

CLINICAL CORRESPONDENCE

Grappling with the “human” problem hiding behind the technology: Telehealth during and beyond COVID-19

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Cancer survivors exit hospital doors grappling with a “new normal”. In much the same way, the world must adapt to the *surreality* of life-post-COVID-19. It now seems almost absurd to shake hands with a stranger or catch a tightly packed peak-hour bus. In this new world, anything happens over videoconferencing—from comedy shows, family brunches, to business meetings. Yet curiously, prior to this pandemic telehealth (videoconferencing) was used only minimally by the health system.

In Australia, the COVID-19 pandemic triggered swift changes to hospital services. Telehealth rapidly became routine for outpatient appointments to minimise hospital traffic. We can report that in our clinical experiences at a metropolitan, hospital-based adolescent and young adult (AYA) service, this led to 100% of our AYA patients accessing outpatient clinical psychology services remotely, of which 75% occurred using online videoconferencing (an increase of 63% from the level of videoconferencing-based telehealth use prior to COVID-19). The clinical work remained the same; AYAs' presenting issues remained unchanged. But the mode of service delivery was rapidly re-designed (see Table 1).

What enabled this necessary practice change? (Table 2) Certainly, the prior existence of a versatile, secure online platform, with an interface easy to navigate using a smartphone, tablet or computer. Existing protocols for undertaking telehealth and billing processes were also available. However, although telehealth was already at our fingertips,

it took COVID-19 for it to become a business-as-usual option. This pandemic has served as a trigger to nudge us collectively in this direction. So, what can we learn by reflecting on the barriers to its use prior to March 2020?

The relative lack of telehealth uptake pre-COVID-19 appears to be a problem of implementation. Concerns around privacy and technological disruptions are commonplace, yet also the most easily remedied; purpose-built, secure videoconferencing platforms are available, and accompanying training programmes accessible. These are *usability* concerns: *is the technology able to do what it promises, and will I as a user, be able to navigate it?*

Challenges in this area, of course, remain; in some countries, technological disruptions are more likely to be the rule than the exception when delivering online interventions.^{1,2} However, just as beeping medical devices can be ignored during consultations in an oncology ward, the technical glitches can be ignored during telehealth-delivered clinical interventions.¹ Rather, health professionals' anxiety about these glitches—how to resolve them or how competent they might appear in their management—may be the more intransigent barrier.³

In our combined clinical and research experience, a second set of ill-defined reservations poses a greater barrier to telehealth. These concerns speak to the technology's capacity to translate and transmit *human-ness*: the notion that telehealth may be unable to facilitate the

human-to-human connection required, or that something of the therapeutic interaction's essence may be lost in the process. These concerns often become the core barrier to telehealth's integration with the health system.²⁻⁴ The development of good rapport and an effective working relationship with a distressed adolescent can be challenging at the best of times. Within paediatric/AYA oncology therefore, it is likely that concerns around how the interaction will be felt and experienced—and how each party may be perceived—are doubly challenging.

We argue there is a wealth of evidence to counteract these fears.⁵ Between us, we have used telehealth to undertake thorough psychological assessments and deliver individual therapy to highly distressed cancer patients as well as therapeutic groups to young cancer survivors with vastly different prognoses. Across the virtual divide, AYAs have disclosed highly sensitive information (eg, about a peer with cancer recently dying),^{1,6,7} and palliative care consultations with families whose child was actively dying of cancer have occurred.⁸ Telehealth research to date has tended to focus on feasibility, acceptability and efficacy end-points. However, to build on telehealth's potential beyond COVID-19, rigorous research will be needed to capture and evaluate these critical user experience and relational components beyond satisfaction studies.

Our recent experiences throughout COVID-19 continue to highlight while telehealth can reduce some interpersonal cues (*without a full-body view, we may miss noticing a patient is swinging their leg in*

Key points

- Telehealth (online videoconferencing) has been used successfully with a range of adolescents and young adults to access outpatient, clinical psychology services throughout the COVID-19 pandemic.
- Our combined, recent clinical experiences demonstrate that a range of potentially sensitive clinical interactions with young people and their families can be successfully delivered and experienced using telehealth.
- The relative lack of uptake in telehealth prior to COVID-19 requires clinicians and researchers to consider the barriers that prevented its use.
- We argue that a key, lesser-acknowledged, barrier is the contention that telehealth is not capable of transmitting the “human-ness” required to support effective interactions within psychosocial clinical care.
- Telehealth preferences cannot be assumed for any patient/client demographic, to advance telehealth beyond COVID-19 clinical research needs to find new ways to rigorously capture and evaluate these critical experiential and relational aspects to telehealth-delivered care.

TABLE 1 Telehealth-delivered outpatient clinical psychology practice with adolescent and young adults during the first 3 months of the COVID-19 crisis in Australia (late March–June 2020; N = 8 oncology outpatients)

Sex	Female (n = 6, 75%); male (n = 2, 25%)
Age	15–17 year old (n = 3, 37%); 18–21 year old (n = 1, 13%); 22–25 year old (n = 4, 50%)
Location from the hospital ^a	Within 60 minutes' drive (n = 2, 25%); 1–3 hours' drive (n = 5, 63%); >3 hours' drive (n = 1, 12%)
Cancer status	Active treatment (n = 2, 25%); within 12 months post-treatment (n = 2, 25%); 12–24 months post-treatment (n = 3, 38%); >24 months post-treatment (n = 1, 12%)
Therapy focus	Adjustment, re-integration and/or engagement with activities, education, work (n = 6, 75%); depression, low mood, low self-esteem (n = 5, 63%); social anxiety, social concerns, isolation and peer-group reintegration (n = 4, 50%); family relationships, managing family conflict (n = 4, 50%); anxiety and fear of cancer recurrence (n = 4, 50%); grief, identity narrative and post-treatment processing (n = 3, 37%)
Uptake during COVID-19	Online videoconferencing (n = 6, 75%); telephone only (n = 2, 25%)
New clinical psychology client?	New client (n = 3, 67%); pre-existing client (n = 5; 63%)
Telehealth user prior to COVID-19?	No telehealth-delivered psychological therapy prior to COVID-19 (n = 5, 63%); telehealth-delivered psychological therapy experienced prior to COVID-19 (n = 3, 37%)
Example feedback regarding telehealth experiences ^b	<p><i>I thought they worked well in practice the face-to-face interaction felt less rambling and distant than a phone call. And having that contact did make me feel safer. However, I found that it was difficult to find a physical space to have the sessions in and talk freely in the way that the physical distance from my 'normal' life had allowed me to do. (Female, 17 years)</i></p> <p><i>It was very good at the time to stay connected that way [via telehealth] especially through COVID. Helped with managing my own personal struggles along with what was happening in the world around me (COVID). However, I did find it a bit impersonal. Being in person face-to-face is more beneficial. But it was adaptable for that time and I knew that we would eventually be able to have sessions face-to-face. Makes me appreciate and be more grateful to be able to have face-to-face sessions. (Female, 22 years)</i></p> <p><i>I like being able to do the appointments online as not living in [CITY] it is easy to connect and get the support needed. I also like it because some days with treatment you may be feeling a little 'off' and unwell and being able to have the calls from home and in comfort is a nice feeling. During COVID everyone needs to keep their distance and this way you are able to do that in the safest way possible and limit your exposure. It also makes it feel less confronting when talking about how you are coping and feeling as there is less pressure on you as you are not in an unfamiliar place. (Female, 25 years)</i></p>

^aLocation during the period where telehealth-delivered clinical psychology support was provided, as some AYAs would normally live in rural locations but re-located to a metropolitan area close to the hospital for the active treatment period.

^bFeedback included with permission.

TABLE 2 Factors that enabled successful engagement with telehealth-delivered care for young people and families during COVID-19

Factor	Experiences	Recommendations
Technology		
Online platform	Having a secure, versatile platform accessible via a range of devices was critical. Many patients connected using their smartphones	Have connection instructions you can email or text to patients in advance, including technology needed, and where would be an appropriate setting to connect from Consider a "test" session Ensure you have their telephone number so you can "walk them through" the process of connecting the first time if needed
Relational processes		
Consent processes	Patients benefited from discussions about the process of telehealth and hearing about experiences with other patients using it	Consider institutional and country-specific consent processes regarding telehealth Clarify for patients the security of the platform, and whether you will be recording Discuss in advance what you will do in the case of technical difficulties Ensure you have contact details (eg, phone) in case of disconnection/technical difficulties
Ongoing evaluation of telehealth model	AYA patients' preferences for/comfort with telehealth were variable. Some patients preferred a simple telephone connection to videoconferencing. Patients' engagement with telehealth was strengthened by continually reviewing how they were finding the modality and openly addressing when their situations meant that telehealth was no longer feasible (eg, due to lack of privacy at home)	Do not assume that particular patient groups will feel the same way about using telehealth. Patients' feelings about telehealth will likely also change over time Acknowledge the limitations and benefits of communicating using telehealth upfront Make time to explicitly "check in" with patients at each session about how they are finding the telehealth model. This could include asking about perceived advantages/disadvantages, what the patient-therapist pair are learning through the process (and/or about each other), and whether they would prefer to revert to face-to-face (if possible) or telephone-only connection
Risk management		
Regular screening, action plan should safety risks arise	As in face-to-face practice, patient presentation was part of risk screening as necessary Safety discussed with new patients upfront, also ensuring we had their home contact details in case concerns arose	Telehealth is appropriate to use with patient groups with a range of vulnerabilities, provided adequate risk screening is put in place prior to the first session, and at each online session Important to ensure contact details are available for the patient's home/next-of-kin, and/or a trusted health professional (eg, general practitioner) should acute mental health risks arise
Therapeutic strategies		
Explicitly naming/exploring their setting	Patients engaged with describing their current setting such as where they were, what room (and what they normally do in that room, eg., an "art room"), who else was home. This was especially helpful as rapport-building for new patients	Consider explicitly using the new online connection as a point of discussion and connection with patients/families, and an opening to learn about where each is situated, both in terms of their geography, their family/home situation and in terms of what they have experienced in their day/week so far
Flexible use of online tools	Collaborative exercises during sessions (eg, case formulation development, brainstorming new concepts) were undertaken using the "share screen" function to create a virtual notepad	Ensure familiarity with the online tool prior to use with patient so that you are ready to capitalise on all its features, to enable collaborative activities. Ensure computer desktop is presentable and ready for screen sharing prior to session

agitation)—different information can instead become available (*an adolescent's reaction as their parent knocks on their bedroom door can be instructive*). Moreover, an entirely new intimacy emerges when connecting with an individual using their smartphone while lying on their bed. In this case, their face can fill the entire screen, magnifying every micro-emotion that flashes across their face. Therapeutically, how often would we otherwise spend so much of a session closely observing the changing emotional engagement on a patient's face when they are in their own bedroom? Such experiences counteract the criticism that human connection is not possible.

Ultimately, comparing face-to-face with telehealth-delivered psychosocial services is an apples-and-oranges scenario; each modality shines and falters in unique ways; in a post-COVID-19 world, a pragmatic, complementary combination of the two will be beneficial. But patient-centred care does mean we need to pay attention to patients' and families' whole worlds when we engage with them. Face-to-face sessions may feel more satisfying to the health professional, but is it patient-centred if we are asking the young person to first drive (or be driven) 2 hours to reach us, and then pay parking costs for the visit?

Also worth considering, is that some individuals who have never previously accessed services might be more inclined to do so using telehealth. Though this contention has not been well studied, this may be especially the case for AYAs, who may be particularly susceptible to the stigma associated with mental health help-seeking, and who are also vulnerable to practical issues that can hamper their capacity to attend face-to-face therapy (eg, lack of independent transport if they do not have their driver's license).^{7,9} Telehealth may lessen logistical barriers and enable the comforts of the individual's home environment to dilute the anxiety or stigma associated with consulting a psychologist.^{2,7} This may be especially true for palliative care, a profession that continues to be hampered by stigma and taboos around its intent and core business.

So, as health professionals across the globe grapple with integrating telehealth into their patient care, we are hopeful it will live up to the hype. Much as exposure therapy can reduce an individual's fear of heights, we anticipate the exposure health professionals and patients alike have experienced during this pandemic will engender a sense of competence and confidence with telehealth. Studies have shown as much: as health professionals' experience with telehealth grows, so too does their satisfaction with it.⁶

True telehealth integration requires flexibly accounting for the human factors that play into its use. Beyond COVID-19, when our choices between face-to-face or telehealth expand once again, the opportunity to offer true patient-centredness in service delivery should prevail. Preferences cannot be assumed (see Table 1). Even among tech-savvy digital natives, telehealth is not necessarily their overwhelming preference, but an acceptable alternative for business as usual.¹⁰ And practicalities need careful consideration. Amidst this pandemic, we can report that telehealth has not been ideal for some of our patients, when home and family situation may be the very crux of their problems, where achieving privacy and a sense of security during a therapeutic session may not be possible from within the four thin walls of their bedroom (Table 1). By understanding what limited

telehealth's use prior to COVID-19, we can pave the way for its routine integration into the future—whatever our new physically distanced world looks like.

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DATA AVAILABILITY STATEMENT

N/A

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REFERENCES

1. Sansom-Daly UM, Wakefield CE, Bryant RA, The Recapture Life Working Party. Feasibility, acceptability, and safety of the recapture life videoconferencing intervention for adolescent and young adult cancer survivors. *Psychooncology*. 2019;28(2):284-292.
2. Connolly SL, Miller CJ, Lindsay JA, Bauer MS. A systematic review of providers' attitudes toward telemental health via videoconferencing. *Clinical psychology: science and practice*. 2020;First Published: January 6, 2020. 2020;27(2):e12311. <https://doi.org/10.1111/cpsp.12311>.
3. Sansom-Daly UM, Wakefield CE, McGill BC, Wilson HL, Patterson P. Consensus among international ethical guidelines for the provision of videoconferencing-based mental health treatments. *JMIR Mental Health*. 2016;3(2):e17.
4. Bradford NK, Caffery LJ, Smith AC. Telehealth services in rural and remote Australia: a systematic review of models of care and factors influencing success and sustainability. *Rural Remote Health*. 2016;16(4):4268.
5. Orlando JF, Beard M, Kumar S. Systematic review of patient and caregivers' satisfaction with telehealth videoconferencing as a mode of service delivery in managing patients' health. *PLOS One*. 2019;14(8):e0221848.
6. McGill BC, Sansom-Daly UM, Wakefield CE, Ellis SJ, Robertson EG, Cohn RJ. Therapeutic alliance and group cohesion in an online support program for adolescent and young adult cancer survivors: lessons from "recapture life". *J Adolesc Young Adult Oncol*. 2017;6(4):568-572.
7. Sansom-Daly UM, Wakefield CE, McGill BC, Patterson P. Ethical and clinical challenges delivering group-based cognitive-Behavioural therapy to adolescents and young adults with cancer using videoconferencing technology. *Aust Psychol*. 2015;50(4):271-278.
8. Bradford NK, Armfield NR, Young J, Herbert A, Mott C, Smith AC. Principles of a paediatric palliative care consultation can be achieved with home telemedicine. *J Telemed Telecare*. 2014;20(7):360-364.

9. Holland LR, Walker R, Henney R, Cashion CE, Bradford NK. Journal of Adolescents and young adults with cancer: barriers in access to psychosocial support. *J Adoles Young Adult Oncol*. 2020. <http://doi.org/10.1089/jayao.2020.0027>. Online Ahead of Print: June 2, 2020.
10. Chalmers JA, Sansom-Daly UM, Patterson P, McCowage G, Anazodo A. Psychosocial assessment using telehealth in Adolescents and Young adults with Cancer: a partially randomized patient preference pilot study. *JMIR Res Protocols*. 2018;7(8):e168.

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