Telepsychiatry Training

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Telemedicine—the use of electronic technologies to deliver medical care at a distance—continues to gain popularity and widespread use in all medical specialties, including psychiatry.1,2 However, many residents enter their training without any clinical experience in telemedicine in general or its applications in psychiatry. Residents’ knowledge about telemedicine may come from reports in the medical literature that portray telemedicine as “difficult.”3 Some of these reports may leave residents thinking that telemedicine always requires special training; bulky, expensive equipment; and substantial technical support.

As with most other trainees, psychiatry residents are introduced to telepsychiatry services delivery anecdotally during their clinical rotations. Although there are some formal “telehealth” curricula that provide hands-on experience, these are lacking in many residency training programs.4 This is surprising because, unlike other medical specialties, telepsychiatry does not need sophisticated equipment or peripherals. This simplifies use, keeping costs and the need for technical support to a minimum.

Available technologies
Telepsychiatry applications range from no image (NI) technologies for information exchange, to interactive videoconferencing (VC) systems that exchange both information and image. NI applications include home-based telephones, e-mail, and interactive voice response devices that can be used for periodic patient monitoring and assessment.5 While lacking a visual component, NI telepsychiatry optimizes the real-time exchange of clinical and educational material between patient and clinician and allows patients to communicate from home rather than from a satellite clinic or mental health center.

Nearly all image-based clinical services in psychiatry occur through VC.6 Medication management, psychological testing, and individual and group therapy are services frequently offered through VC. In addition to these clinical applications, further expansion of telepsychiatry includes novel forensic uses such as commitment hearings using VC.7 Psychiatric assessments through VC can be as reliable as those done in person. Furthermore, patients evaluated through VC express levels of satisfaction equal to those seen in face-to-face therapy.8

A recent randomized trial investigated treatment outcomes and patient satisfaction in 2 groups of participants with depression. Each group received medication management, psychoeducation, and brief supportive counseling; one via traditional face-to-face treatment, the other using VC. Clinical outcomes and patient satisfaction were comparable for both treatment modalities.9

Telepsychiatry at work
In our outpatient, intensive case management clinic, third-year residents are introduced to telepsychiatry during their clinical rotation. In this clinic, videophones have been adopted as a complement to face-to-face medical care.10 Case managers carry videophones while making home visits and call the office-based attending or resident psychiatrist when a medical opinion is needed. Videophones are easy to use and are a valuable tool with which to introduce the novice clinician to
telemedicine concepts, advantages, and limitations. Technical terms such as “camera resolution” and “transmission speed” can be easily taught during the clinician’s rotation. Liability issues involved in remote assessments can easily be taught with this “plug-and-play” telehealth alternative. Because videophones are limited to the standard telephone system transmission speed of about 24 to 56 kilobits per second, there are limitations to their image resolution. For example, there can be a perceptible delay in image transmission that can limit the clinician’s ability to evaluate subtle signs such as affect and some small-amplitude movement disorders. Sudden movements of either patient or staff can result in a “frozen” picture or snapshot of either one, temporarily interrupting the video connection while maintaining the audio communication. Videophones offer an interactive video image alternative superior to NI technologies while allowing the patient to communicate from home. Anecdotally, our patients report they are satisfied for a variety of reasons. For patients who have multiple medical comorbidities that make travel uncomfortable, this portable modality can supplement face-to-face medical contact when an in-person evaluation is not required. Moreover, many patients appreciate being able to remain at home to care for their extended family and to perform other social functions. Other patients prefer videophones as a means of avoiding urban traffic or gasoline expenses.

Cautions for use
Videophones may not be a good alternative for patients with ideas of reference or other specific symptoms that may be exacerbated by this technology (eg, the fear that their image or thoughts are being recorded and/or broadcast). Patients with anxiety, hypomania, or psychomotor activity that exceeds videophone image transmission speed may also be unsuitable candidates for this technology.

Our clinical rotation introduces residents to less publicized aspects of telepsychiatry, such as its effect on the doctor-patient relationship and privacy-liability issues. While most of the literature on telepsychiatry has focused on service delivery, effects on the clinician-patient relationship remain largely understudied. Psychiatrists clearly require more than just the exchange of verbal information in the evaluation and treatment of patients.

Nonverbal data, including gestures, nods of the head, direction of gaze, smiles, or frowns, are necessary for the evaluation of the patient’s emotional state. The mutual exchange of such nonverbal signals helps ground the doctor-patient relationship and facilitates mutual understanding, clinical task completion, and the development of a positive therapeutic alliance.11,12 These nonverbal cues may have a perceptible transmission delay, even with high bandwidth (384 kilobits/s) VC equipment. In theory, this delay may lead to diagnostic errors. For example, a brief delay in psychomotor movements and a decrease in the cadence of speech may lead an inexperienced practitioner in telepsychiatry to suspect a depressive mood disorder. In addition to problems arising from bandwidth limitations, a limited field of view may also restrict evaluation. For example, a view confined to the patient’s head and shoulders does not permit evaluation of posture, or movements of the extremities. All these factors may interfere not only with diagnosis but also with development of the therapeutic alliance. This raises the question of whether an established in-person doctor-patient relationship is desirable before telepsychiatry is employed. Periodic face-to-face contact has been found to be helpful for patients treated mainly via VC.13 Clearly, these are issues in need of further controlled study.

Privacy and liability are other important issues to consider when practicing telepsychiatry. When using VC, it is important to place equipment in an area where privacy can be maintained. When using portable applications, visiting case managers at the originating site (usually the patient’s home) can assist in maintaining privacy. Practitioners at the distant site also need to make sure that there is no one else in the office during a teleconference. Use of alternate communication lines (redundancy) and/or emergency protocols should be discussed with patients and instituted in the event of sudden equipment failure.

Summary
As telepsychiatry continues to expand and become an alternative in underserved or remote populations, more and more residents are likely to encounter it. There is also increasing acceptance of telepsychiatry for reimbursement purposes. Several states now recognize telemedicine as a legitimate health care delivery modality. States such as Louisiana and California require private insurance plans and Medicaid to reimburse practitioners for telemedicine services and prohibit private plans from excluding telemedicine coverage services.14 Despite the issues described earlier regarding the clinician-patient relationship, a recent court decision could be interpreted as establishing a new standard of care. In United States v Baker, the defendant claimed that the use of videoconferencing equipment during his psychiatric evaluation
was, in essence, substandard care. However, the court determined that the use of videoconferencing allows for “patient interview to be conducted in a normal fashion,” and that videoconferencing constitutes treatment comparable to a face-to-face evaluation. Our outpatient clinic’s telepsychiatry component has been a successful clinical platform for introducing third-year residents to this treatment modality. Residents learn not only the knowledge base and technical skills applicable to telepsychiatry but also the most compelling reason to use telepsychiatry: improving our patients’ access to good clinical care.

**References:**


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