Issue Brief: Tele Mental Health in California Schools

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I. INTRODUCTION

About This Issue Brief

This issue brief summarizes recent telehealth and youth mental health policy development and discusses the survey result of the use of telehealth in providing mental health services for children and youth in California schools in 2020-2021. Through this brief, I will provide policy makers, advocates, and state agencies an understanding of how tele mental health is used in California schools, another perspective of the challenges and needs young people are facing in receiving mental health care in California, and additional recommendations.

Why focus on mental health for children and youth?

According to a 2016-2020 study, 12% of California children ages 3-17 had one or more behavioral or mental health conditions, and at least 35% of school-aged children experienced depression-related feelings in the previous year.[1] The COVID-19 pandemic intensified the pre-existing mental health crisis for children and youth in California and brought them new challenges, including social isolation, grief, and trauma. [2] In 2020, not only did the suicide rates of youth ages 10-18 in California increased by an alarming 20%, but the psychiatric hospitalizations rates of youth ages 15-19 also increased by 9.1%.[3] Additionally, in 2021, more than 65% of California caregivers reported concerns for their children's emotional or mental health. [4] Our children and youth are experiencing a mental health crisis, and ensuring access to quality mental health care for our children and youth is more critical than ever!

Why focus on telehealth?

Telehealth is the use of digital technologies to deliver health care, health information, and other health services by connecting two or more users in separate locations.[5] Telehealth modalities include synchronous (i.e. video calls, audio only telephone calls, and text messages),

asynchronous store-and-forward, remote patient monitoring, and mobile health.[6] Telehealth is not a distinct service type but a way of delivering services that is as effective as in-person care for various types of services, including mental health.[7] During the COVID-19 Public Health Emergency (PHE), telehealth usage in the U.S. skyrocketed, especially among those with Medicaid and Medicare.[8] To ensure broader access to care, California quickly expanded its telehealth policies and Medicaid ("Medi-Cal") service provisions. In 2020, nearly seven in ten Californians reported having received health care via telehealth.[9]

At the height of the PHE, telehealth played a huge role in helping meet California's mental health service needs.[10] From August 2020 to August 2021, although the overall health care visits remained about the same from the pre-COVID-19 to the COVID-19 period, the number of behavioral health visits conducted via audio-only and video modalities drastically increased.[11] Telehealth visits for outpatient mental health and substance use services in California went from 0% in 2019 (prior to the PHE), to a peak of 40% in mid-2020, and then to a steady 36% in early 2021.[12]

Although there remain barriers to care associated with telehealth (especially for people with disabilities and those with limited English proficiency), providers have identified telehealth as a helpful tool for their patients to receive the mental health care they need at a time behavioral health demand continues to exceed supply.[13] Many youth have also reported the use of technology (including applications such as TikTok) as an important way to get health care information, connect with peers, and get mental health services.[14] Utilizing tools and resources that youth are familiar with not only improve youth outreach and engagement, but also ensure that youth are provided with options in how they get help.[15]

Why focus on schools?

School is a hub and center of the community. It is where many children and youth get help and support for their mental wellbeing. A 2020 study found that 75% of U.S. children who receive mental health care got the care in schools.[16] Also, youth are 21 times more likely to visit a school clinic for mental health needs than a community-based clinic and are six times more likely to receive evidence-based services in a school than other community based settings.[17] School-based services not only help normalize mental health stigma, increase access to care, but also help identify early depression in youth.[18] Having a strong school-based mental health collaborative is extremely critical to ensure the mental health of our young people.[19]

II. POLICY DEVELOPMENT

Federal telehealth laws and policies

The Centers for Medicare & Medicaid Services (CMS) recognizes telehealth as a "cost-effective alternative to the more traditional face-to face way of providing medical care that states can choose to cover under Medicaid"—a definition that is consistent with federal Medicare statute.[20] Following the U.S. Department of Health and Human Services (HHS) Secretary's declaration of the COVID-19 Public Health Emergency (PHE) on March 13, 2020, CMS announced a number of telehealth related flexibilities and waivers to make it easier for providers to deliver health care services to Medicaid beneficiaries through telehealth.[21] To assist states in expanding their telehealth policies, in 2020, CMS issued a COVID-19 Telehealth Toolkit and later a Toolkit Supplement.[22] In 2020, the HHS also established a website, Telehealth.HHS.gov, to provide health care providers and patients information and resources on telehealth.

California telehealth laws and policies

During the COVID-19 PHE, California temporarily expanded its telehealth service provisions to allow coverage of several telehealth modalities across the state, including in schools.[23] These temporary policies included expanded access to telehealth through non-public technology platforms, such as Apple FaceTime, Zoom, or Skype, as well as payment parity between medically appropriate services rendered over the phone and via video for Medi-Cal beneficiaries.[24] In July 2021, California lawmakers enacted AB 133 to ensure that several of the temporary PHE Medi-Cal telehealth flexibilities remain available through December 31, 2022.[25] Then, on June 30, 2022, SB 184 was signed into law, permanently requiring coverage of and payment parity of synchronous video, synchronous audio-only, and asynchronous telehealth modalities, effective January 1, 2023.[26]

Federal youth mental health policies

The dire need for mental health services among youth in California reflects the national trend. On October 19, 2021, the American Academy of Pediatrics, the American Academy of Child and Adolescent Psychiatry, and the Children's Hospital Association declared a National Emergency in Child and Adolescent Mental Health.[27] On December 7, 2021, the U.S. Surgeon General, Dr. Vivek Murthy, issued a formal Advisory on youth mental health crisis and emphasized that "it would be a tragedy if we beat back one public health crisis only to allow another to grow in its place."[28] On March 1, 2022, President Biden addressed the nation's mental health crisis in his first State of the Union.[29]

The federal government has taken steps to address this crisis. On March 24, 2022, U.S. Health and Human Services (HHS) Secretary Xavier Becerra and U.S. Education Department (ED) Secretary Miguel A. Cardona reaffirmed their commitment to children and youth by launching a joint-department effort to expand school-based health services.[30] Then on July 29, 2022, the HHS and ED issued a joint letter that announced a future guidance on free care policy and future policy initiatives on addressing the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) requirements in schools, directing resources to address youth suicide crisis, and providing more grants for school-based mental health services program.[31]

On August 18, 2022, as a part of its efforts to support President Biden's call to address the nation's youth mental health crisis, CMS, which is a part of HHS, announced three key actions to strengthen and expand access to high-quality, comprehensive health care for children across the country.[32] The three key actions included: (1) Reminding states of their mandate to cover behavioral health services for children in Medicaid and urging them to leverage every resource to strengthen mental health care for children; (2) Urging States to expand school-based health care for children, including mental health care; (3) Issuing a proposed rule that, for the first time ever, would require states to report certain quality measures to strengthen Medicaid and the Children's Health Insurance Program (CHIP) to ensure that the millions of children and families enrolled in these programs have access to the highest quality of care.[33] On November 10, 2022, HHS, through the Substance Abuse and Mental Health Services Administration (SAMHSA), released a new report, National Guidelines for Child and Youth Behavioral Health Crisis Care with guidance on how communities can address the existing gaps in care for youth.[34]

California youth mental health laws and policies

In 2021, California enacted several laws and policies to address the youth mental health crisis. Lawmakers enacted SB 428 to require all health plans that provide pediatric services to cover Adverse Childhood Experiences (ACEs) screenings and include ACE screening in preventative care, effective 2022.[35] AB 46 will create the California Youth Empowerment Act to engage youth directly with policymakers by establishing the California Youth Empowerment Commission—which consists of 25 voting commissioners between the ages of 14 to 25—in state government.[36] To promote mental health awareness and access in schools, AB 309 will require the California Department of Education (CDE) to develop model mental health referral protocols and make these protocols available for schools.[37] SB14 will allow students to take excused absences for mental health or behavioral health reasons, as well as to require the CDE to identify and recommend to districts best practices mental health training programs for their staff.[38] Additionally, SB 224 requires each school district and other educational institutions to offer one or more courses in health education on mental health to middle school and high school students before 2024.[39]

As part of the Budget Act of 2021, California began developing a multi-billion dollars, multiyear, and multi-department Children and Youth Behavioral Health Initiative (CYBHI) that seeks to reimagine the systems that support behavioral health for all California's children, youth, and their families.[40] One of the priorities of the CYBHI is to expand equitable access, with no wrong door for children, youth, and families by "making school-linked and school-based behavioral health services available for all."[41] The CYBHI includes a number of school-related efforts, such as: (1) Creating behavioral health coaches in schools by 2025, (2) Developing a statewide school-linked fee schedule and behavioral health provider network by 2024, and (3) Providing funding opportunities to increase capacity and partnerships between health plans, county behavioral health plans, community-based organizations, and schools to improve school-linked behavioral health services.[42] One funding opportunity is the Student Behavioral Health Incentive Program (SBHIP) that was created under AB 133 and led by the Department of Health Care Services (DHCS) to incentivize Medi-Cal Managed Care Plans to work with Local Education Agencies (LEAs) and county mental health plans.[43] The CYBHI also includes a Behavioral Health Virtual Services Platform that aims to provide free app-based behavioral health services to children, youth, and caregivers in California, regardless of insurance coverage.[44]

In addition to the CYBHI, in 2022, California continued to take legislative and administrative actions to promote youth mental health. On August 18, 2022, Governor Newsome announced a "Master Plan for Kids' Mental Health" that aims to ensure that youth can access support for behavioral health, including mental health, and substance use, where they are, including in their schools, homes and communities.[45] The plan includes several school related efforts, including: (1) Providing additional resources for schools to provide prevention and treatment, (2) Adding more school counselors and training for teachers, and (2) Creating a virtual platform to expand remote access to services. AB 58 will require schools to review and update their suicide prevention policies by 2025 and encourage districts to provide suicide awareness and prevention training to teachers in all grades by the 2024-2025 school year.[46] AB 748 will require each school site that serves grades 6 to 12 to create and display a poster that identifies approaches and share resources regarding student mental health before the start of the 2023-2024 school year.[47] Additionally, AB 2806 will prohibit suspension and expulsion in state preschool and childcare programs and strengthen early childhood mental health consultation (ECMHC) as a means of providing support to teachers, children, and families to promote positive mental health, buffer the effects of toxic stress and trauma, and bring out the most optimal development and learning of each child.[48]

III. SURVEY FINDINGS

From January 2022 to June 2022, I interviewed school administrators and mental health service providers from eight school districts across California. The eight school districts were selected because they had best practices in delivering tele mental health services, were interested in expanding their tele mental health services, or were identified as having "higher or highest needs" based on the California Student Health Index.[49] To ensure a representative sample, I included school districts from different regions (one from Northern California, two from Central California, and five from Southern California) and different areas (three rural and five urban counties). I also reviewed publicly available records and policies from additional school districts, as well as relevant guidance and resources.[50]

How are mental health services provided in California schools?

There are several ways mental health services are provided in California primary and secondary schools. These services may include school-based or school-linked services, which may be provided on or near a school site, via a community mobile van, or through telehealth. While some school districts provide mental health services through their school staff, school-based health centers, or local community-based mental health service providers, some districts provide mental health services through telehealth-only providers, County Mental Health Plans, or Medi-Cal Managed Care Plans.[51] More recently, more districts also started to implement Peer-to-Peer support programs.[52] These models are not mutually exclusive, as districts often utilize more than one model to maximize the services that are provided to their students.

What is Medi-Cal's Role in California's School-Based Mental Health Services?

In California, students may receive two different categories of services in schools: educational services and health care services. Educational services include special education and individualized education plan (IEP) services, which are mandated and provided through the Individuals with Disabilities Education Act.[53] Health care services may include mental health services and substance use disorder services and expand beyond what educational services offer.

School based or linked mental health services may be reimbursed through Medi-Cal, paid by private insurance, financed through school districts, or supported by other sources (such as grants or special funding like the COVID-19 relief funds).[54] Medi-Cal plays an important role in school-based mental health services, because it is a source of health care coverage for nearly 40% of children in California.[55] It is also a source of funding for many school-based programs and community-based organizations that serve students. Medi-Cal does not cover all school-

based mental health services (such as school-wide prevention and early intervention services), but it must cover comprehensive and medically necessary Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services for all Medi-Cal beneficiaries who are under the age of 21.[56]

How is telehealth used to provide mental health services in California schools?

Of the eight school districts I interviewed:

- **No** district utilized telehealth to provide mental health services prior to 2020.
- **Seven** districts utilized telehealth temporarily when the schools closed in March 2020 (due to the COVID-19 public health emergency).
- **One** district reported to pause mental health services completely when the schools closed in March 2020, due to the public health emergency order (restricting in-person services) and lack of technical resources ("when the pandemic hit in 2020, we did not even have electronic records").
- **All eight** districts resumed in-person mental health services after the schools resumed in-person operation.
- **Six** districts continued to utilize telehealth to provide mental health services through a hybrid case-by-case model after the schools resumed in-person operation (although the use of telehealth became very minimal for 4 districts).
- **One** district discontinued the use of telehealth after the schools resumed in-person operation, citing district policies (and had revised its contract with community-based organizations to reflect the restriction).

Some additional findings included:

- **Two** districts utilized telehealth-only mental health service providers to complement their existing services (a third district was in the process of initiating services by the same telehealth-only mental health service provider company).
- **One** district identified not having a designated space to utilize telehealth as a main barrier to effectively utilize telehealth to provide mental health services to students.
- **One** district reported occasionally using telephone (audio-only) modality to provide mental health services to students, while other districts reported to be using only video modality as a primary telehealth modality to provide mental health services (several interviewees did not know audio-only may be a telehealth modality to provide mental health services).
- **Most** districts that allowed telehealth to be conducted on school sites had designated navigators (usually school staff) to help students initiate the telehealth visits.
- **One** district reported that it initially delivered mental health services to students via telehealth with the students calling in from home and the clinicians calling in from a

different location. As school campuses opened back up, students started to request to do the telehealth sessions on school campus (with their therapists remaining off-site), because "a lot of times, their problems were at home and they didn't feel comfortable to talk about it when they were at home."

What are the benefits of utilizing telehealth to provide mental health services in schools?

There are many benefits of utilizing telehealth to provide mental health services in schools.

More ways to get help. For some districts, telehealth created an opportunity to engage and reach students who otherwise might not have received mental health care due to a variety of reasons, including the stigma associated with mental health. For example, one district in a mid-sized rural community where "everyone knows everyone" recently began utilizing a telehealth-only company to provide mental health services for their students. The district administrator shared that "many students are actually more comfortable talking with strangers through telehealth than someone they know in-person."

More opportunities to engage. Several districts identified telehealth as "a great tool to supplement students' unmet needs." Traditionally, when mental health services were provided in-person, they were mostly conducted on school sites during or near regular school hours. The use of telehealth has provided youth additional opportunities to receive mental health care outside of school campus and outside of regular school hours. The use of telehealth was also reported to offer caregivers – who otherwise and traditionally have not been able to due to work schedule, transportation, or other reasons – an additional opportunity to participate in their children's care plan. For example, one school district in a suburban "commuter community" shared that in the past, most of the parents and caregivers were never available to participate in their children's care plan due to their work schedule and long commute. Now, with the use of telehealth, parents and caregivers can engage through telephone or video.

A way to fill the service gap. Some districts reported that telehealth has helped address their staffing issue. Prior to the pandemic, teacher and mental health provider shortage had long been a standing issue in California.[57] The COVID-19 pandemic not only increased the demand for mental health care for children and youth, but also worsened the school staffing shortage, which had a further dire impact on student's mental health.[58] The use of telehealth or contracting with telehealth-only providers was reported by district staff informants to be useful in helping fill in the gaps that the school districts or local community-based mental health providers have struggled with for a long time.

What are the challenges and needs?

The interviewees shared some challenges and needs in providing mental health services to children and youth in California schools through telehealth.

Harder to build rapport. When the schools closed in-person instruction in March 2020 due to the COVID-19 public health emergency, most school districts pivoted to remote learning and using telehealth to deliver health care services to their students. Many districts not only suddenly had to navigate new technologies and policy changes, but also experienced additional challenges obtaining consent from caregivers, as many parents and caregivers (and some school staff and providers) expressed privacy concerns and questions about privacy and information sharing laws in schools and through telehealth.[59] For example, one district in a mid-sized suburban community shared that "building trust was difficult in a remote setting. When we came back in-person, our counselors could better leverage their relationships with parents to help them see the benefits of mental health services. It was much harder when we were remote." Some districts also experienced challenges keeping youth engaged in sessions. A district in an urban community shared that "telehealth was challenging for students as it was used during the beginning of covid when schools were also remote."

Inequitable access to telemental health. Because school-based and school-linked mental health service delivery vary greatly between counties, school districts, and individual schools, how telehealth is utilized and whether it is utilized in schools to deliver mental health services also vary significantly between counties, school districts, and individual schools. Currently, while most districts continue to allow tele mental health on a case by case basis, a few districts have limited or completely restricted the use of telehealth. One community-based mental health service provider (who contracted with a district that recently updated its contract to allow only in-person mental health services) shared its concern for students who need mental health care but might not be able to receive care in-person for reasons such as being absent from school due to illness, special needs, or disabilities.

Inequitable access to technical resources. An area of need is the lack of or inadequate technical resources. Although telehealth has and can help fill the gaps of existing mental health services, not every school district or families have the technology, devices, or broadband to take advantage of it. Broadband and technical resources are especially crucial for the use of video modality, which was most commonly used in the school setting compared to any other telehealth modalities. In fact, when asked if they utilized audio-only telehealth modality to deliver mental health care to students, several schools reported "no" and two schools did not know that telephone was a telehealth modality. Several interviewees shared that not having the device, access to broadband, or sufficient private space to conduct the telehealth session was a huge

barrier for some of the families ("imagine trying to use your parent's smartphone, which is the only phone in the house in a 5-person household in a one-bedroom apartment to talk to your therapist"). Many school districts have now transitioned back to mostly, if not all in-person mental health services, because of the technical difficulties and lack of broadband. One interviewee shared that "although schools value mental health programs and see telehealth as valuable, they are struggling because of limited resources."

Digital literacy and language access. Although telehealth was reported to be used in all ages, it was mostly used with middle school and high school students because of older youth's ability to navigate the technology on their own. For students (such as younger children and youth with special needs) who may require an adult or caregiver's assistance to access telehealth, digital literacy is sometimes a barrier for the caregivers as different providers might use different web platforms or different apps, which sometimes require complex steps to access the "meeting room." Also, many telehealth service platforms are not yet made available to people with disabilities or people with limited English proficiency. Students with disabilities, those who are English learners, or those who have parents or caregivers with limited English proficiency may have additional challenges accessing the digital platform or application.

IV. POLICY RECOMMENDATIONS

Based on the needs and challenges our community partners have experienced and shared, I identified the following five policy recommendations to improve California youth's access to mental health services.

1. Ensure students have access to mental health services via different modalities

Some of the challenges experienced in delivering tele mental health services to students arose from either not having adequate resources or not being allowed by school districts to provide children and youth mental health services through different modalities. How mental health services are delivered should be determined on a case by case basis between the clinician and the youth (and parents or caregivers, if applicable). Because every student's needs are different, restricting the use of telehealth can harm students who need services through alternative modalities and put the most at-risk students at a further disadvantage.

Recommended action steps:

- **For policy-makers and state agencies**: Require school districts to allow both in-person and telehealth (including audio-only and video) modalities be made available in all school-based and school-linked behavioral health settings.

- **For school districts that currently do not allow the use of telehealth to deliver mental health services**: Evaluate the pros and cons of the use of tele mental health in school-based or linked services for students and offer alternative solutions to address any concerns with the use of telehealth.

2. Ensure students have access to broadband and technical resources in schools and communities

Nearly all schools have now returned to full-time in-person instruction. However, the need to use technology to access educational and health care services remains. The pandemic not only taught us the importance of ensuring flexibility in our educational and health care service delivery, but also reminded us of the need to ensure equitable access to resources in schools and communities so families may access educational, health care, and other resources. Setting clear guidance and policies to allow the use of educational devices for mental health care purposes can reduce confusion or misunderstanding. It will also make it easier for school administration or technical support teams to assist students with accessing telehealth service applications or programs on school-issued devices.) As California prepares for a post-PHE environment, ensuring equitable access to digital resources for all schools remains necessary, if not more crucial than before and during the PHE.

Recommended action steps:

- **For policy-makers and state agencies**: Create a statewide broadband needs map based on school districts (using the California School Student Health Index and the Statewide Construction Evaluation Map as bases) to ensure that certain school districts are not left out of the Middle-Mile Broadband Network, a statewide broadband network that is currently in the works to bring equitable high-speed broadband services to all Californians.[60]
- **For school districts that issue digital devices to students**: Examine existing policies for the use of district or school-issued digital devices and revise policy language as needed to allow for devices that are issued for educational purposes to also be used for health care purposes.
- **For all school districts**: Utilize existing federal telehealth resources, such as the Telehealth.hhs.gov website and the Affordable Connectivity Program (ACP), a federal program that provides eligible households financial assistance toward internet services and purchase of equipment.[61] Currently, even though 45% California households are eligible for the ACP program, only 30% are enrolled.[62] Helping students tap into existing federal resources will allow school districts to expand their current capacity.

3. Utilize community-based, peer-to-peer, and other existing resources

When developing and creating state-wide programs or policies, it is essential to build upon existing resources and community knowledge and not to create new programs that are siloed..[63] It is also important to involve youth, families, schools, and community-based providers in program development, implementation, and policy making, because they who know best what their needs are and what service barriers they face. Additionally, community-based and peer resources can help provide education and training (such as digital literacy), as well as combat misinformation in the community.

Recommended action steps:

- **For policy-makers and state agencies**: Engage with policy experts and large organizations, as well as smaller community-based organizations, youth-led or focused organizations, and individual consumers with lived experiences to identify service needs, gaps, and barriers.[64] Bringing in those who traditionally have not had a chance to make their voices heard and might not be familiar with policy work because of lack of opportunities or awareness can help make sure that diverse community and youth voices are represented.
- **For policy-makers and state agencies**: Invest in more peer-to-peer pilot programs in middle schools and high schools through collaborating with community-based service organizations and expanding criteria for existing Medi-Cal programs, such as Peer Support Specialist and community health workers.[65] For example, California currently covers Peer Support Services as a Medi-Cal benefit, but it requires that all specialists must be over the age of 18.[66] Many young people (such as middle school aged children) may benefit from receiving peer support services from another youth who is closer to their age (such as high school-aged youth) and under 18.[67]
- **For school districts**: Create more youth-led peer-to-peer support and mentorship programs through the CYBHI.
- **For school districts that are looking to maximize their mental health services through telehealth**: Consider adding telehealth-only providers or other collaborative to their network of support.[68]

4. Provide easy-to-access resources and technical assistance

Resources are only helpful if people access them. It's important to have easy-to-access resources and technical assistance that even smaller community-based organizations may understand and utilize. It is also important to have resources that are collaborative. Partnerships and collaborations between schools, providers, and health plans are not only important but also

necessary to ensure continuum of care and quality services for children and family in the school settings.

Recommended action steps:

- **For state agencies, such as DHCS, CDE, and Department of Social Services (CDSS):** Compile, jointly publish, and regularly update a centralized list of funding resources and grant opportunities for school districts and community-based organizations that provide school-based or school-linked behavioral health services. The list should include both educational and Medicaid funding, as well as other health-based sources. Some examples include the funding list published by the CDE, the funding guide created by the CDSS, and the funding chart updated by the California School-Based Health Alliance.[69] These state agencies should also set up regular virtual "office hours" or educational webinars to provide technical assistance on grant writings and funding applications.
- **For California Department of Human and Health Services and its departments:** Regularly publish mental health services data reports (that are integrated and cross-reported with Medi-Cal, foster care, and justice involved populations data) that are easy to understand and accessible by the public.
- **For California Department of Human and Health Services and its departments:** Publish a resource list that includes California specific school-based health services resources (similar to the resource list the U.S. Department of Health and Human Services published in 2022) and update it annually.[70]

ENDNOTES

[1] PRB, KidsData: Children's Emotional Health in California in 2020, https://www.kidsdata.org/export/pdf?cat=68#:~:text=According%20to%202016%2D2020%20estimates,at%20the%20time%20of%20survey (last visited Jan. 24, 2023).
[2] The Children's Partnership, *COVID-19 Intensified Pre-Existing Mental Health Crisis for Children* (2021), https://childrenspartnership.org/wp-content/uploads/2021/10/Covid-Childrens-Mental-Health-Ver.6-2021.pdf; *see also* Isabelle Lina de Laia Almeida et al., *Social isolation and its impact on child and adolescent development: a systematic review*, Rev Paul Pediatr. 2022; 40: e2020385 (Oct 4, 2021), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8543788/#:~:text=Social%20isolation%20leads%20to%20higher,after%20the%20COVID%2D19%20pandemic; *see also* Harvard University et al., *COVID-19 Associated Orphanhood and Caregiver Death in the United States*, https://imperialcollegelondon.github.io/orphanhood_USA/ (last visited Jan. 24, 2022).
[3] *See* Cal. Dep't of Public Health, *California Suicide and Self Harm Trends in 2020* (2020), https://www.cdph.ca.gov/Programs/CCDPHP/DCDIC/SACB/CDPH%20Document%20Library/Suicide%20Prevention%20Program/SuicideAndSelfHarmIn2020-DataBrief-ADA.pdf; *see also* PRB, KidsData: Hospitalizations for Mental Health Issues by Age Group in 2020, https://www.kidsdata.org/topic/715/mental-health-hospitalizations-age/table#fmt=2342&loc=2,127,1658,1659,331,1660,171,1661,357,369,362,360,1662,364,356,217,354,1663,339,365,343,367,344,366,368,265,349,361,4,273,59,370,326,1772,341,338,350,342,359,363,340,335&tf=110&ch=1309,446,1137&sortColumnId=0&sortType=asc (last visited Jan. 24, 2023).
[4] PRB, KidsData: Concerns for Children's Emotional or Mental Health in Past Month in 2021, https://www.kidsdata.org/topic/2408/covid19-emotional-concern/pie?utm_source=newsletter&utm_medium=email&utm_content=https%3A//emma-assets.s3.amazonaws.com/59lfb/431de3b8a71a779eb19f6325bc178c9c/2021.11.02_mental_health.jpg&utm_campaign=2021.11.02_KD%20News_Final_Mental%20Health#fmt=2960&loc=2&tf=152&ch=1586,1588,1589,1587&pdist=219 (last visited Jan. 24, 2023).
[5] HHS Health Res. & Serv. Admin. ("HRSA"), *What is Telehealth?,* https://telehealth.hhs.gov/patients/understanding-telehealth/ (last visited Jan. 24, 2023).
[6] Synchronous care is a "real time interaction for patient health communication," which may include video calls to share progress or check on healing, audio-only calls to confirm instructions, and text messaging to answer patient questions. Asynchronous is communication between providers, patients, and caregivers stored for future reference or response. Examples may include emails or text messages with follow-up instructions or confirmations, images for evaluation, and lab results or vital statistics. Remote patient monitoring consists of transmitting and storing patient data and clinical measurements from in-home devices to patient portals. Data examples may include: blood pressure monitors, pacemakers, glucose meters, and oximeters. Mobile Health is also known as mhealth. *See* HHS HRSA, *Getting Started with Telehealth*, https://www.telehealth.hhs.gov/providers/getting-started/ (last visited Jan. 24, 2023).

[7] Zara Abrams, Am. Psychological Ass'n., *How well is telepsychology working?* (July 1, 2020), https://www.apa.org/monitor/2020/07/cover-telepsychology.
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