TeleMental Health Guides for Infancy to Young Adult

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Introduction

Development of the TMH Guides

The TeleMental Health (TMH) Guides were developed collaboratively by the Harborview Behavioral Health Institute and the CoLab for Community and Behavioral Health Policy in the Department of Psychiatry and Behavioral Sciences at the University of Washington School of Medicine. The project was funded under Senate Bill 5092 passed by Washington State's 67th Legislature's 2021 Regular Session. The State recognized the benefits of TMH for serving the mental health needs of its Medicaid enrollees based, in part, on its successful integration into clinical practice during the COVID-19 pandemic.

The TMH Guides are intended to help clinicians integrate TMH into their clinical practice with young people according to their developmental stage from young childhood to young adults 24 years old. This Introductory Guide is appended with a bibliography that has multiple relevant links to helpful publications. Also appended are two checklists, one each for clinicians and patients, to help them to optimally conduct their TMH sessions. Then, there are eight clinical TMH Guides: six by developmental stage, one for suicidality and one on neuropsychological testing. Each is arranged in six sections: Safety and Privacy; Engagement; Family Involvement; Diagnostic Considerations; 2-3 Helpful Tips; 2-3 references; and a Case Example. Each section is specific to the developmental stage addressed by that TMH Guide; for example, the Engagement section for an elementary school-aged child differs considerably from that for a high-school teen. The guides allow the clinician to quickly ascertain the core aspects of adapting evidence-based clinical care to the virtual environment. As such, they do not review clinical care guidelines that are available to clinicians by their professional organizations and publications. They also do not provide an in-depth discussion of TMH topics that have been covered widely and in detail elsewhere in telemedicine websites, publications, and book chapters. This Introductory Guide is intended to provide an overview of several TMH topics that apply across all of the developmental stages, such as regulatory, safety, technology, and clinical service.

Following are several topics that apply across all of the TMH Guides and, therefore, are only minimally repeated in the individual guides. Refer to the bibliography for relevant resources supporting each topic.

Legal and Regulatory Considerations

Legal and regulatory guidelines have been formulated nationally. Additional regulations may be enacted by individual states. Several salient points include, but are not limited to, the following:

- Clinicians must have appropriate licensure and liability protection (malpractice insurance) in both the state where the clinician practices and the state where the patient is located during the visit. Note that this is not the patient's official home residence but the state where the patient is receiving services at the time of the visit.
- Credentials and privileges must be maintained at the clinician's home institution and, if the patient is located at a clinical agency, at that agency.
- Clinicians must comply with the U.S. Health Insurance Portability and Accountability Act (HIPAA) of 1996, as well as any state privacy requirements to protect patient privacy, especially related to patients with Substance Use Disorder (42 CFR part 2). Clinicians cannot waive HIPAA.
- Clinicians must comply with the Ryan Haight Online Pharmacy Consumer Protection Act of 2008 (aka "The Ryan Haight Act") which regulates the prescription of controlled substances during telehealth. Of note, the Drug Enforcement Administration (DEA) suspended this rule during the COVID-19 pandemic and has extended the suspension until December 2024.

Guide for Infants & Toddlers

DEFINING INFANTS & TODDLERS

Typical development in infancy and during the toddlerhood years (birth to 3 years) varies greatly by developmental status and caregiving experiences (e.g., exposure to learning opportunities, participation in daycare or preschool). Most information gathered for young children within this age range will be via parent report (e.g., interviews, standardized rating scales) and observation. Recognizing that a wide range of caregivers may bring infants and toddlers to appointments (e.g., parents, foster families, grandparents, etc.) "caregivers" is used throughout.

SAFETY AND PRIVACY

Establishing safety and privacy depends on the site at which the infant or toddler is receiving (TeleMental Health) TMH services. If services are delivered to a clinic, such as a mental health or pediatrics clinic, safety and privacy will be ensured by staff at those sites. If services are delivered to a non-clinical site such as the family's 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 other children in the home and minimize household interruptions whenever possible. Below are a few recommendations for establishing safety and privacy prior to the visit:

- **At the beginning of each session** ascertain and document patients' locations 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 Protocol Tool (PSP Tool); see Appendix 1 of the Overview 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 caregiver and child into consideration.** At the outset of a visit, it may be helpful to ask caregivers if they are in a private location and feel comfortable moving forward with the visit. If caregivers are meeting outside of their home (porch, deck etc.), or in a public place, the clinician should ensure the session remains HIPAA compliant by asking the caregiver to not use speaker phone, use headphones or earbuds, speak with a lowered voice, and/or move away from other people in the space. Generally, public spaces are only appropriate for history gathering and not for observation of the child.

- **It is helpful for all clinicians involved to introduce themselves prior to the visit,** giving the caregiver and child a virtual tour of the clinician's office, and providing reassurance that the visit is not being recorded.

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.

SAFETY AND PRIVACY CONT.

- **Slowing down the session when needed will help ensure safety.** Sometimes caregivers become very involved in discussing a topic with the clinician and may have a lapse in monitoring the very young child in the room. In this case or if the child goes out of view of the camera, the clinician can gently pause and slow down the session to allow the parent to check-in with the infant and toddler. The clinician may say something like, "I can see this is a really important topic to discuss, I wonder if . . . [refocus attention on the child]."

- The clinician should monitor the child's safety throughout the session and remind caregivers to prioritize the safety of the infant or young child (e.g., discuss the activity that will be observed in advance, talk about where the child will be located, etc.).

ENGAGEMENT

Infant and toddler mental health services require the involvement of caregivers, alone and in interaction with their child.

- **TMH for infants or toddlers and their caregivers can be challenging.** Consider whether the caregiver can engage in evaluation or treatment through TMH or if it may be too challenging (after some coaching and practice) to navigating the equipment and virtual relationship with the clinician.

- **Explain and demonstrate the TMH technology** to the caregiver: When appropriate, include an older toddler. For example, the clinician may instruct toddlers to hold a toy or activity up to the camera versus in front of the screen to share with the clinician.

- **Most caregivers will use their smartphone for the session.** One way arrangment is to set it in a tennis shoe, such that the camera portion of the phone is leaning against the heel of the shoe, facing the dyad. Alternatively, the parent may set the phone against something like a stack of books or box.

Continued on following page.

ENGAGEMENT CONT.

- **Clinicians should expect to have a caregiver present** during the entirety of a TMH visit. Infants and toddlers should not be left alone with the TMH clinician.
- **Because infants and toddlers still depend so much on their caregivers,** clinicians should be mindful that parents may be balancing their attention between the clinician and the very young child during the visit. Therefore, it is important for clinicians to remain flexible during these visits and pause throughout the visit in response to caregiver and child needs (e.g., child may need to be fed, diaper changed, may be seeking comfort, etc.).
- **For observation, make sure to ask the caregiver to have any toys or materials available** and nearby prior to setting up the interaction. It may be helpful to also have any items the infant or toddler might need during the visit nearby (e.g., burping cloth, bottle, pacifier, etc.).
- **Caregivers provide information.** It is possible for caregivers to provide information to clinicians regarding their own functioning and the stress involved in caring for their infant or toddler. 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. It is recommended that the caregiver stay close enough to the video device for the clinician to detect these shifts.
- **Use the "White Board" function** to allow the caregiver to share ideas, provide teaching materials, and develop treatment plans.
- **Use the "Share Screen" function** to share caregiver handouts, short instructional videos, and materials to aid the child assessment (e.g., feelings, social stories, videos).

FAMILY INVOVEMENT

- **Infant and early childhood mental health services are dyadic** (caregiver and child together) and typically require an observational component (e.g., caregiver-child playing together, engaging in daily routine, mealtime, etc.). Caregivers may have an increased sense of stress and pressure during the dyadic observations as they try to make sure their child is correctly situated or within the frame.
- **As infant and early childhood services are often focused on the dyadic** (caregiver-child) relationship, a clinician can expect to gather most information via caregiver report (e.g., interviews, standardized ratings scales) and observations (e.g., parent-child interactions). While TMH may complicate clinicians' direct interaction and engagement with infants and toddlers, it does allow for contextually meaningful observations of the child in interactions with primary caregivers in their familiar environment.
- **Prepare for the dyadic session.** If services will require the caregiver and child to interact while they are viewed by a clinician, allow time for caregivers to learn how to set up their devices for the observation. It is preferable that the caregiver and child are seated in a way that is comfortable, this often means they are sitting on the floor, or at a table with a booster seat or highchair. The caregiver may want to sit on the couch with the child, caution is warranted to assure that the child does not fall from this location. The camera will have to be adjusted to capture the dyadic interaction in its different arrangements.

TIP: Be proactive. Help the family plan if the child does not need to be available for the visit. For example, encourage the caregiver to find an additional caretaker to be present to care for the child or get materials/toys and setting options prepared before the visit to reduce stress.

DIAGNOSTIC CONSIDERATIONS

Clinicians must determine how TMH service delivery might affect their diagnostic process and treatment for infants and toddlers.

- Recommendation for observation: It is preferable for the caregiver and child (birth to 3) to interact via face-to-face play, with toys, books, pretend play, coloring, or engagement in a daily natural activity rather than having the child engage with the parent and technology (e.g., watching a video, playing a game online). It may be helpful to brainstorm a couple of options for toys or activities the caregiver and child can engage with prior to the observation visit.
- **Disruptive behaviors:** In TMH, the clinician may have the caregiver use Bluetooth earbuds to accomplish the objective of unobtrusively receiving instruction from the clinician during child-directed play.
- **When evaluating caregiver-child attunement:** As much as possible, keep both the caregiver and child within the frame to observe caregivers' ability to pay attention to how their child is feeling and responding to the child's cues (e.g., adjusting how they hold the child, change the environment- lights/sound, etc.).
- **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, observations require preparation so that caregivers have the materials needed and instructions to elicit the child's engagement at the beginning of the session. 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).

Case Example

Kayden is a 3-year-old boy who is showing behavioral issues at daycare. Kayden is an only child who resides with his mother and maternal grandmother in a studio apartment with a back deck, which lacks privacy. Mother's internet connection is strong, and she conducted the visits with her smartphone. Through a discussion about privacy, the grandmother agreed to sit on the back deck during the visit. The clinician explained her role, service, and the functions of the telehealth platform. The clinician also explained that, at times, she will ask the mother to place the phone so that she can watch her and Kayden play together. The clinician used the screen share option and showed a picture of a parent and child on the floor with a smartphone propped in a tennis shoe on a chair.

At the start of the visit, Kayden frequently interrupted his mother. Due to the child's persistence for his mother's attention, the clinician engaged with Kayden on the smartphone. He was talkative and full of energy. He spoke positively regarding his grandmother. He climbed on the couch and bounced on it while holding the phone. Kayden's mother asked him not to climb and jump on the couch, but he ignored her.

Recognizing the tension between Kayden and his mother, the clinician switched her strategy and asked the mother to participate in a shared activity with Kayden. The clinician asked the mother to prop the phone as earlier instructed and find something they could play with together for about 10-15 minutes. Kayden chose a book. Kayden sat on his mother's lap, and she read the first few pages, but he could not sit still. The mother registered his disengagement and skillfully chose a more engaging block activity. They had 10 minutes of uninterrupted play together. The clinician observed the mother's patience with Kayden, how she adapted to his non-verbal disengagement cues and helped him build a tower, and Kayden's delight at having his mother's full attention. When Kayden's interest started to wane, his mother quickly registered it and suggested he get his tablet and watch a show. He complied and remained engaged with his tablet for the rest of the visit. Kayden's mother and the clinician then completed some intake questions. During this time, the clinician assessed Kayden's intellect and strong verbal skills, his ability to calm down when engaged, and his mother's skillful management of his behavior and ability to detect his non-verbal language and adapt accordingly. They completed the appointment and set up a time for a second visit, preparing for the grandmother to take Kayden to the park so they could complete assessments that would not involve him.

TIP: Help the parent choose toys that allow the clinician to adequately observe the dyadic relationship (caregiver-child's play and interaction) 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. Adjust the device to fully capture the interaction.

Bibliography

General Information for all Age Groups and Sites

American Medical Association. Telehealth implementation playbook. Available at: https://www.ama-assn.org/system/files/ama-telehealth-playbook.pdf Accessed October 2, 2023.
A comprehensive document for implementing a telehealth program.

Harvard Medical School. Best practices for patient engagement with telehealth. Available at: https://postgraduateeducation.hms.harvard.edu/trends-medicine/best-practices-patient-engagement-telehealth Accessed October 2, 2023.
A succinct presentation of best telehealth practices for establishing patient engagement. The document is organized into three brief sections: setting the stage for TMH, video presence, and communicating.

Myers KM and Roth DE. Child and Adolescent Telepsychiatry. In: Martin A, Bloch MH and Volkmar FH, Eds. Lewis's Child and Adolescent Psychiatry: A Comprehensive Textbook, 5th Edition; Wolters-Kluver, Philadelphia; Chapter 6.3.5, pp885-897
This chapter provides practical information on telemental health practice from setting up the technology, to lighting the room, to clinical intervention.

Northwest Regional Telehealth Resource Center (NRTRC). https://nrtrc.org/. Accessed September 1, 2023.
The NRTRC (serving (Washington, Alaska, Montana, Idaho, Oregon, Utah, and Wyoming) is one of 12 regional and 2 national Telehealth Resource Centers that comprise the Consortium of Telehealth Resource Centers (NCTRC; https://telehealthresourcecenter.org). The NCTRC's 2 national centers include the National Policy Center – Center for Connected Health Policy (CCHP) and the National Technology Center -Telehealth Technology Assessment Resource Center (TTAC) which are available to the 12 regional TRCs. The NCTRC provides a useful newsletter to assist the centers in their endeavors and updates news regarding telehealth, such as policy changes and Medicare reimbursement. The NRTRC provides consultation and assistance to guide programs through building and developing a successful telehealth program with focus on rural and underserved communities.

NRTRC provides several Telehealth Toolkits. https://nrtrc.org/resources/toolkit.shtml Accessed September 1, 2023.
NRTRC toolkits aid administrators in program development and evaluation. Several toolkits also provide clinicians with resources to guide establishing a telehealth practice. Examples include:

- Telehealth Start-Up Resources: https://nrtrc.org/education/downloads/NRTRC-Telehealth-Start-Up-Resources-handout-4-15-2020.pdf ;
- Telehealth Start-Up Checklist: https://nrtrc.org/education/downloads/NRTRC-Telehealth-Start-Up-Checklist-handout-4-15-2020.pdf ;
- Telehealth Services and Codes: https://nrtrc.org/resources/downloads/Telehealth-Services-Codes.pdf ; and Patient Telehealth Checklist: https://nrtrc.org/resources/downloads/patienttelehealthchecklist.pdf

Shore JH, Yellowlees P, Caudill R, et al. Best practices in videoconferencing-based telemental health. Telemed e-Health. 2018; 24(11): 827-832. Published Online, ahead of print: November 14, 2018. https://doi.org/10.1089/tmj.2018.0237 Accessed September 15, 2023.
This publication is a joint effort by the American Psychiatric Association and the American Telemedicine Association to present basic guidelines for the practice of telemental health. It is intended for those interested in the background for the development of current telemental health practice.

Home-Based TeleMental Health (HB-TMH) Privacy & Safety Planning Tool

Overview

Home-Based Telemental Health (HB-TMH) entails risks to privacy and safety that are not encountered during in-person, or even office-to-office telemental health (TMH), care. During the virtual visit, clinicians may have difficulties discerning risks that are evident during in-person visits. Further, tele-clinicians do not have access to the usual safety resources available during in-person services. Security staff, emergency rooms, and other clinical personnel are not available to assist with crises. Often, the clinician is not familiar with the families' local community resources making it difficult to respond to crises or other risk situations. Yet, the standards of care established for usual in-person treatment apply during TMH across settings (American Academy of Child and Adolescent Psychiatry et al., 2017).

To meet these standards, a HB-TMH Privacy and Safety Planning Tool (PSP Tool) should be developed ***prior to the start of any HB-TMH services*** and briefly reviewed with each session. To facilitate this review within each session, the PSP Tool introduces the concept of the "TMH Time-Out" which assists the clinician and families to pause, check in, and ensure that the environment and the clinical session are private and safe.

Each clinical setting has its own specific and available resources, procedures, and institutional policies. Therefore, the PSP Tool is constructed in modular form in order to be adaptable to each setting's needs.

Finally, programs will vary regarding which patients they deem to be appropriate to HB-TMH due to the clinical expertise and other resources at their program, such as families with active abuse in the home, children whose parents/caregivers cannot participate, or adolescents who engage in high-risk behaviors. Therefore, the PSP Tool includes steps at initial screening and at the end of the first intervention session to determine the appropriateness of HB-TMH for a specific program. Of course, families must have adequate connectivity to allow the clinician to accurately assess the patient, and thus allow the patient to safely participate in HB-TMH. Although many other clinical factors go into deciding the appropriate level of care for children or adolescents and their families, the PSP Tool assists with assessing the appropriateness of HB-TMH as a vehicle for private, safe, and clinically appropriate care delivery.

This tool is not meant to be comprehensive. Additions and modifications to fit local practice are encouraged.

Module 1: Screening for Safety for HB-TMH

Timing: At referral or pre-visit
Completed by: Administrative or clinical staff if available, or by patients and their parents/caregivers through the clinician's patient portal.

A. Environmental Safety

Address where the session will occur: _____

Caregiver to be present or available during the sessions:_____

Their telephone:_____

Backup telephone number (not used for session) if available: _____

PCP (name, address, telephone): _____

_____