

AMERICAN ACADEMY OF CHILD AND ADOLESCENT PSYCHIATRY
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**PRACTICE PRINCIPLES FOR TELEPSYCHIATRY
WITH CHILDREN AND ADOLESCENTS**

AACAP Committee on Telepsychiatry

AACAP Committee on Quality Issues

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ABSTRACT

These Practice Principles review the use of telepsychiatry to deliver psychiatric, mental health and care coordination services to children and adolescents across settings, both as direct service and in collaboration with primary care providers or other clinicians. The review defines terms and presents the current status of telepsychiatry as a mode of health service delivery. The review presents unique principles for conducting telepsychiatry services and optimizing the clinical experience. The principles presented are based on existing scientific evidence and the clinical consensus of psychiatrists. **Key Words:** telepsychiatry, telemental health, telemedicine, telehealth, e-health, children, adolescents, practice principles, best practices, practice guidelines.

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DEVELOPMENT AND ATTRIBUTION

These Practice Principles were developed by the American Academy of Child and Adolescent Psychiatry (AACAP) Telepsychiatry Committee (TPC): Kathleen Myers, MD, MPH, MS, and David Pruitt, MD, Co-Chairs, and Ruby Agoha, MD, Daniel Alicata, MD, PhD, Patricio Fischman MD, Nicole Gloff, MD, Dehra Glueck, MD, Felissa Goldstein, MD, Pamela Hoffman, MD, Daniel Lieberman, MD, Jennifer McWilliams MD, Ujjwal Ramtekkar, MD, David Roth, MD, and Lloyd Williamson, MD; the AACAP Committee on Quality Issues (CQI): Heather J Walter, MD, MPH and Oscar G Bukstein, Co-Chairs, and Carol Rockhill, MD, PhD, MPH, Christopher Bellonci, MD, Michelle Durham, MD, MPH, Larry Greenhill, MD, Munya Hayek, MD, Helene Keable, MD, Nicole King, MD, Katherine Shea, MD, Jane Ripperger-Suhler, MD, Saundra Stock, MD, and Roma Vasa, MD; and Sharon Cain, MD and Kristopher Kaliebe, MD.

AACAP Practice Principles are developed by AACAP Committees under the direction of the AACAP CQI. The development of Practice Principles is an iterative process between the Committee, the CQI, topic experts, and the representatives from multiple constituent groups, including the AACAP membership, other relevant AACAP Committees, the AACAP Assembly of Regional Organizations, and the AACAP Council. Details of the Practice Principles development process can be accessed on the AACAP Website. Responsibility for Practice Principles content and review rests with the Committee, the CQI, the CQI Consensus Group, and the AACAP Council.

The primary intended audience for the AACAP Practice Principles is child and adolescent psychiatrists; however, the information presented may also be useful for medical or mental health clinicians.

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These Practice Principles were approved by the AACAP Council on [month/day/year] and is available on the Internet (www.aacap.org).

Disclosures: [Committee Chairs and CQI Chairs]

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INTRODUCTION

The past two decades have brought new approaches to effective pharmacotherapies and psychotherapies for the 20% of the nation's youth diagnosed with psychiatric disorders.¹ More

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individuals are seeking care² and the Patient Protection and Affordable Care Act³ has broadened eligibility for mental health services.³ However, most youth with psychiatric conditions do not receive intervention.^{4, 5} These deficits in access to mental health care reflect the shortages of child and adolescent mental health specialists, a maldistribution of available specialists, the “aging-out effect” of the psychiatric workforce,⁶⁻⁹ and insufficient funding to sustain a stable workforce for public mental health programs.^{10, 11} These access deficits disproportionately affect children and adolescents living outside of major metropolitan areas and in inner city communities.^{8, 12-15} New approaches to meeting this demand are needed.

Technology makes it possible to increase access to health care using interactive televideo (ITV), allowing clinicians and patients at different locations to interact in real time. When ITV is used to deliver medical care, the term *telemedicine* is used; and when specifically used to deliver psychiatric care, the term telepsychiatry is used. Telepsychiatry requires little adaptation to practice to provide care comparable to usual in person care as emphasis is on verbal communication, nonverbal communication and clinical observations.

This flexibility makes telepsychiatry a reasonable alternative to office visits for patients who cannot readily access needed care and addresses the workforce shortage and maldistribution of child and adolescent psychiatrists.^{16, 17} Telepsychiatry extends the psychiatrist’s reach across large geographic areas to youth in a variety of community settings, including schools, daycare facilities, detention centers, and homes.

As various technical, interpersonal, and financial barriers to telepsychiatry fall, programs are proliferating across the country. Clinical practice guidelines for telepsychiatry are needed to

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shape practice models, identify provider training needs, and ensure that the quality-of-care meets the standards of traditional in person care.

These Practice Principles update the prior AACAP Practice Parameters for child and adolescent telepsychiatry,¹⁸ and respond to calls for further guideline development.¹⁹ Due to the limited empirical evidence-base, these principles draw from child-specific telemental health research (Table 1), practice parameters for child and adolescent psychiatric disorders, guidelines for evidence-based psychotherapies,²⁰ general telemental health evidence-base,²¹ and expertise of child and adolescent telepsychiatry providers.²²⁻³³

Telepsychiatry, like all telemedicine, is not a separate medical specialty. Products and services are part of a larger investment by health care institutions in information technology or delivery of clinical care. The telemedicine landscape is rapidly evolving. This parameter provides a scaffold for integrating new technologies and evolving therapeutic interventions into a service delivery model for youth under-served by traditional models of care and for psychiatrists who seek to diversify their practices. Modifications and updates may be needed as the field evolves.

METHODOLOGY

A medical librarian conducted a systematic review of the literature in April, 2016. Searches were performed in the following databases – on the Ovid platform: Medline, PsycInfo, Cochrane Database of Systematic Reviews and Cochrane Central Register of Controlled Trials; elsewhere: EMBASE, Web of Science and the National Guideline Clearinghouse. Retrieval was limited to publication dates January, 2004 to April, 2016, English language, and human species. In Medline, PsycInfo and EMBASE, appropriate Medical Subject Headings (MeSH), terms from

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the Thesaurus of Psychological Index Terms and Emtree headings were used respectively, along with text words, and the search strategy was adapted for other databases as appropriate. Terms searched were telepsychiatry, telepsychology, telemental, telebehavioral medicine; or teletherapy, telehealth, telepractice, telemedicine, video conferencing, remote consultation and mental disorders. All retrieval was further limited to certain evidence categories, such as relevant publication types, index terms for study types and other similar limits.

In addition to the systematic search, we included material from three other sources. We included book chapters from texts published by recognized leaders in telepsychiatry, particularly chapters addressing topics not well addressed in the research literature, such as ethics and cultural competence. Second, we retained several articles published prior to 2004 from the original Practice Parameter for Telepsychiatry with Children and Adolescents¹⁸ due to their relevance to establishing a telepsychiatry practice. Third, we reviewed multiple websites. The most up-to-date information on telemedicine law, regulation, policy, models of care, prescribing, coding, and reimbursement are addressed on these dynamic websites. We also queried the telemental health special interest group of the American Telemedicine Association (ATA) and telemedicine clinicians at international and national centers regarding trending issues.

The evidence supporting telepsychiatry practice with adults greatly outweighs the evidence for practice with children and adolescents. Therefore, we included material gleaned from work with adults in diverse settings if deemed to support the feasibility, acceptability, sustainability, or effectiveness of telepsychiatry practice with youth. We included high level studies, such as meta analyses (N=146); as well as lower level reports (N=1,346), such as

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randomized controlled trials, intervention trials, pre-post interventions, case series, observational studies, and program descriptions.

The search methodology described above is depicted in Figure 1.

DEFINITIONS

There is no clear definition of telehealth-related activities and some agencies do not distinguish between the terms telehealth and telemedicine.³⁴⁻³⁶ In these practice principles, we adhere to definitions from the Centers for Medicare and Medicaid Services (CMS). CMS defines *telehealth* as the use of telecommunications and information technology to provide access to health assessment, diagnosis, intervention, consultation, supervision, and information across distance.³⁷ The term telehealth is a broad umbrella of services that involves telephones, facsimile machines, e-mail, and remote patient monitoring and interpretation. It does not necessarily meet the Medicaid definition of *telemedicine*.

CMS notes that “for purposes of Medicaid, *telemedicine* seeks to improve a patient's health by permitting two-way, real time interactive communication between the patient and the physician at the distant site. This electronic communication means the use of interactive telecommunications equipment that includes, at a minimum, audio and video equipment.”³⁸ CMS views *telemedicine* as a cost-effective alternative to the more traditional face-to-face method of care.^{39, 40}

When telemedicine is used to provide psychiatric, or more general mental health services, the terms “telepsychiatry” and “telemental health” (TMH) are respectively used.^{41, 42}

Terms and definitions relevant to the practice principles follow. A comprehensive glossary can be found at the ATA website.⁴³

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- ***Applications or Platforms:*** technology used to provide videoconferencing, classified as standards-based or consumer-grade.^{44, 45}

- ***Standards-based applications/platforms, or*** “legacy hardware,” offer the highest quality of audio and video, and the most stable data connection. These proprietary, telephone-based systems transmit data over digital subscriber lines (DSL) with high-bandwidth (≥ 1.5 mbps), over satellite or fiberoptic systems. These systems offer features such as the ability to zoom and pan/tilt cameras at both sites and connect to multiple microphones, and multiple monitor systems.

- ***Consumer-based software platforms*** transmit data over the internet and interface software runs on personal computers, tablets, and smartphones. When run off the vendor’s servers, this is referred to as cloud-based computing. Software vendors who advertise as telehealth solutions must provide appropriate software encryption and sign Business Associate Agreements to comply with regulations of the Health Information Portability and Accountability Act (HIPAA).

- ***Bandwidth:*** data that can travel through a communications network in a fixed period of time expressed as kilobits per second. The higher the bandwidth, the more data that can be transmitted.

- ***Broadband:*** transmission of signals in a frequency-modulated fashion over a segment of the total bandwidth available, permitting simultaneous transmission of messages.

- ***CODEC:*** Acronym for coder-decoder. A microchip that converts analog video and audio to digital and vice versa.

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- ***Frame and frame rate:*** A video signal is composed of multiple still images, or frames. Their rate of display is determined by the bandwidth and quality of the camera and monitor. Broadcast-quality video used in most telepsychiatry work has 25 to 30 frames per second.
- ***Interactive televideo (ITV) communication:*** real time interaction of two or more individuals sharing information through electronic media: “synchronous telemedicine.”
- ***“Patient site” (patient’s location), “psychiatrist site” (psychiatrist’s location):*** participants at each end of the ITV link. CMS uses *originating site* for patient location and *distant site* for physician/psychiatrist location.
- ***Telepresenter:*** an individual, located at the patient site, who supports the patient and the psychiatrist. Telepresenters may include licensed professionals or allied health professionals depending upon resources within the community.
- ***Teletherapy:*** informally refers to any non-pharmacologic, psychotherapeutic interventions delivered through videoconferencing.
- ***Young people or youth:*** children and adolescents. If a section is specific to children or adolescents, we will use that developmentally specific term.

HISTORICAL REVIEW

The earliest dispensing health care information at a distance was “The Radio Doctor.”⁴⁶ Telephone added the ability for interactive, real time health care interactions. The first use of interactive video to deliver health care occurred at the University of Nebraska in 1959, when a closed-circuit television system was used for educational and medical purposes, mainly in psychiatry.⁴⁷ In 1973, the term telepsychiatry was first used to describe consultation services

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provided from Massachusetts General Hospital to a medical site in Boston’s Logan International Airport and the Bedford Veteran’s Administration.⁴⁸ Shortly thereafter, telepsychiatry was reported with children and adolescents when Mount Sinai School of Medicine connected to a child guidance clinic in East Harlem.⁴⁹ There was little further published activity until the 1990’s, when Internet and web-cam technologies lowered financial and technical barriers to routine videoconferencing and the growth of telemedicine services.

The number of telepsychiatry programs and telepsychiatrists, particularly those serving children and adolescents, is unknown but the growing options are evidenced by a simple search of the Internet for “telepsychiatry jobs.”

The ATA has captured the complex policy landscape of 50 states with 50 different telemedicine policies.⁵⁰ At this writing, their report indicates that 24 states have enacted telemedicine parity laws mandating commercial insurers to reimburse telemedicine services on par with in-person services. CMS has established guidelines for telemedicine care and policies for reimbursement that include a small care coordination fee paid to the local site on a per patient, per month basis.^{37, 51, 52} There is a national call to approve state-wide Medicaid coverage of telemedicine, instead of focusing solely on rural areas or designating a mileage requirement, and there is movement away from a clinical site “hub-and-spoke” model in favor of reaching patients in non-traditional service sites, such as schools (16 states) or homes (25 states).⁵⁰ The Office for the Advancement of Telehealth (OAT) funded the development of several regional Telehealth Resource Centers (TRCs) to provide assistance, education, and information to organizations and individuals who are providing, or interested in providing, health care at a distance.⁵³ The Patient Safety and Affordable Care Act (ACA) has recommended telehealth

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technologies to improve access to and quality of care for underserved populations.³ Innovative child and adolescent telepsychiatry programs are being integrated into the Pediatric Medical Home model (PMH).^{54, 55} and sited in diverse community settings, such as pediatric clinics,^{27, 28,}⁵⁶ community mental health centers,^{57, 58} urban daycare centers,⁵⁹ schools,^{60, 61} juvenile correctional settings,^{62, 63} and homes.⁶⁴⁻⁶⁶ Telepsychiatry services have expanded beyond major medical and academic centers,^{28, 67, 68} to the private practice setting.^{25, 57} Psychiatrists may contract with a commercial vendor that provides a patient-base and the practice infrastructure or more enterprising psychiatrists may assume these activities in their private practice.²⁵

PRINCIPLES

Principle 1. AACAP suggests that CAPs planning to provide telepsychiatry services become knowledgeable about the relevant legal, regulatory, and ethical issues.

Legal Issues.

The legal and regulatory process in medical practice is dynamic in response to scientific progress, medical research, new products and procedures, best practices per medical disciplines, and stakeholders' interests. Accordingly, state and federal agencies have started to scrutinize telepractice, largely in response to the epidemic of opioid drug abuse.⁶⁹ State regulations vary, are in flux, and may not be fully congruent with federal guidelines. Additional regulations may apply to international practice. As a result, it is not possible to provide a set of uniform regulations. Therefore, prior to initiating telepsychiatry services, psychiatrists should consult their state's laws and medical board guidelines as well as the Drug Enforcement Administration's (DEA) regulations,⁶⁹ particularly the Office of Diversion Control regarding illicit pharmaceutical activities online.⁷⁰ Many professional liability/malpractice carriers cover

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telepsychiatry services, but may require that their clients indicate services provided through ITV. Finally, reimbursement of telepsychiatry services varies at the state level for both Medicaid and commercial vendors⁵⁰ and at the federal level for Medicare coverage.^{52, 71} Germane issues that vary by state relate to licensure, parameters constituting the practice of medicine, definition of the doctor-patient relationship, and prescribing.^{72,73}

National licensure and/or portability of licensure for telemedicine practice has been widely discussed⁷⁴ and recently proposed⁷⁵ -- but not enacted. No change is expected soon. If the patient site and psychiatrist site are located in different states, full licensure in both states is usually required. The requirement does not pertain to the state where the patient *is residing* but where the patient is receiving the intervention. Several states allow for limited licensure specific to providing services through ITV. These licenses have varying restrictions to the scope and practice allowed, but are usually more quickly obtained than a full license. A few states allow telepsychiatry services to be provided by a physician licensed in a neighboring state. While most states allow consultations between physicians without reciprocal licensure, a few states require the consultant to be licensed in the state where the patient is located.⁵⁰ Some states allow for emergency telepsychiatry services without a license, but with regulations on the extent and frequency of implementation.

Prospective telepsychiatry providers should assess other legislation. Some states mandate conditions of the clinical encounter or require a telepsychiatrist maintain a physical practice location in that state. Some states require the patient be evaluated and treated only in a state or federally operated clinic or hospital, or alternatively for a licensed health care professional to accompany the patient during the evaluation. Even if psychiatrists are licensed in a distant state,

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regulations may prohibit their participation in the civil commitment process. Regulatory and procedural guidelines regarding the mental health treatment of youth may vary by jurisdiction including the reporting of child endangerment and the treatment of children in foster care and correctional settings.⁷²

Providing pharmacotherapy through ITV is a topic receiving national and state attention. Congress passed the Ryan Haight Online Pharmacy Consumer Protection Act of 2008 to stem the illicit practice of online dispensing of controlled substances without appropriate patient evaluation.⁷⁶ This Act caught legitimate medical and psychiatric practice in its broad net. The legislation restricts prescribing of controlled substances through ITV unless selected criteria are followed, such as requiring at least one in-person evaluation prior to prescribing a controlled substance or having another licensed provider present at the DEA-certified patient site during the session. The law mandated the DEA to establish a registration process for telemedicine practice involving controlled substances. While awaiting implementation of this registration, several states have enacted their own regulations that may appear at odds with the federal legislation. Potential telepsychiatry providers should review this Act and consult with their medical board if planning to prescribe controlled substances.

Regulatory Issues.

Regulatory issues related to confidentiality, records management, and ethical standards governing telepsychiatry are the same for in-person practice. They vary with the patient's site of service. Hospital-based clinics will be accustomed to maintaining charts and abiding by regulations of the Health Insurance Portability and Accountability Act (HIPAA).⁷⁷ Some community sites have similar guidelines. For example, school-based health clinics must adhere

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to guidelines of the Family Educational Rights and Privacy Act (FERPA).⁷⁸ Other nonmedical clinics will require guidelines to ensure security of private medical information according to HIPAA rules. Telepsychiatry providers should check for federal and state regulations regarding their site of practice.

The Joint Commission on the Accreditation of Healthcare Organizations,⁷⁹ and other accrediting agencies, have established guidelines for medical specialties providing services through ITV. Two medical staff standards address telemedicine. One requires medical staff to recommend the clinical services provided by telemedicine providers and the other requires the telemedicine provider to be credentialed at the patient site. Reciprocity of credentialing has recently been authorized. Psychiatrists are encouraged to contact representatives from telemedicine departments, information technology, health information management systems, and information security for assistance. Other resources include the ATA⁸⁰ or the regional Telehealth Resource Centers (TRC) established to assist in the development of telehealth programs across the nation.^{81, 82} CMS also provides guidelines regulating telehealth and telemedicine.^{83, 84}

Ethical Issues.

Telepsychiatry practice should comply with the ethical guidelines for child and adolescent psychiatry provided in the AACAP Code of Ethics.⁸⁵ Guidelines specific to telepsychiatry with youth are evolving^{85, 86} Psychiatrists should give special attention to practices that may require special implementation, like obtaining informed consent, preventing malfeasance, and ensuring confidentiality.

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As in traditional in-person practice, psychiatrists should document informed consent for ambulatory care and should determine whether separate consent is needed for delivering care through ITV. This requirement may vary by state or facility. Relevant forms are available online.

Steps to ensure privacy and data security are needed, especially when services are provided in non-traditional settings. Adhering to ethical care during telepsychiatry should be considered in the context of the community-based system of care principles.⁸⁷ Of particular relevance, patients and families should be informed of the practice of telepsychiatry, its benefits, and any risks that may be involved at the patient's site, such as equipment malfunction, familiarity with clinic staff, or steps needed to prevent malfeasance.

Principle 2. AACAP suggests that CAPs planning to provide telepsychiatry services conduct a needs assessment and establish the model of care for service delivery.

When planning to implement a child and adolescent telepsychiatry service, a needs assessment should be conducted.^{25, 88, 89} Many underserved communities allocate their mental health funds to the adult chronically mentally ill. A needs assessment conducted with stakeholders in the welfare of children and adolescents will identify which communities are likely to support telepsychiatry services for youth and which telepsychiatry services will complement existing services. Stakeholders and the psychiatrist may identify age groups, behavioral presentations, and interventions that are of highest priority for the community. They may determine which disorders meet medical necessity criteria by third party payers in the jurisdiction in order to ensure sustainability of the program.^{50, 52}

Child and adolescent psychiatrists should establish their model of care during contracting, which often begins with determining the site of care. Services may be delivered to traditional

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outpatient medical or psychiatric clinics⁵⁴, clinics within non-medical facilities such as schools,^{61, 90, 91} juvenile justice programs,⁶² or non-clinical settings such as the home.⁶⁴⁻⁶⁶ The site of service will have implications for the model of care and operational procedures, such as staffing, patient selection, patient management, safety, and emergency planning. The model of care may range from direct care of patients to consultation with PCPs. In a direct care model, the psychiatrist is responsible for diagnosis and ongoing treatment. This model may be more common at non-medical sites, such as mental health clinics or correctional facilities. In a consultation model, the psychiatrist evaluates the patient and makes treatment recommendations to the PCP, who maintains responsibility for patient care. This model may be more common at primary care offices. Although not well described in the child and adolescent literature, collaborative models in which the psychiatrist manages a population of patients with a PCP^{92, 93} are promising, particularly within the pediatric medical home.⁵⁵ Regardless of the model of care chosen, it is recommended that psychiatrists establish partnerships with stakeholders, facilitate communication with others involved in the youth's care (i.e. school staff, primary care physicians, therapist), and determine their role within the youth's system of care.⁸⁷

Once the site of service and model of care are determined, the psychiatrist should determine the flow of administrative tasks, such as obtaining consent forms, making referrals, and obtaining information from the schools. In most models, a dedicated staff person, the telepresenter, is assigned these tasks.^{25, 57} The staff's skills may vary, from nurses to case managers to patient advocates, and requires appropriate levels of supervision from the psychiatrist.

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Billing for telepsychiatry services currently requires modification of Current Procedural Codes.⁹⁴ Documentation should include the location of the patient and psychiatrist at the time of service. If a shared electronic medical record is not utilized, procedures are needed for securely maintaining copies of documentation at the originating (patient) and distant (psychiatrist) sites. The psychiatrist should determine procedures for providing prescriptions to patients consistent with legal guidelines for prescribing controlled substances as well as the preferences of the patient site. Some sites send prescriptions to the site for distribution to patients, but other sites send prescriptions directly to families or pharmacies.

An important issue for partner sites is to note the psychiatrist's availability between sessions, a staff to respond to patient calls, and procedures to obtain medication refills. Concisely written instructions with contact numbers will help families and staff to understand the process of telepsychiatric care.

The psychiatrist and site staff should develop a comprehensive safety plan including protocols for managing urgent needs and emergencies, utilizing local resources, and defining circumstances for involving the psychiatrist.⁹⁵ The psychiatrist and staff should establish concrete crisis plans with the patient and family and share the plan with the youth's PCP, therapist, and components of the youth's system of care.⁹⁶⁻⁹⁸ Emergencies that occur between visits should be managed as for usual care. Psychiatrists should clearly indicate whether they are available for emergencies and, if so, provide patients and staff instructions for contacting them.

Principle 3. AACAP suggests that CAPs planning to provide telepsychiatry services consider whether the potential sites and patients are appropriate for telepsychiatry services.

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There are no absolute contraindications for care delivered through ITV with youth, other than the youth or parent refusing services.⁴² Similarly, there are limited criteria for determining patient appropriateness for telepsychiatric care. Some psychiatrists have suggested that telepsychiatry may be especially suited for adolescents who are familiar with the technology and may respond to the feeling of control allowed by ITV.^{91, 99}

Appropriateness is partly determined by weighing need versus resources. First, the psychiatrist should assess *site* appropriateness, including adequate space, visual and auditory privacy, and trained staff to assist the youth in safely engaging in the session either alone and/or with the parent in the room.¹⁸ If an appropriate site is not available, the patient may need to be referred to in-person services, recognizing that may mean no psychiatric care. *Patient* appropriateness may vary by circumstances, e.g., youth with depression living within a day's drive of a medical center versus a youth living in an Alaskan village accessible by air or boat; or for a youth with a psychotic disorder living in a stressed family versus one living in a residential setting. Appropriateness is determined by the psychiatrist in relation to the referral question, patient's needs, developmental and diagnostic status, system of care, caregivers' abilities, available alternatives, as well as the psychiatrist's perceived competence and availability of a collaborating PCP or other clinicians.¹⁸ Determination of appropriateness also addresses interim care such as whether treatment should be stepped up to a higher level of care, either to in-patient services or intensive community services, such as wrap-around programs.^{87, 100}

Parents may be diagnosed with psychiatric disorders and their ability to supervise youth during sessions may be compromised. Therefore, the psychiatrist should assess the ability of the caregiver to contain the youth and to safely participate in sessions and follow treatment

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recommendations. If treatment is provided at home, the psychiatrist should determine whether the parent is a sufficient authority figure to safely supervise care.

Patient appropriateness also considers community factors as psychiatrists often differ in race, ethnicity, or culture from the families they serve through telepsychiatry.¹⁰¹ As the psychiatrist will likely reside at a distance from the patient site, it may be difficult to become familiar with the community's values and resources.^{102, 103} For example, an urban-based psychiatrist may be concerned about guns in homes with children, but families in rural communities may not agree to remove guns. A visit to the patient site may help to appreciate community values. Respectful and candid questions about these differences can help to determine an appropriate "match" between the site and the psychiatrist.^{26, 88} Staff at the site are a great source for helping the psychiatrist to bridge cultural "gaps."

Some relative contraindications for child and adolescent telepsychiatry services to consider include assessment in settings that are not considered neutral, such as a hostile home environment, settings without resources to contain a disruptive child, or settings without appropriate collaborating systems especially when escalation of care is needed.

Principle 4. AACAP suggests that CAPs planning to provide telepsychiatry services consider the sustainability of services with respect to technology choice and funding.

Technology

The psychiatrist should choose a technology that is appropriate to the clinical work. The ATA recommends a bandwidth of at least 384 Kbits/second⁴² to facilitate detection of clinical details, such as abnormal movements, voice inflections, and subtle dynamic cues, such as

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changes in affect and relatedness. As noted in the Definitions section, there are three technology approaches: standards-based applications, consumer-based applications, and mobile devices.^{44, 45}

Standards-based, or “legacy” hardware-based systems, have been difficult to implement, due to their high upfront costs, relative immobility, infrastructure needs, and maintenance. Such systems are not feasible for clinics with few resources and supports, or for the home.

In order to overcome barriers of legacy systems, many telepsychiatry programs are transitioning to HIPAA-compliant cloud videoconferencing. Users simply download an application or link to a website to join a session. Stakeholders can connect with each other through various devices, such as desktop computers, laptops, tablets, and smartphones.

Most video software clients are programmed to be firewall friendly. Sophisticated algorithms that monitor the network connection are incorporated into the software and automatically adjust the call quality based on the available bandwidth, so it works in suboptimal network conditions (e.g. Wi-Fi, 3G, and 4G). With hosted videoconferencing, the service provider manages all of the back-end information technology (IT) infrastructure reducing the need for on-site IT staff. Many vendors offer flexible subscription plans, making it easy to start with a single account and expand as partner sites expand.

There is no evidence that the selected technology is related to treatment outcomes, and no guidelines exist to “match” devices to clinical needs or reimbursement. Psychiatrists should choose the platform that is appropriate to the clinical service, manageable by both sites and financially sustainable. Psychiatrists should also have a backup plan should the technology system fail. This may include a second line, or, more often, a telephone.

Funding.

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Various financial models are possible depending on whether the psychiatrist is providing contracted services, billing third party payers per session, or some other revenue-generating and risk-sharing model.²⁵ Psychiatrists establishing services across a geographic area may consider cultivating partnerships with other agencies, collaborating with community organizations, working with state programs, and developing a shared vision with other stakeholders.¹⁰⁴ At the federal level, Medicaid and Medicare programs reimburse for specific mental health services. Billing and reimbursement are based on the usual Healthcare Common Procedure Coding System (HCPCS) or Common Procedural Terminology (CPT) codes with a modifier (GT modifier) to indicate that services were provided using technology.⁷¹ Additional codes may be forthcoming, as the American Medical Association has convened a workgroup to consider codes specific to telemedicine practice. At the state level, telemedicine services are generally covered through Medicaid programs.¹⁰⁵

As of January 2016, forty-eight states and the District of Columbia report providing some form of Medicaid reimbursement for telemedicine services. Add-on costs such as technical support, transmission charges, and equipment can often be included in the fee-for-service rate or reimbursed as an administrative cost.^{38, 50, 53, 71}

Another avenue is for states to require private insurance plans to cover telehealth services. As of 2016, thirty-two states and the District of Columbia report requiring private insurance plans to cover telehealth services.⁵⁰ Psychiatrists should check with individual insurance carriers to verify the accepted services and reimbursement rules. ATA provides periodic analysis of service coverage and reimbursement guides by state.⁵⁰ Psychiatrists may find assistance in identifying funding sources at various federal, national, and private websites.^{50, 53, 106, 107}

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Principle 5. AACAP suggests that CAPs who provide telepsychiatry services deliver care in a therapeutic virtual space.

The patient and psychiatrist sites should avoid small, poorly ventilated, dark, or noisy rooms. The room should be appropriate to the intervention to establish a therapeutic alliance. Psychotherapy sessions may warrant a comfortable but minimally decorated room to minimize distractions for the youth. Parent-child training may be facilitated with specific tools for the parent to use in giving clear instructions to the child. Diagnostic sessions may include developmentally appropriate implements, like a desk and crayons to assess the child's fine motor skills, creativity, and attention span. A small selection of simple toys will help to determine the child's interpersonal and communication skills. Noisy, multiple component, and messy toys should be avoided because the sensitive microphones will pick up the noise and compromise conversation.

The room should be large enough for at least one to two adults to be included on screen with the youth. Too large a room, such as a conference room, may allow the youth to wander and preclude maintaining a presence on screen. A medical examination room may overstimulate the youth and risk damage to equipment. One approach to ensure adequate room size and configuration is to communicate the specific room requirements to remote sites before clinical services commence, and then ask a staff to send a picture sitting in a chair about eight feet from the camera, facing away from a window. Lighting is crucial so that the whole room can be easily visualized. Overhead fluorescent lights may cast shadows. Natural lighting can change during the day, interfering with the interactions.

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“Telepsychiatry etiquette” includes all participants on camera at both sites; if the camera span is too narrow to include all participants, each participant should be identified initially and then when speaking. Families must give permission for observers to be present at the psychiatrist’s site.

Youth are dependent upon their parents to access care, and so the psychiatrist should establish a therapeutic alliance with both the youth and parent. This includes introducing and explaining telepsychiatry in developmentally appropriate terms. Both youth and parents should feel that their perspectives are understood. Developing a therapeutic alliance can be challenging when working in person with children with developmental or disruptive behaviors or adolescents who feel alienated. The technology may add another challenge to establishing an alliance. The psychiatrist should ensure that bandwidth is adequate to transcend this challenge, so that visual, auditory, and interactional cues are adequate to understand the youth, convey empathy, respond fluidly, and show variability in emotional tones. Insufficient bandwidth interferes with developing a therapeutic alliance by producing pixilation, delay of the audio signal, and desynchrony of the video and audio signals. When psychiatrists are unsure of the patient’s response, based on visual cues, they should seek verbal confirmation of their observation and interpretation from the youth or accompanying adults.

Adequate bandwidth ensures high-resolution, synchronized transmission so that the psychiatrist can use real-time changes in visual and auditory cues to determine the youth’s affective state, communication, and interpersonal relatedness. High quality microphones, placed to pick up voices, but not ambient noise, facilitate the development of rapport by transmitting a clear signal. Sound quality improves by reducing hard surfaces, such as placing carpeting on the

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floor, draperies on the windows, and sound panels or textiles on the walls. A sound machine outside of the room decreases interference from outside noise and increases auditory privacy.

Adequate bandwidth facilitates the accurate assessment of affect, speech, tremors, tics, fine motor control, and neuroleptic-induced abnormal movements. Administration of the Abnormal Involuntary Movement Scale through videoconferencing has shown reliability comparable to its administration in person.¹⁰⁸

As mentioned earlier, cameras with pan, tilt, and zoom capabilities facilitate the development of a therapeutic alliance.^{26, 88} Control of the camera at the patient site assists in evaluating dysmorphology and developmental anomalies by zooming in on facial features, and assessing motor and activity skills by following the patient around the room.

Assessing eye contact is an essential component of the developmental assessment of youth and is challenging during an ITV encounter due to the placement of the camera above or below the monitor. The psychiatrist should determine whether the child's apparent decreased eye contact represents a technical limitation or clinical impairment and query the youth and parent about the ability to sustain eye contact. The psychiatrist can optimize the patient's experience of his/her eye contact by alternating gaze between the monitor and camera during the session. If the psychiatrist uses two monitors, one for the ITV interaction and one for the medical record, vertical placement of the monitors with the camera between them will force eye contact as the psychiatrist alternately gazes between the two monitors and past the camera.²⁷

The telepresenter at the patient site can facilitate development of a therapeutic alliance. The telepresenter should be organized and flexible in assisting with tasks during and between sessions, such as assisting with management of the youth, obtaining vital signs, ordering

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laboratory tests, requesting school records, and triaging medication refill requests. Telepresenters can help psychiatrists to learn about the community and sharing observations that may be difficult to see via camera or after the session. However, in smaller communities, the telepresenter may be well known to the family, which can raise concern about confidentiality and compromise the ability to develop a therapeutic alliance.

Building therapeutic alliances at the community level involves interacting with general psychiatrists, PCPs, local therapists, school personnel, and other families. Involving these stakeholders in appointments or having phone contact can help psychiatrists to learn about their patients, feel connected to the community, and build confidence in referral sources.

Principle 6. AACAP recommends that CAPs who provide telepsychiatry services provide evidence-based care.

Clinical Specifications

The psychiatrist and patient sites should ensure that care delivered through ITV is consistent with established guidelines of care for child and adolescent psychiatry. Methods are needed to evaluate the care provided, including process variables (e.g., appointments kept or cancelled, satisfaction, relationship) to assess the service delivery,^{73, 109} participants' perspectives,^{67, 110, 111} and outcome variables (e.g., syndromal recovery, symptom reduction, academic progress) to assess patients' progress.^{30, 112} Patient portals can be an inexpensive and easy approach to collecting rating scales and for providing psychoeducation materials.¹¹³ The current evidence-base for telepsychiatry with youth is summarized in Table 1.

Pharmacologic Care

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Pharmacotherapy is one of the most frequently requested telepsychiatry services, although the evidence-base supporting its effectiveness is limited.¹¹⁴ Therefore, guidelines for pharmacotherapy with youth are extrapolated from systematic studies with adults^{115, 116} and youth,^{30, 117} and descriptive reports with youth.^{22, 58}

A psychiatrist may provide pharmacotherapy through various models of care including: direct service, consultation to a PCP, collaboration with mid-level mental health providers, or some combination of the above. The psychiatrist should ensure that the infrastructure at the patient site supports the chosen model, establish processes that ensure effective communication between the patient and psychiatrist sites, maintain communication with other providers, guide medical record documentation, and maintain compliance with regulatory guidelines^{41, 42, 118} Any need to modify best practices due to service delivery through ITV should be documented along with the rationale.

There are several logistical issues in establishing a telepharmacotherapy service.^{119 26} Information sharing is best accomplished with a shared electronic medical record (EMR), although other approaches that ensure confidentiality and security of data are used. The psychiatrist can address patient education and medication consent during the telepsychiatry encounter and may be assisted by the telepresenter.^{22, 26, 57} Procedures are needed to share documentation of the session with the site and ideally with the PCP.

Procedures for prescribing non-controlled medications include e-prescribing, calling prescriptions to the pharmacy, or sending hard copies to the family or pharmacy. Some programs prefer that prescriptions are sent to the patient site for their distribution to the family. As noted in Principle 1, controlled medications, including Schedule II stimulants, have additional regulations

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when prescribed remotely as mandated by the Ryan Haight Online Pharmacy Consumer Protection Act of 2008.^{76, 120} Psychiatrists should become familiar with this federal legislation and state guidelines while awaiting clarification from the DEA.

Monitoring the effects of psychotropic medications and managing their side effects require procedures at both the psychiatrist's and patient's sites to obtain vital signs, order laboratory tests, or other assessments. Ideally, these tasks would be managed at the patient site, but some non-medical sites may collaborate with a local medical clinic to assist monitoring. Psychiatrists can assess abnormal movements through ITV with some minimal assistance from staff at the patient site.¹⁰⁸ Alternatively, local nursing staff may be trained in this assessment. A video is available from the Northern Arizona Regional Behavioral Health Association (NARBHA) at: www.rbha.net/presentations/AIMSDemo/player.html. Rating scales can be made available for the psychiatrist to use in assessing treatment response.^{21, 113} If the psychiatrist's schedule does not accommodate unanticipated or increased visits for example, to assess youth after the initiation of antidepressant medications,¹²¹ staff at either site can provide telephone, ITV, or in-person follow-up visits and communicate findings to the psychiatrist. Planning for unanticipated issues is a necessary component of pharmacotherapy. Psychiatrists and staff at the patient site should develop procedures for medication refills and reports of adverse medication effects.

Psychotherapeutic Care

Requests for psychotherapy services through ITV (teletherapy) for children and adolescents are increasing. Standard practice guidelines for adult psychotherapy should direct teletherapy^{41, 42} while awaiting formal guidelines with youth.²⁰

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No specific theoretical orientation or approach for teletherapy has been indicated or contraindicated, and psychiatrists should adapt best practices and evidence-supported approaches from the in-person setting. Cognitive behavioral approaches appear most common and relevant given their structure and skills-building focus. As in traditional treatment, best practices often include working both alone with the youth and together with the parent. Telepresenters assist with managing the session, such as who participates, when, and steps to ensure privacy. In home-based settings, it is important to acknowledge the parent's role in managing the session. Teletherapy requiring direct one-on-one interaction (e.g., play therapy) requires considerations for child characteristics and the setting. Behavioral interventions require coaching of parents in behavior training such as reinforcement or time-out strategies.

Information regarding the effectiveness of teletherapy is limited, but growing.^{31, 122-126} Clinicians have shown high fidelity to manualized interventions.^{127, 128} Reviews of treatment outcome studies have concluded that teletherapy is feasible, applicable to diverse populations, tolerable in a variety of therapeutic formats, and acceptable to users with outcomes that are comparable to in-person treatment.^{122, 125}

Most teletherapy studies with young people are descriptive indicating that teletherapy is feasible, acceptable, and well tolerated.^{31, 129} In ten outcome studies ranging from feasibility trials to pre-post designs and a few randomized controlled trials, PCPs and families endorsed high levels of satisfaction with therapy.^{24, 31, 130-132} Several randomized trials are noteworthy. Nelson and colleagues found comparable reductions for childhood depressive symptoms treated with eight sessions of cognitive-behavioral therapy (CBT) delivered through ITV versus in-person.¹³⁰ Storch and colleagues¹³³ found superior outcomes for youth diagnosed with obsessive-

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compulsive disorder (OCD) who were treated through teletherapy compared to youth treated in-person. Outcomes of the behavioral treatment of tics through ITV also appear comparable to in-person treatment.¹³⁴ Two pre- to post- intervention outcome studies suggest the benefit of parent training offered through ITV¹³⁵ and consultation to PCPs in the psychiatric care of young patients.¹³⁶ Five small randomized trials have demonstrated potential effectiveness of providing family interventions through ITV.^{64, 137-140}

Consultation and Psychosomatic Care

Teleconsultation to PCPs concerning mental health care of patients with medical illness is well established for adults.^{21, 141} Teleconsultation regarding the behavioral and mental health care of children with medical conditions,^{142, 143} developmental disorders,¹⁴⁴ and special needs¹⁴⁵ is emerging. The preliminary evidence supports the feasibility and acceptability of providing behavioral interventions through ITV for conditions such as feeding disorders,¹⁴⁶ diabetes,^{147, 148} and obesity.¹⁴⁹⁻¹⁵¹ Given the paucity of child mental health specialists,^{4, 12, 13, 152} and development of the pediatric medical home,^{3, 147, 153} teleconsultation for psychosomatic medicine appears promising, but further experience is needed.

Principle 7: AACAP suggests that CAPs who provide telepsychiatry services consider adapting services to care provided outside of traditional clinic settings.

There is a long tradition of moving mental health services out of the traditional clinic and into the community. A natural next step for telepsychiatry is to offer services to more naturalistic and ecologically valid settings --- settings that are often more convenient for youth and their families and provide some assistance for staff involved in youths' care. Schools and correctional settings are the most common community settings in which services are provided, and services in

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the home are growing. Psychiatrists should establish their model of care appropriate to the community setting and clarify their role to those involved in the child's care.

In community settings, patient privacy, security of information, and an appropriate, sound-proof space are more difficult to regulate; also, medical personnel may not be available to obtain vital signs and provide medical monitoring. The psychiatrist should work with staff/family to determine a protocol to ensure that medical monitoring of medications occurs in a timely manner. As in other settings, the psychiatrist should determine how the patient receives medications, particularly controlled substances. In case of equipment failure, the psychiatrist should determine a procedure to ensure prompt patient contact (i.e., telephone contact with family/staff) and a plan for continuity of care.

In community settings, it is important that an emergency intervention protocol be established prior to initiating care and that all persons involved in the patient's care be informed. All documentation should be maintained at the psychiatrist site, and the psychiatrist should determine whether specific documentation should also be maintained at the patient site. Community settings will require guidelines to ensure security of private medical information.

School-Based Telepsychiatry

School-based mental health clinics provide services to more youth than outpatient clinics, with minimal disruption to classroom time or demands on the parent's workday.^{154, 155} In communities with limited access to mental health professionals, especially psychiatrists, school-based telepsychiatry can provide an array of services and allows the psychiatrist to be efficiently involved in student evaluation and multidisciplinary planning with school personnel.^{60, 87} School-based telepsychiatry services have demonstrated benefit for students and staff.^{60, 61, 90, 156}

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The psychiatrist should obtain knowledge of school culture, define the model of care, and clarify the psychiatrist's role and expectations within the school system. Potential services include evaluations, collaborations with the youth's PCP, medication management, psychosocial interventions with students and families, evaluations for support services, and continuing education for staff and consultation on classroom-specific and general school issues.^{61, 157} If helping the school address an adverse event, such as the untimely death of a student or teacher, natural disaster, or violence, psychiatrists should provide services consistent with in person consultations and standard protocols

The Family Educational Rights and Privacy Act (FERPA)⁷⁸ specifies privacy rules for accessing student health information and applies to telepsychiatry.⁷⁸ FERPA should guide determination of the infrastructure for telepsychiatry services, including privacy of the interview room, which can be challenging in overcrowded schools.⁶¹ Staff accompanying the youth should have a mental health or medical background (i.e., school counselor or school nurse); and participating staff must be educated about protected health information. Documentation and maintenance of records must be maintained in a private and secure location (e.g., nurses' station or counselor's office) and not included in educational records.¹⁵⁸ Informed consent should consist of the legal guardian and the patient (if over the age of majority).^{60, 72, 118} The consent process should be conducted by the psychiatrist with the patient and guardian in real-time, according to local, regional, and national laws,⁴¹ and in compliance with the minors' access to mental health services in the absence of parental knowledge and consent. The school clinician or nurse may assist in obtaining consents. If the model of care involves direct service, the

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psychiatrist must determine whether the psychiatrist or PCP will provide prescriptions, and how medications will be provided during the summer.

Telepsychiatry in Juvenile Corrections

Youth involved in the juvenile justice system experience psychiatric disorders at a rate far exceeding general population rates.¹⁵⁹ Correctional programs that lack access to psychiatric services are increasingly obtaining services through ITV.⁶²

As for in-person correctional services, psychiatrists delivering services through ITV require knowledge of the legal process in the youth's jurisdiction, especially whether the patient's status is pre- or post-adjudication. This may require virtual meetings with the youth's legal counsel. The psychiatrist should clarify with the patient that he/she is subject to "dual agency" status, i.e., responsible to both serve the patient and to assist the facility. The psychiatrist must then clarify his/her role as a treating clinician/forensic examiner, that he/she is a mandated reporter regarding abuse, and that all information may be accessed by the court. Finally, the psychiatrist must work with legal counsel and the facility to obtain consent for services from the legal guardian and patient, which may require a videoconference depending on the facility's regulations.

Protecting confidentiality in correctional settings is challenging. A virtual tour of the site via mobile device can be helpful to view the records room, examination room or other relevant service-related space. Digital records management should also be clarified.

Occasional ITV meetings can help correctional staff to understand the needs of mentally ill juvenile offenders, such as the need for a suicide watch, protection from the general community, or monitoring medication side effects. The correctional setting may require staff to

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chaperone the youth during the sessions. Youth are often concerned about privacy and may be more comfortable if chaperoned by clinical staff rather than security staff. Added benefits are having two clinicians to model therapeutic techniques and to align staff which is critical in the correctional setting.

Home-Based Telepsychiatry

Home-based telemental health has been safely and successfully implemented with adults with serious psychiatric disorders.⁹⁷ Preliminary work suggests that home-based teletherapy with youth and families is feasible, acceptable, and effective,^{64, 65, 119} and may be especially relevant for children who do not tolerate traveling outside of the home or to provide continuity of care for families who relocate, such as military families. Using laptop computers and mobile devices in the home offers the potential to observe children's behaviors in their naturalistic setting and to develop interventions in the setting where they will be used.^{65, 66}

Prior to initiating home-based services, the psychiatrist should determine whether the family is appropriate to home-based care. Particular attention should be paid to privacy as it is difficult to find an isolated, sound-proof space where conversations are not overheard by others, intentionally or unintentionally. The psychiatrists should develop a safety plan⁹⁷ consisting of the physical location and address of the patient in case emergency services are required, as well as consent regarding contact of community resources in case of an emergency. A written informed consent, specific to using home-based telepsychiatry, should be obtained. The psychiatrist should inform the patient's PCP of home-based services and elicit collaboration regarding monitoring the youth's status. Home-based telepsychiatry services should be avoided if there is a serious concern for patient safety and/or if the family does not consent to developing

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the safety plan. This assessment of appropriateness should be ongoing, as circumstances may change over time.

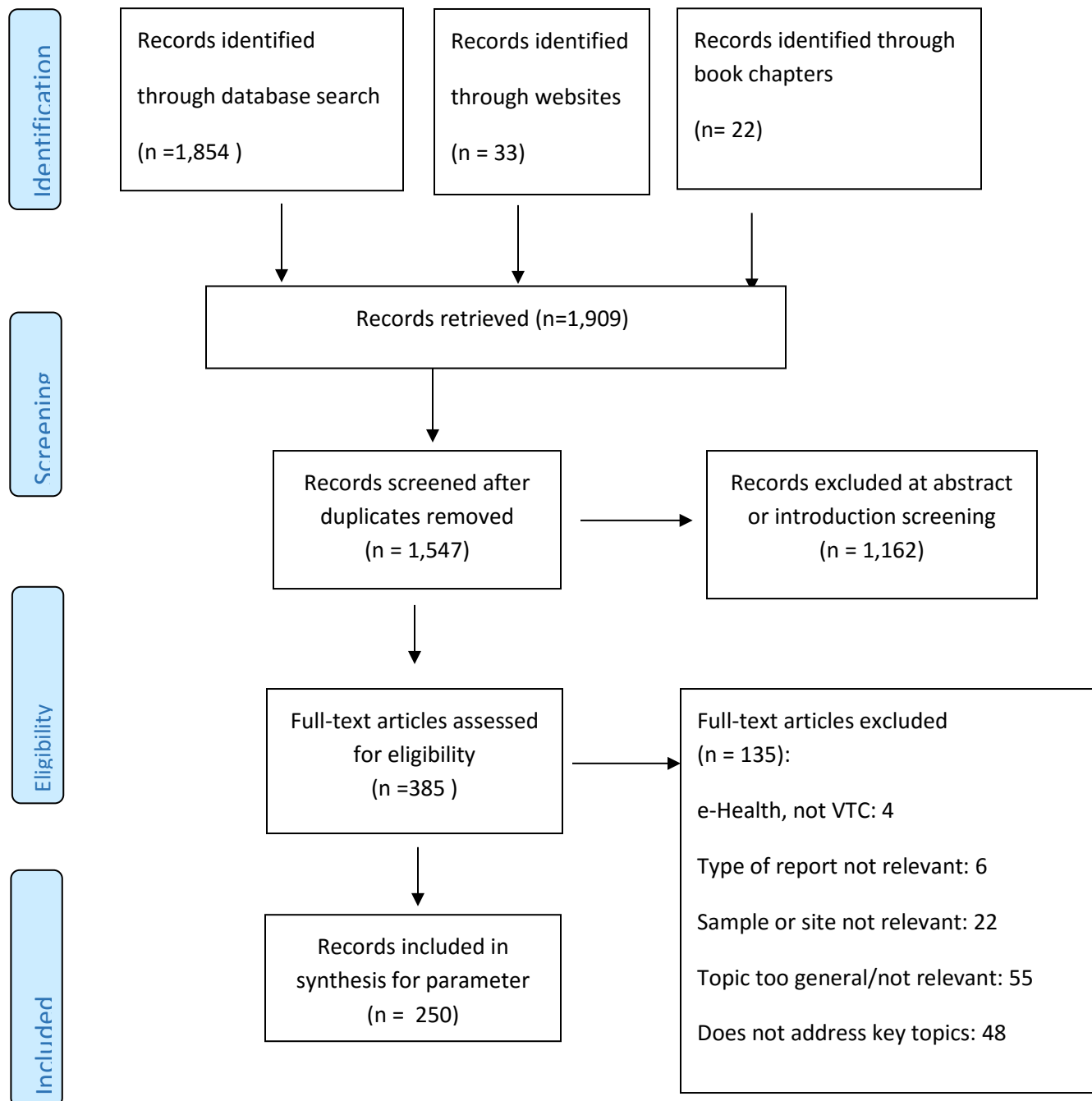
There are some relative contraindications for home-based telepsychiatry, including child custody assessments, forensic evaluations, investigating allegations of abuse or neglect, family therapy with a history of interpersonal violence in the family, and/or a volatile parent. The child may not feel free to be candid about his/her environment or circumstance. In the home environment, the psychiatrist will have less ability to redirect the situation should the parent become upset. Some children with developmental disorders may not tolerate the ITV platform.⁶⁶

Finally, the patient and family should be given written information regarding the operation of equipment and how to address technical difficulties, as they will not have additional technical support available to them. A backup plan in case of technical difficulties is needed.

PRACTICE PRINCIPLES LIMITATIONS

AACAP Practice Principles are developed to assist psychiatrists in decision-making. These principles are not intended to define the standard of care or guarantee successful treatment of individual patients, nor should they be deemed inclusive of all proper methods of care or exclusive of other methods of care directed at obtaining the desired results. These Practice Principles do not usurp sound clinical judgment. The ultimate judgment regarding the care of a particular patient must be made by the psychiatrist in light of all the circumstances presented by the patient and his/her family, the diagnostic and treatment options available, and the accessible resources.

FIGURE 1
Literature Search Flow Diagram



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TABLE 1: EVIDENCE-BASE SUPPORTING CHILD AND ADOLESCENT TELEPSYCHIATRY

Citation	Sample	Assessment	Findings
Randomized Controlled Trials			
Nelson et al., 2003 ¹³⁰	28 youth (age 8-14 years; M=10.3 years) with depression	Diagnostic interview and scale	Comparable improvement of depressive symptoms in response to therapy delivered in-person or through ITV
Storch et al., 2011 ¹³³	31 youth (age 7-16 years; M=11.1 years)	ADIS-IV-C/P, CY-BOCS, COIS, MASC, CDI, Satisfaction with services	ITV was superior to in-person care on all primary outcome measures, with a significantly higher percent of individuals in the ITV group meeting remission criteria
Himle, 2012 ¹³⁴	20 children (age 8-17) with Tourette's Disorder or Chronic Motor Tic Disorder	YGTS, PTQ, CGI-S, CGI-I	Youth in both ITV and in-person service delivery modalities experienced significant tic reduction with no between group differences

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Myers et al., 2015 ³⁰	223 youth (age 5.5-12.9)	DISC-IV, CBCL, VADPRS, VADTRS, CIS	Caregivers reported improved inattention, hyperactivity, combined ADHD, ODD, role performance and impairment Teachers reported improvement in ODD and role performance
Xie, 2013 ¹⁴⁰	22 children (age 6-14) with behavioral disorder	PCQ-CA, VADPRS, CGAS	Parent training through ITV was as effective as in person training and was well accepted by parents
Tse et al., 2015 ¹³⁹	38 children (age 5.5-12) with ADHD	VADRS, CIS, PSI, CSQ, PHQ-9, FES	Parents of children with ADHD received parent training either in person or through ITV. Children in both groups improved comparably. Parents' distress did not change for those who received training through ITV.
Pre-Post or Comparison Studies			
Glueckauf et al., 2002 ¹³⁷	22 adolescents (age: M=15.4; 100% Caucasian) 36 parents	SSRS, WAI, issue-specific measures of family problems, adherence to treatment	Improvement for problem severity and frequency in all conditions. Therapeutic alliance high; teens rated alliance lower in ITV format.

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Fox, 2008 ¹⁶¹	190 youth (age 12-19; M=17) in juvenile detention	GAS	Improvement in the rate of attainment of goals associated with family relations and personality/behavior
Yellowlees, 2008 ¹³⁶	41 children in an e-mental health program	Child Behavior Check List (CBCL)	A retrospective assessment of 3-month outcomes with a convenience sample found improvements in the Affect and Oppositional Domains of the CBCL
Reese et al., 2012 ¹³⁵	8 children; age: M=7.6; 12.5% Asian	ADHD	Families reported improved child behavior and decreased parent distress via ITV format of Group Triple P Positive Parenting Program
Heitzman-Powell et al., 2013 ¹⁶²	7 parents; youth age not reported	OASIS training program	Parents increased their knowledge and self-reported implementation of behavioral strategies
Satisfaction Studies			
Blackmon et al., 1997 ¹⁶³	43 children (age 2-15; M=9)	12-item Telemedicine Consultation Evaluation	All children and 98% of parents report satisfaction equal to in-person care

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Elford et al., 2001 ¹⁶⁴	30 children (age: 4-16 years; M=13 years)	Satisfaction Questionnaire	Show high satisfaction of children, teens, parents, and psychiatrists with ITV
Kopel et al., 2001 ¹⁶⁵	136 --- article does not specify age but refers to participants as “young person”	Satisfaction Questionnaire	High satisfaction by families and rural health workers in New South Wales, Australia.
Greenberg, 2006 ²⁹	35 PCP’s, 12 caregivers Mean age of children: 9.3 years	Focus groups with PCP’s, interviews with caregivers	PCP and caregiver satisfaction with telepsychiatry. Frustration with limitations of local supports.
Hilty, 2006 ¹⁴¹	15 PCP’s for children and adults --- 400 patients (number of children not specified)	PCP Satisfaction Survey	PCP satisfaction was high and increased over time
Myers et al., 2007 ⁶⁷	172 patients (age 2-21) & 387 visits	11-item Psychiatrist Satisfaction Survey	Describes telepsychiatry services in 4 sites, high satisfaction of primary care physicians, and reimbursement of services. Pediatricians more satisfied than family physicians

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Myers et al., 2008 ¹¹¹	172 patients (age 2-21) & 387 visits	12-item Parent Satisfaction Survey	Describes utilization of telepsychiatry by families, and their high satisfaction with initial and return visits. Less satisfied with care for adolescents than for younger children
Myers et al, 2010 ⁵⁶	701 patients 190 PCP's 18% <7 years 43% 7-12 years 39% >12 years	Collection of patient demographics and diagnoses.	Telepsychiatry with young people is feasible and acceptable
Pakyurek et al., 2010 ⁹⁹	Children/adolescent in primary care 5 case studies	Effectiveness of telepsychiatry in treating a range of problems	Video might actually be superior to in-person for consultation
Lau et al., 2011 ²⁸	45 children and adolescents Age: 3-17 years (M=9.7 years)	Description of patients referred for consultation, reason for consultation, treatment recommendations	ITV reaches a variety of children, with consultants providing diagnostic clarification and modifying treatment
Szeftel et al., 2012 ¹⁴⁴	45 patients – 31 of them under 18 years old	Retrospective chart review – medication changes, frequency of patient appointments, diagnostic	ITV led to changed Axis I psychiatric diagnosis (excluding developmental disorders) 70%, and changed medication 82% of patients initially, 41% at 1 year and 46% at 3 years. ITV

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		changes, symptom severity and improvement	helped PCPs with recommendations for developmental disabilities.
Descriptive and Service Utilization			
Myers et al., 2004 ⁵⁸	159 youth (age 3-18)	Comparison of patients evaluated through ITV vs. in person	ITV patients were representative of usual outpatient population demographically, clinically, and by reimbursement. More “adverse case mix” for ITV sample
Myers et al., 2006 ⁶³	115 incarcerated youth (age 14-18)	11-item Satisfaction Survey	Describes large series of incarcerated youth, including medication management
Jacob et al., 2012 ¹⁴²	15 children (age 4-18 years; M=9.73 years)	12-item Parent Satisfaction Survey	Patient satisfaction high and PCPs found recommendations helpful; outcomes pending on follow-up
Nelson et al., 2012 ¹³¹	22 youth (M=9.3 years)	Chart review	No factor inherent to the ITV delivery mechanism impeded adherence to national ADHD guidelines
Diagnostic Validity:			

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Elford et al., 2000 ¹⁶⁶	25 children (age 4-16 years) with various diagnoses	Diagnostic interviews	96% concordance between ITV and in-person evaluations; no differences in satisfaction.
Stain, 2011 ¹⁶⁷	11 adolescents and young adults (age 14-30 years)	Diagnostic Interview for Psychosis	Strong correlation of assessments done in-person versus ITV
Reese et al., 2013 ¹³⁸	21 children; age: 3-5; 90% Caucasian	ADOS – Module 1, ADI-R, Parent Satisfaction	No difference in reliability of diagnostic accuracy, ADOS observations, ratings for ADI-R parent report of symptoms, and parent satisfaction between ITV and in-person groups
Chart Review			
Marcin, 2005 ¹⁶⁸	223 patients (age 6 months - 84 years; M = 33 years; SD = 19 years) including psychiatry and other specialties	Chart review	Tele-consultation resulted in changes in diagnosis and treatment and was associated with clinical improvement

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Boydell, 2007 ¹¹²	100 children and adolescents Ages 2-17 Mean - 11 yrs.	Chart review and interviews with case managers	Pros & cons of adherence
Psychosomatic Pediatrics Interventions			
Bensink et al., 2007 ¹⁶⁹	8 youth; inclusion criteria for age is 2-18 years, but no specified age range or mean age for actual sample)	Cost-minimization analysis Structured interviews	Using ITV over videophone to families with a child diagnosed with cancer, the study noted technical feasibility and high parental satisfaction
Clawson et al., 2008 ¹⁴⁶	15 youth (age 8 months – 10 years)	Family satisfaction Costs to family Psychiatrist satisfaction Clinical outcomes	ITV was feasible with the pediatric feeding disorder population and resulted in cost-savings
Shaikh et al., 2008 ¹⁵⁰	99 youth Age 1-17 years	Retrospective review of patient medical records	ITV consultations resulted in substantial changes/additions to diagnoses. For a subtest of patients, repeated ITV consultations led to improved health behaviors, weight maintenance, and/or weight loss

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Witmans et al., 2008 ¹⁷⁰	89 children Age 1-18 years; M=7.5 years	Sleep diary Childhood Sleep Habits PQoL, Client Satisfaction	Patients were very satisfied with the delivery of multidisciplinary pediatric sleep medicine services over ITV
Mulgrew et al., 2011 ¹⁷¹	25 youth Age 4-11 years	Consulting psychiatrists' listening skills Ease of understanding instruction delivered to patients and their families Comfort level of parents in discussing health concerns	No significant difference in parent satisfaction between consultations for weight management delivered by ITV or in-person
Davis et al., 2013 ¹⁴⁹	58 youth Age 5-11 years; M=8.6 years	Body Mass Index (BMI) 24-hr dietary recall ActiGraph, CBCL, Behavioral Pediatrics Feeding Assessment Scale	Both groups showed improvements in BMI, nutrition, and physical activity, and the groups did not differ significantly on primary outcomes

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Freeman et al., 2013 ¹⁴⁷	71 youth ITV: M=15.2 years In person: M=14.9 years	Baseline metabolic control CBQ Diabetes Responsibility and Family Conflict Scale WAI	No differences were found in therapeutic alliance between the groups
Hommel et al., 2013 ¹⁴⁸	9 youth M=13.7 years	Pill count PHBI Pediatric Ulcerative Colitis Activity Index Feasibility Acceptability Questionnaire	The ITV approach resulted in improved adherence and cost-savings across patients
Lipana et al., 2013 ¹⁵¹	243 youth M=11 years	Review of medical records	Using a nonrandomized design, the ITV group demonstrated more improvement than the in-person group in enhancing nutrition, increasing activity, and decreasing screen time
ADI-R: Autism Diagnostic Interview – Revised; ADIS-IV-C/P: Anxiety Disorders Interview Schedule- Child/Parent Version; ADHD: attention-deficit hyperactivity disorder; ADIS-IV-C/P: Anxiety Disorders Interview Scale-DSM-IV- Parent and Child Versions; ADOS: Autism Diagnostic Observation Scale; BMI: body mass index; BPFAS: Behavioral Pediatrics Feeding Assessment Scale; CBQ: Conflict Behavior Questionnaire; CBCL: Child Behavior Checklist; CDI: Children’s Depression Inventory; CGAS: Clinical Global Assessment Scale; CGI-I: Clinical Global Impressions of			

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Improvement Scale; CGI-S: Clinical Global Impressions of Severity Scale; CIS: Columbia Impairment Scale; COIS: Child Obsessive Compulsive Impact Scale; CSQ: Caregiver Strain Questionnaire; CY-BOCS: Child Yale-Brown Obsessive Compulsive Scale; DISC-IV: Diagnostic Interview Scale for Children for DSM-IV; FES: Family Empowerment Scale; GAS: Goal Attainment Scale; ITV: Interactive televideo; MASC: Multi-dimensional Anxiety Scale for Children; OCD: obsessive compulsive disorder; ODD: oppositional defiant disorder; PHBI: Partial Harvey-Bradshaw Index; PCP: primary care provider; PCQ-CA: Parent Child Relationship Questionnaire; PHQ-9: Patient Health Questionnaire-9 Items; PTQ: Parent Tic Questionnaire; PSI: Parenting Stress Index; PQoL: Pediatric Quality of Life; PDD-NOS: pervasive developmental disorder, not otherwise specified; RCT: randomized controlled trial; SSRS: Social Skills Rating System (teen functioning); VADPRS: Vanderbilt ADHD Parent Rating Scale; VADTRS: Vanderbilt ADHD Teacher Rating Scale; WAI: Working Alliance Inventory; YGTS: Yale Global Tic Severity Scale

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