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[Edited for grammar and clarity by CAMH]

Episode #8 – What all physicians need to know about telemental health

[Musical intro]

Allison Crawford: ***I think we're in the future. Although we've been doing telemental health for the last 10 years, I think now we're at a point where it's just about to become endless possibilities. So if you can imagine telehealth totally integrated into your daily work—so patients can either get care in the hospital, outside of the hospital, even within their own homes—and that we can do that with the flick of a switch.***

David Gratzer: Welcome to Quick Takes. My name is Dr. David Gratzer. And today, we're joined by Dr. Allison Crawford, psychiatrist here at CAMH, associate chief in the General Adult Psychiatry and Health Systems division and associate professor at the University of Toronto. And we are talking about telemental health.

Dr. Crawford, let's define what telemental health is.

Allison Crawford: Great question. And in fact, we're in the middle of rebranding: we went from telehealth to telepsychiatry and then recognized that it is over video, not telephone, so that's confusing to some people. So that was one thing that we realized, and also that we work as part of interprofessional teams. So we don't just want to emphasize psychiatry. We want to think about the broader context of mental health. We are moving to the term virtual mental health, but it will mean care via televideo, which can either be synchronous care, like in real time, or even asynchronous care, where you can take brief recordings of clients, and the psychiatrist can see them on their own time or at a different time.

David Gratzer: Times have changed. I mean, telemental health used to be very clunky, a lot of technology.

Allison Crawford: It's true: monitors the size of this room. Now you can do it on your phone if you wanted to, but certainly on a desktop computer. And you're not tied to one of the OTN—Ontario Telemedicine Network—systems that are tied to an intranet. Everything is doable on your own personal computer.

David Gratzer: And, of course, that presents a lot of advantages. What are some of the advantages you see for patients and their families?

Allison Crawford: I think flexibility. If we think about some of the barriers that different patients and clients will face, I think of people with chronic pain or people who have young children at home or who don't live right downtown and find it difficult to get in to CAMH. They'll be able to join from their own home or from a clinical site that's closer to their home.

David Gratzer: So this is going to be more convenient.

Allison Crawford: I think more convenient, and it's going to allow better continuity of care and follow-up, because we all know that people often come for a first consult and may not follow up. So I think reducing some of those barriers might keep people connected for longer. So it goes beyond convenience to actually getting better quality of care.

David Gratzer: A skeptic might say there's something about being in the room with a patient. Looking at the literature—and I know you not only know the literature, you contributed to the literature—how would you respond?

Allison Crawford: I think that's an area that we need to do more research in. But now what we know is that the care that's received virtually is just as valid. We have the same outcomes for the most part, make the same diagnoses. So there aren't major concerns in the therapeutic world, if you're doing psychotherapy. I do think more . . . there are also very good trials showing positive outcomes—for depression, for PTSD—through virtual care, even groups where people aren't together in the same room.

So we also carry with us a lot of that knowledge about relationships and about being in a room with people, so that even if you're not physically in the room with them, I think your mind still acts and reacts in the same way. If you've ever done psychotherapy by telehealth, you feel very similarly to what you would feel in the room. But I think more research is definitely needed.

David Gratzer: It sounds like the world of mental health care delivery is being reshaped.

Allison Crawford: I think it is, yeah. But I think it's also important that we think about our foundational principles and the things that we know provide good care, and make sure that we translate those into the digital world.

David Gratzer: Such as?

Allison Crawford: Well, just what you were talking about, about being in the room with someone. We're doing some work around digital compassion, for example, trying to understand the basic qualities of compassionate care and how those might be translated into the digital world.

David Gratzer: And what are some of your learnings so far?

Allison Crawford: That people—that generally patients—rate the quality of care and the relationship via telehealth better than providers. There are also things that are entrained in us and that we're used to in providing care; so, I think, exposing people earlier in their training, so that they feel like they're providing that compassionate care that they do in person. But certainly there's much less evidence that it matters to patients. Patients seem very satisfied with care that they receive virtually.

David Gratzer: So there's a lot of upside to patients: there's a convenience, they're unbound by geography. Are there disadvantages or things you worry about?

Allison Crawford: I do. I think especially in populations—in unique populations—I think we probably don't have the same preponderance of evidence. So, for example, working in smaller communities or with First Nations clients, there are conflicting studies. You know, there's one study that says that people prefer telehealth, because they don't have the issues around privacy and they have someone to see from outside of the community. On the other hand, there's a study that shows that it's much easier to pick up what we in psychiatry call externalizing problems, like anger or something that's more externally visible, than sort of internalizing problems, like anxiety or depression in some groups. So, again, I think in certain populations, we need more information, in order to provide culturally safe care.

David Gratzer: As a clinician, how might you compensate for those things?

Allison Crawford: Well, I think communicating with a client can go a long way. Especially as you gain facility and ease with telehealth, that you can ask the client, and say, "Hey, how is this feeling for you?" We have developed a satisfaction survey that we have validated for patients and for providers, and that's giving us some important information. We're also doing qualitative follow-up with people. So the program can ask people, but individually, as clinicians, we often check in with people.

David Gratzer: In thinking about Ontario—and some of our listeners aren't from Ontario, but thinking about Ontario—there's one big paper, which you're co-author on, talking about providers and the telemental health experience. Providers actually tend to be older, not younger. Why?

Allison Crawford: That was a huge surprise to us. We really thought that young people would be taking this on—new graduates—so that was a bit of a surprise. I think perhaps people have carved out niche aspects of their practice and so maybe are providing that telehealth, you know, as they've transitioned into other roles later in their career, or they're just more comfortable. We don't really know the answer to it. Maybe as you become a more experienced clinician . . . I feel much more flexible now than I did. I feel much more comfortable in my clinical skills than I did when I first graduated. So, perhaps, that's the reason. We don't really know.

David Gratzer: But you're an early adopter. You've actually been doing this since kindergarten.

Allison Crawford: Yes, pretty much.

David Gratzer: Joking aside. How did you get interested in telemental health?

Allison Crawford: I've been very involved in outreach since, really, residency and then very early in my career. As the director of the Northern Psychiatric Outreach Program, I worked in Nunavut, and I really valued working in those contexts but was concerned about the lack of continuity of care. Clients don't just necessarily need to be seen when you're on the ground, so being able to see people in between and also being able to provide indirect care is much easier via telehealth. You can just be more available.

David Gratzer: And how did your interest in scholarship around this grow?

Allison Crawford: I think I saw what a new field it was and there wasn't a lot of guidance. And I've been particularly interested in developing competencies for providers. I think a lot of people feel—while we want to be really encouraging and get lots of people to do telehealth—a lot of people also felt, "Oh it's just the same as in-person care." I think there are unique things to learn, and I was interested in that, so that we could not just teach residents, but get faculty involved and engaged.

David Gratzer: And pivot for a moment. Many of us are clinicians. What tips would you offer us with regard to telemental health versus an in-person assessment?

Allison Crawford: Do it. Try it. Don't be afraid of it—that's probably the number one. I think people get set; they already have established practices. We all have lots of people to see, so there's not much incentive, but I think being able to be available for your clients is a good rationale. So just do it. I think . . . to be aware of confidentiality and privacy—there are some unique considerations around those issues, and we've got lots of policy around that now. And, I think, to rely on the team on the other end: you may be seeing a client in their home, but if you're seeing them and they're at a clinical site, rely on the team at the other end. They can really bridge some of the things that are more challenging by telehealth, like lab work and physical exam and so on.

David Gratzer: Those are good tips, Dr. Crawford. Do you have other suggestions?

Allison Crawford: I think shadowing someone can be very helpful. If you do feel a barrier to doing it, if it doesn't come naturally to you, shadowing someone who's very used to telehealth can help. And also connecting with your administrative counterparts is extremely helpful. It sounds like, yes, it is as easy as turning the computer on, but there are lots of administrative tasks, especially when you're starting out, so partner with those people in your work. And we'd say number one is: don't just think about the ease of telehealth or the equipment, think about the end you're trying to achieve. So we do try to get people to keep in mind the community that they're serving and the patient's unique needs outside of the telemedicine studio.

David Gratzer: Those are the dos.

Allison Crawford: Those are the dos.

David Gratzer: What are the don'ts?

Allison Crawford: Well, I'm going to turn one of the dos into a don't. Don't forget about privacy and confidentiality. So, for example, there are still prescribed ways that we can offer telehealth. You can't do it on Skype or on Facebook. It has to be an accredited provider. Right now, those are all through the Ontario Telemedicine Network in Ontario, but I'm sure each province has guidelines around that. And don't forget about getting informed consent. It really is up to the individual provider to assess the capacity of the person in front of them on telehealth, about whether they're suitable to receive telehealth, consult tour or treatment. And that needs to be documented in the chart, so don't forget to do that.

David Gratzer: And there are also a couple other things that are different since the person isn't beside you: you need to think a bit about geography, if the person were to need a certificate or something of the sort.

Allison Crawford: That's one of the most common questions that we get asked. Yes, you can certify someone under the Mental Health Act via telehealth. Sometimes there are easier ways to do it, in collaboration with people on the other end. You can always call the police if you're worried about people. But, absolutely, safety is an issue, and especially as we move more and more into providing care within people's homes—we definitely have to think about safety. One of the things that we're doing at CAMH is ensuring that the first time someone is seen for a consult, they're in a clinical setting, even if it's by telehealth.

David Gratzer: So maybe there's a big role for telemental health, but maybe the first contact ought to be in person.

Allison Crawford: It could be in person or it could be at a clinical site, so that there are other people around.

David Gratzer: Traditionally, this involves a lot of equipment and a one-on-one contact and usually is telephone or telephone and video. That's evolving a lot with the technology. How do you think this is going to look in the next few years?

Allison Crawford: Well, I think we'll see very seamless integration. So when you open the electronic health record, there'll be a button there—we'll see that this year, I think. There'll be a button there, and you can connect with the client via that button, right in their health record. So it's not going to feel like a lot of extra steps and it's not going to involve really specialized equipment. I also think the other area is going to be offering more interventions. So we know that evidence-based treatment is not usually just a consult. There are lots of interventions: psychotherapy, motivational interviewing, group therapy, things that require follow-up. And I think we're going to see that, but we need investment by the province in interprofessional care, not just psychiatrist-driven care.

David Gratzer: So, historically, a person goes to see his or her psychiatrist, and now somebody could do this virtually, in their office, in their home, in their favourite Starbucks.

Allison Crawford: Well, that's a very interesting point. I mean, it's one thing that we are really telling people: it's up to you as a clinician, when you sign on to telehealth, to inform patients that they should be in a confidential and private location and to think through some of the limitations of certain settings. So, definitely, they can't be in a moving vehicle. That's happened before, but now we are very explicit about that, and it behooves the clinician to be in a clinical setting. So one that is private, quiet and conducive to doing that kind of work.

David Gratzer: Dr. Crawford, you've provided a lot of information for people interested in learning more. What are some resources you might recommend?

Allison Crawford: Well, I will say it again: I think doing it is the best resource—so just really exposing yourself to doing telemedicine and shadowing someone, if necessary. One of our limitations in Canada: we don't have any current telemedicine or telepsychiatry guidelines. There are some very dated ones. There's some very vague guidance from the CPSO and the CMPA, mainly that says it's up to the clinician to determine if the client is suitable for telehealth. There are some American guidelines: the ATA (Association for Telemedicine) and also the APA have put out joint guidelines, which can be useful to go over things. There's a textbook called Telemental Health, Clinical, Technical and Administrative Foundations, by Myers and Turvey, that's become kind of the standard in the field. And it's such a growing area of research, so MEDLINE is always good. We, in Canada, have developed competencies: if people are interested in training or teaching people, we have a competency framework.

David Gratzer: It is a Quick Takes tradition for us to close with a minute of rapid fire questions. We'll put a minute on the clock. Dr. Crawford, let's begin.

Dr. Crawford, you've done this for some time. What's the biggest surprise in telemental health?

Allison Crawford: How close you can feel to patients.

David Gratzer: Is this a big deal that the technology is changing?

Allison Crawford: Absolutely. It's going to make it way easier.

David Gratzer: Your big prediction for the next decade.

Allison Crawford: Volume. We will see a much larger proportion of our work done by telemental health.

David Gratzer: Should I give up my office?

Allison Crawford: You could. You can definitely wear pyjama bottoms to work.

David Gratzer: What is one tip you would suggest to clinicians, outside of pyjama bottoms?

Allison Crawford: Think about your video face.

David Gratzer: And what is one thing that concerns you about this and keeps you up at night?

Allison Crawford: What I would call cloud care: people providing care in community contexts where they're not connected to people.

David Gratzer: At the buzzer, one last question. Are you optimistic about the future?

Allison Crawford: Yes.

David Gratzer: Why?

Allison Crawford: I think that there's a lot of potential to create increased access to mental health and to put that back in the hands of patients to increase flexibility.

David Gratzer: That at the end of the day, it's not about technology, it's not about delivery of care, it's about empowering people to get care on their terms.

Allison Crawford: It is, while not forgetting about their relationships. That would be my only worry. That's one of our strengths in psychiatry: that we know about relationships. And that's still more important than machines.

David Gratzer: That's this episode of Quick Takes. If you liked this topic and you want to do a deeper dive, we would point out that this is now part of a larger digital mental health certificate course, which you can find more information on, on our web page.

Until next time.