

VIEWPOINT

Opportunities From the Coronavirus Disease 2019 Pandemic for Transforming Psychiatric Care With Telehealth

John Torous, MD

Department of Psychiatry, Beth Israel Deaconess Medical Center, Harvard Medical School, Boston, Massachusetts.

Til Wykes, DPhil

Institute of Psychiatry, Psychology and Neuroscience, Department of Psychology, King's College London, London, United Kingdom; and South London and Maudsley National Health Services Foundation Trust, London, United Kingdom.



Viewpoint

The mental health outcomes of the coronavirus disease 2019 pandemic are producing new demands but also new opportunities for psychiatry. We know that there are mental health outcomes of social distancing policies and financial uncertainty, as well as worries about personal health, family, and friends. This will produce a global increase in adjustment issues and anxiety among the population, which may increase demands on mental health services. On the other hand, the widespread requirement for remote working has also fueled a renewed interest in telehealth with opportunities to increase access to care. Interest and use in telehealth have surged with past disasters, such as September 11, 2001; the Indian Ocean tsunami in 2004; and Hurricane Katrina in 2005¹—but the unparalleled scope and outcome of the current crisis warrants a different approach than in the past.

The urgent need for clinical training and skills building around telehealth, as well as newer technologies, such as mobile apps, will determine the influence that psychiatry can have in addressing the mental health sequelae of the coronavirus disease 2019 pandemic. While companies will use this moment to market their telehealth platforms or a panoply of apps, ensuring these new tools are fully used will have an influence on care that is more critical than the tools themselves. The US government's temporary 60-day relaxation (on March 17, 2020) of regulations around Health Insurance Portability and Accountability Act security rules to permit telehealth via nonsecure platforms is a striking example of the correct focus on care over the tools enabling it. But there is more to ensuring care than relaxing security regulations.

We already know that disasters exacerbate existing mental health difficulties,² so we do have a challenge, but the mental health needs associated with this pandemic are different than before. Previous disasters were more circumscribed and localized, which meant that a brief and focused telehealth response was sufficient and could be delivered by telehealth experts or involve training just a few clinicians. Today, the challenge is different. This pandemic is associated with illness concerns, school closures, self-quarantining, and financial and vocational uncertainty, all of which are stresses associated with mental health issues. Some people living with schizophrenia or affective psychosis, including those whose conditions are currently stable, may be at higher risk of symptom exacerbation or relapse. Some people without any mental health condition may potentially be at heightened risk of a new onset. This generates an unprecedented challenge in this period of elevated risk, especially when some programs for patients at clinical risk are actually closed, inpatient unit beds are full, and the

mental health protective factors of physical activity, sleep, routines, social interactions, and more are being disrupted.

In response to physical distancing, health services around the world have turned again to telehealth via video visits. This has enabled expanded access to psychiatric care, whereas face-to-face care would lead to the spread of infection. The benefits of increased access to telehealth services are apparent for telepsychiatry, but in the present crisis, these benefits can only be realized if these digital tools are used by clinicians who have the appropriate training and guidance and know these services are accepted by organizations providing services and payers.

The need for training among health care professionals is the number 1 priority. A recent review bluntly noted such efforts have been "sparse, heterogeneous, and primarily descriptive."^{3(p55)} In the UK, the National Health Service commissions services from telehealth services and so has a history of use and trained professionals available, but even these prior solutions will fail as the need for clinical contact expands. Frameworks for telehealth training and faculty development already exist, although few have been implemented today.⁴ Building rapport and therapeutic alliance via telehealth have been cited as areas of resistance for adoption by clinicians. But as with all skills, this so-called webside manner can be improved with knowledge, training, and supervision.⁵ Clinicians may have more concerns about alliance than patients, including whether, with practical considerations around technology use, forming and maintaining a strong alliance can be the norm. Offering digital literacy and telehealth competencies training can ensure all clinicians have the knowledge and skills necessary to work at full capacity through new digital media.

Next, clinical guidance around implementation and delivery of telehealth and digital health is necessary. Fortunately, there is a strong body of evidence for how telehealth can be used to offer effective care in every psychiatric condition. For example, we know that online cognitive behavioral therapy shows evidence of efficacy but often lacks effectiveness in real-world settings when provided without human support and interaction.⁶ Likewise, we know that smartphone apps can be useful tools for some patients, but their efficacy more than doubles when used with a clinician.⁷ In terms of disaster responses, the actual evidence that can be incorporated into clinical guidance today is minimal,¹ highlighting the need for urgent research. Codifying current evidence in preliminary guidelines and expanding research on real-world implementation and effectiveness will ensure the digital health tools are optimally used.

Corresponding

Author: John Torous, MD, Department of Psychiatry, Beth Israel Deaconess Medical Center, Harvard Medical School, 330 Brookline Ave, Boston, MA (jtorous@bidmc.harvard.edu).

Finally, for telehealth and digital health to thrive and not follow the cycle of interest and then abandonment seen after previous disasters, there is a need for agreements on payment and supportive regulation. In the UK, the Improving Access to Psychological Therapies service was written into national guidance and funding. In the US, there is temporarily payment parity for treating certain patients on government-backed insurance plans, which increased access to care overnight. After the immediate crisis, offering data on its cost-effectiveness will be critical to lobby for permanent payment parity and the need for private insurance to follow. Regulatory changes around the practice of psychiatry in the US, such as the temporary suspension of the Ryan Haight Online Pharmacy Consumer Protection Act of 2008, which limited prescribing controlled substances without in-person visits, highlight how policy changes can also rapidly increase access to care. When the immediate crisis subsides, we need to offer compelling outcomes data on these supportive changes if we are to continue them in the future.

Patient partnerships in digital service design is vital in new pandemic-driven research programs because they will ensure new services are accessible and usable. We already know that there is a digital divide because of both a lack of technology skills and access to online resources (eg, reliable internet connection, smartphone credit).⁸ Although the digital divide is declining each year, it re-

mains highest in those who already have the highest unmet needs, including those living in rural areas, with less income and education, and of older ages. Patients with cognitive impairments will need adapted digital offerings or additional support. We can already build platforms and tools today, but building the right ones for patients will require closer partnerships.

Precedents for ensuring changes in digital mental health after crises exist and illustrate the themes of investing in the training, guidance, and policy support. For example, in the US, the need for additional mental health resources during the conflict in Afghanistan resulted in the Veteran's Administration (VA) creating a library of clinically studied and well-used mental health apps,⁹ many of which are being recommended during this pandemic. The enduring outcome of the VA's efforts was not only because these apps were innovative but because the VA created training, clinical guidance, and support for their use.

While disasters inevitably recur, we can ensure that we build technology systems that can stand the test of time not just for pandemics, but also for use in routine clinical practice. New digital health platforms could be important developments from this pandemic, but the most enduring will be investment in the people, process, and support to ensure telehealth cycles of interest are not tied to disasters but rather improve care every day.

ARTICLE INFORMATION

Published Online: May 11, 2020.

doi:10.1001/jamapsychiatry.2020.1640

Conflict of Interest Disclosures: Dr Torous is supported by a research grant from the National Institutes of Mental Health (1K23MH116130-01), a philanthropic grant from Jeremy Wertheimer, and research support from Otsuka Pharmaceuticals. Dr Wykes acknowledges the support of the National Institute of Health Research Maudsley Biomedical Research Centre at the South London and Maudsley National Health Services Foundation Trust and a National Institute of Health Research Senior Investigator award.

REFERENCES

1. Reinhardt I, Gouzoulis-Mayfrank E, Zielasek J. Use of telepsychiatry in emergency and crisis intervention: current evidence. *Curr Psychiatry Rep*. 2019;21(8):63. doi:10.1007/s11920-019-1054-8

2. Maunder R, Hunter J, Vincent L, et al. The immediate psychological and occupational impact of the 2003 SARS outbreak in a teaching hospital. *CMAJ*. 2003;168(10):1245-1251.

3. Sunderji N, Crawford A, Jovanovic M. Telepsychiatry in graduate medical education: a narrative review. *Acad Psychiatry*. 2015;39(1):55-62. doi:10.1007/s40596-014-0176-x

4. Hilty DM, Chan S, Torous J, Luo J, Boland RJ. A Telehealth framework for mobile health, smartphones, and apps: competencies, training, and faculty development. *Journal of Technology in Behavioral Science*. 2019;4(2):106-123. doi:10.1007/s41347-019-00091-0

5. McConnochie KM. Webside manner: a key to high-quality primary care telemedicine for all. *Telemed J E Health*. 2019;25(11):1007-1011. doi:10.1089/tmj.2018.0274

6. Gilbody S, Littlewood E, Hewitt C, et al; REEACT Team. Computerised cognitive behaviour therapy

(cCBT) as treatment for depression in primary care (REEACT trial): large scale pragmatic randomised controlled trial. *BMJ*. 2015;351:h5627. doi:10.1136/bmj.h5627

7. Linardon J, Cuijpers P, Carlbring P, Messer M, Fuller-Tyszkiewicz M. The efficacy of app-supported smartphone interventions for mental health problems: a meta-analysis of randomized controlled trials. *World Psychiatry*. 2019;18(3):325-336. doi:10.1002/wps.20673

8. Robotham D, Satkunanathan S, Doughty L, Wykes T. Do we still have a digital divide in mental health? a five-year survey follow-up. *J Med Internet Res*. 2016;18(11):e309. doi:10.2196/jmir.6511

9. Ruzek JI, Kuhn E, Jaworski BK, Owen JE, Ramsey KM. Mobile mental health interventions following war and disaster. *Mhealth*. 2016;2:37. doi:10.21037/mhealth.2016.08.06