Behavioral Health Institute (BHI)
Training, Workforce and Policy Innovation Center
TeleBehavioral Health 401 Training Series

Behavioral Health Telehealth Resource
Website: https://bhinstitute.uw.edu
Email: bhinstitute@uw.edu

December 15, 2023

Behavioral Health Institute (BHI)
Training, Workforce and Policy Innovation Center

The Behavioral Health Institute is a Center of Excellence where innovation, research and clinical practice come together to improve mental health and addiction treatment. BHI established initial priority programs which include:

- Improving care for youth and young adults with early psychosis
- Behavioral Health Urgent Care Walk in Clinic
- Behavioral Health Training, Workforce and Policy Innovation Center
- Expanded Digital and Telehealth Services

Speaker Disclosures

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

Planner disclosures

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

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DISCLAIMER

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

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

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

We gratefully acknowledge the support from

TeleBehavioral Health 401

Overview of TeleMental Health Guides for Infancy to Young Adult

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Learning Objectives

During these presentations on TeleMental Health (TMH) with young people, infancy to young adulthood, participants will have the opportunity to learn about:

- Adapting evidence-based treatment guidelines to brief and practical TMH Guides
- Evaluating and treating young people using TMH
- Using the technology to capture perspectives of young people
- Preparing young people for TMH sessions
- Determining their ability to assume care for young people who are suicidal and/or who develop suicidality during TMH

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Development of the Guides

Best Telehealth Practices for Prenatal - 25 Behavioral Health
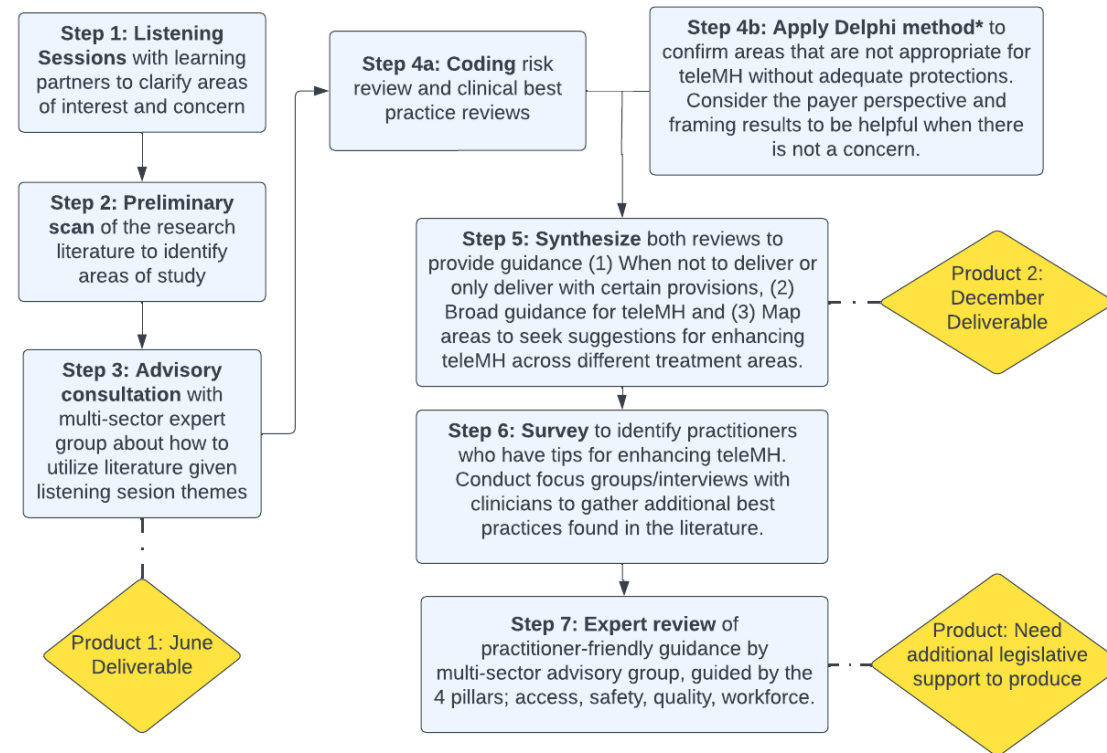
*Delphi Method
1. Identify the relevant literature: systematic reviews, then individual papers that comment on access, safety, quality, and workforce.
2. Code articles for when the conclusions/results points to an area of concern.
3. Code areas of concern for whether the literature offers solution to mitigation.
4. Clinical subject matter experts confirm synthesis.

Development of the Guides

	Perinatal	Infancy and Postpartum	Early Childhood	School Aged Children	Adolescence	Young Adults
Safety	🟥	🟥	🟥	🟩	🟩	🟩
Effectiveness	🟨	🟥	🟥	🟩	🟩	🟦
Access	🟨	🟥	🟥	🟨	🟩	🟩
Equity	🟨	🟥	🟥	🟨	🟨	🟨
Workforce and Provider Experience	🟥	🟥	🟥	🟥	🟥	🟩
Identifying subgroups clinically inappropriate for telehealth	🟥	🟥	🟥	🟥	🟥	🟥

Color Key	Adequacy of Evidence for Actionable Recommendations
🟥	No expert consensus and negligible existing synthesized evidence
🟨	Moderate existing evidence, not yet translated into actionable recommendations
🟩	Moderate existing evidence and developing expert consensus on recommendations
🟦	Strong existing evidence and/or expert consensus on recommendations

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TeleMental Health Quick Guides for Children & Youth

TMH Guides (8)

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

Supporting Documents

- Overview/Introduction to TMH with Young People ("primer")
- Bibliography
- Privacy and Safety Planning (PSP) Tool
- Checklists
  - Clinician Checklist
  - My Telehealth Checklist (patient)

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Components of the Guides & Checklists:
An Introduction to TMH with Young People (a "Mini Primer")

- Legal and Regulatory Issues

- Safety and Privacy

- Technology

- Workflow Considerations

- Preparing for the TMH Session

- Conducting the TMH Session

- TMH Checklists

Guide for Pre-School Children

DEFINING PRE-SCHOOL CHILDREN (3 - 5 YEARS)

Typical development in preschool-aged (PS) children (3 to 5 years) varies by gender, birth order, developmental status, and caregiving experiences (e.g., exposure to learning opportunities, participation in daycare or preschool). Most information gathered for young children will be via parent report (e.g., interviews, standardized rating scales) and observation, though preschoolers can often provide relevant information in TeleMental Health (TMH) interviews. Recognizing that a wide range of caregivers may bring PS children to appointments (e.g., parents, grandparents, foster families, guardians), "caregivers" is used throughout.

SAFETY AND PRIVACY

Establishing safety and privacy depends on the site at which the PS child is receiving TMH services. If services are delivered to a clinic, such as a mental health or pediatrics clinic, safety and privacy should be ensured by staff at those sites. Needs for support may vary depending on the child's presenting concerns. For example, caregivers may have difficulty managing disruptive children and ensuring the child's safety and damage to clinic equipment. If services are delivered to a non-clinical site such as a school or home, careful planning to ensure safety and privacy is needed. This might involve problem-solving with the caregivers before the visit to arrange for help to care for siblings and minimize household interruptions.

- **At the beginning of each session** ascertain and document patient's location and exchange immediate contact information (phone, text message, or e-mail). Include any new address, in case the clinician needs to call emergency services, as outlined in the Privacy and Safety Planning Tool (PSP Tool) appended to the Introduction Guide, as well as to comply with documentation regulations in the medical record. If patients are in a car, be sure they are parked and document the nearest stable location.

- **Privacy must take both the adult and child into consideration.** Caregivers may wish to arrange a time to talk with the clinician without the child present.

- **Introducing all clinicians involved,** giving the caregiver and child a virtual tour of the clinician's office, and providing reassurance that the visit is not being recorded are all helpful.

- **Remind the caregiver to turn off all social media** that could lead to observation of the sessions.

- **PS children are optimally evaluated in familiar,** private settings. Non-traditional settings (e.g., backyard, automobile) pose logistic and safety/ privacy concerns and should be avoided.

- **Hyperactive children may stray** from the clinician's view over the monitor. Work with the caregiver to ensure child safety when they are out of view.

- **If allowing asynchronous contact** between sessions (e.g., email, texting, or contact through a portal website), include the contacts in the patient's chart.

TIP: Choose toys that allow the clinician to adequately observe the child's play over the telemonitor. Depending on the device the family uses, this may allow the clinician to observe play on the floor but may require play on a table.

ENGAGEMENT

Although TMH complicates clinicians' direct interaction and engagement with PS children, it allows contextually meaningful observations of the child in interactions with primary caregivers and potentially to observe the child in the home setting. Caregivers often have the assumption that the visit will be 1:1 with the child, and it is helpful to orient them to the need for observation of caregiver-child interactions to assess the child's development and to inform interventions and recommendations.

- **Consider unstructured observations** (e.g., "I'd like to see you and your child play together as you normally would") and structured protocols that are responsive to the referral question and helpful in identifying targets for intervention. Arrange the observation to fit the devices used. For example, if the family uses a smartphone, the observation will be situated at a considerable distance from the camera to observe both the child and caregiver and capture a narrow range of their actions.

- **Explain and demonstrate the TMH technology** to the caregiver and, when appropriate, the older PS child. For example, instruct the child on holding activities or toys they would like to share with the examiner up to the camera versus the screen.

- **Determine the child's ability to be interviewed** with, or observed in a structured activity with, a non-parental adult, e.g., to assess the ability to separate, the quality of the reunion, interact with and respond to a "stranger." Coach the "stranger" to remain within the device's range if the child becomes distraught so the clinician can observe the child's reaction.

- **Use the "White Board" function,** if available, to allow the caregiver to share ideas, provide teaching materials, and develop treatment plans.

Continued on following page.

ENGAGEMENT CONT.

- **Curate toys, if available, and tasks** at both the patient and clinician sites to engage the child and facilitate a developmentally relevant mental status examination over the monitor, e.g., drawing materials, dolls, model cars, puppets, or a favorite toy with symbolic implications. Avoid noisy toys with many parts as these interfere with the microphone and interrupt the interview and can create additional clean-up for the caregiver.

- **Consider engaging the PS child through verbal games** such as "Simon Says," singing the ABCs together, or possibly drawing on the "White Board" (well-regulated children who can draw).

- **Use the "Share Screen" function** to share caregiver handouts, short instructional videos, and materials to aid the child assessment (e.g., feelings cards, social stories).

FAMILY INVOLVEMENT

Family involvement in the child's treatment varies according to clinical best practices guidelines as implemented through videoconferencing. For PS children, evidence-based treatments focus almost exclusively on caregivers. This may include a parent and primary caregiver, as well as others involved in the child's care (e.g., grandparents, nanny).

- **Caregivers will provide information** regarding their own functioning and the stress involved in caring for a child with atypical development. Clinicians must be attuned to the caregiver's affective shifts which may be more difficult to detect over the monitor than when interacting in person.

- **PS children will not be evaluated** without a caregiver present.

- **The clinician should ensure** that the selected device can detect the visual and auditory signals if the interaction is distant from the device.

- **Caregivers will be involved in all evaluation,** planning, and intervention sessions. The focus of sessions will be on the dyadic relationship and behavioral interventions between the child and caregiver. The clinician should ensure that the selected device can detect the visual and auditory signals if the interaction is distant from the device.

- **Consider using an asynchronous portal** on the clinician's website to collect rating scales/outcome measures from the caregiver and the teacher between sessions.

- **At pivotal times during treatment,** provide the caregiver with a few resources through the "Chat" or "Text" or website portal to aid in understanding the child's treatment and caregiver actions. For example, this is a handy way to provide recommended reading, website links, and other resources in real-time.

DIAGNOSTIC CONSIDERATIONS

- **Autism Spectrum Disorder (ASD):** In addition to caregiver interview, observation is exceptionally important for evaluating children's social engagement. During in-person visits, clinicians accomplish this with direct engagement with the child either informally (e.g., as part of a mental status evaluation) or using structured prompts (e.g., Autism Diagnostic Observation Schedule). In TMH evaluations, these observations require preparation so that caregivers have the materials needed and instructions to elicit the child's engagement. It is helpful for the caregivers to gather toys for free play (pop-up toys with buttons, musical toys, shape sorter, puzzles, blocks, cars, or a ball). Caregivers will be prompted to ask children questions, engage in child-directed play, observe child eye contact, and familiar play routines. A container with a lid that has a snack or other desired object in it (e.g., stickers) provides an opportunity to observe verbal and non-verbal strategies a child uses to request a caregiver's help.

- **Anxiety:** Caregivers and child interviews are used to identify child anxieties and fears, as well as areas of functional impairment. TMH observations can be used to assess caregiver-child interactions during preferred activities (e.g., child-directed play) and challenging situations. Caregivers may be prepared in advance of the TMH visit to engage the child in activities that expose anxieties or fears. For example, the child and caregiver might look at a picture book with images of a feared animal, or, for children with separation anxiety, remain in the room with another adult while the caregiver steps out.

- **Disruptive behaviors:** Child-directed play is the foundation of evidence-based treatments that emphasize differential reinforcement (e.g., praise, attention) of prosocial behavior. Child-directed play is easily implemented in TMH. Other useful observations, such as a transition to a caregiver-directed activity, clean-up, or teaching task are also quite possible with some advanced preparation to make sure that caregivers have any materials needed. Some treatments use an earpiece for the clinician to provide caregivers with live instruction during the interaction (e.g., a "bug-in-the-ear" used in Parent Child Interaction Therapy). In TMH, the caregiver might use Bluetooth earbuds to accomplish the same objective of unobtrusively receiving instruction.

TIP: Be creative in using verbal activities to engage the young child over the telemonitor. These simple activities will help to assess the child's development verbally, intellectually, and interpersonally.

Case Example

Latoya is a 4 y/o African-American girl who was adopted at 2.5 y/o after two foster placements and termination of parental rights due to neglect and suspected abuse. There is a suspicion of intrauterine exposure to alcohol and illegal substances, but this cannot be independently confirmed. The preschool teacher observed academic delays, a preference to play by herself, and difficulty sharing with peers. She did not listen well during story time nor rest during nap time. The parents noted similar difficulties at home, including oppositional behaviors, tantrums, and difficulty with sleep. Latoya did not easily seek affection from her parents. The parents and teacher agreed to TMH services conducted in the home and at school using desktop and laptop computers with excellent connectivity.

The clinician met with Latoya's mother alone via video teleconference to gather relevant history and assess her mental health, marital satisfaction, and access to other social support, parenting practices, and adjustment to parenting a child with atypical development. Her husband then also joined the session via video teleconference but from another location. The clinician explained the evidence-based approach to the evaluation and treatment of preschool children, particularly the dyadic focus. The clinician also explained the modification needed in the clinician's interaction with Latoya due to the videoconferencing modality, including the possible need to include a "strange" individual for selected protocols. The mother was introduced to the videoconferencing technology, including the "Share Screen" and "White Board" functions, through which they shared concepts underlying the treatment of young children. Latoya's mother completed a battery of symptom and behavior questionnaires on the asynchronous patient portal. The clinician met with Latoya's preschool teacher to obtain teacher reports. They also arranged for the teacher to use an iPad for videoconferencing so that Latoya could be observed during the day while other children were napping and off-screen.

The clinician made several observations of Latoya during class tasks with the teacher, in interaction individually with her mother and her father at home, and in play with an older sibling. During these times, the clinician tested Latoya's ability to relate and enjoy social interactions. As she appeared curious about the sessions, the clinician engaged Latoya by asking about body parts and singing her ABCs. For example, while Latoya was seated at the computer, the examiner used prompts like "Here is my eye. Show me your eye. How about your nose?" She also invited Latoya to draw a picture and coached her to hold it to the camera so the examiner could see it. Latoya was typically engaged briefly, but quickly lost interest and wandered away from the camera or drifted off-task. During puppet play, Latoya did not follow tasks in which the puppets spoke to each other and played together. She focused on making them growl aggressively at each other. She did not allow her mother to join in the play. The clinician also noted that Latoya did not make good eye contact over the monitor. For example, she tended not to orient to the examiner on screen and instead turned away. Similarly, she did not appear to orient towards her mother's face or eyes during play. Latoya's mother confirmed this as a longstanding difficulty.

The clinician referred Latoya for formal functional and academic testing by the preschool staff. Results demonstrated delays and led to the implementation of special services. Latoya and her mother completed a course of i-Parent-Child Interaction Therapy (i-PCIT), a behavior-focused parent-training program for young children that places the central emphasis on improving parent-child interactions and the quality of parent-child relationships. Over the year, Latoya improved her progress in school academically and socially. She progressed to pre-kindergarten. At home, she showed better behavioral regulation, settled at night for sleep, and became more affectionate with her parents.

TIP: Consider developing instructions and materials lists for caregiver-child interaction observations, so the caregivers will have the toys and other items needed and they will be able to elicit relevant child behaviors.

Guide for Pre-School Children

DEFINING PRE-SCHOOL CHILDREN (3 - 5 YEARS)

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- At the beginning of each session ascertain and document patient's location and exchange immediate contact information (phone, text message, or e-mail).

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Guide for Pre-School Children

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Typical development in preschool-aged (PS) children (3 to 5 years) varies by gender, birth order, developmental status, and caregiving experiences (e.g., exposure to learning opportunities, participation in daycare or preschool). Most information gathered for young children will be via parent report (e.g., interviews, standardized rating scales) and observation, though preschoolers can often provide relevant information in TeleMental Health (TMH) interviews. Recognizing that a wide range of caregivers may bring PS children to appointments (e.g., parents, grandparents, foster families, guardians), "caregivers" is used throughout.

SAFETY AND PRIVACY

Establishing safety and privacy depends on the site at which the PS child is receiving TMH services. If services are delivered to a clinic, such as a mental health or pediatrics clinic, safety and privacy should be ensured by staff at those sites. Needs for support may vary depending on the child's presenting concerns. For example, caregivers may have difficulty managing disruptive children and ensuring the child's safety and damage to clinic equipment. If services are delivered to a non-clinical site such as a school or home, careful planning to ensure safety and privacy is needed. This might involve problem-solving with the caregivers before the visit to arrange for help to care for siblings and minimize household interruptions.

- **At the beginning of each session** ascertain and document patient's location and exchange immediate contact information (phone, text message, or e-mail). Include any new address, in case the child needs to call emergency services, as outlined in the Privacy and Safety Planning Tool (PSP Tool) appended to the Introduction Guide, as well as to comply with documentation regulations in the medical record. If patients are in a car, be sure they are parked and document the nearest stable location.

- **Privacy must take both the adult and child into consideration.** Caregivers may wish to arrange a time to talk with the clinician without the child present.

- **Introducing all clinicians involved,** giving the caregiver and child a virtual tour of the clinician's office, and providing reassurance that the visit is not being recorded are all helpful.

- **Remind the caregiver to turn off all social media** that could lead to observation of the sessions.

- **PS children are optimally evaluated in familiar,** private settings. Non-traditional settings (e.g., backyard, automobile) pose logistic and safety/privacy concerns and should be avoided.

- **Hyperactive children may stray** from the clinician's view over the monitor. Work with the caregiver to ensure child safety when they are out of view.

- **If allowing asynchronous contact** between sessions (e.g., email, texting, or contact through a portal website), include the contacts in the patient's chart.

TIP: Choose toys that allow the clinician to adequately observe the child's play over the telemonitor. Depending on the device the family uses, this may allow the clinician to observe play on the floor but may require play on a table.

ENGAGEMENT

Although TMH complicates clinicians' direct interaction and engagement with PS children, it allows contextually meaningful observations of the child in interactions with primary caregivers and potentially to observe the child in the home setting. Caregivers often have the assumption that the visit will be 1:1 with the child, and it is helpful to orient them to the need for observation of caregiver-child interactions to assess the child's development and to inform interventions and recommendations.

- **Consider unstructured observations** (e.g., "I'd like to see you and your child play together as you normally would") and structured protocols that are responsive to the referral question and helpful in identifying targets for intervention. Arrange the observation to fit the devices used. For example, if the family uses a smartphone, the observation will be situated at a considerable distance from the camera to observe both the child and caregiver and capture a narrow range of their actions.

- **Explain and demonstrate the TMH technology** to the caregiver and, when appropriate, the older PS child. For example, instruct the child on holding activities or toys they would like to share with the examiner up to the camera versus the screen.

- **Determine the child's ability to be interviewed** with, or observed in a structured activity with, a non-parental adult, e.g., to assess the ability to separate, the quality of the reunion, interact with and respond to a "stranger." Coach the "stranger" to remain within the device's range if the child becomes distraught so the clinician can observe the child's reaction.

- **Use the "White Board" function,** if available, to allow the caregiver to share ideas, provide teaching materials, and develop treatment plans.

Continued on following page.

ENGAGEMENT CONT.

- **Curate toys, if available, and tasks** at both the patient and clinician sites to engage the child and facilitate a developmentally relevant mental status examination over the monitor, e.g., drawing materials, dolls, model cars, puppets, or a favorite toy with symbolic implications. Avoid noisy toys with many parts as these interfere with the microphone and interrupt the interview and can create additional clean-up for the caregiver.

- **Consider engaging the PS child through verbal games** such as "Simon Says," singing the ABCs together, or possibly drawing on the "White Board" (well-regulated children who can draw).

- **Use the "Share Screen" function** to share caregiver handouts, short instructional videos, and materials to aid the child assessment (e.g., feelings cards, social stories).

FAMILY INVOLVEMENT

Family involvement in the child's treatment varies according to clinical best practices guidelines as implemented through videoconferencing. For PS children, evidence-based treatments focus almost exclusively on caregivers. This may include a parent and primary caregiver, as well as others involved in the child's care (e.g., grandparents, nanny).

- **Caregivers will provide information** regarding their own functioning and the stress involved in caring for a child with atypical development. Clinicians must be attuned to the caregiver's affective shifts which may be more difficult to detect over the monitor than when interacting in person.

- **PS children will not be evaluated** without a caregiver present.

- **The clinician should ensure** that the selected device can detect the visual and auditory signals if the interaction is distant from the device.

- **Caregivers will be involved in all evaluation,** planning, and intervention sessions. The focus of sessions will be on the dyadic relationship and behavioral interventions between the child and caregiver. The clinician should ensure that the selected device can detect the visual and auditory signals if the interaction is distant from the device.

- **Consider using an asynchronous portal** on the clinician's website to collect rating scales/outcome measures from the caregiver and the teacher between sessions.

- **At pivotal times during treatment,** provide the caregiver with a few resources through the "Chat" or "Text" or website portal to aid in understanding the child's treatment and caregiver actions. For example, this is a handy way to provide recommended reading, website links, and other resources in real-time.

DIAGNOSTIC CONSIDERATIONS

- **Autism Spectrum Disorder (ASD):** In addition to caregiver interview, observation is exceptionally important for evaluating children's social engagement. During in-person visits, clinicians accomplish this with direct engagement with the child either informally (e.g., as part of a mental status evaluation) or using structured prompts (e.g., Autism Diagnostic Observation Schedule). In TMH evaluations, these observations require preparation so that caregivers have the materials needed and instructions to elicit the child's engagement. It is helpful for the caregivers to gather toys for free play (pop-up toys with buttons, musical toys, shape sorter, puzzles, blocks, cars, or a ball). Caregivers will be prompted to ask children questions, engage in child-directed play, observe child eye contact, and familiar play routines. A container with a lid that has a snack or other desired object in it (e.g., stickers) provides an opportunity to observe verbal and non-verbal strategies a child uses to request a caregiver's help.

- **Anxiety:** Caregivers and child interviews are used to identify child anxieties and fears, as well as areas of functional impairment. TMH observations can be used to assess caregiver-child interactions during preferred activities (e.g., child-directed play) and challenging situations. Caregivers may be prepared in advance of the TMH visit to engage the child in activities that expose anxieties or fears. For example, the child and caregiver might look at a picture book with images of a feared animal or, for children with separation anxiety, remain in the room with another adult while the caregiver steps out.

- **Disruptive behaviors:** Child-directed play is the foundation of evidence-based treatments that emphasize differential reinforcement (e.g., praise, attention) of prosocial behavior. Child-directed play is easily implemented in TMH. Other useful observations, such as a transition to a caregiver-directed activity, clean-up, or teaching task are also quite possible with some advanced preparation to make sure that caregivers have any materials needed. Some treatments use an earpiece for the clinician to provide caregivers with live instruction during the interaction (e.g., a "bug-in-the-ear" used in Parent Child Interaction Therapy). In TMH, the caregiver might use Bluetooth earbuds to accomplish the same objective of unobtrusively receiving instruction.

TIP: Be creative in using verbal activities to engage the young child over the telemonitor. These simple activities will help to assess the child's development verbally, intellectually, and interpersonally.

Case Example

Latoya is a 4 y/o African-American girl who was adopted at 2.5 y/o after two foster placements and termination of parental rights due to neglect and suspected abuse. There is a suspicion of intrauterine exposure to alcohol and illegal substances, but this cannot be independently confirmed. The preschool teacher observed academic delays, a preference to play by herself, and difficulty sharing with peers. She did not listen well during story time nor rest during nap time. The parents noted similar difficulties at home, including oppositional behaviors, tantrums, and difficulty with sleep. Latoya did not easily seek affection from her parents. The parents and teacher agreed to TMH services conducted in the home and at school using desktop and laptop computers with excellent connectivity.

The clinician met with Latoya's mother alone via video teleconference to gather relevant history and assess her mental health, marital satisfaction, and access to other social support, parenting practices, and adjustment to parenting a child with atypical development. Her husband then also joined the session via video teleconference but from another location. The clinician explained the evidence-based approach to the evaluation and treatment of preschool children, particularly the dyadic focus. The clinician also explained the modification needed in the clinician's interaction with Latoya due to the videoconferencing modality, including the possible need to include a "strange" individual for selected protocols. The mother was introduced to the videoconferencing technology, including the "Share Screen" and "White Board" functions, through which they shared concepts underlying the treatment of young children. Latoya's mother completed a battery of symptom and behavior questionnaires on the asynchronous patient portal. The clinician met with Latoya's preschool teacher to obtain teacher reports. They also arranged for the teacher to use an iPad for videoconferencing so that Latoya could be observed during the day while other children were napping and off-screen.

The clinician made several observations of Latoya during class tasks with the teacher, in interaction individually with her mother and her father at home, and in play with an older sibling. During these times, the clinician tested Latoya's ability to relate and enjoy social interactions. As she appeared curious about the sessions, the clinician engaged Latoya by asking about body parts and singing her ABCs. For example, while Latoya was seated at the computer, the examiner used prompts like "Here is my eye. Show me your eye. How about your nose?" She also invited Latoya to draw a picture and coached her to hold it to the camera so the examiner could see it. Latoya was typically engaged briefly, but quickly lost interest and wandered away from the camera or drifted off-task. During puppet play, Latoya did not follow tasks in which the puppets spoke to each other and played together. She focused on making them growl aggressively at each other. She did not allow her mother to join in the play. The clinician also noted that Latoya did not make good eye contact over the monitor. For example, she tended not to orient to the examiner on screen and instead turned away. Similarly, she did not appear to orient towards her mother's face or eyes during play. Latoya's mother confirmed this as a longstanding difficulty.

The clinician referred Latoya for formal functional and academic testing by the preschool staff. Results demonstrated delays and led to the implementation of special services. Latoya and her mother completed a course of i-Parent-Child Interaction Therapy (i-PCIT), a behavior-focused parent-training program for young children that places the central emphasis on improving parent-child interactions and the quality of parent-child relationships. Over the year, Latoya improved her progress in school academically and socially. She progressed to pre-kindergarten. At home, she showed better behavioral regulation, settled at night for sleep, and became more affectionate with her parents.

TIP: Consider developing instructions and materials lists for caregiver-child interaction observations, so the caregivers will have the toys and other items needed and they will be able to elicit relevant child behaviors.

TMH Guide for
Elementary School Children

Kathleen Myers, MD MPH MS

Safety and Privacy

Establishing safety and privacy depends on the child's location: clinics, school, home, other.

- Prior to starting services, complete a Safety Planning Tool (PSP Tool)
- At the beginning of each session ascertain the patient's location and exchange contact information (phone, text, e-mail): document in EHR
- Consider a virtual tour of the clinician's and patient's sites
- Consider non-traditional settings for sessions
- Secure any equipment (e.g., in clinics)

Engagement

Consider how to use the devices to engage children

- Use the PIP function to show children their image, if possible
- Instruct children on using the technology, as possible
- Determine the child's ability to be interviewed alone (c/w EBT)
- Consider innovative use of the device, e.g., flipping the camera
- Consider limitations of the device used, e.g., smartphones
- Avoid child's use of electronics in sessions (exceptions apply)

Family Involvement

Caregivers are more involved during TMH than during in-person care

- Caregivers' skepticism about TMH may limit success: address
- Discuss conditions for having caregivers in, or out of, the session
- Children who are dysregulated or neuro-divergent may need a caregivers, or another adult, to remain throughout the session

Diagnostic Considerations

Some conditions may not be appropriate to TMH. Further, clinicians must determine how TMH might affect their diagnosis and treatment

- Severe aggression may preclude TMH: Wrap team
- Severe dev disorders may be difficult to assess: Hybrid model
- DBDs and neurodivergence may limit access to the equipment
- Try the chat or whiteboard for children who do not speak (e.g., SAD)
- Some children are difficult to assess thru TMH: Hybrid model

TMH Guide for
Preschool Children

Brent Collett, PhD

Guide for Preschoolers: Safety and Privacy

- Before the visit, discuss plans for caring for the child and any siblings during the session.

- Non-traditional settings (e.g., car, park, backyard) pose logistic and safety/privacy concerns and should be avoided.

- Introduce all clinicians involved and provide a "tour" of your space.

TIP: It is often helpful for caregivers to have an opportunity to share sensitive information with the patient and siblings out of the room.

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Guide for Preschoolers: Engagement

- Caregivers often assume visits will be 1:1 with the child. Orient caregivers to the need to observe caregiver-child play and other interactions.

- Consider unstructured (e.g., "Play with your child as you normally would") and structured observations (e.g., "Help your child with this developmentally challenging task").

> TIP: Prepare a list of example toys/materials and activities that you would like to observe. It helps for caregivers to have this in advance of observation visits.

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Guide for Preschoolers:
Special Considerations

- Asynchronous data collection (e.g., rating scales, smartphone recordings of caregiver-child interaction, daycare provider/teacher interviews) is an important addition to TMH sessions.

- Use the "share screen" function to share handouts, short videos, and other materials for intervention.

> TIP: Most evidence-based treatments for preschoolers are caregiver-focused. These treatments lend themselves to TMH in both individual and group formats.

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TMH Guide for Young Adults

Johanna Folk, PhD

Guide for Young Adults: Safety and Privacy

- Follow Privacy and Safety Planning Tool procedures and considerations previously discussed

- Establish extra privacy measures at home to allow for discussion of sensitive topics

- Prepare and discuss a crisis plan

TIP: Appreciate that young adults will likely not have the same family involvement as younger age groups. Explore ways to optimize the virtual patient-clinician relationship and involvement from supportive adults.

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Guide for Young Adults: Engagement

- Explain technical functions and use them to facilitate engagement

- Be creative!

- Review commercial therapy tools' evidence base and face validity

- If prescribing medication, "share screen" for photos and discussing benefits and risks

TIP: Young adults are often very experienced with technology. Leverage their interest and expertise to promote engagement.

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Guide for Young Adults: Special Considerations

- Some young adults may have difficulty engaging in telemental health services
  - Developmental disorders
  - Psychosis
  - Active substance use
- Family involvement will vary

TIP: Young adults may wish to involve other supportive adults in their care (e.g., romantic partner, friend, roommate) rather than caregivers.

TMH Guide for Suicidality

Kathleen Myers, MD MPH MS

Safety and Privacy

It is not known whether the clinician working through TMH can manage suicidality comparably to in-person services.

- Clinicians must determine their ability to manage suicidality remotely
- Crisis planning protocols increase clinicians' skills in mitigating risk
- Tool: Develop Privacy and Safety Planning (PSP) Tool <u>before</u> any sessions
- Tool: Have an adaptive plan available at <u>start</u> of sessions
- Tool: Columbia Suicide Severity Rating Scale and Stanley-Brown Safety Plan

Engagement

- Determine the suicidal patient's appropriateness for TMH prior to assuming ongoing care; reassess during treatment

- Consider the optimum site for service if patient is suicidal

- If the clinician notes decreased engagement --- a potential issue for remote detection --- assess and query the patient about suicidality

- Use the adaptive plan to practice soothing and/or distracting activities, with emphasis on interpersonal contacts

- Use the Chat or Whiteboard to communicate if patients "shut down"

Family Involvement

- Ensure ready access to caregivers or another adult during sessions
- Update the safety plan if the clinician and family decide that the patient can remain at home, rather than be evaluated in person
- Develop and share with patients and caregivers a plan for how to stay in the video session while arranging emergency rescue
- The clinician stays in sessions until other providers are present
- Decide with the patient and family whether TMH continues to be an appropriate service

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Diagnostic Considerations

- There are no diagnostic variations relevant to care delivered through TMH when a patient is suicidal

Supportive Documents

Kathleen Myers, MD MPH MS

Privacy and Safety Planning (PSP) Tool

- Module 1: Screening for Safety
  - Environmental Safety
  - Clinical Safety
  - Disposition Planning

- Module 2: Assessment for Safety during TMH Session
  - Environmental Safety
  - Clinical Safety

- Module 3: End of Session Safety and Disposition Planning
  - Review of Environmental and Clinical Safety
  - Disposition Planning

- Module 4: Timeout & Re-assessment
  - TMH Timeout
  - Review of Clinical Safety Planning

My Telehealth Checklist

Preparation, Safety, and Privacy

☐ I sent my medical information and any requested forms to my clinician, if indicated.
☐ I have arranged space with visual and auditory privacy; there will be no interruptions.
☐ I have a list of questions ready for my clinician.
☐ I asked everyone else in my home to not use the internet during my session.
☐ My clinician sent me directions on how to log on and then wait to join the session.
☐ My clinician sent me a plan in case the technology fails. I have a phone number to call.
☐ My clinician completed a privacy and safety planning form with me in case of emergency.

Technology

☐ I have internet (or other connection, such as my secure phone data plan) for our session.
☐ My device has a camera, microphone, and speaker; I have tested the system with someone.
☐ My device is placed on a stable platform; I am not holding it in my hand.
☐ My device's camera is placed at eye level to approximate eye contact.
☐ My face and chest are centered on the screen. If I cannot tell, I will ask my clinician.
☐ I have headphones to improve hearing, if needed.
☐ I have turned off all other social media.
☐ I know I cannot record the session, or take any screenshots.

Environment: Setting up the Space

☐ I am not in a public place or a moving vehicle.
☐ I closed all windows and decreased other sources of noise, e.g., TVs, radios, nearby talking.
☐ My space has an uncluttered background according to directions from my clinician.
☐ The lighting is in front of me; there are no lights or windows in back of me.

Personal Presentation

☐ I am dressed, and will behave, just as during an in-person appointment. ☐ I do not have anything to eat or drink (except water) during the session. ☐ I will not multi-task. I have put away other activities and distractions.

Communication and Engagement

☐ I will introduce myself and anyone else in the room with me.
☐ I will arrange the room so that all participants are seen on screen.
☐ I will let the clinician know if I cannot hear or see my clinician adequately.
☐ I have all my medication bottles nearby.
☐ My clinician told me the follow-up plan including any tests, any referrals, visits with my primary care provider, and a subsequent TMH session, if indicated.
☐ My clinician told me numbers to call for any questions or problems after hours.

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Training, Workforce and Policy Innovation Center

Additional Information & Resources

After today's session:

Slides & resources will be posted after the session

https://bhinstitute.uw.edu/

Additional <u>Free Resources</u> for Washington State Behavioral Health Providers

EDUCATIONAL SERIES:
- UW Traumatic Brain Injury – Behavioral Health ECHO
- UW Psychiatry & Addictions Case Conference ECHO
- UW TelePain series

PROVIDER CONSULTATION LINES
- UW Pain & Opioid Provider Consultation Hotline
- Psychiatry Consultation Line
- Partnership Access Line (pediatric psychiatry)
- Perinatal Psychiatry Consultation Line