Received: 8 May 2020 | Revised: 8 May 2020 | Accepted: 8 May 2020

DOI: 10.1002/eat.23300

COMMENTARY

International Journal of EATING DISORDERS WILEY

Digital technology can revolutionize mental health services delivery: The COVID-19 crisis as a catalyst for change

C. Barr Taylor MD[1,2] | Ellen E. Fitzsimmons-Craft PhD[3] | Andrea K. Graham PhD[4]

[1]Department of Psychiatry and Behavioral Sciences, Stanford University School of Medicine, Stanford, California

[2]Center for m2Health, Palo Alto University, Palo Alto, California

[3]Department of Psychiatry, Washington University School of Medicine, St. Louis, Missouri

[4]Center for Behavioral Intervention Technologies, Department of Medical Social Sciences, Northwestern University Feinberg School of Medicine, Chicago, Illinois

Correspondence
C. Barr Taylor, Center for m2Health, Palo Alto University, Room E10, 5150 El Camino Real, Mountain View, CA.
Email: btaylor@stanford.edu

Funding information
National Institute of Diabetes and Digestive and Kidney Diseases, Grant/Award Number: K01 DK116925; National Institute of Mental Health, Grant/Award Numbers: K08 MH120341, R01 MH115128

Action Editor: Ruth Weissman

Abstract

The unprecedented COVID-19 crisis presents an imperative for mental health care systems to make digital mental health interventions a routine part of care. Already because of COVID-19, many therapists have rapidly moved to using telehealth in place of in-person contact. In response to this shift, Waller and colleagues compiled a series of expert recommendations to help clinicians pivot to delivering teletherapy to address eating disorders during COVID-19. However, numerous barriers still impede widespread adoption and implementation of digital interventions. In this commentary, we aim to extend the recommendations for clinicians offered by Waller and colleagues by presenting a roadmap of the systems- and policy-level requirements that are needed. We advocate for addressing barriers associated with training, licensing, safety, privacy, payment, and evaluation, as these factors have greatly limited use of these promising interventions. We also indicate that longer-term goals should include introducing truly innovative digital mental health practices, such as stepped-care models and simultaneously providing preventive and self-management services in addition to clinical services, into the health care system. Now is the time to catalyze change and comprehensively address the barriers that have prevented widespread delivery of these efficacious digital services to the millions of people who would benefit.

KEYWORDS

coronavirus, COVID-19, digital technology, mental health services, telehealth

1 | INTRODUCTION

The COVID-19 crisis has brought to the fore significant challenges for mental health services delivery. With social distancing guidelines and shelter-in-place orders to reduce the spread of the virus, traditional in-person services cannot be delivered. Already because of COVID-19, many therapists have rapidly moved to using telehealth (i.e., treatment that is delivered either by audio and/or video call) in place of in-person contact.

In response to this shift, Waller et al. (2020) compiled a series of expert recommendations to help clinicians pivot to delivering teletherapy to address eating disorders during COVID-19. Their article focuses on teletherapy given the rapid global shift to this approach; however, digital mental health interventions also include guided self-help interventions (e.g., online/mobile self-help content paired with support from a coach), pure self-help interventions, or some combination (e.g., including as blended with in-person care). These tools are efficacious for many mental health problems including eating disorders (Carlbring, Andersson, Cuijpers, Riper, & Hedman-Lagerlof, 2018; Taylor, Graham, Flatt, & Fitzsimmons-Craft, in press), and offer the advantage of providing relatively easy access to services typically at lower cost compared to traditional face-to-face psychotherapy.

The unprecedented COVID-19 crisis presents an imperative for mental health care systems to make digital mental health interventions available—not only in response to the COVID-19 crisis but as a routine part of care. To do so will require governing bodies and others to address a number of barriers that have, to date, greatly limited use of these promising interventions. In fact, Waller and colleagues

remind readers to attend to supervisory, reimbursement, and regulatory frameworks that are critical to the delivery of digital services, yet these factors are not trivial and require large-scale, systematic attention. Although digital therapies are standard practice in many clinics around the world (Titov et al., 2019) and teletherapy has become routine practice in the United States' Veteran's Affairs Health Care system, on the whole, continued attention is needed to sustainably embed digital mental health in routine care.

In this commentary, we aim to extend the excellent recommendations for clinicians offered by Waller and colleagues, to present a roadmap of the systems- and policy-level requirements that are needed to facilitate the widespread adoption and implementation of digital mental health interventions in routine care.

2 | TRAINING

For many therapists, the pivot to teletherapy in response to COVID-19 is the first time they are using technology to deliver services. Therapists are rapidly having to teach themselves how to not only use the technology required but also how the therapy itself might need to change in response to digital delivery. Indeed, very few mental health training programs provide training in digital therapy. Furthermore, in psychology training programs, licensing bodies have required supervisors be physically present, and online supervision has not counted for training hours. Models of online training and supervision exist and are effective in helping clinicians achieve competence (Karlin et al., 2012). Training in and supervision of these practices needs to be legitimized and integrated into standard mental health training. One advantage of digital service delivery is that it lends itself to quality assurance measures and the provision of measurement-based care. COVID-19 has highlighted the need for mental health training programs to offer training and supervision in digital mental health, and overseeing bodies should consider adding this as a requirement.

3 | LICENSING

Despite the benefits of digital mental health service delivery for widespread use, in the United States, state licensing regulations are a major impediment. States generally require therapists to practice only in states where they are licensed. Consider the impact of this regulation on college students, many of whom attend school in another state from their home. In typical circumstances, therapists often have to discontinue treatment during school breaks, resulting in potential lapses in necessary care. This challenge is heightened in response to COVID-19, in which regulations for colleges to provide distance learning may force an abrupt discontinuation in treatment. Similarly, and not specific to COVID-19, individuals who move to another state are typically not able to continue seeing their therapist via telehealth, even if that support could be critical in a time of transition. In response to the pandemic, some states have waived such requirements, but currently, these changes are only temporary and only apply in certain states. Thus, COVID-19 has heightened the imperative of considering ways to address the licensing barrier. One possible solution would be a national license to practice digital therapy.

4 | SAFETY

Safety concerns are often cited as a reason not to allow therapists to practice digital therapy, given the notion that having a therapist in a room with an individual requiring emergency services is likely to lead to a better outcome than if the individual were seen virtually. While many digital interventions should be not relied on for emergencies, guidelines and programs have been developed to address patient safety (e.g., https://www.psychiatry.org/psychiatrists/practice/telepsychiatry/toolkit; https://www1.racgp.org.au/ajgp/2018/april/etherapy). Digital tools also could connect individuals to safety resources that provide in-the-moment support such as the suicide prevention hotline. Furthermore, one must also consider that in some instances, such as the COVID-19 crisis or for individuals living in rural areas, the only available treatment may be digital. In such a case, one could argue the benefits of offering the intervention outweigh such risks.

5 | PRIVACY

Protecting the privacy of digital therapy interactions is a concern. Fortunately, several HIPAA-compliant telecommunication services and other digital programs have become available. Still, it should remain a concern because it is almost impossible to fully ensure privacy. An important component of training in digital therapy will be to teach providers how to help ensure patient confidentiality.

6 | PAYMENT

The COVID-19 crisis has led insurers, including the United States' Centers for Medicare and Medicaid Services, to consider reimbursement for teletherapy. These are welcome changes, but currently, individuals have to pay out of pocket for access to many digital guided self-help and self-help mental health programs, limiting accessibility. Alternatively, many individuals turn to the vast array of digital tools that are freely-available in app stores but that lack any or sufficient evidence to support their use, or include harmful content that is contraindicated. Thus, reimbursement coverage needs to be broadened to include other types of digital therapy, with guidelines that specify what kinds of digital therapies will be reimbursed and at what level.

7 | EVALUATION

Though there is substantial evidence supporting digital interventions for many mental health problems, scientific gaps remain. There are

limited data on the efficacy of digital therapies for many serious mental health disorders, including alcohol and substance abuse and comorbid disorders, engagement and retention is a problem for many digital programs, and few studies have addressed cost-effectiveness. Continued research progress is needed in these domains.

8 | A BROADER VISION

The immediate focus should be on reducing barriers to using digital mental health to extend existing services. However, digital technologies can also be harnessed to simultaneously provide preventive, well-being, self-management, and clinical interventions to populations at scale, to implement stepped-care models, and to provide paraprofessional or even automated support via technology such as chatbots. These functions are rarely addressed in current mental health delivery systems. Thus, in addition to harnessing digital technology for more traditional functions, longer-term goals should include introducing truly innovative digital mental health practices into the health care system.

9 | CONCLUSIONS

COVID-19 has highlighted the great need for digital mental health interventions, but also the barriers to their implementation. Some of these barriers are being rapidly addressed in some fashion in light of this crisis. The article by Waller and colleagues provides a timely and useful collection of recommendations for clinicians delivering telehealth eating disorder services. We commend the authors for their initiative and innovation in rapidly establishing an international collaboration to stimulate positive change for eating disorder service delivery. Global collaborative models like theirs will be pivotal for yielding the systems- and policy-level changes we are proposing. Indeed, now is the time to catalyze change and comprehensively address the barriers that have prevented widespread delivery of these efficacious services to the millions of people who would benefit.

CONFLICT OF INTEREST

Dr Taylor reported serving as an unpaid advisor to several digital health companies. Dr Graham received consulting fees from Actualize Therapy.

DATA AVAILABILITY STATEMENT

Data sharing is not applicable to this article as no new data were created or analyzed in this study.

ORCID

C. Barr Taylor https://orcid.org/0000-0002-4564-6548
Ellen E. Fitzsimmons-Craft https://orcid.org/0000-0001-7064-3835
Andrea K. Graham https://orcid.org/0000-0002-9736-8906

REFERENCES

Carlbring, P., Andersson, G., Cuijpers, P., Riper, H., & Hedman-Lagerlof, E. (2018). Internet-based vs. face-to-face cognitive behavior therapy for psychiatric and somatic disorders: An updated systematic review and meta-analysis. *Cognitive Behaviour Therapy*, *47*(1), 1–18. https://doi.org/10.1080/16506073.2017.1401115

Karlin, B. E., Brown, G. K., Trockel, M., Cunning, D., Zeiss, A. M., & Taylor, C. B. (2012). National dissemination of cognitive behavioral therapy for depression in the Department of Veterans Affairs health care system: Therapist and patient-level outcomes. *Journal of Consulting and Clinical Psychology*, *80*(5), 707–718. https://doi.org/10.1037/a0029328

Taylor, C. B., Graham, A. K., Flatt, R. E., & Fitzsimmons-Craft, E. E. (in press). Current state of scientific evidence on internet-based interventions for the treatment of depression, anxiety, eating disorders, and substance abuse: An overview of systematic reviews and meta-analyses. *European Journal of Public Health*, *Supplement Paper*, ckz208.

Titov, N., Hadjistavropoulos, H. D., Nielssen, O., Mohr, D. C., Andersson, G., & Dear, B. F. (2019). From research to practice: Ten lessons in delivering digital mental health services. *Journal of Clinical Medicine*, *8*(8), 1239. https://doi.org/10.3390/jcm8081239

Waller, G., Pugh, M., Mulkens, S., Moore, E., Mountford, V., Carter, J., … Smit, V. (2020). Cognitive-behavioral therapy in the time of coronavirus: Clinician tips for working with eating disorders via telehealth when face-to-face meetings are not possible. *The International Journal of Eating Disorders*. https://doi.org/10.1002/eat.23289