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Patient Perspectives on Telepsychiatry on the Inpatient Psychiatric Unit During the COVID-19 Pandemic

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Abstract

Hospitals have eliminated many in-person interactions and established new protocols to stem the spread of COVID-19. Inpatient psychiatric units face unique challenges, as patients cannot be isolated in their rooms and are at times unable to practice social distancing measures. Many institutions have experimented with providing some psychiatric services remotely to reduce the number of people physically present on the wards and decrease the risk of disease transmission. This case report presents 2 patient perspectives on receiving psychiatric care via videoconferencing while on the inpatient unit of a large academic tertiary care hospital. One patient identified some benefits to virtual treatment while the second found the experience impersonal; both were satisfied with the overall quality of care they received and were stable 2 weeks after discharge. These cases demonstrate that effective care can be provided remotely even to severely ill psychiatric patients who require hospitalization.

Keywords

telemedicine, mental health, psychiatry, COVID-19, patient experience

Introduction

Hospitals around the country are working to limit the number of in-person contacts between patients and providers to prevent the further spread of COVID-19. Inpatient psychiatric units face unique challenges when implementing mitigation strategies: many patients cannot be isolated in their rooms for safety reasons while others cannot reliably wear safety equipment or follow social distancing precautions due to their psychiatric illness. To decrease exposures and the risk of disease transmission, many inpatient units are adjusting staffing levels and considering alternative care delivery models to protect patients and providers.

Telepsychiatry—the use of phone and videoconferencing technologies to provide psychiatric services remotely—is used in a wide variety of settings, including correctional systems, the Department of Veterans Affairs and private practice (1). A growing body of evidence supports telepsychiatry as a means of providing mental health services, including surveys indicating high patient satisfaction (2,3). Many institutions are now experimenting with new virtual mental health care delivery models (4). However, there are far less data regarding implementation (5) or patient satisfaction (6) when telepsychiatry is utilized on inpatient units. The American Psychiatric Association has lamented the lack of broader adoption of telepsychiatry services for inpatient treatment (7); the coronavirus pandemic has made broader adoption of this method of mental health care delivery a safety necessity.

This article attempts to capture the experiences of 2 patients who were under our care on the inpatient unit of a large urban academic tertiary care hospital during the early stages of the outbreak. Both patients were treated initially by psychiatrists in person but were subsequently treated remotely when the institution temporarily transitioned to a telepsychiatry model. Their cases illustrate different degrees of patient satisfaction and demonstrate that some psychiatric

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treatment can be effectively provided remotely even to the most acutely ill patients.

Description

For this case report, Ms D and Ms N were interviewed 12 and 17 days, respectively, after they were discharged from the hospital. Both patients consented to have their interviews recorded and included in this report, provided their details were anonymized. A transcript of these interviews, edited for length and clarity, can be found in the online supplement.

Ms D

Ms D is a 26-year-old recently engaged college graduate who had previously been diagnosed with bipolar disorder and was brought to the hospital by her family for erratic, bizarre behavior—she became convinced that her fiancé was stealing from her, thought her mother's eyes had turned black, and briefly ran away from home. She had recently been hospitalized at another psychiatric facility for 7 days, but within 24 hours of discharge her symptoms returned. At the urging of her family, she presented to our hospital for further treatment. Over the course of admission, she was treated with risperidone, which was increased to 4 mg nightly, and clonazepam 0.5 mg, which was stopped prior to discharge. With these medication changes, Ms D's sleep normalized and her paranoia and delusions resolved. Although her thought process became linear, she continued to have deficits in abstract thinking and had difficulty appreciating the nature of her illness. Her diagnosis was amended to schizoaffective disorder as she had experienced delusions for more than 2 weeks in the absence of a prominent mood episode. She was discharged home with plans to enroll in a virtual intensive outpatient program.

Ms N

Ms N is a 33-year-old married nurse with recurrent major depressive disorder and borderline personality disorder who was referred to the hospital from her partial hospitalization program for depressed mood and suicidal thoughts. Ms N had been hospitalized more than a dozen times previously with similar presentations, most recently in December 2019. On admission, she was on a complex regimen that included 8 psychoactive medications. During admission, Ms N was treated with electroconvulsive therapy, and her medication regimen was consolidated to venlafaxine 150 mg nightly, lithium 600 mg nightly, asenapine 20 mg nightly, trazodone 100 mg nightly, and lorazepam 1 mg twice daily. With treatment, Ms N's mood brightened and her suicidal thoughts became less intense. She was discharged to a residential program.

Transition to Telepsychiatry

On March 23, 2020, the inpatient psychiatrists on our unit began conducting interviews remotely, first over telephone and then via videoconferencing using iPads. Nursing staff remained on the unit to observe patients, dispense medications, and lead group therapy sessions. One psychiatrist remained in the hospital or at the nearby outpatient clinic to perform in-person evaluations when necessary.

During the first week of this transition, Ms D and Ms N were treated by an attending and a resident psychiatrist who had admitted them in person. On March 30, these physicians rotated off service, and Ms D and Ms N were treated until discharge by a different attending psychiatrist and resident psychiatrist exclusively via videoconference.

Results

Ms D's Perspective on Telepsychiatry

When the inpatient unit transitioned to telepsychiatry, Ms D worried that her doctors would be less capable of accurately evaluating her over the phone. She felt that her body language and hand gestures were crucial to understanding her mood and personality, and she feared that with telepsychiatry, physicians would not pick up on this type of communication. When her first treatment team rotated off the service, Ms D did not completely trust that her new team would be able to make an accurate diagnosis or sound treatment decisions based solely on videoconferencing interviews.

Ms D had the impression that during her virtual interviews she did not have the doctors' full attention. She felt the interactions were rushed, and that time was not left for adequate back-and-forth conversation. Overall, she found the experience dehumanizing. She found that the nurses' physical presence on the unit helped her with this transition and she felt that her ability to work with the in-person staff that remained was an important element of her recovery.

Reflecting back on her 2 psychiatric admissions—the first where all treatment was provided in person, the second where some treatment was provided remotely—Ms D felt that her care during her second hospitalization had been better. Despite her criticisms of video conferencing, Ms D felt the psychiatry team had made good decisions regarding her medication regimen and that her hospitalization had changed her life for the better.

Ms N's Perspective on Telepsychiatry

Ms N did not find the switch to a telepsychiatry model disruptive. As a nurse, she felt the shift was reasonable and would decrease the risk of disease transmission to patients and staff. Even though she thought videoconferencing was less personal, she did not feel it made a significant difference in her care.

When her treatment team changed, Ms N found working with her new doctors challenging, but she attributed this to

personal struggles and difficulty trusting new people rather than to the videoconferencing technology itself. She was comfortable with treatment adjustments made by her new team and assumed that psychiatrists were able to make good decisions by working collaboratively with nursing staff.

Ms N was satisfied with telepsychiatry on the inpatient unit and noted some benefits of remote treatment. Specifically, she reported that when multiple psychiatrists had physically entered her room as a team in the past, she found the experience intimidating. Telepsychiatry was less uncomfortable.

Lessons Learned

- Two patients on an inpatient psychiatric service were effectively treated when psychopharmacological management was provided remotely.
- Some patients may find videoconferencing interviews impersonal, while others may find it less intimidating than in-person evaluations performed by large teams.
- Providers should consider spending additional time during remote interviews, as patients may experience videoconferencing as abbreviated compared to those performed in person.

Conclusion

In this case report, we presented 2 patients' impressions of having received portions of their treatment remotely while hospitalized on an inpatient psychiatric unit. Neither experienced setbacks during hospitalization, indicating that virtual follow-up did not adversely impact their treatment. Although these cases support the hypothesis that telepsychiatry can be safely utilized in this setting, our results should be interpreted with caution. Ms D's symptoms had markedly improved prior to the transition and we likely would not have attempted to use videoconferencing during her initial evaluation when she was more floridly psychotic. When patients were disorganized, agitated, and aggressive, psychiatric evaluations were still performed in person. Both patients found virtual visits acceptable in part because they continued to have positive face-to-face interactions with nurses who remained on the inpatient unit; without high-quality in-person nursing care, the results may have been different. Finally, the data presented are from 2 patients; many more cases will need to be reported before drawing firm conclusions.

Future research should focus on evaluating outcomes in psychotic and nonpsychotic patients to assess and improve their experience with telepsychiatry. Ms N was satisfied with her experience, while Ms D felt that her interactions with doctors over videoconferencing were rushed and less personal than her in-person evaluations. That these 2 patients were effectively and safely treated remotely and were stable 2 weeks after discharge provides reasons for optimism that further refining remote care delivery methods can lead to good outcomes and patient satisfaction in the setting of the current pandemic.

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Supplemental Material

Supplemental material for this article is available online.

References

1. Shore J. Telepsychiatry: videoconferencing in the delivery of psychiatric care. Am J Psychiatry. 2013;170:256-62.
2. Hubley S, Lynch SB, Schneck C, Thomas M, Shore J. Review of key telepsychiatry outcomes. World J Psychiatry 2016;6:269-82.
3. Reinhardt I, Gouzoulis-Mayfrank E, Zielasek J. Use of telepsychiatry in emergency and crisis intervention: current evidence. Curr Psychiatry Rep. 2019;21:63.
4. Sullivan AB, Kane A, Roth AJ, Davis BE, Drerup ML, Heinberg LJ. The COVID-19 crisis: a mental health perspective and response using telemedicine. J Patient Exp. 2020;7:295-301.
5. Grady B, Singleton M. Telepsychiatry "coverage" to a rural inpatient psychiatric unit. Telemed J E Health. 2011;17:603-8.
6. Holden D, Dew E. Telemedicine in a rural gero-psychiatric inpatient unit: comparison of perception/satisfaction to onsite psychiatric care. Telemed J E Health. 2008;14:381-4.
7. American Psychiatric Association. Telepsychiatry Toolkit in Inpatient Settings. 2020. https://www.psychiatry.org/psychiatrists/practice/telepsychiatry/toolkit/inpatient-settings

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