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Original Research Article

Survey of Clinician Experiences of Telepsychiatry and Tele-Consultation-Liaison Psychiatry



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Background: The COVID-19 pandemic created pressure to implement telepsychiatry across practice models. **Objective:** We sought to evaluate the overall success of this change and to identify what types of practice settings, provider groups, and patient groups were best served by telepsychiatry and telepsychotherapy utilization. We were particularly interested in how providers of consultation-liaison psychiatry adapted to remote care. **Methods:** An anonymous provider survey querying demographics, education, training, technological experience, practice setting, treatment modalities, patient groups, transition process, and outcomes was made openly available via social media and professional listservs. We used multivariable regression modeling to evaluate for predictors of the positive outcomes of overall satisfaction, subjective ability to diagnose and treat patients adequately using exclusively telepsychiatric platforms, and patient satisfaction by proxy. **Results:** Three hundred thirty-three respondents, mostly young (59.4% younger than 50 years), female (69.7%), and physicians (67.9%), completed the survey. One hundred ninety-seven (59.1%) worked in consultation-liaison psychiatry. Of the total, 85.9% gave affirmative answers to overall satisfaction. Multivariable linear regression models found that satisfaction was predicted by general comfort with technology ($P < 0.001$), but negatively correlated with having technical issues ($P < 0.001$), a

priori skepticism ($P < 0.001$), clinician being male ($P = 0.004$), and treating LGBTQ+ patients ($P = 0.022$). Completeness was associated with having training in telehealth ($P = 0.039$) and general comfort with technology ($P < 0.001$) but negatively associated with treating LGBTQ+ patients ($P = 0.024$) or inpatients ($P = 0.002$). Patient satisfaction by proxy was positively associated with general comfort with technology ($P < 0.001$) and the respondent being a nonphysician ($P = 0.004$) and negatively associated with encountering a technical issue ($P = 0.013$) or treating inpatients ($P = 0.045$). Consultation-liaison psychiatrists had similar results overall and were more likely to have other staff assist in making televisits effective (mean [standard deviation]: $-1.25 [3.57]$ versus $-2.76 [3.27]$, $P < 0.001$) especially if consultative (mean [standard deviation]: $-0.87 [3.67]$ versus $-2.39 [3.01]$, $P = 0.010$). **Conclusions:** This study suggests high rates of overall satisfaction in telepsychiatry adoption, even in consultation-liaison psychiatry. There is distinct benefit in bolstering training, providing technical support, and addressing skepticism. Future research should include patient surveys and control groups and should focus on vulnerable populations such as sexual and gender minorities.

(Journal of the Academy of Consultation-Liaison Psychiatry 2022; 63:334–344)

Key words: telepsychiatry, survey, consultation-liaison psychiatry.

BACKGROUND

The way patients and clinicians interact has been significantly affected by the COVID-19 pandemic. The need to reduce hospital traffic and in-person interaction heightened the importance of care delivered from a distance.¹ The availability and use of telehealth has increased in importance, with many providers having to abruptly adopt telehealth. Telemedicine is known to be

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feasible, reliable, acceptable, and effective throughout a wide range of settings, specialties, age ranges, and cultural groups.²⁻⁵ Various barriers to widespread application of telehealth, including legal and licensing challenges, broadband connectivity barriers, cost considerations, and patient and clinician resistance, have been examined. Privacy, safety, and digital literacy concerns generally contribute to provider reluctance.⁶⁻⁸

Current telepsychiatry literature is limited and heterogeneous. The literature referring specifically to consultation-liaison psychiatry (CLP) is even more sparse, in spite of the potential for unique challenges and opportunities in providing remote care to critically ill patients.^{1,9} Clinicians using telepsychiatry during the pandemic period may range from the enthusiastic and experienced to the unprepared, skeptical, or even potentially disparaging. We set out to add to the extant literature by studying the experiences of clinicians, particularly focusing on those abruptly implementing or adapting telepsychiatry consultation programs during the pandemic. We investigated more aspects of prior experience and different ways of looking at satisfaction than prior studies.¹⁰ We also specifically recruited to ensure a significant population of CLP clinicians, as this is an understudied area within telepsychiatry.

Our hypothesis was that in spite of a range of *a priori* expectations and prior experiences, most providers would feel they were able to complete an evaluation, make a diagnosis, and prescribe or provide a treatment over a teleconference platform. We predicted that more experience with technology, more training, outpatient work, younger age, younger patient population, and less skepticism would be associated with higher satisfaction with the abrupt telepsychiatry rollout. We used 3 index outcomes: overall satisfaction, subjective ability to diagnose and treat patients adequately using exclusively telepsychiatric platforms, and patient satisfaction by proxy. We anticipated that these outcomes might be rated less favorably by CLP and investigated what specific factors would improve the ability to provide psychotherapeutic care to medically ill patients.

METHODS

This study was approved by the Columbia University Medical Center Institutional Review Board.

Recruitment

An introduction with a link to the online survey was distributed via social media postings and email including listservs: the Academy of Consultation Liaison Psychiatry, The American Psychosocial Oncology Society, and an internal Columbia University Psychiatry Psychopharmacology listserv. See [Figure 1](#). The survey was accessible for completion for 6 months, from September 8, 2020 through March 9, 2021.

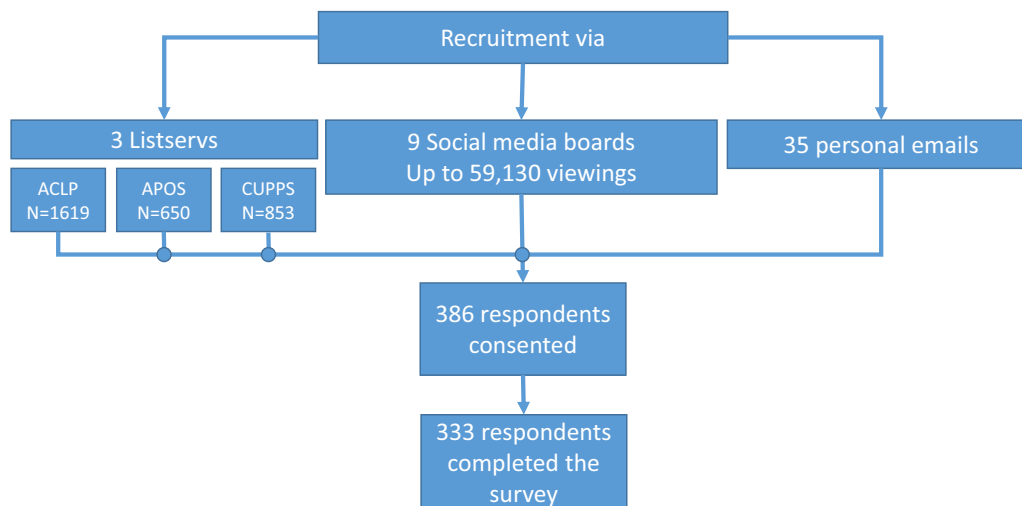
Study data were collected and managed using REDCap electronic data capture tools hosted at New York Psychiatric Institute.¹¹ REDCap (Research Electronic Data Capture) is a secure, web-based application designed to support data capture for research studies, providing (1) an intuitive interface for validated data entry; (2) audit trails for tracking data manipulation and export procedures; (3) automated export procedures for seamless data downloads to common statistical packages; and (4) procedures for importing data from external sources.

Survey Questionnaire

The survey collected information on categorical independent variables, allowing for multiple selections where relevant, including gender, clinical degree, other relevant degrees, postgraduate training, technological background, earliest use of a computer and internet, telepsychiatry training, experience with telepsychiatry, encountering a technical issue, *a priori* skepticism, and working with special populations. We defined C-L psychiatry clinicians by asking respondents whether they work with medically ill patients, to be inclusive of both C-L psychiatrists and social workers, psychologists, and others who work in this field but for whom formal fellowship is not the standard. For those who indicated that they work specifically with medically ill populations, we collected an additional categorical item interrogating what type(s) of relationship(s) they have with the medical team(s) (multiple selections were allowed): consultative, collaborative, and/or embedded. Continuous independent variables were inpatient effort (%), general comfort with technology (“Please rate your comfort, where -5 is Extremely Uncomfortable, 0 is neutral, and $+5$ is Extremely Comfortable: I feel comfortable using technology in general.”) and clinician age (by decade).

Primary outcome variables collected were overall satisfaction with providing care via a telepsychiatric platform, hereafter “overall satisfaction,” feeling

FIGURE 1. Recruitment.



comfortable that the evaluation could be complete and preliminary recommendations could be made based on the tele-encounter, hereafter “completeness,” and whether patients spoke favorably about telepsychiatry in general, or heretofore, “patient satisfaction by proxy.” These were measured on respective Likert scales from -5 (never) to 5 (always). A secondary outcome of interest was a continuous variable asking how often the telepsychiatry session was accomplished only because of the help of other in-person staff such as nurses, physician assistants, residents, medical assistants, or other professionals, measured on a Likert scale from -5 (never) to 5 (always).

See [Supplementary Material 1](#).

Statistical Methods

ANOVA was used to assess the association between categorical covariates and outcomes. Pearson correlation coefficients were calculated to assess the association between continuous covariates and these outcomes. Covariates associated with outcomes on the single variable level with a P value < 0.05 were selected to build multivariable linear regression models while additionally adjusting for gender and age.

RESULTS

Response rate was not calculated because of the anonymity of the survey and overlapping recruitment modes.

Three hundred eighty-six individuals accessed and consented to the survey. Of these, 53 did not complete the entire survey and were excluded, resulting in a sample size of 333 respondents with degrees including MD, DO, PhD, PsyD, MSW, master’s degree in music or art therapy, and master’s degree in psychology or counseling. All respondents provided psychiatric or psychotherapeutic services over teleplatforms in 2020–2021.

Study Population

Of the respondents, 69.7% are female, 59.4% are younger than 50 years, and 67.9% are physicians. Of the total, 33.9% received telehealth training, and 25.5% had used telepsychiatry more than occasionally before the pandemic. One hundred ninety-seven (59.1%) clinicians reported that at least part of their practice involved working with medically ill populations (hereafter CLP) and 57 (17.1%) reported working with perinatal populations (38 respondents care for both perinatal and medically ill patients). See [Table 1](#).

The survey allowed for multiple selections, and in the case of inpatient and outpatient work, requested respondents enter a percent effort. One hundred forty respondents indicated at least some inpatient effort, and of those, 120 also reported seeing the medically ill population. Of the 197 respondents in CLP, 104 see a combination of inpatients and outpatients, comprising the largest subset of respondents (31.2%). Seventy-five

TABLE 1. Descriptive Statistics (n = 333)

Recruitment	n	%	Gender	n	%
How participants received the survey*			Gender		
From a friend or colleague	37	11.1	Female	232	69.7
Listserv	143	42.9	Male	100	30
Personal email	77	23.1	Any other gender	1	0.3
Personal social media	37	11.1			
Professional social media	26	7.8			
Education			Age		
Clinical degree*			Age in y		
MD or DO	226	67.9	<30	11	3.3
PsyD or clinical psychology PhD	66	19.8	30–39	107	32.1
MSW	20	6.0	40–49	80	24
Master's degree in psychology or counseling	16	4.8	50–59	55	16.5
Master's degree in art or music therapy	2	0.6	60–69	60	18
Other	13	3.9	70–79	19	5.7
			80+	1	0.3
Technological background			Earliest time of owning or regularly using a computer with internet access		
Earliest time of owning or regularly using a smartphone or tablet			Earliest time of owning or regularly using a computer with internet access		
Never	2	0.6	Never	0	0.0
After completing training	110	33	After completing training	50	15
Postgraduate training	64	19.2	Postgraduate training	27	8.1
Professional or graduate school	96	28.8	Professional or graduate school	61	18.3
College	44	13.2	College	70	21.0
High school	13	13.9	High school	54	16.2
Middle school	3	0.9	Middle school	49	14.7
Elementary school or earlier	1	0.3	Elementary school or earlier	22	6.6
Telehealth background			Provided telemedicine services pre-COVID		
Pre-COVID telepsychiatry training			Never	112	33.6
Yes	113	33.9	Only during telepsychiatry training	7	2.1
No	220	66.1	Only the phone over but never via teleconference	29	8.7
			Rarely	53	15.9
			Occasionally	47	14.1
			Sometimes	24	7.2
			Often	15	4.5
			As part of one's regular practice	46	13.8
Practice details			Special populations*		
%Inpatient			Inmates	18	5.1
Min, max	0, 100		LGBTQ+	85	25.5
Mean, SD	16.5, 26.9		Maternity	57	17.1
Median, mode	0, 0		Medically ill	197	59.1
Setting (may be more than one)			Undocumented or refugees	45	13.5
Rural	30	9.0	Undomiciled	36	10.8
Suburban	133	39.9	Other	36	10.8
Urban	261	78.4			

* Totals do not equal 333 because respondents could select more than one answer.

of the C-L clinicians (22.5%) see exclusively outpatients, and 16 (4.8%) exclusively see inpatients. The remaining 2 C-L clinicians specified no inpatient or outpatient effort. Five respondents (1.5%) see exclusively psychiatric inpatients without medical illness. Inpatient work was treated as a continuous variable in our model.

Descriptive Statistics and Bivariate Analysis

Most survey respondents were satisfied: for overall satisfaction, 85.89% gave a score of 1 or higher on a (–5 worst to 5 best) Likert scale; the overall mean and standard deviation were 3.02 (2.13) (see Figure 2). As only a single respondent selected the gender

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FIGURE 2. Outcomes for entire data set. Overall Satisfaction: “Overall, I have been satisfied with my ability to provide quality psychiatric or psychotherapeutic care utilizing teleconferencing during the COVID-19 Pandemic ____.”. Completeness: “In general, I was able to complete my evaluation and make a diagnosis utilizing exclusively telepsychiatry ____.”. Patient Satisfaction: “In general, my patients spoke favorably of using telemedicine services ____.”.

Overall Satisfaction:

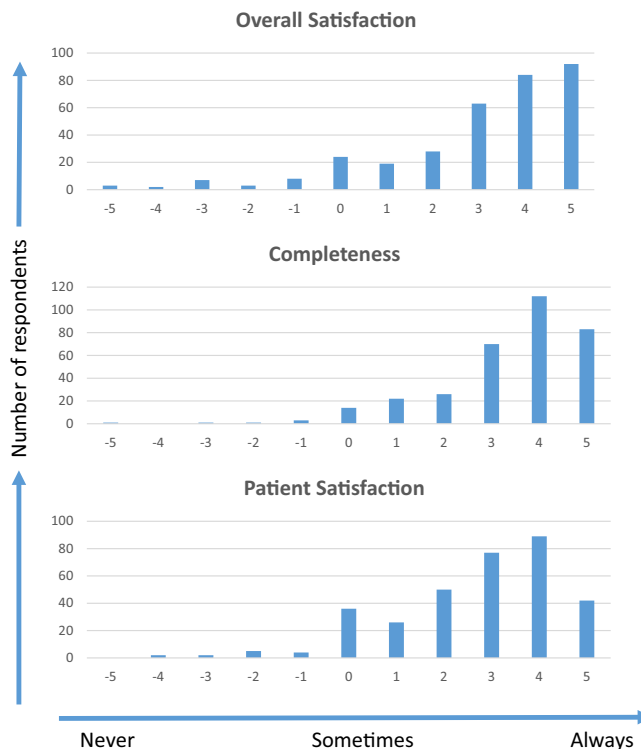
Overall, I have been satisfied with my ability to provide quality psychiatric or psychotherapeutic care utilizing teleconferencing during the COVID-19 Pandemic ____:

Completeness:

In general, I was able to complete my evaluation and make a diagnosis utilizing exclusively telepsychiatry ____:

Patient Satisfaction:

In general, my patients spoke favorably of using telemedicine services ____:



“nonbinary/other,” this was insufficient data to include for statistical analysis. Younger age and past experience with telepsychiatry trended toward higher satisfaction ratings but did not meet significance. Providing care to medically ill patients did *not* correlate with any of our primary outcomes. See [Table 1](#) for more descriptive statistics, and see [Supplementary Material 2](#) for complete tables of all bivariate analyses assessing marginal associations between outcomes and predictors.

Multivariable Model

Multivariable linear regression models adjusting for predictors identified from marginal association analyses (with *P* values < 0.05) were fitted for the 3 primary outcomes of interest separately: *overall satisfaction*, *completeness*, and *patient satisfaction by proxy*. Age and gender were also included.

General comfort with technology was associated with *overall satisfaction* (continuous covariate,

beta = 0.32, *P* < 0.001). Experiencing technical issues (beta = -1.00, *P* < 0.001), being male (beta = -0.676, *P* = 0.004), having been skeptical (beta = -0.818, *P* < 0.001), and treating LGBTQ+ patients (beta = -0.569, *P* = 0.022) were negatively associated with *overall satisfaction* when controlling for other variables. *Completeness* was associated with having training in telehealth (beta = 0.363, *P* = 0.040) and being comfortable with technology in general (beta = 0.232, *P* < 0.001). Worse *completeness* was associated with treating LGBTQ+ patients (beta = -0.425, *P* = 0.024) and treating inpatients (beta = 0.010, *P* = 0.002). *Patient satisfaction by proxy* was positively associated with the respondent not being a physician (beta = 0.605, *P* = 0.004) and being comfortable with technology in general (beta = 0.255, *P* < 0.001). *Patient satisfaction by proxy* was negatively associated with having a technical issue (beta = -0.568, *P* = 0.013) and treating inpatients (beta = -0.007, *P* = 0.045). See [Table 2](#) for notable multivariable model

TABLE 2. Statistically significant results from multivariable linear regression model

Factors	Direction of correlation	Overall satisfaction	Completeness	Patient satisfaction
		Estimate (SD)	Estimate (SD)	Estimate (SD)
Technology factors				
General technological comfort*	Improved	0.320 (0.078) [§]	0.232 (0.059) [§]	0.255 (0.066) [§]
Pre-COVID telepsych training	Improved		0.363 (0.175) [†]	
Encountering technical issues	Worsened	−1.005 (0.269) [§]		−0.568 (0.227) [†]
Practitioner traits				
Having had <i>a priori</i> skepticism	Worsened	−0.818 (0.226) [§]		−0.575 (0.196) [†]
Being a nonphysician (vs physician)	Improved			0.605 (0.207) [‡]
Being a male practitioner (vs female)	Worsened	−0.676 (0.235) [‡]		
Patient population				
% of effort i.e. inpatient*	Worsened		−0.010 (0.003) [‡]	−0.007 (0.004) [†]
Working with LGBTQ+ population	Worsened	−0.569 (0.247) [†]	−0.425 (0.188) [†]	

* Continuous variable.
† $P < 0.05$.
‡ $P < 0.01$.
§ $P < 0.001$.

output. See [Supplementary Material 3](#) for the full model.

Unique Features of Consultation-Liaison Psychiatry

One hundred ninety-seven respondents self-identified as working in CLP. We surveyed the type(s) of relationship(s) the C-L clinicians had with their medical team(s): consultative ($n = 148$), collaborative ($n = 109$), and/or embedded ($n = 76$). Respondents could select multiple relationships. In the bivariate analysis, C-L respondents overall had similar results for the 3 primary outcomes compared with those who cared for patients with only psychiatric illness ($n = 135$), with no significant differences. See [Table 3](#). When asked how often the telepsychiatry session was accomplished only because of the help of other health professionals, the responses for C-L respondents were on average significantly higher than those for other respondents, indicating higher reliance on other staff (mean [SD]: -1.25 [3.57] versus -2.76 [3.27], $P < 0.001$). In bivariate analysis of only the 197 C-L respondents, having a consultative relationship with the medical team was associated with higher reliance on help from other professionals in comparison to those who did not indicate a consultative relationship (mean [SD]: -0.87 [3.67] versus -2.39 [3.01], $P = 0.010$). Having a collaborative relationship with the team was associated with lower reliance on help from other professionals (mean [SD]: -1.71 [3.50] versus -0.68 [3.60], $P = 0.045$). Embedded relationship did not correlate with

reliance on help from other professionals. See [Supplementary Material 2](#).

DISCUSSION

In this analysis of 333 completed surveys from psychiatrists and psychotherapists, most respondents felt that telepsychiatry was an acceptable modality—even for those who work largely with medically ill populations. There were positive ratings of their overall satisfaction, completeness, and patients' reported satisfaction. By using this triad of outcomes, we hope to characterize the experience of respondents adapting to telepsychiatry in a nuanced way.

As we hypothesized, much of the positive experience using telepsychiatry related strongly to general comfort with the use of technology. Having any type of training in telepsychiatry was associated with higher *completeness*, although not *overall satisfaction* or *patient satisfaction by proxy*. Running into technical difficulties was associated with worse satisfaction outcomes. Of note, having prior experience with telepsychiatry was not a significant predictor; therefore, these other thematic factors were better indices of overall preparedness. It is key for future implementation that training in telepsychiatry, general technological comfort, and preventing technical problems during sessions are all more important than clinician telepsychiatry experience. This means that hospitals and clinics that invest in good training and technological

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TABLE 3. Outcomes for C-L vs non-C-L (Does respondent work with a medically ill population?)

Result	No/non-C-L (N = 135)	Yes/C-L (N = 197)	Total (N = 332)	P value
Overall satisfied				0.187
Mean (SD)	3.21 (2.10)	2.89 (2.15)	3.02 (2.13)	
Range	−5.00, 5.00	−5.00, 5.00	−5.00, 5.00	
Completeness				0.451
Mean (SD)	3.48 (1.74)	3.35 (1.42)	3.40 (1.56)	
Range	−5.00, 5.00	−2.00, 5.00	−5.00, 5.00	
Patient satisfaction				0.723
Mean (SD)	2.74 (1.80)	2.67 (1.77)	2.70 (1.78)	
Range	−4.00, 5.00	−4.00, 5.00	−4.00, 5.00	
Telehealth possible only because of help				<0.001
Mean (SD)	−2.76 (3.27)	−1.25 (3.57)	−1.86 (3.53)	
Range	−5.00, 5.00	−5.00, 5.00	−5.00, 5.00	

support services are likely to see real benefits in clinician preparedness and function, and these services should be invested in pre-emptively to build technological capacity.

C-L respondents reported equivalent satisfaction with the use of telepsychiatry when compared with non-CL respondents. This is a particularly important finding. First, medically ill patients can include those who are delirious or unable to reposition themselves or even hold a device, which could create barriers to telehealth care. Second, some medically ill patients may be uniquely in need of psychiatric care delivered remotely because of their specific medical problems, such as limited mobility for outpatients, immunosuppression, or having COVID themselves. In our survey, C-L clinicians were more likely to consider staff help integral to successful telepsychiatry adoption, particularly if they worked in consultative relationships with medical teams. We hypothesize that this result reflects that reaching out to floor staff to coordinate was a more conscious part of their daily work, whereas embedded and collaborative providers had comparatively seamless engagement with other staff. We recognize that we asked only how often this was vital and did not ask exactly *how* staff were helpful. Respondents may have relied on other staff in a variety of ways, from having a nurse hand an iPad to a patient or scheduling a phone call to having physician assistants or residents present in the room and facilitating the entire evaluation. The degree of staff involvement may be more important for some teams than the frequency given the potential for burdening other staff, or for doing truly integrated work. In our clinical experience, evaluating delirious patients sometimes required staff to be at bedside

during the brief evaluation, whereas working with depressed or anxious patients was facilitated by staff notifying the patient to expect a phone call at a scheduled time.

Contrary to common age biases, there was no association in our study between respondent age and any outcomes. We believe this is most likely to be because it is not age *per se* but technological exposure that correlates with this skill set. Older members of the current medical workforce, particularly in academia, are more likely to be technologically literate than nonacademic seniors because of ongoing use of electronic medical records, personal use of technology, and a general interest in continuing to learn across the lifespan. In addition, older, more experienced clinicians have other well-honed skills, especially in building relationships with patients. These skills may offset any potential technological limitations, when applicable.

Physician respondents had lower *patient satisfaction by proxy*. This may reflect shorter patient-physician interactions or fewer physicians asking specifically about the patient's experience with the software. It is also possible that physician appointments via telehealth are actually less satisfactory than teletherapy. In a medically oriented appointment with a psychiatrist, care can sometimes include a physical examination, labs being taken, or vital signs checked. As expected, inpatient settings correlated with slightly worse experiences (see [Supplementary Material 2](#)). Our inpatient providers were almost entirely self-identified as working with the medically ill, making the inpatient data finding particularly relevant to CLP, although we recognize that, in academic settings, having mixed responsibilities is common and may lead to

respondents forming opinions based on a variety of experiences. Contributing factors to inpatient CLP work being more difficult include a patient population who may have delirium, cognitive or motor deficits, or medical equipment or treatments that limit their ability to communicate via teleplatforms. Inpatient settings may have variable access to devices and reliable internet, ambient noise from medical equipment, lack privacy because of staff presence and roommates, and greater need for changes to workflow.

Respondents who treat patients identifying as sexual and gender minorities reported significantly lower overall satisfaction and lower completeness; however, *patient satisfaction by proxy* was not different in this group. We speculate that these differences are around privacy concerns. Anxiety about privacy may originate with the patient, the clinician, or both. Some patients, especially young adults, may not have sufficient privacy at home to fully express all concerns. As this survey was exclusively of clinicians, and they did not report *patient satisfaction by proxy* was lower, it may be that it is the *professionals* who are uncomfortable asking sexual and gender minority patients potentially private questions when using telepsychiatry. Patient perspectives and best practices for these populations must be studied further.

Prior studies have found both synchronous and asynchronous telehealth to demonstrate improvements in communication, access to care, patient empowerment, medical outcomes, and efficiency.^{2,4,6,12,13} Despite these benefits, the use of and research on telehealth are limited. Parity laws securing insurance coverage and reimbursement for telehealth exist in 36 states for private payer coverage, although fewer states had pre-pandemic Medicaid coverage for telehealth.¹⁴ International reports estimate telehealth to meet demand in only a fraction of the developing world.^{7,15,16} In addition, previous investigations of telehealth have been overwhelmingly composed of voluntary groups of patients and clinicians looking to solve a specific problem of access or outcome. Telehealth research has focused on implementation,^{1,5,17–19} satisfaction,^{3,10,20} and cost,¹⁴ but only among self-selected health care providers and patients—and few in psychiatry. What evidence there is in telepsychiatry has been largely related to implementation process,^{17,18} provider resistance,^{21,22} and strategies to bolster physician acceptance.^{19,23} Clinicians' perception of a telepsychiatry program as beneficial, which predicts motivation to adapt, is integral to the success of a novel program.^{17,23}

Documented causes of physician resistance to telepsychiatry include a sense of reduced autonomy, situational anxiety, and cost.²¹ Triage systems and workflows sometimes improve provider acceptance.^{5,19} A new health care climate emerged during the pandemic, involving providers who might not otherwise have chosen to provide care via telehealth. A recent survey of general psychiatry providers who were new to telehealth during the pandemic found a 73% overall satisfaction rate and identified benefits (flexible scheduling, timely starts) and limitations (technological issues, limitations in personal connection) of telepsychiatry.¹⁰

Psychiatry and psychotherapy are distinct from other medical practices in terms of implementing telehealth in several important ways. In theory, most of the work could be done remotely, as the treatments provided do not generally require physical contact. Care could be complemented by basic in-person preventive services such as vital sign and laboratory monitoring. Psychiatry is unique in that we seriously consider the relational and dynamic meanings of our choices. We must contemplate whether the patient will experience our choice to provide telepsychiatry as a sign of our profound commitment to continuing their treatment no matter the context, or whether the patient will feel abandoned by the lack of our physical presence. Patients feeling sufficiently safe and comfortable to share their innermost thoughts is paramount to the usefulness of the treatment. The potential effects of anxiety about infection risk and the use of face-obstructing personal protective equipment on the therapeutic relationship are important considerations influencing the return to in-person care. It is particularly important that psychiatry have its own research in the appropriate use of telehealth and that subspecialties such as CLP investigate how and when we should use these technologies.

Our findings suggest that telepsychiatry can be part of the ongoing available forms of CLP, not only during periods of crisis. Based on our data, we would provisionally suggest that this mode of treatment be considered in particular for medically ill outpatients who may especially benefit from the ability to receive care without physical travel, or immunologic reasons to avoid medical centers. Patients concerned about the stigma of entering a mental health facility may appreciate the opportunity to have their psychiatric care via telehealth. Other groups such as inpatients, and potentially sexual and gender minority patients, may be

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better served in a clinical setting. Providers themselves may also benefit from the opportunity to work from home, particularly those who have chronic disabilities or those with competing obligations. Clinicians with children, elderly, or disabled adults in their lives who need partial attention throughout the day may be able to work from home and successfully provide care to both their families and the public. On the other hand, the potential to work from home could further erode work-life boundaries and create a culture in which there is an expectation of constant availability via teleconference. There is also the risk that patients and providers will default to teleconference because of accessibility when an in-person examination would have brought greater rapport, nuance, and growth in treatment. Finally, we see physical presence in the hospital as an integral part of CLP. Our relationships with other medical providers, including having personal connection with colleagues, camaraderie, and informally providing support to staff are important aspects of our role. The COVID pandemic has been a period of huge stress for hospital workers. Our ability to appreciate when a colleague is struggling, and to provide or recommend support, is limited when working remotely. Overall, we see the best permanent future use of telepsychiatry is for in-person CLP divisions to have telepsychiatry as one of the available modalities that can be used when appropriate. A coded thematic analysis of our survey-free responses is underway and will provide additional nuance about the benefits and disadvantages of this format of providing psychiatric and psychotherapeutic care in the CLP setting.

STRENGTHS AND LIMITATIONS

Strengths of our study include recruitment of clinicians across settings, particularly including multiple CLP settings, with varied educational and training backgrounds. We believe our survey contained thorough and nuanced questions with Likert-style responses, comprehensive categorical variable options, and space for comments, all of which helped capture the full experience of respondents. A thematic coded analysis of the comment content is ongoing, but the comments were also useful in assuring ourselves of the legitimacy of the 3 summary outcomes we chose to analyze. We collected information on both age and experience with technology to be able to differentiate between

biological age and exposure to relevant education and to avoid making erroneous, stereotypical conclusions about older clinicians. The timing of our survey was an asset: The study dates were September 2020 to March 2021, a period of time when most respondents had a similar amount of exposure to telepsychiatry, were still new enough to it to reflect on its adoption, and had enough experience to judge how well it performed.

A limitation of our study is that the systems and technology being used for telepsychiatry are rapidly changing, which may mean ongoing research is required as the technologies progress. Our multi-pronged recruitment with high overlap between professional listservs (C-L psychiatrists and oncology providers are a prime example) made it impossible to calculate a response rate. We did not have a control group of clinicians seeing patients in person. This is especially important because the in-person practices during this period also changed in many ways, including changing schedules, shorter appointments, and use of face-covering personal protective equipment. Comparing rapport-building and efficiency between telepsychiatry and the realistic peri-pandemic alternatives was therefore not possible.

CONCLUSION

This survey demonstrated widely acceptable use of telepsychiatry. Based on our findings, we recommend that clinicians who are open-minded and have appropriate telepsychiatry training available are likely to be able to use this technology to extend access to care—regardless of their age or prior telepsychiatry experience. We further recommend that this medium can be applied to consultation-liaison settings.

Crisis situations overlap with increased need for psychiatric and psychotherapeutic care at the individual and population level. Ironically, during and after natural and man-made disasters, access to care is often particularly limited. If telepsychiatry can be routinely taught and practiced, we will be more prepared to offer high-quality care from a distance when needed. The implications of our findings go far beyond the pandemic era. There are many reasons why patients may need to access care from a distance, including home-bound patients, those in rural regions or in geographic areas with less expert care, as well as during crises.

Future research should focus on patient perspectives, include control groups, and further investigate barriers to access to appropriate telepsychiatry for sexual and gender minorities. Investigation of the impact of facial coverings on in-person rapport-building should be considered. Hospital systems should build telepsychiatry training programs in case of future need, as those we surveyed found it much easier when they had been trained, even if they had never had a telepsychiatry practice.

SUPPLEMENTARY DATA

Supplementary data related to this article can be found at <https://doi.org/10.1016/j.jaclp.2021.10.005>.

Conflict of Interest: The authors declare that they have no known competing financial interests or personal

relationships that could have appeared to influence the work reported in this article.

Acknowledgments: The authors thank Peter A. Shapiro, MD, Professor of Psychiatry at Columbia University Irving Medical Center, Terry Rabinowitz, MD, DDS, MS, Professor of Psychiatry at the University of Vermont, The Academy of Consultation Liaison Psychiatry, The American Psychosocial Oncology Society, The Mailman School of Public Health Biostatistics, Epidemiology, and Research Design program (BERD), and the Nathaniel Wharton Fund for their assistance. This publication was supported by the National Center for Advancing Translational Sciences, National Institutes of Health, through grant number UL1TR001873 and NIH/NCATS Colorado CTSA grant number UL1 TR002535. The content is solely the responsibility of the authors and does not necessarily represent the official views of the NIH.

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