

**HOW TO CITE THIS ARTICLE:** Tharoor H, Thara R. Evolution of community telepsychiatry in India showcasing the scarf model. *Indian J Psychol Med.* 2020;42(5S):69S–74S**Address for correspondence:** Hema Tharoor, Dept. of Mental Health and Social Sciences, Schizophrenia Research Foundation, Chennai, Tamil Nadu 600101, India. E-mail: hematharoor@scarfindia.org

Copyright © 2020 Indian Psychiatric Society - South Zonal Branch

Creative Commons Non Commercial CC BY-NC: This article is distributed under the terms of the Creative Commons Attribution-NonCommercial 4.0 License (<http://www.creativecommons.org/licenses/by-nc/4.0/>) which permits non-Commercial use, reproduction and distribution of the work without further permission provided the original work is attributed as specified on the SAGE and Open Access pages (<https://us.sagepub.com/en-us/nam/open-access-at-sage>).**ACCESS THIS ARTICLE ONLINE**Website: [journals.sagepub.com/home/szj](http://journals.sagepub.com/home/szj)  
DOI: 10.1177/0253717620958161

# Telepsychiatry and Telepsychotherapy: Critical Issues Faced by Indian Patients and Psychiatrists

Avinash De Sousa<sup>1,2</sup>, Amresh Shrivastava<sup>3</sup>, Bhumika Shah<sup>1</sup>

## ABSTRACT

Telepsychiatry and telepsychotherapy are new treatment modalities that have been used more than ever during the COVID-19 pandemic. There are many challenges that are faced with the use of this modality for both patients and psychiatrists alike. There are critical issues faced with regard to the development of rapport, managing the entire teleconsultation set up, privacy and issues related to fees, issues related to prescribing and monitoring, and issues while handling emergencies. The challenges faced are discussed and some solutions if possible are laid out. </Abs>

**Keywords:** Telepsychiatry, telepsychotherapy, patients, psychiatrists

Telepsychiatry and telepsychotherapy are by no means new treatment modalities as even from the 1960s consultations and therapy by using the telephone have happened.<sup>1</sup>

Even as these modalities came into more common use in other parts of the world, in India; however, it became more widespread in the last few years only. With the onset of the coronavirus disease (COVID-19) pandemic, there has been a surge in telepsychiatry services, online and telepsychotherapy services with patients and psychiatrists alike being compelled to resort to these media of services due to the restrictions imposed.<sup>2</sup>

There have also been the development of clear guidelines for telepsychiatry<sup>3</sup> and telepsychotherapy<sup>4</sup> from an Indian perspective. While these guidelines are truly comprehensive, some lacunae and gray areas remain in clinical practice that need to be addressed. The current article is based on the clinical experience of the authors and discusses the advantages and key issues faced by patients and psychiatrists in the rendering of these services in a private practice single standalone clinic scenario from an outpatient standpoint.

## Challenge 1: The Acceptability of Telepsychiatry and Telepsychotherapy as a Mode of Treatment

Many Indian patients have always been used to physically seeing their doctor, and in Indian society, with a patriarchal pedestal given to doctors, the concept of having visited the doctor and being examined by the doctor is vital to patient satisfaction.<sup>5</sup> Many patients may not accept telepsychiatry and telepsychotherapy as does not substitute the real experience of a clinic and a consultation. Patients often are not adept at using digital media and may not be able to connect

well on a video call. They would want to see their doctor clearly, and the feeling of remoteness exists and has been expressed by many patients when a teleconsult happens. It is also important to mention that doctors are also new to telepsychiatry and telepsychotherapy as a treatment modality and would need time to adapt to the same. They also need to start using these modalities regularly to understand what it entails and offer better services to their patients. There is a need for psychiatrists to be trained in telepsychiatry while, more importantly, patients need to be trained in using the right media and right devices to get the most of the telepsychiatry consultation and more so because they are actually paying for the service. More awareness in the general public needs to be created with regard to telepsychiatry as a modality to enable more users to accept and utilize it as a treatment method.<sup>6</sup> There is a need for the establishment of full-time telepsychiatry units in the current scenario in various medical colleges and hospitals to cater to the needs of varied populations.

## Challenge 2: Prescription of Various Drugs via Telepsychiatry

One of the major challenges for psychiatrists is the prudent and judicious pre-

scription of medication via telepsychiatry. Although most psychiatric drugs are safe and can be prescribed via telepsychiatry, there is a need to be able to monitor various parameters while the patient is put on certain medications. The prescription of injectables like depot antipsychotics via telepsychiatry can only be affected through a registered medical practitioner or a trained health worker.

There is a confounding area on whether drugs like disulfiram could be prescribed via telepsychiatry in view of treatment-emergent side effects and possibilities of disulfiram ethanol reactions that can occur. Prescribing drugs like lamotrigine or clozapine will require monitoring for drug reactions or drug levels. Patients may not follow-up regularly in telepsychiatry. Thus, life-threatening side effects may occur, and the prescribing doctor may not be in a position to follow-up and monitor the same in patients. The telepsychiatry guidelines list these drugs under list B, and hence doctors must exert utmost caution while prescribing the same. The issue of prescribing these drugs also arises when the patient is already maintained on the same rather than starting a new prescription. It is also prudent to mention that sometimes these drugs may be the drug of choice for the condition the patient presents with, like treatment-resistant schizophrenia in the case of Clozapine. The decision is best rested with the treating doctor.<sup>7</sup>

### **Challenge 3: When Patients May Misuse Telepsychiatry**

There may be instances when patients may turn to telepsychiatry for want of a prescription of the drug that they want to abuse. This happens when patients that have been misusing and escalating the dose of the drug on their own may visit a psychiatrist and suggest that certain drugs suit them better just to procure a prescription of the same. These patients may escalate dose on their own and not adhere to the prescription. They may also visit different helplines and telepsychiatry portals and take the same prescription from different doctors to have a greater stock of their drug of abuse, and this may result in them gaining further impetus in their abuse patterns.

One issue that we have observed due to teleconsultation is the rise in fake calls with the aim to seek prescriptions for benzodiazepines and other drugs of abuse, including cough syrups. Many patients who want to abuse drugs may manage to get multiple prescriptions by calling numerous doctors. There are no robust mechanisms to check these tendencies, and in the situation of a drug overdose, the prescribing doctor can be blamed.<sup>8</sup> The current telepsychiatry guidelines are clear about which drugs must be prescribed, where caution is to be exerted and which drugs must not be prescribed.<sup>3</sup>

### **Challenge 4: Telepsychiatry in Special Populations**

One of the major challenges of telepsychiatry is the use of the same in special groups like older adults and children and adolescents. Older people may not, at times, have the digital know-how to be part of video sessions and thus may be crippled while using telepsychiatry. They may, at times, have to use an audio call and may also have problems in accessing documents that are emailed and prescriptions that may be sent. Even after receiving medication and treatment online, most elderly are alone and may not have access to medications and thus may not be able to procure medication that has been prescribed.<sup>9</sup>

At our center, we observed that many children and adolescents suffering from attention deficit hyperactivity disorder had to stop methylphenidate as it was not available on an e-prescription. Many of these children were prescribed atomoxetine, which did not have the same effect. Parents may want to be around children and adolescents during telepsychiatry counseling sessions and may thus not allow the privacy that is otherwise possible in a clinic setting.<sup>10</sup>

### **Challenge 5: The Issue of Fees in Telepsychiatry and Telepsychotherapy**

There are many clinical, legal, and ethical dilemmas that confound fees in telepsychiatry and telepsychotherapy. One of the first dilemmas is whether fees must be collected in advance before the session in order to confirm the ap-

pointment and whether fees would be refunded in the event of cancellation of sessions. This would all have to be mentioned in the proforma and consent form that patients may fill. The issue of collecting fees in advance is a vexing one, as normally doctors usually collect their fees after a consultation. Furthermore, doctors may have to run after patients who do not pay fees even after having received a full consultation. Another issue is whether the fees charged for a telepsychiatry consultation must be the same or must be less than a face-to-face consultation. This is so as most people believe that the face-to-face consultation has far more value than a video consultation. Another important facet is that in India, many doctors offer advice on the phone and usually do not charge for the same. Even as many nongovernmental organizations and voluntary agencies offer telepsychiatry services free of cost, the private practitioners is in a dilemma whether they must charge for the services. Many doctors who never charged for telephonic advice may have to charge now as their telephone consultations are the only source of income for them.<sup>11</sup>

### **Challenge 6: Handling of Psychiatric Emergencies in Telepsychiatry Settings**

Another concern with telepsychiatry is the handling of psychiatric emergencies. The key question is how does one handle a patient that may be suicidal and who refuses to give details of family members, and the only details we have are his address and personal details with no details of family members. It is important that when a patient calls a psychiatrist for a telephonic consultation and expresses suicidal ideation, and may leave the consultation suddenly, or switches off his phone, the psychiatrist must inform the local police about the same. The psychiatrist must keep details and the name and number of a relative who can be informed in such emergencies. One can keep the number of anyone the patient deems fit as many patients may be feeling some oppression by their family members itself.

This may also happen when someone on the phone may disclose domestic vi-

olence and child sexual abuse, and when under the law, we are supposed to report such matters to local authorities. Do we refer such patients to specific helplines for these causes or do we take it on ourselves to report such matters and there is also a need for specific telepsychiatry units that cater to specific cases and probably have trained personnel to manage such cases when they arise.<sup>12</sup>

### **Challenge 7: The Medium to Conduct Telepsychiatry Services**

There is a debate about whether telepsychiatry would be conducted on a special application devised for the same or whether social media platforms like WhatsApp and Skype would suffice for counseling sessions. Many doctors use WhatsApp or Skype as a medium for communication using their personal phone numbers. Even if the service is free, would using their personal number be a viable approach or whether one must have a dedicated phone line for the same. There is a chance for lack of encryption, privacy, and chances of these accounts being hacked, which is an issue as many times personal chats here are intertwined with personal chats and groups. Guidelines on the storage of records of teleconsultations, chats, and legal aspects of these services is another dilemma for the telepsychiatry movement. There will also be an additional investment in this infrastructure if security and storage had to be maintained.<sup>13</sup>

### **Challenge 8: Research in Telepsychiatry and Telepsychotherapy**

Telepsychiatry and telepsychotherapy hold enormous potential and needs to be permanently available rather than just in times of emergencies and pandemics. Indian studies on reliability, efficacy, and cost-effectiveness of telepsychiatry also need to be carried out in the future in both rural and urban settings. Postgraduate students must be encouraged to take up research in these areas. Psychiatrists and psychologists in training must be prompted to work in helplines and telepsychiatry units so that they get

a first-hand idea of how these services function. Unlike the west, we need large, robust studies on telepsychiatry operations across rural and urban landscapes, and the data gathered shall help us establish the efficacy of the system while also fill lacunae that exist. These studies need to be planned well to assess both the operational and the interventional dimensions of telepsychiatry.<sup>14</sup>

### **Challenge 9: Training in Telepsychiatry and Telepsychotherapy**

Many voluntary agencies have started offering free mental health services telephonically during the COVID-19 lockdown. While these services are available, there is no stringent body, guidelines, or regulations that would monitor the quality of these services and whether ethical standards are adhered to. Doctors and professionals offering telepsychiatry services must be qualified and trained in this regard to some extent. Different clinicians may have different telepsychiatry approaches, which may result in nonuniformity of telepsychiatry services across the country. Mental health professionals handling calls in a helpline need training on the various types of calls that may come and how they have to respond in various situations. There must be help and access to legal authorities and police where needed in emergency situations. It is also vital that all procedures be laid down on writing as a standard operating procedure for the organization so that no deviation from what has been stated happens.<sup>15</sup>

### **Challenge 10: Critical Issues in Telepsychotherapy**

Telepsychotherapy may either happen in an audio or video format. It is very important to have sound internet connectivity so that no interruptions in sessions happen when video calls are being used in therapy. There have been arguments that telepsychotherapy aided with video calls may dehumanize the therapeutic environment and remove the basic essence of psychotherapy, which was supposed to be a face-to-face treatment. There is a need for therapists to also be aware of issues like setting and place

of treatment when online. There must be a clinic like atmosphere, not the background of the house, one must be dressed appropriately, and the same goes for patients as the seriousness of a therapeutic environment needs to be maintained. There is also a need for adherence to time and conduction of the therapy in a professional manner. No distractions and interruptions from family members must happen even if the therapist operates from home. There is a need for psychotherapy courses to have specific modules and training in online or telepsychotherapy in the view that very little about the same is taught in postgraduate psychology programs. Even a diploma course in the same is warranted considering the current situation.<sup>16</sup>

### **Challenge 11: Institutional and Private Practice Telepsychiatry/ Telepsychotherapy**

There is also a huge difference between telepsychiatry practice in a government or medical college set up versus in private practice. Although there have been guidelines that have been set, many a time, private practitioners, particularly in stand-alone single doctor private clinics, may have their own styles of delivering telepsychiatry care. Many times, in cases of emergencies, there may be a need to issue prescriptions to old patients who have been under the care of the doctor at the behest of relatives. This is more so when the patient may refuse to come on the video call, maybe aggressive or noncompliant with medication prescribed earlier. Sometimes patients may be referred to the doctor via known sources, and he may have to see them and prescribe medications in emergency situations, and this is more so in places where medical colleges or government hospital help may not be possible. This may also be the case where the patient is staying far away from the doctor's clinic and cannot travel for a consultation physically. Thus, all the guidelines may not always be adhered to correctly, and some laxity may be exerted. In a private practice set up, when the referral is through known sources, it may appear rude if the doctor asks for the identification of the patient on telepsy-

chiatry platforms, especially when a patient known to the doctor introduces the new patient as a close relative. These are practical difficulties that are encountered in a private practice set up.<sup>17</sup>

## Challenge 12: Telepsychiatry, Telepsychotherapy, and Advertising

The challenge of letting people know that telepsychiatry services exist is one that is fraught with an ethical dilemma. If the doctor puts up posters of his telepsychiatry services along with pictures of himself, it may attract censure as a form of advertisement. There is also a chance that patients may feel that this is a money-making gimmick. There need to be guidelines with regards to the poster, permissible content, and how one may not be pulled up by medical councils when using social and print media to advertise telepsychiatry services.<sup>18</sup> The current telepsychotherapy guidelines laid out speak clearly about misconduct in this regard.<sup>4</sup>

## Challenge 13: Certain Issues That Are Specific to Telepsychotherapy

Telepsychotherapy poses its own unique challenges for practitioners and patients alike. It is worthwhile to think whether 45 minutes to an hour of online or telephonic counseling could be at par with face-to-face counseling. This may be mutually decided. There may be difficulties in developing rapport and establishing a sound therapist-patient relationship solely over an online video consult. There are many facets of emotional and body language observations that may not be possible over the video as would be in a clinic setting. Both therapists and patients are not used to speaking into a screen for long times, and even therapy dynamics may not evolve as robustly as in a face-to-face consult. Many aspects of psychotherapy that involve focused conversations between therapist and patient may not be as effective in telepsychotherapy as would be in a regular clinic setting. Rules may also have to be set for missing appointments online, late arrivals and exceeding time limits as would be in regular psychotherapy.<sup>19</sup>

There are other issues that also remain at large. Consent may be obtained via online means or as physically signed to be scanned and emailed. There may be times where an in-person consult may be essential to ascertain facial expression and also to conduct a proper mental status examination.<sup>4</sup> Robust and practical guidelines for telepsychotherapy in the Indian setting are available, and the same is true for family therapy in case of social work via teleconsultation are available.<sup>20</sup>

## Effectiveness of Telepsychotherapy Services

There have been multiple studies and systematic reviews that have been done with regard to both computer-assisted psychotherapy and telepsychotherapy services for various psychiatric disorders, while the literature base from India is scarce. The computer-assisted therapies serve as useful means of therapy when there is a scarcity of professionals, and the caseload is high, and when the demand and supply needs are not met with therapists and clinicians in person.<sup>21</sup> These forms of therapy have been useful for the patient who is unable to travel while they can avail therapy at their homes linking many people to systems of care in an affordable manner. Mild cases that may not need direct clinical interventions may also benefit from such services.<sup>22</sup>

There has been one meta-analysis of internet-based cognitive-behavioral therapy (CBT) for depression (four studies) and anxiety disorders (seven studies). The effect sizes reported for interventions targeting anxiety was greater ( $d = 0.96$ ) than for depression ( $d = 0.4$ ). Significant variability in the studies existed, and they concluded that studies that had clinician-based support did better than those with computer-assisted intervention alone.<sup>23</sup>

A review on internet-based CBT found just two papers on the same with good effect, but the study size was too small to give robust evidence, and further evidence for the same remains to be ascertained.<sup>24</sup> Also, many internet-based CBT interventions have been developed by multiple individual researchers from a monetary aspect rather than a rigorous focus on quality. There is a need for good methodological rigor when it comes to developing these online therapies so that

the quality and essence of the intervention are retained rather than focusing on financial aspects.<sup>25</sup>

A good amount of literature is available on the internet and web-based interventions for smoking and tobacco cessation, as well as other substance use disorders. Most of these studies have huge heterogeneity in inclusion and exclusion criteria, diagnostic criteria for substance use disorders, and methods used in the web-based and computer-assisted interventions.<sup>26</sup> Some authors have dismissed it as a descriptive feast but an evaluative failure while carrying out meta-analyses of the same. Despite positive effects, many of the studies on smoking cessation and alcohol use had a website that did not cover the key components of cessation treatment as recommended in the national guidelines with huge inadequacies in the accuracy of the information presented and variability in the level of interactive features.<sup>27</sup> Recent better studies have been appearing, albeit with small sample sizes and methodological issues that remain abundant.<sup>28,29</sup>

A systematic review and meta-analysis involving 21 studies and 810 participants found guided self-help to be as efficacious as face-to-face psychotherapy for depression and anxiety and mentioned that we must look at using guided self-help in routine care.<sup>30</sup> A review that looked at 44 studies, 27 of which were randomized controlled trials (RCTs) found that compared with standalone face-to-face therapy, blended therapy is superior. It saves clinician time, leads to lower dropout rates and greater abstinence rates of patients with substance abuse, and help maintain changes got via psychotherapy. However, there is a lack of comparative outcome studies when one looks at the superiority of the outcomes of blended treatments in comparison with traditional face-to-face or internet-based treatments in substance abuse disorders.<sup>31</sup> A recent small review of 15 studies that compared interactional aspects of telephone and face-to-face psychological therapy found little difference between them concerning therapeutic alliance, disclosure, empathy, attentiveness, or participation. However, telephone therapy sessions were significantly shorter than those conducted face to face.<sup>32</sup>

A Cochrane review for internet-based CBT in anxiety disorders in adults reviewed 38 studies (3214 participants) with the use of internet-based CBT for social phobia (11 trials), panic disorder with or without agoraphobia (8 trials), generalized anxiety disorder (5 trials), post-traumatic stress disorder (2 trials), obsessive-compulsive disorder (2 trials), and specific phobia (2 trials), and mixed anxiety disorders (8 studies). The review showed that therapist-supported internet CBT is an efficacious treatment for anxiety in adults. There was also no significant difference in outcome between unguided CBT and therapist-supported internet CBT, and therapist-supported internet CBT may not be significantly different from face-to-face CBT in reducing anxiety in adult patients.<sup>33</sup>

A systematic review of internet-delivered transdiagnostic and tailored CBT for anxiety and depression evaluated 19 randomized trials with a total of 2952 participants. It was concluded that when compared to disorder-specific treatments, there were no differences on anxiety and quality of life outcomes, while there were differences in depression outcomes. Transdiagnostic and tailored internet CBT are effective interventions for anxiety disorders and depression and must be integrated into regular care.<sup>34</sup>

A Cochrane for internet-based psychological therapies in chronic pain evaluated 15 studies and 2012 participants. The therapies reduced pain and disability post-treatment; however, no clear evidence of benefit was found for depression and anxiety. Headache patients benefited the most from such treatments.<sup>35</sup> Another review on the efficacy of therapist-guided and self-guided internet-delivered treatment for young adults with symptoms of anxiety and depression found no significant differences between the two forms of therapies on various aspects of psychological treatment, but overall therapist guided methods had a slight edge over self-guided internet-based treatments.<sup>36</sup> Research in this domain is yet nascent in India, and we need systematically conducted research studies in India that efficiently work across different centers and negotiate cultural barriers and yield evidence to support the need to integrate telepsychotherapy into routine mental health care.

## Certain Other Critical Aspects

1. There are guidelines that have been developed for telepsychiatry though we do not have an adequate research base or clinical experience, unlike the west. There is a need for modification of these guidelines as this would be useful information as we go along and encounter newer problems along the way, and multiple revisions in the existing guidelines will be needed as telepsychiatry progresses.
2. There is a need for doctors who practice telepsychiatry to be culturally aware as India is a land of multiple religions and cultures. The patient using the telepsychiatry service may not be from the state or background, and cultural beliefs about mental illness and treatments present in that state must be known to the doctor treating such patients.
3. There will be a need for specialized telepsychiatry services to be developed for geriatric psychiatry, dementia, developmental disabilities, children and adolescents, and women so that patients with specific problems may access specialists to get a proper solution to their problems.
4. Telepsychiatry aided by a local doctor or nurse may be needed when a clinical examination is needed or when some facts and symptoms may not be ascertained over a teleconsult or video call.
5. We need to be digitally sound and aware, digitally literate, and make ourselves equipped to understand all gadgets and equipment we use well before we look at telepsychiatry as a good platform for regular use. A dedicated space for the same, proper background, and other logistics must also be in place.
6. There is a need for therapists and psychiatrists to keep adequate audio and video recording as per the guidelines of the Mental Healthcare Act 2017.<sup>37</sup> There is also a need to explore established online options like online CBT.<sup>38</sup> The role of using virtual reality and other forms of virtual reality interventions using psychotherapy must be explored in the cur-

rent online therapy paradigm and must be used to the maximum to facilitate a better psychotherapy experience.<sup>39</sup> Couples may also engage in marital therapy online together and separately, and the scope to expand the services for sex therapy to married couples must be explored via online programs and treatment paradigms.<sup>40</sup>

## Conclusions

India is a vast country with diverse societies, cities, and communities, and there cannot be a single model of telepsychiatry services. One should not hesitate to develop as may model as necessary, and it would be unfortunate to push for a uniformity concept. The financial and administrative limitations of telepsychiatry in smaller settings should not jeopardize the best possible interest of the patients. Telepsychiatry services need to be based upon a team approach to provide follow-up care. We need to be sure about what can be provided, what cannot be provided, and what should be optional depending upon the confidence of the clinician and his comfort. We may certainly feel confident about doing everything in psychiatry, all treatments, and working with all subgroups, but there must always be a need to set standards and explore newer options and necessities. The risk of litigation, allegations of neglect, the poor risk assessment needs to be kept in mind, along with adherence to rules and regulations. The subject of telepsychiatry is not yet incorporated in post-graduate and undergraduate training, and there is no well evaluated, peer-reviewed program to support it as a service where we can improve efficacy in terms of outcome deliverables. Telepsychiatry is here to stay, and we need to make it a very viable model for the country just as it has stuck for the west. We must also keep ourselves abreast of the advantages of virtual reality and the need to incorporate the same in telepsychiatry and telepsychotherapy as the future of this field shall be immensely technology-driven.

### Declaration of Conflicting Interests

The authors declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

## Funding

The authors received no financial support for the research, authorship, and/or publication of this article.

## References

- Naskar S, Victor R, Das H, et al. Telepsychiatry in India—where do we stand? A comparative review between global and Indian telepsychiatry programs. *Indian J Psychol Med* 2017; 39(3): 223–242.
- Math SB, Moirangthem S, and Kumar NC. Tele-psychiatry: after Mars, can we reach the unreachable? *Indian J Psychol Med* 2015; 37(2): 120–121.
- Board of Governors. Telemedicine practice guidelines enabling registered medical practitioners to provide healthcare using telemedicine, 2020. <https://www.mohfw.gov.in/pdf/Telemedicine.pdf> (last accessed August 10, 2020).
- NIMHANS. *Guidelines for tele-psychotherapy services*. Bengaluru: NIMHANS, 2020. <https://nimhans.ac.in/wp-content/uploads/2020/04/Guidelines-for-Telepsychotherapy-Services-17.4.2020.pdf> (last accessed August 10, 2020).
- Goodyear-Smith F and Buetow S. Power issues in the doctor–patient relationship. *Health Care Analysis* 2001; 9(4): 449–462.
- Rangaswamy Thara JS. Mobile telepsychiatry in India. *World Psychiatry* 2013; 12(1): 84.
- Nichols J, Gannon JM, Conlogue J, et al. Ensuring care for clozapine-treated schizophrenia patients during the COVID-19 pandemic [published online May 26, 2020]. *Schizophr Res*. DOI: 10.1016/j.schres.2020.05.053.
- De Sousa A and Karia S. Telepsychiatry during COVID-19: some clinical, public health, and ethical dilemmas. *Indian J Pub Health* 2020; 64(6): 245–246.
- Malhotra S, Chakrabarti S, and Shah R. Telepsychiatry: promise, potential, and challenges. *Indian J Psychiatry* 2013; 55(1): 3–11.
- Malhotra S, Chakrabarti S, Shah R, et al. A novel screening and diagnostic tool for child and adolescent psychiatric disorders for telepsychiatry. *Indian J Psychol Med* 2015; 37(3): 288–298.
- Satalkar P, Shrivastava S, and De Sousa A. Internet-mediated psychotherapy: are we ready for the ethical challenges. *Indian J Med Ethics* 2015; 12(4): 220–227.
- Shore JH, Hilty DM, and Yellowlees P. Emergency management guidelines for telepsychiatry. *Gen Hosp Psychiatry* 2007; 29(3): 199–206.
- O'Brien M and McNicholas F. The use of telepsychiatry during COVID-19 and beyond [published online May 21, 2020]. *Irish J Psychol Med*. DOI: 10.1017/ipm.2020.54
- Rangaswamy T. Using mobile telepsychiatry to close the mental health gap. *Curr Psychiatr Rep* 2012; 14(3): 167–168.
- Victor AM. Telepsychiatry and comprehensive mental health India. *Perspect Psychiatr Care* 2019; 55(3): 459–463.
- Chakrabarti S. Usefulness of telepsychiatry: a critical evaluation of videoconferencing-based approaches. *World J Psychiatry* 2015; 5(3): 286–304.
- Pandya A, Shah K, Chauhan A, et al. Innovative mental health initiatives in India: a scope for strengthening primary healthcare services. *J Fam Med Prim Care* 2020; 9(2): 502–507.
- Chakrabarti S and Shah R. Telepsychiatry in the developing world: whither promised joy? *Indian J Soc Psychiatry* 2016; 32(3): 273–280.
- Wade SL, Gies LM, Fisher AP, et al. Telepsychotherapy with children and families: lessons gleaned from two decades of translational research. *J Psychother Integr* 2020; 30(2): 332–347.
- NIMHANS. *Guidelines for tele-psychiatric social work practice*. NIMHANS, 2020. <https://nimhans.ac.in/wp-content/uploads/2020/06/Guidelines-for-Tele-Psychiatric-Social-Work-Practice.pdf> (last accessed August 23, 2020).
- Carroll KM and Rounsaville BJ. Computer-assisted therapy in psychiatry: be brave—it's a new world. *Curr Psychiatry Rep* 2010; 12(5): 426–432.
- Spurgeon JA and Wright JH. Computer-assisted cognitive-behavioral therapy. *Curr Psychiatry Rep* 2010; 12(6): 547–552.
- Spek V, Cuijpers P, Nyklicek I, et al. Internet-based cognitive behavior therapy for mood and anxiety disorders: a meta-analysis. *Psychol Med* 2007; 37(3): 319–328.
- Tumur I, Kaltenthaler E, Ferriter M, et al. Computerised cognitive behaviour therapy for obsessive–compulsive disorder: a systematic review. *Psychother Psychosom* 2007; 76(4): 196–202.
- Bewick BM, Trusler K, Barkham M, et al. The effectiveness of web-based interventions designed to decrease alcohol consumption—a systematic review. *Prev Med* 2008; 47(1): 17–26.
- Copeland J and Martin G. Web-based interventions for substance use disorders: a qualitative review. *J Subs Abuse Treat* 2004; 26(2): 109–116.
- Marsch LA and Borodovsky JT. Technology-based interventions for preventing and treating substance use among youth. *Child Adolesc Psychiatr Clin* 2016; 25(4): 755–768.
- Gilbertson RJ, Norton TR, Beery SH, et al. Web-based alcohol intervention in first-year college students: efficacy of full-program administration prior to second semester. *Subs Use Misuse* 2018; 53(6): 1021–1029.
- Paris M, Silva M, Añez-Nava L, et al. Culturally adapted, web-based cognitive behavioral therapy for Spanish-speaking individuals with substance use disorders: a randomized clinical trial. *Am J Pub Health* 2018; 108(11): 1535–1542.
- Cuijpers P, Donker T, van Straten A, et al. Is guided self-help as effective as face-to-face psychotherapy for depression and anxiety disorders? A systematic review and meta-analysis of comparative outcome studies. *Psychol Med* 2010; 40(9): 1943–1957.
- Erbe D, Eichert HC, Ripper H, et al. Blending face-to-face and internet-based interventions for the treatment of mental disorders in adults: systematic review. *J Med Internet Res* 2017; 19(9): e306.
- Flückiger C, Del Re AC, Wampold BE, et al. The alliance in adult psychotherapy: a meta-analytic synthesis. *Psychotherapy* 2018; 55(4): 316–340.
- Olthuis JV, Watt MC, Bailey K, et al. Therapist-supported internet cognitive behavioural therapy for anxiety disorders in adults. *Cochrane Database Syst Rev* 2016; 3: CD011565.
- Păsărelu CR, Andersson G, Bergman Nordgren L, et al. Internet-delivered transdiagnostic and tailored cognitive behavioral therapy for anxiety and depression: a systematic review and meta-analysis of randomized controlled trials. *Cogn Behav Ther* 2017; 46(1): 1–28.
- Eccleston C, Fisher E, Brown R, et al. Psychological therapies (internet-delivered) for the management of chronic pain in adults. *Cochrane Database Syst Rev* 2014; 2: CD010152.
- Dear BF, Fogliati VJ, Fogliati R, et al. Treating anxiety and depression in young adults: a randomised controlled trial comparing clinician-guided versus self-guided internet-delivered cognitive behavioral therapy. *Austr NZ J Psychiatry* 2018; 52(7): 668–679.
- Math SB, Basavaraju V, Harihara SN, et al. Mental Healthcare Act 2017—aspiration to action. *Indian J Psychiatry* 2019; 61(Suppl 4): S660–666.
- Andersson G and Cuijpers P. Pros and cons of online cognitive–behavioural therapy. *Br J Psychiatry* 2008; 193(4): 270–271.
- Riva G. Virtual reality in psychotherapy. *Cyberpsychol Behav* 2005; 8(3): 220–230.
- Hertlein KM. The integration of technology into sex therapy. *J Fam Psychother* 2010; 21(2): 117–131.

**HOW TO CITE THIS ARTICLE:** Sousa AD, Shrivastava A, Shah B. Telepsychiatry and telepsychotherapy: Critical issues faced by Indian patients and psychiatrists. *Indian J Psychol Med.* 2020;42(5S):74S–80S

**Address for correspondence:** Avinash De Sousa, De Sousa Foundation, Carmel, 18 St Francis Road, Off SV Road, Santacruz West, Mumbai, Maharashtra 400054, India. E-mail: avinashdes888@gmail.com

Copyright © 2020 Indian Psychiatric Society - South Zonal Branch



Creative Commons Non Commercial CC BY-NC: This article is distributed under the terms of the Creative Commons Attribution-NonCommercial 4.0 License (<http://www.creativecommons.org/licenses/by-nc/4.0/>) which permits non-Commercial use, reproduction and distribution of the work without further permission provided the original work is attributed as specified on the SAGE and Open Access pages (<https://us.sagepub.com/en-us/nam/open-access-at-sage>).

**ACCESS THIS ARTICLE ONLINE**

Website: [journals.sagepub.com/home/szj](http://journals.sagepub.com/home/szj)

DOI: 10.1177/0253717620960407

# Prescribing Psychotropics: Perspective From Telepsychiatry Operational Guidelines 2020

P Lakshmi Nirisha<sup>1</sup>, Barikar C Malathesh<sup>1</sup>, Narayana Manjunatha<sup>1</sup>, Channaveerachari Naveen Kumar<sup>1</sup>, Suresh Bada Math<sup>1</sup>, Rajendra Madegowda Kiragasur<sup>2</sup>

## ABSTRACT

As telemedicine gained both importance and momentum following COVID-19 pandemic, Telemedicine Practise Guidelines (TPG) March 2020 was notified by the Central Government of India. Following the above, the Indian Psychiatrists Society, Telemedicine Society of India (TSI) and National Institute of Mental Health and Neurosciences (INI), Bangalore came together to address the specific needs of Psychiatrists practicing tele consultations, there by releasing Telepsychiatry Operational Guidelines 2020. This article discusses the guidelines outlines in the above documents with respect to prescribing psychotropics. We have discussed the thought process behind formulation of Telepsychiatry Operational guidelines, the challenges that may arise while following the above guidelines with possible solutions.

**Keywords:** Telepsychiatry Operational Guidelines, Telemedicine Practice Guidelines, online prescriptions, e-pharmacy

Telemedicine in psychiatric care has opened avenues for individuals in need of psychiatric services ranging from consultation, obtaining medications, and obtaining nonpharmacological interventions. In the recent past, the Government of India has notified guidelines for telemedicine practice, *The Telemedicine Practise Guidelines—March*

2020 (TPG).<sup>1</sup> In lines with the above document, *Telepsychiatry Operational Guidelines—2020* was brought forth to tailor the use of Telemedicine in psychiatric practice. In this article, we would discuss the guidelines concerning psychotropic medications. “Psychotropic drug” is defined as any drug that can cause a change in mood, emotion, or behavior.<sup>2</sup> We will discuss the pros and cons of the guidelines, about writing an online prescription, on how to ensure that medications reach patients following a telepsychiatry consultation, and the ethical issues involved in all of the above.

During a teleconsultation, the psychiatrist has the responsibility of prescribing appropriate medications to the patient wherever required. Although the rules of Narcotic and Psychotropic Substances Act, Drug and Cosmetic Act 1940, and Rules 1945 apply while prescribing any medication similar to a traditional in-person consultation,<sup>3</sup> still some differences need to be understood while prescribing during a telepsychiatry consultation. Although there are some restrictions as to what drugs can be prescribed online and in what context, the same clinical practice guidelines that are applicable for in-person consultation also apply here. Telepsychiatry Operational Guidelines

describe the process involved in prescribing medication, that is, psychotropics from a psychiatrist’s perspective following a psychiatry teleconsultation.

## Prerequisite Before Prescribing Psychotropics Online

Prerequisite before prescribing psychotropic medication online is that the psychiatrist should arrive at a provisional or final diagnosis following a consultation; the mode of consultation can be audio/video/text. During a teleconsultation, if a psychiatrist is unable to arrive at a diagnosis, then an in-person meeting needs to be considered.

Prescribing medication following telepsychiatry consultation depends upon the following factors:

- Type of consultation: first or follow-up consultation
- Mode of consultation: text/audio (telephonic consultation)/videoconferencing
- The appropriate list of medicines suitable for a prescription will depend on the above two criteria

It is important to note that psychotropic medications should be written in generic names.<sup>4</sup>