

# Remote Treatment Delivery in Response to the COVID-19 Pandemic

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Because containment efforts for the COVID-19 pandemic include social distancing, quarantine, and isolation, if indicated, health care providers are confronted with major challenges in delivery of care. As we write this editorial, the situation in the USA is extremely fluid with some clinics shuttering their doors and delivering services only via telephone, telemedicine, or other technologies; other clinics are continuing some face-to-face visits while moving toward the use of alternatives. Email channels among health care professionals are pulsing with questions about the use of telemedicine and other technologies.

If you are already familiar with telemedicine methods and have used them in the past, the transition may not be daunting. However, most clinicians have not used telemedicine as a routine part of their daily work. Among the resources that can help clinicians learn about telemedicine, “Best Practices in Videoconferencing-Based Telemental Health” (<https://www.psychiatry.org/File%20Library/Psychiatrists/Practice/Telepsychiatry/APA-ATA-Best-Practices-in-Videoconferencing-Based-Telemental-Health.pdf>) [1], a consensus guideline from the American Psychiatric Association and the American Telemedicine Association, is a good place to start. Another valuable resource is an overview of administrative, clinical, and technical issues in videoconferencing by Jay Shore, MD, MPH [2].

These experts in telemedicine [1, 2] have outlined key administrative issues for implementation. These include: (1) *licensure requirements* which usually dictate that the provider must be licensed in the state where the patient is located at the time of service; (2) *malpractice insurance* for telemedicine; (3) *status of insurance coverage* for virtually delivered services; (4) *adherence to confidentiality and security regulations* including those of the Health Insurance Portability and Accounting Act (HIPAA) in the USA; and (5) *establishment of protocols* for managing laboratory tests, prescriptions, and scheduling.

In a time of crisis, these stipulations present barriers to rapid and broad implementation of telemedicine. However, governmental agencies in the USA have issued an emergency waiver suspending the requirement for complying with HIPAA and have noted that popular applications for video chats, such as *Apple FaceTime* and *Facebook Messenger* video chat, which are not HIPAA compliant, may be used if necessary. Also, the USA Center for Medicaid and Medicare Services released a guidance on March 17, 2020 allowing patients to be seen via videoconferencing in their homes, without having to travel to a qualifying “originating site” for Medicare telehealth encounters. Furthermore, the USA Drug Enforcement Administration (DEA) approved an exception that allows prescriptions for controlled substances via telemedicine

without a prior in-person evaluation. Because of rapid changes in response to the COVID-19 pandemic, clinicians need to stay up-to-date with the current status of privacy, licensing, insurance, and other issues that could impact service delivery.

Telemedicine is considered to be an especially good fit for psychiatric treatment and has been found to be effective, while reducing cost and improving access to care [2]. There are no absolute contraindications; however, it is recommended that patients be assessed for suitability for videoconferencing and that emergency protocols be developed for situations such as heightened risk for suicide or aggression toward others [1, 2]. Technical considerations have become less problematic in recent years as a variety of platforms have been developed with high-quality video transmission and appropriate confidentiality and security. Some of these platforms that offer secure options for medical applications include *Zoom*, *Bluejeans*, *Doxy.me*, *thera-LINK*, *TheraNest*, *SimplePractice*, and *Vsee*.

Although telemedicine offers a great potential for delivering treatment during the COVID-19 pandemic, older technologies, such as telephonic communication and email, offer immediate and easy-to-use ways of providing care remotely. Research on telephone-delivered psychotherapy has found no decline in effectiveness compared to face-to-face therapy, in addition to an advantage for telephonic treatment in completion rates [3]. Email is typically used for brief exchanges with patients, but some internet-delivered programs use email extensively to offer an asynchronous psychotherapy experience.

Other technologies that can be applied to help provide treatment during the pandemic are computer-assisted psychotherapy and mobile apps for behavioral health. Meta-analyses of computer-assisted cognitive-behavioral therapy (CCBT) for depression have found evidence for effectiveness [4], and studies comparing CCBT with face-to-face treatment have reported no differences in outcome [5]. CCBT is considerably more effective if it is delivered with at least a small amount of clinician support (usually 1–4 h for the entire course of treatment) as opposed to using a computer program as stand-alone treatment.

Because CCBT reduces the amount of clinician time to provide evidence-based therapy, it offers an efficient method for reaching large numbers of patients. Clinician support can be provided via telemedicine, telephone, and/or email, thus providing a useful alternative during the COVID-19 crisis. CCBT programs that have been studied in multiple randomized controlled trials include *Beating the Blues*, *Deprexis*, *Good Days Ahead*, and *Mood*

*Gym*. Details on these programs and others can be found in a recent review of CCBT and mobile apps for depression and anxiety [6].

CCBT has been studied much more rigorously than mobile apps for behavioral health [6], and multiple concerns have been raised about the integrity, security, and effectiveness of the thousands of mobile apps that have flooded the marketplace [6]. Nevertheless, there are many apps developed by reliable sources such as the USA Department of Defense and university-based researchers that are showing promise in clinical use and can be recommended to patients. Among such apps highlighted in a recent review [6], *Virtual Hope Box*, *Breathe-to-Relax*, *Calm*, and *Headspace* stand out as tools that could help patients manage anxiety and stress related to the COVID-19 outbreak. For example, *Virtual Hope Box*, a USA Department of Defense app, has features including breathing exercises, deep muscle relaxation, guided meditation, and a way to download and display photos that generate hopefulness. Chatbots, such as *Woebot*, and other artificial intelligence (AI)-informed developments may one day also play a role in scaling up care options when supply challenges arise. Development of these programs is still in early stages but may offer opportunities for extending the psychotherapy workforce [7].

In a time of great uncertainty and danger, we need all the resources we can gather to help our patients and ourselves manage the crisis. New and old technologies need to be mustered without delay and put into action. Barriers such as confidentiality requirements, lack of technology expertise, and reimbursement issues need to be identified and solved with compassionate zeal. In an encouraging sign, governmental agencies have thus far responded by relaxing stipulations that choke our ability to do our best to provide care. Now more than ever, we need to band together in our effort to deliver greatly needed psychiatric treatments.

## Disclosure Statement

Dr. Jesse Wright is an author of the *Good Days Ahead* program discussed in this article and has an equity interest in Empower Interactive and Mindstreet, developers and distributors of this program. He receives no royalties or other payments from sales of *Good Days Ahead*. His conflict of interest is managed with an agreement with the University of Louisville. He receives book royalties from American Psychiatric Press, Inc., Guilford Press, and Simon and Schuster; and he receives grant support from the Agency for Healthcare Research and Quality. Dr. Robert Caudill has no disclosures to report.

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