INNOVATIONS IN TELEHEALTH IN MENTAL HEALTH AND SUBSTANCE USE DURING COVID-19

NATIONAL COUNCIL *for* Mental Wellbeing

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Executive Summary

Behavioral health needs in the United States, already on the rise prior to the coronavirus pandemic of 2019 (COVID-19), have skyrocketed in the face of the pandemic. [1,2,3] Further, COVID-19 disproportionately and negatively impacted the mental health of certain populations in the United States, exacerbating historical disparities in access to care across different racial, ethnic and socio-economic groups. Telehealth use grew rapidly during COVID-19, especially for behavioral health services, due to relaxed regulations and the desire to maintain social distancing standards. The National Council for Mental Wellbeing, with funding from the California Health Care Foundation, explored implications of the rapid adoption of telebehavioral health services during COVID-19, including successes, challenges, innovations and future considerations. This report is based largely on provider feedback as shared in a series of round table discussions facilitated by the National Council, perspectives from two technical expert panel meetings convened by the National Council, and a structured review of recent academic and gray literature.

The major successes of telebehavioral health as reported by providers and other stakeholders included expanded access to behavioral health care; maintained or, in some cases, improved quality of care; unique benefits for people with certain diagnoses, such as social anxiety, obsessive-compulsive disorder and substance use disorders, as well as some children and families; and new pathways to help address health disparities. Additionally, stakeholders reported that telebehavioral health resulted in a wide range of ancillary benefits, such as the ability to better understand clients' home environments and reducing stigma associated with attending services in-person at a behavioral health facility. Likewise, a robust body of research has shown that telephone and audio-visual interventions can provide an effective mode of treatment for a wide range of behavioral health conditions, including more severe conditions, that can overcome barriers and increase access to care.

In terms of challenges related to telebehavioral health, nearly all providers cited service disruptions related to technology or distractions in the location where clients receive services as a major barrier to providing services. Other reported challenges included lack of ability to easily assess client safety and control the therapeutic environment; exacerbation of behavioral health provider burnout; challenges working with certain populations, in some cases including those requiring an interpreter service or with severe behavioral health symptoms and/or co-morbid physical health conditions; and a complex and rapidly changing policy environment. However, most providers agreed that the appropriateness of telebehavioral health should be assessed on a case-by-case basis, and that no populations or groups should be broadly excluded from being able to receive telebehavioral health care.

Despite these challenges, providers demonstrated considerable creativity, resilience and innovation in the rapid shift to telebehavioral health. Selected examples of emerging innovations and promising practices include being mindful of disparities related to telebehavioral health, assessing digital literacy when possible – a task the peer workforce is well-equipped to help address; experimenting with digital therapeutics to deliver emotional and mental health support via evidence-based applications ("apps") and other digital resources as a complement to clinical services delivered via telehealth; taking steps to help ensure client safety in a telehealth environment; investing in necessary equipment to enhance "tele-presence" or "webside manner"; and taking advantage of the digital aspects of telebehavioral health to revamp how client satisfaction and outcomes data are collected and analyzed.

Moving forward, providers would like additional training and technical assistance in several areas, including determining when to use in-person, audio-only, or audio-visual services, or a hybrid model that combines modalities, and appropriate uses of digital therapeutics. Stakeholders also pointed to the unique opportunity the pandemic created for a different approach to delivery of behavioral health care services. Providers underscored the need to leverage telebehavioral health to help alleviate, not worsen, long-standing challenges with access and disparities in care – ideally taking steps to ensure that telehealth is not a privileged service, but rather a care delivery model accessible to all.

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Introduction

Behavioral health needs in the United States, already on the rise prior to the coronavirus pandemic of 2019 (COVID-19), have skyrocketed in the face of the pandemic. [4,5,6] The United States has long faced a persistent gap between individuals with behavioral health needs and those receiving care, often with stark disparities in access to care across different racial and ethnic groups and socio-economic statuses. Further, COVID-19 disproportionately and negatively impacted the mental health of certain populations in the United States. For example, Chinese Americans reported COVID-19 related racism and racial discrimination that negatively impacted mental health[7]; Black youth were more likely than other youth to lose a parent or caregiver to COVID-19[8]; and lesbian, gay, bisexual, transgender and queer (LGBTQ) youth were sometimes constricted to home environments where they were not supported or accepted as a result of the pandemic.[9]

State and federal lawmakers significantly relaxed regulations related to telehealth under the public health emergency, including lifting clinic-based and interstate restrictions to allow for service delivery in people's homes and across state lines, allowing providers to use any non-public facing virtual platforms to treat their patients (e.g., Zoom, Google Hangouts), eliminating requirements that people served have an established, pre-existing relationship with a provider, reimbursing telehealth at the same rates as in-person-services, and allowing payment for audio-only (i.e., telephone) services.[10] In turn, the use of telehealth has grown rapidly in response to more flexible regulations and the desire to maintain social distancing standards due to COVID-19, especially for behavioral health services.[11] According to a national study, telehealth accounted for fewer than 3% of behavioral health visits prior to 2020, but grew to nearly two-thirds by June 2020.[12] Additionally, even prior to the pandemic, it was estimated that at least 250,000 additional behavioral health providers would be needed to fully meet America's growing behavioral health needs by 2025, and experts have suggested that telehealth can help enable broader access to services given a limited and "maldistributed" workforce.[13,14]

The National Council for Mental Wellbeing, with funding from the California Health Care Foundation, explored implications of the rapid adoption of telebehavioral health services during COVID-19, including successes, challenges, innovations and future considerations. For the purposes of this paper, we focus primarily on clinician-to-person served level telebehavioral health services, defined as the use of two-way, interactive, video and/or audio technology to provide behavioral health care to individuals experiencing mental illness and/or substance use disorders **(see Exhibit 1)**. For policy development or other purposes, a broader definition of telehealth may be used. This report is based largely on provider feedback as shared in a series of round table discussions facilitated by the National Council, perspectives from a technical expert panel convened by the National Council, and a structured review of recent academic and gray literature. It includes several brief case studies to help illuminate the efficacy of different types of telebehavioral health services, as well as where telehealth was not an effective means of service delivery for behavioral health care, and showcases provider innovations. Where necessary, identifying details have been changed to protect the anonymity of the people served.

Exhibit 1

Overview of Telehealth Modalities and Services in the Context of Behavioral Health

Type of telehealth	Telehealth tools or modalities	Examples of services in the context of behavioral health
Clinician-to-Person Served This type of telehealth is the primary focus of this report; it is referred to as "telebehavioral health" in the context of delivering mental health and/or substance use services	Video (i.e., "audio-visual") or telephone (i.e., "audio-only")	Counseling, psychiatry, substance use disorder treatment, case management, medication management, group sessions
Clinician-to-Clinician This type of telehealth may be referred to as "e-consults"	Clinicians often communicate through telephone, e-mail or video	Behavioral health providers such as addiction specialists, psychiatrists or therapists provide clinical advice or support to primary care or pediatric providers via phone, e-mail or secure messaging on electronic medical record
Person-to-Mobile Health Technology This type of telehealth may be referred to as "digital therapeutics[15]" in the context of behavioral health	Wearable monitors, mobile applications ("apps"), video, e-mail, web portals, games	Web-based cognitive-behavioral therapy programs; digital dashboards to track moods and emotions; apps to track substance use, cravings and triggers Example tools can be found through online repositories such as the M-Health Index and Navigation Database or the VA App Store[16]

Source: Adapted from The New England Journal of Medicine: Telehealth - Special Report.

Telebehavioral Health: Successes and Challenges

Major successes of telebehavioral health

Expanded access to care

Nearly all providers highlighted the success of telebehavioral health in not just maintaining, but in some cases expanding access to care during the COVID-19 pandemic. Providers reported that telebehavioral health helped remove obstacles to care for individuals with "compounding circumstances[17]" that make it difficult to attend in-person sessions, such as those with limited or no transportation, people living in remote regions, high-needs single-parent families, and/or those with limited available time for in-person appointments.

Most providers also reported a reduction in no-show rates coinciding with the increased use of telebehavioral health. In addition to the ease of accessibility for those with scheduled telehealth appointments, several providers appreciated the option to use telehealth as a "backup" for clients with in-person appointments who may have forgotten about their sessions or were otherwise unable to make an appointment due to traffic, inclement weather, a need to quarantine due to COVID-19 exposure, or other circumstance. The ease of scheduling telehealth sessions at different times, such as during a client's lunch hour at work, also reportedly helped to expand access and reduce delays in care. Additionally, the American Psychiatric Association reported that telebehavioral health has led to better client outcomes by helping to facilitate integration of behavioral health and primary care and reducing unnecessary use of the emergency room.[18]

> **"I have a client who is 66 years old with a lot of chronic medical conditions, including chronic obstructive pulmonary disease. She's dependent upon an oxygen tank to get around and has limited English proficiency. She must budget out her oxygen supply, which she prefers to use to go to church, go grocery shopping, and attend medical appointments with her rheumatologist and cardiologist. For her to not have to spend her limited oxygen supply to receive behavioral health services has made a huge difference in accessibility [of behavioral health services]. She now regularly attends group sessions with our peer specialist and therapy sessions with me, all via telehealth."**
>
> ***- A Licensed Clinical Social Worker***

Largely maintained or improved quality of care

Most providers felt positively about the quality of care delivered via telehealth. There is robust evidence that telebehavioral health is as effective as in-person care – and in some cases even more effective – for a wide range of populations, settings, services and diagnoses, including complex conditions such as suicidality and psychosis.[19, 20] Several studies have also concluded that clinician-person relationships can be established in a video-first model, without a previous in-person encounter.[21] Some providers also reported benefitting from the shift to behavioral health, appreciating its convenience and potential to reduce overhead costs. Research also indicates that telebehavioral health may save costs compared to in-person care.[22]

> **"Telehealth is effective across the continuum of care for serious mental illness and substance use disorder, including screening and assessment, treatments, including pharmacotherapy, medication management, and behavioral therapies, case management, recovery supports, and crisis services."**
>
> ***- Federal Substance Abuse and Mental Health Services Administration (SAMHSA)***

While there is some skepticism from both policymakers and providers related to the efficacy of audio-only (i.e., telephone) telebehavioral health services, many providers highlighted that this can be an effective method of providing services, especially for engaging contemplative or pre-contemplative individuals in care (e.g., those who are skeptical about or question the benefit of counseling).[23] Research also supports that telephone interventions can be an effective way to provide treatment for a wide range of mental health and substance use disorders.[24, 25]

Exhibit 2

Review of Outcomes for Selected Types of Telebehavioral Health

Treatment/ Condition	Select Telebehavioral Health Outcomes
Alcohol Use Disorder (AUD)	☑ **Reduction in harmful and hazardous drinking behavior** ■ Preliminary results of a brief telehealth intervention focused on motivational interviewing and cognitive behavioral therapy found significant reduction in average and peak alcohol consumption in primarily alcohol-dependent veterans.[26]

Alcohol Use Disorder (AUD) (Continued)	**Feasible format to deliver AUD group therapy treatment sessions** • A study that examined eight sessions of group therapy over four weeks via videoconference found high satisfaction with this format. Attrition was comparable to the conventional in-person treatment.[27]
Behavioral Activation (BA) Therapy	**Comparable outcomes to clinic-based therapies for Post-traumatic stress disorder (PTSD) and major depressive disorder (MDD)** • A study that randomized VA participants to telehealth, home-based therapies vs. in-person therapies for PTSD and MDD found both modalities to be effective in improving mental health; telehealth, home-based therapies proved noninferior to in-person therapies.[28] **Reduction in anxiety, depression and PTSD** • A study that looked at telehealth, home-based therapies for combat military personnel found this modality led to significant reductions in PTSD, anxiety and depression.[29] **Lower health care costs without significant difference in quality of life** • Those who participated in BA therapy via telehealth had lower health utilization costs 1 year after the intervention without a significant difference in quality-adjusted life-year as shown in a randomized trial of veterans.[30]
Cognitive Processing Therapy (CPT)	**Significant reductions in PTSD with outcomes "as good as" in-person therapy** • A study that randomized participants into in-person or telehealth based cognitive processing therapies found significant reductions in PTSD symptoms with no difference between these groups.[31]
Eating Disorder Treatments	**Similar levels of improvements and satisfaction with services as in-person treatments** • A study that compared traditional in-person therapy format with internet-based virtual format for eating disorder treatment found similar outcomes and no differences in response to treatment between these two formats, suggesting that telehealth is a viable and noninferior option for treating this population.[32]

Family Therapy	**Equivalent outcomes to in-person delivery of therapy** - Meta-analytic evidence finds that telehealth for family therapy is superior to wait-lists or information-only controls. It also found equivalent outcomes to in-person delivery.[33] **Significant reduction in severity and frequency of family problems** - Narrative summaries of studies examining family therapy demonstrate effectiveness for parent-teen dyads engaging in videoconferencing-based therapies.[34] **Equivalent outcomes for child behavioral health problems and parental depression compared to in-person therapies** - Meta-analysis finds telehealth intervention equivalent to in-person and superior to resource-based treatments for child behavior and parental depression.[35]
Intensive Outpatient Programs (IOP)	**Adults with serious mental illness report high satisfaction with IOP via telehealth** - A study that examined an IOP that transitioned from outpatient to telehealth format during the COVID-19 pandemic found that 50% of patients desired for the program to continue in a telehealth format and 15% were neutral. Patients were overall satisfied with the telehealth format, with 92.5% reporting that they would recommend this format to their friend or family member.[36]
Medication-Assisted Treatment (MAT)	**Increased access for rural populations** - A MAT program that offered care to rural patients via telehealth found that of patients still engaged with treatment at 3 months, 86% had opioid-negative urine toxicology.[37] **Increased retention rates** - A study examining a Rhode Island based clinic that provided MOUD counseling during the COVID-19 pandemic found that telehealth improved access to care and retention rates.[38]

Medication-Assisted Treatment (MAT) (Continued)	☑ **No significant difference in outcomes between MAT delivered via videoconference vs. face-to-face** ■ Retrospective data of MAT programs examining three outcomes – (1) average time to achieve 30 to 90 days of abstinence, (2) additional substance use and (3) treatment retention rates at 90 and 365 days – found no significant difference between telepsychiatry buprenorphine MAT intervention versus face-to-face interventions for all three outcomes.[39]
Prolonged Exposure Therapy (PE)	☑ **Noninferior for PTSD compared to in-person** ■ Randomized control trial of veterans assigned to home-based, telehealth versus in-person exposure therapy found similar reductions in PTSD at post-treatment, 3- and 6-month follow-up.[40]
Psychotherapy	☑ **Potential to reduce mental health disparities in rural populations** ■ A study that looked at delivering psychotherapy to a rural population in Texas via telehealth within a primary care setting found that telehealth videoconferencing psychotherapy led to a statistically significant reduction in depressive symptoms and overall psychological distress.[41]
Substance Use Disorder (SUD) Treatment	☑ **Similar rates of counseling attendance and drug positive urinalysis when compared to in-person counseling** ■ A study that randomly assigned participants with computer and internet access to web-based vs. in-person counseling and found comparable outcomes related to attendance and sobriety, demonstrating that this format is feasible, acceptable and likely noninferior.[42]
Telepsychiatry	☑ **Satisfactory for both patients and health care providers** ■ Literature reviews demonstrate that the majority of patients and health care providers were satisfied with telepsychiatry. Therefore, this modality is feasible and appropriate for the delivery of psychiatry services.[43,44]

Source: *Adapted from* Telehealth for the Treatment of Serious Mental Illness and Substance Use Disorders, *Chapter 2,* ***"What Research Tells Us."***

Offered unique benefits to people with certain diagnoses, including social anxiety, obsessive-compulsive disorder and substance use disorder

Providers reported that clients with certain diagnoses experienced outsized benefits of telebehavioral health, including clients with SUD, OCD and social anxiety. For example, several providers reported an increase in the use of audio-only counseling sessions for clients with SUD receiving MAT. Clients who historically skipped in-person therapy tended to answer their phones when called, giving clients a chance to experience the value of counseling and providers time to build the therapeutic relationship. Many of these individuals ultimately ended up attending counseling sessions on a regular basis, either in person or via audio-visual sessions.

One provider suggested that the increased use of telebehavioral health among individuals with opioid use disorder could be the result of the people served having "passive rather than active engagement" from the person's perspective (i.e., simply answering a phone call versus taking all the steps necessary to attend an appointment in-person), while another suggested the self-stigma and shame often associated with substance use could have played a role in this trend. This finding has been backed up by research, which demonstrated that the use of telehealth for counseling associated with medication-assisted treatment has mitigated many long-standing barriers to the traditional system.[45]

"In our suboxone program, we highly recommend that clients also see a behavioral health therapist at the same time they are receiving medications [to treat opioid use disorder]. In the past, these people rarely showed up for their in-person appointments. With telehealth, we can just call them up on the phone, and generally speaking, they pick up and say 'Yeah, I'll talk' and we can engage them that way; it's been very useful for increasing access to care for that population."

- A Licensed Clinical Social Worker and Behavioral Health Manager

One provider reported that a client with OUD who previously found it difficult to shop in public settings "managed to get to the store after seeing her provider via telehealth for 6-8 months." Another provider reported that individuals with extreme social anxiety who used to show up for care only periodically became weekly clients in the transition to telebehavioral health because they did not need to leave the comfort of their home. While the goal might be to eventually get such clients comfortable enough to attend in-person sessions, telehealth filled a void for needed care that likely would not have occurred otherwise.

"A 65-year-old man with severe obsessive-compulsive disorder (including hoarding) did not have sufficient wireless bandwidth in his rural area, nor technical knowledge, to have video telehealth sessions. His shame around the state of his living conditions was also so high that he would not have participated in services with his new therapist if he was required to be on video. Providing him with audio-only services allowed him to seek out treatment for an incapacitating disorder."

- A PhD Psychologist

Offered unique benefits for some children and families

A potential benefit for some children is that parents or other caregivers may become more engaged in sessions as a result of telebehavioral health; some providers reported working with parents if a child walks away or disengages during a telehealth session. One provider likened it to "using PCIT [parent child interaction therapy[46]] without complete fidelity; the parent or caregiver is right there to engage his or her child, with the therapist providing support, getting creative and using theraplay[47] as needed." Another reported advantage is that children from families with separated parents who would not historically sit together in a provider's office were able to be "on the screen" together. Some providers also reported the added benefit of being able to "dial in" a child's teacher or guidance counselor during telehealth sessions. One provider reported that telebehavioral health also enabled real-time assessment and coaching for parents and other caregivers, creating a "layer of realness in the moment" that enables providers to, for example, see how a caregiver reacts to a crying baby or shouting toddler.

"I see one mother, in part to address her mental health condition but also to support the parent-child relationship. Prior to COVID-19 and expanded use of telehealth, she was very inconsistent in attending her in-person appointments; then, in the transition to telehealth, she preferred telephone-only sessions. It's been valuable to be able to support not only her mental health symptoms, but because she's a single parent and often responding to the children, I'm in her ear coaching her on how to respond to her children. She also had an infant during COVID-19, and I was able to help her meet the needs of the baby and help her to not be angry with the baby and not see her as purposely trying to keep her up all night. It's been helping her meet one of her key goals – to be a more responsive versus reactive mother."

– A Licensed Clinical Social Worker and Early Childhood Specialist

Created new pathways to better address health disparities and reduce the impact of stigma

Telehealth created many new opportunities to better address access and equity in health care.[48] First, telehealth enables people to access a more diverse pool of providers who may be outside of the person's geographic area, which is beneficial given that research shows that matching person served and provider characteristics in areas such as race, language, gender identity and cultural background often leads to higher-quality care and better outcomes for people.[49] Second, during COVID-19, many behavioral health providers were at capacity or had long waiting lists for treatment of new patients. Telehealth can enable people to seek care from a wider range of providers and specialists across the country, including those who specialize in treatment of vulnerable populations and/or those with expertise using treatment modalities that might not be widely available.

"Although I live in New York, temporary state licensure programs under COVID-19 enabled me to treat clients across the country [using telebehavioral health], including in New Jersey and Florida. I have a background in working with members of the LGBTQ community, especially trans- and nonbinary folks. By nature of that experience, I attracted a number of different transgender and gender non-conforming clients during COVID-19; it was especially important for these people to receive care because they historically had trouble finding providers who are very explicitly gender affirming and who've had experience helping to navigate everything from [gender] transition to just gender expression in everyday life. These people tend to experience major depression and frequent microaggressions around their gender identity and expression.

Over the course of almost 2 years, I was able to help such clients establish coping mechanisms and ways to escape feelings of shame, and better manage family dynamics, including processing past traumas. One client in particular is experiencing greater stability than they ever had before, accepting a stable housing situation, advancing their education, making decisions about eventual career prospects and finding stable relationships."

– A PhD Psychologist

Third, telehealth can enhance equity by avoiding the stigma related to attending services at a behavioral health facility common in some underserved communities. For example, a provider from a Federally Qualified Health Center based in Minnesota serves a population that is approximately 85% East African refugees. In this population, there is reportedly "enormous stigma" with receiving mental health services. The shift to telebehavioral health at this clinic has resulted in an increase in teenagers and young adults reaching out for therapy since they can now receive services more privately, such as from a car or library. Another provider, treating primarily Asian immigrants, has noted that young people whose parents were refugees tend to feel guilty talking about mental health because they think, "Well, my parents went through an actual struggle – they went on a boat, swam across a river, walked through bombs, and here I am complaining about mental stress.[50]" Many providers indicated that they had clients who preferred audio-only services, especially those experiencing shame or trauma associated with race, class, gender or sexual orientation. The ability to receive services while retaining anonymity reportedly caused an increased use of behavioral health services by anyone who historically did not want to be seen entering a behavioral health treatment facility. One provider noted that some clients used to refer to walking down the hall that led to the behavioral health offices of a large community health center as the "walk of shame."

"A Black man was interested in receiving treatment for an eating disorder but had several negative experiences with previous therapists. His first several sessions with me were audio only, by his request. After informed consent, including explicit and at-length discussion of when confidentiality would be broken (per the client's concerns about when police might be called or records disclosed), and rapport building, the client then agreed to have his video on for ongoing sessions. Due to the client's justifiable distrust in a medical system due to past acts of racism, and severe body image concerns due to his eating disorder, the audio-only method allowed the client to re-enter treatment, despite being quite hesitant."

– A PhD Psychologist

Finally, use of telehealth can also mitigate logistical barriers that may disproportionately impact vulnerable populations and make it difficult to attend behavioral health care in person, such as lack of childcare (especially for single parents), lack of time off work and transportation barriers, which can apply to both urban and rural areas. For example, one provider in an urban setting reported that clients who previously relied on non-emergency medical transportation (NEMT) for transport to appointments appreciated the ability to participate in telebehavioral health sessions, as some found NEMT services to be unsafe, not culturally sensitive and/or not reliable.

Resulted in a wide range of ancillary benefits, such as better understanding clients' home environments

Most providers also reported various ancillary or "side-effect" benefits of telebehavioral health sessions, such as having a window into home environments that might be indicative of changes in severity of symptoms. For example, a provider stated that observing changes in the orderliness or chaos of a person's home can be helpful when noting severity of schizophrenia and other thought disorders. One provider reported observing that a client with severe depression had a large, framed photograph of a spouse who had passed away hanging directly across from her bed. This provider was able to suggest that the client move the photograph to a less visible spot in the house to assist in the grief healing process. Another provider reported that being able to see clients' faces without a mask was a great benefit of telebehavioral health, as it can be difficult to fully assess a client's emotional state without complete visual cues.

Providers also reported an overall shift in how they provide care and engage with the people they serve as a result of the expansion of telehealth. Some providers acknowledged historically believing that the burden of responsibility was with the people served to show up for appointments. One of the providers interviewed reported that they began to see the burden of responsibility switch to the provider and realized it should have always been that way. These providers reported improved care outcomes that resulted from engaging clients in new ways, such as texting or calling in between appointments to check in and proactively calling all "no-shows." According to research, key factors for perceived efficacy of telebehavioral health from the client and therapist perspectives include accessibility; the ease of talking in telehealth, where turn-taking is clearer; and ease of revealing vulnerability for some clients, invoked by a sense of distance that may be conducive to disclosure.[51] These and other "side-effect" benefits could help explain why telebehavioral health may demonstrate better outcomes than in-person care in some cases **(see Exhibit 3)**.

Exhibit 3

Ancillary or "Side-effect" Benefits of Telebehavioral Health

- Ability to follow the instructions to log onto a telehealth platform can be factored into a client's mental status exam
- Ability to see clients' faces without a mask
- Better understanding of the potential clinical impact of an individual's home environment (e.g., is the house very organized or chaotic, or has it recently changed dramatically)
- Can provide "real-time" assessments of behaviors and interactions (e.g., how client responds to a crying baby)
- Changed overall approach to care delivery for some providers, such as more proactive engagement of seemingly disengaged clients (e.g., broader acceptability of a patient or provider calling or texting in between scheduled appointments)
- Clients who feel particularly safe and comfortable at home may be more inclined to share personal information; several providers reported that the therapeutic relationship improved in the shift to telebehavioral health
- Creates a back-up option for clients planning to attend in-person services but who may have forgotten about an appointment, ran late due to traffic, needed to quarantine due to COVID-19 exposure, etc.
- Decreased exposure to infection for clients and staff
- Easier to conference in a third party as needed (e.g., a family member, another health care provider or specialist, teacher or guidance counselor)
- Helps overcome the barrier of stigma associated with being seen seeking in-person care from a mental health or substance use disorder treatment facility
- May provide more privacy than certain in-office settings (e.g., cramped facilities with thin walls)
- Parents/caregivers may become more engaged in telehealth sessions with children

Source: *Summary of provider round table discussions facilitated by The National Council.*

Major barriers or challenges associated with telebehavioral health

Service disruptions related to technology or distractions in the location where clients receive services

Nearly all providers reported technological difficulties as a challenge with administering telebehavioral health, particularly as it relates to slow or disconnected internet connections on either the client's or the provider's end during audio-visual sessions. A behavioral health provider in Maine noted that internet disruptions seem to be common due to severe weather events. One provider stated that "Video connections not working becomes frustrating for all parties and leads to disengagement," with another pointing out how "painful" it can be to discuss sensitive topics or even trauma histories and not be able to hear a client because the Internet connection is unstable.

Another provider noted that technological difficulties impact the quality of the entire session, and "undermines the experience before it even happens." In some cases, service disruptions were not due to technology per se, but to clients having limited technological literacy to join audio-visual sessions. Scheduled video visits may also turn into audio-only visits when technical difficulties arise, potentially resulting in an underestimation of audio-only telehealth services based on analysis of claims data.[52] Such technological challenges did not affect all populations the same way, and tended to vary by geography, age, race and income, which is covered in more detail below. A related challenge is variation in access to high-speed Internet/broadband, with roughly 25% of Americans still lacking access to broadband Internet service at home.[53]

Several providers also reported reduced productivity during telehealth start-up, which involved getting both clinicians and people served comfortable with video and/or audio sessions. One provider said: "The first full month of the pandemic, April 2020, was famine. People were not picking up the phone; they were not engaged." Other providers reported that their clients would initially take calls for telebehavioral health sessions while driving or shopping, requiring some additional education regarding appropriately private settings for receipt of services. Several providers reported challenges providing telebehavioral health services to clients with phones that include limited data plans or minutes. Disruptions at home created another big challenge for telebehavioral health providers. One provider reported that it was "nearly impossible" to provide audio-visual sessions to a person with four siblings due to the chaos at the house.

Lack of ability to easily assess client safety and control the therapeutic environment

Many providers cited the lack of ability to easily assess safety and otherwise control the therapeutic environment – defined as physical, social and psychological safe spaces that are specifically designed to be healing[54] – as a significant challenge. Telebehavioral health reportedly hindered the ability to conduct complete assessments. One provider questioned how to truly know if someone is in danger – for example, because of intimate partner violence – and what to do about it in a telehealth environment. Another provider's supervisee had a non-English speaking client whose spouse lingered in the background of their sessions. After three sessions, the client stopped showing up for services, and the interpreter on the call shared with the provider that the spouse was asking "why she was telling the therapist the things she was telling them." A psychiatrist also reported potential safety concerns when suicidality is uncovered during a telehealth visit and both the provider and client are at home, adding that it can be difficult to virtually connect with other provider "support staff" if needed to obtain full suicide assessments or interventions, such as through the Columbia-Suicide Severity Rating Scale (C-SSRS) or Stanley-Brown Safety Planning Intervention.

> **"The 15- to 20-minute appointment times for physicians in some mental health clinics or practices create stresses with telemedicine that are not present for the 45- to 50-minute therapy appointments. This time issue also creates unusual concerns for patient safety for psychiatrists with little time to address suicidality without keeping the other patient waiting somewhere without a "waiting room" on some platforms, such as Zoom. Also, [these practitioners] can face difficulty obtaining vital statistics, labs and the Abnormal Involuntary Movement Scale (AIMS - to assess level of dyskinesias in patients taking neuroleptic medications). Remote visits (except by using on-site telemedicine rooms) can create health care risks for clients and liability issues for physicians, nurse practitioners and physician's assistants."**
>
> ***- A Psychiatrist***

In general, providers are not able to see what else a client might have on the screen or happening behind the screen; confidentiality and engagement is hard to ensure in a telebehavioral health setting. One psychiatrist reported that this is one of the most problematic aspects of telepsychiatry, as sessions may be attended by family members without a clinician's knowledge and can result in disruptions such as uninvited feedback or suggestions by other individuals. For providers interested in soliciting direct client feedback on this topic, see the safety-related questions listed in the sample client satisfaction tool for telebehavioral health as included in **Appendix II**.

Exacerbation of behavioral health provider burnout

Provider burnout, which encompasses emotional exhaustion, depersonalization and reduced personal accomplishment, was a significant problem for behavioral health providers even prior to the coronavirus pandemic.[55] Several providers reported that the shift to telebehavioral health during COVID-19 exacerbated burnout for several reasons, including:

- **Increased productivity expectations:** One provider reported having up to nine sessions in an 8-hour day during the pandemic, which likely would not have been possible with in-person visits.
- **"Zoom fatigue":** Providers reported difficulty "sitting constantly" and with the eye strain and poor body posture that can result from participating in audio-visual sessions for most of the day.
- **Client concern:** Providers reported increased emotional stress resulting from worrying about treating clients not being seen in person, including worrying about their safety.

Some research has also shown that patients may be more satisfied with telebehavioral health than are their providers.[56]

Exhibit 4

Wellbeing of the Therapist in a Telehealth Context

Therapists have reported that the usual boundaries that exist between in-session and out-of-session work done in-person were difficult to maintain when using telehealth. Some reported feeling detached from their work when using telehealth: they were disempowered and at times helpless about what they perceived as a limited capacity to detect and adequately respond to nuances of expression. To preserve wellbeing, therapists expressed a need for quality supervision; collegial support; the availability of reliable technology (to mitigate stress associated with the technological challenges of operating via telehealth); a manageable workload; a sense of acceptance regarding constraints associated with telehealth; prioritization of self-care activities such as breaks and exercise; and co-therapy to ease feelings of isolation.

Source: *Excerpt from* *https://link.springer.com/article/10.1007/s10567-020-00340-2*

Challenges working with certain individuals, such as those requiring an interpreter and/or with severe behavioral health symptoms and/or co-occurring physical health conditions

While research generally suggests that telebehavioral health can be appropriate for a wide range of populations, conditions, services and settings, several providers acknowledged that it might not be helpful for every situation or person. For example, some providers reported having challenges providing services to non-English speaking individuals requiring an interpreter service, offering psychotherapy to children, and treating individuals with significant trauma or experiencing severe symptoms such as paranoid delusions.

"I was treating a Somali man who had PTSD as a result of being beaten by troops while fleeing his village when he was a young child. He does not have many words for describing the experience, so while this client was receiving services in-person, he engaged in many mindful movement activities, such as walking and stretching exercises. When receiving in-person care with me in the office, he had physical supports and space to do things like move and draw, and he was advancing; during COVID-19 when participating in audio-only sessions, he stagnated."

– A Clinical Social Worker and Behavioral Health Manager

Providers, especially psychiatrists, reported difficulty obtaining physical health indicators, such as blood pressure and weight, that are important for assessing metabolic syndrome – a collection of risk factors associated with use of some antidepressants or antipsychotics that increase risk of developing heart diseases, stroke or diabetes. For example, many clients do not have a scale at home to monitor weight. Providers also reported that, typically, they cannot see more than an individual's face during audio-visual sessions, making it difficult to assess things like body language, hygiene, pregnancy, tremors or shakes. It can also be difficult to assess a client's general affect, or outward display of an emotional state, on video, and very difficult if not impossible via telephone. As one psychiatrist noted, with audio-only telehealth, "one is relying on what is said, and not what is observed."

> **"I had one patient with serious mental illness on a long-acting antipsychotic who gained lots of weight during COVID-19. Rather than engage him in telehealth, I asked him and other high-risk clients to come to the back door of my office at the clinic, where they could still receive face-to-face care in a socially distant way without being exposed to other patients or employees in other parts of the clinic. After getting his laboratory results, I had to get him on insulin; he had full-blown diabetes and his hemoglobin A1c (HbA1c) was off the charts. If I hadn't asked him to show up at the back door, he could have gone into ketoacidosis and died."**
>
> ***– A Psychiatrist***

Several providers reported concerns treating individuals with SUD. While the COVID-19 public health emergency lasts, urine testing for buprenorphine treatment does not have to be mandatory. One provider expressed concern with the recent increase in overdoses, acknowledging that it is more difficult to see signs of intoxication or other overdose risks when not seeing people in person. Another reported that the reduction of toxicity testing made it difficult to coordinate with court and probation officers who wanted progress updates on the people they serve.

One provider who provides eye movement desensitization and reprocessing (EMDR)[57] – an evidence-based psychotherapy practice designed to alleviate distress associated with traumatic memories – reported challenges associated with providing this service via telehealth. It was reportedly difficult to have a client re-live trauma and not have the ability to see the client's response in-person, which could include physical reactions such as vomiting, tremors or stumbling. People who engage in self-injurious behaviors like cutting often need intense security, safety and containment established for them. One provider said clients with these behavior types have repeatedly asked, "When can I get back to face-to-face services?" Providers reported that some patients do not trust that telebehavioral health is private; they believe they are being recorded or monitored and withhold conversations about sensitive issues.

Several providers reported unique concerns treating children via telehealth. As reported above, "Zoom fatigue" was a challenge for both clients and providers, but this phenomenon was exacerbated for children during the height of the COVID-19 pandemic, as they were attending school primarily online. One provider said, "The last thing these children wanted to do is get back on the screen for a telehealth session." Many children refrained from speaking freely because caregivers were in the room. A psychiatrist reported the sheer difficulty with engaging young children in telehealth sessions without play materials, even for shorter pharmacotherapy visits. As one behavioral health provider recently summarized: "Telehealth is great with adults, good with teens and a struggle with kids."[58]

Providers also reported challenges working with people who speak languages other than English. Poor sound quality or lacking visual cues (when using audio-only mediums) make it difficult for both the provider and the person being served to understand each other when trying to speak a second language. Some providers also mentioned that when needing an interpreter, there were difficulties identifying and affording trained interpreters who have access to the necessary technology to join sessions in an audio-visual capacity.

However, most providers agreed that the appropriateness of telebehavioral health should be assessed on a case-by-case basis, rather than proactively and broadly excluding certain populations or individuals with selected behavioral health diagnoses from receiving telebehavioral health care. In fact, several therapists reported more effective sessions with some clients with severe mental illness diagnoses, such as schizophrenia, as they preferred to be in-home and thus felt more comfortable and open to sharing. Another provider reported that it is possible to work with individuals with psychosis via telehealth, provided they have awareness of their symptoms (i.e., they can recognize when they are having delusions or hallucinations and when they are not).

Rapidly changing and complex policy environment

The United States public health emergency declaration related to the COVID-19 pandemic, originally established January 31, 2020, has been extended numerous times by the Department of Health and Human Services.[59] With this extension, various federal flexibilities and waivers remain in effect – such as flexibility to use everyday technology (e.g., Zoom, Google Hangouts) for virtual visits; more flexibility to deliver telehealth services across state lines; and prescribing controlled substances via telehealth, without the need for an in-person medical evaluation.[60] Meanwhile, providers have had to navigate not only numerous regulatory flexibilities due to the pandemic, but also temporary state licensing, Medicaid, commercial insurance, and other local agency expansions and flexibilities that could end at times different from the federal public health emergency. Further, while interstate licensing may promote access by enabling providers to see clients across multiple states, it is possible that these regulatory flexibilities could diminish continuity of care.

> **"There are many, many layers of complexity in terms of maintaining legal compliance, that includes, at the federal level, waiting for guidance in terms of what modalities you can use, then confirming that with your state. If you're licensed in multiple states, it adds more complexity. With the pending end of these [temporary interstate licensure] measures, my clients and I are struggling to find someone in their state with expertise treating the LGBTQ population and will need to end the relationship after nearly two years of work together, simply because of a regulatory pen stroke versus a change in clinical competencies or client need."**
>
> ***– A PhD Psychologist***

Emerging Innovations and Promising Practices

Leverage existing resources, trainings and best practices

As many providers noted, telehealth is not new, especially within the field of behavioral health.[61] As such, there are many existing resources and best practices to draw upon. For example, detailed guidance on competencies for telebehavioral health care has been created and published in, *"An Interprofessional Framework for Telebehavioral Health Competencies"*,[62] which covers seven domains, 51 objectives and 149 measurable telebehavioral health practices. Dr. Marlene Maheu, lead author of this framework and executive director of the Telebehavioral Health Institute, recommends at least 15 hours of training to be considered "competent" in provision of telebehavioral health. Best practices for treating certain conditions, such as substance use disorder **(see Exhibit 5)** and suicidality, via telehealth are available in the research below. The National Council has also published telehealth best practices during COVID-19 and a resource guide for supporting telehealth and technology-assisted services for people who use drugs.

Exhibit 5

Best Practices for Conducting a Substance Use Disorder-Focused Telehealth Visit

Assessment

- ☑ Complete history of substance use
- ☑ Use DSM-5 criteria to establish SUD diagnosis
- ☑ Look for visual signs of intoxication or withdrawal
- ☑ Evaluate for current depression or suicidal thoughts
- ☑ Have patient do drug testing (using a mail-in kit or by visiting a lab)
- ☑ Provide treatment recommendations
- ☑ Assess medical and mental health co-morbidities
- ☑ Prescribe anti-craving medications

Subsequent Visits

- ☑ Monitor substance use through either remote process or random urine drug screens at labs
- ☑ Encourage ongoing participation in virtual treatment groups
- ☑ Encourage use of asynchronous sources
- ☑ Encourage use of virtual self-help resources (AA/NA)
- ☑ Augment with phone-based support as needed

Source: *https://www.sciencedirect.com/science/article/pii/S0025619620311952#bib11*

Be mindful of disparities and assess digital literacy

The COVID-19 pandemic has disproportionately affected the physical and mental health of vulnerable populations, and also resulted in calls to address structural racism more systematically in the United States. The Centers for Medicare & Medicaid Services (CMS) recently reported that certain vulnerable populations had lower use of telehealth during COVID-19, including individuals with lower incomes, with limited English proficiency, and who are older, Black, Hispanic or Asian. This could be due to factors such as differential access to Internet-enabled devices, Internet and phone affordability, and varying use and quality of electronic health records (EHR) used by providers; more specifically, research has shown that access to and use of personal electronic medical records and other information technology for health-related purposes tends to vary across socio-demographic and geographic factors, creating additional disparities in access to care for providers that have chosen to embed telehealth platforms within their EHRs.[63,64,65]

To help address health equity as part of direct provision of telebehavioral health services, consider assessing for "digital literacy"[66] as recommended in Telemental Health Through a Racial Justice and Health Equity Lens.[67] This could involve proactively assessing people's access to technology and resources needed to engage in telebehavioral health services, including access to broadband; availability of monthly allotted cell phone minutes; access to a smartphone, computer or tablet (when possible); and language preference. If needed, providers would ideally suggest solutions to telehealth barriers, such as directing clients to local libraries for free Wifi, often available in parking lots, and Lifeline[68], a federal program that lowers the monthly cost of phone or Internet services.

Several providers also reported success creating "telehealth rooms" within clinics during COVID-19 to cater to individuals with no or limited technology. Another provider created a "mobile telehealth team" to deliver loaner devices and educate people about how to log onto the telehealth platform. See details in **Exhibit 6**.

Exhibit 6

Telebehavioral Health Innovation: Wilder Clinic's Mobile Telehealth Team

Wilder Community Mental Health & Wellness Clinic ("Wilder"), based in Saint Paul, Minnesota, developed a mobile telehealth team, repurposing existing staff to avoid layoffs at the beginning of the pandemic. The mobile telehealth team delivers loaner devices (e.g., electronic tablets or laptops) and teaches both clients and staff how to use Wilder's telehealth platform. This was essential for clients who did not have access to technology, and helpful to clients who do not speak English as their primary language, as well as some of their elderly and low-literacy clients.

As a result of the mobile telehealth team, many of Wilder's clients can access via telehealth not only behavioral health services, but also primary care or other needed physical health services because they have access to the necessary hardware/software and comfort to connect with providers remotely. Wilder also has clients who figured out how to access family and friends via Facebook, which has benefited many patients, including elders, who felt isolated prior to and/or as a result of the pandemic; this has opened a new world of reconnection with clients' natural supports.

Wilder staff reported "while technology has underscored the huge inequities in our society, if we can provide people with the right tools, supports and access, it can also be a huge equalizer."

Leverage Peer Workforce

Providers also underscored the unique role that peer workers[69] can play in the broader expansion of telehealth, helping to augment the telehealth experience by serving in roles such as a digital navigator. Digital navigators help to ensure all individuals, including the most disadvantaged, have access to and can use information technologies, including affordable Internet, Internet-enabled devices, technical skills and application support.[70] Digital Peer Support, an organization focused on advancing virtual peer support programs, created a certification training program to equip peer support specialists with skills and knowledge to provide effective services in virtual environments, which includes technology literacy and usage skills.[71] California's peer support specialist training curriculum standards were also updated in July 2021 to include "digital literacy" as one of the core competencies.[72]

However, the digital navigator role should not overshadow the other roles that peer support specialists have always fulfilled in behavioral health care clinics. In some ways these roles – including but not limited to educator, advocate, systems navigator, providing support for clients to identify life goals associated with treatment (beyond symptom reduction and medication management) and supporting clients to identify, monitor and celebrate achievement of goals – are even more important in clinics promoting behavioral telehealth and hybrid models.

Exhibit 7

Los Angeles County Department of Mental Health: Peer-Developed Digital Health Literacy Curriculum

Starting in 2019, the Los Angeles County Department of Mental Health (LACDMH) partnered with a local peer-run organization, The Painted Brain, to better understand what people wanted out of technology related to mental health and wellbeing. To achieve this, LACDMH, in coordination with The Painted Brain, surveyed approximately 700 people, including 500 transitional age youth and 200 LACDMH service users, to better understand needs and preferences related to technology and mental health.

Through this work, they discovered that not only did many people not have consistent access to technology, but that some people would periodically rent out their phones, for example, to other people in congregate living. The survey revealed that people were more interested in apps that would help them succeed in their day-to-day life and achieve life goals. At the time, they were not necessarily interested in telehealth or apps to monitor their mood or symptoms; they wanted to know, for example, how to use the bus app to catch a bus on time, how to use the calendar app to set appointments, and how to set sleep and wake timers to consistently go to bed on time, which is a problem for many individuals living with significant mental health conditions.

This research culminated in the development of a Digital Health Literacy Curriculum, created by a core team of seven peers, plus several peer artists, with support from the Digital Psychiatry Program at Harvard. The initial focus was on the more practical aspects of technology, such as helping clients set up email accounts, download apps, and think critically about digital privacy and footprint. With the onset of COVID-19 and the rapid adoption of telehealth, providers expressed concern that they did not have time to help people understand how to get set up to do telebehavioral health. As a result, the Digital Health Literacy Curriculum was updated to cover how to use the telehealth app, along with telehealth etiquette tips (including things like ensuring clients are in a private location, and refraining from driving or engaging in other activities that require full attention during a telehealth session). People can access the information in the curriculum in many ways: tip sheets, one-pagers, animated videos and infographics.

According to Keris Myrick, former chief of Peer and Allied Health Professions with LACDMH, this work resulted in "a different way of thinking about the goal of technology and mental wellbeing; the target shouldn't necessarily be creating something really 'mental health-y,' but rather something 'life-y' that impacts mental health."

Assess and help to ensure client safety in a telehealth environment

While social distancing helped to mitigate the spread of COVID-19, in some cases these restrictions heightened safety risks related to intimate partner violence and suicidality.[73] Research has shown that with proper crisis planning protocols adapted to the telehealth environment, client risk for suicide can be mitigated, helping to reduce client and clinician anxiety, enhance accuracy and reliability of suicide assessments, and support client safety.[74] Promising evidence is also emerging for the use of telehealth to address intimate partner violence[75], along with strategies to ensure safety during sessions.

The Violence at Home Signal for Help

1 Palm to camera and tuck thumb

2 Trap thumb

Exhibit 8

Safety Planning During Telebehavioral Health Sessions

Note: These suggestions are meant to broadly address a range of safety concerns when providing care in a telehealth environment, such as suicidality and intimate partner violence. More specific resources are hyperlinked below.

1. Request the client's location at the start of every telebehavioral health session.
2. Understand who else, if anyone, is in the home (or location where telehealth services are being received), and confirm whether it is a safe time to talk.
3. Recommend the client use a headset or headphones if available when others are in the home (or location where services are being received).
4. Document the client's local emergency medical response team, emergency contacts and social supports, and obtain necessary authorization for release of health information to these individuals, if needed.
5. Develop a plan for how to stay in contact with a client while arranging emergency rescue, if needed.
6. Use alternative means to communicate if needed, such as e-mail, text, chat function embedded within the telehealth platform and/or the international sign for violence at home (see image).
7. Ask directly about recent suicidal ideation using a tool like Columbia Suicide Severity Rating Scale (C-SSRS); recognize that suicidal feelings can be exacerbated by COVID-19 due to social distancing, grief, job loss, substance use, etc.
8. Work with clients to develop an ongoing safety plan that can help clients manage suicide risk on their own, if needed (e.g., see Brown Stanley Safety Plan).
9. Inquire about access to lethal means (e.g., firearms, or stockpiles of Tylenol or other medications).
10. Provide National Suicide Prevention crisis hotline (1-800-273-8255), crisis text (Text **"HOME"** to 741741), and National Domestic Violence Hotline (1-800-799-7233) numbers.
11. Acknowledge that virtual contact may feel different from other means of communication and determine which methods of remote contact best suit client needs (e.g., texting, videoconferencing, phone calls).

If risk becomes imminent and cannot be managed remotely, arrange for the client to go to the nearest crisis center or emergency department (if a crisis center is not available).

Source: *Tips adapted from Responding to Intimate Partner Violence During Telehealth Clinical Encounters, Telehealth Tips: Managing Suicidal Clients During the COVID-19 Pandemic and "Optimizing Telehealth Podcast," produced by Marlene M. Maheu, PhD; photo from The Latch*

Get creative and experiment with digital therapeutics

Providers demonstrated considerable creativity, resilience and innovation in the rapid shift to telebehavioral health. One provider engaged a young client by having him use a toy car to drive the phone around the entire house using Facetime with the therapist, "in the driver's seat," helping work through the layers of his experience in quarantine. Another provider reported young clients who thrived by jointly logging into online games such as Minecraft or Roblox and sharing these virtual worlds with their therapist.

Embedding digital therapeutics – such as applications for mindfulness, meditation, substance use disorder treatment and mood tracking, and digital cognitive behavioral therapy – into telebehavioral health pathways is considered by some experts to be the "wave of the future." Emerging evidence has shown that such tools can provide significant help for patients with mild to moderate mental health issues such as anxiety and depression, especially if integrated into a client's overall treatment plan. Digital therapeutics can be beneficial in multiple ways, including helping to get new clients ready for therapy, enabling existing clients to start their next sessions – whether telehealth or in-person – at a deeper level, and better engaging children and youth in behavioral health care. The ability to engage young people in care is noteworthy, given the U.S. Surgeon General's recent advisory regarding youth mental health, which reported "alarming increases" in the prevalence of certain mental health challenges among young people.[76]

Exhibit 9

Kaiser Permanente's Mental Health and Wellness Digital Ecosystem

In 2017, Kaiser Permanente began design of a digital mental health ecosystem to be provided via clinician referral and self-care pathways. Kaiser Permanente's goal was "to deliver the appropriate and desired level of emotional and mental health support to members with mild to moderate issues by offering user-friendly, evidence-based apps and other digital resources."

Kaiser Permanente leveraged human-centered design principles to solicit stakeholder feedback and inform development of a mental health and wellness digital ecosystem, a network of interconnected and interacting elements that included:

- A curated portfolio of recommended apps with evidence of clinical efficacy and user satisfaction
- The ability for clinicians to recommend apps to patients and to document this in the EHR, and to easily send patients secure text messages containing links to download apps
- Clinician training and support materials developed by Kaiser Permanente's national team with frontline clinicians
- Robust user-friendly audio and video information and activities on a new organization-wide mental health and wellness hub on kp.org (Kaiser Permanente's member-facing website)

Kaiser Permanente leveraged the American Psychiatric Association (APA) app evaluation model and an expert clinical review team to evaluate and select apps. The APA evaluation model addresses accessibility, privacy and security, clinical foundation, engagement and interoperability. Kaiser Permanente recommends avoiding use of free apps when possible, as their revenue models can be based on selling patient data, and they may not have the ongoing support needed for future iteration and development.

In early deployment, 562 clinicians in specialty mental health and primary care settings made 20,906 recommendations of digital apps to 16,348 patients. Of these, 58% downloaded and enrolled in an app, 40% actively used an app at least once, and 27% used an app more than three times. Kaiser Permanente reported a steep increase in demand for resources due to the pandemic, with 86,470 unique monthly visits to self-care tools and resources in April 2020, a 900% increase from the previous year.

Early qualitative data also suggest that patients who used these tools experienced symptom relief, and clinicians reported that having these tools integrated into their approach to care delivery expands and modernizes the capabilities of their practice. Moving forward, Kaiser Permanente plans to embed screening tools like the Patient Health Questionnaire 9 (PHQ-9 for depression) and General Anxiety Disorder 7 (GAD-7) to track reduction of symptoms at the individual and population levels.

According to Dr. Trina Histon, senior principal consultant with Kaiser Permanente: "Use of digital therapeutics can be destigmatizing, educating and normalizing. They help someone know they're not their depression, they're not their anxiety; they help to build awareness and enable clients to start their next sessions at a 'deeper level'."

Make space for self-care and remote work options

Providers reported that building staff wellness and self-care into staff supervision meetings can help to ensure wellbeing of providers in a telebehavioral health environment. Consider building in periodic breaks in between telehealth sessions to the extent possible; research shows that the optimal "work-to-rest" ratio is a 10-minute break for every 60 minutes in front of a computer. Several behavioral health providers reported that they would likely continue a "hybrid" work schedule post COVID-19, working at home some days and in-office other days. These providers recommended prioritizing higher-risk patients, including those with physical co-morbidities, for in-person sessions. Provider organizations could also consider ways to better acknowledge the hard work of their behavioral health workforce, as these staff have arguably not been as recognized for the increased labor and emotional toll resulting from the COVID-19 pandemic as physical health care professionals, such as nurses and doctors. **See Exhibit 4** above for additional strategies to help promote behavioral health providers' wellbeing in the context of telehealth.

Monitor client satisfaction and outcomes with telebehavioral health care

Where feasible, providers should try to assess patient satisfaction specifically with telebehavioral health services, monitoring for trends such as dissatisfaction with certain clinicians and/or within specific client populations. In general, telehealth is well suited to improving the measurement of patients' experience of care, as historical mail-based surveys tended to have low response rates and lacked representation from vulnerable populations. [77] Providers can leverage telehealth's "uniquely digital aspects" to improve timeliness, ease and representativeness of perception of care surveys by, for example, administering short electronic surveys at the end of telehealth sessions.[78] A validated survey has been developed to measure satisfaction and experience of care with telepsychiatry across four domains: access and timeliness, appropriateness, effectiveness, and safety **(see Appendix II)**.

Likewise, telehealth can be leveraged to expand use of measurement-based care, which is the practice of basing clinical care on client data collected throughout treatment.[79] One provider noted that telehealth allows for easier administration and review of patient self-assessments needed to collect timely information about symptoms and treatment progress, especially when related tools, such as symptom rating scales, are digital and incorporated into a provider's EHR. Several interviewees emphasized that measuring increased access or engagement in behavioral health care via telehealth should be considered a starting point. Providers should also assess the quality of the interactions, including therapeutic alliance[80] – the extent to which the client and therapist agree on the goals of treatment, agree on the methods or tasks necessary to achieve goals, and develop a personal bond made up of reciprocal positive feelings – and whether individuals feel they are making progress toward recovery by, for example, having a purpose in life and being part of a community.

Invest in necessary equipment to enhance "tele-presence" or "webside manner." Many providers underscored the importance of investing in necessary equipment to help ensure good "webside manner,"[81] including lighting, a good microphone and noise-cancelling headphones. Several providers also stressed the importance of having large or multiple monitors, to simultaneously review assessments, screening results or handouts while still being able to see a client on video. For hybrid group sessions, where some participants are virtual and others are in-person, one provider suggested a 360° conference camera, such as Owl Labs Meeting Owl, which uses a rotating camera, microphone and split screen to show the whole meeting room, automatically highlighting and shifting focus to different people in the room as they speak.

Develop telehealth assessment and client education tools

Providers may want to consider sharing client education tools prior to telehealth appointments, which could be shared via a patient portal, receptionist, peer specialist and/or handout (e.g., do not hold calls while driving or shopping, limit distractions, download and test software prior to call and so forth). The Substance Abuse and Mental Health Services Administration has published a tip sheet titled "How to Prepare for a Video Appointment with Your Mental Health Clinician." Providers may also want to create a checklist of factors to consider when determining whether to provide behavioral health services in person or via audio-visual or audio-only **(see Exhibit 10)**.

Exhibit 10

Factors to consider when assessing whether to provide behavioral health care via audio-only, audio-visual or in-person

- ☑ Ability to confirm client's identity over phone or video (e.g., privacy/confidentiality issues)
- ☑ Availability of broadband
- ☑ Access to an interpreter (if needed)
- ☑ Client preference*
- ☑ Client's phone plan (e.g., limited data or minutes)
- ☑ Presence of distractions in home environment (or wherever client typically is during sessions)
- ☑ Relationship/familiarity between provider and client
- ☑ Secure, safe, private living space
- ☑ Severity of and/or worsening of symptoms (including physical and behavioral health)
- ☑ Travel time to office

**An NCQA report noted that individuals should receive a choice in modality of service, whether it be in-person or via telehealth, which could be part of an initial assessment process.*

Looking Forward: Future Considerations for Telebehavioral Health Policy and Practice

The expansion of telehealth under the COVID-19 pandemic has been widely viewed as a major benefit to the field of behavioral health; it has expanded access to care, maintained or improved quality and outcomes, and is viewed as convenient by both providers and clients. However, not every client is a suitable candidate for telebehavioral health, nor is every provider capable of providing high-quality telebehavioral health services, especially without appropriate training. While the transition to telehealth may be perceived as simple, high-quality services can be complicated to perform, and providers require specific training in the provision of telebehavioral health. Further, the specific benefits and challenges of telebehavioral health varied by provider type in some instances; for example, psychiatrists reported unique challenges resulting from shorter appointment times and the need to obtain physical health indicators such as vitals and labs as part of managing a client's medications and associated side-effects.

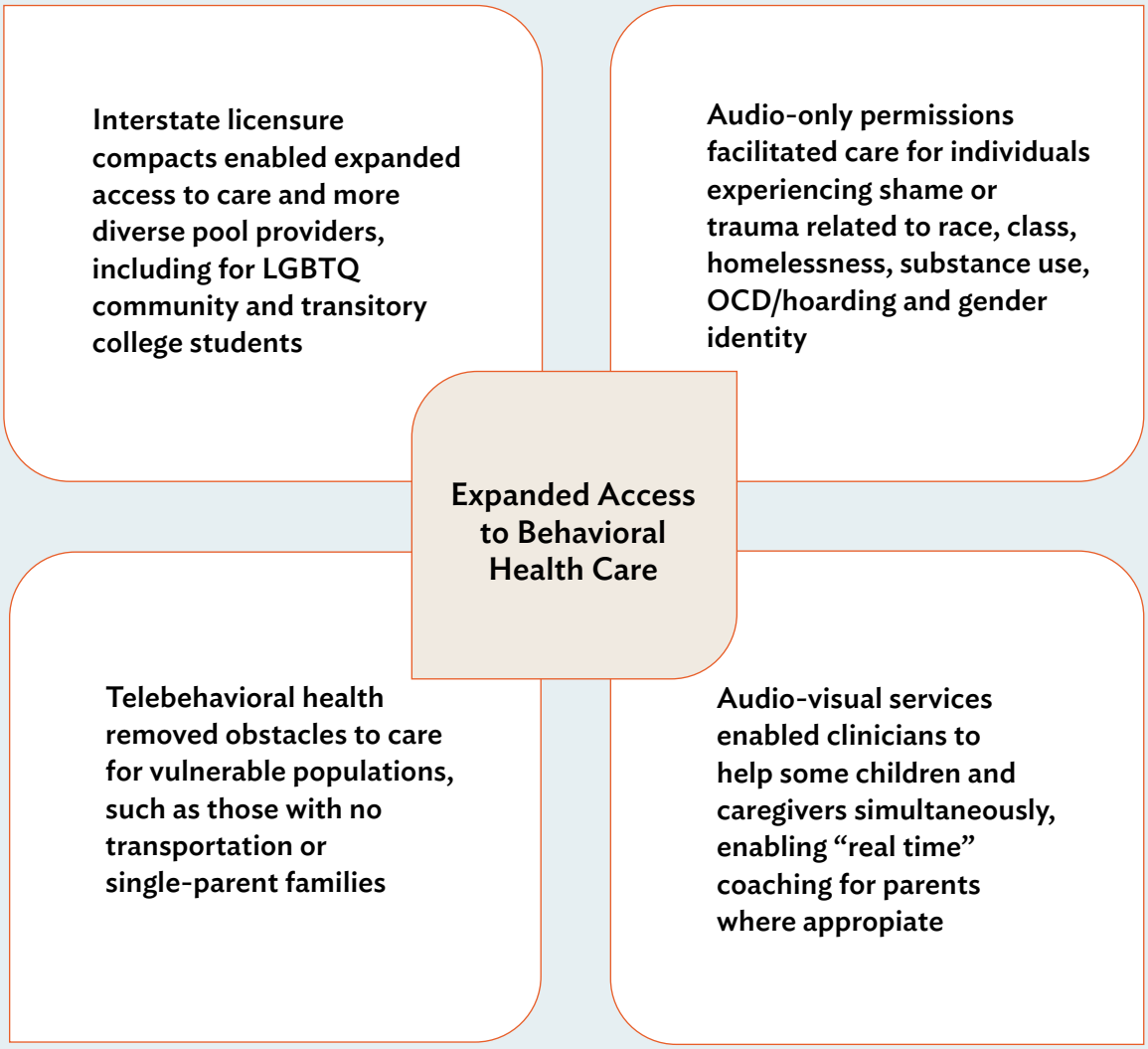
Moving forward, providers expressed interest in clearer guidelines on when to provide behavioral health care services in person versus via audio-only and/or audio-visual, potentially exploring the appropriateness of hybrid models that combine different modalities where feasible and clinically appropriate. Providers also expressed interest in better strategies for using interpreters during telehealth sessions, including more sustainable funding arrangements for interpreters who can provide audio-visual services; this is especially challenging when using telehealth platforms embedded within an EHR. Many provider organizations will likely need to re-engineer their entire systems to make telebehavioral health feel supported and streamlined to both clients and providers, given that most organizations were historically designed to provide in-person care.

Effective January 2023, a new Current Procedural Terminology (CPT®) code (989X6) will be available to enable providers to report remote therapeutic monitoring device use to monitor cognitive behavioral technology.[82] In light of this change, more provider education and technical assistance is likely warranted to help providers understand digital therapeutic options, evidence and potential outcomes. Although some provider organizations enthusiastically promoted digital therapeutics, the evidence for Internet-delivered text-based interventions has previously been ranked as "unknown,"[83] with more recent research suggesting that these tools hold some promise for modestly reducing common psychological symptoms (e.g., depression and anxiety), though effect sizes were generally small.[84] Several providers indicated that it would be helpful to have digital platforms for sharing and reviewing documents with people in real time (e.g., assessment tools, a quiz, "homework"), and also ensuring a virtual "waiting room" feature is embedded within all major telehealth platforms.

Regarding policy and payment, many providers seemed optimistic that the COVID-19 pandemic would lead to permanent expansions of regulations that helped to enable broad use of telebehavioral health. For many of the United States' most vulnerable clients, the ability to also use telephone services was cited as critical in increasing access to needed mental health and substance use services, including for many non-English speaking and unsheltered clients. If minimum requirements for reimbursed telehealth services involve access to broadband and a secure, private living situation, many already underserved individuals would ultimately be excluded from care, including elderly, minority populations and individuals in rural areas. At the federal level, CMS has already approved audio-only mental health and substance use disorder services for Medicare in cases where the beneficiary is not capable of, or does not consent to, the use of two-way audio/video technology through at least December 31, 2023.[85]

Exhibit 11

How Telebehavioral Health Expanded Access to Care for Vulnerable Populations: Specific Examples as Referenced throughout this Report



Further, the broader movement to value-based payment and other non-fee-for-service based payment structures could also help to alleviate some concerns regarding fraud, waste and abuse as it relates to continued expansion of telehealth; in other words, providers paid on a population-based or per member per month basis, including many Certified Community Behavioral Health Clinics, do not have financial incentives to provide unnecessary telehealth services.[86] Likewise, the potential for broader adoption of measure-based care as a result of expanded use of telehealth could help better position behavioral health providers for value-based care by generating client-level and population health data and allowing for better client-provider matching. Overall, providers and stakeholders pointed to the unique opportunity that the pandemic created for a different approach to delivery of behavioral health care services, underscoring the need to leverage telebehavioral health to help alleviate, not worsen, long-standing challenges with access and disparities in care – ideally taking steps to ensure that telehealth is not a privileged service, but rather a new care delivery model accessible to all.

Appendix I: Methodology

To understand the implications of the rapid adoption of telebehavioral health services during COVID-19, including successes, challenges, innovations and future considerations, the National Council for Mental Wellbeing conducted a structured review of recent academic and gray literature; convened technical expert panel meetings on June 29 and November 30, 2021, with participating experts listed under the **Acknowledgements on p. 4;** and facilitated a series of round table discussions using the interview protocol included below. The round table discussions included mental health, substance use and prescribing professionals representing Community Mental Health Centers and Certified Community Behavioral Health Clinics across the country.

The structured review of recent academic research identified a total of 83 relevant articles, categorized into six key categories of information: (1) trends in use; (2) outcomes and efficacy; (3) best practices; (4) provider perceptions; (5) client perceptions; and (6) billing. For the purposes of this report, the National Council prioritized review of articles published in 2020 or later in order to capture research most directly related to the COVID-19 pandemic. Key search terms included "telebehavioral health," "telemental health," "depression video conferencing," "telebehavioral health satisfaction," "substance use telehealth," "virtual medication assisted treatment" and "telepsychology."

Interview Protocol

Innovations in Telehealth in Behavioral Health During COVID-19

Questions for Provider Round Table Discussion with Probes

Introduction: The National Council, with funding from the California Health Care Foundation, is researching the use of telehealth for behavioral health services during COVID. We are gathering information from you today to write a report and host a webinar that will include case studies to illuminate the efficacy of both audio-only and two-way video as well as identify populations for whom telehealth was not ideal. We would like to include innovations in telehealth provision and learnings about how you determined with the people you serve when to utilize telehealth and when to meet in person.

1. What's working well with clients receiving telebehavioral health services?

- How has the use of telehealth impacted **access** to care, including no-show rates and/or populations that have historically been hard to engage?
- Have there been any successful **innovations** to highlight (e.g., distributing iPads for consumers to access a 24/7 crisis line or therapist; use of peers in telehealth)?
- How, if at all, have you tried to ensure **equity** in access and use of telehealth (e.g., addressing disparities in use of telehealth by people of color, lack of broadband, etc.)?
- What is your overall assessment of the **effectiveness of audio-only** versus audio-visual for telebehavioral health care?

2. Where is it not working and why? Where are the gaps?

- Have you experienced any challenges, such as:
  - Obtaining **payment** for services and/or navigating insurer policies?
  - Adhering to **legal**, privacy and/or regulatory standards?
  - Using **technology**, on either the clinician or client side?
  - Managing **client safety** in a virtual setting?
- What **trainings, resources and/or guidelines,** if any, have you used to guide your transition of behavioral health services from in-person to virtual care?
- How has the movement to telebehavioral health impacted **burnout**?

3. What has the client experience of care been like?

- Have you experienced any variation in effectiveness of telebehavioral health across **different populations and conditions** (e.g., eating disorders, SUD, suicidality, group sessions, children/families, etc.)?
- To what extent are you using measurement-based care in conjunction with telebehavioral health and/or **assessing patient satisfaction** with telehealth? Do you have **outcomes** to share?

4. To what extent are "hybrid" models of care currently being used with clients?

- How are clinicians collaborating with clients to determine what type of sessions to use for client visits (e.g., in-person, video, audio-only)?

5. Do you have any client-level examples to share regarding use of telebehavioral health (without sharing protected health information)?

- Both successful and "unsuccessful" examples of telebehavioral health at the client level.

6. What is needed to scale and spread high-quality, equitable telebehavioral health services going forward?

- If possible, please try to solicit suggestions across various domains, such as policy, payment, technology, clinician-level, client-level, etc.
- What should telebehavioral health look like in a post-COVID environment?

7. What types of information would be most beneficial for you to see in the forthcoming report on innovations in telebehavioral health?

Appendix II: Sample Client Satisfaction Tool for Telebehavioral Health

This is a sample tool that can be used to elicit clients' experiences and satisfaction with telebehavioral health services. It is adapted from "Client Satisfaction and Experience with Telepsychiatry: Development and Validation of a Survey Using Clinical Quality Domains."[87]

Note: The terms "telepsychiatry" and "psychiatrist" could be replaced as needed throughout the questionnaire depending on the appointment type and type of clinician providing services.

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
Access and timeliness					
1. I am satisfied with the length of time I had to wait between my referral and the telepsychiatry appointment.					
2. It was easy to book my telepsychiatry appointment.					
3. I was able to get an appointment through telepsychiatry health sooner than an in-person appointment.					
4. The physical location of my telepsychiatry appointment was convenient for me to get to.					
Appropriateness					
5. I believe telepsychiatry is just as effective as an in-person psychiatry appointment.					
6. The psychiatrist understood my concerns.					
7. The psychiatrist involved me in decisions about my treatment plan.					
8. I am confident that I will be able to follow the psychiatrist's recommendations.					

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
Effectiveness					
9. During my telepsychiatry appointment, I was able to see the psychiatrist clearly.					
10. During my telepsychiatry appointment, I was able to hear the psychiatrist clearly.					
11. I am confident that the psychiatrist and my health care providers are working as a team.					
12. I feel that there was an adequate amount of time allotted for the telepsychiatry appointment.					
Safety					
13. I felt comfortable during my telepsychiatry appointment.					
14. I felt that confidentiality was protected throughout my telepsychiatry appointment.					
15. The psychiatrist treated me with courtesy and respect.					
16. The psychiatrist explained my diagnosis in a way that I could understand.					
17. The psychiatrist explained the benefits and risks of any medications recommended.					
18. I understand what to do if I have a mental health emergency following this appointment.					

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