TeleBehavioral Health 2025 Training Series

Behavioral Health Institute (BHI)
Harborview Medical Center
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Northwest Regional
Telehealth Resource Center (NRTRC)
Website: https://nrtrc.org
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November 21, 2025

Behavioral Health Institute (BHI)

Training, Workforce and Policy Innovation Center

The **Harborview Behavioral Health Institute** (BHI) is a program of Harborview Medical Center that is dedicated to advancing innovation, research and clinical practice to improve community mental health and addiction treatment. The BHI also serves as a resource for the advancement of behavioral health outcomes and policy, and supporting sustainable system change.

The BHI brings the expertise of Harborview Medical Center/UW Medicine and other university partners together to address the challenges facing Washington's behavioral health system, through innovation and improving access to effective behavioral health care. BHI pillars include:

- Clinical Services
- Research and Program Evaluation
- Training, Policy and Workforce Development
  - **Expanded Digital and Telehealth Services and Training**

Northwest Regional Telehealth Resource Center (NRTRC)

Telehealth Technical Assistance Center

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

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

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

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Speaker Disclosures

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

Planner disclosures

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

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DISCLAIMER

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

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

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

We gratefully acknowledge the support from

Washington State Health Care Authority

NRTRC NORTHWEST REGIONAL TELEHEALTH RESOURCE CENTER

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FOR WESTERN WASHINGTON AT WHATCOM COMMUNITY COLLEGE

TeleBehavioral Health 2025

Does modality matter? Comparing the quality of mental health care delivered by video, phone, and in-person

SAMANTHA CONNOLLY, PHD

INVESTIGATOR, VA BOSTON CENTER FOR HEALTH OPTIMIZATION AND IMPLEMENTATION RESEARCH

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NOVEMBER 21, 2025

Acknowledgments

- Contents are solely the responsibility of Dr. Samantha Connolly and do not represent the official views of the US Department of Veterans Affairs or the US Government.

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- No conflicts of interest to report.

Mental health care modalities

In-person

Pros: personal connection, better able to pick up on cues

Cons: need for transportation, traffic, distance, parking, time

Video

Pros: patient and provider can see each other, convenient

Cons: need for video-enabled device, internet, tech literacy, loss of in-person connection

Phone

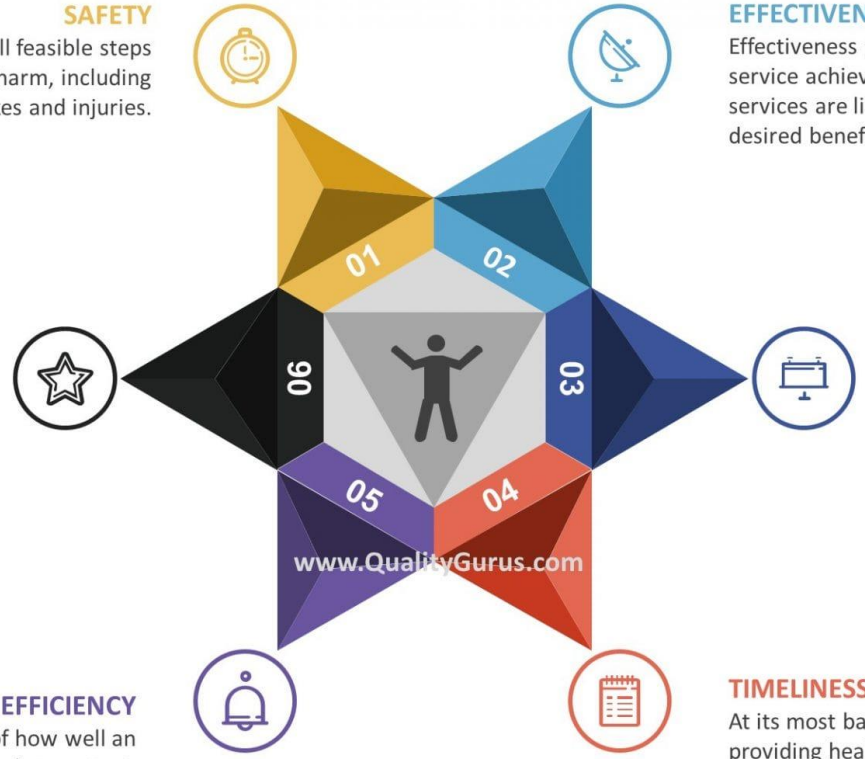
Pros: easy, efficient, accessible

Cons: loss of non-verbal information (body language, grooming, surroundings)

National Academy of Medicine
Six Domains Of Healthcare Quality

SAFETY
Healthcare providers must take all feasible steps to protect patients from harm, including preventing medical mistakes and injuries.

EFFECTIVENESS
Effectiveness refers to how well a healthcare service achieves its intended purpose. Effective services are likely to be safe and provide the desired benefits for patients.



EQUITY
Healthcare systems should be equitable, meaning that no one group of people receives better or worse care than another.

PATIENT-CENTERED
Patient-centred care is a philosophy and approach to health care that emphasizes the importance of the patient's perspective.

EFFICIENCY
Efficiency is a measure of how well an organization uses resources to produce output.

TIMELINESS
At its most basic level, timely care means providing health services as soon as possible. Delivering health services on schedule keeps patients safe and allows them to receive the best possible care.

Committee on Quality of Health Care in America. (2001). *Crossing the quality chasm: a new health system for the 21st century*. National Academies Press.

Poll question #1

What percentage of clinical care do you currently provide by **video telehealth**?

- 0-10%
- 10-25%
- 25-50%
- 50-75%
- 75-100%

Poll question #2

What percentage of clinical care do you currently provide by **audio only phone**?

- 0-10%
- 10-25%
- 25-50%
- 50-75%
- 75-100%

Poll question #3

What percentage of clinical care do you currently provide **in-person**?

- 0-10%
- 10-25%
- 25-50%
- 50-75%
- 75-100%

Comparing the quality of video versus in-person care

Effectiveness of video versus in-person care

- Video shown to be clinically effective as compared to in-person in multiple rigorous RCTs and non-inferiority trials
- Studies examining the full range of disorders (e.g., PTSD, depression, anxiety), therapy/med management/some neuropsych assessment, children/adults

A Non-Inferiority Trial of Prolonged Exposure for Posttraumatic Stress Disorder: In Person versus Home-Based Telehealth

Teletherapy Versus In-Person Psychotherapy for Depression: A Meta-Analysis of Randomized Controlled Trials

Randomized Noninferiority Trial of Telehealth Delivery of Cognitive Behavioral Treatment of Insomnia Compared to In-Person Care

Patient satisfaction: video versus in-person care

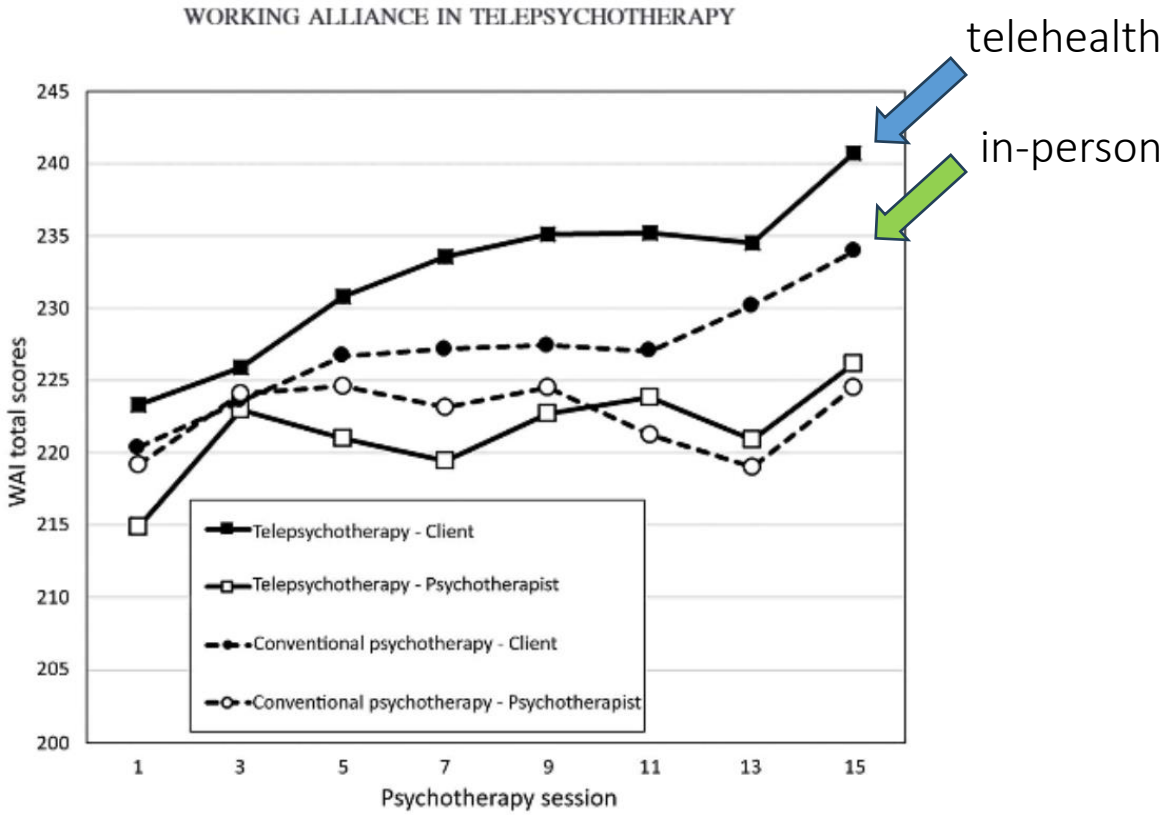
- Generally high across diverse populations (older adult, veteran, incarcerated, indigenous populations, parents of children receiving care)

- Multiple studies have found no difference in patient-reported satisfaction and working alliance between video telehealth and in-person care

Jenkins-Guarnieri, M. A., Pruitt, L. D., Luxton, D. D., & Johnson, K. (2015). Patient perceptions of telemental health: Systematic review of direct comparisons to in-person psychotherapeutic treatments. *Telemedicine and e-Health*, *21*(8), 652-660.

Telepsychotherapy for Generalized Anxiety Disorder: Impact on the Working Alliance

- RCT showing that patients with GAD rate working alliance **higher** in telehealth condition vs. in person
- May feel more comfortable, less intrusive, gives patients more control



Watts, S., Marchand, A., Bouchard, S., Gosselin, P., Langlois, F., Belleville, G., & Dugas, M. J. (2020). Telepsychotherapy for generalized anxiety disorder: Impact on the working alliance. *Journal of Psychotherapy Integration*, *30*(2), 208.

Group therapy: an exception to the rule?

- Patients may rate working alliance lower for group therapy via video (Jenkins-Guarnieri et al, 2015)
- A recent qualitative study (Sousa et al., 2025) found:
  - Telehealth allowed for more empowered engagement in group teletherapy and enabled better access and longitudinal attendance for many patients, vs. in-person.
  - However, many patients reported a reduced sense of emotional intimacy and connectedness with telehealth, and some reported that technology challenges and distractions contributed to feelings of disconnection.
  - Patients were divided in their modality preferences, but many expressed an interest in receiving at least some of their group therapy sessions by telehealth.

Sousa, J. L., Raja, P., Rabinowitz, M., Richard, J., Smith, A., Huskamp, H. A., ... & Uscher-Pines, L. (2025). Patient experiences with group teletherapy for the treatment of mental illness: A qualitative study. *Psychiatric Services*, *76*(2), 157-162.

There are pros and cons to video telehealth

- **Benefits**:
  - Convenience
  - May feel less stigmatizing or anxiety-provoking than attending care in person
  - Easier for those with physical health concerns, childcare, or eldercare responsibilities that make leaving home difficult
  - Get to see patient's home environment/meet family, pets, etc
- **Drawbacks**:
  - No in-person connection, don't get to see the 'full person'
  - Requires technology ownership and literacy
  - Requires strong enough Wifi/internet/adequate data plan
  - **Remember: smartphone ownership ≠ telehealth readiness**

What are providers endorsing as significant challenges of video?

Patient difficulty with device or platform (25%)
Patient does not have adequate internet access (23%)
Lack of patient training/tech support (20%)

Not…

Inappropriate/distracting patient behavior (7%)
Provider training (6%)
Safety/confidentiality (2%)
Establishing rapport (1.5%)

Connolly, S. L., et al (2021). Provider Perceptions of Virtual Care During the Coronavirus Disease 2019 Pandemic: A Multispecialty Survey Study. *Medical care*, *59*(7), 646.

dig·it·al di·vide

noun

the gulf between those who have ready access to computers and the Internet, and those who do not.
"a worrying “digital divide” based on educational attainment and income"

Assessing Telemedicine Unreadiness Among Older Adults in the United States During the COVID-19 Pandemic

Kenneth Lam, MD[1]; Amy D. Lu, MD[1]; Ying Shi, PhD[1]; et al

» Author Affiliations | Article Information

JAMA Intern Med. Published online August 3, 2020. doi:10.1001/jamainternmed.2020.2671

Telemedicine and the Forgotten America

Howard M. Julien ✉, Lauren A. Eberly, Srinath Adusumalli

Originally published 11 Jun 2020 | https://doi.org/10.1161/CIRCULATIONAHA.120.048535 | Circulation. 2020;142:312–314

Strategies for Digital Care of Vulnerable Patients in a COVID-19 World—Keeping in Touch

Darrell M. Gray II, MD, MPH[1]; Joshua J. Joseph, MD[2]; J. Nwando Olayiwola, MD, MPH[3]

Author Affiliations | Article Information

dig·it·al di·vide

*"For 2018, we estimated that of all older adults in the United States, 13 million **(38%) were not ready for video visits,** predominantly owing to inexperience with technology."*

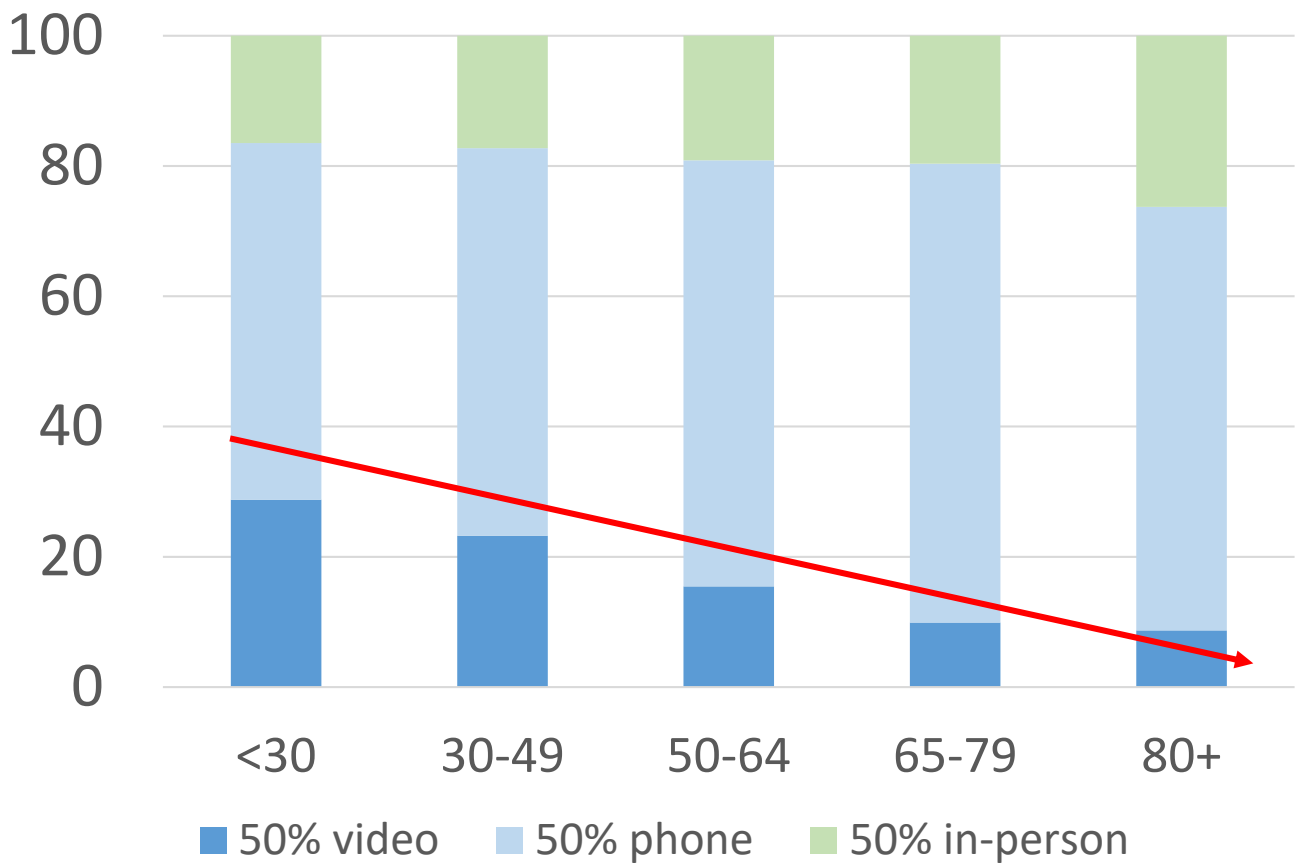
Race/ethnicity	% unready
White, non-Hispanic	32
Black, non-Hispanic	60
Other, non-Hispanic[a]	45
Hispanic	71

Income quintile[b]	% unready
Highest	17
Higher	23
Middle	34
Lower	43
Lowest	67

Lam, K., Lu, A. D., Shi, Y., & Covinsky, K. E. (2020). Assessing Telemedicine Unreadiness Among Older Adults in the United States During the COVID-19 Pandemic. *JAMA Internal Medicine*.

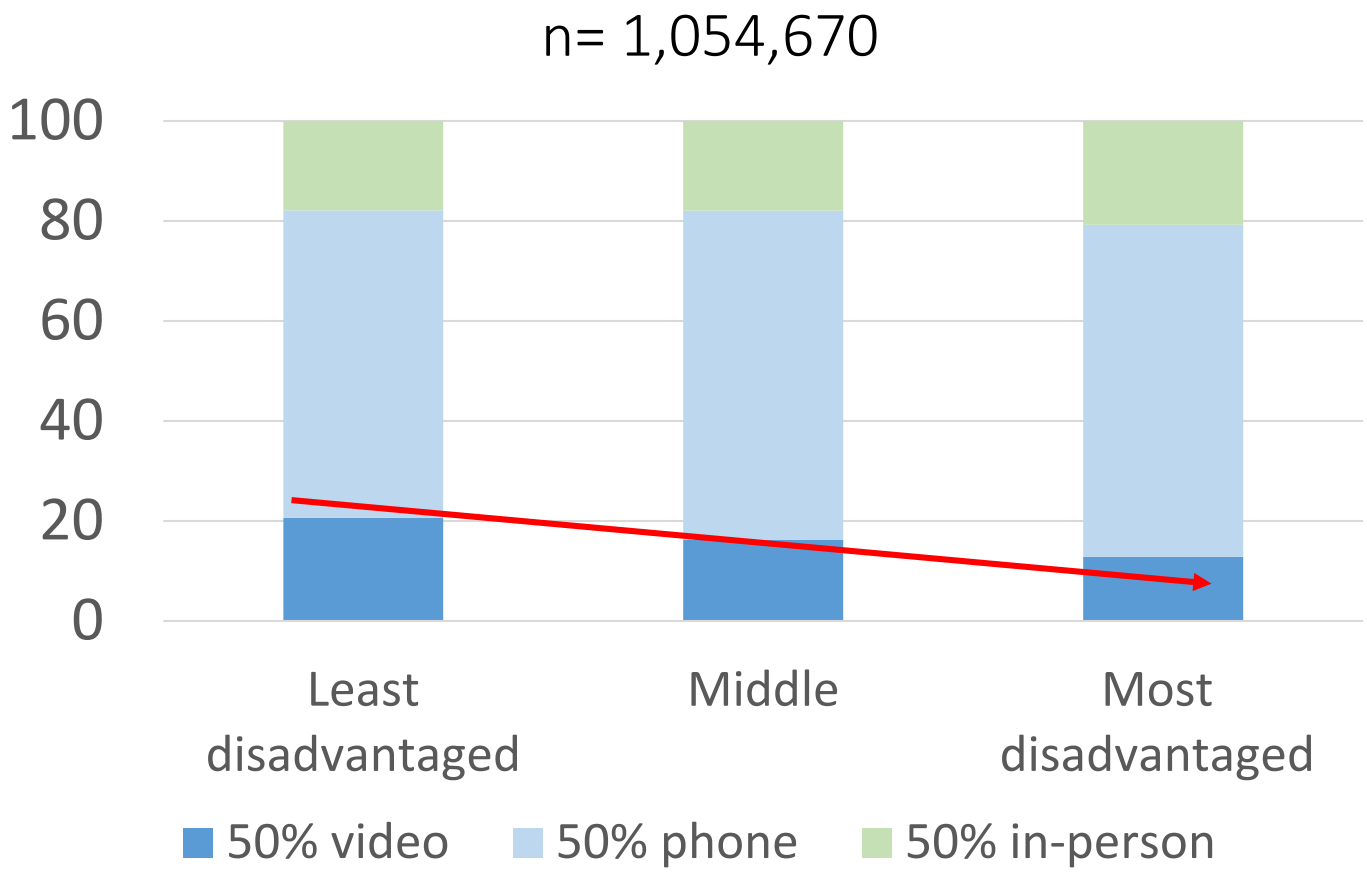
Age differences in % of VA Mental Health patients receiving ≥50% of their care via video during COVID-19

n= 1,054,670



Connolly SL, et al. Patient and provider predictors of telemental health use prior to and during the COVID-19 pandemic within the Department of Veterans Affairs. American Psychologist. 2021.

Socioeconomic differences in % of VA Mental Health patients receiving ≥50% of their care via video during COVID-19

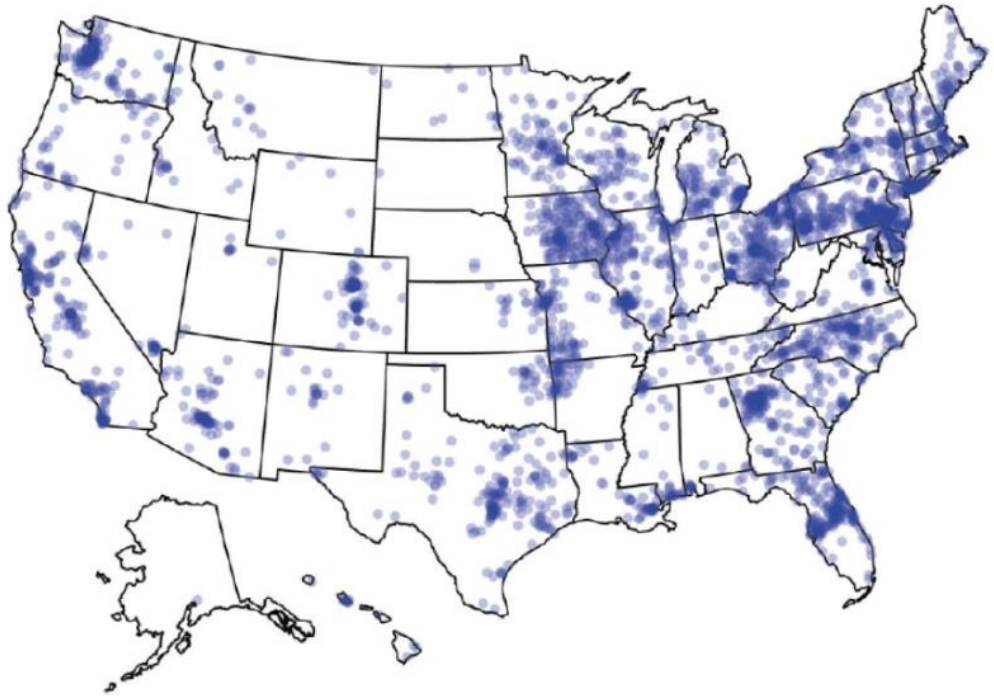


Connolly SL, et al. Patient and provider predictors of telemental health use prior to and during the COVID-19 pandemic within the Department of Veterans Affairs. American Psychologist. 2021.

VA's response to structural patient barriers

- T-Mobile, Verizon, Sprint, and SafeLink by Tracfone waive all data charges for video appointments
- iPads available via Digital Divide consult for veterans without a device/connectivity
- ATLAS sites (telehealth pods at libraries, Walmarts, VFW halls)

Geographic Distribution of VA-Issued Tablets Sent to N=7,221 Patients (in 3,652 zip codes) During the First Two Months of the COVID-19 Pandemic (3/11/20-4/30/20)



Heyworth, L., Kirsh, S., Zulman, D., Ferguson, J. M., & Kizer, K. W. (2020). Expanding access through virtual care: the VA's early experience with Covid-19. *NEJM catalyst innovations in care delivery*, *1*(4).

Comparing the quality of video versus phone care

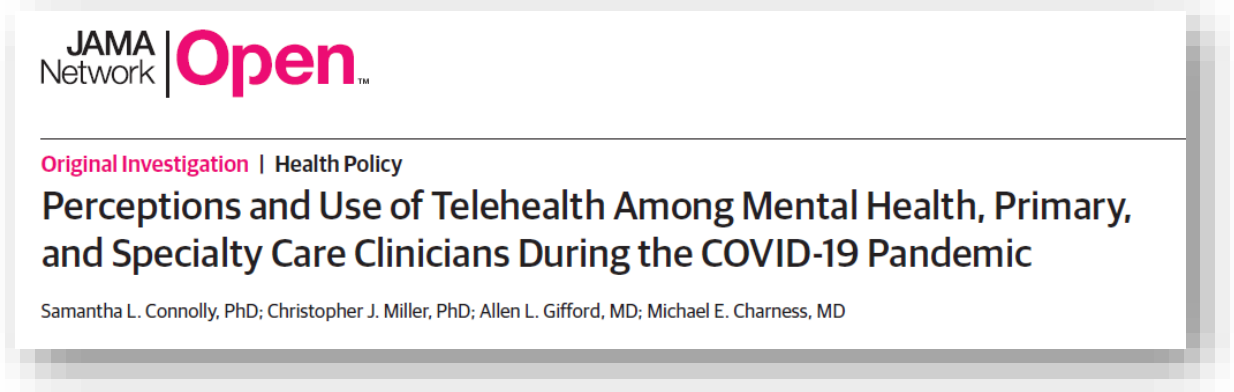
Growing findings that video may have advantages

- Meta-analysis: “Videoconferencing was more effective than telephone for depression (d = 0.86 and 0.46, respectively) and trauma (d = 1.00 and 0.51, respectively).”
  - McClellan, M. J., Osbaldiston, R., Wu, R., Yeager, R., Monroe, A. D., McQueen, T., & Dunlap, M. H. (2022).

- “Veterans attending telephone appointments during COVID-19 were significantly more likely to present to the psych ER (25.8%) compared to those with video as their main modality (12.5%) or those with no therapy (15.0%); $\chi 2$ [2,N=390]=8.3, p=.016.”
  - Meshberg-Cohen, S., Farook, M., Gross, G., Levina, V., & DeViva, J. (2023).

- Smoking cessation studies show poorer patient medication compliance, satisfaction, perceived support from their provider, treatment completion, and abstinence rates in phone versus video conditions

Providers rate phone as lower quality than video


JAMA Network Open

Original Investigation | Health Policy

Perceptions and Use of Telehealth Among Mental Health, Primary, and Specialty Care Clinicians During the COVID-19 Pandemic

Samantha L. Connolly, PhD; Christopher J. Miller, PhD; Allen L. Gifford, MD; Michael E. Charness, MD

Voluntary, anonymous 32-item survey of VA providers from Aug-Sep 2021 assessing telehealth quality, factors contributing to modality choice, telehealth challenges, and modality preferences

76% of mental health providers (n= 403) rated phone as being lower quality than video when treating **new patients**

56% rated as phone as lower quality when treating **established patients**

There are discipline level differences in attitudes

Psychological Services

Discipline-Level Differences in Mental Health Provider Perceptions of Video and Phone Telehealth

Samantha L. Connolly, Michael E. Charness, Allen L. Gifford, and Christopher J. Miller

Online First Publication, July 13, 2023. https://dx.doi.org/10.1037/ser0000791

Secondary analyses of mental health providers only (n=403):

-75% nonmedical providers (psychologists and social workers)

-25% medical providers (psychiatrists, pharmacists, PAs, and NPs)

Findings

- Nonmedical providers were more likely to rate phone care as lower quality than video care when treating new patients
  (nonmedical: 78%; medical: 69%; $\chi 2 = 7.06$, $p = .03$)
- Nonmedical providers were more likely to endorse research as contributing to their decision-making (nonmedical: 30%; medical: 16%; $\chi 2 = 8.26$, $p = .01$)
- Medical providers were more likely to endorse significant challenges of video care
- Administrative data confirmed that medical providers delivered less video and more phone care (52% video; 27% phone) as compared to nonmedical providers (60% video; 13% phone)

Patient and Provider Attitudes Toward Video and Phone Telemental Health Care During the COVID-19 Pandemic: A Systematic Review

Samantha L. Connolly[1, 2], Sierra D. Ferris[1, 3], Robert P. Azario[3], and Christopher J. Miller[1, 2]
[1] Center for Healthcare Organization and Implementation Research, VA Boston Healthcare System Boston, Massachusetts, United States
[2] Department of Psychiatry, Harvard Medical School
[3] Boston University School of Medicine

- Systematic review of 24 papers published during COVID
- Providers more strongly favored video over phone with regard to effectiveness, overall satisfaction, and preference for future use
- Studies of patients varied between favoring video and reporting nonsignificant differences between the two modalities. Patients tended to prefer the modality they were currently using
- Both patients and providers rated video as more complex than phone in several studies

Review > Telemed J E Health. 2024 Sep 5. doi: 10.1089/tmj.2024.0355. Online ahead of print.

A Qualitative Evidence Synthesis of Patient and Provider Attitudes Toward Audio-Only Telemental Health Care

Samantha L Connolly [1 2], Yamini Adusumelli [3], Robert P Azario [3], Sierra D Ferris [1 3], Andrew R Hwang [1], Christopher J Miller [1 2]

— Qualitative systematic review of 29 papers (27 were published during COVID)

— Phone care was seen as easy to use, particularly for briefer check-ins or as a back-up option if video calls failed, and some patients preferred the privacy of not being seen

"I never think I look appropriate for how [my providers] want me to look. At least on the phone I don't have the 'Oh my God, I don't look like I'm in enough pain . . .'. At least it's just about how I sound."

(Direct quote, adult patient with autism; Ali et al., 2023)

- However, the loss of visual information during phone visits was considered particularly challenging in the treatment of patients with more complex or severe clinical issues
- Providers questioned whether they were able to provide high quality care, and patients reported feeling less supported and understood by their providers

"There was one incident…where [my provider]…said something that really upset me. And she didn't realize that I was upset because she couldn't see me. And I did try to… tell her and I thought she had heard it in my voice that I wasn't okay…But I don't think she had any idea…And actually later that evening, I ended up in [the emergency department] because I was quite upset and not really coping with things…I felt like that might have been different had we been face to face…"

(Direct quote, adult patient; Vera San Juan et al., 2021)

Career Development Award Findings

- Provision of High Quality Telemental Health Care during COVID-19 and Beyond
  - VA Career Development Award, PI: Connolly (2022-2027)
- Assessing the relative clinical effectiveness of video, phone, and in-person care that occurred in **real-world conditions** between July 2021- Oct 2022

- 813,699 VA patients
  - >50% in person care: 38%
  - >50% video care: 42%
  - >50% phone care: 20%

Career Development Award Findings

Characteristics of the Sample	Video	Phone	In-person
% 60+ years old	28%	53%	56%
% Female	24%	15%	11%
% Urban	74%	65%	65%
% Highest SES tercile	30%	23%	18%
% w/ Schizophrenia or Bipolar disorder	9%	14%	16%

Career Development Award Findings

Clinical Outcome Variables	Video	Phone	In-person
Any mental health hospitalization	0.9%	1.6%	2.1%
Any mental health ED visit	1.5%	2.3%	2.6%
Any suicide attempt / completion	1.0%	1.3%	1.2%
Percent of appointments completed	71%	68%	68%

Career Development Award Findings

- Inverse probability weighted regression adjustment was used to account for imbalanced groups
  - i.e., the video group is younger, lower clinical complexity, more urban, greater percentage female, higher income
- The expected probability of MH hospitalization was 0.005 percentage points lower if all patients received care via video instead of in-person (SE=0.001) or phone (SE=0.001).
- The same pattern emerged for MH ED visits and suicide attempts and behaviors, with expected probabilities being lower for the video group compared to in-person (Average Treatment Effects (ATEs) < -0.001) or phone (ATEs < -0.003).
- When considering the percentage of completed appointments, the ATE of the video group versus in-person was 3.6 points higher; and when comparing the video group to the phone group, video was 4.1 points higher.

Career Development Award Findings

- A large, national, real-world sample found that the video group had small but significantly improved clinical outcomes as compared to the phone group and the in-person group
- We used advanced statistical techniques to try to account for imbalances between the groups
- However, we still think there is unmeasured confounding, which may explain why the video group was shown to have advantages over the in-person group
  - The video group is less clinically severe than the in-person group
- We are more confident in the finding that the video group has some advantages over the phone group, as there is less of a confounding issue.

Disparities in accessing care could worsen if audio visits aren't available as a telehealth option

versus

"the risk benefit calculation of audio-only visits has changed, and it is increasingly important to protect patients from potentially lower-quality audio-only visits"

Uscher-Pines, L., & Schulson, L. (2021). Rethinking the impact of audio-only visits on health equity. *Health Affairs Forefront*.

Odukoya, E. J., Andino, J., Ng, S., Steppe, E., & Ellimoottil, C. (2022). Predictors of video versus audio-only telehealth use among urological patients. *Urology practice*, *9*(3), 198-204.

Summary

- There is a solid evidence based demonstrating video is comparable in quality to in-person care
- Video may have advantages over phone with regards to clinical effectiveness, satisfaction, and preference
- Phone is easier than video and may work well for briefer follow-up visits and/or patients with less complex clinical presentations
- If there is a **choice** between video and phone, video may be the better pick
- Phone may be the only viable option for patients with lack of access to in person and/or video care

Thank you!

Research Collaborators and Partners

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- Michael Charness, MD
- Leonie Heyworth, MD, MPH
- Kendra Weaver, PsyD
- Lisa Eisele, RN

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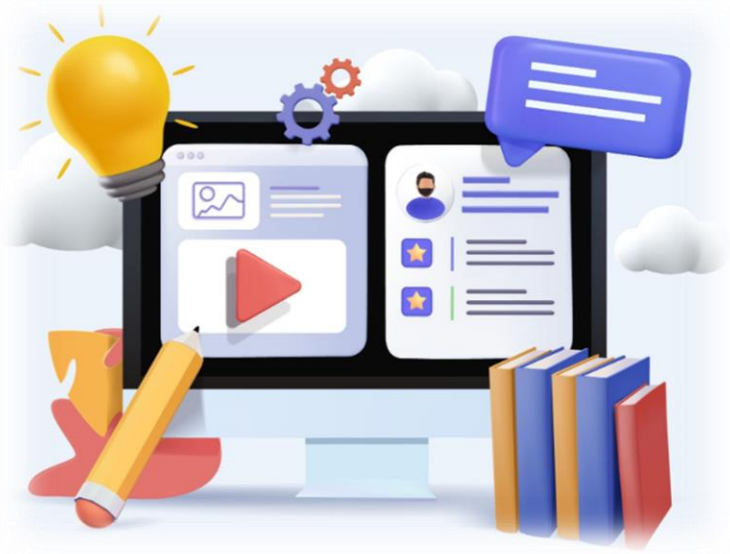
TeleBehavioral Health On-Demand Training Series

In partnership with the NRTRC, the **TeleBehavioral Health 101, 201, 301, 401, and 501** series are available **on-demand and free of charge**.



- Series 101, and 401 & 501 are **accredited for Continuing Medical Education (CME)** and are clearly marked as such. Nominal fee applies.

- A **Continuing Education (CE) certificate** will be provided for *all* sessions, at no cost.
- These certificates may be accepted by various licensing boards to meet continuing education or licensure renewal requirements.
- Please contact your licensing board to confirm eligibility.
- Course 101 #1 module meets Washington State Telehealth Training requirement.

Access the trainings: bhinstitute.uw.edu/tbh-on-demand

CME Accreditation

- ✓ New & Updated TeleBH 101 online courses: CME only (max 7 credits)

Accreditation with Commendation: The University of Washington School of Medicine is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

Credit Designation: The University of Washington School of Medicine designates this enduring material for a maximum of 7 *AMA PRA Category 1 Credits™*. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Learners have the opportunity to complete up to 7 modules, with each module accredited for *1 AMA PRA Category 1 Credit™.*

- ✓ TeleBH 401 and 501 online courses: CME only (max 22 credits)

Accreditation with Commendation: The University of Washington School of Medicine is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

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Learners have the opportunity to complete up to 22 modules, with each module accredited for *1 AMA PRA Category 1 Credit™.*

CME Credit Costs

- CME fees: TeleBH 401 webinars
  - $25 for 8.0 hours or less
  - $35 for 8.25 -16.0 hours
- CME fees: TeleBH 101/201/301 and 401/501 online
  - $25 for 8.0 hours or less
  - $35 for 8.25 -16.0 hours
  - $45 for 16.25 - 64.0 hours

Looking for Health Ethics & Equity Training?

Empowering Recovery: Ethics & Collaborative Decision-Making in Behavioral Health

- Free two-hour module
- On-demand & self-paced
- Meets **Law & Ethics** training requirements in WA State

Cultural Humility In Behavioral Health Care

- Free two-hour module
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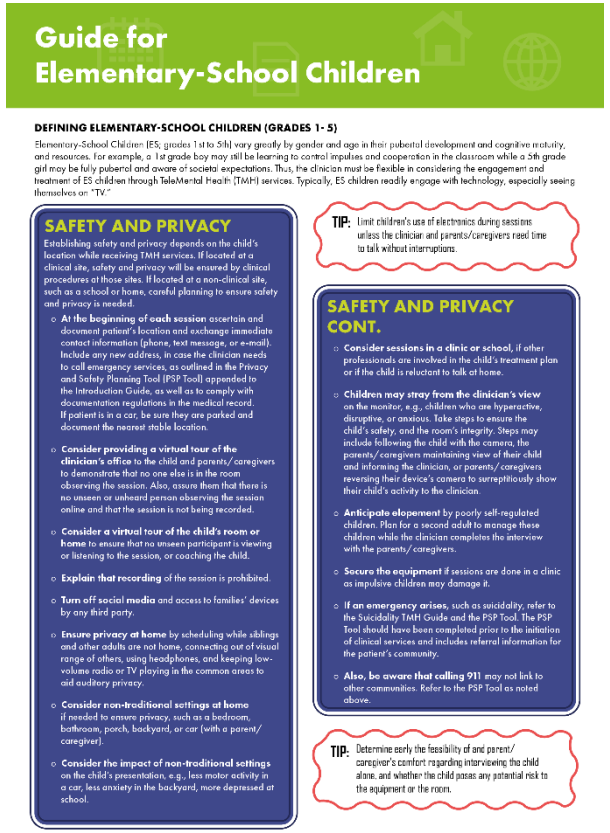
- Meets **Health Equity** training requirements in WA State

Learn more at: https://bhinstitute.uw.edu/learn-online

TeleMental Health Guides for Infancy to Young Adults

Guides (8)

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



Guide for Elementary-School Children

DEFINING ELEMENTARY-SCHOOL CHILDREN (GRADES 1- 5)

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

SAFETY AND PRIVACY

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

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

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

SAFETY AND PRIVACY CONT.

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

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

TELEMENTAL HEALTH GUIDE FOR ELEMENTARY-SCHOOL CHILDREN

Case Example

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

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

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

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

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

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

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