ASPE
ASSISTANT SECRETARY FOR PLANNING AND EVALUATION

OFFICE OF BEHAVIORAL HEALTH, DISABILITY, AND AGING POLICY

ISSUE BRIEF

November 25, 2024

UNDERSTANDING THE OPTIMAL BALANCE OF USING TELEHEALTH AND IN-PERSON SERVICES TO SUPPORT ADULTS WITH SERIOUS MENTAL ILLNESS AND CHILDREN WITH SERIOUS EMOTIONAL DISTURBANCE

KEY FINDINGS

- Providers, patients, and caregivers believe that telehealth can support mental health care for adults with serious mental illness (SMI) and children with serious emotional disturbance (SED) when balanced appropriately with in-person services.
- Decisions about when and how to use telehealth should consider treatment goals and clients' symptom severity, safety, preferences, and comfort with technology. Both providers and clients value the flexibility to make session-by-session choices about the appropriateness of telehealth.
- During the COVID-19 public health emergency, mental health providers struggled to transition some services for adults with SMI and children with SED to telehealth. However, telehealth was critical in helping these populations maintain access to care, as clients were often able to access mental health care more quickly through telehealth than in person.
- Providers and clients believed telehealth helped expand access to mental health care for underserved groups, including racial and ethnic minority populations and refugees, non-binary populations, and people living in rural and frontier areas.
- In some cases, adults with SMI and parents of children with SED were unable to choose between telehealth and in-person care due to the lack of local mental health providers within their insurance networks.
- Providers reported confusion about their ability to deliver telehealth services across state lines because of state-specific license and insurance-related restrictions, which often disrupted care for their clients.
- Behavioral health systems and policymakers can provide practical guidance on how to choose between these modalities of care, incentivize provider participation in insurance networks and ensure adequate network adequacy standards for behavioral health, and monitor the quality and outcomes of care to safeguard against potentially inappropriate substitution of telehealth for in-person services.

BACKGROUND

The COVID-19 public health emergency (PHE) necessitated a rapid shift from in-person to telehealth services to provide mental health care for adults and children in the United States (Mulvaney-Day et al. 2022; CMS 2023a). Several changes in Medicare and Medicaid policy facilitated this shift, including permitting audio-only sessions, allowing providers to conduct telehealth visits from their homes and other settings that were previously prohibited, and approving delivery of telehealth services across state lines (CMS 2023a).

Before the PHE, telehealth was used to provide care for people with mild to moderate mental health conditions, but it was not the primary mechanism for delivering care for adults with serious mental illness

(SMI)[1] or children with serious emotional disturbance (SED)[2] (Talley et al. 2021). Care for SMI and SED has typically involved in-person therapy, and, according to the Substance Abuse and Mental Health Services Administration (SAMHSA), these populations have historically been excluded from telehealth for mental health treatment and research (SAMHSA 2021). Moreover, most evidence-based interventions to manage complex mental conditions were designed to be delivered in person, with only a few adapted to be delivered virtually before the onset of the pandemic (Swanson et al. 2018; Dent et al. 2018).

During the PHE, telehealth may not have fully supplemented care for adults with SMI and children with SED when in-person services were unavailable due to facility closures or social distancing requirements. One study showed that people with SMI were underrepresented in telehealth encounters and may have gone without care during the PHE (Zhu et al. 2022). Other studies that considered Medicaid and CHIP data from 2019-2020 showed that increased use of telehealth during the PHE did not fully account for the decrease in in-person mental health services among children (Ali et al. 2023), especially among Black, Hispanic, and Asian children. (Ali et al. 2022). There is also evidence that children receiving care from community behavioral health clinics were unable to fully maintain psychotherapy services through telehealth during the PHE (Hoffnung et al. 2021). Several studies from this period concluded that a combination of in-person and telehealth services was necessary to support people with SMI and SED, even when some in-person services were adapted for virtual delivery (Skime et al. 2022; Couser et al. 2021).

As policymakers consider permanent changes to telehealth policies, it is important to understand the role telehealth can play in supporting high-quality mental health care for adults with SMI and children with SED, as well as the appropriate balance of telehealth and in-person services in treating these populations. Recent literature explains that telehealth can reduce symptom severity, address logistical barriers, and help people adhere to treatment (Chaudhry et al. 2022; Donahue et al. 2021). However, the perspectives of people with SMI, parents of children with SED, and providers that serve these populations are not well represented in current studies on telehealth for mental health. These groups may have different levels of receptivity toward telehealth and the role it should play in supplementing or replacing services historically provided in person.

To fill this gap in knowledge and better understand the optimal balance between telehealth and in-person care for SMI and SED, the Office of the Assistant Secretary for Planning and Evaluation commissioned this study. We conducted an environmental scan and focus groups with mental health providers, adults with SMI, and parents of children with SED. During focus groups participants described how they made decisions about using telehealth versus in-person mental health care and discussed how telehealth facilitated or hindered access to care and engagement in treatment relative to in-person services. Findings from these focus groups complemented existing literature on the clinical outcomes of telehealth for mental health care by obtaining the perspectives of providers and people who have lived experience with telehealth to help guide policy decisions (Skelton-Wilson et al. 2022). The perspectives of people with lived experience, that is, "those directly affected by social, health, public health, or other issues, and the strategies that aim to address those issues" (Ramirez et al. 2023), are critical to ensure that mental health services align with the needs of the people they are intended to serve.

[1] SAMHSA has defined adults with SMI as persons age 18 and over, who currently, or at any time during the past year, have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria that has resulted in functional impairment which substantially interferes with or limits one or more major life activities (SAMHSA 1993).

[2] SAMHSA has defined children with SED as persons from birth up to age 18, who currently, or at any time during the past year, have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria that resulted in functional impairment which substantially interferes with or limits the child's role or functioning in family, school, or community activities (SAMHSA 1993).

METHODS

Environmental Scan

We conducted an environmental scan of peer-reviewed and grey literature on the use of telehealth versus in-person care for mental health services among adults with SMI and children with SED. We used findings from the environmental scan to summarize existing research on how telehealth versus in-person care has been used to support care for SMI and SED and to ensure topics covered in the focus groups complemented existing literature.

Focus Groups

We conducted five 90-minute virtual focus groups: two with adults with SMI, one with parents of children with SED, and two with mental health providers who deliver care for people with SMI and SED. All focus group participants had experience using telehealth and in-person care for mental health services. Participants were encouraged, but not required to use video during the focus group and used the chat function to share their perspectives. We collaborated with five organizations to recruit focus group participants: The National Mental Health Self-Help Clearinghouse (for adults with SMI), the National Alliance on Mental Illness and Family Voices (for parents of children with SED), and SAMHSA's SMI Adviser and the National Council for Mental Wellbeing (for providers).

Table 1. Summary of Focus Group Participant Demographic Characteristics

Characteristics	SMI	SED[a]	Providers
Number of participants	9	9	9
Race and ethnicity			
White	2	3	5
African American	4	3	0
Asian	1	1	2
American Indian or Alaskan Native	0	1	0
Hispanic/Latinx	0	1	1
Unreported	2	0	1
Gender identity			
Female	7	3	7
Male	0	5	0
Non-binary	1	1	1
Unreported	1	0	1
Geographic location			
Urban	5	2	6
Rural	0	2	1
Suburban	3	5	1
Unreported	1	0	1

Note:
a. Parents reported on characteristics of their child with SED that used telehealth.

With some exceptions, our recruitment yielded a diverse group of focus group participants with respect to race, ethnicity, gender identity, and geography, but the groups were limited to nine adults with SMI, nine

parents of children with SED, and nine providers (***Table 1***). We were unable to recruit providers who identified as African American or adults with SMI who were male or lived in rural areas. Adults with SMI reported ages between 18 and 64 with half of the group under age 40. Approximately 77% of parents in the group reported that their child was over age 10.

Both adults with SMI and parents of children with SED reported using telehealth to obtain treatment for a variety of diagnoses including anxiety, depression, and post-traumatic stress disorder (***Table 2***).

Table 2. Summary of Focus Group Participant (or child) Diagnoses

Client Diagnosis[a,b]	SMI	SED[c]
Anxiety	5	5
Depression	4	2
Post-traumatic stress disorder	5	2
Schizophrenia	1	1
Schizoaffective disorder	1	0
Bipolar disorder	2	1
Dissociative disorders	0	1
Oppositional defiant disorder	0	1
Eating disorder	0	1

Notes:
a. Respondents were invited, but not required to report their diagnoses.
b. Several respondents reported multiple diagnoses.
c. Parents reported their child's diagnoses.

Providers in the focus groups included psychiatrists, psychologists, mental health counselors, and social workers, and they delivered services for SMI and SED in emergency departments, youth crisis centers, alternative schools, university settings, primary care offices, outpatient mental health centers, and specialty care clinics. We did not systematically collect insurance status from respondents; however most mentioned insurance coverage--either Medicare, Medicaid, or commercial insurance--during the discussion. Most providers reported that they did not accept insurance for their services.

FINDINGS

Factors that Influence Decision-Making between Telehealth and In-Person Care

Adults with SMI, parents of children with SED, and providers consider several factors when deciding between telehealth or in-person care, including client diagnoses and the complexity of conditions, type of service, client access to a safe space to conduct a session, and client preference.

> *"[My child] has experienced a lot of trauma and needs that connection with someone in person to be able to draw out the information."*
>
> —Parent of child with SED

Mental health diagnoses, symptoms, and complexity of conditions. Providers account for clients' diagnoses and symptoms to assess the appropriateness of in-person versus telehealth for mental health services. Providers, adults with SMI, and parents reported that in-person care is helpful for clients with a lengthy or complex history of mental illness and those whose conditions or situations can impede the development of trust, such as psychosis or post-traumatic stress disorder, as well as children in the foster care system who have experienced trauma.

Providers found it easier to assess cues of mental health status such as physical agitation, emotional affect, or speech patterns through in-person care compared to telehealth.

> *"I'll be working with kids in which their escalation cycle, or when they're becoming dysregulated, is constricted. When you're in person, you can read some of those cues much sooner like an increase in fidgeting or breathing rate change. In video, it'll feel like it's going from zero to 100, this kid is totally spiraling, when you're just missing some of those initial cues."*
>
> —Provider

Providers also commented on the difficulty of assessing other physical signs of distress via telehealth such as cuts or bruises (which could indicate self-harm) and body odor (which could indicate the client is unable to take care of themself). In particular, providers believe it is easier to assess medication side effects and client safety when conducting sessions in person. However, providers noted that telehealth allows them to observe a client in their home environment and use that information to support their care. Many providers said that telehealth helps them evaluate how the client interacts with their environment and assess any signs of abuse or escalation of symptoms. Clients echoed this benefit of telehealth, noting that with in-person care, they must describe their environment or bring pictures to offer the same context. Providers also value using telehealth to support people who are afraid to leave their homes. Telehealth allows clients to participate in mental health care from the safety of their space and gives providers an opportunity to help build the client's confidence to leave their home.

According to providers, people with a longer history of receiving in-person mental health services are often more comfortable receiving in-person care than those who are newer to mental health care. Providers noted that they frequently have limited access to electronic health records from other providers from whom clients have previously received care. Clients can bring their paper records to in-person visits, allowing the provider to leverage information about the client's medical history as they develop a treatment plan.

> *"I've noticed that when we are able to meet with a person, it goes so much better. If kids are self-harming, we can see how it got more severe, the scars getting deeper or further changing direction. We're able to get eyes on the safety, not only what we're hearing from our teens, but also being able to see from them, disheveled appearances, things like that."*
>
> —Provider

Providers and parents observed how children with SED often find the in-person service environment stressful and feel more comfortable receiving treatment at home. Some children and adolescents have challenges interacting or focusing during in-person treatment sessions. Providers in our focus groups reported conducting video game-based therapies using telehealth to help children and adolescents overcome this challenge; recent research have shown such therapies to be effective in improving cognition among people with schizophrenia (Molina et al. 2022). However, parents of young children expressed concerns about their child's ability to navigate technology and focus on a camera for a full session.

> *"My trauma that's unresolved, has manifested in compulsive spending habits and clutter. I'm able to take the computer around and say, this is what I mean… That's helpful. Otherwise, I could take a photo, but it's not necessarily the same as being able to have them walk through, in a way, embarrassing as it may be."*
>
> —Adult with SMI

Type of service. Focus group participants indicated that telehealth works well for certain types of mental health services, while other types of services are better provided in person. Both clients and providers expressed that in-

person care works best for treatment approaches that require the provider to engage with the client in physical space, such as Eye Movement Desensitization and Reprocessing therapy, play therapy with children using tactile objects, and therapy that supports activities of daily living. Both clients and providers prefer telehealth for individual therapy sessions that involve instructional videos, noting that it is more effective to work through such activities together through screensharing than using a video during an in-person therapy session, which can create an overly didactic experience for the client. Further, telehealth is not an option for mental health services that can only be provided in person, such as inpatient and respite care.

Focus group participants varied in their preferences for using telehealth or in-person modalities for initial therapy sessions. Some adults with SMI and parents of children with SED prefer using telehealth to establish rapport with their providers and build self-confidence before meeting a provider in person. Others prefer conducting initial visits in person to help the provider understand their needs, communication style, and body language before shifting to telehealth.

> *"I really love being able to share my screen and do interactive lessons together [via telehealth]. I do a lot of mindfulness-based interventions. Rather than instructing them on how to engage in the practice, using instructional videos, is a way for me to back off and engage in the practice with them, rather than feeling like I'm the instructor and you're the student, and creating an awkward dynamic."*
>
> —Provider

Availability of private and safe locations for telehealth. Although some clients appreciate receiving care from the comfort of their home, adults with SMI, parents of children with SED, and providers in our focus groups emphasized the importance of having a private and safe space to engage in telehealth. This can be particularly problematic for people experiencing homelessness, adolescents who may want to share sensitive information about themselves or their family dynamics, victims of trauma or abuse, or any client who would discuss personal or sensitive information during sessions.

> *"I've had families flat out lie to me, where a kid keeps looking over the shoulder. I'm like, is somebody over there? And then it's like, oh yes, the mom that you asked to leave the room is still in the room, and saying something to the child, and making them respond in a different way because of fear, or anxiety, or whatever about the assessment or evaluation situation. So, you just don't have the same amount of control [as you do in person]."*
>
> —Provider

Providers said they prefer using in-person care when they need to protect privacy or ensure the person receiving care can freely express themselves. For example, in-person care allows providers to determine when a child or adolescent needs to participate without their parent present. Providers explained that parents occasionally ask to observe their child's test, assessment, or therapy session. In person, the provider can decline and separate the parent from the physical space. In contrast, when using telehealth, the provider cannot ensure the child's privacy or that their responses are not being influenced. Some parents echoed this sentiment and said that conducting telehealth in the home limits a child's ability to talk openly about issues related to their parents, as the parents may be nearby and able to hear them.

Client preference. Some providers in our focus groups explained that they prioritize their clients' preferences when deciding whether, when, and how often to use telehealth or in-person care, and often made those decisions on a session-by-session basis to tailor services to their client's evolving needs and treatment progress. Providers also consider the availability of the preferred treatment mode.

Providers said they occasionally use the less-optimal mode for their sessions when options were limited. For example, if there are no providers available in their region to offer in-person services, the provider and client will opt for a telehealth session even if in-person care would be more beneficial. In some cases, clients felt their options for using telehealth versus in-person modalities were limited. A 2023 survey of individuals receiving therapy found that nearly one-third of respondents' clinicians offered only one visit modality, which was most frequently telehealth (Sousa et al. 2023). Focus group participants noted that telehealth was often the only option during the PHE, when in-person services were restricted, and in general, remains more available than in-person services, even after the PHE ended. This observation could reflect provider preferences, as providers may experience higher satisfaction and better work-life balance from delivering telehealth compared to in-person services (MacDonald 2022). Providers in the focus groups said both their job requirements and restrictions during the PHE limited their ability to provide both telehealth and in-person care. For example, providers in large health systems or community mental health centers whose job requirements dictate they provide only telehealth services (or only in-person services) did not have the flexibility to offer both modes of care. Instead, the providers would offer what they could or refer the client to another provider.

> *"Sometimes we'll tell them… I know that we've been meeting the past couple times virtually, but these next couple of sessions, it's going to be really important for you to come in person because we're going to be working on breathing techniques."*
>
> —Provider

> *"I would say some care is better than no care. So, at least they're able to get some sort of treatment."*
>
> —Provider

Considerations for Prematurely Ending Mental Health Sessions

Telehealth allows clients to easily end sessions, making it challenging for providers to maintain client engagement in care and presenting potentially dangerous situations during a crisis. Clients and parents described how they or their children could choose to end a telehealth session by walking away from the computer or hanging up the phone. As one client said, "Telehealth allows you to hit the disconnect button, which can be a lot easier than if something happens in a session… standing up and walking out of the room." For an adult with SMI, this appeared to be a benefit to telehealth as it provided autonomy to end a session if a provider wasn't a good fit for their needs or they if experienced harm. The participant further clarified, "… [the session] is not going anywhere, this is not going to end well [after a disagreement with provider], I'm going to leave now, but it's a heck of a lot easier to push the end button and then try and get support than it is to walk out of somebody's office in that moment." Providers in our focus groups expressed concern that clients who abruptly end sessions could be at risk if they are in crisis or experiencing suicidal thoughts.

> *"I work with teens who might be experiencing suicidal ideation. Not being able to be there in person, they can hang up the phone whenever they want. That poses a pretty big safety risk. I ask them where they are, who they're with, but there's really no confirmation that they're safe. If the phone line gets disconnected, we can't reach kids who don't have a phone and many don't want their parents to know that they're experiencing suicidal ideation. But we have to call their parents in order to get a hold of them. It just breaks that level of strict confidentiality that we would otherwise be able to maintain in person."*
>
> —Provider

Wait Times for Accessing Telehealth and In-Person Care

Focus group participants reported that the wait times for mental health care via telehealth are the same as or better than for in-person services, but telehealth did not overcome all the barriers to accessing timely care. For some focus group participants, telehealth provided temporary support while they waited for in-person treatment. For example, one parent from a suburban area noted that their child has been on a waitlist for in-person mental health care for 18 months, and telehealth has been the only option for care while they wait. This parent's experience reflects severe deficits in mental health provider networks for children and adolescents across many states and communities (MACPAC 2021). Several adults with SMI and parents of children with SED were able to meet with their telehealth provider within one day of making an appointment, instead of waiting several weeks or longer, for in-person care. However, telehealth did not always facilitate immediate access to care, especially if the provider did not offer on-call services. Some clients who could not obtain a timely telehealth visit relied on national, state, or local telephone crisis lines to obtain support or request a crisis provider to visit their home. One parent explained that telehealth can help to immediately de-escalate crises and noted that they preferred to receive crisis support through telehealth to avoid exacerbating their child's symptoms.

> *"Telehealth is really the only option we've been able to utilize [when my child's symptoms worsen]. My child has really violent tendencies and in-person crisis means in-home, which can be difficult because he does not like people in our home. This is his safe place and when these people are coming into his home and really trying to get him to do things he's uncomfortable with, his safe space then becomes a trigger place for his PTSD.*
>
> —Parent of child with SED

Telehealth Expanded Access to Underserved Populations

Through their professional and lived experience, focus group participants described how telehealth expanded mental health care to racial and ethnic minority populations and refugees, non-binary populations, and people living in rural areas.

Non-Binary populations. Some focus group participants reported that telehealth allows people who identify as transgender to obtain mental health care across state lines when they lived in states that prohibited gender affirming care. As of September 2023, 19 states ban gender-affirming physical health care (Movement Advancement Project 2023). In some cases, these bans have led people to seek out-of-state providers for both physical and mental health conditions due to confusion around whether gender-affirming mental health care was also banned and a desire to obtain whole-person care (Vollers 2023).

> *"One of my kids is non-binary and does need trans [mental] health care. In [my state,] they have outlawed that. So we have to go out of state, but we do it through telehealth. Otherwise, I'd have to drive several states over, which is kind of impossible for me."*
>
> —Parent of child with SED

Rural populations. Rural areas often have few, if any, mental health providers. Focus group respondents emphasized that telehealth allows clients to receive care from distant providers without traveling. This was particularly notable in the parent focus group, in which one participant, who lives in a rural area, shared that their child was able to continue receiving care from a provider who initiated treatment while the child was in a foster care home located in a city. In addition, stigma and concerns about privacy are common issues in rural communities, where it is challenging to discretely obtain in-person mental health care (Townsend 2011). Focus group participants shared how telehealth allowed those living in sparsely populated rural areas to receive care from the privacy of their homes. One provider based in a

primary care setting shared how telehealth has allowed them to reach a rural farming population with high risk of suicide and low participation in mental health treatment.

Racial and ethnic minority and refugee populations. People in racial and ethnic minority groups have historically accessed mental health care at lower rates than other populations, often because of stigma or mistrust of the health care system (Henderson et al. 2015), lack of affordability, transportation barriers, and the geographic availability of providers (Young et al., 2015). Providers shared that telehealth could offer a lower-barrier transition into care for racial and ethnic minority populations who may be hesitant to begin in-person treatment due to stigma or transportation challenges. Focus group participants also reported that telehealth has expanded access to mental health providers across a broader geographic area, allowing people to find a provider of their own cultural background, which is an important determinant for receiving mental health care (Imel et al. 2011).

> *"Our farming population, [generally] middle-aged to close to retirement white men who are not going to see a psychiatrist… [are] very high-risk individuals for completing suicide. So, I think that's been a benefit for us to be able to offer [telehealth] for them, where they wouldn't otherwise be able to get it, and I think they feel comfortable being able to access it from their homes."*
>
> —Provider

Providers have also used telehealth to engage refugee populations in mental health care. One provider shared that some refugees have negative perceptions of health care from their home countries and are therefore not inclined to seek care from a physical location, but they are receptive to talking with someone using telehealth.

Providers also consider how language barriers could interfere with the effectiveness of telehealth. For example, one provider recounted experiences using interpreters for sessions when clients and their families communicated in languages the provider did not speak. The provider felt using an interpreter during telehealth was a barrier to care because the interpreter was not fully engaged in the conversation, "It's impossible for an interpreter to tune me out in my office, but I've had that happen to a patient on telehealth. And it damages rapport, it damages my information gathering, it takes more time, and it's not fair to the patient." In such cases, a provider may elect to conduct an in-person session assisted by an interpreter.

> *"I'm fortunate enough to have full [private] insurance, but I was not able to find a provider in my area at all, in person or telehealth through my insurance. I ended up going through alternative resources like community resources, sliding-scale kind of stuff… And I got connected to my current therapist through this free community therapy program, and they only operate via telehealth. I think that's been huge for accessibility for me and for a lot of other people, too."*
>
> —Adult with SMI

Insurance Coverage and Availability of Providers for Telehealth and In-Person Mental Health Care

Among adults with SMI and parents of children with SED in our focus groups, who were predominately enrolled in public insurance programs, including both Medicaid and Medicare, differences in insurance coverage limits and out-of-pocket expenses for in-person versus telehealth services do not influence decisions about where to obtain mental health care. Co-payments for mental health services, if any, were similar for in-person care and telehealth, and respondents shared that they rarely incur out-of-pocket expenses for mental health care when visiting a provider who accepts their insurance. However, focus group participants enrolled in public and private insurance programs both experience substantial difficulty identifying mental health providers that accept insurance and sometimes pay out-of-pocket for care or obtain free or reduced cost

services from community mental health centers. The few adults with SMI and parents enrolled in commercial health plans were considering other options for health care coverage because of limited mental health coverage (for both telehealth and in-person care) under their current plan. Despite these challenges, focus group participants hoped coverage for telehealth will remain equal to that of in-person care now that the PHE has ended.

Adults with SMI and parents in our focus groups have experienced high levels of turnover among both in-person and telehealth providers. They described how this turnover disrupted care and impeded their ability to maintain therapeutic relationships, requiring them to frequently reintroduce themselves and re-establish treatment goals.

Licensing Impacts on Adoption of Telehealth for Mental Health Care

Providers expressed confusion regarding whether they were permitted to deliver telehealth across state lines because of state-specific license and insurance-related restrictions. Providers noted that their clients experienced disruptions in care when they were temporarily in another state (for example, when returning home from college or traveling) or permanently moved across state lines. In these scenarios, the provider needed to determine on a state-by-state basis whether they had authority to deliver services in the state in which the client was located. Some providers reported instances in which they were legally unable to provide urgent care to someone in crisis located in another state due to these restrictions. Some adults with SMI and parents of children with SED reported paying out-of-pocket for care in another state when their usual providers were unable to continue delivering treatment via telehealth. Interstate compacts that allow certain types of mental health providers to practice across state lines could help address these challenges (Center for Connected Health Policy 2023). For example, as of fall 2023, 28 states have joined Counseling Compact, which allows licensed counselors to provide telehealth services across state lines (Counseling Compact 2023), 40 states participate in Psychology Interjurisdictional Compact (PSYPACT), which allows licensed psychologists to practice across state lines (PSYPACT n.d.), and 37 states participate in the Interstate Medical Licensure Compact, which allows psychiatrists to practice across state lines (IMLCC 2023). No states have implemented compacts for social workers or licensed marriage and family therapists to operate in multiple states (Center for Connected Health Policy 2023). However, a Social Work Interstate Compact Model Bill was introduced in February 2023 (Social Work Licensure Compact 2023). Providers must actively enroll in these compacts to deliver care in multiple states, which entail potentially burdensome fees and continual education based on state-specific regulations.

> *"It's hard because even though we do telehealth, [my child] has had seven or eight different workers in three years because the turnover rate is so high… A lot of the times, we'll show up for telehealth and they'll tell us, 'By the way, I quit my job, next week you'll have somebody new, we don't know who it is yet, so just log in and see who you get.' We've had more than one provider log in to the Zoom and not even remember what client they're seeing. The amount of times my child has been called by another child's name… If I had a dollar for every time, I could probably buy a new house at this point."*
>
> —Parent of child with SED

POLICY CONSIDERATIONS

Telehealth will likely continue to play a critical role in the delivery of mental health services as providers and the people they serve become increasingly comfortable with the use of technology to support care. However, telehealth alone may not sufficiently support the needs of all populations. During the COVID-19 PHE, people with SMI and children with SED benefited from a balance of telehealth and in-person care, and providers found

it challenging to transition some types of services to telehealth (Talley et al. 2021). The findings from this study highlight several policy considerations for behavioral health systems as they strive to ensure that people with SMI and children with SED have flexibility in their decisions between telehealth and in-person care.

Develop standards for provider network adequacy requirements to balance the availability of telehealth and in-person services for people with SMI and children with SED. Receiving the optimal balance of in-person and telehealth services requires the option to choose between these modalities of care. People with SMI and parents of children with SED in our focus groups often did not have a choice because they struggled to find any mental health care provider within their managed care network, and when they did, the provider often provided only in-person or telehealth services. Their experiences reflect well-documented network adequacy challenges (Covino 2019; MACPAC 2021; Sousa et al. 2023). In May 2023, the Centers for Medicare & Medicaid Services (CMS) proposed regulatory changes intended to increase mental health and substance use disorder care provider network adequacy within Medicaid managed care plans by establishing national standards for timely access to care and ensuring the accuracy of provider directories (CMS 2023b, 2023c).[3] States are critical to implementing and enforcing Medicaid network adequacy requirements, but they do not apply consistent standards to account for the availability of telehealth or the prevalence of SMI and SED in their assessments of network adequacy (Bradley et al. 2021). This could result in disparate access to both modalities of care across managed care plans. For example, some plans relax time and distance requirements for in-person services when telehealth is available without fully considering whether telehealth is able to support people with SMI and children with SED. Network adequacy requirements could account for not only the availability of telehealth relative to in-person care, but the extent to which both in-person and telehealth providers offer specific evidence-based services designed to meet the needs of people with SMI and SED relative to the prevalence of these conditions within a community.

Monitor the outcomes of telehealth and in-person care for people with SMI and SED. Some focus group participants described how telehealth primarily served as gateway to in-person services while other focus group participants described continuing to rely on telehealth even after starting in-person care. In the absence of standards for how telehealth should complement in-person care for people with SMI and SED, behavioral health systems have an opportunity to measure the extent to which variation in the use of telehealth among these populations translates into differences in the quality and outcomes of care over time. Monitoring how the duration, frequency, and specific types of services delivered through telehealth impact client functioning and the use and costs of other health and mental health services could help build evidence to inform future policymaking specifically focused on people with SMI and children with SED. Such monitoring could also help health systems identify gaps in the availability of care, for example, if they observe some services appropriate for both modalities of care are almost exclusively delivered through only one modality of care.

Use telehealth to complement in-person crisis services. SAMHSA's National Guidelines for Behavioral Health Crisis Care describe how telehealth can support people experiencing a crisis when coupled with in-person services (SAMHSA 2020). Behavioral health systems should consider where telehealth fits into the broader continuum of crisis care. While telehealth cannot replace the critical work of mobile crisis teams and other in-person care, it could support functions such as providing follow-up care, connecting families and trusted caregivers to a person in crisis, and coordinating care across providers (Minkoff et al. 2021). Focus group participants described several unique uses of telehealth in the context of crisis services, including de-escalating crisis situations through telehealth and maintaining contact with a trusted provider to help with crisis

[3] At the time of writing of this report, September 2023, these proposed regulatory changes were not finalized. In 2024, CMS published the final rules for both proposed regulatory changes: Federal Register: Medicaid Program; Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality, https://www.federalregister.gov/documents/2024/05/10/2024-08085/medicaid-program-medicaid-and-childrens-health-insurance-program-chip-managed-care-access-finance.

situations when traveling or after a move to a new community. However, they also identified several risks of relying on telehealth to detect and manage crisis situations, including barriers to providers' ability to confirm client safety. Behavioral health providers would benefit from additional resources on the appropriate role of telehealth to support people in crisis.

Consider the implications of interstate licensing compacts on people with SMI and children with SED. Interstate compacts could have positive or negative consequences for people with SMI and children with SED depending on the state and community in which they are located. According to focus group participants, accessing care across state lines could support the provision of telehealth to clients out of state, including those in areas with few service providers and those seeking gender-affirming care. For some states with higher Medicaid or commercial health plan reimbursement rates, participation in a compact could help address behavioral health workforce shortages if higher reimbursement rates attract out-of-state providers. However, this could also further exacerbate workforce shortages in states with low reimbursement rates. Providers might also have an incentive to avoid providing in-person or telehealth services for people with more complex conditions in their own state if they can receive higher reimbursement for less complex clients in another state. This could potentially impact people with SMI and SED, who are often covered by Medicaid. Physicians in states with a lower Medicaid-to-Medicare fee ratio accepted fewer new Medicaid patients than providers in states with higher Medicaid fees (MACPAC 2019). Although these compacts could potentially increase access to care or facilitate care continuity for people who move across state lines, states will need to monitor provider participation in the compacts to identify and respond to any adverse consequences.

Develop guidance to help providers and people who receive mental health services decide between telehealth and in-person care. Providers in this study used their best clinical judgment to make decisions about whether telehealth was appropriate for a specific client on a session-by-session basis. Likewise, people who received mental health care in our focus groups relied on their judgment about their functioning and what they hoped to receive from care to assess whether telehealth was right for them. Although clinical judgement and personal preferences should drive decisions about where to receive care, providers and people who receive mental health services could benefit from practical guidance to inform their choices about telehealth or in-person services. This guidance should reflect the best evidence, clinical expertise, and experiences with care. It should be grounded in models of shared decision-making (Elwyn et al. 2012) to help providers and people who receive services determine if telehealth best supports their care at a particular point in time. Such guidance should account for the factors that focus group participants cited as critical to informing their decisions about using telehealth, including symptoms, functioning, living environment, and goals of the session. This guidance should also account for any specific needs of people with SMI and children with SED. In practice, this guidance could serve as a tool for providers and clients to support their decisions about the use of telehealth over the course of treatment.

STUDY LIMITATIONS

The findings from this study reflect the perspectives of a limited number of adults with SMI, parents of children with SED, and providers who have experience with telehealth and in-person mental health services. These individuals were willing and able to participate in virtual focus groups, and therefore might be more adept with technology than other individuals who did not participate. This study was conducted in 2023 before the PHE ended, but during a time in which in-person care was once again available, and many flexibilities for providing tele-mental health services were still applicable (CMS 2023a). Ending the existing flexibilities could potentially impact provider willingness to offer tele-mental health services, however the Consolidated Budget Act of 2023 has extended these flexibilities through 2024. Most of the providers did not accept insurance, and therefore might not reflect the perspectives of providers who participate in insurance programs. In addition, most of the adults with SMI and parents of children with SED were enrolled in Medicaid and/or Medicare, and their perspectives might primarily reflect their experiences with care delivered through these insurance programs.

The focus group were not intended to yield information generalizable to all people with SMI, parents of children with SED, or providers but instead were conducted to gain new insights into how these groups make decisions about using telehealth versus in-person care and to understand their experiences with telehealth.

CONCLUSIONS

This issue brief offers new insights for the field by providing in-depth perspectives from those directly affected by mental health policies around the use of telehealth and in-person services, an area in which the literature is limited. The brief reflects feedback from providers and clients from across the country on factors considered when deciding between use of in-person care or telehealth, and how they balance the use of each modality while considering patient safety, access to care, and the structural influences of the mental health system. Future policy should support flexible decision-making regarding use of telehealth and in-person care and promote ongoing monitoring of the impacts of balancing service provision across the two modalities.

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SUGGESTED CITATION
Little, J., Dormond, M., Croake, S., Bory, C., Tran, A., & Brown, J. Understanding the Optimal Balance of Using Telehealth and In-Person Services to Support Adults with Serious Mental Illness and Children with Serious Emotional Disturbance (Issue Brief). Washington, DC: Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services. November 25, 2023.

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