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**REVIEW ARTICLE**

# Telehealth for adolescent mental health: a narrative review of effectiveness, acceptability, and ethical-legal considerations

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## Summary

Adolescents experience a high burden of mental health problems but face substantial barriers to care. Telehealth, encompassing synchronous teletherapy, telephone contacts, and digital mental health interventions (apps, internet CBT), has expanded rapidly, especially since the COVID-19 pandemic. The primary purpose of this narrative review was to synthesize current evidence on the effectiveness, acceptability/engagement, clinical safety, and ethical-legal aspects of telehealth interventions in adolescent mental health, with attention to regional regulatory gaps. The reviewed data suggest that telehealth modalities (video, telephone, and digital interventions) can deliver clinically meaningful improvements for common adolescent conditions (depression, anxiety) and, in many settings, achieve outcomes comparable to those of treatment-as-usual. Acceptability among adolescents is generally high but variable and depends on privacy, platform usability, and perceived therapeutic relationship. Remote care raises distinct safety challenges (managing suicidality and crisis response), and the ethical-legal landscape remains underdeveloped in many regions: data protection, consent/assent rules for minors, professional licensure across jurisdictions, and reimbursement policies are recurrent concerns. The supplied reports emphasize important local/regional gaps–limited regulation, infrastructure barriers, and the need for formal protocols and clinician training. In conclusion, telehealth is a viable modality for adolescent mental health care when implemented with clear clinical protocols, robust datasecurity safeguards, and attention to consent and crisis pathways. Policy action is required to standardize legal and ethical frameworks, ensure equitable access, and integrate telehealth within routine adolescent mental health services.

**Keywords**: telehealth, adolescents, mental health

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## INTRODUCTION

Adolescence is a critical period for mental health: many psychiatric disorders begin during the teen years, yet adolescents routinely encounter barriers to timely, evidence-based care, including stigma, shortage of specialized clinicians, transportation difficulties, and geographic disparities (see source reports provided). Telehealth, defined as the remote delivery of mental health services via telecommunications technologies, including synchronous video/telephone sessions and asynchronous digital interventions, has the potential to overcome several access barriers. The COVID-19 pandemic accelerated telehealth adoption worldwide and generated a growing body of evidence. At the same time, remote care poses clinical, ethical, and legal questions that warrant careful examination before widespread scaleup, particularly in settings where legislation and infrastructure are incomplete.

## OBJECTIVE AND METHOD

### Objective

We aimed to synthesize evidence on telehealth for adolescent mental health, focusing on effectiveness, acceptability/engagement, clinical safety (including crisis management), and ethical–legal/regulatory issues, with emphasis on the supplied regional reports.

Information used to write this manuscript was collected from the sources listed in **Table 1**.

Selection criteria and synthesis:

- Population: adolescents (generally ages 10–19); where adolescentspecific data were unavailable, mixed youth samples were used and noted.
- Scope: telehealth modalities (video, telephone, digital apps), clinical outcomes, engagement/acceptability, safety/crisis management, and ethical/legal/regulatory issues.
- Approach: narrative (nonsystematic) synthesis. The extracted data included the study design, population, modality, outcomes, and limitations. Given the heterogeneity, no meta-analysis was performed; higher-quality evidence (RCTs, systematic reviews) was given greater weight when available.

Notes on limitations: This is a narrative review prioritizing the supplied reports for regional detail; it is therefore not exhaustive and may reflect selection bias. Key limitations are acknowledged in the manuscript.

### About telehealth

Telehealth covers the delivery of health services and information using electronic information and telecommunication technologies. Common forms include video conferencing, telephone consultations, internet-based services, and mobile phone applications (1). Telehealth enables clinicians to advise, remind, educate, intervene, and follow up with geographically remote patients. It also supports remote supervision, team meetings, and sharing of clinical information, which can improve system integration and online management of health data (2). Although the terms are often used interchangeably, they are not identical. Telemedicine usually refers specifically to clinical diagnosis and treatment delivered remotely via telecommunications. Telehealth is broader, encompassing preventive and promotive activities in addition to curative care. Related terms include m-health (mobile health via smartphones, tablets, and laptops) and e-health (internet-based services). Key aims of telehealth include improving access to care for people in remote areas, reducing transmission of infectious diseases during epidemics or pandemics, increasing availability for people with mobility or transport constraints, enhancing communication and coordination among care teams, supporting selfmanagement, and strengthening social support. The COVID-19 pandemic sharply accelerated telehealth adoption worldwide, demonstrating clear advantages for safe continuity of care across clinical areas, which may be especially relevant for adolescents with mental health problems since the majority of them are active on the Internet (3,4). Studies in the past three years have documented benefits in resource use, clinical outcomes, and provider efficiency (5-7). Telehealth also has the potential to narrow gaps between high and

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**Table 1.** Sources used for this review

| Sources |
|---|
| Medline/PubMed search from January 2000 to January 2026. Keywords (used in combinations): telehealth, telemedicine, telepsychiatry, teletherapy, digital mental health, internetCBT, adolescent*, youth, child*, depression, anxiety, PTSD, ethics, data protection, consent, regulation. Article types: randomized controlled trials, cohort studies, implementation/feasibility studies, clinical trials, reviews, systematic reviews, metaanalyses, and guidelines. |
| Cochrane Library search from January 2000 to January 2024–keywords: adolescent mental health, telehealth, telepsychiatry, digital interventions. Focus on systematic reviews and evidence syntheses. |
| Handsearch of references in retrieved articles and in the supplied reports. |
| Personal and university library searches for methodological texts and relevant background literature. |
| Discussions with experts in adolescent mental health and telehealth implementation. |
| The authors' prior experience and involvement in telehealth projects and literature reviews; few documents supplied by the author team were used as core sources for regional/regulatory content and informed interpretation throughout the review. |

**Table 2.** Telehealth modalities for adolescents

| Telehealth modalities |
|---|
| Synchronous video teletherapy (telepsychiatry/telepsychology): live, facetoface video sessions that mirror traditional psychotherapy and medication management visits. Video platforms vary from general-purpose videoconferencing to dedicated, secure clinical systems. |
| Telephone-based care: audioonly contacts for assessment, brief interventions, or checkins; often used when video is unavailable. |
| Digital mental health interventions (DMHIs): mobile apps, webbased programs, computerized CBT (cCBT), and selfguided modules. These can be fully automated or therapistassisted (blended care). |
| Blended/hybrid models: combinations of inperson and remote care, or steppedcare approaches where digital tools are used as lowintensity interventions with escalation to clinician contact as needed. |

low-resource regions and to reduce costs through a more rational use of resources (8,9). Despite clear benefits, implementation faces important barriers: regulatory and accreditation challenges, payment and insurance systems, concerns about clinical versus technical quality, data safety and privacy, and infrastructure inequities. Socioeconomic differences limit access to highspeed internet and appropriate devices, and not all users are equally trained to use telehealth tools (10-14).

## Telehealth for people with mental health problems

Recent studies, mostly conducted in high-income countries, show that professionally delivered telehealth interventions can improve mental health outcomes and reduce symptoms across a range of conditions, including depression, anxiety, PTSD, burnout, and COVID-19–related mental health problems (15). Interventions vary widely in format and intensity. For example, a sixweek online program with weekly sessions led by a certified psychotherapist produced significant reductions in anxiety and depressive symptoms in a small sample (16). Structured weekly psychotherapy delivered over 15 weeks also showed significant anxiety reduction (17). Shorter, twice-weekly group programs over four weeks produced notable reductions in depressive symptoms (18). Daily supportive and skills messages delivered via mobile phone over 60 days resulted in decreases in depression and anxiety scores (19). Teledelivered occupational therapy for 270 people with mental disorders was associated with fewer relapses and rehospitalizations over six months (20). Although these interventions are promising, the evidence does not consistently point to one telecommunications modality as superior. Effectiveness appears to be individualized–depending on diagnosis, severity, and the needs and capabilities of the target population (21).

## Telehealth for children and adolescents with mental health problems

Over the last few years, mental health services have been the most widespread telehealth application for children and young people (22). Growth in this area began even before the pandemic. For example, Australia piloted the Mental Health eClinic (MHeC) in 2018 for early intervention among young people, with positive results (23). Evidence suggests that tele-based assessment and evidence-based interventions for children and adolescents can be as effective as face-to-face care (24). Programs like Youthchat and other online selfhelp or guided interventions have shown significant benefits in reducing depressive symptoms and suicidal ideation among participants (25, 26). Digital cognitivebehavioural interventions are among the most commonly used and have consistent support (27). As elsewhere, most adolescent telehealth services are concentrated in urban areas of wealthier countries; technical and infrastructure limits remain the main obstacles in other regions. The main modalities are described in **Table 2**.

The reports emphasize that adolescents generally view telehealth favorably–convenience, reduced travel, and ease of scheduling are commonly cited advantages. However, acceptability depends on privacy at home (e.g., lack of a private space reduces willingness to disclose), perceived rapport with the clinician, and the usability/appeal of digital interfaces.

Parental and caregiver perspectives: Parents may appreciate the accessibility and reduced disruption to school life, but they also express concerns about data privacy, treatment quality, and the capacity to manage crises remotely. Effective telehealth programs often include caregiver education and clear communication pathways.

## Challenges in implementing telemental health

We identified several ethically and legally challenging domains for telepsychiatry and telepsychotherapy:

1. Data security and confidentiality: Protecting personal health information is critical. Using nonspecialized or lowsecurity software risks privacy breaches (28). Guidance on the secure use of technology is available and necessary (29).
2. Clinical safety: It is essential to define which patients are appropriate for telecare; for instance, remote delivery is risky for actively suicidal patients. Clinicians must be able to recognize when patients need referral for in-person treatment.
3. Clinician competence and training: Providing telecare requires specific skills and accredited training, especially with new technologies such as smartphone apps, so standards and credentialing should be developed
4. Legal legitimacy and regulation: Many legal questions remain unresolved: licensure across borders,

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liability, and clear regulatory frameworks for teleservices. Item 140002 in Chapter 18, as defined by the Republic Health Insurance Fund (RFZO), authorizes teleconsultations with appropriately specialized physicians at secondary and tertiary care levels, encompassing patient–physician information exchange, advice based on remotely monitored laboratory and other parameters via available ICT, referrals for specialist examinations, and documentation in the medical record (31).

5. Financing and infrastructure: Investing in sufficient information infrastructure is a financial and policy challenge.
6. Social and equity issues: Populations with poor internet access–homeless people, residents of informal settlements, or economically disadvantaged groups–may be excluded. In one practical example, to reduce disparities, some US pediatric organizations limited teleservices to telephone-only (30) to avoid disadvantaging those without video capability.

Discussing the challenges of these modalities, safety, and clinical risk management are also very important to assess. Key considerations outlined include:

- Structured remote risk assessment: use of validated screening tools adapted for telehealth and protocols for suicide risk identification.
- Crisis pathways: clear, pre-established escalation procedures including confirmation of the adolescent's physical location, local emergency contact details, and collaboration agreements with local services.
- Documentation and supervision: thorough session notes, routine supervision focused on remotecare competencies, and training in online therapeutic boundaries.
- Technology contingencies: plans for connectivity loss during highrisk conversations.

The reports underscore that while telehealth can safely support many adolescents, clear limits should be set: facetoface assessment remains essential when immediate safety concerns or complex comorbidities (substance misuse, active psychosis) are present. Some of the practical steps to implement safe, effective telehealth for adolescents include:

- Platform selection: choose encrypted, healthgrade platforms with clear privacy policies and minimal data sharing outside clinical contexts.
- Consent and documentation: implement standardized consent/assent forms that explicitly address confidentiality, parental access, emergency procedures, and technology risks.
- Risk management protocols: routinely confirm the adolescent's location at the start of each session, collect local emergency contact information, and document escalation pathways.
- Clinician training: requires competency training in remote clinical assessment, digital rapport building, and technical troubleshooting.
- Equity measures: provide alternative modalities (telephone, inperson), partner with schools and community centers to offer private spaces for remote sessions, and advocate for subsidized devices or connectivity where needed.
- Quality assurance: monitor outcomes, adherence, and satisfaction; include service users in codesign to improve engagement.

Recent systematic reviews and meta-analyses indicate that telehealth and digital interventions hold significant potential to expand access to mental health care for adolescents by enabling scalable, universal, and school-based programs, improving continuity of care, and offering flexibility and anonymity that can encourage help-seeking (31-33). Quantitatively, effects reported across these syntheses are small to moderate but variable: Takizawa et al. (2026) pooled 29 studies and found a significant overall effect (Hedges' $g = 0.16$) with significant long-term effects, especially for anxiety and depression (≥6 months; $g = 0.09$) (31). Chen et al. (32) reported a moderate overall effect in their metaanalysis ($g = 0.43$; 95% CI 0.20–0.66; $n = 4{,}050$) with substantial heterogeneity ($I2 \approx 78\%$), and FischerGrote et al. (33) (13 trials, $n = 8{,}732$) found notable effects for anxiety ($SMD = 0.44$, 95% CI 0.20–0.67) and a large but highly heterogeneous estimate for depression ($SMD = 1.31$, 95% CI 0.34–2.95; I2 for depression >99%). These analyses also identify moderators (e.g., age and intervention format), with Chen et al. showing larger effects in younger children (primary school $g \approx 0.79$) than in adolescents (junior high $g \approx 0.15$). Taken together, the meta-analytic evidence supports modest effectiveness, particularly for interactive, brief modules or interventions with some human support, but consistently highlights high heterogeneity, variable sample sizes, and short follow-up periods, which limit confidence in long-term durability and generalizability. Finally, these reviews underscore real-world implementation challenges (limited adherence and engagement, the digital divide, and privacy/datasecurity concerns) that may reduce telehealth's practical impact outside controlled research settings (31-33).

Limitations of the evidence and of this review. The underlying evidence base summarized in the reports reflects heterogeneity in interventions, short follow-up periods in many trials, and an overrepresentation of studies from high-income countries–limiting generalizability to low-resource settings.

## CONCLUSION

Telehealth represents a powerful tool to expand access to adolescent mental health care. It can achieve meaningful

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clinical benefits when interventions are evidencebased and implemented with attention to safety and ethics. However, successful scaleup requires: 1) clear legal and regulatory frameworks that address consent and cross-jurisdictional practice, 2) robust datasecurity standards, 3) clinician training and service protocols for remote risk management, and 4) equityoriented policies to ensure all adolescents can access appropriate care. The supplied reports offer a practical roadmap for policy and clinical action (34, 35) in contexts where regulation and infrastructure are still evolving.

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## TELEZDRAVSTVO U MENTALNOM ZDRAVLJU ADOLESCENATA: NARATIVNI PREGLED EFIKASNOSTI, PRIHVATLJIVOSTI I ETIČKO-PRAVNIH RAZMATRANJA

Ana Munjiza Jovanović[1,2], Milica Pejović-Milovančević[1,2], Marija Mitković-Vončina[1, 2], Danilo Pešić

**Sažetak**

Adolescenti imaju visoku zastupljenost mentalnih tegoba, ali se suočavaju sa značajnim preprekama u pristupu nezi. Telezdravstvo, koje obuhvata sinhronu teleterapiju, telefonske kontakte i digitalne intervencije za mentalno zdravlje (aplikacije, internetCBT), brzo se proširilo globalno kao značajna intervencija u ovoj populaciji, naročito od pojave pandemije izazvane Kovidom 19. Primarna svrha ovog narativnog preglednog rada jeste da prikaže sintezu dokaza o upotrebi telezdravstva u oblasti mentalnog zdravlja adolescenata, sa naglaskom na efikasnost, prihvatljivost/angažovanost, kliničku bezbednost i etičkopravna pitanja, uz poseban osvrt na regionalne regulatorne praznine. Prikazani podaci ukazuju na to da modaliteti telezdravstva (video, telefon i digitalne intervencije) mogu doprineti klinički značajnom poboljšanju kod mentalnih problema adolescenata (depresija, anksioznost) i u mnogim uslovima postižu ishode uporedive sa standardnim lečenjem. Prihvatljivost među adolescentima je generalno visoka, ali varira i zavisi od privatnosti, upotrebljivosti platforme i percipiranog terapeutskog odnosa. Udaljena nega otvara specifične bezbednosne izazove (upravljanje suicidnošću i reagovanje u kriznim situacijama), a etičkopravni okvir je u mnogim regionima nedovoljno razvijen: zaštita podataka, pravila o pristanku/saglasnosti maloletnika, licenciranje stručnjaka preko jurisdikcija i politike refundacije predstavljaju česte probleme. Dostavljeni izveštaji naglašavaju važne lokalne/regionalne nedostatke – ograničenu regulativu, infrastrukturne barijere i potrebu za formalnim protokolima i obukom kliničara. U zaključku, telezdravstvo predstavlja održivu modalitetnu opciju za negu mentalnog zdravlja adolescenata kada je implementirano uz jasne kliničke protokole, robusne mere zaštite podataka i pažnju posvećenu procedurama za pristanak i krizno postupanje. Potrebne su mere javne politike radi standardizacije pravnoetičkih okvira, obezbeđivanja pravičnog pristupa i integracije telezdravstva u redovne usluge mentalnog zdravlja za adolescente.

**Ključne reči**: telezdravstvo, adolescenti, mentalno zdravlje

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