Behavioral Health Services (BHS)

Telehealth Practice Guideline

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Approval	Signature	Date
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Introduction

Purpose

The purpose of the Telehealth Practice Guidelines is to inform behavioral health providers of best practices for the delivery of behavioral health services through telehealth. This Practice Guideline aims to assist providers in facilitating safe and effective behavioral health services and to provide resources for the provision of telehealth.

Intended Audience

All staff providing direct clinical services within the Health Care Agency's (HCA) Behavioral Health Services BHS County and County-contracted programs, who will be referred to as **BHS Providers** throughout this document, are the target audience for these Guidelines. BHS Providers include licensed and pre-licensed clinicians, supervisors, medical staff, peer support, and other non-clinical direct service providers.

Definition of Terms

Telehealth, telemedicine, and telepsychiatry are similar terms that are often used interchangeably, but they mean different things. **Telehealth** refers to the use of technology and electronic communication tools to support clinical and non-clinical healthcare services. It is broad in scope and covers all aspects of virtual health. Telehealth offers diverse services including remote client monitoring and health education. Telehealth, for the purpose of this Practice Guideline, refers to behavioral health services that are delivered via ***synchronous*** telecommunications technologies.[1]

Synchronous is "real-time," live communication using an audiovisual or audio-only technology.

Asynchronous, means "not live" and involves digital files containing images, and pre-recorded video and/or audio collected at one location and transmitted to any number of providers at another location at the providers discretion, timing and/or need. Digital images can be video, audio, or text.

Modality refers to the method by which a client receives clinical and non-clinical services, including in-person visits to a clinic or telehealth services accessed remotely. In telehealth specifically, modality refers to the method by which an enrollee receives telehealth services. Telehealth modality may include direct client care or provider-to-provider services, in a synchronous or asynchronous interaction. Other modality examples of telehealth include phone consultations.

Platform is a "catch-all term" for the various means of delivering telehealth services, from secure telehealth software systems that are installed on the provider's computer to mobile apps and all other means.

Telemedicine According to the World Health Organization (WHO), telemedicine is the use of communication technologies to diagnose, treat, and prevent diseases and injuries despite geographic barriers. Telemedicine is a more limited term that falls within the description of telehealth. It is used to describe the utilization of remote clinical services and telecommunications technology to clinically diagnose, treat, and monitor a client's conditions.

Telepsychiatry uses these same technologies above to connect clients with psychiatrists for psychiatric appointments or clinical consultations. Like telemedicine, telepsychiatry is a subset of telehealth and can include psychiatric evaluations, client education, therapy (group therapy, individual therapy, and family therapy), and medication management.

Background

Development of Guideline

This Practice Guideline was developed by the Behavioral Health Services (BHS) Practice Guidelines Workgroup, which is a committee of clinicians, supervisors, psychiatrists, researchers, and BHS managers who represent all BHS areas [e.g., BHS Adult and Older Adult (AOA), BHS Children and Youth Services (CYS), and Quality Management Services (QMS)]. The Practice Guideline Workgroup was developed to create standardized clinical practice guidelines within BHS. The Guideline was developed based on a review of the literature and other popular research sources (e.g. internet websites) in the field.

Selection of Evidence

Existing practice guidelines developed by national and international associations were used as resources in the development of this Practice Guideline. Journal articles referencing established guidelines were also included. All resources used to develop these guidelines were published in the years 2000 through 2023. For the purpose of describing the history of telehealth, resources used were published beginning in the mid-1990s.

Documentation of Need

Telehealth using the telephone was first proposed in medical literature in 1948 and first used in the late 1950s at the University of Nebraska via a two-way television for rural and underserved populations with limited healthcare access.[2,3] According to the literature, telehealth has been utilized in the fields of military and space science,[4,5,6,7] healthcare,[8] psychiatry,[9,10] pediatrics,[11,12] and even underserved regions and populations.[13,14] In the recent decade, the use of telehealth has become more prevalent in delivering services with the advancement of technology.[15] Telehealth has been increasingly used in screening and treating both physical and mental health conditions. During the COVID-19 pandemic, the adoption of telehealth services underwent the most dramatic transformation to meet the needs across the globe.[16,17, 18,19]

Telehealth and telemedicine are often used interchangeably in literature. However, telehealth is used as a broader term than telemedicine.[20,21] There are several ways to define telehealth. *Telehealth* broadly refers to the use of telecommunication technologies to provide care from a distance.[22] According to the Health Resources and Services Administration of the U.S. Department of Health and Human Services,[23] *telehealth* is defined as "the use of electronic information and telecommunication technologies to support long-distance clinical health care, client and professional health-related education, public health, and health administration." The World Health Organization (WHO) defines *telehealth* as "the delivery of health care services, where distance is a critical factor, by all health care professionals using information and communication technologies, for the exchange of valid information for diagnosis, treatment, and prevention of disease and injuries, research and evaluation, and for the continuing education of health care providers, all in the interests of advancing the health of individuals and their communities."

Telehealth can be provided in several different modalities,[24,25] (1) services delivered **synchronously** via telephone or live audio-video interaction in real time; (2) services delivered **asynchronously** via secure email, webinars, or store-and-forward technology, where electronic forms of data (ex. secure messages or images) are collected at one point in time and interpreted or responded to at a later time; and (3) **remote client monitoring (RPM)**, where there is direct transmission of a client's clinical measurements or regular monitoring of a client from a distant site (may or may not be in real time). In addition, **mobile health (mHealth)** which encompasses the use of mobile technology such as mobile apps and smart phones to deliver services may be considered a part of telehealth, but this area is still being studied to determine its effectiveness.

There are several literature reviews outlining the benefits of using telehealth. Many studies have assessed telehealth effectiveness, capability, convenience, and satisfaction to improve outcomes and access to healthcare and eliminate healthcare disparities.[26,27] The literature on telehealth suggests that telehealth technology and the use of electronic referrals and video conferencing are effective.[28] Telehealth interventions were effective in reducing waiting times, waiting lists, and improving the coordination of specialist services.[29] Telehealth has the potential to offer cost

effective services by delivering services promptly and according to each client's needs.[30,31] For example, it was found that telehealth can improve client outcomes at lower cost than traditional face-to-face home healthcare visits.[30] However, not all studies demonstrated that telehealth is a cost-effective means of delivering health care.[32, 36] According to previous research, telehealth improved client access to care and led to improved client satisfaction,[36,37] which is a key indicator for future development of telehealth technology equipment to meet client expectations,[36] While there are many advantages to using telehealth, it has some disadvantages, such as limited use due to technology problems, challenges to the quality of the client-provider relationship, the quality of the examination, quality of care, and decreased client satisfaction.[38] Despite the identified barriers, the use of telehealth has dramatically grown over the past decades and will likely continue to grow with more rapid technological advances over the next decades.

Justification

With the onset of COVID-19, telehealth increasingly became a primary method of service delivery in healthcare settings, due to the need for physical distancing and strong recommendations from the Centers for Medicare and Medicaid Services (CMS). The COVID-19 pandemic resulted in a rapid shift toward the use of telehealth, with additional justification for its use in reaching underserved populations to increase access to behavioral health services. Another strong catalyst, was the reimbursement policy changes directly impacting the delivery of care for older Americans, since Medicare is the primary insurance source for many individuals 65 years of age and older, and children and youth through Medicaid and CHIP programs.[96] As service delivery converted to a largely telehealth modality during the pandemic and has continued to be used as part of regular clinical practice, it is important that Behavioral Health Services (BHS) develops practice guidelines to provide clinicians with information on how to use telehealth safely and effectively in a behavioral health setting. Although the need for telehealth services was obvious during the COVID-19 pandemic, its widespread adoption remains to be assessed for safety and quality especially when considering special populations.[96]

Consistency with Policies, Regulations, Laws, and Professional Standards [92]

Practice Guidelines are expected to meet the following requirements:

- A foundation of valid and reliable clinical evidence or a consensus of health care professionals in the applicable field
- Consideration of the needs of clients across BHS
- Adopted in consultation with contracting health care professionals

- Reviewed and updated periodically as appropriate

A Guideline differs from a Professional Standard, which is mandatory and, thus, may be accompanied by an enforcement mechanism. A Guideline is not mandatory, definitive, or exhaustive. This Practice Guideline is intended to be aspirational, with the intent to facilitate continued development of professional practices and to promote high quality services. This set of guidelines may not apply to every professional or clinical situation within the scope of the Guideline. As a result, the Guideline is not intended to take precedence over professional judgment.

These guidelines are meant to provide consistency with other HCA policies, the Office of Compliance, and any state or federal regulations to which HCA is already adhering. Federal and State laws supersede these Guidelines. Providers should refer to BHS 01.03.04 Telehealth Services in the Mental Health Plan P&P and BHS 01.03.05 Telehealth Services in the Drug Medi-Cal Organized Delivery System P&P for additional information.

Guidelines

Guideline Statement

The American Telemedicine Association (ATA) and the American Psychiatric Association (APA) have outlined best practices and practice guidelines for the provision of telehealth services for behavioral health providers. This Practice Guideline contains components of the guidance put forth by ATA and APA that are applicable to BHS providers within HCA's County and contracted provider network.

Applications

Identity Verification and Location of Provider and the Client

At the outset of telehealth services, BHS providers should provide the client with his or her qualifications and, when applicable, registration or licensure information.[39,40] When a provider is meeting with a client for the first time and the telehealth service is being provided in a setting where another behavioral health provider is not immediately available (e.g. in the client's home), the provider should verify the full name of the client and any support people/family who may be participating in the session. Additionally, the provider may request to verify the identity of the client and any support people/family who may be participating in the telehealth session (e.g. asking for confirmation of date of birth or address/telephone number on file).

BHS providers are to adhere to applicable licensing laws that outline requirements for the physical location of the provider and the client during telehealth services. In the United States, the licensing laws of behavioral health providers are usually tied to where the individual receiving

the service is physically located when the service is provided, not where the individual lives.[41] Providers should verify the location of the client each time a telehealth service is provided, and this should be documented in the progress note.[39,40] Additionally, the location of the provider should be documented in the progress note. For example, "Therapist facilitated telehealth session with client today from her home in California. Therapist verified that client was in his home in California for today's telehealth session" or "Therapist facilitated telehealth session with client today from the Costa Mesa clinic. Therapist verified that client was located at their place of employment in California." This verification and documentation are essential, as BHS providers are not permitted to provide services to clients/beneficiaries who are located outside of California.[39,40]

Another critical component pertaining to verification of client location is emergency and crisis management. If a crisis or emergency arises during a telehealth service, it is essential that the provider knows the location of the client, as this information will be needed if a crisis evaluation is necessary or if a suspected abuse report needs to be made.

Obtaining Contact Information and Discussing Expectations Regarding Contact Between Sessions

At the start of a telehealth service, BHS providers should ensure the client and any support people/family who may be participating in the session have the provider's immediate contact information in the event of a connectivity issue during the telehealth service or in the event of a crisis or emergency. Likewise, the telehealth provider should obtain the immediate contact information for the client and any support people/family who may be participating in the session.

At the outset of services, and periodically as appropriate, providers should review expectations for contact between telehealth sessions. This includes a discussion about the means of contact that is available to the client (e.g., phone, text, and/or electronic communication), the appropriate circumstances for the client to contact the provider between sessions, and the expected timeframe that the client can expect a response. These discussions should also include a review of crisis or emergency management between sessions, including crisis resources, such as OC Links for crisis assessment, the nearest emergency room, or calling 9-1-1.[39,40]

Informed Consent

BHS providers shall obtain informed consent for telehealth services. Providers are to adhere to local, regional, and federal laws as well as agency protocols with regards to whether verbal or written consent is required. Providers shall document the review of informed consent for telehealth services, as well as the obtainment of verbal or written consent from the client or parent/legal guardian, in a progress note.[39]

Informed consent for telehealth services should include a review of the following topics which would also be required for in-person services:

- Structure and timing of services

- Record keeping
- Scheduling
- Privacy
- Potential risks
- Benefits
- Alternatives
- Confidentiality
- Mandated reporting requirements
- Billing

Additionally, the following topics should be included in a review of informed consent for telehealth services:

- Confidentiality and the limits of confidentiality in electronic communication
- An agreed upon emergency plan
- Process by which information will be documented and stored
- The potential for technical issues and what the backup plan will be if a session is disrupted as a result of a connectivity or technical issue
- Procedures for coordination of care with other professionals
- Protocol for contact between sessions
- Conditions that may result in the discontinuation of telehealth services and transition and/or referral to in-person services

To access *BHS Informed Consent for Services and Telehealth Consent* form, please see our BHS's Quality Management Services (QMS) Division webpage for MHP and DMC-ODS, respectively.

Establishing Rapport

Establishing rapport is critical to the effective provision of behavioral health services. The BHS provider's attunement to the verbal and non-verbal communication of the client is key to the process of developing and maintaining rapport. Likewise, the client needs to feel they understand the provider's tone and responses. Additionally, providers need to be able to convey empathy and clients/beneficiaries need to feel heard and understood. Providers should be aware of factors that might impact rapport-building in telehealth services, such as connectivity issues, camera placement, microphone sensitivity, and environmental noise/visual distractions.[42]

Telehealth poses obstacles in Serious Mental Illness (SMI) and Substance Use Disorder (SUD) populations for building rapport, conveying empathy and client agency. Telehealth possesses several intangible aural and visual issues that represent the strength of telehealth, however; telehealth can also overwhelm coping strategies used by SMI & SUD populations. This creates a secondary feedback loop on rapport building[93] and raises the possibility of treatment interruptions.[94]

Some strategies providers can utilize to establish rapport with clients/beneficiaries receiving telehealth services are:

- Seeking verbal confirmation of something the provider has observed and interpreted. For example, "I noticed when you shared about the argument with your mom you looked down and your voice sounded shaky. Are you feeling sad about what happened?"
- Observing and mirroring the emotions, facial expressions, and body language of the client. Telehealth providers have the unique opportunity to see themselves on the screen, which can increase awareness of their own expressions and body language.
- Normalizing any discomfort the client may have with seeing themselves during the telehealth service.
- Maintaining good eye contact. Since it is not possible for the camera to be placed in the middle of the screen where the client's/member's face is, eye contact often appears to be looking up, down, or sideways. To improve direct eye contact, providers can alternate their gaze from the screen to the camera. Additionally, when facilitating groups, providers can say the name of the person they are directing something to.

Client Appropriateness for Telehealth Services

It is critical that BHS providers assess clients for the appropriateness of and comfort level with telehealth services.[39,40] Factors that providers should consider include:

- Cognitive capacity of the client
- Present and/or historical level of cooperation with treatment professionals
- Current or historical substance use issues
- History of violence or self-injurious behavior, suicide risk
- Overall acuity of symptoms or related functional impairments
- Current medical conditions
- Flagging specific medical conditions such as living with a Serious Mental Illness (SMI) including but not limited to schizophrenia, bipolar disorder, or individuals living with a comorbid SUD for limitations or exclusion from telehealth services
- Geographic distance to the nearest emergency medical facility
- Presence, availability, reliability, and/or capacity of support peoples/families
- Client access to and level of competence with technology
- Other logistical factors, such as the client/ member having a private space where they can participate in the telehealth service

Additional factors providers may consider when determining a client's/ member's appropriateness for telehealth services include:

- The client's stated preference for telehealth vs. in-person services and/or offering an accommodation using a combination of both modalities in consultation with provider

- Provider's observations of the client's ability to engage effectively and make progress toward treatment goals using telehealth

Evaluation of the client's appropriateness for telehealth services should take place at the start of telehealth services and be revisited continually throughout the course of treatment. Providers should consult with their supervisor as needed when there are concerns about a client's appropriateness for telehealth services.

Facilitating Telehealth Groups

As with in-person services, BHS providers are responsible for maintaining client confidentiality when facilitating groups, while group members are not required by law to do so. With telehealth services, there are additional risks for confidentiality breaches, including the client participating in group where a family member or someone else in the household can see and/or hear the group or a group member recording or taking screenshots of the group members. As a result of these increased risks, providers are encouraged to provide a more extensive informed consent process with group members. It is recommended that providers screen clients for appropriateness for group services, during which they review the risks and benefits of group participation, informed consent, and established group guidelines or rules.[43] These topics should also be reviewed periodically in group with all members.

When establishing group guidelines, providers are encouraged to include the following components that are unique to telehealth:

- To the extent possible, group members should be in a space free of distractions
- If group members share the space (e.g. client home) with others, ensure that others cannot see or hear the group in progress. Wearing headphones or being in a separate room with the door closed are examples of how to accomplish this.
- Establish backup plans for technology or connectivity issues. For example, if a client gets disconnected, they may need to call in by phone for the remainder of the session. Providers should also establish a plan in case the entire group has technology issues and/or the telehealth platform goes down.
- Discuss how and if chat features should be utilized, as well as when members should mute themselves (e.g. when they are not speaking) in order to minimize background noise.

Telepsychiatry

The American Psychiatric Association Telepsychiatry Toolkit contains the most up to date information on various aspects of telehealth for psychiatry, including but not limited to clinical practice, training, and policy. BHS medical staff are encouraged to familiarize themselves with this toolkit and remain up to date on best practices for their discipline.

BHS medical staff should be mindful of, and discuss with clients/members, some of the limitations of telehealth for psychiatry. For example, the inability to obtain physical examination components, such as vital signs or assessing for Extrapyramidal Symptoms (EPS). BHS medical

staff should maintain ongoing consideration of the impact of such limitations and make recommendations for an in-person appointment when clinically indicated.

Crisis and Mental Health Emergency Management

The State of California Behavioral Health Information Notice No: 23-018 updated telehealth guidance for Specialty Mental Health services and Substance Use Disorder treatment services in Medi-Cal. As part of the notice, telehealth guidance for emergency 5150/5585 evaluations for adults and children was deemed appropriate. However, BHIN 23-018 conflicts with Orange County HCA policy which requires that emergency 5150/5585 evaluations be conducted face-to-face. In this instance, the county maintains control over the modality based on the 'authority to diagnose' belonging to the county over the state. Because of these policy nuances, BHS providers who are facilitating telehealth services should maintain clinical competence with regard to crisis and mental health emergency management. Providers who are using telehealth should engage in regular training pertaining to their role in crisis and mental health emergency management. Additionally, providers should be well-versed in agency protocols pertaining to crisis and emergency mental health management and have knowledge of local emergency services. BHS providers are encouraged to reference our *Guidelines for Suicide Assessment and Treatment Practice* and accompanying Quick Guide at HCA's BHS Practice Guidelines webpage.

Additional considerations are described below for crisis and mental health emergency management in clinically supervised and clinically unsupervised settings.

Clinically Supervised Settings

Clinically supervised settings are those where there are other behavioral health staff available on site in real time.[40] One example of this is when a client comes into the clinic where they receive their behavioral health services and has a telehealth psychiatry appointment using a telehealth cart with a psychiatrist who is located at another behavioral health clinic site. Another example of this would be when a client is in treatment at a Substance Use Disorder (SUD) residential site and has a telehealth session with their therapist at a Mental Health Plan (MHP) clinic. The telehealth provider should coordinate with staff at the clinically supervised site where the client is physically located to familiarize themselves with the emergency protocols at that location.[40] Roles and responsibilities in emergency situations should be made clear between the telehealth provider and staff at the clinically supervised setting.[40]

Clinically Unsupervised Settings

It is recommended that providers encourage clients/member s to be in a consistent setting when they receive telehealth services outside of a clinically supervised setting, for example at the client's/member's home. This consistency will allow the provider to better familiarize themselves with local emergency resources.[39,40] Additionally, providers should request the contact information of a support person/family member who can be contacted to assist, when necessary, in evaluating the nature of the emergency.[39] When working with minors, providers should verify

the location of the parent or caregiver during the telehealth service. During emergency situations where a support person/family member is contacted, the provider should discuss if there is a need to call for a crisis evaluation, 9-1-1, and/or appropriate circumstances for the support person/family member to transport the client to a local emergency location, such as a hospital emergency department.

Clinical Documentation

BHS providers should document the following in each telehealth progress note:[44]

- The reason the telehealth service is being provided (including if by request, stated modality preference or in consultation with clinician), identifying the barrier(s) preventing the client from receiving in-person services
- The telehealth service is intended to take the place of an in-person service
- The service being provided is medically necessary and clinically appropriate to be delivered through telehealth
- The client has agreed to the telehealth service and the provider received verbal and/or written consent
- The specific platform being used to provide the telehealth service (e.g., Microsoft Teams, WebEx, etc.)
- The steps taken to ensure the client's/member 's privacy was protected (e.g., in a separate room, closed door, did not address client by name)
- Discussion with the client regarding limitations or potential lack of confidentiality (e.g. client's acknowledgment of setting, possibility of others overhearing conversation, and agreement to proceed with receiving services)

BHS providers should adhere to all Mental Health Plan (MHP), Drug Medi-Cal Organized Delivery System (DMC-ODS), and/or HCA BHS clinical documentation requirements. Providers should refer to BHS's *Documentation of Services* Policy & Procedure (P&P) as well as documentation resources provided by BHS's Quality Management Services (QMS) Division. Note the Informed Consent for Telehealth and Telephonic Services and the Telehealth Email Acknowledgement Form.

Cultural Competence

BHS providers should facilitate culturally competent services for clients/members. Providers should engage in ongoing training, research, and facilitated discussions where clients/members share about their cultural values and practices. Providers should assess for the client's/member's prior experience and comfort level with technology and video conferencing and how this may impact rapport and service provision.[39,40]

Other Clinical Considerations

BHS providers are responsible for maintaining competence in their roles, scopes of practice, and legal and ethical requirements of their discipline and adhering to these clinical standards when

providing telehealth services in the same way they would when providing in-person services.[39,40] Regulatory bodies, such as the Board of Behavioral Sciences, may mandate specific Continuing Education (CE) requirements in order to provide telehealth services.[90] Prescribing providers may prescribe controlled medications using telehealth services, however; it is mandatory to follow Federal regulations on the subject.[91]

Additionally, providers need to be aware of any billing or coding differences when performing services via telehealth. Provider are encouraged to visit BHS's Quality Management Services (QMS) Division webpage for MHP and DMC-ODS, respectively, for additional guidance on billing and coding.

When it comes to the room or environment for the telehealth service, providers should strive to provide an experience comparable to what a client would have if they were coming into a clinic for an in-person service. As much as possible, room features such as camera placement, lighting, seating arrangements, and other aspects of visibility should be considered to create a comfortable environment for telehealth services. Providers are responsible for ensuring privacy and confidentiality in their environment when providing telehealth services.[39,40]

Telehealth services may commonly be used in addition to in-person services. It is important for providers to maintain awareness of the impact on rapport and the efficacy of services when facilitating both in-person and telehealth services with clients/members. Providers are encouraged to check in with their clients/members regularly as to their experience receiving telehealth services.[45]

BHS providers should participate in trainings specific to the provision of behavioral health services through telehealth. Those who are new to providing telehealth services and/or are using new or different telehealth platforms or devices should practice with colleagues before using with a client. Additionally, providers should develop a backup plan for technology failure issues (e.g. a backup device, switching to telephone services, etc.), which should then be discussed regularly with clients.[45]

Special Populations or Settings

Children and Adolescents

Previous research has compared behavioral health interventions provided to youth using telehealth and face-to-face services. Regardless of treatment type, youth saw similar improvements in their mental health outcomes,[46] but those participating in telehealth saw improvements in fewer sessions[47]. It has also been suggested that this type of treatment modality could be more effective with children and adolescents given that they are more routinely using technology for social connection.[48,49] The literature has more recently expanded on the use of telehealth as an evidence-based mental health treatment among youth and its positive outcomes.[50,51,52,53,54] In 2020, Stewart and his colleagues focused on the effectiveness of telehealth services during the COVID-19 global pandemic. Youth diagnosed with post-traumatic

stress disorder (PTSD) participated in a pilot study to determine the feasibility and effectiveness of this treatment modality. Results demonstrated clinically meaningful improvements in youth and caregiver-reported PTSD symptoms after receiving services.

More recent research on youth and adolescents during the pandemic suggests a more nuanced context for transitioning to telehealth modality.[97,98] F.B. van Rooij, et al (2023) conducted two qualitative interview studies on the experiences with and transition to telehealth during COVID-19: (1) interviews with youth care professionals, and (2) interviews with adolescents who used mental health care support. They specifically asked participants about five themes selected based on pre-COVID literature on telehealth: (1) tools (i.e., which programs are being used), (2) privacy, (3) methods (i.e., what was the same and what was different compared to in-person sessions), (4) relationship/therapeutic alliance, and (5) effectiveness (i.e., what was their impression of effectiveness of telehealth). On several themes professionals and adolescent clients mentioned similar barriers in the transition to telehealth during COVID such as limitations of the available hard- and software (theme 1: tools); forced changes in the content and methods of the sessions (theme 3: methods); and difficulties with non-verbal communication (theme 4: alliance). However, whereas most professionals expressed an intent to continue utilizing aspects of telehealth after COVID restrictions are lifted, most adolescent clients expressed an understanding of telehealth more as a temporary solution and preferred meeting professionals in person. "In general, participants were positive about the possibility of continuation of their treatment during the COVID lockdowns. They related these positive general experiences to 'continuation of the care or treatment.' Nevertheless, they saw telehealth as a temporary solution for the continuation of their treatment in times of the pandemic. No participants preferred telehealth as a substitute of in person care post-pandemic. Nevertheless, some were neutral or positive towards having the option of "blended" care, in which online tools are used as an addition to in-person care."[97] This point underscores the need to inquire into a client's preferred modality and consult together to determine if an accommodation is possible.

Overall, the use of telehealth services is an innovative method that can help to reduce barriers to accessing mental health treatment, the burden on caregivers to take time off work, as well as cost of transportation to and from sessions.[46,53] This type of treatment also allows for more flexibility in locations where sessions can take place, whether at school, in an office, or at home.[46] However, not enough clinical research has been conducted regarding the use of telehealth when working with specific populations or specific diagnosis to suggest giving priority to telehealth over in-person modalities, particularly regarding youth special subpopulations such as LGBTQ+, minority, and youth in foster care services.

Forensic and Correctional

Telehealth services are being provided in a variety of settings to meet the needs of the client; one is within the criminal justice system. The literature shows that this form of treatment has a positive impact on mental health outcomes and social skills.[55,56,57,58] A study showed that using telehealth services is a feasible method of service delivery.[59] The potential benefits of using this

service with clients in the criminal justice system include improved access to care, reducing need to travel, increasing cost savings, and reducing the need to keep inmates on suicide observation.[58,59] In addition, research has found that some prison inmates prefer telehealth consultations to in-person consultations for discussing certain issues or challenges.[60] Another study noted that while some inmates did not prefer telehealth to face-to-face consultations, both types of treatment were determined effective.[61]

Authors cited several studies that examined the impact of providing telehealth services in a juvenile corrections setting.[46] The Bureau of Justice Statistics has indicated that the rates of mental illness among incarcerated youth and adults exceeds the general population and fewer services are provided to this population.[54] While services are scarce, the authors noted the potential benefits for providing telehealth services to youth offenders including, eliminating the need to travel outside the facility, coordination of care with on-site staff, and timely access to ongoing treatment.

Facilitating telehealth services in a correctional setting requires buy-in from not just the client but also doctors and on-site staff. A study determined three factors that help to increase client acceptance including quality of care, quality of video/audio, and client education on telehealth.[57] Additionally, creating clear lines of communication between doctors and on-site staff is essential to the coordination of telehealth services.

Older Adults

Due to chronic health conditions, mobility impairments, and/or social isolation, older adults are more susceptible to depression and suicidal ideation.[62] Due to these types of circumstances, older adults may feel lost or alone and require additional assistance to adjust to new environments or manage conditions.[63] Given this information, providing telehealth services to this vulnerable population is essential to their health and well-being. The potential benefits of providing telehealth services to older adults includes easier access to care, improved overall well-being, and improved health outcomes.[62,63,64] A pilot study examined the effectiveness of telehealth treatment with older adults who lived in a rural setting, where health care access was limited.[64] Older adults were treated for co-occurring insomnia and depression using Cognitive Behavioral Therapy via videoconferencing. Results from this study demonstrated that telehealth was effective and feasible for treating both insomnia and depression among older adults. One study observed clinically significant gains post-treatment, which were maintained at a 2-month follow-up.[64] A second study compared the use of telehealth and in-person services among homebound older adults.[62] In this study, the researchers looked at the impact of service delivery and participants' changes in depression and disability outcomes. Both telehealth and in-person services were effective in reducing symptoms; however, the effects of telehealth on depression and disability outcomes had longer lasting effects compared to in-person treatment. Overall, research shows that some older adults are comfortable receiving services via telehealth[64] and, if continuous support is provided, this type of service is effective.[65]

Veterans

More recently, research has investigated the relationship between behavioral health outcomes and the provision of telehealth therapy to veterans.[66,67,68,69,70] There is little research available on the subject because veterans are less likely to seek evidence-based treatments.[70] Yet, another study suggests that one way to mitigate the barriers to accessing evidence-based treatments is to utilize more telehealth services with this population.[71] A study compared the use of in-person and telehealth therapy with veterans experiencing post-traumatic stress disorder (PTSD).[70] The researchers concluded that both in-person and telehealth were effective modalities in treating client symptoms and increased satisfaction with services provided. Similar research was conducted using Motivational Interviewing (MI) via videoconferencing to treat PTSD and smoking cessation among veterans.[66] It was concluded that integrating this type of evidence-based treatment into home telehealth improved participants' PTSD symptoms and smoking behaviors. Similarly, telehealth has been identified as an effective treatment for women veterans being treated for co-occurring substance use and PTSD symptoms[68] and for veterans and military families experiencing various behavioral health symptoms,[69] as well as veterans who live in rural areas with limited access to care.[76]

Substance Use Disorder Treatment Settings

Research has started to focus on the use of telehealth within substance use disorder (SUD) treatment settings; however, much of this research focuses on the use of mobile or other internet-based technologies.[77,78,79] Overall, the research that has focused on telehealth suggests that in order to successfully implement telehealth services in SUD treatment, both the provider and clients/beneficiaries need to embrace this type of service delivery.[80] This study suggested the use of telehealth in addiction treatment meets the need to provide clients easy access to services and resources that would otherwise be unavailable.[80] Another study identified four benefits of incorporating technology solutions into treatment settings, including an ability to identify a client's care team across multiple disciplines, efficient collaboration between care team members, collaboration across disciplines to develop treatment plans, and increased progress or task monitoring.[81] While this treatment is successful in most settings, challenges do occur, including adjusting to advancing technology, product cost, increased stigma among specific communities, as well as protection of client anonymity and compliance with federal regulations (e.g., HIPAA, 42 CFR Part 2, etc.).[80]

Another consideration is that telehealth services may be easier to implement in some locations than in others. A study outlined that some programs have greater access to technology when compared to others (e.g., integrated electronic health record systems, faster speed internet, etc.).[80] In this study, this created a lag in implementation and a learning curve to adjust to the new system for programs who did not have access to these technologies. Federal guidelines recently provided by the Drug Enforcement Agency (DEA) and Health and Human Services amend previous regulations to expand the circumstances under which practitioners registered by the DEA are authorized to prescribe schedule III–V controlled substances approved by the Food and

Drug Administration for the treatment of opioid use disorder via a telemedicine encounter, including an audio-only telemedicine encounter.[100] Under these regulations, which took effect February 18th, 2025, after a SUD practitioner reviews the client's prescription drug monitoring program data for the state in which the client is located during the telemedicine encounter, the practitioner may prescribe an initial six-month supply of such medications (split among several prescriptions totaling six calendar months) through audio-only means.[100]

Persons with Disabilities

Previous research has identified that people with disabilities have one or more chronic health conditions that affect the individuals' health and functioning.[82] Additionally, evidence suggests that people with disabilities face significant challenges when accessing healthcare to mitigate the impacts of chronic health conditions.[83,84] Because it is more common for this population to need long-term care, it is important that they are incorporated into the use of telehealth services to examine challenges and successes specific to their experiences. Unfortunately, people with disabilities have not been a primary focus for the development of various telehealth technologies.[85] Some of the research that has centered on persons with disabilities looks at the use of mobile health or rehabilitation applications,[85,86] rather than telehealth services. A literature review investigated the use of three technology media to provide telehealth services including: 1) telephone, text messaging, interactive voice responses, and email; 2) videoconferencing; and 3) mobile health applications.[87] This summary showed that most clients with disabilities had a positive opinion of the digital interventions used to provide telehealth services. Outcomes included increased satisfaction, as well as improvements in motor performance, language ability, and self-care habits. Mental functioning and quality of life also improved among some of the participants included in the cited studies. Additionally, of the telehealth modalities investigated by the authors, teleconferencing was the most preferred among study participants. Research has also found that among people with disabilities receiving cognitive behavioral therapy, participants saw clinically significant improvements at discharge and during a four-month follow-up.[88] Specifically, they reported feeling less lonely, more accepting of their disabilities, and more socially engaged.

More recently, one study examined the impacts of COVID-19 among disabled populations and the need for focused telehealth services. While these individuals were not at higher risk for contracting COVID-19, telehealth services were less likely to accommodate their unique needs.[84] A study noted that some virtual services are difficult to navigate for those who are deaf and hard of hearing or who have visual or psychiatric disabilities.[92] Telehealth services should have disability-friendly options to assist with the facilitation of conversations between clinicians, clients, caregivers, and family members. In the future, it is recommended that steps are taken to promote high-quality services, gain staff buy-in, and develop effective client care methods for those with disabilities.[84]

Caveats

As stated in the justification of need for Telehealth Practice Guidelines, the COVID-19 pandemic initiated the rapid shift toward the use of telehealth based on the belief that access for underserved populations would increase through telehealth use. Research analyzing the transition to telehealth and engagement published in 2023 using large-scale data sets identified by the state of NY suggests that access for underserved populations was different for who had at least one telehealth visit compared to those strictly using face-to-face services. For example, minority individuals with schizophrenia did not always have equitable access to telehealth even if they wanted to use it. Another consideration identified, was that individuals with comorbid SUD were more likely to use in-person care, possibly due to in-person requirements for administration of medications for addition treatment. To make telehealth a viable option for this population, additional individualized supports are likely necessary.[93]

When considering special populations, consideration for the appropriateness of telehealth services for such individuals should address how services are structured so as not to reproduce bias leading to disparities and disproportionalities that currently affect access to needed services and resources in the mainstream.

Serious Mental Illness & Serious Emotional Disorder Populations

Avoiding interruptions and dropout in outpatient care can prevent mental illness symptom exacerbation and costly crisis services, such as emergency room visits and inpatient psychiatric hospitalization. During the COVID-19 pandemic, to attempt to maintain care continuity, telemedicine services were increasingly utilized, despite the lack of data on efficacy in clients with serious mental illness. Engagement with clients who struggle with a serious mental illness (SMI) remains a challenge, particularly sustaining clients in randomized controlled trials over time due to fluctuations in disease exacerbation. To capture and examine utilization and efficacy data in community mental health center clients with serious mental illness during the pandemic, researchers an analysis of all claims during two three-month spans creating pre and post pandemic periods to document what actually occurred with SMI clients in the transition to telehealth, to identify and provide characteristics regarding such clients, and to inform future clinical and policy decision-making[94]. They reported that despite the substantial rollout of telemedicine statewide, retention in treatment was less than retention the prior year in the aggregate, and some subpopulations were more at risk for treatment interruptions than others. With regards to clients with an SMI or older adults, that older clients and those with more severe disorders were least likely to utilize telehealth and more likely to be retained in treatment.[94]

The study also reports female clients were more likely to use telemedicine and more likely to be retained than male clients. While youth under 18 years old, who have been found, prior to the pandemic, to have high rates of acceptability and satisfaction with telemedicine services,[101,102,103] the current findings showed that youth and adolescents had the greatest increase in service interruption compared with all other age groups. Although all age groups extensively used

telemedicine services, researchers found that clients 55 years and older had the lowest rates of interrupted service. With limited data currently available on telemedicine care delivery for persons with schizophrenia and bipolar disorder in particular, this slice of state level data and key questions the study addresses should be used moving forward to assess claims at the local level and inform decisions of how best to deliver care in this population on a county level until more data is available.

Older Adults & Disadvantaged Youth

As stated previously, the primary driver for the continuing adoption of telehealth post-pandemic stems from reimbursement policy changes directly impacting the delivery of care for older Americans, through Medicare, and children and youth through Medicaid and CHIP programs.[96] While the need for telehealth services was obvious during the COVID-19 pandemic, its widespread and continued adoption remains to be assessed for safety and quality especially when considering special populations such as older adults and disadvantaged youth.[96]

Drawing on the COVID-19 pandemic as an example, older adults and disadvantaged youth with amplified mental health needs in that context can give rise to additional considerations as to how to best meet the needs of these groups using telehealth.[96] For instance, given the risk for more severe COVID-19 illness with increasing age and comorbid medical conditions, older adults have routinely been cautioned to take more restrictive precautions to prevent infection, including physical distancing and restricting movements within their communities and among social circles. In their efforts to align with public health guidance, geriatric populations may become more socially isolated, and this isolation may negatively impact mental health in these individuals.[104,105]

Disadvantaged youth, who are already at increased risk for psychiatric and behavioral problems and poor health outcomes, grapple with a cascade of disruptions to their lives across multiple domains from family to home, to school, to the community.[106,107,108,109] Disadvantaged youth are disproportionately youth of color and are members of communities who suffered significantly and differentially during the pandemic. Much like their adult counterparts, children hospitalized with the COVID-19 virus have been documented as more likely to be racial/ethnic minority youth.[110,111] Minority youth also represent a large proportion of individuals likely to develop the multisystem inflammatory syndrome associated with the disease.[112,113] When taken together with vulnerability to the virus, the weight of psychosocial challenges is no doubt amplified in the COVID environment, increasing the potential for psychiatric distress and the need for behavioral health services.

Resources

Orange County Health Care Agency Behavioral Health Services BHS 01.03.04 Telehealth Services in the Mental Health Plan P&P and BHS 01.03.05 Telehealth Services in the Drug Medi-Cal Organized Delivery System P&P

Orange County Health Care Agency Behavioral Health Services *Informed Consent for Telehealth and Telephonic Services* and *Telehealth Email Acknowledgement* forms

American Psychiatric Association *Telepsychiatry Toolkit*

American Psychological Association *Guidelines for the Practice of Telepsychology*

The American Psychiatric Association and the American Telemedicine Association *Best Practices in Videoconferencing-Based Telemental Health*

The American Telemedicine Association *Practice Guidelines for Video-Based Online Mental Health Services*

The National Council for Behavioral Health *Best Practices for Telehealth During COVID-19 Public Health Emergency*

Centers for Medicare & Medicaid Services *General Provider Telehealth and Telemedicine Toolkit*

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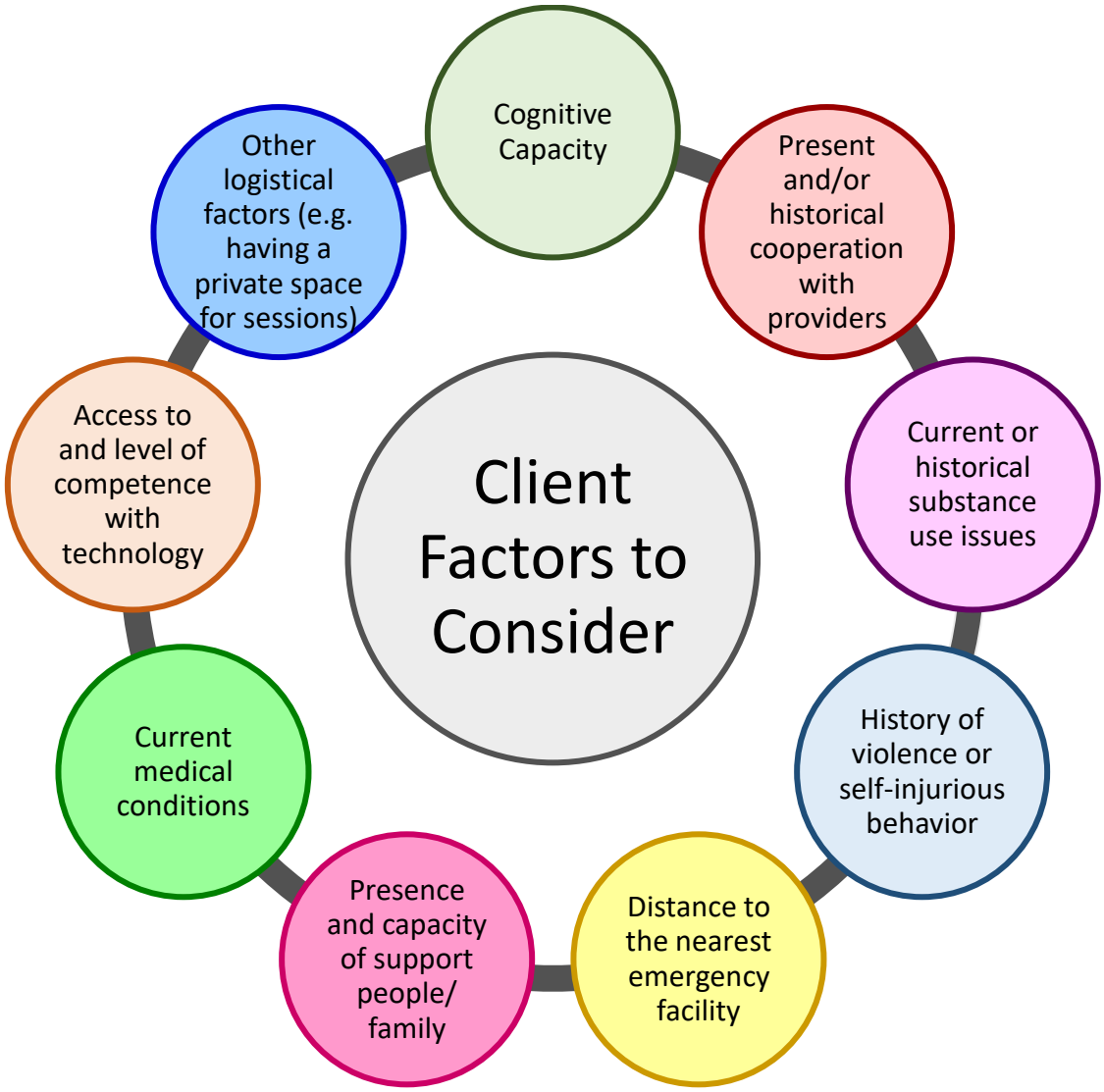
Quick Guide: Assessing Appropriateness for Telehealth Services

Behavioral Health Services providers should continuously assess for client appropriateness for telehealth services. Providers should consult with their supervisor as needed when there are concerns about a client's appropriateness for telehealth services (American Telemedicine Association, 2013; The American Psychiatric Association & American Telemedicine Association, 2018).



Other Important Considerations

- Overall acuity of symptoms or related functional impairments
- Client's/ member 's ability to engage and make progress toward treatment goals
- The client's/member's stated preference for telehealth vs. in-person services
- Suicide risk

Quick Guide: Telehealth Checklist for Behavioral Health Services Providers

Consider Telehealth in specific and/or limited circumstances and in consultation with your program's supervisors and management.

- Confirm the identity of the client and support people/family who are in session
- Verify the location of the client
- Assess client appropriateness for telehealth services continuously
- Give provider's immediate contact information to the client and/or support people/family who are in session
- Obtain immediate contact information for the client and/or support people/family who are in session as well as emergency contact information
- Review expectations for contact between telehealth sessions, including the means of contact, appropriate circumstances for contact, and expected timeframe for response
- Review crisis resources, such as OC Links for crisis assessment, the nearest emergency room, or calling 9-1-1
- Obtain informed consent for telehealth services
- Document the telehealth service in accordance with documentation guidelines for telehealth

*American Telemedicine Association, 2013; The American Psychiatric Association & American Telemedicine Association, 2018

Quick Guide: Clinical Documentation Reminders for Telehealth Services

Behavioral Health Services (BHS) providers should document the following in each telehealth progress note (Orange County Behavioral Health Services, April 2020):

- The reason the telehealth service is being provided, identifying the barrier(s) preventing the client from receiving in-person services
- The telehealth service is intended to take the place of an in-person service
- The service being provided is medically necessary and clinically appropriate to be delivered through telehealth
- The client has agreed to the telehealth service and the provider received verbal and/or written consent
- The specific platform being used to provide the telehealth service (e.g. WebEx, Zoom)
- The steps taken to ensure the client's privacy was protected (e.g., in a separate room, closed door, did not address client by name)
- Discussion with the client regarding limitations or potential lack of confidentiality (e.g. client's acknowledgement of setting and possibility of others overhearing conversation and agreement to proceed with receiving services)

BHS providers should adhere to all Mental Health Plan (MHP), Drug Medi-Cal Organized Delivery System (DMC-ODS), and/or Health Care Agency BHS clinical documentation requirements. Providers should refer to BHS's *Documentation of Services* Policy & Procedure (P&P) as well as documentation resources provided for MHP and DMC-ODS programs by the BHS Quality Management Services (QMS) Division. Note the BHS Combined Informed and Telehealth Consent.