

# Virtual Mentor

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## ETHICS CASE

### Telepsychiatry as Part of a Comprehensive Care Plan

Commentary by Nicholas Freudenberg, MD, and Peter M. Yellowlees, MBBS, MD

Dr. Lincoln, a young psychiatrist with a successful telepsychiatry practice, received a call from Dr. Adams, a hospital psychiatrist who had referred a patient to him a few months earlier.

Dr. Adams explained that he had Dr. Lincoln in mind for a patient named Justin whom he had been seeing recently. Justin had served in the military and completed a tour of combat Afghanistan, where he sustained a severe injury to his leg that ended his military career. He had been suffering from posttraumatic stress disorder and severe depression since his return home. After several months' unsuccessful struggle to find a job, Justin moved in with his parents and, frustrated with his physical condition, attempted suicide by drug overdose. Dr. Adams had been seeing Justin daily for four weeks and had started him on medication that appeared to be having some positive effect. Justin was ready to be discharged home to the care of his parents and thrice-weekly outpatient treatment, but, Dr. Adams explained, the hospital's psychiatrists couldn't take on additional outpatients at the moment, and Justin lived 200 miles from the nearest VA clinic.

Dr. Lincoln agreed to take Justin on. Their first tele-session took place the following afternoon, and Justin kept all of his appointments for the first two weeks. But Dr. Lincoln noticed that, by the third week of their psychotherapy sessions, Justin seemed to be losing his enthusiasm. Justin also reported feeling that his medication was not helping him as much as it had initially done. Dr. Lincoln encouraged Justin to give the treatments a chance to fully exert their effects. In closing the session, he asked Justin—as he had in each of the prior sessions—if he had plans to hurt or kill himself. “No,” Justin mumbled, and then, at a fainter volume not picked up by the webcam, he added, “not today.”

Two days later, Dr. Lincoln logged on to his computer for his scheduled session with Justin. When the appointment time arrived, Justin's username failed to show up on the screen. Later that afternoon, Dr. Lincoln was contacted by Justin's parents, who informed him that Justin had committed suicide that morning.

## Commentary

This case scenario concerns a patient with severe symptoms, an elevated risk for self-harm, and limited access to care. With its tragic ending, the case raises several questions. How does the effectiveness of telepsychiatry compare with in-person treatment? Did Justin's treatment meet the standard of care? Is telepsychiatry

inappropriate for some patients? Would a different approach have prevented Justin's suicide?

In a 2013 review article, Hilty et al. [1] concluded that the effectiveness of telepsychiatry was equivalent to that of in-person psychiatric treatment according to the data available at that time. The article also noted that telepsychiatry increased access to care, which improved outcomes. No specific diagnostic or demographic subgroups were identified for whom telepsychiatry would be inappropriate. For example, psychotic patients were not found to have incorporated the teleconferencing equipment into the content of delusions [1]. Certain subgroups, including children; adolescents; and patients diagnosed with ADHD, panic disorder, and agoraphobia responded positively to telepsychiatry [2].

Telepsychiatry also reduces the need for inpatient treatment among patients who have previously received it. A four-year study that measured outcomes for patients receiving mental health telecare within the VA system reported that hospital inpatient utilization decreased by 25 percent among study participants [3]. While more research is certainly needed to evaluate the long-term effectiveness of telepsychiatry and in-person mental health care, it should be noted that for a great number of patients the choice is not between telepsychiatry and in-person treatment but rather between telepsychiatry and no psychiatric care.

Justin appears to be in such a situation. Thus, Dr. Adams's choice to refer Justin for telepsychiatric care, a modality shown to be of equivalent efficacy to in-person care, was quite reasonable. The poor trajectory of Justin's condition after his transition to outpatient care is of concern, however. Was that trajectory related to his treatment, or was it an issue specifically related to telepsychiatry that contributed to the tragic outcome of this case?

Although Justin is a patient with severe pathology and a high risk for self-harm, thrice weekly visits with a psychiatrist would not be typical in an outpatient setting without the involvement of nonphysician practitioners. For example, in an intensive outpatient program, patients participate in group therapy and have the support of social workers. It is unclear from the vignette whether Dr. Lincoln had considered referring Justin for individual therapy, group therapy, or intensive outpatient or partial hospitalization programs, but these referrals would have been appropriate if such resources were available.

According to practice guidelines established by the American Telemedicine Association (ATA), "health professionals shall ensure that the standard of care delivered via telemedicine is equivalent to any other type of care that can be delivered to the patient/client" [4] and "the professional shall be familiar with local, in-person mental health resources should the professional exercise clinical judgment to make a referral for additional mental health or other appropriate services" [5]. This means that doctors seeing patients via teleconference have the same responsibility to refer their clients for needed services that they do when seeing them

in person. One potential difficulty for telepsychiatrists is that they are less likely to be familiar with the specific services in their clients' geographical areas. This is where the patient's local primary care doctor comes in.

Ideally all telepsychiatry treatment should involve close collaboration with clients' primary care physicians [6]. Approximately half of people treated for mental health and addictive disorders in the US are seen by primary care doctors and hospital emergency department staff for their problems [7]. Primary care physicians are a significant point of contact for those at high risk of suicide; one review study found that 45 percent of those who died by suicide had seen their primary care physicians in the month preceding their deaths [8]. Considerable attention has therefore been given to the potential role for primary care doctors in identifying and mitigating suicide risk factors by, for instance, liaising with remote and local mental health professionals, addressing physical health needs, and decreasing barriers to care [9].

Primary care physicians can also play a valuable role in suicide prevention and intervention. Establishing a suicide safety plan is the standard of care in mental health. Safety plans typically involve suicide-prevention hotlines, mental health warmlines, on-call physicians, mobile crisis teams, first responders, and emergency medical services. In cases like Justin's, active participation on the part of the primary care physician is of vital importance.

One way to increase patient safety in such cases, and to improve collaboration with primary care physicians, is for patients to have videoconference appointments in the primary care medical clinic. When seeing patients in a clinic, telepsychiatrists and primary care doctors can communicate in real time and in the presence of the patient. Health care professionals are also available to assist patients who start to exhibit suicidal ideation. In clinical practice, this approach has been found to be useful, expedient, and therapeutic in urgent or emergency situations [4]. In the case of videoconferencing direct to the home, the ATA guidelines recommend the designation of a "patient support person" who can provide similar assistance in emergency situations [5].

In conclusion, current research shows that telepsychiatry offers a viable alternative to in-person mental health care, one that expands access to care and improves outcomes. Potential limitations of telepsychiatry can be mitigated by adherence to ATA guidelines and the employment of a collaborative approach, particularly one involving the patient's primary care physician. We offer the following specific recommendations:

- Telepsychiatry professionals must ensure that the standard of care delivered via telemedicine is equivalent to any other type of care that can be delivered to the client and should follow the ATA guidelines.
- Active collaboration with primary care physicians is strongly recommended.
- All practitioners should make themselves familiar with the services and resources nearest to the patient.

- Where there are safety issues, telepsychiatry visits should be arranged, if possible, at the patient's primary care clinic. If this is not possible or practical, a "patient support person" should be designated close to the patient for assistance in the case of emergencies.

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**Disclosure:** Peter M. Yellowlees is a co-founder and board member of the commercial telepsychiatry company HealthLinkNow Inc.

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