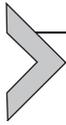




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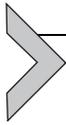
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Challenges and opportunities in the provision of mental health care services during the COVID-19 pandemic and beyond

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1 Introduction

The COVID-19 pandemic is unlike any other pandemic, and it has led to a revolution in mental health care services. This revolution occurred following the World Health Organization's (WHO) declaration of COVID-19 as a pandemic on January 30, 2020 (Lavah, 2020). As of May 2021, 1,637,848 active cases of COVID-19 had been identified in South Africa (Media Statement, 24 May 2021) and this number is expected to grow considering the third wave projections and the ease of transmission of the virus.

When WHO issued recommendations for physical distancing to curb the spread of the virus, governments imposed various strategies to guide populations on quarantine requirements and the need to stay at home. According to Lavah (2020) in Israel, social gatherings were canceled, schools were closed, institutions of higher learning were closed, and public transportation was minimized. Similarly, the South African government acted rapidly imposing a strict “national lockdown” policy on March 26, 2020 which essentially required citizens to stay at home as much as possible, except to get essentials such as food or medications.

When people are prevented to move, there will be adjustment problems. Consequently, populations worldwide presented with psycho-social problems. Some difficulties that they experienced in coping manifested themselves in depression, anxiety, substance use, somatization, and in many other ways (Lavah, 2020; Qiu et al., 2020; Wang et al., 2020). People with certain health conditions and comorbidities were identified as particularly at risk and there was a concern that if they get infected, they faced the

possibility of presenting with more severe symptoms. [World Health Organisation \(2020\)](#) identified comorbidities associated with the respiratory or the circulatory system or compromised immune systems as more vulnerable. We argue that the mental health consequences of such unprecedented societal changes from the lockdown were severe in South Africa given considerable psychiatric morbidity associated with an already challenged health system, a high unemployment rate, and poverty.

The effect of COVID-19 on mental health and well-being was felt at the individual level, interpersonal level, community level, nationally, and internationally. This perspective was adopted from the ecological model. It ensures that we view not only the impact of COVID-19 comprehensively, but we also view benefits, risks, and opportunities related to telehealth in a parallel way. At the individual level, routines were disrupted due to working from home, home-schooling, restricted movements, anxiety, and fear of being infected or even dying was heightened, whether someone was exposed to the virus or not ([Maldonado et al., 2020](#)).

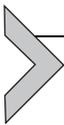
At the interpersonal level, it is noted that people are by nature social beings and need to interact and work cooperatively with one another in order to survive and flourish in an effective manner ([Nature Human Behaviour, 2020](#)). Social life is made up of various relationships with several people who may be family, friends, work colleagues, and so on ([Psychology Today, 2020](#)). COVID-19 has had a severe impact on the amount of social contact that can occur between individuals, including putting severe limitations on physical interactions between individuals. Citizens were not able to provide even the kind of social support they would have otherwise provided to affected friends and colleagues. This lack of contact and usual interactions with friends, family, and colleagues, as mentioned earlier, has impacted negatively on the mental well-being of citizens throughout the world.

[Inchausti et al. \(2020\)](#) distinguish at least three different groups likely to be psychologically impacted by the pandemic. The first group that we identify consists of frontline health care professionals. In some countries, the health care system, including both institutions and frontline workers, has been severely burdened, resulting into high numbers of health care and frontline workers experiencing more severe signs of mental health problems. The literature indicates that increased workload and frequent exposure to the virus, coupled with insufficient access to personal protective equipment resulted in high levels of anxiety, depression, and insomnia. Stress, anxiety, and symptoms of depression were consistently reported in a review of

literature by [Shreffler et al. \(2020\)](#), on the impact of COVID-19 on health care workers. In response to an increased demand for services and the need to use telepsychology, psychologists in South Africa reported experiences of both physical and emotional fatigue ([Goldschmidt et al., 2020](#)).

The second group at high risk includes individuals who, because of the pandemic, had experienced adverse events such as death in the family, threats to their health due to the pandemic, being unable to work, and even losing their jobs. Already, substantial research papers are addressing the devastating impact of bereavement during COVID-19, which has been complicated by the protocols that need to be observed following the death of someone with suspected or confirmed COVID-19 ([Aguiar et al., 2020](#); [Das et al., 2021](#); [Maddrell, 2020](#); [Santos et al., 2021](#)).

A third group of people also at high risk for mental health challenges includes individuals who, prior to the pandemic, already had a history of psychiatric disorders ([Inchausti et al., 2020](#)). Those with severe or complex disorders would even be more vulnerable, due to low resilience and depleted coping mechanisms. Moreover, the lack of social support due to social distancing, as well as the isolation that may be required if one contracts the virus, are some of the additional factors that are likely to exacerbate existing psychiatric disorders.



2 WHO guidelines on mental health response during COVID-19 pandemic

In recognition of the likely increase in mental health conditions, not only with regard to worsening of already existing conditions, but also the likely increase in the number of people suffering from mental health difficulties, the WHO Secretariat, working together with other United Nations (UN) agencies, outlined a policy brief with the following recommendations directed at minimizing the impact of the COVID-19 pandemic on mental health ([United Nations, 2020](#)):

Apply a whole-of-society approach to promote, protect and care for mental health.
([United Nations, 2020, p. 3](#))

In essence, this is an urge to governments to make mental health and psychosocial support services and interventions an integrated part of their COVID-19 response. This is an encouragement toward an adoption of a proactive approach toward prevention by promoting literacy and awareness, in particular with regard to adversities that are generally known to impact

mental health, which are likely to increase during this time, including domestic violence and poverty. The policy also highlights the importance of sensitive communication that acknowledges and empathizes with the distress that people feel at this time.

Ensure widespread availability of emergency mental health and psychosocial support

(United Nations, 2020, p. 3)

Among other things, this encourages nations to invest in technology to facilitate tele-counseling services for both frontline health workers and community members that may require urgent interventions. This is in the context of already existing mental health services to persons who are already diagnosed with mental conditions which should continue uninterrupted despite the pandemic. Nations are urged to recognize the need for extra effort to reach people at high risk and those in vulnerable situations, as well as the promotion of equal access to telehealth and other essential and affordable technologies (World Health Organisation, 2021). This is an area that cannot be overemphasized considering the impact of isolation and social distancing, which has found a lot of people living alone, and not able to attend any social gatherings they may have used in the past as a form of social and emotional support.

Support recovery from Covid-19 by building mental health services for the future.

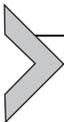
(United Nations, 2020, p. 3)

This is in recognition of the fact that the impact of COVID-19 for many societies is likely to be a long-term process. If one also considers the economic impact of COVID-19, not only to countries but to individuals—the loss of income, the resultant family impact, etc.—mental health services are likely to continue to be even more crucial and in demand beyond COVID-19. The UN urges nations to actually take advantage of the current interest in mental health, subsequent to COVID-19, and reinvest in strategies that will assist in reorganizing their mental health and psychosocial support services; in the process bring in more community-based services and capacitate community members and community organizations to provide support, protect, and promote human rights at large and further assist governments in the planning, execution, and overseeing of these services.

Despite the best of efforts, in a survey undertaken by WHO from June to August 2020, among 130 countries, 93% of them had experienced disrupted or halted critical mental health services during the COVID-19 pandemic. Significant disparities were also quite evident: while over 80% of

high-income countries were able to switch to telemedicine and teletherapy services, less than 50% of low-income countries were able to achieve this (World Health Organisation, 5 October 2020).

China, being the first country to experience COVID-19, with its previous experience with the 2003 SARS outbreak, was, as early as January 2020, able to provide some guidelines for psychological crisis interventions to minimize the psychosocial effects of the COVID-19 outbreak. These guidelines, in line with the UN and WHO recommendations, specified that psychological crisis intervention should be part of the public health response to the COVID-19 outbreak, organized by the joint prevention and control mechanism at the city, municipal, and provincial levels (Dong and Bouey, 2020). Although criticized for lack of clarity when it comes to the actual implementation of the principles, it does show forward thinking and ability to learn from previous experiences. Other countries such as South Africa have been criticized for only prioritizing biological approaches to responses to the pandemic, while putting mental health services on the back seat (Nguse and Wassenaar, 2021). The appointment of a Socio-Behavioral Ministerial Advisory Committee on COVID-19, which became effective in October 2020 (Nguse and Wassenaar, 2021) gives promise and hope to not only the recognition of the psychosocial impact of the pandemic but also hope for an increase in resources toward the management of the mental health outcomes of COVID-19.



3 The delivery of psychological services through online channels

The requirements for citizens to socially distance has led to an increase in the use of digital technologies in the provision of mental health care. Different types of digital services have been introduced with a variety of concepts in circulation. World Health Organization (2016) uses the term e-health to describe the use of technologies to support health and health-related fields including the provision of health care services. The “e” prefix indicates electronic means. One concept that is relevant to psychology is telepsychology.

Telehealth, on the other hand, encompasses a broad scope of technological tools that are used to engage with clients remotely for clinical purposes. In a commentary, Blandford et al. (2020, p. 1364) suggest that “Telehealth is the provision and management of health care in which individuals (often working with family members) manage aspects of their care with remote

support from health-care professionals.” Prior to COVID-19, the Health Professions Council of South Africa (HPCSA) had practice guidelines for telemedicine ([Health Professions Council of South Africa, 2014](#)). The concept “telehealth” was introduced as an umbrella for telemedicine and other health care services provided remotely, such as telepsychology. The above definition for telehealth is closely aligned to an earlier definition used by Dart and colleagues where it was indicated that telehealth is “the use of electronic information and telecommunications technologies to support long-distance clinical health care, patient and professional health-related education, public health and health administration” ([Dart et al., 2016](#), p. 339).

We draw from the available literature, synthesize and summarize the most relevant information to add to the available knowledge on telehealth. The intention is to guide mental health care providers and trainees. The chapter proved to be of importance to the authors, as telehealth remains a relatively new and largely unexplored domain. The chapter provides brief background on telehealth before COVID-19, telehealth during the pandemic and post the pandemic. Opportunities and challenges are identified.

3.1 Methodology

We decided upon a review method which allowed us to conduct a scientific study without being extremely formal. While a quantitative review is often desirable, we used a phenomenological literature review method sourced from [Randolph \(2009\)](#). A phenomenological approach enabled us to capture rich descriptions of the challenges and opportunities encountered in the provision of telehealth services during the pandemic. In compiling this chapter, we observed five steps to ensure that the obtained data were comprehensive and nonjudgmental. These were bracketing, data collection, the identification of meaningful statements, and assign meaning to what we obtained. We are psychologists who have lived and worked through the COVID-19 pandemic. The pandemic has changed our personal lives and working lives. We have experienced the lockdown and shifted from working in the office to work from home. This is an experience worth reporting. However, through bracketing, we placed our experiences of telepsychology aside and engaged deeply with what we found in the literature. Therefore, by focusing on what came out of the literature, our reporting was guaranteed to be unbiased.

We also observed the general guidelines for conducting literature reviews. We conducted an initial selection of potential articles through

the screening of the title and abstract. Where the title and abstract did not provide sufficient information to determine eligibility, we continued to download the full-text publications of all potentially relevant citations. We searched both the gray literature and academic literature. The reference lists of all full-text publications were also retrieved and scanned to determine articles that are relevant to this review. Research studies written in English that also met the following criteria were included: (1) studies that presented qualitative data, commentaries or reviews on the use of telehealth interventions pre and during the COVID-19 pandemic; (2) studies that reported findings for South Africa were of special interest. We structured the literature search and discussion of the findings by identifying the following themes: (1) progress in telehealth, (2) challenges in telehealth services, (3) opportunities in telehealth services, and (4) lessons for the future. In the next paragraph, we provide a brief overview of the method.

3.2 Progress in telehealth

Globally, telehealth has advanced at a rapid pace in most health care specialties and specifically in the practices of psychological assessment, psychotherapy, and rehabilitation. By simply browsing the internet, it is easy to see that the self-help crusade has also benefited from telehealth as there are many health care professionals who now offer internet-based interventions.

In the South African context, telehealth was identified as an intervention that could significantly contribute to improvement of primary health and medical care services in rural areas. [Katchienga \(2008\)](#) reports on a study conducted on 12 sites (hospitals and clinics) in the Eastern Cape Province. In this study, institutional managers, technical support staff, and medical staff were interviewed. The objective was to identify the challenges associated with the introduction and sustainability of telehealth services in rural areas of South Africa. Consequently, budgetary constraints, frequent power cuts, unavailability of technicians, and lack of bandwidth were identified ([Katchienga, 2008](#)).

Both the Health Professions Act ([Department of Health, 1974](#)) and the Mental Health Care Act Number 17 of 2002 ([Department of Health, 2002](#)) make provision for different categories of health professionals to provide a wide range of health services to individuals and communities. Mental health care services in South Africa are provided by some of the following: nurses, psychiatrists, psychologists, social workers, occupational therapists, traditional healers, and, in some instances, nongovernmental organizations. This

list is not exhaustive but provides an idea of the vital role players in mental health care who had to adapt their services to telehealth where possible.

When looking at the literature on the provision of psychological services, we discovered that, prior to the pandemic, despite the availability of adequate technology (e.g., advanced computers), face-to-face psychological interventions were the preferred mode of intervention. Telepsychology was only used when people wanted to avoid the perceived stigma of being seen going to a psychologist or when there were geographical barriers related to distance, or lack of services, transportation, and time to travel to appointments.

During the pandemic, an increased use of telepsychology to provide psychological assessment, diagnosis, and therapy was observed. Keeping in mind that there was no formal training offered in telehealth, generally, psychologists had to upskill themselves rapidly in telepsychology, yet this approach to psychological services brings with it benefits and risks (Goldschmidt et al., 2020). Telehealth involves the use of technological devices ranging from telephones, cell phones to internet, or wi-fi-supported interactive audio and videoconferencing techniques, including but not limited to directing clients to self-help websites, blogs, and social media pages all aimed at eliminating psychological distress (Goldschmidt et al., 2020). It is beyond the scope of this chapter to look in detail at all the modalities that have been used in telehealth; however, an attempt will be made to look at some of the recent trends in this area.

Chou et al. (2016) describe videoconferencing as the use of secure videoconference hardware and software that allows for synchronous and interactive meetings, incorporating both audio and visual streaming between client and service provider regardless of them being at different sites. There has also been significant growth in the area of software to support these virtual interactions. G2 (2021) lists several of these tools, including *Zoom*, *Microsoft Teams*, *Skype*, *Webex Meetings*, and *GotoMeeting* in the top five. The impact of cost of hardware and software, existing infrastructure (or lack thereof), requirements for software updates that may need to be considered (Chou et al., 2016), licensing issues, is likely to be an obstacle especially in medium to low-income countries such as South Africa. The emerging proliferation of these platforms also brings about many other challenges for practitioners who deal with confidential patient information. Issues of privacy and security, compliance with regulatory bodies—professional boards, health insurances—ethical practice, are concerns that need to be high in the minds of health professionals when considering which platforms to use. A number of

countries such as the United States and Europe have put in place some regulatory policies and bodies to facilitate best practices (Crico et al., 2018) on issues of compliance, privacy, and security. The *Protection of Personal Information Act* which recently came into effect in South Africa is also likely to contribute to increased recognition of the importance of protection of client information.

While videoconferencing offers the advantage of synchronous meetings between client and mental health provider, there are also computerized interventions and web-based interventions that provide for asynchronous access. Many therapists have websites in which they put educational and therapeutic information for their clients, as well as for the general public. Even before the widespread use of the internet, certain intervention tools such as *cognitive behavior therapy (CBT)* have been available through specifically designed software programs, *cCBT*, allowing the client to self-diagnose, personalize their treatment goals and make use of the therapy tools the program provides, allowing for both therapist involvement and noninvolvement (Aboujaoude et al., 2015). A recent review on computerized and web-based *CBT* programs has been undertaken by Wright et al. (2019) and provides more information on these and other programs. Other examples in this regard include interventions such as *Computer-Aided Vicarious Exposure* (Clark et al., 1998), *OC-Check* (Baer et al., 1987) which have been used in the treatment of obsessive-compulsive disorders (Herbst et al., 2012). Some of these computer programs are actually internet-mediated programs, examples of which include programs such as *Drinker's Check-up (DCU)*, *Moderate Drinking*, *Alcohol Use Disorders Identification Test* in the area of addiction self-assessment and relapse prevention (Molfenter et al., 2015), to mention but a few. Research suggests that emails have been used largely for brief exchanges with patients rather than as a modality for intervention; however, some web-based programs use emails to support the asynchronous therapy experience.

Another area that seems to be getting more interest is virtual reality exposure therapy (VRET), a new tool for conducting exposure therapy with the help of computer-generated virtual environments, that mimic real-life situations, thus allowing systematic exposure to the feared situation without actually being physically in that situation (Opris et al., 2012; Aboujaoude et al., 2015). In a review on the use of VRET in anxiety disorders, Meyerbroeker and Emmelkamp (2010) concluded that it could be a viable alternative to in vivo therapy, which exposes the client to the actual anxiety provoking situation. Efficacy studies reviewed by Aboujaoude et al. (2015) suggest that VRET appears to have considerable potential in the treatment of

psychiatric conditions such as phobias, posttraumatic stress disorder, obsessive compulsive disorders, and substance use disorders.

Mobile devices are increasingly being used in telehealth programs, through various software applications, which have been enabled by the advent of smartphones. These are capable of more than just making a call or texting but enable users to engage virtually and interactively through both the visual and audio streams. The role of mobile phones in tele-mental health is discussed extensively by Chan et al. (2014) and Price et al. (2014). Mobile devices have been found to be quite useful for a number of activities in the telehealth field, including treatment monitoring and compliance through regular reminders to clients, health education, health surveys, as well as for delivery of services such as counseling and therapy through audio and visual systems (Chan et al., 2014). According to the American Psychological Association (2020), there are up to 20,000 mental health apps on the market. Some of these target specific psychological disorders, as evident in a review of literature by Lui et al. (2017) and in the Psyberguide Website (Psyberguide.org, n.d. (<http://psyberguide.org>)). For “stress and anxiety” alone, Psyberguide gives you information on up to 176 apps with regards to its credibility and whether it has received any professional reviews or not. Psyberguide lists and rate mental health apps on scientific credibility, user experience, and transparency on data handling (American Psychological Association, 2020) and is one of the sites that can be consulted for information on available apps.

Some common features are evident in mobile apps, as evident in those included in Lui et al.'s (2017) review. Some apps are designed as stand-alone interventions in place of patient—therapist interactions, e.g., *PTSD Coach* (Miner et al., 2016), *SuperBetter* (Roepke et al., 2015) which targets depressives, while others are designed to support therapeutic processes, e.g., *The Stress Manager* (Newman et al., 2014), which targets Generalized Anxiety Disorder posttreatment, and *FOCUS* (Ben-Zeev et al., 2014), which targets schizophrenic disorders. Apps may include symptom monitoring, offer therapeutic skills, or psychoeducation; some are interactive and recommend specific therapeutic skills as feedback to the user's self-assessment, as the examples given above.

An area of progress is also evident within the South African context. The South African Depression and Anxiety Group (SADAG) website lists some mental health apps addressing various areas including symptom monitoring, stress, anxiety and sleep management, and many more (www.sadag.org). Collaboration between government, mobile network operators, and

technology companies has assisted in facilitating services such as the logging of referrals and contact tracing of COVID-19 patients. The Vula mobile application, for example, was instrumental not only in contact tracing but also in actually facilitating psychological support for frontline health care workers (<https://www.vulamobile.com/newsmedia>).

Only one-third of the population in South Africa makes use of smartphones (<https://statista.com>), meaning that access to some of these mental health services will still be a challenge for the majority of the population. Short Message Service (SMS) or text messaging, which does not require a smartphone, has also been used successfully in telehealth. In a review of literature, [Aguilera and Munoz \(2011\)](#) noted that text-messaging has been used to send appointment reminders, medication reminders, to share health information and to monitor symptoms and behavior after treatment. From their own study, [Aguilera and Munoz \(2011\)](#) concluded that SMS may have an advantage as an adjunct to psychotherapy because of regular therapist contact, which encourages the client to continue participating and applying therapeutic interventions posttreatment.

The emergence of a greater number of technologies and software applications has certainly contributed significantly in new ways of not only interacting but also treating clients, with the advantage of making clients also to be in control of their treatment. All this though has not come without challenges, as it will be apparent in our next discussion.

3.3 Challenges in telehealth services

From a lay person's perception, the provision of psychological services through emails, SMS's, Skype, Zoom or MS Teams, etc. seems uncomplicated than the provision of medical services; however, from a legal-ethical perspective, this is a complex process. The following discussion highlights some of the challenges. These are presented in terms of the themes identified in the literature.

3.3.1 Therapeutic alliance

[Rees and Stone \(2005\)](#) observed that when working through the internet, the therapeutic alliance is seriously impacted and it is difficult to achieve a deep connection with a client. This observation was confirmed by psychologists that they interviewed. While the interviews were conducted in 2005, there is recent evidence suggesting that concerns about the therapeutic alliance continue to be raised by practitioners ([Sammons et al., 2020](#)).

According to Carl Rogers, a therapist must be nonjudgmental, warm, display respect and a willingness to help. Clients must feel that the therapist is authentic and cares unconditionally (Rogers, 1951). These are conditions for therapy that are difficult to transmit through emails or SMS's yet they are crucial determinants for adherence, treatment progress, and outcome. Additionally, one of the biggest challenges that psychologists face when working online is the absence of nonverbal cues. In technology-mediated communication, there is an increased risk of misinterpretation.

3.3.2 Treatment approaches

Psychologists offer a range of treatment modalities. These include assessing and treating individuals or groups; the provision of short-term or long-term interventions as well as in-hospital or out-of-hospital services. Research indicates that a number of treatment modalities lend themselves fairly well to telehealth interventions (Cooper et al., 2019). However, some clinicians may be more comfortable with one specific modality and duration than others, when they practice face to face, but experience adjustment challenges when they practice virtually. For example, Goldschmidt et al. (2020) note that practitioners in their study tended to use short-term interventions that largely focused on strengthening their clients' coping skills, containment, and or psychoeducation, rather than addressing deep-seated intrapsychic conflicts, which practitioners experience as more amenable to face to face than telehealth settings. This suggests that practitioners may find themselves shifting from one therapeutic modality and duration to another when they provide telehealth interventions, which may not necessarily be well received by some of their existing clients, who are used to or have preference for specific treatment approaches.

3.3.3 Access

Access to efficient mental health care and psychological services has long been considered a human rights issue. However, a proportion of the South African population is technologically illiterate, they have limited economic resources, and some are too old to understand how telehealth works. Despite good intentions of certain practitioners and organizations to make some time available to provide telehealth services, the uptake of these services at times has not been optimum. Second, a wide variety of online platforms can be overwhelming to inexperienced users (both clients and practitioners). Third,

sudden lockdown measures could have averted putting into place adequate technical support (Maldonato et al., 2020), which might have contributed to easier and improved access.

3.3.4 Connectivity, data, hardware, and software

Telehealth requires connectivity and data. There are a variety of factors that affect connectivity. The most common technological problems that have been encountered are related to audio transmission or video transmission. These problems happen as a result of poor connectivity, hardware, software, or a combination of these three computer systems.

Data costs in the South African context have been identified as extremely high (Goldschmidt et al., 2020). The pandemic has brought with it increased rates of unemployment. This means that a majority of the population cannot afford data. Second, recurrent power cuts mentioned previously also contribute to the challenges related to connectivity. Third, lack of suitable technological devices prevents access to telehealth.

3.3.5 Blurred boundaries

Under normal circumstances, clients and psychologists must respect each other's boundaries. This relates to times when they can contact each other and the mode of contact. Psychologists are expected to have policies about when and where they will be available for clients. During the pandemic, it was noted that boundaries were blurred. At times clients found it difficult to keep to the time of the sessions as well as practitioners finding it difficult to keep to 50-/60-min sessions due to clients needing more time to feel contained (Goldschmidt et al., 2020). While earlier studies showed that telehealth services lower the utilization of health care services and the workload of health care professionals, the opposite was observed during the pandemic. Due to anxiety, clients were calling psychologists frequently and expected psychologists to meet their expectations. On the other hand, the frequent contact might have been initiated by psychologists. Psychologists might have felt isolated due to the mandated quarantine requirements and end up boundary crossing consciously or unconsciously through asynchronous communications such as emails, in a bid to reassure their clients of their availability. Such communications could be interpreted by clients as indication that the practitioner is available 24 h of the day, in which case if the practitioner does not respond to client communication after hours, this could be interpreted as neglect (Cooper et al., 2019).

3.3.6 Privacy and confidentiality

The psychology profession holds privacy and confidentiality high on the list of ethical priorities. Cooper and colleagues argue that “the risk of a confidentiality breach is much greater through electronic transmission” (Cooper et al., 2019, p. 1080) than in face-to-face meetings. During the pandemic, privacy and confidentiality was not guaranteed from the increased and numerous technological devices and platforms used to provide psychological services (Goldschmidt et al., 2020). Moreover, due to lockdown regulations and many people working from home, privacy for the clients also became an issue, where one would have to be in session, while other family members are also at home, which heightens the risk of being overheard. Included here are general distractions that may be created within the home environment, which may impact on client not being fully “present” in the session (Scharff et al., 2020).

3.3.7 Multiple relationships

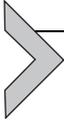
Contact through social media platforms became the norm during the pandemic and this can have a negative impact on professional relationships. As early as 2011, Goss, in Drum and Littleton (2014) had observed that, in telepsychology, communication between the client and the clinician uses modalities that are often used for social interactions with family and friends (emails, video-conferencing, etc.), and can occur at any hour of the day or even at night. As a result, both parties can now virtually enter each other’s homes, which raises the risk for an increased sense of intimacy between client and therapist. Conducting sessions in casual spaces may also risk the practitioner being seen as just another “buddy” or friend the client talks to online (Drum and Littleton, 2014).

3.3.8 Clothing and grooming

The manner in which people dress communicates more information about someone than verbal communication and it plays a significant role in creating the first impression (Forsythe et al., 1985). Generally, psychologists are expected to dress neatly and conservatively. Working from home has made people feel there is no need to dress professionally and this might offend clients, or even reduce the psychologist to the status of just another friend the client is chatting to online (Drum and Littleton, 2014).

3.3.9 Competencies

A major challenge for sustainable telehealth programs is related to competencies. There is a misperception that telehealth is easy to use. Despite considerable access to technology many psychologists lack skills necessary to practice telepsychology effectively and provide safe services to clients. They are then expected to acquire the technical knowledge and skills that will allow them to offer telepsychology services.



4 Opportunities in telehealth services

4.1 Opportunities in patient care

Access is a double-edged sword. Telehealth creates an opportunity for more convenient ways of accessing mental health services. For both client and clinician, this may result in reduced need to travel and saving on associated expenses as such, less time away from families, and a lowered rate of missed appointments. Counseling sessions for individual clients or couples or families or support groups can be carried out without the limitations posed by geographical location or transport needs.

Telehealth facilitates disclosure. In a pilot study conducted by [Saberi et al. \(2013\)](#), 57% of participants reported feeling more at ease to disclose sensitive issues they would ordinarily have had difficulty discussing mainly because they were not face to face with someone. In support of this, during the COVID-19 pandemic, it was observed that domestic violence reporting increased globally ([Mittal and Singh, 2020](#)). The findings were based on the calls for help made to women's organizations and hotlines through telephone, emails, SMS's, and apps.

Telehealth promotes compliance with treatment and prevents premature termination from therapy. In [Traube et al. \(2020\)](#), over 90% of parents participating in a telehealth parenting program reported having a strong relationship with their educator, which made it easier for the parents to be willing to engage in new activities and parenting strategies the educators advised them to try. Furthermore, reporting on their experience of using a telehealth-based modality, the parents felt that this was similar or better than a face-to-face experience; they also indicated that in fact they had specifically chosen the telehealth experience because of its convenience and the privacy it offered.

As a response to the urgent need of psychological services during the pandemic, rapid psychological first aid was identified as highly effective. Psychological first aid is a first-line response intended to minimize the effect of acute stress and trauma and assist people to cope effectively with difficult life events (Maldonado et al., 2020, p. 284). Two objectives were the focus of this intervention: (1) controlling distress and fear of the disease and (2) reducing adjustment difficulties.

In Maldonado et al. (2020), it is conveyed that telehealth has direct and indirect roles in reducing the spread of infections. During the outbreak, technology proved to be very efficient in allowing users to:

- (a) receive the correct information and prevent the spreading of fake news;
- (b) report their symptoms despite the fear of disease;
- (c) encourage activities and strategies directed at prevention; and
- (d) decrease or prevent psychological outcomes due to pandemic regulations.

These opportunities can be observed in future pandemics.

One other opportunity observed from the frequent use of self-monitoring apps for COVID-19 symptoms is the positive impact this process has on enhancing patient self-management. Patient self-management is a vital process in chronic disease management. This can be transferred to the management of chronic mental health problems going forward.

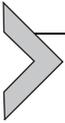
Telehealth also helps to expedite epidemiological research that is needed to inform decisions for future health care delivery as well as to support policy makers to predict society's needs and make appropriate decisions and prompt interventions (Blandford et al., 2020). During the pandemic, the command council relied extensively on data obtained through telehealth research to make decisions related to COVID-19. There is still a great need to enhance the evidence for technology applications within the health sector as clinicians and consumers expand their use in numerous areas.

Another advantage for the use of telepsychology relates to information management. Psychologists obtain information primarily from clients through interviews, psychometric assessments, and through interviews with family members and work colleagues or educators where necessary. They may receive reports from referral sources or other professionals involved in the care of their clients. They are expected to take reasonable steps to keep this information safe and secure. Technology has made this process easier to manage. Audio-recordings and other files are now kept safely protected with passwords.

4.2 Opportunities in the education and training of psychologists

The COVID-19 pandemic necessitated a transformation in the delivery of education and training by institutions of higher learning all over the world.

The education and training of psychologists had to be facilitated through telehealth, including the clinical supervision of interns. Interns are expected by the regulating bodies to have weekly individual supervision and group supervision. Due to COVID-19, the supervision sessions are facilitated securely by technological services. Similar to group face-to-face supervision, interns share cases and are able to learn about a broader spectrum of disorders than they are currently exposed to in their settings. The experiences reported by [Scharff et al. \(2020\)](#) specifically speak to similar changes that many training institutions within the field had to adopt to still be able to continue to fulfill their training requirements. The flexibility and innovation that telehealth can provide cannot be overstated.



5 Lessons for the future

In the light of the contributions and opportunities highlighted above, telehealth services continued to be effective in the promotion of mental health, even at a time of crisis when COVID-19 regulations of social distancing made it difficult for citizens to consult their service providers for psychosocial support. The urgent nature of the interventions and the critical points raised in this chapter shed light on the need to optimize mental health services and telehealth interventions with intelligent systems.

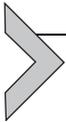
This crisis showed that all health care services should set up new protocols and systems that are capable of managing a wide scale of remote interventions. Governments need to make significant investments and commitments to establish the necessary infrastructure that will make telehealth modalities available to patients living in rural areas and the most vulnerable. Medical aids have increasingly reimbursed telehealth services which can fast-track its adoption going forward.

Through positive outcomes in the use of telehealth services, some encouraging evidence can be highlighted in research. Previously, it was mentioned how telehealth increases self-disclosure in situations where fears of negative evaluation may be prominent with human partners ([Blandford et al., 2020](#)). We need comparative studies on the diversity of telehealth platforms.

To facilitate more inclusion in the digital space, telehealth solutions must be easy to use, and be affordable for individuals and health care organizations. Funding models may need to be revisited to cater more for vulnerable citizens and organizations. Governments need to benchmark and learn from each other what works well. Just as COVID-19 has accelerated digital literacy, so too telehealth can accelerate health literacy.

Access to the latest data security and encryption systems will become more and more important to protect patient privacy. Patients need to be educated continuously so that they are aware of the privacy choices they are making when they select telehealth. This knowledge will promote data security and avoid disclosure of sensitive personal information. Privacy and security issues are likely to become more complex, as the use of different telehealth modalities expands.

Finally, telehealth is technology driven. It is crucial for developing countries like South Africa to invest in a basic communication infrastructure capable of linking the remote areas with the metropolitan areas and medical facilities. With partnerships between government and telecommunications entities, combined with the current advances in digital communications, substantial progress can be achieved in improving service delivery in remote areas and enhance health management of citizens regardless of their geographical location.



6 Conclusions

The primary objective of the chapter was to provide a brief overview of the developments in telehealth services, as well as to identify challenges and opportunities in telehealth services. Consequently, it was noted that there has been progress in the use of telehealth services. Telehealth is a rapidly growing exciting practice with numerous possibilities. Several challenges were also identified. These included the impact on the therapeutic alliance, treatment approaches, access, connectivity, blurred boundaries, privacy and confidentiality, multiple relationships, clothing and grooming, and competencies. These challenges are not in any way the only ones observed in the use of telehealth. We are highlighting them because of their ethical implications for the practice of the professionals involved.

We have also identified opportunities and grouped them into two broad themes. The themes are opportunities in health care and opportunities in the education and training of psychologists. A possible way forward

was highlighted. We conclude by highlighting that as telehealth clinical tools proliferate (with supportive evidence-based research on their effectiveness), they can be incorporated into the education and training of psychologists and other health care professionals, as well as assist in public health management. Indeed, studies in the efficacy of telepsychology also continue to provide substantial evidence in support for its effectiveness either in short-term interventions or in long-term interventions and in individual or group settings. We acknowledge that we have not included discussions of policy developments related to technology-mediated services. This is an important area to be covered in future.

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