Prevention Services Division:
Recommendations for Using Telehealth When Providing Specialty Mental Health Services to the 0-5 Population

What is the recommended practice for assessing a child, age 0-5, during the current COVID-19 crisis?

The Prevention Services Division highly recommends at least one face-to-face assessment contact, whether it be done in-person (adhering to physical distancing guidelines) or via telehealth. In assessing very young and potentially vulnerable children, it is important for practitioners to be able to observe both the physical characteristics and the behavior of the child as well as quality of the parent/caregiver-child relationship.

Prevention Services Division Recommendations for Using Telehealth When Providing Specialty Mental Health Services to the 0-5 Population

In light of the current COVID-19 crisis situation, we have outlined recommendations regarding the assessment and treatment of children Birth to Five and their families. It is of utter importance for practitioners to understand that these guidelines apply under this special circumstance as it is always best practice to see young children face-to-face multiple times and across different contexts to arrive at a thorough assessment and diagnosis. It should be made clear that once the crisis is resolved, children and their families need to be seen face-to-face in order to conduct an assessment and arrive at a diagnosis and to provide treatment services.

Given the current situation and national crisis with COVID-19, the following Guidelines are recommendations for utilizing Telehealth services for the Birth to Five population. Again, it should be noted that Telehealth is not the recommended course of treatment for children under the age of five and is not recommended beyond the COVID-19 crisis.

Conversation about use of Telehealth:

- Ensure the child and parent/caregiver have the ability and capacity to participate in Telehealth services (does the parent/caregiver have access to technology required to participate in Telehealth services? Will the parent/caregiver have access to private, distraction-free space during the scheduled time of the appointment?).

- Parents/caregivers should be informed that Telehealth services are being provided solely due to the current COVID-19 crisis. Parents/caregivers should not expect Telehealth to be routine or business as usual.

Safety:

- Is the child and parent/caregiver in a safe environment to be able to participate in Telehealth services (is there DCFS involvement, a history of interpersonal violence, a history of parental/caregiver substance abuse, etc.)?

- Once safety is secured, the practitioner needs to consider how much privacy there is in the home when the telehealth service is being offered.

- Issues related to mandated reporting: practitioners should follow the same procedures as they would during in-person sessions, including calling the CPS hotline or 911.

- Parents/caregivers should have a way to contact the practitioner, whether that is via a company-issued phone or other mode of communication. For Directly Operated clinics, please refer to the most updated Telework Toolkit for approved applications. For contract agencies, please discuss with your own agency regarding approved applications.

Documentation:

- Notes written by the practitioner should have a statement indicating that the client/guardian agreed to receive services via telehealth*. Refer to QA Bulletin 20-01.*

- The practitioner also needs to ask for an outside emergency contact and discuss a safety plan at the beginning of the call.

- It should be documented in every step of treatment (engagement, assessment, treatment, termination) that services were provided via Telehealth. Refer to QA Bulletin 20-01

Translation/Interpretation Needs:

- In the event that the practitioner and the caregiver(s) speak different languages, the practitioner needs to arrange for an interpreter to be present. For privacy and confidentiality, it is recommended against using family or friends as interpreters. If no professional interpreters are available, a possible option might be for another practitioner to interpret.

Considerations that may be relevant in the assessment and treatment phases

- To begin, practitioners are assuming that clients and their families will have access to certain technology to be able to participate in a telehealth services. With the abundance and availability of smart phones, it is more likely that families will have access to phone applications that can allow practitioners to see and observe the child and primary caregiver(s), a critical piece in conducting a thorough assessment and arriving at an appropriate diagnosis for the infant/young child (Refer to QA Bulletin 20-01 regarding approved telehealth applications).

- Determine if it would be feasible to have a telehealth room in a clinic set up, so that clients could be scheduled to come in for 1-2 hours to conduct the assessment. In this case, practitioners would not have to be in the same room. Camera(s) would already be set up to capture as much clear a picture as possible (rather than relying on camera

phones). While it is true that the room would then need to be cleaned and disinfected between clients, it would address other factors (e.g., confidentiality, privacy, safety etc.).

- With children and families continuing to need to access mental health services, at a time when face-to-face contact is strongly discouraged, assessment of young children via telehealth services includes a need to consider several factors. One very important factor to keep in mind is confidentiality and using technology that will ensure client information will be confidential and private.

- Telehealth sessions/services should be treated as in person services – limitations to confidentiality, personal and professional boundaries, and consistency with treatment apply, should be discussed with the family and remain the same.

- In order to be able to observe the dyad and make determination of medical necessity, the assessor needs to be able to have a full and clear view of the child and caregiver. The foundation of Birth to Five mental health services lies in the observation of cues, the child, the parent/caregiver ability to read and respond to cues, the dyad, and the quality of the relationship. There really is no substitute, whether it is in asking direct and specific questions about behaviors from multiple caregivers or otherwise, for conducting an observation of the quality of the relationship between a child and their caregiver(s).

- The practitioner needs to be able to determine whether the child displays any fear/anxiety/sadness or any other negative emotion/affect towards or around the caregiver(s). This is not a question that can be asked of a caregiver, as there is a likelihood that there would be incentive to minimize any negative feelings/interactions in the dyad (this issue is likely to be of even greater relevance for DCFS involved families).

- The parent/caregiver should expect to be in contact with the practitioner 3-4 different times in order to complete the assessment. This will allow the practitioner time to gather relevant information in order to come to an appropriate diagnosis.

- Similar to procedures for assessments in the clinic, the practitioner needs to be able to speak with the caregiver separately, without the child present, to gather any sensitive information where it is not appropriate for the child to be present.

- Relationships are key. Does the practitioner have a good enough relationship with the parent/caregiver to utilize this medium to provide assessment and/or treatment services?

- Discuss ahead of time with the parent/caregiver (via a collateral phone call), how the practitioner and parent/caregiver will work together to regulate the child should the child become dysregulated at any point during the Telehealth session.

- Dyadic treatment necessarily involves having developmentally appropriate toys available for the dyad. How will this work without the families having to go out and buy toys?

Perhaps a discussion between the caregiver and practitioner to discuss what toys are already available to the family can address this issue.

- As in typical face-to-face sessions, a realistic and attainable Safety Plan should be put in place if deemed appropriate. In other words, what is the parent/caregiver's plan in the event the parent/caregiver cannot get in contact with the practitioner.

- Sessions should be held to the same time bound limitations as in face-to-face sessions (i.e., being on time for session, cancelling appointments ahead of time if needed). It may also be appropriate to schedule shorter sessions multiple times a week during times of crisis.

- Importantly, while some therapy content is appropriate via telehealth, the practitioner needs to consider that there may content that may best be postponed in order to address it in person. For instance, it might be appropriate to conduct supportive or skills-based therapy, but not in-depth trauma work like the trauma narrative.

Termination

- The practitioner should be mindful of how to provide the last (termination) session and if a Telehealth session is appropriate.
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- Determine how the parent/caregiver will receive after care referrals and information following the termination session.

Note: For more information regarding documentation and claiming of services during COVID-19, please refer to QA Bulletin 20-01