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Choosing Or Losing In Behavioral Health: A Study Of Patients' Experiences Selecting Telehealth Versus In-Person Care

ABSTRACT **It is not known how the growth of telehealth has affected patients' choice of visit modalities (telehealth versus in person). In 2023 we conducted a mixed-methods study that paired a nationally representative survey of 2,071 adults (including 571 who used behavioral health services) and semistructured interviews with twenty-six people with depression or bipolar disorder. We explored patients' experiences with visit modality selection and their agency in the decision. Approximately one-third of patients receiving therapy or medication visits reported that their clinicians did not offer both modalities. Thirty-two percent reported that they did not typically receive their preferred modality, and 45 percent did not believe that their clinician considered their modality preferences. Qualitative findings revealed that some clinicians did not elicit patients' modality preferences. Perceived lack of choice affected satisfaction and rapport with clinicians and encouraged some people to seek care elsewhere. These findings highlight trade-offs in policies to preserve patient choice and approaches that clinicians can take to identify and accommodate patients' preferences.**

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Clinicians rapidly adopted telehealth in 2020 as COVID-19 dramatically reduced in-person encounters of all types. Telehealth use has been particularly high and enduring in behavioral health care because effective treatment does not rely on physical exams.[1] In 2022 approximately 30 percent of behavioral health visits were delivered via telehealth.[2]

Telehealth offers many advantages for patients and clinicians. It increases access, and many are satisfied with it.[3] Convenience is particularly important in behavioral health care because patients often require recurring visits. Many studies have demonstrated that, for a range of conditions, telebehavioral health services provide equivalent quality, compared with in-person care, in outcomes such as diagnostic assessment, retention in treatment, medication adherence, and reduction in symptoms.[1] Nonetheless, studies from before and after the pandemic have suggested that most patients prefer in-person care, including for behavioral health services.[4,5] Patients have also reported multiple disadvantages of telehealth. For example, telehealth can negatively affect therapeutic rapport or create concerns about data security or privacy.[1,5] Further, some patients lack a private location to conduct telehealth visits.

There is ongoing debate about plans for permanent telehealth policy in the US. Many payers and integrated health systems, including the Department of Veterans Affairs and several state Medicaid programs, have stated that they want to craft policy in a way that is patient centered, incentivizes clinicians to offer hybrid care models (that is, both telehealth and in-person care), and allows patients to choose the modality that

they prefer.[6,7] However, some behavioral health clinicians are moving to telehealth-only models in part because of its lifestyle and productivity advantages, whereas others no longer provide any telehealth options.[8] When receiving care from these two categories of clinicians, patients do not have a choice of modalities.

Patient choice is a key dimension of patient-centered care and a core domain of health care quality.[9] Promoting patient choice is also consistent with shared decision making, a collaborative treatment planning process in which clinicians consider patients' values and preferences in making treatment recommendations.[10] This may be particularly important in behavioral health care, where good rapport is crucial to therapeutic efficacy. Working alliance—the degree of therapeutic attachment and collaboration between clinician and patient—accounts for a significant proportion of therapeutic efficacy in individual psychotherapy.[11] Although there has been some work to investigate the impact of telehealth on working alliance,[12] most studies do not explicitly consider patients' choice of modalities.

Despite the importance of patient choice, little research has explored whether patients perceive that they have access to both in-person and telehealth visits and how the decision to use a particular modality is made.[13] This study aimed to explore patients' experiences with selecting the visit modality (telehealth versus in person) for behavioral health services and perceptions about their agency in the decision. We applied a concurrent mixed-methods study design that included a nationally representative survey and interviews with adults with depression and bipolar disorder.

Study Data And Methods

OVERVIEW To obtain a complete understanding of the current state of modality options and patient choice, we used a mixed-methods design.[14] We conducted a cross-sectional, national survey from February to March 2023 and, concurrently, conducted in-depth interviews with patients with depression and bipolar disorder. Through the survey, we set out to understand patients' perceptions regarding access to different visit modalities and sense of agency in the choice of modalities. Through interviews, we aimed to understand how visit modality was negotiated between patients and providers and to reveal detailed information about patients' experiences. Quantitative and qualitative data were analyzed separately and integrated through narrative, using a contiguous approach.[15] This study was approved by RAND's Institutional Review Board.

NATIONAL SURVEY We conducted a survey using RAND's American Life Panel. The American Life Panel is a probability-based sample of adults who are provided with internet-connected devices and incentives to complete surveys (details about the American Life Panel are reported elsewhere).[16] Data were obtained from the American Life Panel Omnibus Survey, which is fielded three times per year. Our research team added eight dedicated questions to this standing survey. Of the 2,866 panelists invited to participate, 2,071 completed the survey, for a response rate of 72.3 percent. Analyses used sampling weights to match sample demographics to the US population and to account for nonresponse.[16,17]

We asked respondents whether they had any visits for individual therapy or medication for mental health in the prior year. Those who reported having visits were asked whether their clinician or clinicians offered both in-person and telehealth visits and how the visit modality was decided (clinician decided, I decided, or we decided together). Finally, respondents rated how much they agreed with the following statements: "When deciding whether visits would be in-person or by telehealth, my provider considered my preference" and "Most of the time, I was able to get the type of visit (telehealth versus in-person) that I preferred" (online appendix exhibit A1).[18] We conducted cognitive testing on the draft survey instrument with four people who had lived experience with depression or bipolar disorder, and we revised questions to improve clarity and flow.

We calculated descriptive statistics using sampling weights to produce nationally representative estimates of responses to survey questions. We used chi-square tests for bivariate comparisons of agreement (strongly agree or agree, versus neutral, disagree, or strongly disagree), with statements about choice in modality stratified by urbanicity (rural or small town, versus small, midsize, or large city) and income (median income of up to $59,999 versus $60,000 or more). Missing data were limited (<1 percent of all variables) and likely random; entries with missing values were dropped from analyses. Analyses were conducted using Stata, version 17.

IN-DEPTH INTERVIEWS We conducted interviews between December 2022 and March 2023. We worked with the Depression and Bipolar Support Alliance,[19] a national nonprofit peer support and patient advocacy organization, to recruit participants. The Depression and Bipolar Support Alliance shared a study description with 40,000 of its members by email in November 2022. People communicated interest in the study by completing a brief screening survey administered using REDCap, a web-based data manage-

ment platform.[20] To be included, participants had to have been diagnosed with depression or bipolar disorder and have received outpatient care for the condition in the past two years. People with no telehealth experience were excluded, as our goal was to compare and contrast in-person and telehealth care and explore experiences with hybrid care models. Of the 124 people who indicated an interest in participating, 103 screened eligible. After heterogeneity sampling, we obtained a final sample of twenty-six participants who varied with respect to US region, race and ethnicity, and degree of experience with telehealth and in-person care for different behavioral health services.

Participants participated in sixty-minute semi-structured interviews conducted via Microsoft Teams and received a $50 Amazon gift card. The interview protocol covered experiences with in-person and telehealth visits for individual therapy and medication, including services received, perceptions of quality, what modalities were offered, and how the modality was negotiated. Transcript-like notes were taken by a trained research assistant to protect patients' privacy. Participants provided oral informed consent.

We conducted a rapid thematic analysis using matrices.[21] Interview notes were entered into a spreadsheet after each interview, with quotes organized for each participant (row) by interview question (columns). We categorized interviewees by preferred modality (telehealth or in person), type of care received (therapy or medication), and degree of patient choice, and we explored how themes differed across these dimensions.[14] Two members of the research team reviewed the matrix and presented preliminary themes for discussion and refinement.

PEER COUNCIL We partnered with the Depression and Bipolar Support Alliance to convene a peer council comprising ten people with lived experience receiving treatment for depression or bipolar disorder. Members participated in two ninety-minute meetings via Zoom: one before data collection and one during the analysis phase. At these meetings, members provided feedback on the formulation of research questions, refinement of study materials, and interpretation of findings. They received a $75 gift card for participating in each meeting. In addition, we sought written feedback from council members on the American Life Panel survey questions before fielding.

LIMITATIONS This study had several limitations. First, for the survey, we were unable to distinguish between behavioral health services provided in primary care (where telehealth use is lower) versus specialty care settings. Differences in availability of in-person care may be driven in part by whether behavioral health conditions were treated within primary care versus other settings. Second, our sample size for qualitative interviews was determined a priori rather than as a result of reaching thematic saturation. However, after completing twenty interviews, the study team no longer identified examples of new themes or different conceptualizations of existing themes. Third, our samples represented different populations. The American Life Panel is a nationally representative sample, including people with mild to severe behavioral health conditions. In contrast, the Depression and Bipolar Support Alliance sample we recruited for qualitative interviews had behavioral health conditions of greater severity, and participants likely received more services. The benefit of using two different samples was that the survey allowed us to generate nationally representative estimates. However, to understand how decisions about modality are made across a range of services, it is necessary to sample people who are high users of behavioral health services. As a result, the qualitative results might not generalize to people who use behavioral health services more sporadically. Further, it was not clear from the survey data whether participants took modality into consideration when first selecting their clinicians. The extent to which modality preference drove the choice of clinicians may influence the interpretation of the findings. Finally, analyses comparing the perceptions of rural versus urban and higher- versus lower-income participants were not specified a priori and should be considered exploratory.

Study Results

SURVEY AND INTERVIEW SAMPLE DESCRIPTIONS

Survey respondents ($N = 2{,}071$) had a mean age of 48.5 years, and 18.3 percent self-identified as Latino, 12.6 percent as Black, and 73.8 percent as White. Among respondents, 51.3 percent were female (exhibit 1). A total of 571 (30.0 percent, weighted) reported having behavioral health visits in the prior year. These respondents received subsequent survey questions on experiences with different visit modalities. Recipients of individual therapy ($n = 423$) were more likely to have telehealth visits (80.1 percent) than in-person visits (41.6 percent) in the prior year ($p < 0.01$). Recipients of medication visits ($n = 373$) were similarly likely to receive telehealth (54.4 percent) and in-person visits (57.9 percent) ($p < 0.10$) (data not shown).

Of the twenty-six interview participants, twenty-one had bipolar disorder, and five had depression (see appendix exhibit A2 for a table presenting the demographic characteristics of interview

EXHIBIT 1

Characteristics of American Life Panel survey participants with and without behavioral health visits, 2023

Characteristics	All participants (*N* = 2,071)		Participants with behavioral health visits (*n* = 571)	
	Frequency (unweighted)	Percent (weighted)	Frequency (unweighted)	Percent (weighted)
Sex				
Female	1,169	51.3	373	59.9
Male	902	48.7	198	40.1
Age group, years				
20–39	245	35.4	115	42.2
40–59	651	32.5	207	34.9
≥60	1,175	32.1	249	22.8
Race[a]				
Black	194	12.6	51	12.8
White	1,687	73.8	461	69.6
Other[b]	190	13.6	59	17.6
Ethnicity[a]				
Latino	254	18.3	70	16.2
Household income				
<$35,000	441	24.0	140	30.1
$35,000–$59,999	435	18.6	107	16.9
$60,000–$99,999	506	23.6	131	20.2
≥$100,000	688	33.8	185	32.8
Urbanicity				
Rural or small town (population <50,000)	506	22.8	128	80.5
Small to midsize or large city (population ≥50,000)	1,562	77.2	442	19.5

SOURCE Authors' analysis of RAND American Life Panel survey data, February–March 2023. **NOTES** The table shows the demographic characteristics of all survey participants and of the subset who received behavioral health visits for individual therapy or medication in the prior year. [a]Race and ethnicity were self-reported by survey participants, who chose from a set of race and ethnicity options defined by American Life Panel investigators. [b]Includes Asian or Pacific Islander, American Indian or Alaskan Native, or other race.

participants).[18] Most resided in cities (85 percent; appendix exhibit A2), and the mean age was 49.4 years (data not shown). Participants represented all US regions, and approximately half had commercial insurance.

CLINICIAN CONTROL Many patients did not have a choice of visit modalities because either their clinician only offered one modality or their clinician offered both modalities but the clinician (rather than the patient) generally decided the visit type. Among respondents receiving therapy, 30.6 percent said that their clinician only offered one visit modality (telehealth or in-person). Only offering telehealth for therapy was more common than only offering in-person visits: 21.6 percent of therapy recipients reported that their clinician only offered telehealth visits, and 9.0 percent reported that their clinician only offered in-person visits. Among respondents receiving medication, 33.2 percent said that their clinician only offered one visit modality, more commonly in-person (20.3 percent) than telehealth (12.9 percent) visits (data not shown).

Survey respondents whose clinicians offered both modalities were asked how the visit type was decided. For respondents seeking therapy ($n = 235$), 24.4 percent said that the provider decided the visit modality. For those seeking medication visits ($n = 267$), 34.9 percent said that the provider decided (exhibit 2).

Interviews explored how visit modality decisions were made. Multiple interview participants mentioned that they had not discussed their preferred modality with their clinicians and were just scheduled for the default option. A participant from Illinois explained, "When I schedule an appointment, I am just scheduled via telehealth. …But, my provider has never asked [what I prefer]." Other participants seemed reluctant to voice their preferred modality to their clinician, possibly because of power imbalances in the patient-provider relationship. A participant from Texas said, "I have no idea if [the psychiatric nurse practitioner] offers [in-person visits]. I never discussed it with her. …I just figured she prefers telehealth visits better."

Other participants also assumed that their clinician would be inconvenienced by their preferred modality. A participant from California explained, "I mean, I don't really force [in-person care]. …My psychologist just came back

from maternity leave, so she has a baby, so I'm not going to push that."

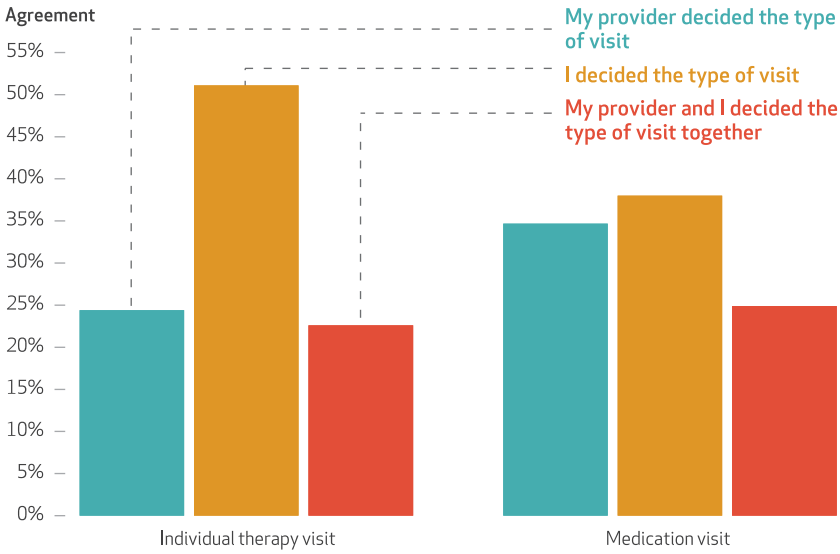
Even in cases where interview participants reported that they did have choice, they often needed to advocate for their preferred modality to their clinician. A participant from Utah explained, "I think [the clinician] would prefer if I came in person, so I don't know if [telehealth is] a choice for other people, but I've advocated for myself for it."

More than half of the 571 survey respondents (54.9 percent) agreed that their clinician considered their preference when deciding the modality, and 68.2 percent agreed that they got the type of visit they preferred most of the time. There were no significant differences in perceptions comparing higher- versus lower-income participants and urban versus rural participants (exhibit 3).

PATIENT PREFERENCE Although preferences regarding modality varied, with some preferring in-person care and others preferring telehealth for different types of behavioral health visits, the majority of interview participants wanted to have the choice. Participants generally liked the convenience and access advantages of tele-

EXHIBIT 2

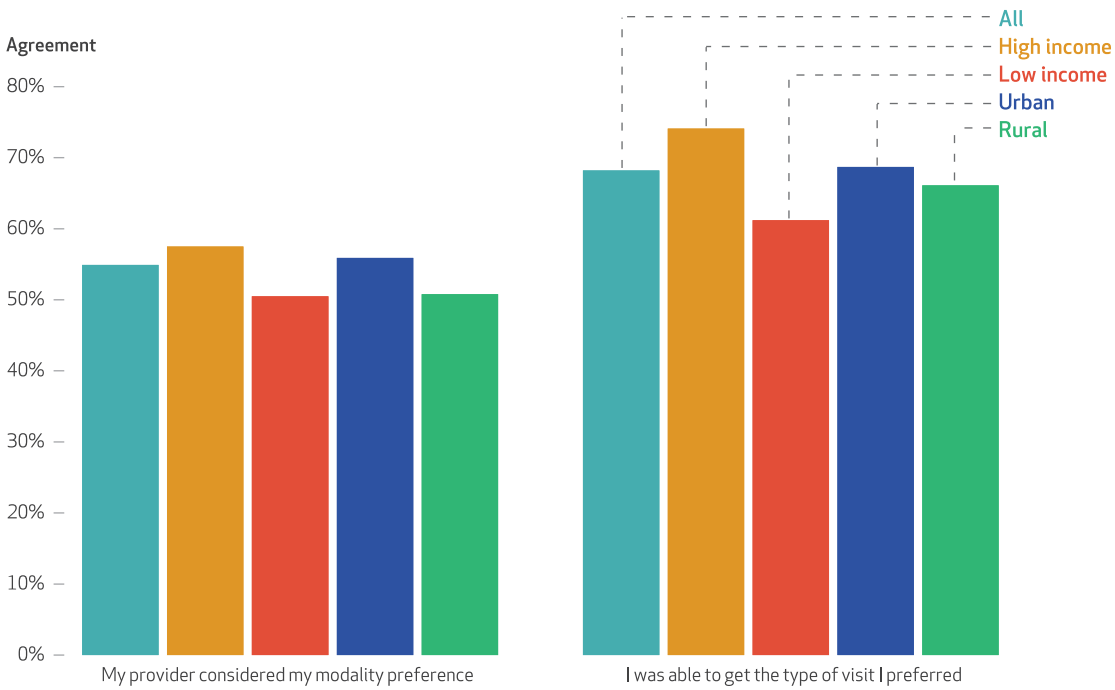
Provider versus patient determination of visit modality (telehealth or in-person) among American Life Panel survey respondents, by type of visit, 2023



SOURCE Authors' analysis of RAND American Life Panel survey data, February–March 2023. **NOTES** Survey participants were asked whether they or their provider determined the visit modality. The sample consisted of 345 patients reporting about individual therapy and 267 patients reporting about medication visits. Percentages are weighted.

EXHIBIT 3

Providers' consideration and granting of visit modality (telehealth or in-person) preference among American Life Panel survey respondents, 2023



SOURCE Authors' analysis of RAND American Life Panel survey data, February–March 2023. **NOTES** The figure summarizes the proportion of survey participants who agreed or strongly agreed with each of the following statements: "When deciding whether visits would be in-person or by telehealth, my provider considered my preference" and "Most of the time, I was able to get the type of visit (telehealth versus in-person) that I preferred." The sample consisted of 571 respondents. Percentages are weighted.

health, but many thought that in-person care was better for rapport and to ensure that both the patient and clinician were fully focused on the visit. As described by a participant from New York, "It could feel easy to check out [on telehealth]. ...And on my computer, emails come in, and that can be distracting." A participant from California explained, "Sometimes I don't think [the psychiatrist] pays enough attention to my answers [on telehealth]." Many participants, however, credited telehealth with allowing them to see their clinicians when they otherwise would not have been able to attend in person because of scheduling conflicts, and to avoid travel.

Participants were more likely to stress the importance of modality choice and express a preference for in-person care for therapy visits than for medication visits. Participants generally recognized the importance of strong therapeutic rapport for therapy, viewing medication visits as more transactional. A participant from New York said, "[Telehealth] has [negatively] impacted quality because the therapeutic relationship *is* the treatment in therapy." Regardless of modality preference, however, multiple participants stated that they wanted clinicians to offer both modalities and patients to have a choice. A participant from Utah explained, "If they said to come in every other visit for my weight, that would be OK, but I would want the choice." About half of the participants said that they usually received their preferred modality, although they were less likely to receive the modality they wanted for therapy than for medication.

NEGATIVE IMPACTS OF LIMITED CHOICE Interview participants reported that lack of choice regarding visit modality can have negative impacts, including straining the therapeutic relationship. Lack of choice was associated with feeling disconnected and less attuned to the provider, particularly for participants who preferred in-person care. Explained one patient from Georgia, "[Telehealth has] definitely affected the quality. ...One therapist thought I was doing fine, and I was like, 'no.' ...It's like I couldn't make her understand that I wasn't OK."

Multiple participants switched providers because their provider did not offer the modality they preferred. Others thought about switching or attempted to do so but found it too difficult. A participant from Massachusetts reported, "I've been looking for another psychologist [to treat me in-person]...but it's been so hard to find providers. So, I deal with what I have." Other participants decided that getting the modality they preferred, although important, was less critical than maintaining continuity of care with a trusted provider with whom they had an established relationship.

Patients' modality preferences need to be a greater consideration in both clinical discussions and policy decisions.

Discussion

For patients to have a choice in visit modalities, they must see clinicians who offer the preferred modalities and who ask about and accommodate patients' preferences. We found that 31 percent of patients receiving therapy and 33 percent of patients receiving medication who were surveyed during February–March 2023 reported that they did not see clinicians who offered both in-person and telehealth visits (data not shown). Further, significant minorities of patients (32–45 percent) did not agree that their preferences about modality were considered or that they received their preferred modality most of the time (exhibit 3). Clinicians offering both modalities frequently did not initiate discussions about patients' preferences. Patients reported that lack of choice can affect satisfaction with care and rapport with clinicians and encourage people to seek care elsewhere. Together, the results emphasize that patients' modality preferences need to be a greater consideration in both clinical discussions and policy decisions.

The focus of telehealth policy in recent years has been on increasing access to telehealth services. Although generous payment policies may encourage clinicians to offer telehealth, they may also inadvertently lead to cannibalization of in-person care. If behavioral health clinicians are reimbursed the same for in-person and telehealth visits and prefer the convenience of telehealth, they may offer few in-person appointments. As a consequence, patients who prefer in-person care might not have the option, especially considering shortages of behavioral health clinicians in many communities.

To mitigate this, a growing number of state policies are starting to emphasize patient choice. Some policies are focused on increasing patients' awareness of modality options, and others are focused on maintaining access to in-person care for patients who prefer it. For example, Nebras-

ka's Medicaid program requires that patients consent to telehealth, and the consent statement must inform patients of alternatives to telehealth, including in-person care.[22] California's Medicaid program has gone further, and in 2024 it will require clinicians who offer telehealth to also provide in-person care or at least facilitate a referral to in-person care with a different provider.[23] Pennsylvania released guidance in 2022 stating that providers must allow Medicaid beneficiaries to resume in-person treatment, if desired, and must maintain capacity to provide in-person services if needed.[24]

These policies serve as examples of efforts to increase patient choice in the current policy environment, in which in-person care may be more limited. In the future, clinicians may scale back on their telehealth use for a variety of reasons, including changes to reimbursement policy. Regardless of the dominant modality at the time, preserving patient choice will remain important.

Our findings have implications for clinicians and policy makers. Expanding telehealth is a laudable goal, given that it often is more convenient, increases access to care, and is effective for treating many behavioral health conditions. However, telehealth alone might not be sufficient. Ideally, patients should have access to some amount of in-person care, given that many prefer it or may need it. Also, if telehealth is not accessible to some populations because of the digital divide, ongoing availability of in-person care will be needed to support equitable access. It is not clear whether the policy goal should be to encourage every clinician to offer both modalities or whether the focus should be on ensuring that both modalities are available at the community or health system level and then supporting patients in sorting themselves by preference.

Requiring every clinician to offer both types of visits could have multiple disadvantages. For example, enabling some clinicians to only deliver telehealth visits might reduce burnout and encourage more providers to remain in the workforce. Further, a requirement that in-person care be available may paradoxically worsen access to care. Telehealth may be the only way to serve some communities—in particular, rural areas facing difficulty recruiting local clinicians. If policy makers choose to focus solutions on individual clinicians, they could incentivize clinicians to offer some minimum number of in-person appointments, or at least maintain the capacity to provide in-person care. If policy makers choose to focus more broadly on communities, they should develop standards on network adequacy that consider the availability of both telehealth and in-person care.[25] Policy makers should ensure that patients have the appropriate tools (for example, accurate directories and patient navigators) to identify clinicians who offer their preferred modality.

At the practice level, clinicians and health systems can strive to improve communication about modality options. Patients should be informed of available modalities at the time of scheduling and again as part of telehealth consent. Further, in a manner consistent with patient-centered care, behavioral health clinicians should have ongoing discussions with patients about their preferences and needs before determining how care will be delivered. In cases where clinicians cannot accommodate patients' preferences, they can explain why and, in some cases, help patients seek care elsewhere. It is especially important for clinicians to clarify when a decision to use a particular modality is related to clinical appropriateness or quality. For example, a patient with agoraphobia may prefer telehealth, but their clinician may feel that attending visits in person is an important component of treatment. Patients should be informed about these considerations. In the absence of a conversation, multiple participants in our study assumed that their clinician was choosing telehealth for the clinician's own convenience.

Conclusion

The large-scale adoption of telehealth services for behavioral health has had many positive impacts. It has increased access for some patients who would not have otherwise received services because of workforce shortages, stigma, and time and travel barriers.[26,27] It has also increased the capacity and productivity of clinicians and, in some cases, improved work-life balance and job satisfaction.[8] However, the growth of telehealth has occurred in the context of a deeply flawed behavioral health care system, in which an estimated 122 million Americans live in a Mental Health Professional Shortage Area.[28] For telehealth to achieve its potential to increase overall access to high-quality, patient-centered care, it is important to implement it in a manner that expands, rather than contracts, behavioral health access and options for patients. ■

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