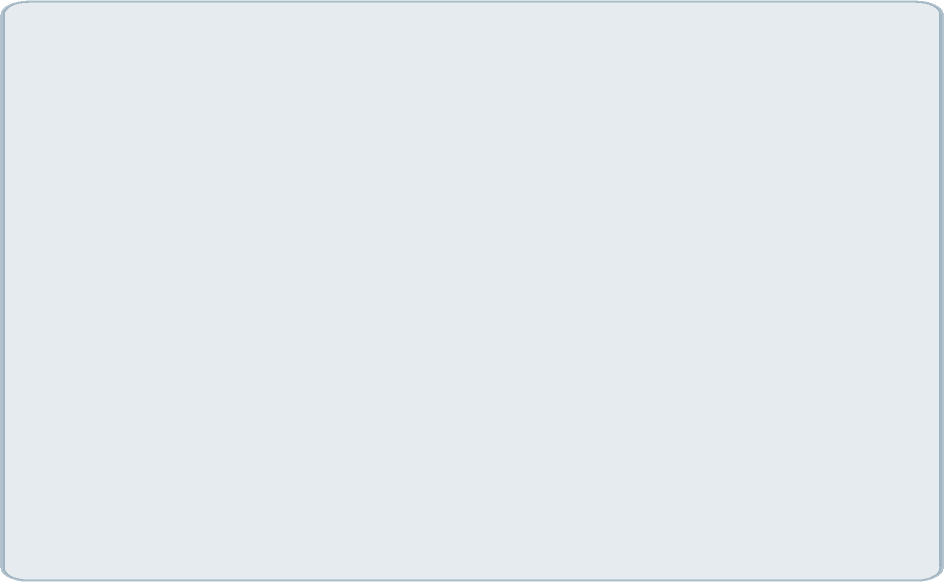
The term "virtual" often refers to anything that takes place online rather than in the real world, but for the purposes of this TIP, "virtu­ al reality" (VR) refers specifically to technolo­ gy that reproduces realistic conditions and/or computerizes certain aspects of monitoring and/or data collection. The use of VR in help­ ing veterans with PTSD is just one glimpse of the types of future progress that may be achiev­ able with these new technologies.

VR allows users to visualize, manipulate, and interact with computers and highly complex

data (Aukstakalnis and Blattner, 1992). Ex­ tensive and promising work has been conduct­ ed for more than 15 years in the use of VR to treat combat-related PTSD. Comparing VR with the use of aircraft simulators to train pi­ lots, Brennan (2013) described VR's ability to create "context-relevant simulated environ­ ments where assessments and treatment of cognitive, emotional, and motor processes can take place... extend[ing] the skills of the clini­ cian by allowing the clinician to precisely and systematically deliver complex, dynamic, and ecologically relevant stimulus presentations... within which sophisticated interaction, behav­ ior tracking, performance recording, and phys­ iological monitoring can occur" (pp. 377-378).

In addition to more than 190 clinical trials related to VR and exposure therapy for PTSD and other health-related uses of **VR** (see the "VR and ClinicalTrials.gov" box on the next page), the Army's immersion VR system has produced advances in measurement capabili­ ties, such as the development of a measure for a stress indicator referred to as allostatic load (AL). Allostasis is how the body tries to main­ tain stability in the face of acute stress. The Army has used **VR** to develop a measure of AL based on inflammatory, metabolic, cardio­ vascular, adrenal, and renal systems of the body. According to Brennan (2013), AL gauges the cumulative negative impact of the stresses of daily life, indicating how a person is influenced by such stress in the long term.

The concept of AL has led to research on the differences in how people experience stress and on possible measures of resiliency to stress. Thus, the use of VR for research and treatment may not only expand the range of knowledge and the options for treatment, but also lead to a higher level of understanding and experience than has been possible in the past.



**VR and ClinicalTrials.gov**

A search for VR in the [http://www.clinicaltrials.gov](http://www.clinicaltrials.gov/) search engine in early May 2014 yielded 190 clinical trials with topics such as:

* Exposure therapy for PTSD.
* Rehabilitation after a stroke.
* Balance training exercises in older adults.
* Weight loss through the use of a VR plat­ form, Second Life, compared with face-to­ face methods.
* Medical and scientific training and educa­ tion, such as the effects of marijuana.
* Wearable sensors.
* Other physical conditions (e.g., pain and memory conditions) and behavioral condi­ tions (e.g., anxiety management, social phobia, agoraphobia, panic disorder, au­ tism spectrum disorder, attention deficit hyperactivity disorder, smoking cessation, fear of flying).

###### Integrating Technology Into Existing Services

The ever-widening range of technology-based therapeutic tools becoming available may seem daunting as you attempt to determine which tools will be the most useful in providing

TAC to your clients. This section outlines several issues to consider when integrating electronic technologies into your work. First and foremost, you must maintain awareness of the scope of your professional competence and work within its boundaries even as you explore TAC approaches. It is also important to un­ derstand which technology-based therapeutic tools have been shown to be the most effec­ tive, as not all such tools have both evidence­ based content and evidence-based guidance for use. An ethical behavioral health service provider considers available evidence support­ ing the incorporation of a given technology­ based intervention into clinical practice. **Ra­** ther than use a technology-based intervention merely because the opportunity exists, review

such interventions to ascertain which have been shown to produce optimal outcomes in contexts similar to those in which you will be working (see Part 3 of this TIP, available online, for many such reviews).

Additionally, the types of technology-based tools that will be most useful depend on the audiences being targeted and the settings in which those tools will be used. For example, self-directed, technology-based interventions and asynchronous forms of technology-based communication may be particularly useful with specific subgroups of clients, such as those with social phobias. The same types of technology-based interventions may elicit more honest communication with clients due to the perceived anonymity or confidentiality they enable; clients may be more comfortable ad­ dressing particularly sensitive topics in front of a computer screen or a mobile device than dur­ ing in-person communication. Asynchronous communication and self-directed, technology­ based tools can also be particularly useful to people who don't routinely have access to a private space where they can talk on the phone or through VOIP to a clinician but do have access to a computer or mobile device.

In some cases, however, the use of technology in therapy is contraindicated. For client popu­ lations that include individuals who are expe­ riencing significant emotional distress or com­ plex situations (such as domestic violence), counselors must give careful thought to how to use technology appropriately to enhance care. Clients who are actively suicidal, homi­ cidal, or severely emotionally distressed may not be good candidates for online care (CSAT, 2009c; International Society for Mental Health Online-Clinical Study Group, 2010; Stofle, 2001). Keep in mind that self­ directed and asynchronous tools cannot con­ vey your clients' nonverbal cues (e.g., intoxica­ tion, crying) and may not be ideal for clients

who find typing difficult or frustrating. Cli­ ents who are isolated and crave social interac­ tion or feel the need to get out of the house may not be good candidates for technological interventions that decrease in-person contacts.

By contrast, self-directed and asynchronous tools may be particularly appealing to teens and young adults who have grown up on the Internet and spend most of their time interact­ ing with some technology. A Kaiser Family Foundation study (Rideout, Foehr, & Roberts, 2010) found that the exposure to media of children and teenagers 8 to 18 years old in­ creased roughly 20 percent from 2004 to 2009. Estimates of the amount of total recreational use of all devices, per day, every day of the week, reached almost 7.5 hours in 2009.

Several studies underscore the acceptability and appeal to youths of computer-delivered interventions relative to more traditional mod­ els of care. For example, among the most sig­ nificant barriers to adolescents' participation

in substance use disorder treatment is dislike for their counselors, discomfort talking about personal problems with another person, and finding counseling unhelpful (Mensinger, Diamond, Kaminer, & Wintersteen, 2006). As a result, computer-based counseling may be appealing to youths. Indeed, youths may prefer Internet-delivered substance use disorder interventions over more traditional interven­ tions (Chambers, Connors, &McElhinney, 2005). Many youths report that they find in­ teractive computer learning environments preferable to traditional learning environ­ ments, in that computer-based learning allows them to solve problems actively and inde­ pendently while still receiving individualized feedback (McKinsey and Company & U.S. National Information Infrastructure Advisory Council, 1995; Roker & Coleman, 1997).

Additionally, a growing body of research has highlighted the utility of technology for health promotion among aging populations, including the promotion of health-related knowledge and functional longevity (Tse, Choi, & Leung, 2008). Furthermore, comput­ erized cognitive remediation tools designed to enhance cognitive skills through exercises that target problem solving, attention, memory, and abstract reasoning have been shown to have promise in populations with SMI as well as among individuals with substance use dis­ orders (McGurk, Twamley, Sitzer, McHugo, &Mueser, 2007; Pedrero-Perez, Rojo-Mota, Ruiz-Sanchez de Leon, Llanero-Luque, & Puerta-Garcia, 2011).

A key benefit of telephone-based counseling is the accessibility of phones (including cell phones) to a number of populations. Thus, phone-based counseling has broad appeal and utility. It is, however, important to add that the use of technology for technology's sake does not help the clinician or the client. Any use of technology should engage both the cli­ nician and the client, making the use of time more effective and valuable for both.

###### Legal and Ethical Issues To Consider

Ethical considerations in TAC are often ex­ tensions of (and in many cases, overlap with) ethical considerations in traditionally delivered behavioral health services. However, some unique considerations arise for TAC. As clini­ cal practices differ in various settings, it is not possible to cover every possible ethical and le­ gal consideration relevant to the incorporation of technology into behavioral health services. That said, this section addresses some of the most significant ethical and legal issues to consider when providing TAC.

**Confidentiality, Privacy, and Security**

The use of technology-based therapeutic tools in behavioral health warrants a number of con­ siderations related to confidentiality, privacy, and security. As in traditional clinical scenarios ethical principles and procedures related to ' protecting clients' privileged information (con­ fidentiality), protecting clients' rights to control access to their information (privacy), and pro­ tecting client data from being accessed without authorization (security) are of paramount im­ portance. However, some unique considera­ tions arise when collecting data and/or deliver­ ing interventions using electronic media.

Text-based communications provide a literal transcript of communication between you and your clients (e.g., email, online moderated cha\_t forums) or among groups of clients (e.g., onlme support groups), but this mode of communication poses certain risks. For exam­ ple, if a mobile device is used for communi­ cating with a client via text, depending on the settings and device properties, messages stored on the mobile device as well as those sent from the device are likely unencrypted and vulnerable to security threats. Email messages are also usually unsecured and can be accessed by third parties. Even if emails are deleted by both the sender and recipient, they may be preserved by other third parties, such as Inter­ net service providers (ISPs). As mentioned in Exhibit 1.1-1, managing security and confi­ dentiality in TAC is the responsibility of all parties engaged in their use.

A thorough discussion of the broad set of se­ curity issues related to the use of mobile devic­ es in the general healthcare environment is beyond the scope of this TIP. The U.S. Food and Drug Administration (FDA) has been issuing guidance as to which sorts of technol­ ogies are considered medical devices and which are considered health or medical apps

that do not require approval from the FDA as medical devices. In general, apps that pose lower risk to the public will not be required to seek review as medical devices. The FDA (2014) has described some of these low-risk devices as apps that:

* Help people maintain coping skills.
* Alert people with asthma of environmen­ tal conditions.
* Prompt users to check on possible drug interactions with food, herbs, or other medications.
* Use videos to motivate patients to do their physical therapy at home.
* Provide information or screening, counsel­ ing, and preventive recommendations from well-known and established authorities.
* Enable a clinical conversation to be rec­ orded for review after the visit.
* Allow users to track behaviors related to diets, exercise, and sleep.
* Engage in mind-challenging tests or games.

Apps that may constitute a risk to patients or others if the device fails to work properly re­ quire approval as medical devices. For exam­ ple, certain devices relay heart function data to medical services that monitor a patient's heart function; if such a device provided false in­ formation or failed to operate, it could endan­ ger the patient (FDA, Center for Devices and Radiological Health & Center for Biologics Evaluation and Research, 2013).

The HealthIT.gov Web site ([http://www.healthit.gov/providers­](http://www.healthit.gov/providers) professionals/your-mobile-device-and-health­ information -privacy-and-security), operated by the Office of the National Coordinator **(ONC)** for Health Information Technology, offers a number of resources for healthcare providers related to using mobile devices in a way that helps protect and secure client health information. Exhibit 1.1-4, adapted

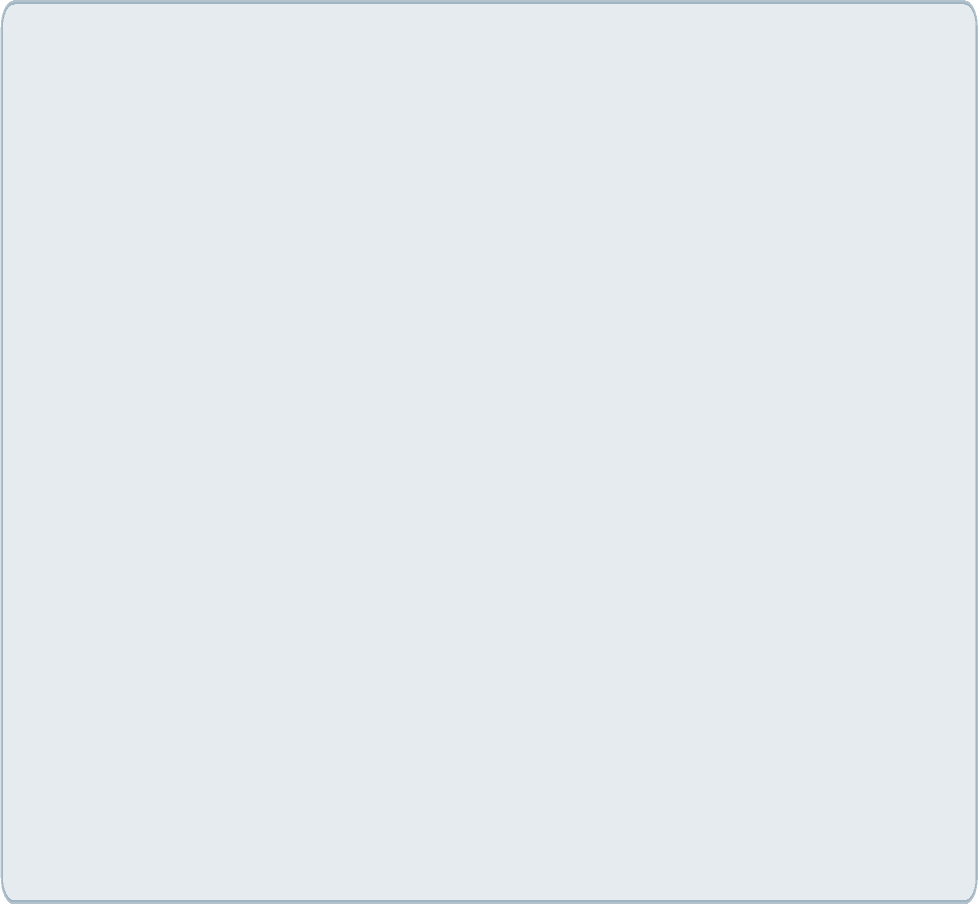
**Exhibit 1.1-4: Areas of Concern for Mobile Computing Devices**

|  |  |  |  |
| --- | --- | --- | --- |
| **Threat Type:**  **Area of Threat Privacy (P)/**  **Concern Considerations Level Security (S)** | | | |
| DEVICE | | | |
| Access control | Control over the user authorization process required to access the device | High | PS |
| Encryption | Technology in place to protect data at rest | High | PS |
| Updates | How and when the device is updated | Moderate | s |
| Software vulnerabilities | Weaknesses in the platform and operating system that may allow unauthorized access to the device | Moderate | s |
| Backups | How, when, and where backups are handled | High | PS |
| Mobile malware | Viruses and other malicious software that can steal data, capture keystrokes, or perform other compro- mising actions | Moderate | PS |
| Remote management | How the device is managed remotely, if at all, in- eluding ability to restrict application access or Web access, encrypt data, remotely wipe data, and so on | High | PS |
| Device- specific issues | Issues specific to mobile computing devices but not other computing platforms, such as inability to truly erase mobile device storage | High | PS |
| Platform- specific issues | Issues specific to each mobile computing device platform, such as password storage, application backgrounding or suspending, and so forth | Moderate | PS |
| APPLICATION | | | |
| Access control | Control over the user authorization process required to access the application, including session initiation and management and least-privilege access | High | PS |
| Inappropriate storage | What information the application stores and wheth- er the level and sensitivity of information support local storage | High | PS |
| Insecure storage | Ensuring that data are stored in an adequately en- crypted fashion. | High | PS |
| Insecure transport | Ensuring that sensitive data transported over the network are encrypted, including usernames and password, management information, and other da- ta; does the application force the use of encrypted technologies? | High | PS |
| Updates | How and when the application is updated | Moderate | s |
| Software vulnerabilities | Weaknesses that may allow unauthorized access to the application | Moderate | PS |
| Backups | How and where backups are handled | High | PS |

*(Continued on the next page.)*

|  |  |  |  |
| --- | --- | --- | --- |
| **Threat Type:**  **Area of Threat Privacy (P)/**  **Concern Considerations Level Security (S)** | | | |
| Data leakage | Potential for leaking sensitive information, such as user name, device ID, location, and so forth | Low |  |
| Platform­ specific issues | Ways in which the application uses, disables, or works around platform-specific security issues | Moderate | PS |
|  | |
| Back-end server | Server security, presence of a firewall, and protec­ tion against normal application security flaws like structured query language injection, misconfigura­ tions, and so forth | High | PS |

from HIMSS (2011), describes considerations to address in the particular uses of an app. For current information on app security issues, refer to the HIMSS Web site (http://www.himss.org).



**Exhibit 1.1-4: Areas of Concern for Mobile Computing Devices {continued)**

*Source: Healthcare Information and Management Systems Society (HIMSS), 2011. Adapted with*

permission.

New information about the regulation of mo­ bile medical apps is rapidly developing. The FDA Web site lists examples of mobile medi­ cal apps that it will (<http://www.fda.gov/> MedicalDevices/DigitalHealth/MobileMedical Applications/ucm368743.htm) and will not (<http://www.fda.gov/MedicalDevices/Digital> Health/MobileMedicalApplications/ucm38874 6.htm) seek to regulate. For a detailed over­ view of the issues related to the regulatory framework emerging for digital medicine, in­ cluding developments outside of the United States, Elenko, Speier, and Zahar (2015) pro­ vide a cogent review and analysis.

In the United States, text-based communica­ tions between providers and clients are pro­ tected under HIP AA and some state laws that cover protected health information (PHI), but they can be subpoenaed from providers or ISPs. Text-based communications between a counselor and a child or adolescent pose unique risks, as parents typically have a legal right to view their children's medical records-which

may include some types of communication (Recupero, 2008). HIP AA does not explicitly address the use of some technologies, such as SMS and cell phones. However, several guidelines regarding clinical use of such tech­ nologies are available, including the National Institute on Standards and Technology's guidelines for mobile device security, which address potential security issues that must be managed when using such devices for thera­ peutic purposes Gansen & Scarfone, 2008), and the ONC Web site on privacy and securi­ ty for providers and professionals. For exam­ ple, the subscriber identity module card on a mobile device stores text messages and identi­ fies users of cell phones to the cell phone net­ work. This raises important questions regard­ ing the physical security of the mobile device, along with the importance of encrypting text messages. Encryption is available for tele­ phone communication as well, although it can be cost prohibitive. VOIPs, which enable phone communication over the Internet, typi­ cally allow for more accessible encryption technology.

An option with increased security is the use of secure, Web-based messaging systems that allow providers to email clients with a prompt

to log in to a password-protected Web site to retrieve a message (rather than sending the message through multiple servers, as with normal email). You may wish to set up pass­ word protection, automatic logouts, firewalls, audit trails, encryption, and authentication for any programs that you use. Also consider whether to include transcripts of electronic communication with clients in client records.

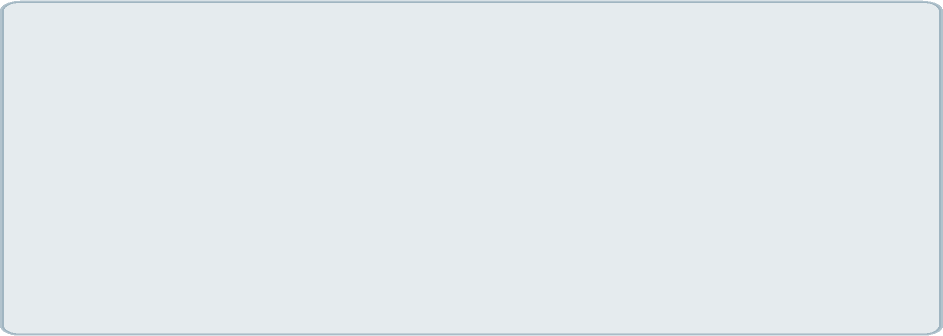
Online counseling services allow for tracking of clients' Internet protocol addresses. This information does not automatically reveal the exact geographic location of a client, but an ISP may be able to provide such information in an emergency. Large online counseling ser­ vice providers often use proprietary systems for communicating with clients. These sys­ tems may include encrypted chat stream iden­ tifiers, storage of text communication with clients, and emergency procedures for locating a client's local hospital or police station (Derrig-Palumbo, 2010), which may help ef­ fectively manage several of the confidentiality issues reviewed thus far. Ascertaining the se­ curity of technology-based communications between providers and clients is important, given that third parties can potentially access such communication. That said, the largest risks are typically low tech and include send­ ing an email to the wrong address, posting one's password in a place visible to others, for­

getting to log off, or using an employer-hosted

email server (Sands, 2004).

There are a number of legal considerations related to online counseling models. Inter­ jurisdictional issues (licensure laws and regula­ tions) that apply when practicing across state lines, for example, must be understood. State licensing boards typically require that a practi­ tioner providing services in a different state also has a license to practice in that state.

States also vary in their mandatory reporting laws, such as those related to concerns about



**The Distance Certified Counselor**

The Center for Credentialing and Education, a subsidiary of the National Board for Certified Counselors, offers a certification called the Dis­ tance Certified Counselor, which identifies pro­ viders who have met established standards in distance counseling. It is a critical responsibility of clinicians to stay abreast of the evolution of legal issues and best practice guidelines and to implement these in their own work (Maheu, McMenamin, & Pulier, 2013).

abuse of and/or harm to self or others. Addi­ tionally, you should be aware of ethical stand­ ards and guidelines regarding online counsel­ ing models provided by professional organizations. You should further be aware that online counseling best practice guidelines may vary with the specific system and tools you use to deliver TAC. As technology and ethical issues continue to evolve, it is im­ portant to obtain professional training and certification.

Clear policies should dictate the use of various technologies to communicate with clients. Es­ tablish your own policies (in compliance with your organization's overarching policies) based on your understanding of the risks and bene­ fits of various approaches and clearly com­ municate this policy to all clients. Ideally, these policies would differentiate between what constitutes **PHI** and what does not.

Many professional organizations offer stand­ ards and guidelines in this arena and may be able to help you formulate your own policies as well.

Policies on the use of communication tech­ nologies should address issues such as which technologies providers are willing to use in communicating with their clients, when each technology is and is not appropriate for use, and what the potential risks and benefits of using each technology may be. These policies should also cover the extent to which other

**Essential Elements of Informed Consent To Participate in TAC**

Services process and alternatives:

* Whether communication will be synchronous or asynchronous
* Response standards and scheduling
* Frequency of interactions
* Misunderstandings (text-based and video-based risks)
* Alternative treatments or delivery approaches

Individuals who may have access to clinical information:

* Other providers on both ends of a Web conferencing exchange
* Technical staff members required to operate or maintain the technology
* Other participants in groups or chats
* Supervisors
* Program evaluators or quality assurance monitors

Potential benefits of the service:

* Access to services
* Privacy
* Reflection time
* Access to specialists and supervisors

Confidentiality of communications and records:

* Confidentiality laws that apply to clinical exchanges using technology
* Legal exceptions that apply to telemental healthcare or telemedicine just as they do to in-person clinical work, including child abuse, elder abuse, medical emergencies, threats of violence, or danger to self, as dictated by state and federal laws

Privacy and privacy risks:

* What is being transmitted, including identifiable images, clinical information, appointment re­ minders, and billing information
* Form of transmission, including attempts to protect privacy using encryption
* Privacy risks inherent in transmission, such as failures of technology, and unauthorized access to electronic information
* Storage/destruction policies for electronic communications (e.g., text messages, emails)

Roles and credentials of all individuals involved in service delivery:

* Names, roles, and credentials of all providers who participate in clinical care and how the client can confirm credentials (includes providers on both ends of a telemedicine exchange)
* Billing or administrative staff members who may contact clients about administrative issues

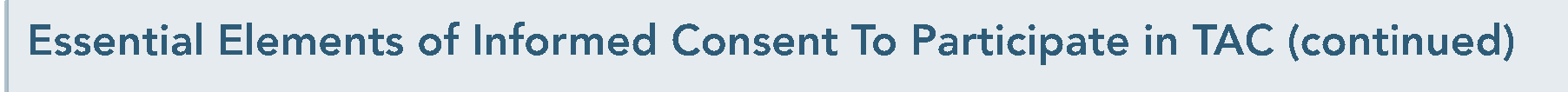
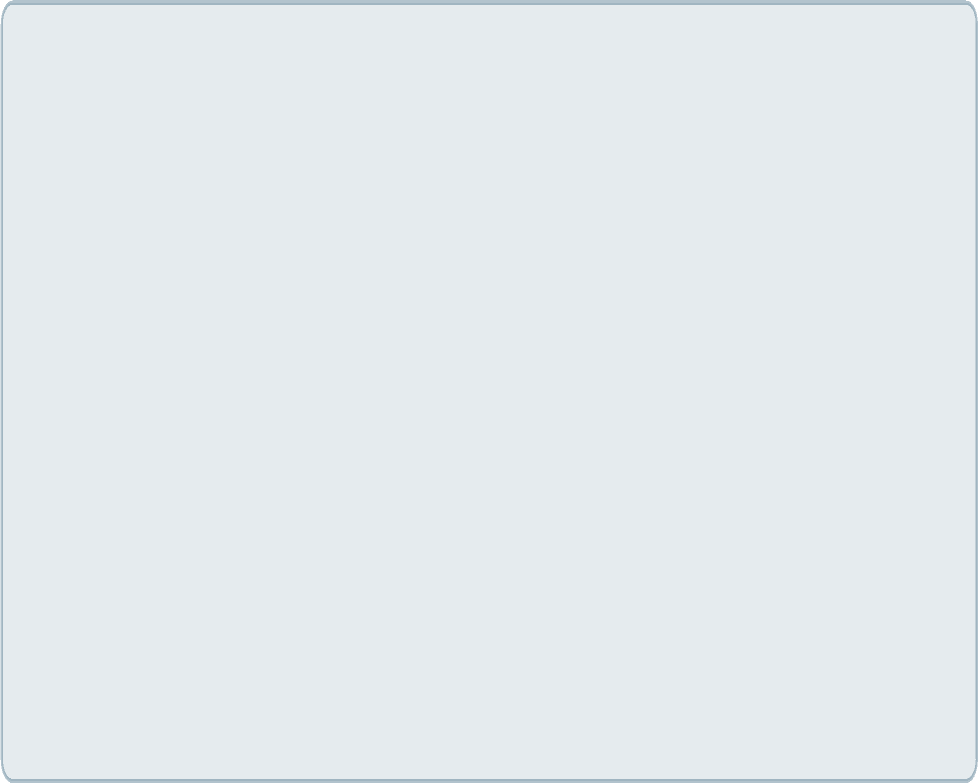
Emergency procedures:

* Expectations for response to postings, emails, telephone calls, or text messages
* Contact information and procedures if immediate follow-up is needed
* Emergency/crisis services contact information
* Steps providers may take if concerned about safety of a client

Ways for clients to protect their privacy:

* Controlling access to communications through establishing passwords, deleting cookies, and con- trolling computer access
* Understanding the risks of sharing email accounts
* Limiting or preventing the provision of identifying information on social media
* Identifying Internet security risks
* Installing virus, spyware, and malware detection software

*(Continued on the next page.)*



Charges and payment:

* What the charges for services are, including email exchanges, telephone calls, and text messages
* How charges will be billed
* What the charges will be for no-shows

Service disruptions:

* Ways to handle service disruptions
* Potential impact of service disruptions on privacy or confidentiality
* Alternative ways to contact the provider

Regulatory agencies and grievances:

* Who regulates the service provided
* What are the internal and external channels and contact information for filing a grievance

staff members in a clinical practice may access technology-based communications with cli­ ents. These policies should additionally ensure that clients do not assume that there will be real-time communication with clinicians (e.g., a policy to inform clients that they should not use a technology-based intervention to contact their clinician when in crisis, such as when experiencing suicidal or homicidal ideation, making plans, and/or exhibiting intent). All providers should put their TAC policies in writing and clearly communicate them to cli­ ents at the start of the therapeutic relationship using an informed consent agreement. It is also helpful to have clients sign off on these policies to acknowledge that they have re­ viewed them and agree to comply.

SAMHSA offers confidentiality and health privacy resources (CSAT, 2004c; [http://www.samhsa.gov/healthprivacy).](http://www.samhsa.gov/healthprivacy)) For information on providing TAC to veterans, see the planned TIP, *Reintegration-Related Behavioral Health Issues in Veterans and Military Families* [SAMHSA, planned e]).

Informed Consent

Providers of technology-assisted services are bound by the same legal and ethical require­ ments and standards of practice that apply to in-person service delivery; however, technology

introduces some additional risks and benefits that should be covered with participants in technology-assisted services. The risks and considerations vary by type of technology used, as well as the type of service delivered. The box beginning on the previous page out­ lines some of the more common considera­ tions related to technology-facilitated care.

The Digital Divide and Healthcare Disparities

Although Internet and mobile phone access is rapidly increasing all over the world, some populations may have greater access to these technologies than others. Variables that influ­ ence access include rural versus urban loca­ tions; socioeconomic status; and various de­ mographic characteristics, such as age. Even with access, some people may not be able to engage in TAC readily due to challenges with technological literacy, health literacy, or read­ ing literacy. Additionally, some technology­ based tools and interventions may not be ac­ cessible to or perceived as useful by various groups if they don't address individuals' needs in a culturally responsive manner. Clients will benefit from tools that are in the language with which they have the greatest facility.

TAC offers great potential to lessen the digi­ tal divide and address healthcare disparities

that exist in many traditional models of care. For example, although White Americans (80 percent) are more likely to use the Internet than African (72 percent) or Hispanic (61 per­ cent) Americans, African Americans are the most active users of the Internet via mobile devices. The rate of increase in the use of mobile devices to access the Internet among minority groups has, since 2007, remained at roughly twice the national average-for exam­ ple, 141 percent increased use for African Americans versus the 73 percent national av­ erage (Horrigan, 2009). By offering interven­ tions on a wide variety of platforms to capital­ ize on the technology most frequently used by various target populations (e.g., developing interventions for mobile devices for specific minority groups), TAC may offer a new ser­ vice delivery model that could substantially reduce the healthcare disparities present in many traditional care models (Gibbons, 2007). For examples of the use of TAC with Native American populations, see the planned TIP, *Behavioral Health Services far American Indians and Alaska Natives* (SAMHSA, planned b).

Technology-based therapeutic tools not only offer clinical information and support to di­ verse audiences, but also provide social and supportive functions that may be absent or inaccessible to certain populations via tradi­ tional healthcare systems. Because TAC can provide information tailored and responsive to each individual's level of understanding and needs, this approach can accommodate diverse users with differing cultural needs and varying levels of health, technological, and reading literacies (Gibbons et al., 2011).

Legislation and policy changes may soon promote broadband access and digital compe­ tence, reducing the digital divide. On May 28, 2015, the Federal Communications Commis­ sion (FCC) received proposed changes to the Lifeline Program, which has existed since the mid-1980s and was originally designed to help

people with low incomes pay for phone serv­ ices; proposed changes would allow the pro­ gram to support broadband access for low­ income individuals (FCC, 2015). Today, households with incomes of $150,000 or above have easy access to broadband services, whereas slightly less than half of households with in­ comes below $25,000 can access such services; moreover, almost half oflow-income families have had to cancel or suspend smartphone ser­ vices due to costs (FCC, 2015). As ofJune 2015, drafts of proposed legislation had been

introduced to the United States Senate: The Broadband Adoption Act (Senate **Bill** 1472, 2015) and the Digital Learning Equity Act (Senate **Bill** 1606, 2015). Passage of such types of legislation and related policy changes may help narrow the digital divide.

Electronic Health Records

Another important consideration in using technology-based therapeutic tools in the be­ havioral health arena is electronic health rec­ ords (EHRs), which are also called electronic medical records (EMRs). The terms are often used interchangeably, but an EMR typically refers to an individual's patient record created in a single healthcare setting, whereas an EHR typically collects data cumulatively across healthcare settings. EHRs are part of a larger effort to promote meaningful use of health information technology that improves

healthcare and enhances information exchange among healthcare professionals. The Health Information Technology for Economic and Clinical Health Act of 2009 and the Patient Protection and Affordable Care Act of 2010 emphasize the widespread and meaningful use of EHRs, which are intended to improve recordkeeping, outcomes reporting, patient transitions across providers (along with their medical records), and quality of patient care (by increasing communication across providers and reducing medical errors). The three main

components of meaningful use are the use of a certified EHR in a meaningful manner, the electronic exchange of health information to improve quality of healthcare, and the use of certified EHR technology to submit clinical quality measures and other measures.

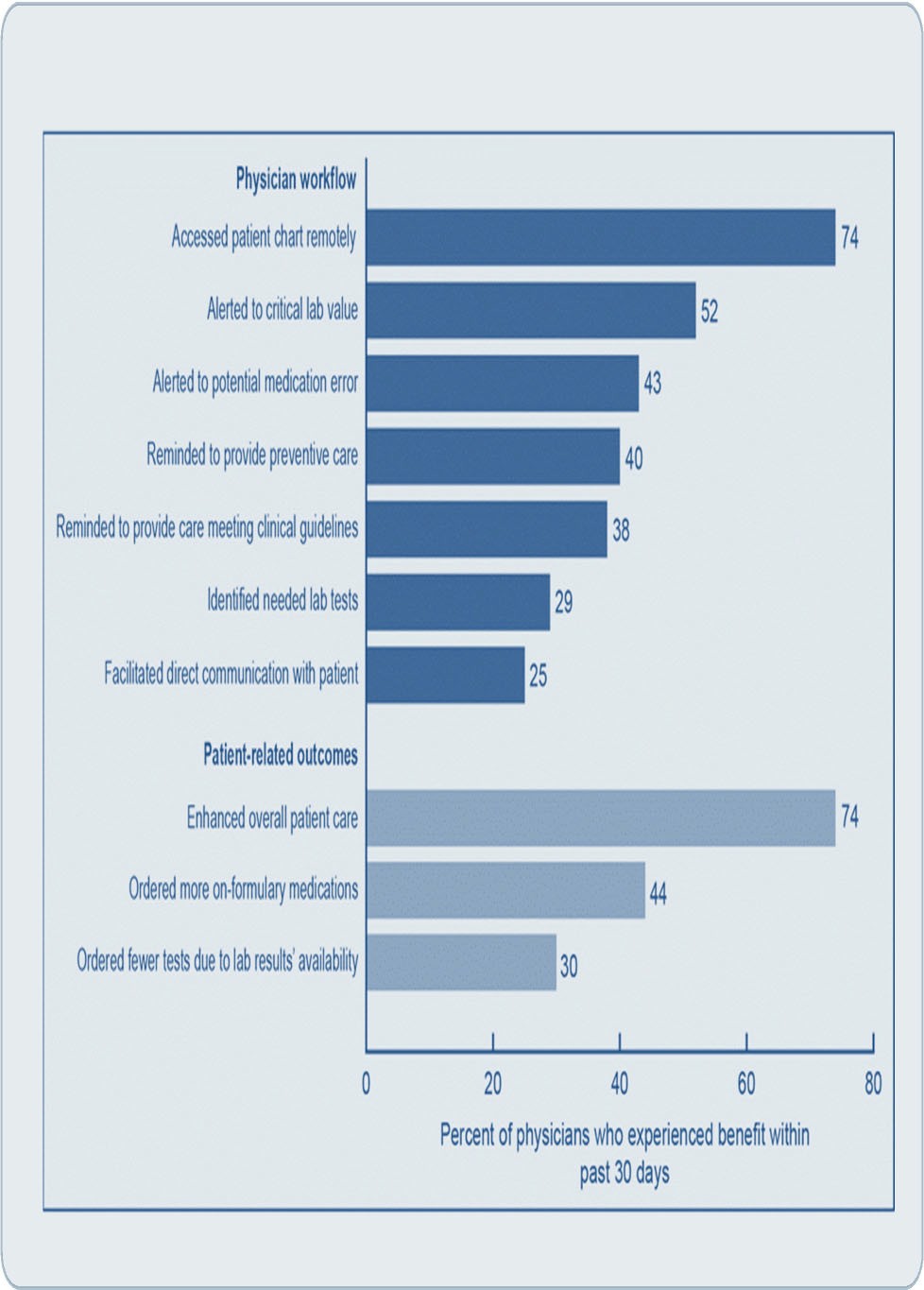
Research and development efforts with EHRs are rapidly expanding in the United States and elsewhere. A complete review of EHRs is be­ yond the scope of this TIP, but the evolution of EHRs and their application in healthcare settings are well characterized in a number of existing resources. The Agency for Healthcare Research and Qiality and the ONC for Health Information Technology provide de­ tails on EHRs online (http://www.ahrq.gov; http://www.healthit.gov).

EHRs offer considerable promise for collect­ ing data on clients' behavioral health along with other medical issues, which may enhance client-centered care and public health.

Limited work to date has focused on the inte-

gration of EHRs that include behavioral health data with other technology-based ther­ apeutic tools targeting behavioral health; combining them may markedly influence be­ havioral health services. For example, Web­ based or mobile interventions that collect data as part of screening or assessment activities could code those data in a format that is com­ patible with EHRs and then interface with EHRs to update relevant information. Such data would provide a richer, more comprehen­ sive picture of clients' behavioral health. Infor­ mation collected on a client's behavioral health in real time via a mobile application may allow for a better characterization of the client than information collected only during in-person appointments with behavioral health service providers. Such information may enable pro­ viders to manage clients' behavioral health more effectively (Exhibit 1.1-5).

At this time, there are no national standards for the collection of data on clients' behavioral



**Exhibit 1.1-5: The Benefits of Using an EHR System**

*Source: Jamoom* et *al., 2012. Reproduced* from *material in the public domain.*

health, and incompatibility among different types of EHRs impedes the efficient sharing of data. Little research to date has focused on effective strategies for integrating data from technology-based therapeutic tools into EHRs. However, SAMHSA; the National Qiiality Forum; Health Language, Inc.; and several other groups are working to fill these gaps. For example, several institutes at the National Institutes of Health, in collaboration with the Society of Behavioral Medicine, have launched an initiative to identify common da­ ta elements for client-reported measures of behavioral health, which can be used in EHRs (<http://www.sbm.org/UserFiles/file/EHR_> Meeting\_May\_2-3-2011-- Executive\_ Summary.pd£). These common data elements, such as measures of quality of life, eating pat­ terns, substance use, anxiety and depression, and stress, could be used in primary care and public health settings to screen clients for be­ havioral health risk factors. Doing so could lead to a number of possible benefits, includ­ ing improved clinical decision making (with greater involvement of clients in shared deci­ sions) and delivery of tailored, brief interven­ tions in these settings.

Emerging research and development efforts will be especially important as behavioral healthcare is increasingly integrated into other healthcare settings and, as a result, is less con­ fined to specialty treatment programs. For ex­ ample, the 2010 National Drug Control Strat­ egy from the White House Office of National Drug Control Policy (ONDCP) set several goals to integrate treatment for substance use disorders into an array of healthcare settings and not confine such treatment to specialty addiction treatment programs (ONDCP, 2010), and these goals as well as additional goals to increase integration have continued to be part ofONDCP's strategies (ONDCP, 2013). A key strategic action to meet this goal involves expanding addiction treatment into

community health centers (CHCs) and other settings that service low-income populations most often in need of treatment for substance use disorders and mental illness. A critical issue will be maintaining the specifications of Title 42, Part 2, of the Code of Federal Regulations, the confidentiality regulations that govern pri­ vacy and confidentiality of records related to substance use disorder treatment. Technology­ based approaches to assessing clients' behavior­ al health and evidence-based interventions that are responsive to clients' behavioral health risk factors may enable clinicians to conduct these activities with excellent fidelity and at low cost for broad client bases. The flexibility and ease of use of technology-delivered approaches can promote access to behavioral health services for hard-to-reach populations who use CH Cs and other nonspecialty healthcare settings for other medical services. A technological infrastructure allows collection and storage of select client data; this improves coordination of and conti­ nuity of care and activity reporting that facili­ tates service reimbursement.

Technology-based tools are also growing in use in terms of self-help techniques entirely outside of any formal healthcare-related activities.

Many health-promoting apps suggest, but do not require, coordination with healthcare professionals. It is too early to tell which technology-based tools may be helpful as stand-alone, wholly self-directed interventions and which may facilitate coordination and co­ operation. Whatever the future holds, TAC is especially likely to enhance the capacity of pri­

mary care organizations to attend to the behav­ ioral health needs of their clientele.

Concluding Comments

TAC is widely applicable in targeting behav­ ioral health and may be clinically useful across a spectrum of behavioral health and physical health services, including screening,

assessment, prevention, treatment, recovery management, and continuing care. Various electronic media are of use in behavioral health services and enable entirely new mod­ els of behavioral health service delivery. This is an exciting time for harnessing technology

to increase the quality and reach of effective behavioral health services, but a carefully planned approach for embracing TAC is es­ sential to grant behavioral health service pro­ viders and program administrators-as well as their clients-the greatest benefit.

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