

TeleBehavioral Health 2025 Training Series

Behavioral Health Institute (BHI)

Harborview Medical Center

Website: <https://bhinstitute.uw.edu>

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Northwest Regional

Telehealth Resource Center (NRTRC)

Website: <https://nrtrc.org>

Email: info@nrtrc.org

October 17, 2025



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Behavioral Health Institute (BHI)

Training, Workforce and Policy Innovation Center

The Behavioral Health Institute is a Center of Excellence where innovation, research and clinical practice come together to improve mental health and addiction treatment.

The BHI brings the expertise of Harborview Medical Center/University of Washington Medicine and other university partners together to address the challenges facing Washington's behavioral health system through:

- Clinical Innovation
- Research and Evaluation
- Workforce Development and Training
- Expanded Digital and Telehealth Services and Training

The BHI serves as a regional resource for the advancement of behavioral health outcomes and policy, and to support sustainable system change.



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Northwest Regional Telehealth Resource Center (NRTRC)

Telehealth Technical Assistance Center



The NRTRC delivers telehealth technical assistance and shares expertise through individual consults, trainings, webinars, conference presentations and the web.

Their mission is to advance telehealth programs' development, implementation and integration in rural and medically underserved communities.

The NRTRC aims to assist healthcare providers, organizations and networks in implementing cost-effective telehealth programs to increase access and equity in rural and medically underserved areas and populations.

These sessions were made possible in part by grant number U1UTH42531-03 from the Office for the Advancement of Telehealth, Health Resources and Services Administration, DHHS.



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Speaker Disclosures

None of the series speakers have any relevant conflicts of interest to disclose.

Planner disclosures

The following series planners and team have no relevant conflicts of interest to disclose:

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DISCLAIMER

Please be aware that policy changes may take place after the original date of this presentation.

Any information provided in today's talk is not to be regarded as legal advice. Today's talk is purely for informational purposes.

Please consult with legal counsel, billing & coding experts, and compliance professionals, as well as current legislative and regulatory sources, for accurate and up-to-date information.



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TeleBehavioral Health 2025

Virtual Pathways to Recovery: Telehealth in Correctional Settings

MARY OCHSNER KRAMPEN, LPC, CRC, BC-TMH
BAY RIVERS TELEHEALTH ALLIANCE

OCTOBER 17, 2025



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Learning Objectives

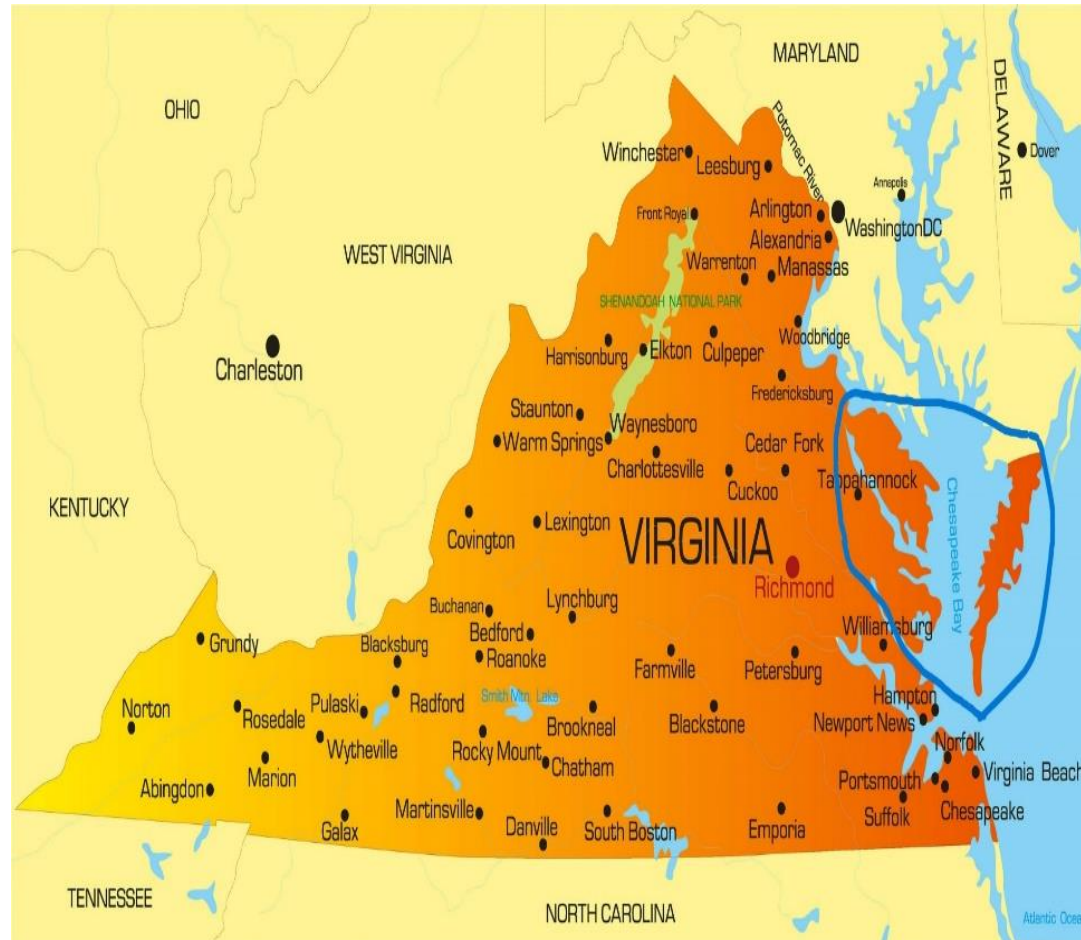
- Recognize the importance of cross-sector collaboration between correctional staff, behavioral health providers, and community organizations.
- Explain how telehealth can address disparities in behavioral health access among justice-involved individuals.
- Identify key barriers and solutions to implementing telebehavioral health services within correctional facilities.



Who are we?

- Non-profit membership organization serving Northern Neck, Middle Peninsula, and Eastern Shore.
- Started by the regional AHEC in 2003 through a RHNDP grant and incorporated and adopted new name in 2007.
- Expertise in Grant Resource Development, Project Management, Evaluation and Consortium Development has resulted in expanding access to medical care for rural populations via telehealth technologies-from remote, live interactive videoconferencing consults by urban-based specialists to reach rural patients and provider facilities.

Service Region



12 Rural Counties in Eastern Virginia

Eastern Shore

- Accomack
- Northampton

Middle Peninsula

- Essex
- Gloucester
- King and Queen
- King William
- Mathews
- Middlesex

Northern Neck

- Lancaster
- Northumberland
- Richmond
- Westmoreland

BRTA Members

- Bay Aging (2004)
- Bay Consortium Workforce Development Board (2015)
- Eastern Shore Community Services Board (2020)
- Eastern Shore Rural Health (2020)
- Ledwith-Lewis Free Clinic (2018)
- Macon & Joan Brock Virginia Health Sciences at Old Dominion University (2015- formerly Eastern Virginia Medical School)
- Master Center for Addiction Medicine (2022)
- Middle Peninsula/ Northern Neck Community Services Board (2005)
- Northern Neck Middlesex Free Health Clinic (2024)
- Rappahannock Community College (2015)
- Riverside Health System (2004)
- Virginia Commonwealth University Health Services (2004)
- Virginia Department of Health (2004)

Our Project Partners Over the Years

- [Alzheimer's Association Great Richmond Chapter](#)
- [Bay Transit](#)
- [Bon Secours Rappahannock General Hospital](#)
- [Colonial Beach Public Schools](#)
- [Eastern Shore Community College](#)
- Eastern Shore Regional Jail
- [Eastern Shore Rural Health Services Inc.](#)
- [Essex County EMS](#)
- [HCA Capital Division](#)
- [Lancaster County Sheriff's Office](#)
- [Martha W. Goodson Center \(formerly Riverside Center for Excellence in Aging & Lifelong Health \(CEALH\)\)](#)
- [Mathews County Sheriff's Office](#)
- [Mid-Atlantic Telehealth Resource Center](#)
- [Middle Peninsula Regional Security Center](#)
- [Middlesex Department of Social Services](#)
- [Northampton County Sheriff's Office](#)
- [Northampton County EMS](#)
- [Northumberland County Department of Social Services](#)
- [Northumberland County Public Schools](#)
- Peninsulas EMS Council
- Rappahannock Area Health Education Center
- [Rappahannock Westminster-Canterbury](#)
- [Richmond County Department of Social Services](#)
- [Riverside Shore Memorial Hospital](#)
- [Riverside Walter Reed Hospital](#)
- [The College of William and Mary](#)
- [UVA Health System Center for Telehealth](#)
- [Virginia Career Works Bay Consortium Region](#)
- [VCU Center for Trauma & Critical Care Education](#)
- [Virginia Department of Veterans Services](#)
- [Virginia Healthcare Workforce Development Authority](#)
- [Virginia Department of Health](#)
- Virginia Opioid Abatement Authority
- Virginia Telehealth Network
- Virginia Rural Health Association
- Virginia Workforce Consortium
- [Westmoreland County Department of Social Services](#)
- [Westmoreland County Public Schools](#)
- [Westmoreland County Sheriff's Office](#)

Bay Rivers Telehealth Alliance Awards Timeline

2005-2006	HRSA Network Development Planning Grant through RAHEC. \$77,678
2006	Riverside Foundation. \$18,000
2006-2009	HRSA Network Development Grant through RAHEC. \$463,243
2009-2012	HRSA Rural Health Care Services Outreach Grant Bridges to Health Rural Outreach. \$375,000
2011	USDA Distance Learning & Telemedicine. \$214,199 w/Riverside Health System Match. \$200,000
2012-2014	HRSA Rural Health Care Services Outreach Grant, Telemental Health Project. \$208,962
2012-2016	Office for Advancement of Telehealth Network Grant Program: Bridges to Geriatric Behavioral Telehealth in Long-term care and Community. \$999,055
2014-2019	Virginia Health Care Workforce Development Authority: BRTA became the Rappahannock Area Health Education Center. \$484,856.26
2015-2018	Rural Health Outreach Bridges to Care Transition. \$600,000
2016-2019	Virginia Department of Health: Veteran's Behavioral Telehealth Project. \$162,500
2016-2020	Office for Advancement of Telehealth Network Grant Program: School Based Telehealth Initiative. \$1,505,322
2017	FAMILIES (Family Access to Memory Impairment and Loss Information, Engagement and Supports). \$10,200
2018	USDA Distance Learning & Telemedicine. \$226,511
2018-2019	Rural Communities Opioid Response Program Planning. \$200,000
2018-2021	Rural Health Outreach Bridges <u>To</u> Cardiovascular Population Health. \$600,000
2020-2023	Rural Communities Opioid Response Program Implementation NNMP. \$1,000,000
2020-2023	Virginia Department of Health- CDC InnoVAte. \$146,572.49
2020-2024	Established Eastern Shore Telehealth Consortium (ESTC) with HRSA Rural Health Network Development grant (RHND). \$900,000
2021-2024	Rural Communities Opioid Response Program Implementation ESTC. \$1,000,000
2021-2024	Rural Communities Opioid Response Program Psychostimulants. \$500,000
2022-2025	Rural Communities Opioid Response Program MAT Access. \$3,000,000
2022-2025	HRSA Rural Public Health Workforce Training Network Program grant, EMS Workforce Project. \$1,545,000
2023-2028	SAMSA-Enhancement and Expansion of Treatment and Recovery Services for Adolescents, Transitional Aged Youth, and their Families. \$2,052,637
2024-2029	HRSA Office for the Advancement of Telehealth (OAT). Integrating Behavioral Health into Primary Care through Telehealth Evidence-Based Telehealth Network. \$1,750,000

Poll Time

- Are you currently providing **In-Person** behavioral health services in a correctional facility? Yes or No
- Are you currently providing **Telehealth** behavioral health services in a correctional facility? Yes or No

Virtual Pathways to Recovery: Telehealth in Correctional Settings

FORHP Rural Health Network Development Program Grant #D06RH37494

Rural Communities Opioid Response-Implementation Grant #GA1RH42877

Partners: Eastern Shore Community Services Board, Eastern Shore Health District, Eastern Shore Regional Jail, Eastern Shore Community College, and Riverside Shore Memorial Hospital

Key Activities: Development of Eastern Shore Telehealth Consortium, piloted Integrated Behavioral Health in Primary Care setting (virtual and in-person models), expansion of telehealth equipment, increased workforce development with telehealth focused trainings and curriculum, and expanded telehealth into the local regional jail.

Telehealth Addresses Disparities

- Improve access to underserved areas
- Continuity of care
- Address high prevalence of MH in correctional settings
- Reduces delays in care and reduces stigma
- Timely crisis intervention
- Cost-effective care delivery
- Supports Re-Entry, suicide prevention, and crisis programs
- Expands access to specialists
- Helps facilities meet legal and ethical standards

Virtual Pathways to Recovery: Telehealth in Correctional Settings

Goals: To establish a bridge to services for 150 justice involved individuals over the course of 3 years for outpatient therapy via telehealth (RHND). Engage 75 justice involved individuals in SMART Recovery program (RCORP-I)

Services to include outpatient counseling, case management, and peer recovery were identified as crucial elements for success.

Medication for Opioid Use Disorder (MOUD) sometimes referred to as Medication-Assisted Treatment (MAT) was also identified, but occurred at a later date with other funding sources.

Virtual Pathways to Recovery: Telehealth in Correctional Settings

- Results: 241 justice involved individuals received outpatient therapy (telehealth)
- 78 justice involved individuals stayed with the outpatient provider post release (telehealth and in-person options)
- 98 justice involved individuals participated in SMART Recovery Program (in-person) with a Peer Recovery Specialist
- 88 justice involved individuals participated in the correctional facility's Re-Entry Program (in-person)
- 72 justice involved individuals participated in GED and Digital Literacy programming (in-person)

Virtual Pathways to Recovery: Telehealth in Correctional Settings

- The Re-Entry program was developed to initiate pre-release partnerships with local jails and community resources. The program provides reentry transition services to individuals and helps to reestablish them back into the community.
- SMART Recovery Program- This program works with individuals with SA and co-occurring disorders as well as having a modality for justice involved individuals with MH and SA disorders.
- GED and Digital Literacy- Focuses on educational goals through partnership with local community college.

Poll Time

What do you think would be some of the challenges to providing telehealth based behavioral health in correctional facilities?

One/Two-Word answers- for example workforce, funding, administrator(s) buy-in

Virtual Pathways to Recovery: Telehealth in Correctional Settings- Challenges & Solutions

- Technology & Infrastructure Issues
 - Challenges: Unreliable internet and connectivity, limited equipment, security restrictions
 - Solutions: Partner with IT/create protocols, HIPPA-compliant platforms, grants for equipment, mobile unit
- Privacy & Confidentiality Concerns
 - Challenges: Lack of private space, staff presence, risk of recording
 - Solutions: Secure communications, private therapy rooms, white noise machines, train staff on privacy and minimize presence during sessions unless absolutely necessary

Virtual Pathways to Recovery: Telehealth in Correctional Settings

- Scheduling & Access Barriers
 - Challenges: Competing facility operations, limited staff availability, inconsistent access to clients
 - Solutions: Engage leadership to integrate telehealth appointments into facility routines, assign a facility liaison, provider flexibility on scheduling, session lengths
- Clinical & Therapeutic Limitations
 - Challenges: Rapport, treatment modalities, crisis management
 - Solutions: telehealth foundation training, adapt therapy techniques, develop crisis plan (outside contact number), staff training

Virtual Pathways to Recovery: Telehealth in Correctional Settings- Challenges & Solutions

- Legal & Ethical Dilemmas
 - Challenges: Informed consent, mandated reporting, licensing and jurisdiction
 - Solutions: Facility specific consent forms, research licensing in your state, consult with legal advisors, review legal principles (8th Amendment, 14th Amendment, ADA, Rehabilitation Act)
- Cultural & Institutional Resistance
 - Challenges: Facility and Government buy-in, correctional staff doubt, inmate mistrust, institutional disinterest
 - Solutions: Meetings, collaboration, build relationships with key staff (identify the telehealth champion), discuss the value of the service- normalize mental health support, advocate, respect correctional culture

Virtual Pathways to Recovery: Telehealth in Correctional Settings

- Equity & Continuity of Care
 - Challenges: Disparities in care, post-release continuity
 - Solutions: Standardize services across facilities in a region by partnering, advocate, coordinate with Re-Entry programs, use case managers, provide referrals and schedule post-release appointments before discharge
- Overall Suggestion- Begin conversations, be flexible, piggyback on in-person programs to build trust/rapport, pilot the program, track outcomes, and apply for funding while ensuring a plan for sustainability

Implementing Effective SUD Treatment in Regional & County Facilities- 3 Part Webinar Series-2024



- **Legal Requirement for Medication Assisted Treatment (MAT) Provision in Correctional Institutions:** Presenter - Steve Gordon, Civil Rights Enforcement Coordinator, Assistant United States Attorney, Eastern District of Virginia.
- **Why MAT:** Tackling the Medical Implications and Stigma of Effective Treatment for Substance Use Disorder in Correctional Institutions and the HARP Program: Helping Addicts Recover Progressively. Presenters - G. Mantovani Gay, MD, Medical Director and Kerri Rhodes, LPC, LMFT, Director, Behavioral and Mental Health Division, Chesterfield County Sheriff's Office
- **Jail-Based Recovery Initiatives in the Fairfax County Detention Center:** Presenter - Sheriff Stacey Kincaid
- **The Nuts and Bolts of Implementing STAR:** Striving to Achieve Recovery Program. Presenters - Laura Yager, LPC, and Sahana Karpoor, LCSW, Behavioral Health/MAT Program Manager
- **Funding Effective SUD Treatment in Regional and Local Jails:** A look at Virginia Opioid Abatement Authority. Presenter - Cecil "Charlie" Lintecum, Director of Operations at Virginia Opioid Abatement Authority (OAA)
- **Resources and Funding from the U.S. Department of Justice:** Presenter – Michelle White, Senior Policy Advisor, Bureau of Justice Assistance (BJA), Co-Presenter – Kashif Siddiqi, Senior Director at Rulo Strategies
- **Building Regional Collaboration to Access Funding:** Presenter - Donna Dittman Hale, Bay Rivers Telehealth Alliance Grant Resource Development Expert

YouTube Channel:
<https://www.youtube.com/channel/UCBiFNr9uummHeZlLTj4vtzg>

Bay Rivers Telehealth Alliance



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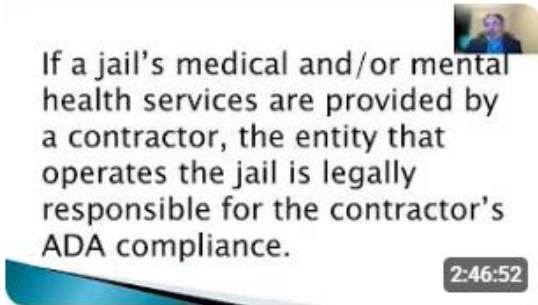
Videos



BRTA_NRHA Award_Acceptance Speech 2025



BRTA VOAA Webinar Day 2 Recording



BRTA VOAA Webinar Day 1 Recording



BRTA VOAA Webinar Day 3 Recording

Questions

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- Newsletter: <https://brtava.org/news-events/subscribe/>
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TeleMental Health Guides for Infancy to Young Adults

Guides (8)

- Infancy and Toddlers
- Pre-schoolers
- Elementary School Children
- Middle School Youth
- High School Teens
- Young Adults
- Neuropsychological Testing
- Suicidality

Guide for Elementary-School Children

DEFINING ELEMENTARY-SCHOOL CHILDREN (GRADES 1-5)

Elementary-School Children (ES; grades 1 to 5th) vary greatly by gender and age in their pubertal development and cognitive maturity, and resources. For example, a 1st grade boy may still be learning to control impulses and cooperation in the classroom while a 5th grade girl may be fully pubertal and aware of societal expectations. Thus, the clinician must be flexible in considering the engagement and treatment of ES children through TeleMental Health (TMH) services. Typically, ES children readily engage with technology, especially seeing themselves on "TV."

SAFETY AND PRIVACY

Establishing safety and privacy depends on the child's location while receiving TMH services. If located at a clinical site, safety and privacy will be ensured by clinical procedures at those sites. If located at a non-clinical site, such as a school or home, careful planning to ensure safety and privacy is needed.

- At the beginning of each session ascertain and document patient's location and exchange immediate contact information (phone, text message, or e-mail). Include any new address, in case the clinician needs to call emergency services, as outlined in the Privacy and Safety Planning Tool (PSP Tool) appended to the Introduction Guide, as well as to comply with documentation regulations in the medical record. If patient is in a car, be sure they are parked and document the nearest stable location.
- Consider providing a virtual tour of the clinician's office to the child and parents/ caregivers to demonstrate that no one else is in the room observing the session. Also, assure them that there is no unseen or unheard person observing the session online and that the session is not being recorded.
- Consider a virtual tour of the child's room or home to ensure that no unseen participant is viewing or listening to the session, or coaching the child.
- Explain that recording of the session is prohibited.
- Turn off social media and access to families' devices by any third party.
- Ensure privacy at home by scheduling while siblings and other adults are not home, connecting out of visual range of others, using headphones, and keeping low-volume radio or TV playing in the common areas to add auditory privacy.
- Consider non-traditional settings at home if needed to ensure privacy, such as a bedroom, bathroom, porch, backyard, or car (with a parent/ caregiver).
- Consider the impact of non-traditional settings on the child's presentation, e.g., less motor activity in a car, less anxiety in the backyard, more depressed at school.

TIP:

Limit children's use of electronics during sessions unless the clinician and parents/caregivers need time to talk without interruptions.

SAFETY AND PRIVACY CONT.

- Consider sessions in a clinic or school, if other professionals are involved in the child's treatment plan or if the child is reluctant to talk at home.
- Children may stray from the clinician's view on the monitor, e.g., children who are hyperactive, disruptive, or anxious. Take steps to ensure the child's safety, and the room's integrity. Steps may include following the child with the camera, the parents/ caregivers maintaining view of their child and informing the clinician, or parents/ caregivers reversing their device's camera to surreptitiously show their child's activity to the clinician.
- Anticipate elopement by poorly self-regulated children. Plan for a second adult to manage these children while the clinician completes the interview with the parents/ caregivers.
- Secure the equipment if sessions are done in a clinic as impulsive children may damage it.
- If an emergency arises, such as suicidality, refer to the Suicidality TMH Guide and the PSP Tool. The PSP Tool should have been completed prior to the initiation of clinical services and includes referral information for the patient's community.
- Also, be aware that calling 911 may not link to other communities. Refer to the PSP Tool as noted above.

TIP:

Determine early the feasibility of and parent/ caregiver's comfort regarding interviewing the child alone, and whether the child poses any potential risk to the equipment or the room.

TELEMENTAL HEALTH GUIDE FOR ELEMENTARY-SCHOOL CHILDREN

Case Example

Abdul is a 10 y/o Afghan refugee boy who presented with his mother due to the school's concern with his inattention and distractibility in class, restlessness and difficulty staying seated, yelling out answers impulsively, and falling behind academically. The Mother noted similar difficulties in the home, especially regarding homework. Both parents worked and lived in an urban neighborhood with poor transportation options, so they agreed to home-based TMH. The family used their smartphone for the sessions, with adequate, but not optimal, cell reception. Sessions were held in the parent's bedroom, for privacy. An older sister watched the siblings in another room or took them for a walk.

Abdul was readily engaged over the smartphone and told of his favorite videogame, his love of Legos, and his best friend at school, as well as the injustices of his siblings. The clinician conducted the interview by alternating between the mother's history and the child's input.

Even with the spotty connectivity, the clinician appreciated Abdul's good verbal skills, intellect, charming personality, as well his impulsive intrusiveness and mild mid-facial and gurgling tic. To assess his gross motor skills, the clinician asked Abdul to do some movements, including some dance movements. He was awkward and had difficulty cooling down once wound up. To assess his fine motor skills, and to keep him occupied in order to obtain the mother's history, Abdul was asked to draw a picture of his favorite animal. He impulsively scribbled something and quickly returned to the smartphone to show his artwork: not an animal, but he enthusiastically told of its meaning, demonstrating his creativity and knowledge.

The clinician then asked Abdul to play with his Hot Wheels in front of his mother, allowing more time with the mother while monitoring Abdul. He did so, fairly quietly for a while, then became increasingly louder, and then disruptive. At various times, Abdul's mother quietly flipped the smartphone's camera to allow observation of Abdul's play without his knowledge. He did show symbolic play, although somewhat aggressive with the Hot Wheels breaking off some wheels.

Then, the clinician sent an ADHD rating scale and an anxiety rating scale to the older daughter's tablet so that the mother could complete these behavior reports in another room while the clinician spent some individual time with Abdul. The mother also logged into the school's website to check Abdul's grades, missing assignments, and the teacher's recent comments. Meanwhile, the clinician observed Abdul's play and engaged him verbally regarding his Hot Wheels. The clinician asked Abdul to trace his favorite Hot Wheel car and write the name of it along with his name on top of the paper. He showed some difficulties with tracing and penmanship but had correct spelling. He showed increased tic movements while engaged in this task.

The clinician made a diagnosis of ADHD with a concern about a fine motor disability and tics. They wrote a treatment plan on the "White Board" that included: a) the clinician requesting completion of behavior rating scales from selected teachers, to be uploaded into the clinician's website portal; b) making the child a "Focus of Concern" under Public Law 94-142 for further school evaluation and possibly special education services; and c) developing a structured plan for homework including turning it in reliably; and d) the mother reviewing the treatment plan on the website and reading information about ADHD treatment, including using behavior charts. As the family did not have a printer, the clinician also sent a hard copy of the treatment plan and readings. They made a plan for the mother to meet alone with the clinician in a week to set up a behavior program and discuss the relevance of a medication trial, consistent with evidence-based treatment for ADHD.

uwcolab.org/tmh-guides

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The clinician then asked Abdul to play with his Hot Wheels in front of his mother, allowing more time with the mother while monitoring Abdul. He did so, fairly quietly for a while, then became increasingly louder, and then disruptive. At various times, Abdul's mother quietly flipped the smartphone's camera to allow observation of Abdul's play without his knowledge. He did show symbolic play, although somewhat aggressive with the Hot Wheels breaking off some wheels.

Then, the clinician sent an ADHD rating scale and an anxiety rating scale to the older daughter's tablet so that the mother could complete these behavior reports in another room while the clinician spent some individual time with Abdul. The mother also logged into the school's website to check Abdul's grades, missing assignments, and the teacher's recent comments. Meanwhile, the clinician observed Abdul's play and engaged him verbally regarding his Hot Wheels. The clinician asked Abdul to trace his favorite Hot Wheel car and write the name of it along with his name on top of the paper. He showed some difficulties with tracing and penmanship but had correct spelling. He showed increased tic movements while engaged in this task.

The clinician made a diagnosis of ADHD with a concern about a fine motor disability and tics. They wrote a treatment plan on the "White Board" that included: a) the clinician requesting completion of behavior rating scales from selected teachers, to be uploaded into the clinician's website portal; b) making the child a "Focus of Concern" under Public Law 94-142 for further school evaluation and possibly special education services; and c) developing a structured plan for homework including turning it in reliably; and d) the mother reviewing the treatment plan on the website and reading information about ADHD treatment, including using behavior charts. As the family did not have a printer, the clinician also sent a hard copy of the treatment plan and readings. They made a plan for the mother to meet alone with the clinician in a week to set up a behavior program and discuss the relevance of a medication trial, consistent with evidence-based treatment for ADHD.

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