

# Interprofessional Telebehavioral Health Competencies Framework: Implications for Telepsychology

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The Coalition for Technology in Behavioral Science (CTiBS) telebehavioral health (TBH) competency framework is presented to assist in using technology to affirm and adapt existing in-person clinical psychology practices. This paper identifies the theoretical rationale for the development and use of the CTiBS evidence- and consensus-based framework. It examines two derivative applications and then discusses limitations and areas for future research. The CTiBS TBH competency framework is a nested model consisting of seven competency domains (with subdomains), each of which has a distinct number of objectives, which in turn have specific competencies or practices. These then cut across three competency levels. The CTiBS framework applies an interprofessional TBH competency framework to telehealth for psychology, sometimes referred to as “telepsychology.” Relevance of the TBH competency framework is discussed for psychology education, training, supervision, and longitudinal professional development and to guide certification and licensure regulations for psychological practice.

## Public Significance Statement

This paper is written to demonstrate practical ways to implement the CTiBS Framework for Telebehavioral Health Competencies as they relate to the field of psychology. Two of the 49 published telebehavioral health objectives were examined in detail to illustrate a thoughtful approach to telepsychology and to suggest that psychologists and their organizations consider conducting self-assessments using existing consensus documents such as the CTiBS publication to determine their fitness for telepsychology practice.

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Following a review of the literature, extensive knowledge of technological advances, and a broad consensus among telebehavioral health (TBH) practitioners across six behavioral professions, the Coalition for Technology in Behavioral Science (CTiBS) used a Delphi process to develop and publish a TBH competency framework (Maheu, Drude, Hertlein, & Wall, 2018; Maheu, Drude, Hertlein, & Hilty, 2018). The effort was intended to provide a starting point for the behavioral health professions to consider self-assessment and training in the responsible use of technology to affirm and adapt existing in-person clinical practices to a digital format. The role of TBH competencies has become even more relevant since the COVID-19 pandemic, when many previously telehealth-reluctant professionals faced the choice between telepractice or no practice at all.

Defined as the essential building blocks of training, competencies are traditionally developed in a field to identify and impart needed knowledge, skills, and attitudes to engage in day-to-day professional activities. While the American Psychological Association (APA) has a robust history of developing competencies (Rodolfa et al., 2014), guidelines (American Psychological Association, 2013; McCord et al., 2020), and applicable ethical standards (American Psychological Association, 2017a), these documents lack the needed specificity for professionals or their organizations to undertake a rigorous self-assessment of telehealth competence. As a result, psychologists may still be operating with only rudimentary competence when measured against published telehealth recommendations.

At issue is that many psychologists practicing telehealth have historically been unaware of even basic telehealth legal and ethical mandates (Maheu & Gordon, 2000; Gluekauf et al., 2018). With COVID, the overwhelming majority of practicing psychologists were literally forced into telehealth adoption from 1 week to the next, without the benefit of clear training experiences to grasp even basic telehealth terms, concepts, processes, or the competencies needed for legal and ethical compliance and much less the handling of complex clinical challenges.

Attempting to act according to professional mandates, many psychologists may have responded to the COVID challenge by engaging in self-directed training, based on what they could find online, and filled in the remaining gaps with trial and error. They may not have known that an evidence-based, interprofessional set of TBH competencies existed prior to COVID-19. They may not have had the chance to apply such a rigorously developed set of competencies to their day-to-day telepractice or their search for additional training. For example, they may now use a video platform and payment system but lack the perspective to identify which features are essential for secure clinical practice and which are ill-advised for their type of practice; how to accommodate blind, deaf or hard-of-hearing individuals; or how to adjust the intervention depending on the setting of the client/patient (C/P; e.g., home alone, home with others, in prison, in a nursing home, on a job site). They may fail to properly educate their C/P about essential privacy protections; fail to include the proper informed consent (IC) elements, needlessly

putting their online group members at risk; or fail to maintain appropriate professional boundaries. Their lack of telehealth training may compromise those who seek their professionalism at particularly critical times.

To address these needs, researchers associated with the CTiBS published a framework for basic TBH competencies to help clarify previously unaddressed issues related to the complex transition from in-person to digital service delivery (Maheu, Drude, Hertlein, & Wall, 2018; see Supplemental Material for a detailed table of the CTiBS competencies framework). While psychology as a discipline includes practitioners, researchers, and academics, as well as individuals who practice in a wide range of specialties spanning forensic, industrial and organizational, school, military, clinical health, and rehabilitation—all of whom may use technology in service delivery—this article specifically addresses competencies for psychologists who are health service providers. Telehealth competencies grew in relevance to practitioners in the spring of 2020, when worldwide stay-at-home directives and emergency changes in healthcare policy and reimbursement opened the door for the broad implementation of technology-based models of care in response to the COVID-19 pandemic. In the U.S., federal and state officials eased the restrictions on telehealth (U.S. Department of Health & Human Services, 2020). Given predictions about the wide-scale rise in people seeking help for problems following stressful and traumatic events (Substance Abuse & Mental Health Services Administration, 2018), telehealth will be needed in the future to address worldwide, growing behavioral needs after COVID (Keshvaridoost et al., 2020).

Meanwhile, treatment models for individuals as well as local and international teams had been developing for decades with the introduction of technology's unprecedented ability to connect professionals across distance (Luxton et al., 2016). For the first time, primary care physicians, pediatricians, nurses, nurse practitioners, pharmacists, psychiatrists, educators, counselors, psychologists, addiction counselors, or behavioral analysts, and caregivers can now participate in digital collaboration—requiring a shared mindset about how and when technology is to be used for TBH (Drude et al., 2019; Hilty et al., 2017; Maheu et al., 2020). Given psychology's current focus of being less "siloeed," a change in mindset is needed when considering telehealth competencies to position psychology as a key player in the larger healthcare ecosystem as the world moves forward with increasingly more technology.

### Interprofessional Telebehavioral Health Competencies

In 2003, the Institute of Medicine (renamed the National Academy of Medicine), identified "... a set of basic, core competencies that all health clinicians should possess, regardless of their disciplines, to meet the needs of the 21st-century health care system" (Institute of Medicine, 2003). These included competencies to work in interdisciplinary teams and utilize information technology appropriately (Greiner & Knebel, 2003). Since then, competencies have often been considered a foundation for training and workforce

development in all healthcare areas. They provide indicators necessary for the development of an effective curriculum for training, orientation, and continued staff development, while also providing indicators to inform workers and their supervisors of job performance requirements (Centers for Medicare & Medicaid Services, 2013). Despite the passage of decades since the need for competencies was established, progress has been slow to meet the many educational and training needs of graduate students and independent practicing professionals (Dreyfus & Dreyfus, 1980). As interprofessional education (IPE) is defined by Barr and colleagues, “IPE enables two or more professions to learn with, from and about each other to improve collaborative practice and quality of care. Well planned and conducted, it can promote flexible, coordinated, complementary, person centered and cost-effective collaboration in interprofessional teams within a policy-aware understanding of organizational relationships. IPE recognizes and respects profession-specific requirements and safeguards the identity of each profession. Dealing in difference, it works towards meeting competency-based outcomes within a common framework” (Centre for Advancement in Interprofessional Education, 2002, p. 4). However, within the realm of telehealth competencies, existing standards, guidelines, and other peer-reviewed documents to date have done little to acknowledge interprofessional values (Hilty et al., 2017), despite a shared working focus with other behavioral professions on similar clinical telehealth practices, expectations, and ethical standards. When considering how psychology can move to a more interprofessional model, the lack of consensus about general psychology competencies can be viewed as an additional barrier. The APA Benchmarks model (Fouad et al., 2009) drives the APA accreditation standards for doctoral psychology programs (American Psychological Association, 2018). The Cube model (Rodolfa et al., 2005, 2013) is used to inform the development of competencies for psychology practice specialties. Neither of these models outline telehealth competencies as they pertain to psychology.

### Competencies in Telepsychology

Efforts to develop competencies in telepsychology (TP) have been documented in the professional literature. Johnson (2014) article in *Canadian Psychology* proposed a TP competency framework for competency standards based upon the competence framework earlier adopted by Canadian psychology licensing bodies and described in Mutual Recognition Agreement of the Regulatory Bodies for Professional Psychologists (Council of Provincial Associations of Psychologists, 2001/2004) but did not seem to prompt further work. A more recent attempt was made by the CTiBS, an interprofessional coalition, whose mission is to foster the responsible use of technology in the behavioral sciences. The group formed in 2014 to address the need for such a consensus. It appointed a task force of professionals from six behavioral professions to develop the competency framework: psychiatry/addictions, psychology, social work, marriage and family therapy, counseling, and nursing. CTiBS created and published an interprofessional TBH competency framework (Maheu et al., 2017) that outlines a comprehensive yet practical range of dimensions impacting telebehavioral practice for three levels of practitioners: novice, proficient, and authority. An IPE focus allows the framework to be used for professionals across disciplines within teams that serve similar types

of C/Ps using shared technology while complying with shared legal and ethical mandates.

### Goals

The CTiBS TBH interprofessional competencies framework provides a foundation for the advancement of TP in policy development, research, law, regulatory and ethical requirements, training, and practice. The forced adoption of telehealth during COVID-19 has exposed an even greater need for interprofessional and international collaboration in telehealth training as countries worldwide struggle with responding to the growing need for digitized behavioral care. Although differences in individual and aggregate components of professional knowledge, skills, attitudes, and personal qualities will continue to exist among behavioral health professions, the CTiBS TBH framework provides an organizational structure for collaboration.

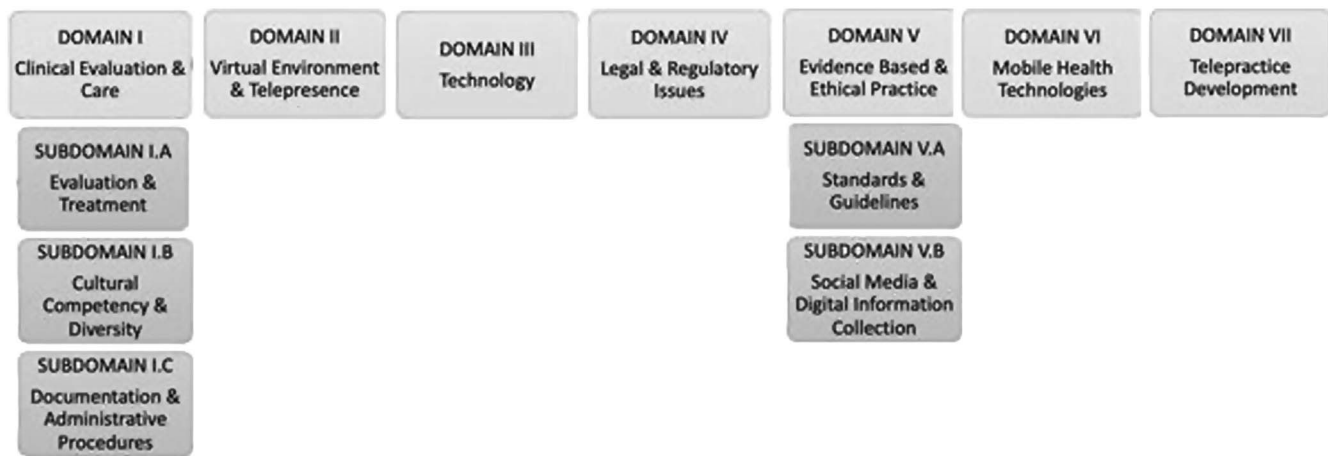
For telepsychologists, the CTiBS competencies provide a way to conduct a top-down, broad-to-specific assessment of competence (i.e., knowledge, attitude, or skill for TP). They allow the clinician to identify needed areas for telehealth or teletherapy training and other key aspects of risk management, as suggested by Kennedy et al. (2014). For educators, supervisors, and trainers, they provide a framework for evaluating the telepractice competencies of students, supervisees, and trainees. Relevant issues in education and training may include (a) the value of competencies in teaching and evaluating TBH practice, (b) strategies for teaching TBH competencies across disciplines in graduate curricula, and (c) learner-specific approaches to guide teaching, assessment, and evaluation of skills and attitudes beyond knowledge acquisition.

The discussion herein proposes the adoption and use of the interprofessional CTiBS TBH competency framework to more actively research and develop a consensus for TP competencies. Such efforts could provide opportunities for psychologists to improve self-assessments; integrate education and training (i.e., curricular and supervisory); and inspire efforts toward longitudinal professional development (i.e., certification) and professional bureaucratic activities (i.e., licensing, accreditation, and other credentialing). These goals are particularly important, given the predicted rise in new individuals and families seeking access to behavioral health services, based on prior disaster/large-scale trauma research related to quarantine and isolation (Furr et al., 2010).

### CTiBS TBH Competency Framework

The CTiBS Competencies Task Force met bimonthly over 40 months using a Delphi process to propose, disseminate, collect, integrate, and apply the results of an extensive literature review to develop a proposed document that then was made public for two rounds of widely published open comments. Several related papers have been published. The first outlined the need for an interprofessional TBH competency model (Hilty et al., 2017). The second paper described the process, provided the proposed competencies, and proposed that interprofessional TBH framework serve as a foundation for further research (Maheu et al., 2017). A corrected version of that paper (Maheu, Drude, Hertlein, & Wall, 2018) contains the list of TBH competencies in a framework table (Figure 1 shows a summary of the competencies. The entire,

**Figure 1**  
CTiBS TBHI Competency Framework Domains and Subdomains



more comprehensive table is in the [Supplemental Material](#)). The CTiBS TBH competencies were then applied to telepsychiatry (Maheu, Drude, Hertlein, & Hilty, 2018). A paper focused on self-assessment and/or training of independently practicing professionals providing TBH was next published (Drude et al., 2019). The most recent publication from this team involves a textbook and learning modules for graduate learners (Maheu et al., 2020).

### Interprofessionalism and Psychology

Based on an “interprofessional” model, which is inclusive of many related professions, this article challenges the reader to consider the commonalities rather than the differences between psychologists and social workers, counselors, MFTs, psychiatrists, behavior analysts, nurses, and so forth. While there are differences across the professions using technology, they are far fewer than might be imagined at first glance. The article then is a challenge to psychologists to move beyond the psychology “silo” to consider telehealth competency-related commonalities, rather than differences, between behavioral professional practice when using technology in an integrated health model, for example.

The CTiBS TBH interprofessional competency framework is a nested model consisting of seven competency domains (with subdomains), each of which has a distinct number of objectives, which in turn have specific competencies or practices. These then cut across three competency levels. More specifically the framework is organized using four dimensions: (a) seven domains (and subdomains); clinical evaluation and care (assessment and treatment, cultural sensitivity and diversity, documentation and administrative procedures); virtual environment and telepresence; technology; legal and regulatory issues; evidence-based and ethical practice (standards and guidelines, social media); mobile health and apps; and telepractice development; (b) 49 objectives; (c) 146 competencies or “practices;” and (d) grouped into novice, proficient, and authority levels.

Shown in [Figure 1](#) are the CTiBS TBH domain and subdomains, where each have three competency levels, Novice, Proficient, and Authority. Novice practitioners include advanced students, residents, or interns. Practitioners at this beginning level have an

awareness of TBH and know basic TBH rules and procedures. Proficient professionals include practitioners nearing graduation, independently practicing, or supervising. They make well-considered, informed decisions based on the evidence; have the skills and attitudes to conduct a wide range of TBH clinical duties; know how to choose the appropriate technologies, protocols and processes; and maintain and document compliance with legal and ethical requirements. Authorities research, train, and consult TBH at an advanced level using evidence-based and consensus-based approaches derived from informed leaders in the field.

### The CTiBS TBH Competencies: Highlights From Two Domains

Given the limited space herein, only two of the seven CTiBS TBH domains are highlighted from the larger framework. These two were chosen for the current article to illustrate real-world considerations that have surfaced in telehealth training provided by the majority of this article’s authors. They are offered here to illustrate how the competencies can be used to identify and guide training. The following discussions then briefly describe how to apply Domain #1 (Clinical Evaluation and Care) and Domain #4 (Legal and Regulatory Issues).

#### Clinical Evaluation and Care Domain

The first CTiBS TBH competency framework domain, that of Clinical Evaluation and Care, contains three subdomains: Assessment and Treatment; Cultural Sensitivity and Diversity; and Documentation and Administrative Procedures (see [Figure 1](#)). Because of space limitations, only the first subdomain (Assessment and Treatment) is outlined. The Clinical Evaluation and Care domain identifies these seven telebehavioral objectives: assessing for C/P appropriateness for TBH services; assessing and monitoring C/P comfort with TBH; applying/adapting in-person clinical care requirements to TBH; implementing and adapting a TBH service plan with policies/procedures adjusted accordingly; monitoring therapeutic engagement related to each TBH modality; establishing and



maintaining professional boundaries; providing training, supervision, and/or consultation to others (for Proficient and Authority).

Given the space limitations of this article, the next discussion will address only one of the seven above-identified TBH objectives to give the reader an example of the considerations related to the Clinical Evaluation and Care domain, that of “Applying/adapting in-person clinical care requirements to TBH.” This discussion will consider behaviors and approaches consistent with Novice, Proficient, and Authority levels of competence for this domain and will end with an illustrative case vignette to highlight relevant issues.

### ***Novice-Level Professional***

The Novice telepsychologist is able to conceptualize the specific skills, knowledge, and shift of attitudes that are needed to practice TP competently, ethically, and lawfully. They set aside extra time prior to the first videoconferencing session to answer questions and help C/Ps become adept at using the therapist’s chosen technology. They recognize and manage their possible personal discomfort while focusing their efforts on addressing the C/P’s potential discomforts and needs. For example, they need to know that a common C/P fear related to videoconferencing is that the video will appear on YouTube for their friends and family to see. Novices are expected to recognize the importance of adapting their established in-person clinical skills to the TP environment, such as how they start and end the session, deal with technical issues, and address IC. Novices reflect upon their use of silence, their personal disclosures, their ability to form a working alliance, their handling of unexpected events in the C/P’s environments, uncooperative C/Ps, and their adherence to treatment plans. While the use of technology may open up new capabilities, both professionally and financially, the Novice TP psychologist must recognize that these new capabilities may bring new risks, for example, privacy and responsibilities that differ from the in-person setting in significant ways. It is incumbent upon the Novice to reflect on ways in which their practice is changed in the TP setting and to seek help from TP-informed supervisors and mentors to address these issues and keep them in line with therapeutic goals.

### ***Proficient-Level Professional***

The Proficient telepsychologist recognizes the clinical challenges and risks inherent in the TP setting and has found or developed ways to successfully adapt their skills and in-person treatment protocols to TP settings. This process happens incrementally for different settings over time, and across the full range of the psychologist’s skill set, with the use of clinical intake and assessment tools and processes, by identifying and systematically learning to adapt and accommodate processes to meet treatment goals. Moreover, the Proficient telepsychologist spends time thinking through how to prevent crises. Their clinical reflexes are developed to the point of knowing and adapting to the unique capabilities of the technology chosen to mediate the therapeutic relationship. They do their best to anticipate when a crisis is likely to occur and arrange as many treatment variables as possible to prevent it.

The Proficient telepsychologist has carefully considered the breadth of clinical issues faced on a daily, weekly, monthly, and even annual basis and developed practice skills to address the full range of complex clinical scenarios that can easily spin out of control

and create trauma when unanticipated. For example, they have developed their command of the therapeutic relationship enough to know how to gently yet firmly take command of the originating site and ask that the C/P “find a private space”; that the door be “closed and locked” when a door is available; and that the C/P be seated, facing the monitor. They are assertive enough to ask that the session be stopped so the C/P gets a nightstand light if improperly lit; “put on a shirt” if improperly clothed; or “sit up with your feet on the floor” if lying in bed with the phone held overhead for the session. Proficient TBH skills for some telepsychologists can take months to develop. Some such skills are often best learned in formal training and/or with supervision or consultation for added guidance when working with complex clinical scenarios.

As mentioned previously, the Proficient telepsychologist would have sufficiently thought through potential privacy issues such as interruptions and intrusions to know how to intervene when they occur, either in their own location or in those of their C/Ps. The Proficient telepsychologist strives to assure, through an opening protocol and other factors, that the C/P is alone, preferably in a room with a locked door, or if the setting is not ideal, the interaction is taken outdoors, to the C/P’s car, or gently terminated—or other such clinically appropriate accommodations are negotiated and thoroughly documented.

Proficient telepsychologists are responsible for establishing their virtual offices or services in a manner that is supportive of evidence-based care, including the means to conduct full and proper intakes, mental status exams, and other assessments—all as expected in a typical brick-and-mortar practice. Such information includes obtaining full and appropriate IC (both initially and ongoing); gathering a full history; giving and receiving local written referrals; accurately documenting goals and the course of treatment; drafting plans for preventing and handling emergencies; offering continuity of care; and meeting other typical clinical obligations.

The Proficient telepsychologist seeks appropriate training and/or consultation and documents these experiences. They know how to prevent and manage complex clinical scenarios with a detailed screening and IC process. For example, this telepsychologist conducts an intake that is consistent with in-person intakes. When appropriate, these involve items of a TP-specific mental status examination (MSE), documentation of symptom checklists and assessment of daily living skills, and physical functioning that are administered through voice via video conferencing. Written aspects of such evaluations are attempted by asking the C/P to write or draw items as usual but to hold them up to the camera for viewing by the telepsychologist or be mailed using surface post to quickly reach the telepsychologist.

Proficient telepsychologists also can involve local brick-and-mortar healthcare services (e.g., primary care physician’s office, federally qualified health center, certified community behavioral health center) to assist with verifying identity and other intake processes such as administering assessments. Practitioners can verify a C/P’s identity by (a) providing an in-person registration process; (b) participating in an in-person intake prior to treatment; (c) providing treatment through telehealth sites that verify identity (i.e., employer-sponsored telehealth programs); or (d) providing a “shoestring” identity confirmation (e.g., secure transfer of photo IDs or having the C/P hold a photo ID up to the camera). However, verifying a C/P’s identity is more difficult when providing TP services to unsupervised settings such as the home.

Proficient telepsychologists are expected to understand and control their communication technology and assist their C/Ps in managing theirs. Reasonable efforts are made to accommodate for people with audio and visual limitations. More specifically, the telepsychologist is aware that a C/P's rate, rhythm, and volume of speech as transmitted through a microphone can all be affected by technological factors (e.g., placement and volume settings of microphone and speaker, bandwidth, and connectivity) and considers such factors in assessment and documentation processes for people who are blind, deaf, and hard-of-hearing or who have limited hand or motor control. Adaptations are offered and made for C/Ps who have disabilities.

Similarly, the Proficient telepsychologist takes into account that the assessment of eye contact, psychomotor activity, and movements can be affected by the quality and placement of the camera, the lighting, the space allocated for the TBH encounter, and the quality of internet connectivity. Other indicators of C/P functioning such as the ability to complete activities of daily living may go unnoticed in TP encounters. The assistance of C/P friends or family may be needed. In addition, the TP practitioner is unable to discern the smell of alcohol or body odor through a videoconferencing session. Injuries such as cuts or bruises, whether self- or other-inflicted, may also be easy for the C/P to hide and therefore imperceptible to the professional. When C/Ps demonstrate difficulties or idiosyncrasies in any of these areas, Proficient telepsychologists make dedicated efforts to discern if the C/P's presentation has been affected by technological or environmental setting factors. Assessment is enhanced by asking direct questions of the C/P, asking them to stand, walk, turn, etc. They can be asked to hold their fingernails to the camera for a quick telehealth assessment of hygiene. When possible, again, the Proficient telepsychologist enlists the aid of collaborators (preapproved friends and family) or other local professionals to augment intake and therapy through collaborative models. Deaf and hard of hearing patients may need the psychologist to move more closely to the monitor to further enable lip-reading. Also, the text telephone (TTY) service available through telephone companies can be engaged by the proficient telepsychologist to type the verbal portions of live webinars. Also, some cues such as olfactory might be irretrievably lost. Therefore, telehealth is not for everyone.

As with delivering in-person care, Proficient telepsychologists have taken the time to consider and write emergency and crisis plans for every C/P treated. These plans are discussed and agreed upon at the initiation of TBH services. During the initial IC process, psychologists inform C/Ps about the steps that will be followed in case of emergency or crisis. Emergency contacts are named along with contact information in the IC document. Telepsychologists may have the legal authority to treat in the state where the C/P is located, but not have access to resources where the C/P is located. Proficient telepsychologists are aware that simply dialing 911 will connect them to their own emergency services, not necessarily the ones in the C/P's location. Proficient telepsychologists are aware of crisis resources in the C/P's locality and develop working agreements with those local resources when feasible. The Proficient telepsychologist collects, documents, and discusses one or two of the C/P's verified emergency contacts during the IC process, notating their names along with a description of what these contacts will be told and when.

The Proficient telepsychologist adapts in-person standards for supervision to the telesupervision environment through an orientation to the process that is very similar to orienting C/Ps to telehealth treatment. Back-up plans are reviewed in case of technology failure. Feedback is elicited from supervisees about their telesupervision experiences. Telesupervisors are also well versed in the legal and ethical requirements of all their supervisees, including those from different professional groups, such as social workers, counselors, and so forth. Telesupervisors are compliant with regulations related to cultural sensitivity and technology issues (see Maheu, Drude, Hertlein, & Wall, 2018; Maheu, Drude, Hertlein, & Hilty, 2018, under Sections I.A and I.C in the Supplemental Material).

Additional adaptations range from in-person practice to TP. In fact, in-person and TP practices have many similarities, such as interview style, treatment planning, and the prevalence of strong emotions. Telepractitioners are encouraged to ask their C/Ps about their use of, preference for, and experience with technology in their personal lives as well as in clinical care. Substantive differences between in-person and telepractice services can quickly become apparent (e.g., establishing and maintaining boundaries; administering assessments; managing emergencies). Preventative planning or training is suggested for dealing with each. In fact, it is advised to train, practice with colleagues or, at the very least, with friends or family members until adaptations become reflective enough to skillfully manage challenges. Such challenges may include organizing protections for privacy and security; adjusting to unpredictable settings; navigating multiple regulatory requirements; navigating unreliable technology; assessing appropriate C/P selection; preventing and managing complex clinical issues without adequate forethought; preparing for moderating emotional reactivity when using technology, including one's own sense of powerlessness in an emergency with TP, such as when dealing with a C/P's self-mutilation, abuse, or suicide or homicide threats. Potentially litigious topics such as when to call the authorities or other external supports can also become thorny, leading the unprepared psychologist to react impulsively, only to deliver substandard care and possibly risk harm. Aside from the liabilities involved, such practice can also be experienced as anxiety-provoking in a world where the guidance of trusted supervisors and colleagues may be lacking. The Proficient telepsychologists develop an informed and supportive peer supervision group when possible.

### ***Authority-Level Professional***

Professionals at the Authority level of TBH competency may teach the fundamentals of TP clinical care, provide supervision, and train others to apply information and resolve dilemmas/conflicts related to complex clinical, legal, regulatory, and other issues. They may help with the integration of clinical care across settings, clarify documentation requirements, and work with interprofessional teams where requirements can differ across disciplines. They can help resolve conflicts that might otherwise preempt TP with teams. The TP Authority, then, assists practitioners with their respective clinical protocols, assuring that they meet all professional ethical, legal, and regulatory requirements related to TP, as well as those of their referral's sources, such as local hospital emergency departments. The Authority investigates all relevant requirements and assists the agency in resolving conflicts so as to maximally serve the populations they seek to treat through TP. The telepsychologist working at

this level may assume several roles related to clinical evaluation and care, including education and training of practitioners, consultation, supervision, and research related to TP.

### *Vignette*

An asylum-seeking C/P by the name of Manuel has been in a Mexican detainee camp for the last 8 months. He successfully traveled to his wife in Northern California last week but is now being referred for a telehealth consult by the local Catholic priest who was called in to assist the couple after their domestic altercation last evening. The referral requests that Manuel be evaluated for Post-traumatic Stress Disorder (PTSD), verbal, and physical aggression, as well as cognitive impairment secondary to repeated head trauma.

The telepsychologist is a bilingual, mid-career psychologist who is relatively new to telehealth. Toward the end of the first session, the C/P informs her that he is feeling desperate. Upon inquiry, the telepsychologist determines that Manuel has been having thoughts of suicide and that the knife he intends to use is on his desk, next to his laptop. The psychologist quickly works to adapt her in-person crisis management skills to telehealth. Her first goals are to de-escalate the situation, stabilize the C/P, and engage immediate support systems. She successfully de-escalates his immediate plan by supporting his involvement with the currently available resources through the priest and telehealth. She then explores his awareness and concern for the impact of his suicide on his wife, who has been awaiting his arrival for months.

Next, the telepsychologist asks for his agreement to remain connected. He agrees to stay on the call. She also asks him to keep his hands in front of him where she can see them while they talk, and he agrees. The psychologist asks if there is anyone in Manuel's home who can be invited into the session and informed of his suicide risk. The C/P states that he is home alone, but states that he is willing to call his wife, who is out grocery shopping. The psychologist assesses Manuel for risk of harm to others and determines that he does not appear to be at risk for harming others. The psychologist asks if she can call Manuel's wife while allowing Manuel to see and hear the psychologist's conversation. Calling the wife directly provides the psychologist the opportunity to further assess for any history of violence and the wife's perception of risk. The C/P agrees, and the psychologist calls his wife. The wife denies any history of violence in the relationship and agrees to return home to join the therapy session. While waiting for the wife, the psychologist assesses the C/P for protective factors and focuses on continuing the de-escalation of his emotional state while recruiting community resources.

Once Manuel's wife arrives, they review the C/P's crisis plan together. His wife agrees to take the knife out of the room and put it in a safe place. When she rejoins the session, the psychologist explains her concerns for the C/P and her assessment of his overall risk. The C/P's wife agrees to not leave him alone for the next 48 hr. They identify triggers to emotional distress and develop a plan to mitigate these triggers for the next 48 hr. The C/P is cooperative and agrees to allow her to remove sharp objects from his home and agrees to allow his wife to manage his medication. The telepsychologist is connected to the telehealth network in her local community. She successfully refers Manuel to a local prescribing professional for evaluation the next day. She knows the prescriber, who received advanced telehealth training. Before ending the session, the telepsychologist reviews the importance of not leaving the C/P alone and

works with the couple to identify a supportive relative who can be contacted if needed. They agree to a schedule for self-care, sleep, and nutrition for the next 48 hr. The psychologist reviews a basic decision tree with the C/P and his wife and instructs the couple to go to the emergency room or call their local emergency services if the C/P is unable to follow the crisis plan or remain safe. The next day, they work together again. In the session, the wife calls the priest with her husband's permission to recruit local support. This process was carefully noted in the patient chart by the telepsychologist. The priest agrees to follow up directly with them tomorrow. He is aware of and will get more information about a group at a neighboring church for men who have immigrated from South America by means of one of the border camps. Assessing, addressing, and managing C/P suicidal and/or homicidal ideation can be daunting even for seasoned clinicians. As highlighted in this vignette, responding to C/P behavioral health crises can be challenging through telehealth. A skilled telepsychologist, however, adapts an in-person suicide treatment protocol to de-escalate, support, and deliver a care plan to assist a volatile, suicidal, traumatized immigrant and his wife.

### **Legal and Regulatory Issues Domain**

Although abbreviated in comparison with the first example of the considerations needed by telepsychologists, this next section nonetheless highlights a second competency domain identified by [Maheu, Drude, Hertlein, and Wall \(2018\)](#) and [Maheu, Drude, Hertlein, and Hilty \(2018\)](#)—that of the TBH Legal and Regulatory Issues domain. It consists of the following four telebehavioral objectives for the competent telepractitioner. (a) Adheres to relevant laws and regulations. (b) Practices in accordance with and educates others on the need to follow relevant legal and regulatory standards. (c) Applies/adapts in-person standards to TP. (d) Attends to TBH contextual and overarching jurisdictional issues in a reasonable fashion.

A major objective within the TBH Legal and Regulatory Issues domain is "Adheres to relevant laws and regulations." The following discussion defines terms, offers a sampling of issues relevant to this stated objective, and, as with the previously discussed objective, ends with a case vignette.

Laws (enacted by legislative bodies) and regulations (adopted by regulatory agencies) may exist and apply at both the federal and state levels. Legislative bodies pass laws to govern the practice of psychology (or any other regulated activity), and regulatory bodies adopt rules that implement those laws. Additional factors affecting TP may include standards published by nongovernmental regulatory authorities and agencies as well as standards and recommendations from professional organizations. It bears noting that standards produced by these entities may overlap or even conflict with each other or leave areas of ambiguity. Key entities potentially requiring review include National professional associations; Joint Commission on Accreditation of Healthcare Organizations (JCAHO); Council on Accreditation (COA); Commission on Accreditation of Rehabilitation Facilities (CARF); Utilization Review Accreditation Commission (URAC); and the Healthcare Information and Management Systems Society (HIMSS).

### **Major Legal and Regulatory Compliance Issues**

Three areas commonly impacted by TP are IC, mandatory reporting, and emergency planning. These critical areas may each

be interpreted differently by regulatory bodies in different jurisdictions. The requirements for obtaining IC—both generally and in the practice of TP specifically—often vary, as do requirements for making explicit emergency plans with some or all C/Ps. Likewise, laws mandating reporting of child or elder abuse, for example, exist in nearly all jurisdictions, but who is mandated to report abuse and the nature of the reporting process itself may vary widely across states. When providing services across jurisdictional lines, mandated reporters afforded immunity in one state might not enjoy the same protections in another jurisdiction, resulting in potential liability exposure for breaking confidentiality. It is incumbent upon the psychologist to know not only the laws and regulations for practicing TP in any jurisdictions relevant to their practice, but also the standard of practice in those jurisdictions, as those standard practices are more likely to be applicable to, but not obvious to, the unaware practitioner.

### **Novice-Level Professional**

The Novice telepsychologist recognizes that TP practice may bring multiple regulatory issues into play and that relevant regulations commonly vary across jurisdictions. The prudent telepsychologist recognizes the principle that “practice occurs at the patient’s location” and takes steps to become aware of which jurisdictions apply in which situations, complying with them as required. They reach out to their supervisor, conduct an internet search for state law, and contact the state licensing board and other resources to clarify the situation.

### **Proficient-Level Professional**

The psychologist operating at the Proficient level understands the jurisdictional requirements of all geographic areas they enter to deliver care and have taken the required measures to document compliance with all relevant state laws and regulations as needed. They routinely ask their C/Ps to identify their location at the beginning of every meeting and document it accordingly before starting every session. They monitor regulatory changes in relevant jurisdictions and recognize situations in which regulatory guidance is unavailable or unclear and take steps to obtain consultation in such situations.

### **Authority-Level Professional**

The Authority-level telepsychologist can follow legal and regulatory developments in multiple jurisdictions and quickly update applicable reference information as it changes or becomes newly available. The Authority is aware of the history and context of many regulations and can both reason through difficult cases and anticipate areas of ambiguity before they develop. Finally, the Authority can teach and advise others how to identify relevant legal issues, pursue accurate and applicable information, and research and develop resources to help others maintain their level of competency across states and internationally.

### **Vignette**

A psychologist was forced to offer video services from home during the COVID pandemic. She checked with her licensing board, only to find that it made no mention of TP, but that her state

Medicaid rules allow reimbursement for psychological services provided via live video. She also learned that the APA’s ethical code and TP guidelines support TBH care. She reviewed the literature to find validated telebehavioral treatment protocols for the C/Ps she serves and then worked with her employer to ensure that the services, IC process, and documentation meet state (including Medicaid) and all relevant professional practice standards.

Three months later, a clinic in a neighboring state asked her to work part-time for them using their telehealth system. She learned that both her home state and the neighboring state have enacted Psychology Interjurisdictional Compact (PSYPACT), the psychology interstate compact advanced by the Association for State and Provincial Psychology Boards (ASPPB). She learned how to become eligible for an E.Passport through PSYPACT, which will allow her to practice virtually in the neighboring state.

She learned that the neighboring state has specific laws about obtaining IC for telehealth services, something her home state did not require. Further, she learned that the new state requires obtaining parental consent for children and that written emergency plans were required for children seen via live video. Some of these rules were delineated in the psychology licensure regulations, but others were in the state Medicaid Provider Manual. She carefully weighed the requirements for practicing in the neighboring state and made updates to her policies and consent documents to cover a wider range of potential regulations.

As is evident in this vignette, the practice of TP can be relatively straightforward in some circumstances, but its complexity can quickly escalate with the number of jurisdictions or other factors that come into play. All competency levels of telepractitioners are aware that some areas of practice may be ambiguous or simply unrecognized in the applicable jurisdictional regulations, and all will have ways of expanding their knowledge of policy through consultation and research.

## **Discussion**

The impact of telecommunications technology on psychology is both broad and deep. The COVID pandemic has made it clear that telehealth is feasible, legal, and ethical for healthcare in general and especially for behavioral healthcare. The challenge for tomorrow is to keep professionals aware that technology keeps evolving, bringing new requirements for telehealth competence. The proficient practice of telehealth is not intuitive. For every new technology, new competencies are involved. It is troubling that the various behavioral health disciplines have not always kept up with the pace of these advances, particularly regarding the education and training of tomorrow’s practitioners and licensees. Meanwhile, the psychologist’s awareness of what is happening in the larger telehealth world is of utmost importance to the profession. For example, many large, heavily funded startup companies are making unfounded claims that text-only interventions, for example, equate to the “digital version” of in-person practice, without supporting evidence. Nonetheless, thousands of unwitting clinicians are flocking to such companies without considering the data as well as their legal and ethical mandates. Unaware of needed competencies, they may not realize that conducting a proper digital IC that involves a clinician-to-patient *discussion of risks or a formalized opportunity for question-asking* is a legal mandate. Unfortunately, without knowledge of telehealth competencies, thousands of licensed professionals are



already allowing online employers to dictate telepractice protocols. The lack of understanding about privacy and security compliance about data storage and electronic patient data is another concern.

As psychology shifts from a profession-specific to a team-based focus through initiatives such as integrated health and interprofessionalism, identifying competencies applicable across professions are playing an increasingly important role. Given the immediate shift to technology by most psychologists due to the sheltering-at-home response to COVID, a broad, an interprofessional model of TBH competencies is needed now more than ever. The CTiBS TBH framework offers a top-down, overarching yet granular perspective to the day-to-day functions of telepractice by psychologists. The CTiBS model also offers an interprofessional view of competency from an integrated healthcare perspective. However, this integrated approach may not fit all psychologists, in all settings, or within all functional teams.

Many psychologists may not know the full range of what they need to know to provide competent and ethical services using technology. Well-defined competencies that identify the legal, regulatory, ethical, and professional issues implicated in using technology can guide psychologists in how to provide TP services appropriately. It is therefore crucial for the welfare of all people treated by psychologists that all psychologists, whether or not they choose to work with technology, are made aware of the challenges and risks inherent in the application of new telecommunications technologies to our field. Challenges to established professions are not only being noted by psychologists, but also by concerned leaders in other behavioral healthcare professional associations (Groshong & Aaronson, 2019). Despite the importance of these points of connection across professions, the reach of these interprofessional efforts is dwarfed by the multimillion dollars available to well-funded TBH companies and startups, who have the ability to set the bar for behavioral health services in unprecedented and difficult to control ways.

## Limitations

There are limitations to this article, the described CTiBS TBH competencies, and the competency-related telehealth and psychology literatures. The article attempts to concisely review these complex topics: TBH; the TBH competencies; their similarities/differences to in-person care as illustrated with two brief examples; applicable psychological research, professional development, and training.

Other limitations also exist. The CTiBS TBH competencies Task Force members included representatives from six professions in behavioral healthcare. However, to be yet more generalizable, a more comprehensive group would need to include a diverse group of representative practitioners to address the entire range of practices, varying racial/ethnic/cultural backgrounds, gender orientation, religions, educational levels, geographic locations, populations served, relevant technologies, and other factors within each of the interprofessional groups addressed by the competencies.

Furthermore, considering the many types of psychology and the many types of psychologists that exist worldwide, the competencies framework is not exhaustive and therefore is most assuredly lacking when psychology is considered in light of international practice. It is possible that a more diverse group of representative practitioners, including those in non-U.S. countries, will be needed to address the

entire range of factors of relevance. Additional investigation is also warranted in how accessibility issues must be addressed with individuals with disabilities, such as deaf/hard-of-hearing individuals (Wilson & Schild, 2014). The TBH competencies also could be further developed to include the need to implement, evaluate, and link them to quality-of-care outcomes. In addition, using a separate Delphi group (de Villiers et al., 2005) could perhaps yield other competencies. Finally, given the pace at which technology-related practice is changing, the current CTiBS TBH competencies may soon be outdated.

## Next Steps

As concluded by Pierce et al. (2020), “Organizations interested in encouraging telepsychology use should adopt policies supporting the use of telepsychology and provide adequate training to do so.” If the CTiBS TBH competency framework is adopted for TP, as is suggested by this research team, next steps may include identifying ways students, supervisees, and trainees can access relevant resources for their educational programs (Maheu et al., 2020). Although challenging, such access might include dedicated educational time for TBH in existing educational, supervision, and training. Even more challenging, a TBH competency focus may require that educators, supervisors, and trainers themselves train or demonstrate their TBH competence before being trusted with training roles. Teams of behavioral professionals using technology are already being brought into solving complex problems across distance, especially since COVID-19. Understanding these TBH competencies and how they influence telepractice could better inform attorneys, administrators, regulators, and policymakers, who are tasked to advance laws, policies, or guidance related to telehealth. In addition, such understanding could help policymakers be better equipped to effect, promote, and support interprofessional and collaborative telepractice models.

An extension of the APA Benchmarks or Cube models may be warranted and is left for future research, if appropriate. The relative value of each domain, objective, and competency in the CTiBS framework is yet to be established. Updates to the TBH framework need to be evaluated and published regularly. The CTiBS ([www.ctibs.org](http://www.ctibs.org)) welcomes comments from stakeholders, including clinicians, educators, trainers, regulatory and ethics board members, insurers, and the public, about the TBH competencies framework.

## Conclusions

The CTiBS TBH competency framework is proposed as a basis for assessment and research related to identifying and organizing discrete, measurable TP practice competencies for TP education and training. With the escalating adoption of TBH in the healthcare workforce and ongoing technological advancements, additional research and modification are needed for competency implementation and evaluation in education, training, faculty development, policy development, independent practice, institutional adoption, as well as regular individual self-assessment by ethical professionals. The current paper is an invitation for psychologists to both individually and as members of groups in a variety of organizations to consider further evaluating the CTiBS TBH competencies as a place to start. Further research is clearly warranted. The authors invite

collaboration with CTiBS for such efforts by offering feedback or suggesting resources to conduct additional research.

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