

Telepsychiatry 2.0

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“Closed-circuit television has been introduced into the field of mental hygiene as a medium for the administration of therapy to a mass audience. The present evidence indicates that the use of this type of television may promote the development of new and more effective methods for the treatment of the mentally ill.”¹ This hopeful statement appeared at the beginning of a 1957 peer-reviewed paper. Four years later, the potential of telepsychiatry “as a means of extending mental health services to areas that are remote from psychiatric centers”² was described. Six decades later, where are we?

Serhal and colleagues³ in this issue of the journal report a health services utilisation perspective on the provision of telepsychiatry in Ontario, characterising who provides it and who receives it. Although they tread on familiar ground, they make an important contribution: providing a Canadian perspective by looking at the state of telepsychiatry in Ontario and offering data to see if it has lived up to the potential of bridging barriers to access, especially for populations most in need. Serhal et al. find that it hasn't. Consider: of the more than 48,000 people in need of psychiatric care (defined by the authors as psychiatric or primary care within a year after a psychiatric hospitalisation), fewer than 1% saw a psychiatrist through telepsychiatry—and 39% saw no psychiatrist. We note the marked contrast with the United States, where telepsychiatry has been rapidly growing.⁴

What are the barriers to this long-established, evidence-supported method for psychiatric assessment and treatment? First is the participation of psychiatrists. In the Serhal et al.³ study, it was surprising that only 7% of Ontario psychiatrists delivered care by televideo and that they were on average 50 years old. The irony: younger psychiatrists are generally very familiar with technology, and younger people are at ease with Skype, Facetime, and other forms of video communication.

Data from the 2014 National Physician Survey indicate that 24% of physicians in Ontario use telemedicine in their clinical practice.⁵ Why does psychiatry, the least physical of the clinical specialties, lag so far behind? We would argue that there are perceived barriers and real barriers—but

addressing them should improve access and overcome the constraints of geographic maldistribution of psychiatrists.

A concern heard from some psychiatrists relates to the potential adverse impact of a telepsychiatry link on the important human connection that underlies the therapeutic alliance. This was addressed in an earlier study from the Centre for Addiction and Mental Health 20 years ago, a randomised trial of telepsychiatry versus in-person assessment⁶ that was the second controlled study of this technology conducted in Canada.⁷ There were no differences found in measures of therapeutic alliance or patient satisfaction—although physicians were less satisfied with telepsychiatry assessment but still positive.

Another concern may involve remuneration for valued work. But in Ontario, additional telepsychiatry billing codes beyond those already available for consultation exist currently and may incentivise psychiatrists to do this type of work; in addition, sessional funding exists in Ontario for telepsychiatry consultation to family health teams, which provides for indirect consultation and education—leveraging technology to provide virtual shared care and compensating psychiatrists appropriately for it.

And some may worry about risk management for a “new” technology. But the Canadian Medical Protective Association acknowledges the reality of telepsychiatry clinical practice and provides its own guidance.⁸ While emphasis is placed heavily on the security of electronic communication, we believe that it is the consent to the process that is most important. When we speak with patients on the telephone, there is always the risk that someone at home is listening in on the upstairs extension! Patients in need are much more

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concerned with access to care than with electronic security, and consent forms that acknowledge the limits to technology confidentiality are already available for email communication.

The article by Serhal et al.³ provides hard data on under-utilisation by providers and inadequate access by patients. How do we move forward?

We propose a 4-part plan:

Meaningful integration into residency training. If our trainees see this as a routine part of clinical care that they observe and deliver, they are hopefully more likely to integrate it into their own practice on graduation. This needs to involve more than the educational tourism of an afternoon spent observing telepsychiatry assessment. Training in telepsychiatry should be incorporated into the psychiatry residency experience. Indeed, detailed pedagogical documents reflect still-aspirational goals for such training.^{9,10} But the experience of the first author of this editorial (D.S.G.), working in Canada's largest training program in psychiatry and providing regular telepsychiatry consultation for 20 years, is that resident observation and participation in this learning opportunity are minimal and haphazard.

Recognition of the larger responsibilities of academic health sciences centres. There is a disproportionate concentration of psychiatrists, both specialists and subspecialists, within the confines of these centres, and they typically have a mandate to share their expertise within their province beyond their immediate catchment area. Telepsychiatry provides an efficient and effective way to fulfill that mandate.

Enhancement of existing technology. At the Centre for Addiction and Mental Health (CAMH), telepsychiatry services are provided principally through televideo studios or portable televideo units; technology exists to make it accessible through the computers of every psychiatrist, removing another barrier. Returning to an earlier point: younger psychiatrists—who have statistically opted out of telepsychiatry—use technology with apps and iPhones, not studios and portable units.

Better coordination of services. Given the potential of telepsychiatry to bridge the geographic divide, a more thoughtful approach is needed, especially in light of the paucity of utilisation. This begs for a province-wide strategy that has defined clinical priorities, geographic rationales, and measured outcomes.

The authors of the 1957 article concluded, "Mentally ill patients will improve significantly in behavior patterns when given therapy by closed-circuit television."¹ Today, we have

the technology, the evidence, the experience, the educational guidelines, the remuneration, and the privacy protection. What else will it take to address the gaps so clearly identified by Serhal et al.³? Perhaps some leadership.

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References

1. Tucker H, Lewis RB, Martin GL, et al. Television therapy: effectiveness of closed-circuit television as a medium for therapy in the mentally ill. *AMA Arch Neurol Psychiatry*. 1957; 77(1):57-69.
2. Wittson CL, Affleck DC, Johnson V. Two-way television in group therapy. *Mental Hospitals*. 1961;12:22-23.
3. Serhal E, Crawford A, Cheng J, et al. Implementation and utilization of Telepsychiatry in Ontario: a population-based study. *Can J Psychiatry*. 2017;62(10):716-725.
4. Mehrotra A, Huskamp HA, Souza J, et al. Rapid growth in mental health telemedicine use among rural medicare beneficiaries, wide variation across states. *Health Affairs*. 2017; 35(5):909-917.
5. National Physician Survey. National Physician Survey, 2014. National results by province [cited Mar 12, 2017]. Available from: <http://nationalphysiciansurvey.ca/wp-content/uploads/2014/10/2014-ByProvince-TelehealthTelemedicine-EN.pdf>.
6. Stevens A, Doidge N, Goldbloom D, et al. Pilot study of tele-video psychiatric assessments in an underserved community. *Am J Psychiatry*. 1999;156(5):783-785.
7. Dongier M, Tempier R, Lalinec-Michaud M, Meunier D. Telepsychiatry: psychiatric consultation through two-way television—a controlled study. *Can J Psychiatry*. 1986;31(1):32-34.
8. Canadian Medical Protective Association (CMPA). [Internet]. 2014. Ottawa (Canada). [updated December 2014; cited 2017 May 29]. Available from: https://www.cmpa-acpm.ca/en/duties-andresponsibilities/-/asset_publisher/bFaUiyQG069N/content/medico-legal-aspects-of-providing-mental-healthcare-topatients.
9. Hilty DM, Crawford A, Teshima J, et al. A framework for telepsychiatric training and e-health: competency-based education, evaluation and implications. *Int Rev Psychiatry*. 2015; 27(6):569-592.
10. Saeed SA, Johnson TL, Bagga M, et al. Training residents in the use of telepsychiatry: review of the literature and a proposed elective. *Psychiatr Q*. 2017;88(2):271-283.