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"LET'S TALK ABOUT IT": NEW JERSEY NEEDS TO CODIFY ITS TEMPORARILY RELAXED LICENSURE REQUIREMENTS FOR TELEMENTAL HEALTH PROVIDERS

*Taylor Lodise**

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I. INTRODUCTION

Although COVID-19 ignited awareness of the importance of mental health care, the serious harms and dangers posed by mental illness have existed long before COVID-19 arrived and will continue to exist long after. Access to adequate mental health care is therefore essential, not

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just during public health emergencies, but always. This commentary proposes a state licensure codification, based on temporary COVID-19 laws, that would permanently expand access to virtual mental health care for New Jersey residents through licensure exceptions for certain providers. Adoption of such by the New Jersey legislature is not only timely, but necessary to combat mental illness as well as various barriers to mental health treatment, such as cost and physical inaccessibility.

Part II of this commentary summarizes telehealth regulations at the federal and state levels, focusing on New Jersey law and explaining why a change in state law is suitable to fix the current inadequacies of licensure regulations. Part III discusses how increased access to virtual mental health care would help to combat the issues of mental illness and inadequate access to treatment. Part IV provides a legislative vehicle for such expanded access for New Jersey residents.

II. TELEMENTAL HEALTH OVERVIEW AND LEGAL LANDSCAPE

While there are many important issues in the telehealth industry, this commentary focuses solely on reimbursement and licensure.[1] Reimbursement requirements for virtual health care services include, among others, establishing a proper patient-provider relationship and meeting state licensure requirements for providers.[2] Health care providers offering virtual treatment must ensure that their practice complies with both federal and state law as well as any applicable private insurance telehealth regulations.[3]

Virtual mental health care in particular has been referred to as telemental health:[4] the use of technology to "connect a patient with a

1. Medicare, Medicaid, and most private insurance companies require that telehealth services include real-time audio and video together to qualify for reimbursement or legal recognition. *Telepsychiatry and COVID-19*, AM. PSYCHIATRIC ASS'N, https://www.psychiatry.org/psychiatrists/practice/telepsychiatry/blog/apa-resources-on-telepsychiatry-and-covid-19 (May 1, 2020); *see also* N.J. STAT. ANN. § 45:1–62(c) (West 2021). Therefore, any references in this commentary to virtual health services refer to synchronous video encounters between provider and patient.

2. *See, e.g.*, N.J. STAT. ANN. §§ 45:1–61 to –66 (West 2021).

3. Robin Locke Nagele & Kerry E. Maloney, *Covid Telehealth Considerations for Providers in PA and NJ*, LAW360 (Apr. 15, 2020, 5:39 PM), https://www.law360.com/articles/1262739/covid-telehealth-considerations-for-providers-in-pa-and-nj.

4. This term is synonymous with "telebehavioral health." *See* Brittany Lazur et al., *Telebehavioral Health: An Effective Alternative to In-Person Care*, MILBANK MEM'L FUND (Oct. 15, 2020), https://www.milbank.org/publications/telebehavioral-health-an-effective-alternative-to-in-person-care/.

broad[er] array of mental [or behavioral] health professionals,"[5] which may include psychologists, psychiatrists, and social workers.[6] Telemental health serves to treat people with various types of mental disabilities, or otherwise undiagnosed hardships, in a variety of ways—ideally, using the virtual treatment type that is best suited for a given patient.[7]

Telepsychiatry, a specific practice within the telemental health industry, allows for "the use of telecommunications technologies to remotely connect patient and psychiatrist."[8] Legal differences between telepsychiatry and traditional, face-to-face psychiatric therapy lie in state regulations, which dictate the circumstances under which a given health service may be reimbursable.[9] Therefore, a key focus for the expansion of telemental health is state reimbursement regulations—specifically, licensure requirements.[10]

A. Federal and State Law Overview

Through significant legislation—most notably the Coronavirus Aid, Relief, and Economic Security ("CARES") Act—the federal government expanded funding for mental health initiatives amidst COVID-19.[11] However, licensure requirements, including those for providers of telemental health services, were only waived "so long as the state in

5. Allison N. Winnike & Bobby Joe Dale III, *Rewiring Mental Health: Legal and Regulatory Solutions for the Effective Implementation of Telepsychiatry and Telemental Health Care*, 17 HOUS. J. HEALTH L. & POL'Y 21, 24 (2017).

6. *See* Lazur et al., *supra* note 4.

7. *See id.* Examples of telemental health services may include: "cognitive behavioral therapy, general psychotherapy, behavioral activation, problem-solving therapy, medication management, and training for parents of children with attention-deficit hyperactivity disorder." *Id.*

8. Winnike & Dale III, *supra* note 5, at 23.

9. *See, e.g.*, N.J. STAT. ANN. § 45:1 (West 2021).

10. *See* Nora Schneider et al., *Telehealth During COVID-19: New Rules and Considerations*, LAW360 (Apr. 1, 2020), https://plus.lexis.com/api/permalink/e7128bd1-e2c2-4913-b799-91454d565ff7/?context=1530671.

11. *See* Jennifer G. Bolton et al., *The CARES Act: Assistance and Funding for Health Care Providers*, 16 PRATT'S J. BANKR. L. (June 2020), https://plus.lexis.com/api/permalink/558244d9-d905-4fe9-98ce-a6704ca9c507/?context=1530671; Nirmita Panchal et al., *The Implications of COVID-19 for Mental Health and Substance Use*, KAISER FAM. FOUND. (Feb. 10, 2021), https://www.kff.org/coronavirus-covid-19/issue-brief/the-implications-of-covid-19-for-mental-health-and-substance-use/ (discussing $4.25 billion in funding). Through the CARES Act, the Federal Communications Commission ("FCC") directly distributed funds to health care centers across the country. *See* Jasmine Pennic, *FCC Surpasses $100M in Approved COVID-19 Telehealth Program Application*s, HIT CONSULTANT (June 10, 2020), https://hitconsultant.net/2020/06/10/fcc-surpasses-100m-in-approved-covid-19-telehealth-program-applications/#.YEjvbp1Kg2y (showing one funded New Jersey location versus several times as much funding in New York and Pennsylvania for multiple locations).

which the patient is located permits it."[12] State law, therefore, ultimately dictates the standards for rendering telehealth services, prolonging what has been called a "patchwork of rules and exceptions" in this area at both the state and federal levels.[13]

Early during the COVID-19 pandemic, all fifty states relaxed telehealth requirements to increase access to health care.[14] By April of 2020, forty-nine states had issued temporary licensure waivers, which allowed more licensed, out-of-state health care practitioners to provide virtual services to residents of the given state.[15] New Jersey was one of them, relaxing its licensure requirements only for the duration of the state's declared public health emergency.[16]

New Jersey telehealth law originates from Title 45, Subtitle 1 of the New Jersey Statutes: Professions and Occupations Regulated by State Boards of Registration and Examination.[17] Under Section 45:1–62(b), health care providers must be licensed in the state of New Jersey to provide telehealth services to in-state recipients.[18] During the height of

12. Arthur Fried & Amy Lerman, *A Look At COVID-19 Telehealth Measures in NY and Beyond*, LAW360 (Apr. 17, 2020), https://plus.lexis.com/api/permalink/1cdcb2d8-dd93-464a-bca9-cd221a69735d/?context=1530671.

13. Winnike & Dale III, *supra* note 5, at 24; *see Medicare Telemedicine Healthcare Provider Fact Sheet*, CTRS. FOR MEDICARE & MEDICAID SERVS. (Mar. 17, 2020) [hereinafter *CMS Fact Sheet*], https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet ("Distant site practitioners . . . [may] furnish and get payment for covered telehealth services (*subject to state law*).") (emphasis added).

14. *See 2020–2021 Executive Orders*, THE COUNCIL OF STATE GOV'TS, https://web.csg.org/covid19/executive-orders/ (last visited Mar. 20, 2022).

15. *See* Schneider et al., *supra* note 10. Other common state-level changes included reimbursement of telehealth services at the same rate as in-person services and waived or otherwise streamlined completion processes for administrative requirements, such as the informed consent process. *See, e.g.*, N.J. STAT. ANN. § 45:1–63 (West 2021); Sarah Blumenthal & Richard Harris, *4 Telehealth Concerns for Care Management After COVID-19*, LAW360 (June 15, 2020), https://plus.lexis.com/api/permalink/c0089f99-c712-40fc-9cbf-3fcbdbfd371c/?context=1530671; Michael DeAgro et al., *11 Post-Pandemic Predictions for Telehealth Regulation*, LAW360 (May 12, 2020), https://plus.lexis.com/api/permalink/ba0277d6-39dc-401a-8e75-c0a9d5b5529e/?context=1530671. An increase in state licensure compacts further enabled this flexibility for providers. *See Participating States*, INTERSTATE MED. LICENSURE COMPACT, https://www.imlcc.org/participating-states/ (last visited Aug. 24, 2022). Prior to the pandemic, only some states waived licensure requirements for out-of-state providers on limited bases. *See* Jeremy Sherer & Amy Joseph, *In This Issue, Physician Law Evolving Trends and Hot Topics: Telehealth*, 32 HEALTH LAW. 20, 23 (2020); *see also* Fried & Lerman, *supra* note 12.

16. *See, e.g.*, Assemb. 3860, 219th Leg., Reg. Sess. (N.J. 2020). Governor Philip Murphy extended New Jersey's state of emergency multiple times. *See* N.J. Exec. Order Nos. 103, 119, 151, 162, 171, 180, 186, 191, 200, 210, 215, 222, 231, 235, 240, 280, 288. However, like those of most other states, New Jersey's COVID-19 measures have already expired as of the date of this commentary. *See, e.g.*, N.J. Exec. Order No. 292.

17. N.J. STAT. ANN. § 45:1 (West 2021).

18. *Id.* § 45:1–62(b)(1).

COVID-19, providers licensed in other states were permitted to waive this requirement when the following conditions were present:

> (1) the health care practitioner is validly licensed or certified to provide health care services in another state . . . and is in good standing in the jurisdiction that issued the license or certification; (2) the health care services provided by the health care practitioner using telemedicine and telehealth are within the practitioner's authorized scope of practice in the jurisdiction that issued the license or certification; (3) unless the health care practitioner has a preexisting provider-patient relationship with the patient that is unrelated to COVID-19, the health care services provided are limited to services related to screening for, diagnosing, or treating COVID-19; and (4) . . . [re-iterating subsection (3)].[19]

To "complement" this legislation, New Jersey waived more licensure requirements for health care professionals from other jurisdictions during COVID-19 through an expedited "temporary-licensure-by-reciprocity" process.[20] While these changes undoubtedly expanded virtual health care accessibility by streamlining various processes, they expired in March 2022 as soon as New Jersey's public health emergency ended.[21]

B. State Law as a Vehicle for Change

Multiple states similarly require in-state licensure before health care providers can provide in-state telehealth services under their own terms.[22] This fragmented and inconsistent state licensure system poses "serious obstacles" to the widespread implementation of and access to telehealth within state borders.[23] Even amidst supporting federal initiatives, telehealth expansion is difficult "largely due to [individual,]

19. N.J. Assemb. 3860.

20. *AG Grewal: NJ Temporarily Waives Rules for Out-of-State Healthcare Providers to Offer Services to NJ Residents During COVID-19 Emergency*, OFF. OF THE ATT'Y GEN. (Mar. 20, 2020), https://www.nj.gov/oag/newsreleases20/pr20200320a.html.

21. *See* N.J. Exec. Order No. 292; N.J. Assemb. 3860 § 1 (stating changes were to last only "[f]or the duration of the public health emergency").

22. *See* Mallory Burney, *Federal Regulation of Telemedicine: Weighing Benefits to Patients with Chronic Illnesses Against Constitutional Questions*, 29 ANNALS OF HEALTH L. AND LIFE SCIS.: ADVANCE DIRECTIVES 111, 115 (2020).

23. *Id.*

restrictive state laws."[24] A permanent change in state law is thus critical to expand access to telemental health.

Sage Grazer, a licensed therapist and co-founder of Frame[25]—a mental wellness network designed to match patients with therapists[26]—has revealed some of the state licensure struggles from a practitioner's perspective. In an interview, Ms. Grazer explained that if a therapist's patient leaves the state for any reason, even just temporarily—as many did at some point during the COVID-19 pandemic—it is illegal under most traditional state licensure requirements for the therapist to continue providing services to that patient beyond the state border.[27] To continue to do so poses a risk that, if a lawsuit occurs for example, the therapist will be deemed "practicing without a license" no matter how long or under what circumstances the therapist previously provided services to that patient legally within state borders.[28] Furthermore, the process of obtaining certification for another state often requires the therapist to take several courses over time and pass a very serious examination.[29] Even when seeking temporary approval to provide finite services to a patient outside of state borders, therapists must petition to state medical boards as part of a complicated process.[30]

Ms. Grazer herself has studied licensure requirements extensively, but has found through her work that the average therapist has a difficult time understanding licensure laws because they are so complex.[31] When it comes to a therapist seeking temporary approval for out-of-state services, or otherwise trying to practice beyond state borders, she describes a general rule: "if you want to be safe, [you just] don't cross the line."[32] In other words, state licensure processes are so complicated that it often puts therapists in a bind; the fear of practicing "illegally" can discourage them from taking on new, out-of-state patients or continuing to service patients who subsequently leave the state.[33] States thus can best help increase access to treatment by streamlining their individual

24. *Id.* "Arguably the largest barrier to wide-spread adoption of telemedicine is the state-by-state regulation of licensing requirements, each of which have unique [licensing] policies . . . ." *Id.*

25. *See About Me*, SAGE GRAZER PSYCHOTHERAPY, https://sagegrazertherapy.com/about (last visited May 23, 2022).

26. For further information about Frame, see FRAME, https://www.tryframe.com/ (last visited May 23, 2022).

27. Video Interview with Sage Grazer, Co-Founder, Frame (June 24, 2022).

28. *Id.*

29. *See id.*

30. *See id.*

31. *See id.* This adds another dimension to the limitations of traditional, strict state licensure laws.

32. *Id.*

33. *Id.*

licensure processes—when appropriate—making it easier for both patients and providers to navigate.

III. WHY PERMANENTLY EXPANDED ACCESS TO TELEMENTAL HEALTH IS NECESSARY AND APPROPRIATE TO COMBAT MENTAL ILLNESS AND BARRIERS TO TREATMENT

Pandemic or not, the need for mental health care is imminent.[34] One of the most common mental illnesses, depression, or major depressive disorder, can cause several life-altering symptoms ranging from "feeling sad" to "thoughts of death or suicide."[35] Untreated depression can turn into a chronic condition,[36] and there are strong statistical ties between depression, anxiety,[37] substance use disorders,[38] other illnesses, and suicidality, especially if untreated.[39] Fortunately, telemental health services, such as telepsychiatry, can—at the very least—be equally as effective as in-person treatment.[40]

34. *See* Panchal et al., *supra* note 11 ("Mental distress during the pandemic is occurring against a backdrop of high rates of mental illness and substance use that existed prior to the current crisis.").

35. *What is Depression?*, AM. PSYCHIATRIC ASS'N, https://www.psychiatry.org/patients-families/depression/what-is-depression (last visited Mar. 10, 2021).

36. *See Major Depression*, HARV. HEALTH PUBL'G (Dec. 2018), https://www.health.harvard.edu/a_to_z/major-depression-a-to-z.

37. Comorbidity of anxiety and depression is common in patients. Jena M. Richer, *Victims of Introspection: Insufficient Legal Protections for At-Risk Users of Automated Mental Health Apps*, 44 VT. L. REV. 893, 908 (2020). In fact, anxiety is the most common mental illness in the United States; even before the pandemic, one in three people were expected to suffer from it in their lifetime. *See id.* at 907. During the pandemic, 41% of Americans reported having frequent and recurring symptoms of anxiety and/or major depression—an "unprecedented share of people." Panchal et al., *supra* note 11.

38. "13% of adults reported [in a June 2020 survey] new or increased substance use due to coronavirus-related stress, and 11% of adults reported thoughts of suicide in the past 30 days." Panchal et al., *supra* note 11 (noting a rise in solitary, as opposed to social, substance use in adolescents that is "associated with poorer mental health"). As a result, suicide rates have risen because of the pandemic, especially for marginalized populations. *See id.*; Benjamin F. Miller & M. Justin Coffey, *Understanding Suicide Risk and Prevention*, HEALTH AFFS. (Jan. 29, 2021), https://www.healthaffairs.org/do/10.1377/hpb20201228.198475/full/.

39. *See* Panchal et al., *supra* note 11.

40. *See* Richer, *supra* note 37, at 902, 906; Lazur et al., *supra* note 4. Research has shown that mental health care mandates at the state level are associated with a decrease in suicide rates. *See* Matthew Lang, *The Impact of Mental Health Insurance Laws on State Suicide Rates*, 22 HEALTH ECON. 73, 85 (2013).

A. Mental Illness, Suicide Rates, and New Jersey Prevention Measures

In 2015, "[o]ne of the leading causes of suicide [was] an untreated or mismanaged mental health disorder."[41] By 2018–19, right before the COVID-19 pandemic, "[n]early one in five U.S. adults (47 million) reported having any mental illness,"[42] and about 17.3 million adults suffered from "at least one episode of major depression."[43] Mental illness therefore has long been a concern in the United States, regardless of any pandemic. However, due to lockdowns, social distancing, job loss, food and housing insecurity, and many other concerns, these numbers skyrocketed in the wake of COVID-19.[44]

Concerningly, rates of mental illness and substance misuse are predicted to continue to climb even after the pandemic ends, "particularly for groups at risk of new or exacerbated mental health disorders and those facing barriers to accessing care."[45] Indeed, "[h]istory has shown that the mental health impact of disasters outlasts the physical impact, suggesting today's elevated mental health need will continue well beyond the [COVID-19] outbreak itself."[46] One analysis predicted that "additional deaths due to suicide and alcohol or drug misuse may [still] occur by 2029."[47] The pertinent need for mental health care and suicide prevention thus likely will not disappear at any point in the near future.

Prior to and still now during the COVID-19 pandemic, certain populations—including people of color, women, young adults, people with low socioeconomic status, and members of the LGBTQ and trans

41. Tristan Serri, *An Examination of the Impact of Malpractice Law on Telepsychiatry Clinicians & Clients with Suicidal Ideations*, 50 AKRON L. REV. 933, 935 (2016).

42. Panchal et al., *supra* note 11.

43. Richer, *supra* note 37, at 908.

44. *See* Jillian McKoy, *Depression Rates in US Tripled When the Pandemic First Hit—Now, They're Even Worse*, BOS. UNIV.: THE BRINK (Oct. 7, 2021), https://www.bu.edu/articles/2021/depression-rates-tripled-when-pandemic-first-hit/; Panchal et al., *supra* note 11; *see also* Jaspreet Singh & Jagandeep Singh, *COVID-19 and Its Impact on Society,* 2 ELEC. RSCH. J. SOC. SCIS. & HUMANS. 168, 171 (2020).

45. Panchal et al., *supra* note 11.

46. *Id.* (citing Maddy Savage, *Covid-19 Has Increased Anxiety for Many of Us, and Experts Warn a Sizable Minority Could Be Left with Mental Health Problems that Outlast the Pandemic*, BBC (Oct. 28, 2020), https://www.bbc.com/worklife/article/20201021-coronavirus-the-possible-long-term-mental-health-impacts) (finding "significant implications for mortality" and that "the increased need for mental health and substance use services will likely persist long term").

47. *Id.* (citing Amy Shields, *New WBT & Robert Graham Center Analysis: The COVID Pandemic Could Lead to 75,000 Additional Deaths from Alcohol and Drug Misuse and Suicide*, WELL BEING TR. (May 8, 2020, 10:40 AM), https://wellbeingtrust.org/press-releases/new-wbt-robert-graham-center-analysis-the-covid-pandemic-could-lead-to-75000-additional-deaths-from-alcohol-and-drug-misuse-and-suicide/).

communities—suffer disproportionately from mental illness.[48] For example, "40 percent of transgender[] individuals have attempted suicide in their lifetime . . . exceeding the rate within the US population by nearly nine times."[49] Black and Hispanic communities also experience particularly adverse mental health effects.[50] Not only did they suffer from a higher number of COVID-19 cases and deaths compared to other demographic groups, but they were also more likely than white communities to suffer from persistent mental illness with more severe consequences, as opposed to episodic illness.[51] Current as well as pre-pandemic data show these disparities.[52]

Additionally, more women than men suffer(ed) from mental illness, as do (and did) more young adults than people in older age groups.[53] According to a survey conducted in December 2020, 56.2% of young adults ages eighteen to twenty-four reported experiencing symptoms of anxiety and/or depression, compared to 48.9%—which is still an alarmingly high percentage itself—of adults ages twenty-five to forty-nine.[54] People of low socioeconomic status have also suffered disproportionately and "are generally more likely to report major negative mental health impacts from worry or stress over the coronavirus."[55] The intersection of multiple marginalized identities cannot be overlooked; communities of color, for example, are more likely

48. *See id.*; *see also Statistics About Disparities in Mental Health Care*, DEPRESSION & BIPOLAR SUPPORT ALL., https://www.dbsalliance.org/education/disparities-mental-health-care/ (last visited Aug. 24, 2022); *Mental Health Disparities Among Racial and Ethnic Minorities: What Providers Should Know*, AM. PSYCH. ASS'N (Jan. 2022), https://www.apa.org/pi/disability/resources/mental-health-disparities; Michelle Guerra, *Black Mental Health: Black Americans' Behavioral Health Needs Outpace Access to Care*, RTI HEALTH ADVANCE (May 31, 2022), https://healthcare.rti.org/insights/black-mental-health-and-behavioral-health-disparities; Andrea Rice, *Pandemic Worsens Youth Mental Health, Especially Marginalized Groups, U.S. Surgeon General Warns*, PSYCHCENTRAL (Dec. 21, 2021), https://psychcentral.com/news/pandemic-worsens-youth-mental-health-says-us-surgeon-general.

49. Miller & Coffey, *supra* note 38. Youth in the LGBTQ community "seriously contemplate suicide at nearly three times the rate of heterosexual youth" and have an attempted suicide rate that is "nearly five times higher." *Id.*

50. *See* Panchal et al., *supra* note 11.

51. *See Statistics About Disparities in Mental Health Care*, *supra* note 48; Guerra, *supra* note 48; Miller & Coffey, *supra* note 38; Richer, *supra* note 37, at 907.

52. *See, e.g.*, Panchal et al., *supra* note 11; Guerra, *supra* note 48 (discussing both "[p]andemic-fueled depression" and "long-term behavioral health problems among Black people [that] are the [effect of] cumulative and lingering adversities").

53. Richer, *supra* note 37, at 907; *see Mental Illness*, NAT'L INST. OF MENTAL HEALTH, https://www.nimh.nih.gov/health/statistics/mental-illness.shtml (Jan. 2022) (comparing 30.6% of young adults aged eighteen to twenty-five with 25.3% and 14.5% of older age groups, and 25.8% of women with 15.8% of men); Panchal et al., *supra* note 11, at fig. 6.

54. Panchal et al., *supra* note 11, at fig. 3.

55. *Id.* (comparing wealth brackets in Figure 5).

to suffer from poverty and other socioeconomic disparities than other groups, which can lead to lower mental well-being and decreased access to resources.[56]

Gravely, mental illness does not just affect people's lives; like COVID-19, it takes lives.[57] "*The vast majority—over 90%—of adults who commit suicide suffer from mental illness*."[58] Risk factors for suicide include "psychosocial trauma, recent loss of a loved one or job, hopelessness, intense anxiety, severe insomnia, isolation or lack of social support, [and] chronic pain,"[59] as well as:

> (i) depression and other mental disorders, or a substance-abuse disorder (often in combination with other mental disorders); (ii) prior suicide attempts; (iii) a family history of mental disorder or substance abuse; (iv) family history of suicide . . . and (viii) exposure to the suicidal behavior of others, such as family members, peers, or celebrities.[60]

These factors work together to beget suicidal risk, starting with the presence of mental illness: suffering from mental illness oneself or being surrounded by family who is mentally ill are risk factors for suicidal behavior, which itself is another risk factor for suicide.[61] Anxiety, an incredibly common mental illness in the United States,[62] is "particularly significant in [its] . . . common correlation to suicide and suicidal ideations, which includes thinking about, considering, or planning suicide."[63] Given the startling prevalence of mental illness—especially depression and anxiety—in the United States, suicide prevention measures and accessible mental health treatment are necessities.

In New Jersey, there are more than twice as many suicides as homicides in the state.[64] The state legislature and Department of Education have responded to this concern through various educational

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56. *Identity and Cultural Dimensions: Black/African American*, NAT'L ALL. ON MENTAL ILLNESS, https://www.nami.org/Your-Journey/Identity-and-Cultural-Dimensions/Black-African-American (last visited Mar. 20, 2022); Guerra, *supra* note 48 ("Black people are more than 7 times as likely [than white people] to live in high-poverty neighborhoods with limited or no access to mental health services.").

57. Suicide, the second leading cause of death for people between the ages of ten and thirty-four in 2017, has been a concern long before the COVID-19 pandemic. *See* Panchal, *supra* note 11; Richer, *supra* note 37, at 910.

58. Richer, *supra* note 37, at 909 (emphasis added).

59. Miller & Coffey, *supra* note 38.

60. Serri, *supra* note 41, at 938.

61. *See id.* (noting factors (i)–(iv) and (viii)); Panchal et al., *supra* note 11.

62. *See* Miller & Coffey, *supra* note 38; Richer, *supra* note 37, at 907.

63. Richer, *supra* note 37, at 908 (emphasis omitted).

64. *See Health Indicator Report of Suicide*, NJSHAD, https://www-doh.state.nj.us/doh-shad/indicator/view/Suicide.year.html (last visited Mar. 10, 2021).

initiatives, including a November 2019 Act to monitor the progress of public-school programs designed to raise mental health awareness and suicide intervention and prevention.[65] Thus, it is clearly a priority of the state government to address the suicidal risk that mental illness poses for students. Education systems contain "proven processes for identifying suicide risk and intervening" to ultimately help reduce suicide risk, alongside health care and criminal justice initiatives.[66] Adopting the legislative proposal outlined in Part IV of this paper would push New Jersey toward fulfilling such reduction processes by strengthening suicide prevention on the health care front and complementing all of the work it has already achieved on the education front.[67]

B. Addressing Traditional Mental Health Treatment Barriers

With the omnipresence of mental illness and suicide risk, adequate access to treatment is essential to preserve New Jersey residents' health and mental well-being. Insufficient physical access to care, along with its unrealistic cost, often prevents people—especially the mentally ill and those of other marginalized backgrounds—from receiving proper care.[68] Such barriers can further exacerbate mental health conditions and heighten suicide risk. Expanding access to telemental health care alleviates both issues.

1. Insufficient Physical Access to Mental Health Care

An overwhelming majority of Americans equally value their mental and physical health;[69] yet, under the current system, people generally do

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65. *See* S. 4196, 218th Leg., Reg. Sess. (N.J. 2019).

66. Miller & Coffey, *supra* note 38.

67. *See infra* Part IV.

68. Elizabeth A. Silberholz et al., *Disparities in Access to Care in Marginalized Populations*, 29 CURRENT OP. PEDIATRICS 718, 718 (2017) (naming those with mental health conditions as among the three most marginalized groups with respect to access issues). Although not the focus of this commentary, stigmatization is also an important barrier to receiving treatment. Judgments—both self-imposed and those of others—can not only prevent people with mental illnesses from getting the best possible treatment for their conditions, but sometimes from getting any treatment at all. *See* Richer, *supra* note 37, at 899, 907. Virtual treatment helps combat stigmatization, if not directly by reducing feelings of shame, then indirectly by allowing for enhanced comfort in many cases and therefore more productive therapy sessions. *See id.* at 900, 903; Peter Yellowlees, *Psychiatry Unbound Podcast: Telepsychiatry and Health Technologies*, AM. PSYCHIATRIC ASS'N, at 05:04 (May 18, 2019), https://www.psychiatry.org/psychiatrists/practice/telepsychiatry/blog/apa-resources-on-telepsychiatry-and-covid-19.

69. *See* Richer, *supra* note 37, at 899 (quoting *Survey Finds that Americans Value Mental Health and Physical Health Equally*, ADAA (Aug. 31, 2015, 8:00 PM), https://adaa.org/survey-finds-americans-value-mental-health-and-physical-health-equally)

not get the mental health care that they need nor do they feel confident that they are physically able to obtain such care.[70] "In 2018-2019, approximately one-third (35.0%) of adults with serious mental illness . . . in the past year did not receive mental health treatment."[71] This problem has not resolved itself over time. *Eleven years is currently the average amount of time between the onset of one's mental illness symptoms and the time they receive treatment in the United States.*[72]

Vulnerable populations especially face greater physical inaccessibility to care due to work-related as well as transportation and other difficulties.[73] For example, immigrants and refugees, Black and Hispanic people, people who live in rural or low-income urban areas, and incarcerated individuals disproportionately face significant limitations to accessing appropriate treatment, ultimately resulting in insufficient preventative care.[74] Indeed, the demographic groups with the three lowest treatment rates for adults in the United States with mental illness are "Hispanic or Latino: 35.1%," "Non-Hispanic black or African-American: 37.1%," and "Non-Hispanic Asian: 20.8%."[75] Across all listed races, only one—"Non-Hispanic white"—was, albeit barely, above fifty percent for the population percentage with mental illness who receives treatment.[76] Treatment access thus is very limited for various demographic groups throughout the United States and is especially so for marginalized groups.[77] Even when mental health care is accessible, marginalized groups often face disparities within the health care system such as lower quality of care, discrimination, and a greater likelihood of mis- or under-diagnosis.[78]

("Nearly 90 percent of Americans value mental health and physical health equally . . . .") (alteration in original).

70. *Id.* (discussing survey results).

71. *Mental Health and Substance Use Fact Sheets*, KFF (Dec. 13, 2021) [hereinafter *Mental Health Fact Sheets*], https://www.kff.org/statedata/mental-health-and-substance-use-state-fact-sheets/.

72. *See Mental Health by the Numbers*, NAT'L ALL. ON MENTAL ILLNESS [hereinafter *Mental Health Numbers*], https://www.nami.org/mhstats (June 2022).

73. Jeff Wurzburg, *CMS Telehealth Policy Can Benefit Vulnerable Communities*, LAW360 (July 20, 2020, 5:39 PM), HTTPS://WWW.LAW360.COM/ARTICLES/1293035/CMS-TELEHEALTH-POLICY-CAN-BENEFIT-VULNERABLE-COMMUNITIES.

74. *See* Silberholz et al., *supra* note 68, at 718; Panchal et al., *supra* note 11; Serri, *supra* note 41, at 934–35; *Mental Health Numbers*, *supra* note 72 (stating that 63% of inmates with a history of mental illness do not receive mental health treatment while incarcerated and 55% of veterans in local jails report experiencing mental illness).

75. *Mental Health Numbers*, *supra* note 72 (also comparing "Male: 37.4% . . . Female: 51.2% . . . Lesbian, Gay or Bisexual: 54.3% . . . Non-Hispanic white: 51.8% . . . [and] Non-Hispanic mixed/multiracial: 43.0%").

76. *See id.*

77. *See id.*

78. *Statistics About Disparities in Mental Health Care*, *supra* note 48; Deep Shukla, *Why Mental Healthcare Is Less Accessible to Marginalized Communities*, MED. NEWS TODAY

Nationally, New Jersey is not among the worst states regarding number of individuals with "serious mental illness" who do not receive treatment, but not among the best.[79] Thus, there is *ample room* for improvement and, given the omnipresence of mental illness and the clear barriers to accessing adequate treatment, *ample need* for improvement. Fortunately, telemental health provides solutions. First, it is less physically demanding than traditional in-person mental health care,[80] as it removes travel from the care equation[81] and otherwise decreases its cost, time, and distance.[82] In particular, telepsychiatry greatly expands access to care and is "especially vital" for providing "basic mental health treatment to individuals with suicidal ideations."[83]

For certain vulnerable populations, including veterans, incarcerated patients in need of care, the "special needs" population, and those with chronic illnesses, "telepsychiatry's role in increasing access to mental health services has [already] been pivotal," as it helps such groups overcome their unique access challenges.[84] Telepsychiatry also "reduces health disparities across a variety of social and ethnic groups" by effectively "increasing utilization and access to culturally relevant care . . . [for] Asian Americans, individuals of Hispanic origin, and Native Americans."[85] Given the benefits of telepsychiatry that are already starting to be seen by society, and the widespread difficulties various demographic groups face with respect to accessing adequate mental health treatment, a further expansion of virtual mental health treatment is timely and appropriate regardless of any pandemic.

(Apr. 20, 2022), https://www.medicalnewstoday.com/articles/why-mental-healthcare-is-less-accessible-to-marginalized-communities#Provider-discrimination.

79. *See Mental Health Fact Sheets*, *supra* note 71.

80. Wurzburg, *supra* note 73; *see* Burney, *supra* note 22, at 113 (stating remote care "will reduce unnecessary travel . . . and prevent the worsening condition that often accompanies a lack of access to specialized care").

81. This paper assumes that codification of COVID-19 licensure changes would, like it did earlier during COVID-19, allow treatment to be received from patients' homes as the appropriate "site," rather than under other "site requirements" of the broader telehealth industry that sometimes call for patients to leave their homes. For discussions about distant-site requirements, see Schneider et al., *supra* note 10; Sherer et al., *supra* note 15, at 32, 46–47.

82. Winnike & Dale III, *supra* note 5, at 45.

83. Richer, *supra* note 37, at 898 (explaining how telepsychiatry "increase[s] efficiency, alleviat[es] the administrative burden on overworked providers, and provide[s] positive clinical outcomes for patients" in underserved areas).

84. *Id.*; *see* Wurzburg, *supra* note 73 (discussing "reduc[ed] impediments to care . . . [such as] transportation, accessibility and the burden on caretakers"); Burney, *supra* note 22, at 111; Winnike & Dale III, *supra* note 5, at 45.

85. Winnike & Dale III, *supra* note 5, at 45.

2. Cost of Receiving Effective Mental Health Care

Mental health care in the United States is costly,[86] due in part to a severe lack of funding for mental health programs.[87] The high cost of treatment itself is often a barrier to care as well.[88] In particular, major depression treatment usually lasts for an extended period of time—a minimum of six to twelve weeks for the patient to stabilize, followed by another four to nine months in the aftermath.[89] As a result, "[m]aintenance of depression can potentially last for years, and costs of treatment can quickly become expensive."[90]

Traditional in-person mental health care also has various indirect costs, such as "necess[ary] time off work, resources to arrange travel, and planning child or elder care."[91] Studies have shown that untreated mental illness produces similar collateral and overall health care costs for the patient, presumably because such individuals "are more likely to have a physical illness [as well] and because untreated mental illness can worsen the prognosis of, prolong the period of recovery from, and increase the risk of mortality associated with physical illness."[92]

Lastly, health care and insurance policies pose additional financial barriers and tend to adversely impact the mentally ill because of limited and insufficient coverage options for mental health treatment.[93] For example, a large fraction—over one third—of counties in the United States "lack 'outpatient mental health facilities that accept Medicaid,'"[94] and adults with serious psychological distress are more likely than the general population to be uninsured and unable to afford mental health care or counseling.[95] Even for those who have health insurance, "an

86. Richer, *supra* note 37, at 902–03 ("Cost stands as a major barrier to [mental health] treatment."); *see also* Winnike & Dale III, *supra* note 5, at 33.

87. Winnike & Dale III, *supra* note 5, at 25.

88. *See id.* at 33 (stating that cost is a "major structural barrier" for the mentally ill).

89. *See* Lang, *supra* note 40, at 76–77; *Major Depression*, *supra* note 36 (stating that even "[w]hen treatment is successful . . . maintenance treatment is often required to prevent depression from returning").

90. Lang, *supra* note 40, at 77 (footnote omitted).

91. Burney, *supra* note 22, at 113.

92. Stacey A. Tovino, *All Illnesses Are (Not) Created Equal: Reforming Federal Mental Health Insurance Law*, 49 HARV. J. LEGIS. 1, 14–15 (2012) (footnote omitted).

93. *See* Panchal et al., *supra* note 11; Wyatt Koma et al., *One in Four Older Adults Report Anxiety or Depression Amid the COVID-19 Pandemic*, KAISER FAM. FOUND. (Oct. 9, 2020), https://www.kff.org/medicare/issue-brief/one-in-four-older-adults-report-anxiety-or-depression-amid-the-covid-19-pandemic/ ("Psychiatrists . . . are the most likely of any physician specialty to opt out of Medicare.").

94. Winnike & Dale III, *supra* note 5, at 33.

95. Panchal et al., *supra* note 11; *see also Mental Health Numbers*, *supra* note 72 (discussing lack of insurance coverage for U.S. adults with mental illness).

increasingly common barrier to mental health treatment is a lack of in-network options for mental health and substance use care."[96]

With all of these treatment expenses, there really is no way to escape the heavy costs of mental illness,[97] but telehealth can play a key role in mitigating such costs over the long term, from the perspectives of employer, insurer, and patient alike.[98] Pertaining to telemental health in particular, "a number of studies suggest that treating mental illness [virtually] can decrease total health care costs."[99] In fact, a known strength of telemental health, and telehealth in general, is its cost-saving capability.[100] From the patient perspective, "cost-effective" is an understatement.[101] "[O]ne study found telehealth consultations ultimately decreased costs by $12,000 compared to in-person consultations, despite initially costing more than in-person consultations . . . [and a]nother study . . . found that telepsychiatry reduced travel costs and expenses for attending a single consultation by $ 137.62."[102]

These economic improvements in the mental health care industry are extremely important for vulnerable groups who may have more limited resources than others. In particular, because of the insurance law barriers that still exist—which preclude people from affording adequate mental health care[103]—any savings, no matter how incremental, can help. One indirect but nonetheless significant cost-saving feature of telepsychiatry is that it has been found "to reduce the severity of mental health disorder symptoms, improve adherence to treatment regimens, and decrease the length of hospitalizations."[104] Telemental health therefore helps alleviate both direct and indirect mental health care costs in the long term, making such care more financially accessible to all.

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96. Panchal et al., *supra* note 11 (citation omitted).

97. The financial burden from mental health treatment is in addition to the many non-financial "costs" of mental illness, especially when untreated.

98. *See* Richer, *supra* note 37, at 903.

99. Tovino, *supra* note 92, at 15.

100. Richer, *supra* note 37, at 906 (describing telemedicine as a cost-effective way to expand access to health care services).

101. *Id.* at 900.

102. Winnike & Dale III, *supra* note 5, at 46 (footnotes omitted) (further stating "[w]hen utilized in a correctional setting, telepsychiatry produced savings in excess of $ 1 million").

103. *See supra* text accompanying notes 87–102.

104. Winnike & Dale III, *supra* note 5, at 44–45.

C. Telemental Health Promotes Optimal Mental Health Care

"There is no 'one size fits all' [mental health] treatment,"[105] so flexibility and patient choice are especially important for effective care.[106] Telemental health has the potential during this "era of personalized medicine"[107] to both empower patients individually and expand their mental health care opportunities generally.[108] First, its virtual aspect allows patients to choose from a potentially much broader selection of mental health care providers located beyond state borders.[109] People have unique mental health care needs,[110] so an increased supply of eligible telemental health providers under state law would help state residents pick and choose what providers and programs work best for their needs.[111]

The field of psychiatry is shifting toward this patient-focused approach that telemental health provides.[112] While telepsychiatry was once primarily used in rural populations to overcome long distances, it is now widely used for the purpose of promoting patient choice.[113] In fact, virtual mental health care as one option of treatment among others has been described as the ideal scenario; that is, a combination of both in-person and virtual care—based on the patient's discretion—provides optimal care.[114] Dr. Peter Yellowlees shared in a podcast with the American Psychological Association ("APA"): "This is the way we should all be practicing; there's no argument about that anymore . . . patients prefer us [providers] to be flexible and to be able to see them in lots of

105. *Treatments*, NAT'L ALL. ON MENTAL ILLNESS, https://www.nami.org/About-Mental-Illness/Treatments (last visited Mar. 10, 2021).

106. *See id.* In addition to mental health treatment through counseling or therapy, other considerations for the most effective care are medication, education about mental health, and "social support." *Warning Signs and Symptoms*, NAT'L ALL. ON MENTAL ILLNESS, https://www.nami.org/About-Mental-Illness/Warning-Signs-and-Symptoms (last visited Mar. 10, 2021).

107. Michael Bauer et al., *Smartphones in Mental Health: A Critical Review of Background Issues, Current Status and Future Concerns*, 8 INT'L J. BIPOLAR DISORDERS 2, 13 (2020).

108. *See* Yellowlees, *supra* note 68.

109. *See id.* Telemental health, with relaxed licensure requirements, empowers patients to choose their providers and determine when they would like to be seen. *See id.*

110. *Warning Signs and Symptoms*, *supra* note 106.

111. *See Treatments*, *supra* note 105. When it comes to mental health services that can be delivered quickly, the context in which care is sought is important; depending on the situation, a patient may prefer to receive care immediately instead of otherwise waiting or paying more for a provider with which they have history. *See* Richer, *supra* note 37, at 900.

112. *See generally* Yellowlees, *supra* note 68.

113. *See id.* at 7:50–8:45.

114. *See generally id.*

different ways."[115] This method of providing mental health care also has an efficiency component: it allows providers to see many more patients than before.[116] By increasing access overall, telemental health thus helps address the common problem of limited available mental health providers for those who need treatment.[117]

The flexibility, facility, and efficiency of telemental health, especially its ability to pair patients with out-of-state providers who can best meet their mental health care needs, is pivotal to enhanced treatment for willing patients. However, telemental health—and the great expansion of care it promises—can only be implemented to the extent allowed by state licensure laws. The New Jersey legislature thus plays a crucial role in permitting this new, ideal, and much needed direction of mental health care to take course within its borders.

IV. LEGISLATIVE PROPOSAL: DESIGNATE A CLASS OF VALID MENTAL HEALTH CARE PROVIDERS WHO MAY PROVIDE TELEHEALTH SERVICES TO NEW JERSEY RESIDENTS WITH OUT-OF-STATE LICENSES[118]

This commentary strongly urges the New Jersey legislature to codify its temporarily relaxed COVID-19 licensure regulations as they pertain to telemental health providers who hold valid licenses to practice mental health care in states other than New Jersey. The below legislative proposal aims—through expanded access to mental health care—to address the issues of mental illness in New Jersey and the legal barriers to treatment at the state level.

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115. *Id.* at 6:56. Yellowlees states that such flexibility should aim to provide maximum comfort for patients. *Id.* at 5:23. "I say to people 'If you are not using this approach with at least some of your patients you are *not* providing the best standard of care." *Id.* at 5:26 (emphasis added). Thus, providers should seek to be "hybrid practitioner[s]" who provide services both in person and virtually. *Id.* at 12:55.

116. *See id.* at 18:30–19:27 (discussing the ability to more efficiently treat groups of patients using a variety of methods, including being reachable by email and using asynchronous services as well as video calls and regular in-person services).

117. *See id.*

118. This Part's legislative solution fulfills the stated purposes of: (1) New Jersey's temporary COVID-19 telehealth measures as implemented at the start of the pandemic, but even as applied to telemental health on a permanent basis; (2) the Interstate Medical Licensure Compact ("IMLC"), of which New Jersey takes part; (3) the New Jersey Constitution; and (4) the mental health care industry, according to the APA's stated purpose. *See Governor Murphy Announces Departmental Actions to Expand Access to Telehealth and Tele-Mental Health Services in Response to COVID-19*, STATE OF N.J. GOV. PHIL MURPHY (Mar. 22, 2020), https://www.nj.gov/governor/news/news/562020/20200322b.shtml; Assemb. 5406, 218th Leg., Reg. Sess. (N.J. 2019) (entering New Jersey into the IMLC); N.J. CONST.; *About APA*, AM. PSYCHIATRIC ASS'N, https://www.apa.org/about (last visited Mar. 12, 2021).

Current licensure requirements for health care providers are codified as Section 45:1–62(b) of the New Jersey Statutes,[119] which requires out-of-state telehealth providers to become licensed in New Jersey before providing services to New Jersey residents.[120] Previously during COVID-19, the state temporarily waived these requirements for various types of telehealth providers when the following conditions were present:

> (1) the health care practitioner is validly licensed or certified to provide health care services in another state or territory of the United States or in the District of Columbia, and is in good standing in the jurisdiction that issued the license or certification; (2) the health care services provided by the health care practitioner using telemedicine and telehealth are within the practitioner's authorized scope of practice in the jurisdiction that issued the license or certification; (3) unless the health care practitioner has a preexisting provider-patient relationship with the patient that is unrelated to COVID-19, the health care services provided are limited to services related to screening for, diagnosing, or treating COVID-19; and (4) . . . [re-iterating subsection (3)].[121]

The New Jersey legislature should codify such revisions as part of Title 45, Section 1-62(b) so that this licensure exception will apply even now that we are nearly beyond the COVID-19 pandemic, but only to mental health care providers—as opposed to the vast array of telehealth providers contemplated by the waiver—who are validly licensed in other states. More specifically, the legislature should designate a class of such licensed mental health care providers, deemed "Valid Mental Health Care Providers" under a new Section 45:1-62(g), which would replace the current subsection (g) and shift the current subsection (g), and all subsequent subsections, down by one letter. The licensure requirements qualifying a provider as a Valid Mental Health Care Provider under the new subsection (g) would be the same as those from New Jersey's COVID-19 waiver, excerpted above. This will ensure any Valid Mental Health Care Providers are legally licensed to practice in whichever other states they hold their certifications from. The proposed revisions to Section 45:1-62, in bold below, would read as follows:

> b. Any health care provider who uses telemedicine or engages in telehealth while providing health care services to a patient [who

119. N.J. STAT. ANN. § 45:1–62(b) (West 2021); *see supra* Part II.A.
120. *See* N.J. STAT. ANN. § 45:1–62(b).
121. Assemb. 3860, 219th Leg., Reg. Sess. (N.J. 2020).

is located in New Jersey], shall**, unless deemed a Valid Mental Health Care Provider under subsection g**: (1) be validly licensed, certified, or registered, pursuant to Title 45 of the Revised Statutes, to provide such services in the State of New Jersey; (2) remain subject to regulation by the appropriate New Jersey State licensing board or other New Jersey State professional regulatory entity; (3) act in compliance with existing requirements regarding the maintenance of liability insurance; and (4) remain subject to New Jersey jurisdiction if either the patient or the provider is located in New Jersey at the time services are provided . . .[122]

f. A mental health screener, screening service, or screening psychiatrist subject to the provisions of P.L.1987, c.116 (C.30:4-27.1 et seq.): (1) shall not be required to obtain a separate authorization in order to engage in telemedicine or telehealth for mental health screening purposes; and (2) shall not be required to request and obtain a waiver from existing regulations, prior to engaging in telemedicine or telehealth.

g. A mental health care provider rendering mental health services using telemedicine or telehealth is a Valid Mental Health Care Provider under this subsection if: (1) the health care practitioner is validly licensed or certified to provide **mental** health care services in another state or territory of the United States or in the District of Columbia, and **is** in good standing in the jurisdiction that issued the license or certification; **and** (2) the **mental** health care services provided by the health care practitioner using telemedicine and telehealth are within the practitioner's authorized scope of practice in the jurisdiction that issued the license or certification**.**[123] **Valid Mental Health Care Providers must remain subject to regulation by the appropriate New Jersey State licensing board or other New Jersey State professional regulatory entity, act in compliance with existing requirements regarding the maintenance of liability insurance, and remain subject to New Jersey jurisdiction if either the**

122. N.J. STAT. ANN. § 45:1–62. Note that only subsection (b)(1) is voided by (g), but subsections (b)(2)–(4) would still apply under the language of subsection (g).

123. This language comes from N.J. Assemb. 3860.

> **patient or the provider is located in New Jersey at the time services are provided.**[124]
>
> **h.** A health care provider who engages in telemedicine or telehealth, as authorized by P.L.2017, c.117 (C.45:1-61 et al.), shall maintain a complete record of the patient's care, and shall comply with all applicable State and federal statutes and regulations for recordkeeping, confidentiality, and disclosure of the patient's medical record.[125]

To reiterate, this codified exception would not—as it did through the COVID-19 waiver—apply broadly to various types of telehealth providers; it would only apply to mental health care providers who already hold valid licenses to provide that type of virtual mental health care in other states.

V. CONCLUSION

The need for increased access to mental health care is imminent today, just as it was in the height of the COVID-19 pandemic.[126] With incredibly high mental illness and suicide rates, this commentary strongly urges the New Jersey legislature to adopt the proposed legislative changes. Such an expansion of telemental health can only be enabled through state law, and it would help to combat the burdensome cost and access barriers to mental health treatment that people face. It would also move New Jersey toward a more modern approach to mental health care, embracing the future of technology for the better. Indeed, it is time for legislative action to help reduce suicide rates, reduce suicide risk, and "protect and maintain the [mental] health . . . and welfare of New Jersey residents"[127] in the long term.

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124. This language reinforces the requirements of N.J. STAT. ANN. § 45:1–62(b)(2)–(4). Note that New Jersey's regulatory and jurisdictional control are both maintained.

125. For context, this is the current language of N.J. STAT. ANN. § 45:1–62(g); note that it will hereinafter be subsection (h)—with the remaining subsections following suit—to accommodate for the new subsection (g) inserted to define Valid Mental Health Care Providers.

126. This is especially true for marginalized populations. Wurzburg, *supra* note 73 ("It is critical that legislators and regulators keep vulnerable populations in mind as they seek to facilitate and accommodate the expansion of telehealth.").

127. N.J. Exec. Order No. 103 (declaring a state of emergency during COVID-19 and, by extension, expanding telehealth provisions).