

Lab to Smartphone

Lab to Smartphone: Has the Use of Telepsychiatry Gone Too Far?

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Telepsychiatry is an extremely useful tool for psychiatrists and was invaluable during the COVID-19 pandemic in maintaining access to care. However, there are some indications that the practice is being overused and may not be ideal for many patients. This article explores some of the negative aspects of telepsychiatry care and advocates for balance in the use of this rapidly expanding technology.

I used to be a big supporter of telepsychiatry. Nearly 20 years ago, before the existence of smartphones, I was involved in pilot programs using telepsychiatry to improve access to psychiatric care in rural areas. People liked telepsychiatry, and its use puttered along for years. Then came COVID-19, and the delivery of psychiatric services changed rapidly. Suddenly, almost everyone was using telepsychiatry to deliver care—whether they wanted to or not. We are fortunate to have had this option. Startup mental health telepsychiatry companies soon began to sprout up everywhere, and promised rapid and easy (arguably, too easy) access to therapy and psychopharmacological services.

As telepsychiatry research progressed, studies generally showed positive results in terms of quality, access, and patient satisfaction.^{1,2} Professional groups used these data to lobby for full reimbursement for services delivered via telepsychiatry or even by phone. Not surprisingly, psychiatrists and other mental health professionals began embracing the telepsychiatry model, enjoying the ability to stay home while starting and ending sessions with a click. Now, with the public health emergency over, many clinicians have not returned to in-person care, leaving many mental health clinics struggling to find people to hire. Some previously in-person services and clinics have remained telepsychiatry-only, while dedicated telepsychiatry-only companies continue to expand.

What has been the effect of this development? My own practice may serve as an exemplar. The use of telepsychiatry in my community mental health center for a geographically large county has provided a lifeline to many families who would otherwise need to spend half a day traveling to the clinic and back. After COVID-19 restrictions were lifted, I continued to offer a telepsychiatry option to my patients. Some families opted to continue with virtual services, while others did not, and now I am starting to observe differences

in the care between my telepsychiatry and in-person patients.

I appreciate how, with telepsychiatry, I can switch an appointment from in-person to virtual rather than cancelling it (if a patient is sick, for example). I value the glimpses of a patient's home. Further, I find that many of my patients, especially youth, are more comfortable on camera than in-person. However, I've increasingly noticed a negative side to the telepsychiatry movement as well. In addition to the frequent technical glitches, my telepsychiatry appointments are often shorter and more medication focused, with less time devoted to relationship-building. Vitals can be hard to obtain, and my patients often seem distracted, with some admitting that they are "multitasking" during our sessions. Challenging but crucial conversations that are often necessary seem less effective, perhaps because it is difficult to read a room that one isn't in.

Overall, the feeling that we all are just going through the motions—to obtain a refill, to bill for an encounter, or to get through the day—has felt more common with telepsychiatry than with in-person visits. There are also the frequent transfer requests from telepsychiatry patients looking to switch to an in-person clinician. We do our best to accommodate them, but there are fewer options for patients these days. There is also recent research that suggests an increased emphasis on telepsychiatry may exacerbate existing racially-based disparities in access to care.³

Of course, there are exceptions, and there are patients and families for whom telepsychiatry is a superior model of care. However, I am growing increasingly concerned that we are starting to lose, en masse, many of the subtle but essential elements of practice that make psychiatry effective. Telepsychiatry is certainly more convenient for everyone, but that may be precisely the reason that so few people—both patients and clinicians—are not complaining about the steady and almost undetectable erosion of care.



For these reasons, I find myself moving toward the conclusion that while telepsychiatry may be easier for everyone involved, it is not better for our patients overall. Like many new technologies and initiatives, telepsychiatry is an example of a good idea taken too far. Telepsychiatry is a great tool that is here to stay, and can improve access and efficiency. For some people, it can support a strong and meaningful therapeutic alliance, but for too many, the format limits our ability to connect to and to sense what is really going on with our patients.

I expect some pushback on this perspective, but I would encourage residents and junior colleagues to think twice before choosing that telepsychiatry-only position. The pay might be good, and the work/life balance might seem attractive, but you might also find yourself in a comfortable but isolated home office becoming increasingly uneasy of doing anything except telepsychiatry work. All the incredible qualities and skills you cultivated over many years of training may not apply the same way through the internet.

The time has come to take a step back and to fully examine telepsychiatry-delivered care. We will not (and should not) eliminate it, but perhaps we can find a better balance between telepsychiatry and in-person care. Like the advice we give our screen-addicted adolescents, it is critical that we use technology wisely, so that the technology does not use us.

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