# Telemental Health: A Saving Grace or An Inadequate Vessel?

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## ABSTRACT

The COVID-19 pandemic has brought about the advent of many new telehealth technologies as providers have been forced to shift their practice from the clinic to the cloud. Perhaps, none of these fields has been as widely advertised and expanded as telemental health. While many have lauded this change, it is important to question whether this method of practice is truly beneficial for patients, and further whether it benefits all patients. This paper critically examines the current structure of telemental health interventions and compares them to more traditional in-person interactions, reflecting on the unique benefits and challenges of each method, and ultimately concluding that telemental health is the wrong modality for certain patients and modalities.

Keywords: Telemedicine, Mental Health, Telehealth, Healthcare Access, Healthcare Technology

## INTRODUCTION

As the e-health revolution rapidly progresses, scientists, healthcare professionals, and technology experts are attempting to determine which areas of medical practice will best adapt to changing dynamics. Two key professions that are ripe for this kind of disruption are psychiatry and psychology. The American Psychiatric Association, along with its partners in the American Telemedicine Association, states that "telemental health in the form of interactive videoconferencing has become a critical tool in the delivery of mental health care. It has demonstrated its ability to increase access and quality of care, and, in some settings, to do so more effectively than treatment delivered in-person."[1]

This claim, though appearing bombastic, is also reflected, though with more nuance, by the American Psychological Association. For its part, the American Psychological Association states that "the expanding role of technology and the continuous development of new technologies that may be useful in the practice of psychology present unique opportunities, considerations, and challenges to practice."[2] Thus, the point of this paper will be to examine whether the rapidly expanding system of telemental health is ethical based on its adherence to accepted standards of care, privacy concerns, and concerns about the boundaries of the patient-provider relationship.

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I.      Standard of Care Concerns

One of the most considerable objections to the broader implementation of telemental health services is the speculation that it is less effective than in-person treatment. It would follow that a system that is broadly implemented would not only fail to be beneficent, but it would also fail to be non-maleficent. Providers would be knowingly providing an ineffective treatment. Some may argue that such a system would also violate the principle of justice. It would create an unequal system of care in which those patients who could afford to see their therapist in person would benefit more than those who could not. However, data from a wide variety of sources at first glance, would seem to contradict these fears.[3]

A review of the literature regarding the implementation of telemental health in geriatric patients, for example, showed that telemental health was as good as in-patient psychiatric care in several areas, including the diagnosis of dementia, nursing home consultations, and in conducting psychotherapy for geriatric patients and their caregivers.[4] On the other end of the age spectrum, a review of nineteen randomized controlled trials and one clinical trial demonstrated high comparative effectiveness between telemental health interventions in children and adolescents.[5] Hailey et al. found that telemental health interventions were effective in over half of the 65 studies reviewed. These studies encompassed a diverse and wide-ranging number of psychiatric disciplines, including child psychiatry, post-traumatic stress disorder, dementia, cognitive decline, smoking cessation, and eating disorders. Methods included phone- and web-based interventions.[6]

Indeed, the data is not just limited to outpatient settings. For example, Reinhardt et al. conducted a literature review of studies about telemental health visits for psychiatric emergencies and crises. They found that no studies reported a significant statistical difference in diagnosis or disposition among psychiatric patients who presented to the Emergency Department. In addition, their review demonstrated a reduction in length of stay, reduction in time to care, and decreased costs among these patients. The authors also reviewed literature pertaining to crisis response teams and patients with severe mental illness. Both studies demonstrated that telemental health visits for these patients were similar, if not better, than face-to-face visits. In addition, both patients and practitioners showed high satisfaction with these services.[7] Thus, the implementation of telemental health is limited to out-patient settings and could feasibly be implemented in the in-patient and emergency settings.

There is, however, one particularly glaring gap in telemental health services: group therapy. Perhaps the most famous example of group therapy is Alcoholics Anonymous, but group therapy has expanded to include many different modalities. Group therapy is a common intervention for many mental illnesses and can be incredibly effective in treating diseases ranging from PTSD to borderline personality disorder.[8] In a pilot study comparing a video teleconference based Dialectical Behavioral Therapy (DBT) group to an in-person DBT group, Lopez et al. found that while patients had similar levels of cohesion with the facilitator, participants in the video teleconference group saw less group cohesion than their peers in the in-person group. Further, while many patients in the video teleconference group believed that the convenience offset the adverse effects, many also wished for an in-person group. Attendance was also significantly higher in the video teleconference group.[9]

Thus, while the video teleconference group did report some positives, some significant differences raise ethical questions. How well does a group do without cohesion?  For example, if a person needing to be consoled breaks down and cries in front of the group, the in-person response may be different from the video conference. In the in-person group, other group members may place a gentle hand on the shoulder of the grieving person or maybe even hug them. The group facilitator or group members in the video

conference group could say the same words of consolation as those in the in-person group. However, there still seems to be some missing action. The idea of physical touch, in this way, can mean a lot more than just a small action. Van Wynsberghe and Gastmans argue that this kind of deprivation may lead to feelings of depersonalization.[10] And, to an extent, their supposition is supported by the data presented by Lopez et.al. The low level of group cohesion in the video conference group could suggest that other group members seem unimportant to the participants. They are simply things on a screen, not real people.

Dr. Thomas Insel, former National Institute of Mental Health Director writes that while technology may hold the key to improving mental health on the population level, there is a human-sized piece of the puzzle missing from these interventions. The solution, he asserts, lies somewhere in the integration of these two types of experiences, one that he terms "high-tech and high-touch."[11] The lack of touch and physical presence is an obstacle for both patients and providers. At best this may lead to a slightly poorer provider-patient relationship and at worst may result in poorer quality care.

II.    Privacy & Confidentiality Concerns

Privacy and confidentiality are among the most serious concerns for practitioners and patients, made more complex by the advent of e-health. Major news outlets provide plenty of examples of breaches of confidentiality of people's electronic records. Even significant systems, often thought to be secure, used to facilitate direct contact between people in the wake of COVID-19, like Zoom, have been breached. Not too long ago, "Zoom Bombing" was a national phenomenon, appearing in online classrooms, often sharing explicit or politically motivated content.

Psychiatric patients are susceptible to issues surrounding privacy and confidentiality, and they may even come from communities that ostracize and stigmatize mental illness. These concerns must be taken seriously. Of course, both the American Psychiatric Association and the American Psychological Association address privacy concerns. Both organizations note in their guidelines that relevant HIPAA regulations apply to telehealth and doctors must use apps and videoconferencing tools with the highest levels of security.[12]

Interestingly, the American Psychiatric Association takes these instructions one step further. It requires providers to be in a private room during telehealth videoconferences or calls and that people seeking care also have a private space so that any conversations are not overheard. This not only prevents violations of privacy but reassures the therapeutic relationship between provider and patient.[13]

While providers can take these steps to ensure their patients' privacy, an internet connection may not guarantee privacy. Many privacy issues are more easily mitigated in a clinical space. For example, walls and doors can be soundproofed, or white noise can be played in the waiting room to ensure that therapeutic conversations are not overheard. And while the American Psychiatric Association asks providers to mitigate these risks as they would in their respective clinics, there is another layer to online privacy. Providers should be concerned about telecommunications providers, how they collect information, and what types of information they collect.[14] If, for example, the patient must navigate to the practitioner's webpage to enter into the therapy portal, that information might be tracked and used to generate personalized ads for the patient. If a person suffering from severe paranoia started receiving ads for psychiatric medication, they may react negatively to the invasion of privacy. That type of targeted advertising could even exacerbate a mental health condition.

The scandals surrounding the National Security Administration (NSA) in recent years have added another layer of complexity to the issue of privacy. Whistleblowers like Edward Snowden, revealed that the

government was collecting metadata from text messages, videos, and social media. Government surveillance is an added risk of mental health videoconferencing.[15] The government would not be bound by the rules that require privacy with few exceptions like the Tarasoff law, which could require disclosure to stop a violent act as a clinical care provider. The government might judge someone a risk based on ill-gotten surveillance data, wrongly add a person to a watch list, or engage in further surveillance of a patient whom non-clinicians working in government assess to be a potential danger. Protection from government surveillance is a fundamental ethical endeavor. Yet government as a collector of data without a warrant or with easily attained FISA and other warrants is problematic. Scenarios may seem far-fetched but are within the realm of possibility.

Secondly, the provider must envision how this might hinder care. For example, patients aware of the possibility of government surveillance may be reluctant to show up to online meetings if they show up at all. Perhaps they are so sensitive to these issues that they stop checking with their therapist altogether. It is easy to see how a person who has schizophrenia and shows signs of paranoia may avoid telehealth for fear of being tracked.

Of course, one could also have privacy concerns about a therapist's office. Perhaps patients are nervous about being seen in the office or parking lot. They might worry about being overheard. These concerns, however, can be mitigated fairly simply, for example, patients could find anonymous means of transportation and practitioners can soundproof their offices. Thus, in both the office and the videoconference, concerns can be mitigated easily and tangibly, but not eliminated entirely. Mental health providers should use the highest quality communication services with end-to-end encryption to bolster online privacy.

III.     Boundary Issues and Professionalism

The boundaries here are philosophical, not physical. Both the American Psychiatric Association and the American Psychological Association work to ensure that the patient-professional boundaries are kept as close to normal as possible. Both organizations expect practitioners to maintain the highest levels of professionalism when dealing with patients using telemental health services. [16] Practitioners are responsible for enforcing boundaries through informing their patients about appropriate behavior so that patients are discouraged from calling at inappropriate times absent an emergency. Videoconferencing systems and multi-layered protections like passwords and gatekeeping would prevent patients from logging into another patient's appointment.

These boundaries exist for a good reason. A 2017 report demonstrated that there is an escalating shortage of psychiatrists.[17] Nearly 1 in 5 people in the US has a mental health condition.[18] Mental health providers are nearly overwhelmed, therefore inappropriate, frequent, and unnecessary contact add another level of complexity to treating patients. Mental health providers need to be stewards of the resource they provide. They must concentrate on the patient they are with. They also must guard themselves against burnout, because dealing with patients too often, even though technology allows for it, will lead to them being less effective for the rest of their patients.

While these professional boundaries must be policed carefully, practitioners should also be careful of having boundaries that are too high. Thus, providers must balance between too much intimacy and too little. [19] Presence and physical touch have symbolic meaning. Being with a person reaffirms their personhood, and both provider and patient can feel that. Humans are relational beings, and a physical relationship often comforts people. It may also legitimize and reinforce the patient through sensation and

perception. There may be something inherently missing from the practice of telemental health, as exemplified by the group members' inability to console others in group therapy sessions over teleconference.[20] The screen may also be an agent of depersonalization. It may make the patient's complaints seem less real. Or perhaps the patient may feel as though they are not being heard.

Although the evidence of telemedicine's successes above may seem to contradict this, none of the studies that extoll the benefits of telemental health have follow-up periods greater than one year. And while many studies show that patients are highly satisfied with telemental health, measurements of satisfaction are not standardized. It remains unclear whether patients benefit enough from their telemental sessions or whether they require more regular sessions to stay as satisfied as they were with in-person mental health care. Perhaps as time goes on, patients become more frustrated with telemental health. The research must answer these questions, but currently, it does not sufficiently address metaphysical arguments against telemental health.

CONCLUSION

Privacy is a key practical issue that remains. Although providers try to combat issues of privacy by using high-level conferencing software, which has end-to-end encryption,[21] surveillance and breaches may occur. While not suitable for all kinds of patients, telemental health services prove to be effective for groups of people that otherwise may not have been able to receive care over the past two years. There are some settings, such as group therapies, that are best suited for in-person meetings.  Although online sessions encourage individuals to show up regularly, their downsides are not yet known.

There is incredible power in the idea of presence, and humans are inherently relational beings. For some, a lack of contact is unwelcomed and makes therapy less satisfying. Opportunities to use in-person clinical care remain a priority for some patients, and healthcare providers should further investigate prioritizing in-person care for those who want it. Telemental health could be beneficial for emergencies, natural disasters, vulnerable groups, or when patients cannot get to their provider's office. However, for now, telemental health should not take a leading role in providing mental health treatment.

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