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Vivian J. White

has been found to be complete and satisfactory in all respects,
and that any and all revisions required by
the review committee have been made.

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Walden University
2025

Executive Summary: Clinical Practice Guideline

Telepsychiatry for Veterans Who Are Homeless

by

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Executive Summary Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Nursing Practice

Walden University

November 2025

Summary

This project was a clinical practice guideline (CPG) for mental health providers to expand telepsychiatry services to veterans who are homeless in a day treatment center. The practice problem was the lack of a standardized approach to increase access to mental health care. This CPG supports nurses in implementing evidence-based interventions to reduce mental health disparities and promote equitable care delivery for veterans who are homeless. The guideline was aimed to ensure safe, effective, and coordinated mental health care through integration with interprofessional teams. The project question was: Does the evidence support development of a CPG for provision of telepsychiatry services for veterans who are homeless that receives a quality score using the Appraisal of Guidelines for Research and Evaluation II (AGREE II) instrument and is approved for use in the practice setting by end users? The purpose of this project was to develop a CPG for providers on use of telepsychiatry to improve mental health care delivery for veterans who are homeless. I used the Johns Hopkins evidence-based model to collect, organize, and analyze the 22 items of evidence that supported this project. An expert panel evaluated the quality of the CPG across six domains using the AGREE II instrument. Domain scores from the two members of the expert panel ranged from 94.4% to 100%, resulting in a high-quality score. The global assessment scores were 97.4% and 96.4%, confirming high methodological quality and recommendation for use without modification. The development of a CPG for telepsychiatry enhances access to equitable, evidence-based mental health care for veterans who are homeless at the project site. This project contributes to reducing mental health disparities, promoting health equity, and advancing social justice for vulnerable and marginalized populations.

Background

There was a significant gap in access to mental health care for the veteran who are homeless at the project site, which contributes to untreated mental health conditions, worsening daily functioning, and declining overall health. The problem focused on in this project was the insufficient access to mental health services to meet the psychiatric needs of vulnerable veteran who are homeless (see U.S. Department of Veteran Affairs [VA], 2023). Without innovative delivery models, such as telepsychiatry, this gap will persist, leading to ongoing disparities in mental health outcomes. The project question was: Does the evidence support development of a CPG for provision of telepsychiatry services for veterans who are homeless that receives a quality AGREE II score and is approved for use in the practice setting by end users? The purpose of this project was to address the lack of access to psychiatric care by developing a CPG that supports the use of telepsychiatry services. Guided by the Johns Hopkins evidence-based practice model (Dang et al., 2022), I developed a CPG and appraised it using the AGREE II tool. In a structured literature review, I identified 22 peer-reviewed studies supporting telepsychiatry as a feasible and effective intervention for veterans' mental health care (see Mazziotti & Rutigliano, 2021). Across systematic reviews and randomized controlled trials, evidence consistently demonstrated that telepsychiatry yields outcomes comparable to in-person care (Slightham et al., 2022). Findings highlight improved access, reduced transportation barriers, and high patient satisfaction, underscoring telepsychiatry role in promoting equitable care delivery (Slightham et al., 2022). Strong evidence supports telepsychiatry as a safe, cost-effective, and scalable approach that improves appointment adherence, reduces emergency room visits, and enhances

treatment engagement among vulnerable and rural populations (Mazziotti & Rutigliano, 2021; Slightham et al., 2022). The VA (2023) endorsed telehealth as a reliable method for reaching veterans in remote or resource-limited settings, supported by federal implementation models and large-scale studies (Slightham et al., 2022; Smelson et al., 2019). Overall, evidence supporting this telepsychiatry CPG is grounded in high-quality research, particularly randomized controlled trials and systematic reviews with additional insights from Level II and Level III studies addressing feasibility, patient experienced, and implementation outcomes.

The VA (2020) has led national efforts to expand telehealth, reporting high patient satisfaction and improved access among rural and veterans who are homeless. Given this strong and growing evidence base, implementing a telepsychiatry CPG at the project site was both timely and aligned with national best practices. This intervention has the potential to reduce disparities in mental health care and ensure that vulnerable veterans receive consistent, high-quality psychiatric support.

CPG Development

This CPG was developed to promote equitable access and consistent delivery of high-quality psychiatric care for veterans. I systematically developed the CPG with the collaboration of licensed professionals in an effort to build on the mutual goals of reducing disparities in mental health care. The expert panel included two licensed clinical social workers (LCSWs) with a combined 25 years of experience working with veterans. One member was a doctorally educated social worker serving as site director for the facility. The second expert holds a masters degree in social work and serves as the facility's director of housing placement. Both are skilled in direct care and care

coordination. I chose them to be on the expert panel because they are proficient using video technology to deliver trauma-informed care, including cultural competence for the veteran populations, suicide prevention, and crisis management. Each of these professional individuals was selected based on their experience, which includes evaluation of mental health symptoms, psychosocial stressors, substance use, and safety/risk (e.g. suicidality, abuse, neglect). They are specifically educated to develop individualized treatment plans with measurable goals and coordinate housing, financial, or legal support. They make referrals for crisis management and advocate for social needs, like housing education and criminal justice. These individuals ensure confidentiality and Health Insurance Portability and Accountability Act compliance in a holistic, interdisciplinary team-based approach.

The AGREE II tool is a standardized instrument designed to assess the quality and methodological rigor of CPGs (AGREE Tool Consortium, 2009). The review process involves structured steps, including independent scoring and consensus, typically carried out by two to four appraisers to ensure it meets criteria for evidence-based practice, usability, and clinical relevance. The AGREE II tool is used to assess the quality of CPGs, specifically how well they are developed and reported as well as whether they are suitable for implementation in clinical practice (AGREE Tool Consortium, 2009). The AGREE II tool is scored by having two or more appraisers independently rate 23 items (1= *strongly disagree*, 7= *strongly agree*). Domain scores are calculated using a standardized formula to produce a percentage, allowing comparison across guidelines. After scoring, reviewers discuss any major differences to reach consensus. Based on the

domain scores and overall quality, the guideline is rated as recommended, recommended with modifications, or not recommended (The AGREE Tool Consortium, 2009).

To ensure a rigorous and transparent process in the development and appraisal of the CPG, I convened an in-person meeting with the two-member expert panel on-site at the project facility. The purpose of this meeting was to review the CPG draft and the AGREE II instrument instructions, which served as the standardized framework for guideline evaluation. The panel was provided with an opportunity to clarify the project objectives, outline the evaluation procedures, and address any questions or concerns from the panel members. Following this meeting, I allotted each expert panel member a 2-week period to independently complete the AGREE II appraisal. Upon completion, the finalized assessments were analyzed and submitted back to me via email.

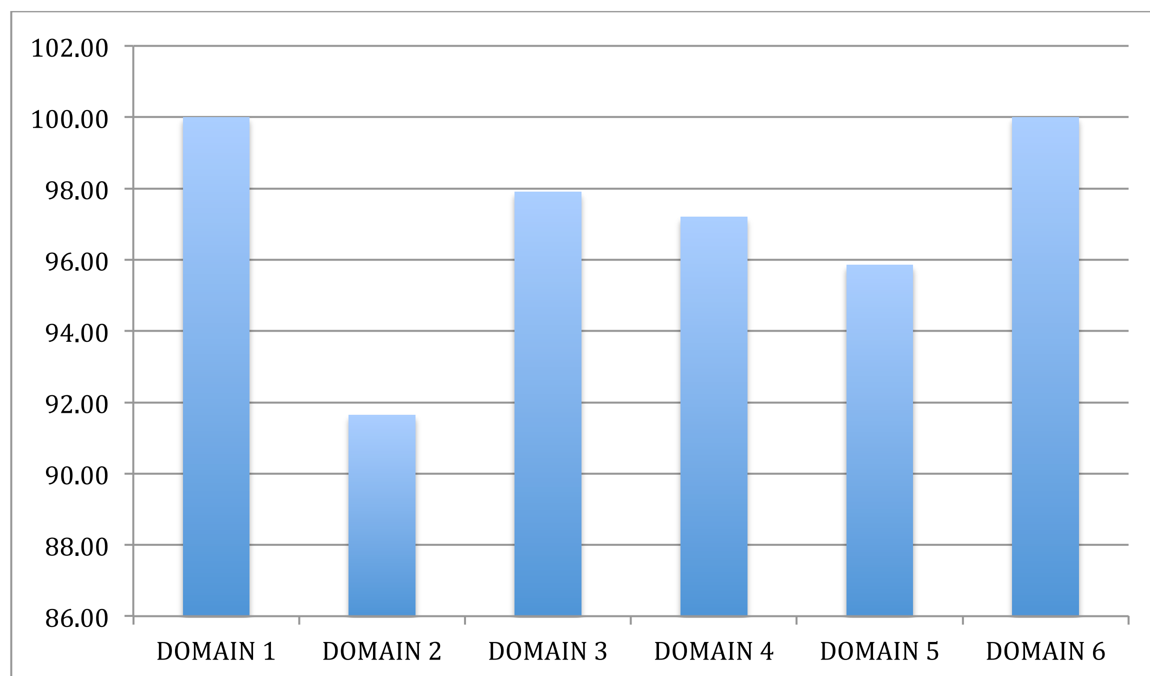
Results

The expert panel's AGREE II appraisal confirmed the guideline's overall high-quality and recommendations for use underscoring its relevance for nursing and its potential to guide effective, culturally responsive, veteran-centered implementation The AGREE II domain of scope and development achieved the highest rated score of 100%, while stakeholder involvement scored 91.65%, rigor of development scored 97.9%, clarity of presentation scored 97.2%, applicability scored 95.85%, and editorial independence scored 100%. All six domains exceeded the required 70%, demonstrating a high-quality CPG. The panel members' global assessment scores were 97.4% and 96.4%. Both appraisers independently recommended the guideline for use without modifications. The appraisers found the guideline to be comprehensive, valid, and implementable. There were no major concerns requiring revisions or additional

clarification. This consistency supports the reliability of the appraisal and the robustness of the CPG. Although the domains of rigor of development and applicability received slightly lower, yet still strong scores, all domain ratings exceeded the acceptable quality threshold of 70%. Both appraisers noted that while the guideline demonstrates high methodological quality, achieving buy-in from some clinicians may require additional engagement or implementation support. The AGREE II appraisal demonstrated consistently strong ratings across all domains, confirming the guideline's methodological rigor and clinical relevance. Domain and global scores are shown in Figure 1.

Figure 1

Domain Scores



The potential impact of adoption of this CPG includes increased access for veterans to receive timely evaluations and follow ups through video-based visits. Improved engagement helps reduce barriers to care, including stigma and housing

instability while also decreasing emergency department use by preventing crisis-driven visits through early intervention and routine management (Dixon et al., 2016). This project's CPG was aimed to reduce emergency department use by preventing crisis-driven care and by supporting early intervention and routine management. Telepsychiatry is cost effective because it utilizes existing VA infrastructure to deliver high-impact care without large financial investments. This project was aimed to foster multidisciplinary coordination by enhancing team-based care among LCSWs, advanced practice registered nurses, psychiatric mental health nurse practitioners, and psychiatrists. The CPG promotes connections to VA shelters, case management, and transitional housing as well as reflects VA (n.d.) strategic priorities and evidence-based telehealth practices.

Limitations that were identified during the AGREE II appraisal that influenced the domain scores, including those in the rigor of development domain, suggest incomplete descriptions of systematic evidence search methods, appraisal processes, and explicit links between some recommendations and supporting evidence. Certain barriers, such as inconsistent access to technology, lack of private spaces, and variable digital literacy among the veterans, may affect real-world application of telepsychiatry. It is important to acknowledge reviewer subjectivity because AGREE II scoring relies on appraiser interpretation of the guideline text; this may explain minor differences observed between the appraisers' ratings. Despite these limitations, the appraisers produced consistently high scores across domains, and the guideline was ultimately recommended for use without modifications.

The telepsychiatry CPG developed for this project can be a scalable, replicable model for other VA facilities, particularly those in rural areas or urban centers facing

staffing shortages and high patient demand. The protocol provides a structured, evidence-based approach that can be adapted across various contexts to meet local needs while maintaining quality and consistency. According to the VA (2023), part of its strategic modernization efforts includes the expansion of telehealth services. This project aligns directly with national VA priorities focused on increasing access, improving health equity, and optimizing care delivery through innovation. Successful implementation at the project site strengthens the case for broader system wide adoption. This CPG also reflects broader national goals related to health equity, digital health, and behavioral integration (see Slightham et al, 2022). Lessons learned from this project can inform policy decisions, funding models, and workforce training in public and private mental health systems beyond the VA.

Conclusions

This project positively impacts the project site organization through provision of an evidence-based framework to support veterans who are homeless by strengthening nursing practice through trauma-informed, culturally responsive care. The project may enhance access to psychiatric services; reduce health disparities; and promote equitable, veteran-centered care. The initiative affirms the dignity of marginalized veterans and advances social change, justice, advocacy, and interdisciplinary collaboration. My recommendations from this project include implementing the telepsychiatry CPG at the project site to improve access to mental health care, streamline workflows, and support evidence-based practice. This may reduce barriers for underserved veterans, promote provider confidence through clear protocols, and decrease reliance on emergency services. A VA evidence brief concluded that most available studies for telehealth-

delivered mental health care indicate that it is similar and is as safe and effective as in-person care for prevalent conditions (i.e., depression, posttraumatic stress disorder, anxiety, substance use disorder), while noting that this does support local standards with use of a CPG (Beech et al., 2022).

The model is scalable across other similar project site facilities and aligns with national goals for equitable, high-quality, and technology-driven care. Implementation within the organization is expected to strengthen evidence-based practice, improve veteran outcomes, and enhance provider confidence in delivering standardized high-quality care (see VA, 2023). The implementation of a telepsychiatry guideline at the project site has system-wide relevance. The project presents a sustainable, evidence-based strategy for transforming mental health care delivery not only for one VA facility but also for veteran populations nationwide and potentially for broader health care systems committed to equitable accessible care.

Additional recommendations include integrating technology support services because many veterans, especially those who are older or unhoused, may face difficulties with digital access. The VA should consider offering technology support, such as device lending programs, digital literacy training, or telehealth kiosks within the project site and other transitional housing facilities.

The development and implementation of this CPG provides a structured, evidence-based framework to expand telepsychiatry services for veterans who are homeless. The CPG equips nurses with the tools to enhance clinical judgment, strengthen professional autonomy, and improve the quality and continuity of patient care (see Dang et al., 2022).

This telepsychiatry CPG was systematically evaluated using the AGREE II instrument to determine its methodological quality, clarity, applicability and alignment with evidence-based nursing standards for improving equitable mental health care among veterans who are homeless. Using the AGREE II appraisal tool, two independent reviewers evaluated the telepsychiatry CPG for quality. The guideline demonstrated consistently high quality across all six AGREE II domains, with particularly strong scores in the domains of scope and purpose, rigor of development, clarity of presentation, applicability, and editorial independence. These findings support the overall strength and credibility of the developed CPG, building on the foundation that discusses the implications of implementing telepsychiatry at this project site for veterans who are homeless and its potential to improve access, equity, and mental health outcomes in this vulnerable population.

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Appendix: Clinical Practice Guideline: Telepsychiatry for Veterans Who Are Homeless

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June 2024

Doctor of Nursing Practice Project

Introduction

The expected benefits of this clinical practice guideline (CPG) is to educate the clinical providers at the Day Treatment Center about evidence-based practices to increase access to mental health services via utilizing the already established telepsychiatry services provided by the Department of Veteran Affairs (VA). This clinical practice guideline serves the providers and benefits the veterans by teaching the importance of using video guided electronic devices to help understand veterans and gain access to medication management, refills, and follow up clinical evaluations when transportation to the clinic is not an option. Currently, the veterans at the Day Treatment Center have access to an in-person mental health provider one day per week. This CPG provides evidence and guidance for creating telepsychiatry services for those veterans who cannot travel to the clinic for in-person care, so that they have equitable access to mental health care services. CPG can serve as a structured tool to advocate for, implement, and standardize telepsychiatry services, because it is a cost-effective, scalable intervention that can help refine services and increase access to mental health services for veterans. Currently the Day Treatment Center does not offer these services; thereby this is a means to provide timely and consistent psychiatric care to veterans who are homeless and reduce ER visits, hospitalization and symptom burden (DiCarlo et al., 2021). The use of telepsychiatry can improve retention and engagement in mental health services; capture veterans who are homeless, diagnosed with suspected mental health or substance use disorders. It can also help increase access to veterans in transitional housing, VA shelters

or community-based settings. In order to accomplish these goals coordination with LCSW, APRNs, and Psychiatrist at the VA Mental Health Clinic is vital.

Background

There is insufficient access to mental health care for veterans at the Day Treatment Center. Lack of access can cause veterans to have untreated mental health problems, leading to worsening of daily functioning and overall health. The purpose of this guideline is to demonstrate the feasibility of extending telepsychiatry services to the veterans who visit the Day Treatment Center (DTC).

Intended Audience

This clinical practice guideline is intended be guidance for conducting telepsychiatry services by staff members to include Licensed Clinical Social Workers (LCSW), psychiatrist (MD), and the advanced practice registered nurse (APRN) who is employed to care for these veterans daily.

How to Use this CPG

This clinical practice guideline regarding increasing mental health care to veterans who are homeless using telepsychiatry and is intended to help expand the use of telepsychiatry in the care of veterans who are homeless by providing guidance to mental health care providers. This provides recommendation for the various applications of telepsychiatry and includes detailed information about the implementation of specific modalities, such as clinical video technology via smartphones I Pads, computers and laptops (Batastini, 2021).

This Clinical Practice Guideline (CPG) is designed to provide best practices for providers to utilize telepsychiatry to increase access to mental health care to veterans who

are homeless. This guideline is intended to help expand the use of telepsychiatry in the care of veterans who are homeless by providing guidance to mental health care providers. This guideline provides recommendation for the various applications of telepsychiatry and includes detailed information about the application of devices using video conferencing using video technology via smartphones, I Pads, computers and laptops (Batastini, 2021) in a reproducible way to benefit veteran who are homeless who visit the day treatment center. This guideline is intended for mental healthcare providers who work with veterans who are homeless, as well as policy makers and leaders in the Veterans Administration (VA) who are able to support and expand the use of telepsychiatry in the homeless veteran population. The Department of Veteran Affairs (VA) and the U.S. Department of Housing and Urban Development-VA Supportive Housing (HUD-VASH) has a strategic priority and partnership to end homelessness among veterans and is committed to ensuring that all veterans have access to the care and services they need to obtain and maintain safe and stable housing and healthcare (Department of Veteran Affairs, 2023). VA and HUD-VASH knows that many veterans who are homeless have complex healthcare needs, and that the general health and mental health problems of the veteran who are homeless tend to be more severe than those of housed veterans (Department of Veteran Affairs, 2023). Veterans who are homeless often do not have access to in person mental health care, which results in missed appointments, which ultimately leads to veterans becoming disengaged with care. Telepsychiatry can increase access to care for veterans who are homeless, and in some instances can be an alternative to in-person care, which can be an acceptable and effective form of care (Batastini, 2021).

This guideline for the use of telepsychiatry that is intended to inform the practice of the clinical providers who work with veterans who are homeless at the Day Treatment Center. The primary goal is to improve the access to care for veteran who are homeless who may have mental illness whether diagnosed or undiagnosed. This is to be accomplished by a simplification of the process of the implementation of telepsychiatry and a standardization to ensure that it is only used in an appropriate manner (Moreno-Poyato, 2021). To simply the process, this CPG has been developed to aid the clinical providers at the Day Treatment Center to determine whether a veteran is an appropriate candidate to receive telepsychiatry services, and if so to schedule the patient for a visit. The CPG is aimed at guiding clinical providers to provide the best care possible for veterans who are homeless, while minimizing additional workload to the staff. Throughout the development of this CPG, the focus has remained on the welfare of the veteran. When it comes to technology, it is often easy to get caught up in the exciting new developments and implementations of said technology (Di Carlo, 2020). However, it is critical to remember that the purpose of technology in this context neither is nor for the sake of technology itself, but for its usefulness to the practitioner to improve the mental health needs of the veterans.

Scope of the Clinical Practice Guideline

This Clinical Practice Guideline serves to inform the clinical providers/practitioners who are providing care for veterans who are homeless or possibly facing homelessness, using telepsychiatry services. The guideline is intended to inform clinical practice and is not intended to replace a provider's judgment, the suggestions in this guideline will be tailored to increase access to veterans who are homeless or those at

risk of becoming homeless. It is hoped that use of these guidelines will give this veteran increased access to a psychiatrist or psychiatric mental health nurse practitioner for diagnosis, baseline labs, medication management and other mental healthcare needs.

Target Audience

This guideline is intended for providers to enhance the access to quality mental health care for veterans who are homeless through the use of telepsychiatry. For the purposes of this document, telepsychiatry is a branch of telemedicine through the use of electronic and digital information and communication technologies to support long-distance (rural) mental health care, patient and professional health-related education, veteran health and wellbeing (Sharma & Devan, 2023). This refers to technologies that enable mental health practitioners to provide service to veterans remotely using synchronized or asynchronous telecommunications (O'Keefe et al., 2021). The focus on telepsychiatry for veterans who are homeless is a result of several interconnected factors (DeLaCruz-Jiron, 2023). The homeless have unique problems when it comes to health care services; they are underserved with both mental and physical needs (DeLaCruz-Jiron, 2023). VHA has been successful in improving care for veterans who are homeless through its outreach programs like the Day Treatment Center and other community-based outpatient clinics (CBOC). There still exist many veterans who are homeless who do not have access to the CBOC's due to lack of resources, distance and transportation.

Methods

A systematic literature search was conducted to identify relevant studies related to telemedicine and veterans who are homeless. Inclusion criterion was peer-reviewed articles, published in English and addressed mental illness, veterans, housing,

homelessness and interventions. Exclusion criteria included abstracts, commentaries and studies that were not full text. A literature review was conducted in three databases (Cochrane Library, PubMed and PsycINFO) using several MESH terms. I identified twenty-two articles eligible articles that concluded with the following themes:

- Patient satisfaction
- Access for veterans who are homeless to telemedicine
- Transportation/rural mental health access
- Diagnostic reliability
- Effectiveness of telepsychiatry

Twelve articles of these articles dated between 2022 and 2024 were derived from a methodologically rigorous review of the best evidence and were used for this guideline (Mazziotti, R., & Rutigliano, G., 2021). A systematic review of multiple randomized controlled trials shows that telepsychiatry is equally effective as in-person care for treating veterans with mental health disorders (Hagi et al., 2023). A systematic review of 5 randomized controlled trials comparing telepsychiatry and in-person therapy for PTSD in veterans (Sharma & Devan, 2023). These studies were high level because they synthesized multiple high-quality studies with critical appraisal, increasing generalizability. A level II Randomized controlled trial evaluated the effectiveness of telepsychiatry-delivered cognitive behavioral therapy (CBT) for veterans with depression (Romijn et al., 2019). Several Level III articles, which were quasi-experimental studies, compared veterans receiving telepsychiatry vs. those receiving standard care at different clinics (Solimini et al., 2021).

The John Hopkins Research Evidence Appraisal tool (see appendix) was utilized to conduct a literature search for evidence to support this project. Robust inclusion and exclusion criteria were formulated to assist in identifying what evidence supported the project The project would require updates every 3 years to keep up with the changes in clinical practice and the guideline should be updated by the clinical staff at the clinic. There is a need for clinicians to have professional guidance or education in the use of telemedicine technology in order to prevent this technology becoming a burden instead of an asset to help veterans who are homeless. The development of CPG serves as a useful tool to guide this education.

To develop these recommendations the AGREE II tool was utilized. An expert panel was identified and will use the AGREE II tool to evaluate the validity of the CPG. The expert panel will consist of 3: one Clinic Director, and one psychiatric mental health provider, and one advanced practice registered nurse. The expert panel was chosen based on years of experienced and their individual expertise and knowledge of the wide range of services available for veterans. The Clinic Director is also a LCSW these roles involve case management who identifies and assesses any potential barriers to care for the veteran and then intervenes to help provide access to mental health services to optimize the care and treatment of the veteran. The advanced practice registered nurse focuses on the design, implementation, management and evaluation of programs to meet the mental health needs of the veterans, including those with serious mental health illnesses and co-occurring substance use disorders.

This clinical practice guideline will be evaluated using the Appraisal of Guidelines for Research & Evaluation instrument (AGREE II) to assess the

methodological rigor and transparency in which this was developed (The AGREE Next Steps Consortium, 2017, Part II: I). AGREE II is valid and reliable because it was systematically developed, psychometrically tested, widely endorsed by organizations like the World Health Organization (WHO) and consistently used in research and clinical settings. It was developed by an international group of researchers and guideline developers that met in a consortium. It is a 23-item tool comprising 6 quality domains and 2 overall assessments developed to assess the quality and rigor of CPG's. This clinical practice guideline will be evaluated using the Appraisal of Guidelines for Research & Evaluation instrument (AGREE II) to assess the methodological rigor and transparency in which this was developed (The AGREE Next Steps Consortium, 2017, Part II:I). It is a 23-item tool comprising 6 quality domains and 2 overall assessments developed to assess the quality and rigor of CPG's. Guideline developers, researchers, policy makers, health administrators, program managers, and others interested in the development of a clinical practice guideline to test the validity and the quality of a practice guideline use this tool.

The Domains include:

Domain 1- Scope and purpose (*concerned with the overall aim of the guideline, the specific health questions and the target population items 1-3)*,

Domain 2-Stakeholder involvement (*focuses on the extent to which the guideline was developed by the appropriate stakeholders and represents the views of its intended users, items 4-6*),

Domain 3-Rigour of development (*relates to the process used to gather and synthesize the evidence, the methods to formulate the recommendations, and to update them items 7-14*),

Domain 4-Clarity of presentation (*deals with the language, structure, and format of the guideline items 15-17)*,

Domain 5-Applicability (*pertains to the likely barriers and facilitators to implementation, strategies to improve uptake, and resource implications of applying the guideline items 18-21*)

Domain 6-Editorial independence (*is concerned with the formulation of recommendations not being unduly biased with completing interests items 22-23)*.

1 Strongly Disagree	2	3	4	5	6	7 Strongly Agree

How to Score with the AGREE II Tool

The AGREE II tool assesses the quality of clinical practice guidelines across 23 specific items (as explained above), organized into 6 domains. You rate each item based on how well the guideline addresses it.

Step 1: Read the Guideline Carefully

- Before scoring, read the entire guideline and supporting materials to fully understand its content and methods.

Step 2: Rate each Item

- Each item is scored individually on a 7-point scale:

- 1= Strongly Disagree (no or very poor information)
- 7= Strongly Agree (exceptional quality, meets all criteria)
- 2-6=Partial Agreement, depending on how well the item is addressed.

Step 3: Understand the Criteria for Each Item

- Each item describes a specific feature of quality (e.g. stakeholder involvement, clarity of presentation).
- You must decide the score based on:
- Presence of relevant information
- Quality of the reporting.
- Completeness of addressing the item.

Step 4: Domain Scores

- After scoring all items individually, group them by domain:
- For example, Domain 1: “Scope and Purpose has 3 items>
- For each domain:
- Sum the scores for all items in the domain.

Step 5: Make an Overall Assessment

- At the end, you make an Overall Assessment:
- Rate the overall quality of the guideline (also on a 1-7 scale).
- Recommend:
- Yes
- Yes, with modifications
- NO

Ideally, two or more people independently score the guideline. After scoring, compare and discuss discrepancies to improve reliability of the clinical practice guideline.

Evidence for Practice

A study by Slightham et al, (2022) identified significant barriers veterans face in accessing care, including transportation challenges, co-occurring health issues**,** personal commitments, and discomfort at VA facilities. Consequently many veterans demonstrated a clear preference for telemedicine over in-person services. Additionally six studies emphasized the critical role telepsychiatry can play in supporting the broader homeless population. Empirical evidence from Battasini et al., (2021) highlighted how recent legislative efforts have facilitated the expansion of telehealth technologies across state lines, transforming remote service delivery methods such as videoconferencing. Theses finding support the potential for the Day Treatment Center and its staff to adopt telepsychiatry as an effective model of care. Moreover, research into digital mental health interventions further suggests that telepsychiatry holds strong promise for improving access to mental health services overall (Vial et al., 2022).

Research identifies several key barriers that individuals like veterans experiencing homelessness face when trying to access mental health services. These include stigmatization and the difficulty of managing daily tasks required for self-care (De La Cruz et al., 2023). Additionally, the instability associated with homelessness often disrupts individuals' ability to maintain consistent contact with healthcare providers, family, and support networks. Several studies have also pointed to the growing role of technology-based treatment options as a successful means of reaching individuals wit limited access to traditional care (De La Cruz et al., 2023). Surprisingly research suggests

that many people including veterans have access to technology, which opens new avenues for mental health interventions including the use of telepsychiatry, which could lead to better mental health outcomes.

Three studies in the examined research provide evidence about how telepsychiatry not only reduces the impact of stigmatization but also addresses the frequent missed opportunities to provide care to veterans who are homeless with mental health needs. It enhances traditional, in-person mental health services by optimizing care delivery in ways that are more accessible, sustainable, and effective for this vulnerable population.

Recommendations

It is recommended to extend the existing telepsychiatry services provided by the Department of Veteran Affairs mental health clinic to the Day Treatment Center, leveraging technology to enhance access to mental health care for veterans.

- This extension should ensure that sessions are conducted in a secure, HIPAA-compliant environment, with a focus on clear communication of privacy measures.
- Regular monitoring of treatment outcomes and patient satisfaction should be implemented to assess the effectiveness of the service and ensure continuous improvement.
- Additionally the examined research studies support the use of innovative strategies, such as telemedicine, should be utilized to provide care for veterans who are homeless, meeting them where they are and addressing their unique barriers to accessing mental health services (Shih et al., 2023). By adopting this clinical practice guideline, veterans will benefit from improved access, efficacy,

and quality of care, reducing missed opportunities for treatment and enhancing their overall well-being.

Guideline

Goal: This guideline provides evidence-based recommendations for the delivery of telepsychiatry services to veterans who are homeless, ensuring equitable access, trauma-informed care, and continuity of mental health support in a population facing complex social and medical challenges**.**

- ❖ The APRN and/or LCSW at the Day Treatment Center should assess veteran's access to a smartphone, tablet or computer with Internet capabilities. Assess digital literacy skills and if technology is lacking, use the access at the Day Treatment Center. Most VA telehealth services use VA VIDEO CONNECT**,** a secure app that works on smartphones, tablets, and computers.
- ❖ The APRN/LCSW will contact the VA Mental Health Clinic directly to schedule the telepsychiatry appointment.
- ❖ The APRN/LCSW will inform the veteran that they will receive an email or text with a secure link to join the video appointment: it will arrive 24 hours prior to the session and he or she will receive a reminder text if possible. For technical support contact the VA HELP DESK (1-866-651-3180) for support or any connection issues.
- ❖ The APRN/LCSW will coordinate safe spaces at the center where privacy will be ensured. Provide noise-cancelling headphones if needed.
- ❖ The APRN/LCSW will greet each initial assessment session with warmth and transparency about what will happen. Recognize and validate the veteran's lived

experiences without forcing disclosure of trauma details. Access SAMHSA'S six key principles of trauma-informed care and embed into all interactions.

- ❖ The APRN/LCSW will understand cultural backgrounds, military service history, gender, and racial/ethnic differences prior to scheduling telepsychiatry appointments with the Mental Health Clinic (MHC).
- ❖ The APRN/LCSW should perform the initial comprehensive mental health assessment (PHQ-9, GAD-7, PCL-5 for PTSD, C-SSRS for suicide risk) makes sure this is documented in the computerized patient record system (CPRS).
- ❖ The APRN/LCSW will establish an emergency procedure if a veteran become suicidal or discloses harm during the telepsychiatry session. CALL 988 or 911.
- ❖ The day of the telepsychiatry session, the veteran will check in as per normal DTC. Existing practices (check in at least 15 minutes prior to session).
- ❖ The check in person on duty will take the veteran to the room or area designated for the privacy of telemedicine calls (remember this space only needs to be scheduled 2 times per week or whatever the staff decides).
- ❖ The APRN/LCSW will greet the veteran and make sure their device or the clinic appointed device is working properly and assist with log on and opening the link that was provided.
- ❖ If the MHC has any questions, they will contact the APRN or LCSW via TEAMs.
- ❖ At the end of the session the veteran will inform the DTC staff that the session has ended and provide any information that may be required.
- ❖ The APRN/ LCSW (or their designee) will remain close by in case the veteran has any questions or needs assistance.

- The APRN/LCSW will facilitate continuity and coordination of care by scheduling consistent tele-health follow-ups (weekly/ monthly based on acuity and partnership with the MHC). Assign the veteran to a consistent case manager as the point-of-contact.
- Lastly create warm hand-offs to VA caseworkers, Day Treatment mental health liaisons, or community-based peer-support workers.

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