American Psychological Association

Journal of Rural Mental Health

© 2021 American Psychological Association
ISSN: 1935-942X

2021, Vol. 45, No. 2, 86–94
https://doi.org/10.1037/rmh0000153

PROGRAM DESCRIPTION

COVID-19 Tele-Mental Health: Innovative Use in Rural Behavioral Health and Criminal Justice Settings

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Tele-mental health (tele-MH) is an important asset in rural areas across the United States where in-person service access can be limited. This resource is even more critical now during the COVID-19 pandemic, which has increased demand for a virtual alternative to community-based mental health and substance use disorder services. Many individuals are seeking behavioral health services due to distress related to COVID-19, in addition to a new group of individuals in need of these services who have been released from jails and prisons to prevent transmission of the virus within the facilities. Jurisdictions around the country have rapidly implemented and/or expanded tele-MH to continue vital service provision. The authors conducted semistructured phone interviews with five senior-level professionals involved in tele-MH provision across four rural U.S. regions (a six-county region of western Montana; Cumberland County, Maine; Polk County, Iowa; and a 10-county region of western South Dakota) concerning tele-MH services before and since COVID-19, benefits of the expanded technology, challenges to implementation, and any data collected thus far regarding satisfaction and effectiveness of tele-MH. These examples of rural communities that have accelerated policy and programmatic changes around tele-MH may be beneficial for other communities considering tele-MH as well as serve as valuable opportunities for additional evaluation and sustainability post-COVID-19.

Public Significance Statement

This article provides an overview of the particular challenges in rural community behavioral health service delivery since the COVID-19 outbreak, as well as how tele-mental health can assist with addressing these significant needs. The discussion includes program descriptions of four rural areas of the United States that have implemented or expanded tele-mental health in behavioral health and criminal justice system services since the outbreak, which may serve as guidance for other rural communities around the United States.

Keywords: tele-mental health, COVID-19, rural, behavioral health, criminal justice

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The 2019 novel coronavirus (COVID-19) has had a major and swift impact on many aspects of life, including behavioral health care and its delivery system. Most individuals who previously received mental health and/or substance use disorder services and treatment within their communities have been forced to adapt to a new landscape where in-person appointments are difficult, if not impossible.

This article was published Online First February 4, 2021.
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We have no known conflicts of interest to disclose.

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This particular challenge has always existed in rural areas across the United States, where roughly one in five Americans live (Ratcliffe et al., 2016), but it is now magnified by the pandemic. Broad geographic service areas and insufficient resources in many rural jurisdictions hinder accessibility of behavioral health services. In addition, emotional distress and trauma related to COVID-19 is leading more people to seek mental health services for what may be the first time (Pfefferbaum & North, 2020), increasing demand for services and potentially overwhelming traditional service delivery systems.

COVID-19 has also created another population in need of these already limited community-based services: individuals with behavioral health needs released early from incarceration. Many jails and prisons have decreased the number of individuals held in both their pretrial and sentenced populations in order to prevent transmission of the virus within these facilities (Hawks et al., 2020). This group most often includes those already scheduled to be released soon and those with medical needs that could make them more vulnerable to the virus. Although commendable, this policy change has resulted in additional layers of complication for rural areas in particular. According to the Vera Institute of Justice (Kang-Brown & Subramanian, 2017), jail incarceration rates in many smaller jurisdictions are higher than in large cities. Commonly cited studies report that at least 17% of individuals in jails have symptoms of a serious mental illness (Steadman et al., 2009). If a rural jail is underresourced, it is less likely that these individuals would have received sufficient mental health services while incarcerated, or that they would have been linked to community services at discharge due to COVID-19. Some of these released individuals may also be without housing, increasing their level of vulnerability to COVID-19, as well as potential return to the criminal justice system (Texas Criminal Justice Coalition, 2019). These circumstances combined resulted in an increased burden on the community-based behavioral health system, particularly at a moment when access to in-person services has drastically decreased.

Tele-Mental Health and Service Expansion

Tele-mental health (tele-MH), also commonly referred to as "telepsychiatry" (American Psychiatric Association Committee on Telepsychiatry, 2018) or "telepsychology" (American Psychological Association, 2013), is the virtual provision of behavioral health services and is one of the most common applications of telemedicine (Barnett & Huskamp, 2020). Although there are many technologies available to provide tele-MH services at various levels (Luxton et al., 2014), traditional models have centered around hub-and-spoke and integrated care designs, necessitating that patients still travel to a physical office to receive remote behavioral health-care services.

Tele-MH has been particularly promising in rural communities, where there tend to be low mental health provider-to-population ratios (Ellis et al., 2009), more geographic barriers to access to care, and greater stigma surrounding mental health conditions (Gale et al., 2019). While more research in the area of tele-MH is needed, a comprehensive review of published literature from 2003 to 2013 summarized that using videoconferencing for tele-MH services appears to be as effective as in-person care across most measures (Hilty et al., 2013), echoing findings from an earlier literature review from 1965 to 2003 (Hilty et al., 2004). Tele-MH's efficacy in rural settings is often highlighted specifically (Holland et al., 2018; Langarizadeh et al., 2017). In one study, providers in rural areas reported even greater satisfaction with the service than in suburban or urban areas (Hilty et al., 2004). While tele-MH has been promoted as a promising practice in rural communities for many years, the COVID-19 outbreak necessitated rapid adoption and expansion of the services, in many cases reducing, though not eliminating, previous barriers to implementation such as provider availability, reimbursement challenges, and technology restrictions and access (Gale et al., 2019).

To meet the growing need for tele-MH services since the COVID-19 outbreak, policy makers and funders at both the federal and state levels have responded with increased opportunities, particularly amplifying tele-MH services that are delivered through personal smartphone and videoconferencing platforms in real-time communication (Warren & Smalley, 2020). Prior to COVID-19, most payers only covered direct-to-consumer virtual behavioral health services in limited cases, often requiring a co-occurring physical health diagnosis (Warren & Smalley, 2020). The Centers for Medicare and

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Medicaid Services (CMS) and the Drug Enforcement Administration (DEA) have since waived many restrictions around the use of tele-MH, allowing for greater reach and reimbursement (Whaibeh, Mahmoud, & Naal, 2020). The Coronavirus Preparedness and Response Supplemental Appropriations Act (2020) reduced previous telehealth[1] geographic restrictions and expanded allowances for telephone use. Subsequently the Coronavirus Aid, Relief, and Economic Security (CARES) Act (2020) increased Medicare coverage and grant funding for telehealth services. Additional relevant significant state and federal legislation has been issued or is being considered (Augenstein et al., 2020; O'Brien & Corlette, 2020). The Office for Civil Rights (OCR) at the U.S. Department of Health and Human Services (HHS, 2020) also eased strict tele-MH privacy concerns by encouraging provider discretion and the use of any non-public-facing remote communication product, allowing for the use of nonmedical software platforms such as Zoom, Skype, Google Hangouts, Apple FaceTime, Facebook Messenger, and other similar products.

In order to highlight successes and challenges in the implementation and expansion of tele-MH since COVID-19, we gathered qualitative data from multiple organizations providing virtual community-based behavioral health and occasionally related criminal justice services in rural areas. Our goal was that the examples of innovative use of tele-MH as well as lessons learned through the rapid adoption and growth of the service would help inform the development of future tele-MH programs.

Method

Sample

We selected four rural regions of the United States for this discussion based on several criteria. Most defining was our ongoing professional roles providing technical assistance to over 50 jurisdictions within the John D. and Catherine T. MacArthur Foundation's Safety and Justice Challenge (SJC). The multiyear SJC initiative began in 2015 with a commitment to support local leaders, typically in cities and counties, determined to address the misuse and overuse of jails in America. Through our relationships with SJC participating jurisdictions over the past five years, we developed communication and rapport with multiple organizations providing behavioral health and criminal justice services in rural areas. Some of these jurisdictions have implemented or expanded the use of tele-MH as a strategy to provide behavioral health services to their communities since the COVID-19 outbreak.

We first focused on jurisdictions within the SJC initiative with populations less than 500,000. Within this smaller group, representatives from two sites (Cumberland County, Maine, and Polk County, Iowa) had already expressed interest in development of telehealth models through an unrelated survey of general SJC-related technical assistance needs on March 27, 2020. Two additional sites (Missoula County, Montana, and Pennington County, South Dakota) were selected from the population-sorted list based on the close collaboration we had established in related work to date. Initial outreach to the four sites was made by contacting SJC stakeholders from each county by email on April 20, 2020, to ask if they were available and willing to be interviewed for the project. Representatives from each of the four sites responded and agreed by email to participate. In two of the four cases (Missoula and Pennington Counties), representatives from the sites forwarded the request to stakeholders more closely connected to their work in rural areas. In both cases, these stakeholders were involved in provision of behavioral health services in broader rural areas than Missoula and Pennington Counties: a six-county region of western Montana[2] and a 10-county region of western South Dakota,[3] respectively. At the end of the selection process, one male and four female representatives in senior-level management from the four regions agreed to be interviewed.

Procedure

We conducted one 30-min semistructured telephone interview with representatives from

[1] "Telehealth" refers to a broader scope of remote healthcare services than tele-MH and is generally the term used in funding statutes.

[2] The western Montana region includes Ravalli, Missoula, Granite, Powell, Deer Lodge, and Beaverhead Counties.

[3] The western South Dakota region includes Bennett, Butte, Custer, Fall River, Harding, Jackson, Lawrence, Meade, Pennington, and Oglala Lakota (previously Shannon) Counties.

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each of the four regions between April 27 and May 7, 2020. Interviews included a brief introduction to the project's goals and how the information would be used. The focus of the interviews was to solicit information about the availability of tele-MH services before and since COVID-19, benefits of the expanded technology, challenges to implementation or expansion of tele-MH since the outbreak, and any data collected thus far regarding satisfaction and effectiveness of tele-MH. The authors conducted all interviews, with one asking questions and the other taking notes. Both authors asked the same open-ended questions related to the topics above with spontaneous follow-up questions. Following the interviews, the authors' notes from the interviews were circulated to the interviewees via email to confirm accuracy and consent was given from each interviewee to include the information in this manuscript.

Analysis

In order to conduct thematic analysis on the qualitative data from each interview, the authors followed several steps. First, we familiarized ourselves with the data through repeated reading of the information while searching for patterns. Second, we used qualitative coding to identify aspects of the data that formed the basis of themes, indexing and sorting important sections of text as they related to major themes using a semantic or explicit approach (Braun & Clarke, 2006). Themes included slow growth of tele-MH prior to the COVID-19 outbreak, followed by rapid expansion of the technology as it became clear that in-person services were becoming ill-advised. Although the greater need for virtual alternatives did not eliminate barriers to widespread tele-MH use in the four regions, especially technological challenges, the expansion in many cases removed perceived barriers such as that tele-MH was too complicated, would not result in client or provider satisfaction, or that it would result in a higher rate of missed appointments than in-person scheduling. Although higher cost and sustainability were considered challenges with some of the sites' more innovative tele-MH uses in particular, all of the representatives reported commitment to continuing many of the virtual services post-COVID-19.

Results

Western Montana

Western Montana Mental Health Center (WMMHC) is the largest mental health service provider in Montana, serving over 15,000 individuals each year across Ravalli, Missoula, Granite, Powell, Deer Lodge, and Beaverhead Counties. Most of these counties are classified by the U.S. Census Bureau (2010) as completely rural (Granite, 100%) or mostly rural (Ravalli, 84.6%; Powell, 54.2%; and Beaverhead, 50.2%), while Missoula (22.3%) and Deer Lodge (33.6%) Counties are classified as mostly urban but also serve rural areas outside of the city centers. At the time of the interview, there were only 11 mental health professionals covering the Region 2 service area, which is roughly one-third the size of Montana.

The center provides comprehensive community-based, outpatient and inpatient mental health and substance use disorder treatment services for adults and children, as well as housing options. Prior to the COVID-19 outbreak, most tele-MH provision in western Montana took place within the more remote jails and hospitals, to allow crisis responders to perform virtual involuntary commitment evaluations for individuals in need of an acute level of care. Typically, the well-known Zoom cloud-based service platform was used. Before the pandemic, WMMHC was slowly increasing its tele-MH capacity to serve the many rural areas across the state, but the outbreak provided an unfortunate opportunity to greatly accelerate the rollout. Behavioral health providers across western Montana are now using tele-MH widely, primarily through the HIPAA-compliant Zoom platform. The tele-MH services allow clinicians to use video conferencing to interact with clients who are alone in another provider's office. If clients are not already familiar with the technology, administrative agency staff are available to provide instructions. This virtual but same-building service provision was not reimbursable through Medicaid prior to COVID-19, but it is now covered under Montana's emergency COVID-19 order. Approximately 90% of individuals served by WMMHC utilize Medicaid as their primary insurer and the expanded coverage has been critically significant.

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Another opportunity for tele-MH expansion in western Montana since COVID-19 has been integrating the service into two existing spaces previously dedicated to adult day treatment. The locations were not providing in-person services at the time due to the virus. In order to avoid overloading local emergency rooms with individuals with mental health needs who are not in serious danger to themselves or others but who may have nowhere else to go to receive services, WMMHC partnered with Bozeman Health and Help Center 211's crisis line to pilot and staff two psychiatric urgent care centers providing tele-MH in the existing spaces. The centers provide crisis intervention, psychiatric evaluations and clinical assessments, brief counseling, brief medication management services, and care coordination. When an individual comes to one of the psychiatric urgent care centers, either by walking in or via transport by law enforcement, they are triaged by a nurse and can "see" a clinician virtually using remote technology within one hour. The clinician will determine if the client needs to see a medication provider, which will also be done virtually. The new process was publicized through word of mouth and email messaging to community partners, law enforcement agencies, and physicians' offices. This has also resulted in more emergency room space and shorter wait times for those with physical needs.

Local behavioral health provider agencies have reportedly adapted well to the expanded virtual technology. The new format has resulted in greater ability to meet clients on their own terms, which sometimes includes outside of a grocery store or in their cars. The virtual technology also allows clinicians to respond much faster, avoiding what sometimes would have meant hours of driving between provider locations. Since the virtual transition, there have reportedly not been many WMMHC clients who have disengaged in services.

Cumberland County, Maine

Both the criminal justice and behavioral health systems in Cumberland County, Maine, have experienced tele-MH growth since the COVID-19 outbreak, as demonstrated through Maine Pretrial Services, Inc. and Through These Doors, a nonprofit domestic violence resource center in Cumberland County. Cumberland County is classified by the U.S. Census Bureau (2010) as mostly urban (23% rural) and contains the City of Portland, as well as many more rural areas across its 1,217 square miles. Maine has the lowest population density of any state east of the Mississippi River and ranks 38th out of all 50 states (U.S. Census Bureau, 2010).

Maine Pretrial Services works with county courts and individuals across the state to provide prearraignment screening and risk assessment, pretrial release and supervision, postconviction alternatives to incarceration, case management for drug treatment and co-occurring disorders courts, and other diversion options. Through These Doors provides services, advocacy, shelter, and referrals for victims of domestic violence, with offices in Portland, Brunswick, and Bridgton, as well as a helpline. The two agencies are collaborative partners in their SJC-funded initiative, Project Safe Release, which aims to improve identification of pretrial victim defendants and provide risk and needs assessments, services, and safety planning to address trauma and victimization. Prior to COVID-19, advocates were able to meet with clients in person to provide support at courthouses. Through These Doors also offers domestic violence support groups for women held at the Cumberland County Jail and Maine Correctional Center.

Although the two agencies have worked in partnership for many years, each has expanded its use of tele-MH services since the pandemic began. Due to the amount of in-person contact normally associated with its service provision, Maine Pretrial Services faced a particularly difficult challenge transitioning to virtual formats. Its initial focus was on moving day-to-day operations to a virtual platform, then ensuring that clients maintained their connections to needed services. Initial barriers included many clients' lack of access to smartphones, as they often utilized prepaid devices with limited capacity. In order to help fill this need, Maine Pretrial Services was able to broker additional resources for clients. As of the interview date, the organization was operating completely virtually in 11 of Maine's 16 counties. Clients engaged in specialty courts are also participating in virtual counseling and recovery meetings, which have been quite well attended, even leading to capacity challenges in some cases. The courts and judicial system have also made virtual adaptations over the last few months. Although some drug courts had been using Zoom and Google Duo for client contact previously, the rest of the judicial system was less prepared to quickly transition. At the time of the

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interview, all hearings across the state were now being conducted using Google Duo.

Maine Pretrial Services has also been piloting innovative virtual drug testing since COVID-19 began. Clients are delivered sweat patch kits with detailed instructions, rubber gloves, and swabs. Using Google Duo, Maine Pretrial Services staff witness the client administering the patch, check in virtually on multiple occasions throughout the week, and at the end of the process walk the client through the patch removal via video conferencing, including how to package the patch to send back to the lab. While certainly groundbreaking, the long-term sustainability of this process is in question, as the patches are quite expensive. In a similar process, a client can be mailed a urine test specimen cup, then utilize the virtual technology to show staff their bathroom, and walk through the house for monitoring purposes. The client hangs up while delivering the sample, then logs back in so the staff member can read the results in real time. The process is not infallible but has reportedly worked smoothly thus far.

Through These Doors has also expanded its use of tele-MH services in Cumberland County since the start of the outbreak. Since that time, the domestic violence resource center has seen an increase in service requests and access. Although most of the organization's advocacy staff already had the technological capacity to work from home, they are now using multiple virtual platforms, including Zoom, Google Duo, and Gruveo, to provide client counseling, linkage to the court for orders of protection, and access to the child welfare system. As of the time of the interview, Through These Doors was preparing to release a new private one-on-one online chat service for survivors to communicate with staff. Given the sensitivity of its services and population, privacy has been a particular concern for Through These Doors. The organization has created formal staff protocols around privacy and confidentiality given the new virtual parameters, including early discussion and creation of personalized, practical safety plans with clients who may be in danger. The plans may include how to be physically safe, cope with emotions, tell friends and family about any abuse, take legal action, and more. In addition, while Through These Doors advocates are not able to meet with clients in person at the courthouse due to the pandemic, they are available virtually before, during, and after to help with the legal process, safety needs, and connection to other community resources.

Western South Dakota

Behavior Management Systems (BMS), a community behavioral health center in western South Dakota, has also expanded tele-MH services since COVID-19. The agency serves Bennett, Butte, Custer, Fall River, Harding, Jackson, Lawrence, Meade, Pennington, and Oglala Lakota (previously Shannon) Counties, with over 11,000 clients across the 20,000-square-mile, 10-county region. Most of these counties are classified by the U.S. Census Bureau (2010) as completely rural (Bennett, Custer, Harding, Jackson, all 100% rural) or mostly rural (Fall River, 50%; Oglala Lakota, 80%), with Butte (48.2%), Lawrence (36.9%), Meade (38%), and Pennington (20.8%) Counties classified as mostly urban.

The center provides a variety of behavioral health services, including crisis triage and care, counseling, screening and assessment, addiction treatment, and medication management. Services are available for children, teens, and adults. Training in motivational interviewing, a collaborative conversation style for strengthening a person's own motivation and commitment to change, is also available at BMS. Although tele-MH had been expanding across South Dakota over the past several years, it was fairly limited until mid-March 2020, when the state's COVID-19 emergency order was declared. At that time, most of BMS' services were in person.

Following the order, Behavior Management Systems quickly transitioned all of its programmatic lines to either virtual Zoom or telephonic formats. Its Crisis Care Center continues to provide in-person crisis support in emergencies only and asks individuals to call ahead for virtual screening prior to potential admission. An early focus in BMS' move to tele-MH was the creation of client safety plans. At the start of every virtual session, the provider confirms the client's location and emergency contact information, should they become disconnected or the situation become unsafe for the client. There is also a discussion between provider and client around privacy issues and informed consent, including how protected health information can be shared or not, given the new meeting format.

At the time of the interview, Behavior Management Systems was also testing an innovative virtual competency to stand trial restoration process with one individual. The individual was released from jail pre-COVID-19, but due to the long wait for

outpatient competency restoration services and the individual's rural location and lack of transportation access, BMS initiated the virtual process using Zoom in early March 2020. Although the client had not attended all of the virtual restoration sessions at the time of the interview, moderate success was reported in this limited case and the organization was considering expanding telecompetency restoration in the future, as well as utilizing telehealth so that individuals waiting in jail custody for competency evaluation or restoration could meet with their providers. Since the start of COVID-19, BMS has seen some decrease in interest in virtual services, particularly for children/family services, but most clients are continuing their engagement, with early estimates of an 8–15% increase in appointment show rates.

Polk County, Iowa

Polk County Health Services (PCHS), the Iowa Mental Health and Disability Services system over Polk County, has similarly expanded its use of tele-MH since the COVID-19 outbreak. Polk County Health Services is a nonprofit that oversees a local network of services and support for people who have mental illness, intellectual, or other developmental disabilities. By working with various partner agencies, PCHS serves approximately 9,000 central Iowans each year. Polk County is classified by the U.S. Census Bureau (2010) as mostly urban (4.9% rural) and contains the City of Des Moines, but similar to Cumberland County, Polk County contains substantial rural service areas as well. Iowa has the 36th lowest population density out of all 50 states (U.S. Census Bureau, 2010).

Through PCHS' network of providers, they offer comprehensive mental health, substance use disorder, and disability services. These may include respite, addiction recovery, crisis and emergency care, assessment and evaluation, care coordination, and medication management services, as well as practical assistance with transportation, education, employment, and housing.

While Polk County's physical health system had gained greater momentum toward virtual service provision than the behavioral health system prior to COVID-19, the pandemic accelerated the county's tele-MH capacity. One provider of children's mental health services reportedly converted all of its programming to virtual platforms in just 48 hr. As PCHS quickly transitioned the majority of its services, the familiar barriers of internet coverage and lack of capable devices were found in rural and agricultural regions in particular. Using funding from the Mental Health and Disability Services Region, PCHS was able to purchase approximately 120 cell phones with six-month service plans for providers to allocate to Polk County clients who did not have access to appropriate devices for tele-MH support. The ability to engage in mental health services virtually, in the privacy of individuals' homes, has helped combat the stigma that still exists particularly in rural communities, where resources are limited, and it is difficult to access services without others noticing.

Another specific expansion of tele-MH recently magnified in Polk County was in response to the need for a public hotline for individuals seeking guidance regarding co-occurring physical symptoms and mental health needs related to COVID-19. Iowa's existing 211 call line provides health and human service information and referrals. However, since the start of the outbreak, many individuals began to call with COVID-related mental health needs, and the service lacked enough mental health professionals to handle the calls. To fill the gap, PCHS collaborated with a relatively unknown and underutilized statewide mental health warmline, Your Life Iowa, created in July 2019 by the Department of Public Health. To make the process as seamless as possible, the well-publicized 211 line now connects directly to the mental health warmline through a single-digit extension (211 ext. 8). This process will be sustained statewide at no cost after COVID-19, enabling many more individuals to easily access mental health services across the state. Staff are hopeful that much of the tele-MH expansion will continue post-COVID-19 and PCHS is collecting relevant data such as suicide and overdose rates, which at the time of the interview were not increasing and, in some areas, had even declined.

Discussion

Common findings from the interviews have implications for other communities expanding tele-MH. Prior to COVID-19, tele-MH services were at best ad hoc and slowly increasing across the four sites interviewed. In each region, the immediate need for a virtual alternative to in-person services, combined with a growing demand for community-based behavioral health services due to two new populations (those with distress due to

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COVID-19 and those released from jails and prisons in order to reduce transmission of the virus), led to acceleration of tele-MH availability. In many cases this quickly brought about policy and programmatic changes that were previously viewed as difficult or impossible (e.g., virtual competency restoration services). Those interviewed for this project reported high levels of satisfaction with the virtual service options in both behavioral health and criminal justice settings, as well as the ability to maintain client confidentiality and safety. Community stakeholders, service providers, and government entities should reimagine the potential of tele-MH and its extended sustainability post-COVID-19 as part of an array of client-centered service options.

While the primary purpose of this article was to provide multiple program descriptions of how tele-MH has been implemented and expanded in rural areas since the COVID-19 outbreak, there are a number of limitations. Selection of the four participating regions was based on prior partnerships and is not inclusive of every major region of the United States, most notably the South. In addition, the interview sample was limited to five senior-level representatives. The interviews did not include frontline provider or client feedback, which likely had an impact on reported outcomes and perspectives. Although all of the representatives reported commitment to continuing many of the virtual services post-COVID-19, it is important to note that sustainability will likely be affected by other factors such as stakeholder/provider buy-in and cost-benefit analysis. The interviews were also conducted only several weeks following the widespread COVID-19 outbreak, which may have not allowed as much time as would be ideal for evaluation and reflection. Finally, the interviews relied on self-report and little quantitative data were available regarding the impact of tele-MH since COVID-19.

Challenges to the broad availability of tele-MH certainly exist in many communities across the United States, with some of these barriers magnified in rural areas, as shown through the site examples. General barriers to the expansion of tele-MH across the regions included clients' limited access to wireless internet, insufficient device capacity, and lack of stable internet coverage. Since the start of the pandemic, local internet providers have equipped many households with school-aged children with internet access, but many other households remain unconnected. Medicaid's new allowance for reimbursement for telephonic-only services since COVID-19 has been very significant for clients who otherwise may not have been able to access behavioral health services virtually. Although creative solutions must still be implemented, the pandemic has lessened many barriers to expansion such as the lack of participating providers, fear of a steep learning curve, privacy issues, and reimbursement sources.

Some challenges are unique to the criminal justice system, which has not had much historical exposure to teleservices. Criminal justice system stakeholders may be understandably cautious about the real or perceived risk of virtual alternatives (e.g., for in-person reporting requirements). However, the pandemic has allowed jurisdictions across the country to see the promise of such solutions, including greater use of citations in lieu of arrest for low-level offenses, a more efficient hearing and court process, and more accessible behavioral health treatment provision for individuals impacted by the justice system.

Given the ongoing and anticipated long-term need for virtual alternatives to in-person services in community and criminal justice settings, organizations should prioritize data collection, particularly once they have moved past the initial state of COVID-19 crisis response. Additional research is needed regarding clinical outcomes of various tele-MH modalities and with various behavioral health conditions, provider and client satisfaction with tele-MH as opposed to (or eventually in combination with) in-person services, cost-benefit analysis, and equity in the availability of tele-MH. Additional flexibility and funding from federal, state, and private stakeholders continue to generate a unique opportunity to expand this field.

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Received May 12, 2020
Revision received October 9, 2020
Accepted November 19, 2020 ■

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