Healthcare systems quickly transitioned from in-person clinic visits to telehealth (phone or video) visits in the wake of the COVID-19 pandemic[1], but the impact of this change on patients with mental health conditions is unclear. At the same time that anxiety, other mental health symptoms and isolation due to mandated social distancing are increasing for many across the country, access or willingness to access care, both routine and urgent/emergent, is decreasing.[2-5] Disruptions in mental health care for patients in minority racial and ethnic groups, those with serious mental illness, or those in rural areas or those of lower socioeconomic status may be much more common than for the general population.[6, 7]

Despite the rapid shift to telehealth, it is not known who is well-served by telehealth, and, more importantly, who is not. Certain patient groups may make the transition to telehealth relatively well, with little change in their access to or continuation of care, while others may not have the means, resources or trust necessary for this transition. Certain groups, including patients who identify as black or Hispanic [8] and older adults[9], indicate a reluctance to use telehealth prior to COVID-19, and with the involuntary transition of nearly all outpatient care to telehealth services, these patients may now be left behind at a time of increased mental health needs.

It is critical to understand the disruptions in mental healthcare due to the COVID-19 pandemic, and its disparate effects on vulnerable patient populations, particularly given the sobering but likely possibility that other national crises will occur that increase mental health needs and require “distance care” for patients, including subsequent waves of COVID-19.[10] Additionally, care system leaders and others expect continued broad use of telehealth after the pandemic subsides.[11, 12] This paradigm shift in care points to a critical need to understand how this change affects mental health access and outcomes for communities of color, older adults, people of lower socioeconomic status, people with serious mental illness, and other at-risk patients.

The Mental Health Research Network (MHRN) is a network of research centers embedded in 14 large health systems serving a combined member/patient population of over 25 million in 16 states. The MHRN focuses on four key attributes of practice based research in a learning mental healthcare system: (a) embedded research, (b) alignment with stakeholder priorities, (c) data infrastructure for rapid learning, and (d) transparency and accountability. This supplemental application fits well within the scope of the MHRN parent award, as it uses data from three MHRN health care systems, leverages programmatic code and development of metrics from ongoing infrastructure work, and takes advantage of ongoing measurement of anxiety and depression severity, suicidal ideation and suicide attempts and deaths over time.

In the context of a rapid shift to telehealth mental healthcare, our supplemental application aims to:

Aim 1. Examine patient-level predictors of disruptions in mental healthcare for patients with mood, anxiety and psychotic disorders, including differences by age, race and ethnicity, and socioeconomic status, controlling for insurance coverage.

Aim 2. Examine the association of adverse consequences of disruptions in mental healthcare on depression and anxiety severity, medication and psychotherapy adherence, emergency department visits, psychiatric hospitalizations, suicidal ideation, and suicide attempts and deaths.

Subpopulations of particular interest in these analyses include patients of racial and ethnic minority groups, patients who need an interpreter for medical visits, children/adolescents, older adults, people with serious mental illness, and people living in rural areas or in neighborhoods with low income or education.

In **secondary analyses**, we will determine whether adherence to psychiatric medications vary by class or subclass, and whether differences in adherence correlate with other patient-level outcomes, including changes in mood or anxiety severity, ED visits or hospitalizations, or suicidal ideation or suicide attempts or deaths.

This work will help us answer important questions about who is best and least served by the transition to telehealth to inform future strategies to improve access to quality mental health care in the wake of the COVID-19 pandemic and in future national crises. If, for example, we can identify patients with increased disruptions in mental healthcare or poorer mental health outcomes after the transition to telehealth, we can work with our care systems to identify such patients and preferentially offer them in-person office visits or additional support and services to be able to access telehealth appointments.