

Initiation of a multidisciplinary telemental health clinic for rural justice-involved populations: Rationale, recommendations, and lessons learned

Ashley B. Batastini^{1,2}  | Ashley C. T. Jones¹ | Michael E. Lester¹ | Riley M. Davis¹

¹School of Psychology, University of Southern Mississippi, Hattiesburg, Mississippi, USA

²Center for Telehealth, University of Mississippi Medical Center, Jackson, Mississippi, USA

Correspondence

Ashley B. Batastini, College of Education, University of Memphis, Memphis 38152, TN, USA.

Email: Ashley.batastini@memphis.edu

Funding information

Federal Office of Rural Health Policy, Grant/Award Number: 6 U66RH31459-02-03

Abstract

Videoconferencing technology (VCT) is rapidly increasing in the mental healthcare industry and is becoming an attractive option to reach justice-involved populations. This paper first highlights the need for alternative service delivery solutions and reviews current literature on the use of VCT for correctional clients. We then outline the specific timeline, procedures, and barriers associated with the initiation of a virtual, multidisciplinary telemental health clinic for jailed and community-released offenders in a rural Mississippi county aimed at reducing criminogenic and psychiatric risks. Finally, we summarize generalizable recommendations for establishing community partnerships, developing structural and logistical processes, and delivering VCT while accounting for unique client factors and integrating evidence-based intervention strategies. We hope other community leaders will feel empowered to initiate similar programs that address needs within in their own jurisdictions.

KEYWORDS

community corrections, justice-involved, telemental health, telepsychology

1 | INTRODUCTION

A recent report from the National Alliance on Mental Illness (2020) estimated that nearly two million individuals with mental health concerns end up in jails across the country each year. This over-representation of individuals with mental illnesses in correctional institutions is a significant global public health concern for which the criminal justice system alone is incapable of handling. Untreated mental illness is associated with prolonged court proceedings (e.g., raising issues of adjudicative competence), behavioral infractions toward staff and other inmates (Wood & Buttaro, 2013), recidivism (Leutwyler, Hubbard, & Zahnd, 2017), and increased taxpayer costs (Roehrig, 2016). Furthermore, an estimated 39% of individuals on community supervision experience significant mental health symptoms (Brooker, Sirdifield, Blizard, Denney, & Pluck, 2012; see also Eno Loudon, Manchak, O'Connor, & Skeem, 2015, with about 13% at high risk for suicide; Cardarelli et al., 2015). Although the question of how best to manage justice-involved persons with mental illness is relevant in all sectors of the criminal justice system, county jails appear particularly overwhelmed with these inmates. Not only does research (Segal, Frasso, & Sisti, 2018) suggest that county administrators and jail staff agree the needs of this population far outweigh the availability of comprehensive treatment options, but similar sentiments have also been echoed through personal communication with correctional personnel and community leaders.

The rural jail population has increased in recent years, even as urban jail populations have decreased (see Neath, 2017; Vera Institute of Justice). Primarily due to their remote geographical location, rural jails face immense difficulties in providing proper care to individuals while in detention and connecting returning citizens to needed services once released. Further, in many rural communities, county budgets are significantly low and mental health resources are drastically limited or nonexistent. Thus, while more urban areas have been successful in implementing alternative programs (e.g., Crisis Intervention Teams [CIT], mental health diversion courts), rural communities may struggle to build and sustain an infrastructure to support these programs (Skubby, Bonfine, Novisky, Munetz, & Ritter, 2013). And, with a shallow pool of local providers or agencies who can contract with the jail to provide assessment and counseling, most interventions in rural jails are aimed at stabilization and containment of mental and behavioral health problems through medication management by jail medical staff or placements in solitary units. Once released, individuals may be provided a one-time supply of psychotropic medications and a community referral; however, there is typically little expectation for follow-up care. One promising avenue for increasing the frequency, consistency, and continuity of mental and behavioral care for justice-involved persons is through less costly virtual mechanisms that are capable of casting a wider net of available providers and allowing connections with clients or agencies to occur with greater ease and convenience.

2 | THE RISE OF REMOTE MENTAL HEALTH SERVICES

Although the use of closed-circuit television links in healthcare delivery emerged in the 1960s, the transition to more advanced technological outlets (e.g., two-way interactive videoconferencing) for mental health services started to gain momentum in the early 1990s (Nickelson, 1996), particularly to overcome barriers in services costs, access to specialty-care providers, transportation difficulties, long wait-times, geographic constraints, and continuity of care within rural communities (Bouchard et al., 2004; McCord, Saenz, Armstrong, & Elliott, 2015). More recently, telemental health has been hailed as the answer to the growing mental health crisis across the United States (Matthews, 2017). There are currently a number of professional guidelines (e.g., American Psychiatric Association & The American Telemedicine Association, 2018; American Psychological Association, 2013; American Telemedicine Association, 2009) that offer specific recommendations to practitioners on how to navigate unique issues of competency, standards of care, informed consent, confidentiality, and security of data among other topics to promote remote ethical practice.

Real-time videoconferencing technologies (VCT) has become an especially popular option given its ability to simulate in-person interactions most closely. In a 2016 survey, Gershkovich and colleagues reported nearly 40% of behavioral health providers used VCT as adjunctive to in-person and about 44% used it independent of in-person. The current COVID-19 pandemic has led to an almost overnight surge in practitioners turning to telemental health, and VCT in particular, as a means of continuing care with clients while adhering to social distancing recommendations—a shift that has been accompanied by temporary relaxed legislative restrictions in many states (see Centers for Medicare and Medicaid Services, 2020). It should be noted, however, that some states (including Mississippi) have long resisted Medicaid expansion policies (Antoniesse & Rudowitz, 2019; Jacobs & Callaghan, 2013) that afford coverage to low-income patients. Fortunately, with regard to VCT, it appears that being physically present in a room with a client is not necessary to produce positive outcomes. A recent series of meta-analyses examining intervention outcomes and assessment reliability across a variety of mental health populations and settings showed VCT was associated with outcomes largely equivalent to in-person delivered services (Batastini et al., 2020).

3 | APPLICABILITY AND ADVANTAGES TO CRIMINAL JUSTICE POPULATIONS

The application of telehealth is perhaps particularly attractive in correctional settings where, often due to burnout and the hostility of the environment, there is a scarcity and/or high-turnover of qualified local providers. Obtaining long-distance providers, especially for specialty-care services, can drive up costs. And, transporting inmates to outside providers introduces both additional cost considerations and safety concerns. In rural areas, the burden of inmate healthcare typically falls on poorer counties and their taxpayers, as Medicaid coverage is either terminated or suspended and private insurance plans cannot be purchased (“Healthcare Coverage for Incarcerated People,” n.d.). Courts, therefore, may be more inclined to release offenders or drop charges when healthcare costs are too high for the county to cover. One multistate survey of telepsychiatry visits in correctional facilities found between \$12,000 and \$1-million-dollar cost savings following the implementation of remote programs (Deslich, Thistlewaite and Coustasse, 2013). In addition to monetary savings, reduced safety concerns, and service access, integrating technology into correctional service provision may also create more seamless connections between differing stages of treatment and incarceration (Magaletta, Fagan, & Peyrot, 2000), or between multidisciplinary interventions and the people delivering them (Batastini, Hill, Repke, Gullledge, & Livengood, 2018). Because jails experience more rapid and unpredictable changes in their daily census (e.g., with people making bail, accepting plea offers, being granted early release), the potential to increase continuity of care is a significant benefit of telemental health in these settings, as justice-involved clients could continue seeing the same provider or at least schedule transition sessions rather than terminating services abruptly. Ultimately, we believe these advantages can help slow the revolving door between the mental health and criminal justice systems.

An estimated 20% of all telehealth applications involve justice-involved clients (Lowes, 2001) and interventions that target the needs of inmates with mental illnesses are one of the most frequently cited uses for this population (Ax et al., 2007). According to a national survey by the Center for Disease Control and Prevention (Chari, Simon, DeFrances, & Maruschak, 2016), over 60% of prison-based telehealth contacts were for psychiatric consultations—the most commonly reported use of this technology. Several recent policy changes also demonstrate the growing focus on remote interventions. For example, the arrest and tragic suicide of Sandra Bland in a Texas jail prompted groundbreaking legislation (S. B. 1849, 2017) requiring all jails within the state to provide access to a mental health professional either in-person or through telehealth 24 h a day. While telemental health in corrections has a newer evidence base, a 2016 meta-analysis found that VCT services (both assessment and intervention) for forensic, criminal justice, and substance abuse clients produced outcomes that were comparable to in-person services across variables measuring mental health symptoms, therapeutic processes, program engagement, and service satisfaction (Batastini, King, Morgan, & McDaniel, 2016).

To our knowledge, the application of telemental health in correctional institutions has been primarily used to bridge the gap in crisis intervention services, psychiatric assessment (Nelson, Zaylor, & Cook, 2004), and psychotropic medication consultations (Brodey, Claypoole, Motto, Arias, & Goss, 2000; Manfredi, Shupe, & Batki, 2005; R. D. Morgan, Patrick, & Magaletta, 2008). And, although at least two published studies (Batastini & Morgan, 2016; R. D. Morgan et al., 2008) described psychological services via VCT to include 30-min sessions “focused on issues of adjustment and mental health stability” (R. D. Morgan et al., 2008, p. 160) and a coping skills group for inmates in long-term administrative segregation (Batastini & Morgan, 2016), both studies were conducted with prison (not jailed) populations and did not appear to employ a multidisciplinary treatment approach. Given the high needs of jailed inmates, the unique environment of county jails, and the limited resources within rural counties to prepare inmates for release, finding more cost-effective approaches that are accessible and comprehensive enough to dually address mental health issues and improve community safety is imperative.

The remainder of this paper is based on the recent initiation of a multidisciplinary telemental health clinic in a rural Mississippi county. This is the first known clinic to offer a one-stop menu of evidence-based psychiatric and psychological services through VCT. First, we detail the process of preparing, implementing, and evaluating the telemental health clinic. Next, we outline general considerations for program developers when collaborating with correctional agencies to establish a telemental health clinic. We then provide support for the larger theoretical framework we adhered to when designing program structure and clinical components. In sharing our experiences and lessons learned, we hope to improve the ease of implementation for other administrators, providers, and community stakeholders who wish to develop a similar service model in their counties.

4 | A MODEL OF PROGRAM STRUCTURE AND PROCEDURES

With one of the highest incarceration rates in the country at 960 inmates per 100,000 residents (Kaeble & Cowhig, 2018), coupled with one of the lowest budgets for a state department of corrections (i.e., an \$11 million deficit reported as of 2017), the State of Mississippi needs urgent action that is both effective and inexpensive. Furthermore, over half of Mississippi is considered rural (Logue, 2011) and ranks last in terms of access to mental health care (Mental Health America, 2016).

The telemental health clinic at the center of this discussion represents a multidisciplinary collaboration between the School of Psychology at the University of Southern Mississippi (USM), the Center for Telehealth and the Department of Psychiatry at the University of Mississippi Medical Center (UMMC), and Adams County in Natchez, Mississippi. Funding for this clinic has been provided by the Health Resources and Services Administration (HRSA-17-123). Our primary objectives have included: (1) testing the clinic's overall feasibility within the system and acceptability by inmates, staff, and providers; (2) establish preliminary efficacy by examining pre-post data on relevant outcomes related to mental health and behavioral functioning; and (3) establishing a standardized protocol for managing and evaluating telemental health services in jails and community supervision departments.

Psychiatric consultations are conducted remotely by UMMC medical providers or contracted physicians; psychological assessment and CBT-based counseling that follow a biadaptive approach (detailed below) for addressing co-occurring criminogenic and psychiatric risks are conducted by advanced graduate-level counselors in USM's APA-accredited Counseling Psychology doctoral program. The USM portion of the clinic also includes a full-time clinic coordinator position and is overseen by the first author, a licensed psychologist. All telemental health sites use real-time audio-visual connections hosted by Cisco Jabber and is HIPAA compliant. Two computer workstations (i.e., laptop, docking station, monitor, webcam, and headset) are located in two private office spaces at USM; and two are located in Adams County—one in the Adams County Jail and one in an office at the Adams County Justice Court, respectively. UMMC providers use approved computers at their respective locations.

4.1 | Getting started

The establishment of the Correctional Telepsychology Clinic (CTC) was somewhat serendipitous and primarily bore out of a state-wide meeting of professionals involved in various mental health sectors that included, among other people, judges, jail personnel, and representatives from UMMC. VCT was discussed as a possibility for addressing mental health needs in rural counties, particularly jails. As a designated National Center of Excellence, the UMMC Center for Telehealth was awarded federal funds to support technological advancements, 25% of which was allocated to mental health services. Approximately 6 months after this statewide meeting, final discussions were underway with UMMC to approve pilot implementation of the clinic. Adams County, which is approximately 2.5 h from USM, was approached for participation for two primary reasons: (1) few mental health services were already available and (2) the county had a reputation for accepting help. After cold calling the sheriff's department, the first author scheduled an initial in-person meeting in November of 2018 to obtain verbal agreement for a partnership. HRSA funds were disbursed in January of 2019 and a second in-person meeting was held in May of 2019 with the first author, UMMC project managers, multiple elected county officials (i.e., the sheriff, justice court judges, county attorney, IT personnel, and jail staff) to discuss intended operations. Clinical services went live in October of 2019. Thus, the initial 9 months of the subaward primarily involved acquiring and installing equipment, establishing logistics, developing policies and procedures, creating schedules and forms for documentation, and executing multiple service (i.e., delegating who was responsible for which services) and business (e.g., to authorize use of UMMC software) contracts among all three agencies involved.

Policies and procedures were outlined in a manual specific to the CTC. Like other clinic manuals, it describes document management and the flow of services, as well as what to do in the event of an emergency or technological issue. Ways in which the manual deviates from typical clinic manuals include unique policies on professionalism, telehealth, and corrections. Examples are included in Table 1.

Notably, the clinic has thus far been sustained on external funds, which have been maximized through the use of supervised graduate-level trainees. Because few agencies may be willing to allocate funds from already minimal budgets to develop a program with unknown or only projected benefits, grant funding is often necessary to offset initial implementation costs (e.g., purchasing equipment) and to show preliminary evidence of program efficacy. However, because external funding of this nature is finite, budgetary plans will need to be established to ensure clinic sustainability. Despite the cost-benefits of VCT over in-person services, agencies (in our case, Adams County) will nonetheless inherit the costs of clinical services and oversight. As the clinic is already situated primarily in a university setting, rolling these services into the in-house departmental training clinic on campus is a logical option; this would ensure costs stay as low as possible while maintaining quality care in a setting that prioritizes objective program evaluation. Using evidence from this pilot program may also give greater credence to advocate for new/specialized staff lines at other state-sponsored mental health agencies specifically to deliver virtual care to incarcerated populations.

4.2 | Clinic operations and examples of unexpected challenges

The CTC provides services only to those who are either pre- or post-conviction; presently, we do not serve clients who are civil status or whose legal status is on hold due to a pending evaluation for adjudicative competency. Clients may present with predominately criminogenic needs, predominately psychiatric needs, or a combination.

At the time of this publication, 27 jail (72.97%) and 10 justice-court (27.03%) clients had been referred for services, 62.2% of whom were male. Slightly more than half (59.5%) of clients were Caucasian and 40.5% were Black, with an average age of 32.38 years ($SD = 9.12$). Of the jail referrals, 15 (40.54% of all referrals made) were preconviction, 12 (32.43%) were postconviction, and 2 (5.41%) were later identified as clients awaiting transfer to the state hospital for civil commitment. Of the justice-court referrals, eight (21.6% of all referrals made) were

TABLE 1 Examples of unique clinic policies and procedures

Domain	Policy	Rationale
Professionalism	Business-casual dress is required for clinicians in session, even if they do not anticipate being viewed below the waist	To maintain a sense of professionalism at all times and prevent awkwardness if there is a need for the clinician to move about the room
	Personal phone calls or engaging in other personal activities in the counseling room while signed-in to the system is prohibited	To ensure clinicians will not inadvertently disclose personal information or act unprofessionally in view of clients
Appointments and scheduling	Client or staff are to initiate video calls at the scheduled appointment time	To reduce confusion over which party should initiate the call and increase the consistency of operations across clinicians
Safety and security	Staff safety and the collaborative relationship between agencies is prioritized over service provision	In correctional settings, treatment may be declined belligerently or in a threatening manner. This policy reduces physical risks to staff in the absence of trained counselors who could otherwise attempt to therapeutic redirect such behavior
	Online completion of clinic documentation must be completed in HIPAA-compliant spaces	To prevent breaches of confidentiality; the manual provides specific instructions and examples (e.g., working in a room alone with the door closed, not storing documents locally)

referred as part of a diversion/specialty court and one (2.7%) was referred as part of state-level community supervision requirements. Clients were referred for various primary clinical concerns including depression ($n = 30$; 81.1%), anxiety ($n = 24$, 64.9%), anger ($n = 21$; 56.8%), behavioral problems ($n = 17$, 45.9%), bizarre or psychotic thoughts ($n = 9$, 24.3%), bizarre or psychotic behavior ($n = 6$, 16.2%), suicidal gestures ($n = 5$, 13.5%), and elevated mood ($n = 5$, 13.5%). Of note, referral sources could check off multiple presenting concerns.

To refer clients, nursing staff (for jail clients) or the presiding judge (for justice-court clients) complete a brief referral form after determining a person's fitness for services. While jail clients are often referred based on current symptoms, justice-court clients are referred either as part of existing community supervision requirements or in lieu of incarceration. Staff at the jail and justice court distribute consent forms and preintake self-report measures to referred clients in paper-and-pencil form. Staff at both locations then securely fax or scan paperwork to USM clinic staff for data entry in the REDCap system (a HIPAA-compliant data storage and management program). While completing some forms online and some on paper often creates a disjointed process for the clinic coordinator, we attempted to accommodate preferences by both site liaisons. After confirming a client's eligibility, the client is scheduled for an intake interview by the clinic coordinator. Intakes include a review of client consent forms, an assessment of prior VCT experience, a semistructured clinical interview, and a mental status exam. Referrals for psychiatric consultation are done electronically through UView by the clinic director based on recommendations of the primary counselor. Psychiatric appointments are scheduled and managed independently by UMMC.

After the intake is completed, the case file is assigned to a primary clinician by the clinic director (first author) during weekly supervision. Clients then progress through treatment guided by manualized protocols. Master binders of all treatment materials were mailed to both sites and, when needed, clinicians contact remote staff to request they distribute copies of specified treatment materials to their clients. Upon termination, clients are asked to complete an exit interview to measure posttreatment outcomes and assess service quality (e.g., Telehealth

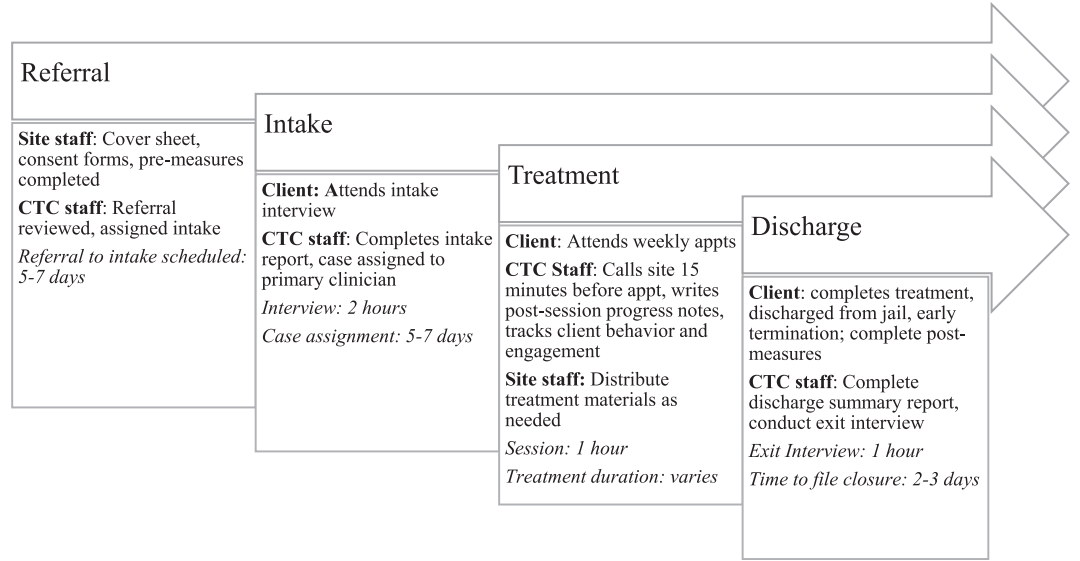


FIGURE 1 Referral to discharge timeline and general procedures

Satisfaction Scale; R. D. Morgan, Kroner, Mills, Bauer, & Serna, 2014; Working Alliance Inventory-Client Version, Horvath, 1994). All clinic documents, such as intake reports, client call logs, and weekly schedules are managed in a HIPAA-compliant cloud-based storage space (Microsoft OneDrive), allowing for real-time scheduling and cancellation across clinic staff. Weekly schedules are finalized and emailed to site coordinators by close of business the Friday before, giving staff adequate time to prepare for upcoming appointments. The general flow of clinic procedures is illustrated in Figure 1.

4.3 | Remaining barriers and intended next steps

There were several components of the CTC that made operations difficult, including long-distance partnerships, interdisciplinary collaborations, and the precarious nature of bridging ideas from ivory towers and the needs of frontline staff and clients. Arguably the most persistent challenge was technical issues resulting in both short-term and long-term delays to client appointments. Short-term delays included changes/damage to terminal equipment, third parties unexpectedly entering the remote telehealth rooms, and reduced audio and visual quality. One client, for example, disconnected all hardwire cables on the VCT terminal following a session, delaying subsequent sessions to repair the terminal. Another client attempted to leave the VCT room immediately following a session without staff escort, resulting in policy changes requiring clients to be handcuffed to the computer terminal desk during sessions.

Long-term delays in appointments were also observed, resulting in canceled sessions. The extent of long-term delays varied depending on the nature of the delay and ranged from 1 day to 3 months. Examples of long-term delays included site understaffing, limited availability to escort and monitor clients during sessions, severe weather conditions (e.g., tornado warnings), damaged power lines, assaults within the jail, unrelated inmate deaths, routine lockdowns, and disconnected phone numbers for community clients. The barrier resulting in the longest delay to services was a damaged internet cable at a remote site that was not identified until after clinic services began. Unfortunately, it took considerable time to identify the source of the problem, as well as the staff and resources needed to repair it.

Recent COVID-19-related changes to university and county operations have also necessitated changes to the clinic structure. Clinic staff are temporarily prohibited from meeting in-person, requiring case assignment and group supervision to take place virtually using a HIPAA-compliant collaboration and telecommunication software (Microsoft TEAMS). Yet, despite these changes, the general workflow was largely resistant to the effects of social distancing and pandemic responses, as much of our work was already completed remotely and with minimal physical contact. In fact, as university training clinics closed entirely, the CTC was allowed to maintain operations with some adjustments. At a time when many traditional workspaces and therapy providers are being significantly disrupted, the CTC exemplifies the adaptability and durability of telehealth clinics in the current technological and sociopolitical age.

We have two primary next steps. First, we aim to expand our reach of services across the state to include additional county jails, community corrections, and state facilities. Second, and through these expansion efforts, we aim to move enough clients through the treatment process so aggregate outcomes can be analyzed with enough statistical power and disseminated. In setting up the CTC, all assessment and data recording procedures were chosen because of their clinical relevance; that is, all data were collected for purposes of treatment planning, tracking individual progress, and quality assurance. Consistent with common clinical practices, clients were informed during the initial intake that their deidentified data may be used for research and evaluative purposes in such a way that no one will be able to identify them individually. Institutional review board approval was pre-emptively received to use nonidentifiable and/or nonconfidential data (e.g., public records such as county recidivism rates) in an archival manner after clients formally terminate from services.

5 | CONSIDERATIONS FOR PROGRAM INITIATION AND DEVELOPMENT

5.1 | General tips for partnering with corrections and criminal justice agencies

From the perspective of a mental health professional and researcher who is not directly affiliated with a county or correctional agency, it can often feel like an uphill battle to develop a trusting partnership, particularly when proposing a time-intensive project that will require a long-term commitment. In the first author's experience, counties may be reluctant (and rightfully so) to adopt programs that are experimental or for which they are unable to grasp the immediate benefits to their organization, staff, or constituents. Other jurisdictions may be quick to dismiss new programming because they believe their needs are adequately met through other resources—sometimes this belief is accurate and sometimes there is a lack of awareness about the gaps remaining to be filled. As an example of this, one county that was initially approached for participation in the pilot telemental health clinic declined because another agency in the region was providing contracted care via a team consisting of a psychiatrist, nurse practitioner, social worker, and Master's level clinicians. While this group of providers is more than what many rural counties have access to, missing from the list was a licensed psychologist. Psychologists bring unique expertise in diagnostic screening, assessment, case conceptualization, and evidence-based counseling practices that are not entirely captured by other mental health professionals. In establishing a comprehensive telemental health clinic (or any clinic for that matter), where front-end set-up can seem daunting and the eventual benefits remain uncertain, it may be useful for developers to adhere to the following general recommendations.

First, it is important to be physically present and available—let county administrators (e.g., clerks, attorneys), judges, sheriffs, wardens, frontline staff, information technology (IT) personnel, and anyone else who may be involved or who can help advocate for you and your team lay eyes on you. Schedule in-person meetings and get as many of these people at the table together. This may be challenging when the goal is to initiate a remote clinic, as the convenience of providing services at a distance is one of the obvious benefits of such a clinic in the first place. However, research suggests that greater familiarity leads to a greater sense of trust (Cheng, Shixuan, & de Verde, 2017). Putting in the effort to be present on-site, regardless of how remote, is especially important when a clinic is

new with no pre-existing reputation within the community. It has also been our experience that successful integration within an organization typically starts by establishing a collegial relationship with a so-called “champion on the inside”; someone who shares your enthusiasm, can help spread your message within the organization, and convince their colleagues it is worth their time to meet with you.

Second, with key stakeholders in the room, respectfully and strategically pitch your idea by highlighting the potential benefits of your program to their mission, staff (e.g., reduced stress resulting from better-managed inmates), and budget. But, take care not to make false or misleading promises; for example, do not advertise cost-savings or recidivism reduction if you are unsure the proposed program can deliver these results. A safer bet is to highlight the ways in which your program can help the agency to fulfill their constitutional obligations in a more effective and efficient manner. As an example, completed suicides in jails are approximately three times higher than in the community (see Hayes, 2010) and the National Commission on Correctional Health Care (2018) stipulates minimum standards of care for accredited facilities. As exemplified in the Sandra Bland case, loss of life associated with inadequate or unavailable mental health services can be extremely costly to an agency's pocket and reputation. Beyond suicide prevention, high-quality virtual mental health programs may offer a solution to other constitutional or policy violations that can arise from correctional or supervision officers who lack training on how to manage people with more serious symptoms of mental illness. Such lack of skills or knowledge often results in no treatment, insufficient treatment, incorrect treatment, and/or punishment-based responses that could lead to iatrogenic effects.

In addition to connecting your objectives with overarching agency goals, provide concrete evidence, in layperson language, that what you want to do will actually work. Although there may not be direct evidence for the specific manner in which you want to package and deliver services, the various components of your proposed plan should be backed by research. In the context of a correctional telemental health clinic, provide data on the dollars saved in other jurisdictions that adopted remote services (if available), present general research findings showing that remote and in-person mental health services yield similar outcomes, and discuss the evidence-base for your chosen service model (including selected assessment and intervention strategies and process of program evaluation).

Third, to increase buy-in, integrate examples into your pitch that are relevant to the agency and their work. For instance, acknowledge the challenging nature of working with justice-involved populations and how your approach may alleviate some of the hardest aspects of their job. Empathizing with the barriers and frustrations staff encounter on a daily basis will not only demonstrate your expertise, but also a genuine interest in meeting a need and improving their overall quality of life. Your message should always convey you are there to help, not criticize or publicly expose their shortcomings. However, while it is necessary to clearly demonstrate the novelty and utility of your concept, we also recommend being cautious not to present as all-knowing. Encourage collaboration and open discussion. Value what the agency has to add and show flexibility in adjusting your proposed plan within reason (of course, we do not advocate for adding components that have no research or theoretical basis; e.g., boot camp models; see Barnett & Howard, 2018; MacKenzie, Wilson, & Kider, 2001).

5.2 | Navigating agency and service logistics

Intervention research has begun to take a step back from evaluating treatment outcome and efficacy to focusing on the overall process of implementation. Implementation science is a field of scientific inquiry that aims to identify factors related to the successful translation of evidence-based practices to real-world service delivery settings (Ogden & Fixsen, 2014). This line of study is intended to prevent program failure by encouraging consideration of the following at all stages of program implementation, from initial construction/development to assessment of specific treatment gains (see Alexander, 2011):

1. The needs of the organization;
2. How the program “fits” with other organizational issues and initiatives;

3. What resources currently exist and what additional resources will be needed;
4. Existing evidence for the program (or, as noted, aspects of the program that do have evidence);
5. Others' experience with program replication;
6. The organization's ability to actually implement and sustain the program.

In other words, the aim of implementation science is to conscientiously anticipate agency needs and implementation challenges, take steps to prevent foreseeable problems, evaluate whether such problems were in fact prevented, and determine what other challenges remain or were revealed in the process. The next three sections represent a summary of lessons learned in the process of implementing the telemental health clinic that we hope will generalize to other, future efforts. We have divided this discussion by agency-, service-, and client-specific considerations.

5.2.1 | Agency considerations

Before contacting an external agency, it is necessary to clearly outline your program's scope of work within the context of your (or your team's) competencies—for example, who is the target population, what services do you plan to offer the agency (keeping in mind these plans may need to be adjusted), what competencies are necessary to ethically provide these services, and do your competencies match what is required? Along with this, it is equally important to determine the types of services or populations that fall outside your scope of work. Sketching out program goals and objectives ahead of time will likely lead to more productive conversations with the agency. Consider this: the sheriff of a rural county jail is overwhelmed with individuals waiting inpatient civil commitment beds because the state hospital is at capacity. Afraid to release these detainees given their level of decompensation and dangerousness potential, the sheriff holds them in custody despite not having a pending criminal charge. Excited about the prospect of your new telemental health clinic, the sheriff and chancery court judge ask if you will accept these individuals for services. Your answer might depend on the type of services you are intending to offer (e.g., crisis/brief counseling vs. long-term psychotherapy) and careful consideration of the possible consequences. We would caution against the initiation of a telemental health clinic that is intended as a substitute for alternative community resources for those with serious mental illness who have no or limited criminogenic risks, as this could inadvertently alleviate pressures to fix the larger systemic issue of psychiatric bed shortages and few local options beyond incarceration. Thus, we argue that treating “displaced psychiatric patients” in a jail setting should not be done in lieu of psychiatric services elsewhere, but could instead be an entry point. In these situations, we also recommend working with counties to advocate for change at the state level (e.g., offer to collect and disseminate data on census, psychiatric presentations/severity, time to hospitalization, costs, etc.).

In addition to drafting a scope of work that reflects professional competencies, take an active learner approach by preparing a list of questions about the specific populations the agency serves or supervises, what (if any) services are already being provided and who is responsible for providing them, the types of services the agency wishes could be offered (i.e., what do they perceive as missing but needed), and what technology systems are already in use. For counties that have some on-site providers and/or receive services from contracted providers, be prepared to discuss how telehealth can enhance (not replace) current efforts and be flexible in finding creative ways to integrate existing services. For example, if another external agency routinely conducts mental health screens, could these screeners be incorporated into the clinic's intake procedures to reduce redundancy and increase efficiency of new referrals? Some jails also already have VCT stations so incarcerated defendants can attend court hearings, meet with their attorney, or have virtual visitations with family. Thus, many jails have the technological infrastructure to support a telemental health clinic.

To avoid frustration during preliminary discussions with the agency and their partners, and especially if you plan to work across multiple jurisdictions, it may be helpful to remember that different agencies have different

policies and security measures (e.g., some facilities may not allow inmates to touch the computer screens or be alone with equipment), different service voids they want filled, and different priorities. Because many rural counties may be struggling with overcrowded jails, high supervision caseloads, staff shortages, lawsuits, negative publicity, or any number of other crises, your project is unlikely to make the top of their list without persistent efforts to achieve buy-in. Even when agencies are eager to collaborate at the outset, these barriers can stymie the momentum necessary to get new program initiatives off the ground. Because of this, be prepared to follow-up frequently—practice the art of friendly harassment (e.g., affirm their challenges, offer help or alternative solutions, and reiterate excitement for the next steps). Frustrations may be further minimized by accepting that trial and error is inherent when initiating any new program. We suggest being transparent about this upfront, giving agencies permission to offer feedback throughout implementation, and then attending to feedback as needed. It is permissible to admit that some aspects of the program are unknown; make it the agency's responsibility to communicate when something is not working well.

5.2.2 | Service considerations

A number of resources are available on setting up and managing an ethical and evidence-based remote clinical practice. For a more comprehensive discussion, readers are referred elsewhere (e.g., see Campbell, Millán, & Martin, 2017; Luxton, Nelson, & Maheu, 2016; Turvey & Myers, 2013). However, we next highlight several service-related preparations we believe are especially important when establishing a telemental health clinic with correctional institutions and agencies. These preimplementation preparations should take place once personnel competencies and the clinic's scope of work has been determined but before the clinic goes live.

First, it is necessary to coordinate with the agency on a regular schedule of clinical services. In-custody settings in particular are likely to have a number of restrictions to scheduling clinic blocks; for example, daily mealtimes, cell counts, medication distribution, appointments with other contracted service providers, court days, and so forth. We also recommend preparing for unexpected events (e.g., lockdowns, connection issues, and staff absences) that will disrupt scheduling and discuss a feasible back-up plan with staff (e.g., maintaining a "reserve" clinic block for rescheduled appointments, checking in with clients by phone).

Second, personnel affiliated with the telemental health clinic, the remote agency where clients will be located, and other service providers who may be integrated into the clinic will need to establish a streamlined workflow from initial referral to termination. This will include, among other tasks, determining procedures for initiating referrals, communicating new referrals with the clinic, securely transmitting paperwork between facilities, assigning clients to counselor caseloads, supervising clinical staff, managing waitlisted clients, tracking client contacts and treatment progress, documenting incidents, exchanging treatment materials (e.g., homework assignments, and readings), and making secondary referrals to other partners (e.g., for psychiatric consultation). In developing a workflow, it will also be helpful to designate a liaison at the remote agencies who can work with an on-site clinic coordinator to exchange documentation and serve as a primary point of contact to communicate and problem-solve other logistical issues. In our experience, as detailed below, it will take time and patience to figure out an efficient workflow and who is best suited to do which tasks. Importantly, workflow development is likely to evolve past the preimplementation stage when procedures are actually put to the test.

Third, it is imperative to identify a reliable on-site or local emergency contact person in the event there is a clinical emergency (e.g., imminent risk of self-harm), a medical emergency (e.g., heart attack, stroke, seizure), or some other issue requiring immediate response (e.g., a client damaging physical property or equipment). In jail, the emergency contact may be the nurses' station, the sheriff's office, or a senior security officer. In community settings, clinicians should obtain and document several emergency contact numbers for their clients. If sessions for community clients take place at a courthouse or supervision department, obtain the direct line for a staff person who can be readily available such as a court clerk, administrative assistant, probation officer, or bailiff.

We recommend obtaining multiple numbers whenever possible (preferably to include a work cellphone) in case the person you are needing to reach is not at their typical post.

Lastly, we strongly encourage role-playing sessions and testing network connectivity in advance. Role plays are useful for practicing the administration of clinical interviews, psychological tests (e.g., mental status exams, self-report tools), and delivery of intervention content while navigating dual screens or multiple windows. Role playing with colleagues will also ensure a professional virtual image through feedback on posture, attire, eye contact, tone, camera position, lighting, and the visibility of background items that may be distracting. Notably, seemingly normal behaviors may be perceived differently on video. Connectivity should be tested between all workstations using all computer software accounts and with all personnel who may be required to use the equipment (e.g., jail staff who need to sign-in on behalf of inmates). When working with community-released clients in their homes, it is advised to schedule a trial session before the first clinical session to again ensure good audio-visual connectivity, but to also assess the feasibility of the client's environment and their comfort with VCT. Many clients, but perhaps especially justice-involved clients, have busy and often chaotic daily lives. Thus, it is important to work with clients to schedule sessions when partners, children, or other household guests are likely to be gone or brainstorm other confidential spaces that will be free of distractors and have reliable access to a high-speed internet connection (e.g., a reserved room at the local library). Encouraging the use of headsets or headphones may help reduce noise and increase focus during sessions. Holding a practice session may also ease anxiety around using the technology and build rapport.

5.2.3 | Special client considerations

Beyond practical considerations for service set-up and general implementation, our experience has provided several specific insights regarding direct clinical service with justice-involved clients via VCT. Similar to in-person psychotherapy with this population, therapists using VCT will need to individualize intervention protocols and work with more challenging behaviors and unique personality characteristics that block progress. Further, clinicians may deal with low levels of motivation or readiness to change among justice-involved clients. Although not always the case (e.g., Han & Redlich, 2016), these factors may be associated with the mandated nature of interventions (Snyder & Anderson, 2009). Practitioners have previously expressed concerns that the remote nature of telemental health services does not provide a rich enough environment to balance direct interpersonal feedback with alliance-restoring techniques (Rees & Stone, 2005). To the contrary, our clinicians have so far not felt impaired in their ability to comfortably take dynamic approaches to resistance. That is, clinicians have still been able to project a stance of openness, interest, and inquisitiveness via expressing exaggerated postures and thoughtful inflections when speaking. Likewise, clinicians have successfully introduced humor, direct therapeutic challenges, and motivational techniques such as "rolling with resistance" (Moyers & Rollnick, 2002) through VCT to help clients recognize their extreme thinking styles or problematic behaviors.

Some clients may be more difficult to engage not because of antisocial tendencies or other difficult personality traits, but because of limited comprehension and impaired concentration. For example, clients with specific learning disorders (SLD) or intellectual and developmental disabilities (IDD) may first require a formal assessment of reading level to determine their responsivity to intended interventions and need for modifications to materials, as well as their ability to navigate technology independently or to what extent caregivers may need to be involved. It is similarly important to determine whether clients with more severe mental illnesses will be able to engage without exacerbating existing symptoms. It may be countertherapeutic to use VCT with someone who is paranoid about government interference or surveillance via telecommunications. In fact, we recommend at least a cursory assessment of prior VCT use and comfort with any client, regardless of their presenting concerns or cognitive abilities. Assessing client familiarity and concerns about VCT at the outset of therapy may reduce resistance or poor engagement that stem from the novelty of VCT. Importantly, clinicians can normalize the experience by citing

the growing use of VCT across mental health settings (a discussion made easier by the rapid shift to telehealth during COVID-19), relating the experience to everyday virtual communication platforms like FaceTime, and noting relevant benefits afforded through VCT that are not possible through in-person sessions such as the use of closed captioning, enhanced audio and integration of multimedia.

5.3 | A crash course in best practices for addressing mental health and criminogenic needs

Within the larger discussion of program set-up and implementation, it would be remiss not to briefly discuss program content—that is, what should be the treatment targets of a telemental health clinic for justice-involved persons?

5.3.1 | The biadaptive model

The limited capability of smaller, rural communities to offer more comprehensive mental health care in local jails is especially troubling when considering the staggering prevalence rates of psychiatric disorders and co-occurring substance use disorders among rural jailed inmates. Of the most prevalent conditions identified in a recent survey of rural jail populations (Raggio, Hoffmann, & Kopak, 2017), 72% of inmates qualified for a substance use disorder, 54% met criteria for a major depressive episode in the past year, 53% met criteria for a manic episode in the past year, and 48% were in the probable range for PTSD. However, treating serious mental health concerns is only half the equation when it comes to effectively reducing future criminal justice contacts. That is, most justice-involved persons are not just displaced psychiatric patients. Perhaps unsurprisingly, the survey by Raggio et al. (2017) also revealed that nearly half of rural jail populations met criteria for Antisocial Personality Disorder. Another study found that a majority of jailed inmates with diagnoses of serious mental illnesses showed elevations in thinking styles that have been known to support a criminal lifestyle (Wilson et al., 2014). Moreover, after examining data from intensive interviews and records, Peterson, Skeem, Kennealy, Bray, and Zvonkovic (2014) found that only a small percentage (10% or less) of offenses were directly motivated by symptoms of mental illness. Therefore, effective therapeutic strategies for jailed populations require a bi-adaptive framework for addressing both mental health needs (e.g., emotional dysregulation, medication compliance, specific symptom clusters) and criminogenic risk factors (e.g., antisocial thinking patterns, procriminal associates, substance abuse; see Andrews & Bonta, 2017). The biadaptive model for justice-involved persons has shown promise. In a sample of probationers, for example, an intervention (*Changing Lives, Changing Outcomes*; R. D. Morgan, Kroner, & Mills, 2018) based on this approach produced significant reductions in psychopathology and pro-criminal attitudes regardless of gender (Gaspar et al., 2019). Positive effects of the biadaptive model were also observed among male incarcerated persons, leading to decreased emotional distress, improved psychiatric symptomology, and reductions in some facets of criminogenic thinking (R. D. Morgan et al., 2014). For examples of manualized treatments that implement a biadaptive model, readers are referred to R. D. Morgan et al. (2018) and Batastini, Morgan, Kroner, and Mills (2019).

5.3.2 | General treatment elements that work

Although programming for justice-involved persons is sometimes tailored for certain subgroups based on their unique risk factors or demographics (e.g., sex offenders or female incarcerated persons), there are several key elements associated with effective treatment programming that are applicable across subgroups and settings. First, effective programs for offending populations follow a structured cognitive-behavioral therapy framework (McGuire et al., 2008),

especially those that integrate social learning methods such as prosocial modeling, selective reinforcement of behaviors, and effective problem solving (Dowden & Andrews, 2004). The use of CBT-based therapies to reduce recidivism has been further supported in meta-analytic reviews (see Landenberger & Lipsey, 2005). Other structured programs, such as dialectical-behavioral therapy, may also be useful for criminal justice-involved populations (Berzins & Trestman, 2004). Further, research has underscored the importance of incorporating motivational techniques at program outset and throughout implementation to facilitate treatment responsiveness (Bourgon & Bonta, 2014; Lester, Batastini, Davis, & Bourgon, 2020). In addition to structured content, clinicians must use specific activities and teaching tools that provide opportunities to apply new information to real-life scenarios (Sperber & Lowenkamp, 2017) and ensure skills are essentially over-learned. The use of homework is one approach that has been effective for justice-involved persons (R. D. Morgan et al., 2012). Lastly, past research suggests that increases in the duration of treatment are uniquely predictive of reduction in recidivism rates when services are matched to an offender's level of risk (Bourgon & Armstrong, 2005; Duwe, 2018). Typically, a minimum of 200 h is recommended for medium to high-risk individuals (Makarios, Sperber, & Latessa, 2014).

6 | PARTING ADVICE AND FINAL CONCLUSIONS

While implementation barriers can be discouraging, evidence-based correctional treatment is essential to improving well-being and protecting our communities, and we cannot bow down to the complexities of county correctional systems. Patience and a marathon mindset, as opposed to a sprint, were adopted. Furthermore, in our experience, counties who want help may simply not know how to navigate existing challenges. Therefore, maintaining empathy toward corrections staff at all levels (e.g., from administrative assistants to security staff to the warden) goes a long way during times of miscommunication or even disagreement. Gentle persistence builds rapport and reminds corrections staff that part of the clinic's mission is to improve their working conditions. We encourage anyone looking to establish a similar model of remote services to be effortful in demonstrating a willingness to adjust policy and procedure whenever appropriate to better suit their needs.

In addition to a solid clinical infrastructure, it is equally important to ensure services are producing intended outcomes. Program evaluation is a key component for good implementation science and the larger task of improving correctional work environments and reducing recidivism. Considering the role program evaluation plays in ensuring evidence-based correctional practices, particularly when attempting to establish novel forms of treatment (e.g., telemental health), building in practices that lend themselves well to conducting program evaluations is highly recommended. If possible, we also encourage future research comparing similar telemental health clinics to treatment-as-usual both in terms of clinical and criminal outcomes as well as cost-savings and staff wellness.

Telehealth in general is a fast-growing practice—one that has been pushed to the forefront of medical and mental health service provision in the wake of a global pandemic, making this paper particularly timely. Though the road to establishing a new telemental health clinic for justice-involved persons in rural communities has been and remains a challenge, it has also been a rewarding learning experience that we hope will benefit others who may be considering this option. It is uncertain whether VCT-based services will be the savior some have proclaimed, but we believe it has the potential to alleviate (perhaps not absolve) existing struggles experienced by counties with few other resources. Nonetheless, we contend that all work should be empirical and want to press upon program developers to work with their collaborators on disseminating outcomes generated from their efforts.

ACKNOWLEDGMENT

Communication regarding this manuscript can be directed to Ashley B. Batastini, Ph.D., Counseling, Educational Psychology & Research, 100 Ball Hall, Memphis, TN 38152, Ashley.batastini@memphis.edu. Dr. Batastini was affiliated with the University of Southern Mississippi at the time this study was completed. This project was supported by the Federal Office of Rural Health Policy (FORHP), Health Resources and Services Administration

(HRSA), U. S. Department of Health and Human Services (HHS) under cooperative agreement award no. 6 U66RH31459-02-03. The information, conclusions, and opinions expressed are those of the authors and no endorsement by FORHP, HRSA, or HHS is intended or should be inferred.

PEER REVIEW

The peer-review history for this article is available at <https://publons.com/publon/10.1002/jcop.22424>

DATA AVAILABILITY STATEMENT

Deidentified data can be available upon request to the first author.

ORCID

Ashley B. Batastini  <https://orcid.org/0000-0002-6725-676X>

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How to cite this article: Batastini AB, Jones ACT, Lester ME, Davis RM. Initiation of a multidisciplinary telemental health clinic for rural justice-involved populations: Rationale, recommendations, and lessons learned. *J Community Psychol*. 2020;1–18. <https://doi.org/10.1002/jcop.22424>