Research Article

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Private metropolitan telepsychiatry in Australia during Covid-19: current practice and future developments

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Abstract

Objective: This paper discusses issues arising from the rapid implementation of metropolitan telepsychiatry in private practice during the Covid-19 public health emergency.

Conclusions: The relatively rapid uptake of private practice metropolitan telepsychiatry may further increase flexibility of the options for appointments through ongoing broad telepsychiatry access after the Covid-19 crisis. Telepsychiatry can be used to facilitate the temporary provision of psychiatric care, and has benefits and risks, but is not a longer-term replacement for the interpersonal richness of face-to-face consultations.

Keywords: telehealth, telepsychiatry, private practice, Covid-19, psychiatrist

In March 2020, Australian Commonwealth and State Governments instituted broad public health measures to slow the spread of the Covid-19, thereby preserving the capacity of health services to respond to Covid-19 cases.[1] To assist with the maintenance of the key public measure of social distancing, the Commonwealth Government expanded the access of telehealth consultations to encompass patients in metropolitan areas, in addition to the existing arrangements for rural and remote telehealth.[2] The constraints of the implementation of telehealth, which initially comprised limited MBS Item consultation numbers and mandatory bulk-billing for all patients, was followed by haphazard weekly expansion of MBS Item consultation numbers and gradual removal of bulk-billing requirements, resulting in considerable confusion and inconvenience for the public and medical practitioners. However, the most recent updates (20 April 2020) for the telehealth arrangements have allowed for the majority of the equivalent face-to-face consultations for psychiatrists to be provided via telehealth (videoconference or telephone) with Medicare rebates for all patients, with the exception of inpatient consultations.

The context

The rapid governmental implementation of measures needed to prevent spread of Covid-19 has not seemed to consider the impacts on private medical services, including private psychiatry. In particular, guidance on personal protective equipment (PPE) use as well as access to PPE has been lacking for psychiatrists in office-based outpatient practice. Consequently, the majority of private psychiatrists have made a rapid transition to providing the majority of outpatient psychiatric care via telehealth, with almost total reduction of face-to-face consultations. Public sector services in Australia, although the legislation and funding are different, have also made rapid transitions to telepsychiatry, especially in remote areas.[3] In Australia and internationally, there has been advocacy and rapid uptake of telepsychiatry to reduce Covid-19 exposure,[4–6] as well as consideration of other digital options for broad telehealth.[7] These Covid-19 innovations build on previous research demonstrating the general effectiveness of telepsychiatry in Australian and US rural settings.[8,9] As private practice psychiatrists are likely to undertake the majority of outpatient telepsychiatry

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Table 1. Videoconferencing options

These are some well-regarded videoconferencing options to consider.
Please determine if these are suitable for your patients, practice and circumstances.

- Skype
- Microsoft Teams
- Webex
- Goto Meeting
- Wickr Pro

during Covid-19, this paper focuses on private practice telepsychiatry.

Current telepsychiatry practice

For those practices with existing telehealth programmes, the transition may have been easier, although the legislative changes with Medicare benefits for metropolitan areas are new for all.[2] Accordingly, the considerations for private psychiatrists newly transitioning to telehealth will be discussed here. Consideration of cybersecurity of psychiatric practices, including telehealth is particularly important, given the rise in Covid-19 malicious cyber activity.[10]

Many private psychiatric practices have either closed or markedly limited to face-to-face appointments because of lack of guidance and access to PPE, and to avoid exposure to Covid-19. This has necessitated the placement of notices at the practice, analogous to those provided to GPs, regarding patients not entering the practice if they have relevant symptoms or may have been exposed to Covid-19.[11]

Telehealth using the telephone may be most useful and is now specifically authorised with the new Medicare benefits. The major considerations for telephone use include: sufficient phone access (landlines), the telephone call cost and payment plan, and protection of identity if you are using your personal mobile phone (blocking your own Caller ID). Practically, using a telephone may be most useful for existing patients, where a therapeutic relationship has already been established. The downside of telephone consultations is that there is an absence of visual, nonverbal and emotional prosody cues, such that the psychiatrist and patient must concentrate solely on the semantic content of conversation. Anecdotally, this can prove curiously more mentally fatiguing for the psychiatrist than a face-to-face consultation.

Videoconferencing on either a mobile phone or via desktop computer will allow video as well as sound for telehealth consultations.[12] It is especially important to select secure videoconferencing (see Table 1) as there have been ongoing concerns expressed about security risks during the Covid-19 public health measures[10] and in general.[13] When conducting videoconferencing with a patient, it is important to consider the use of your camera, microphone, seating position and lighting to assist with maintaining a professional presentation, while considering privacy – much as considering the layout of your practice office if you are working from home.[12] With videoconferencing, both psychiatrist and patient are constrained in viewing and hearing each other by the limitations of the medium and the equipment they are using. Video and sound quality can fluctuate, and most phone or desktop cameras only capture the head and shoulders of the speaker, yielding limited views of facial expression and body language. Eye contact is usually affected by trying to view the other speaker's image and the location of the camera. Therefore, even with videoconferencing, there is a relative lack of access to the nonverbal cues and emotional prosody of a face-to-face consultation.

Patients should be screened at appointment booking for the appropriateness of telepsychiatry. Patients with acute presentations are unlikely to be suitable for telepsychiatry, and if attempted, a backup plan of emergency response is necessary.

Telepsychiatry is likely to be more effective for previously known patients and more challenging for new patients. As with the psychiatrist's office/practice, there may be other persons present in the consultation at the patient's end, which may have a bearing on the nature of the conversation. The effect of other persons present with the patient may range from: having a helpful carer, to others interfering in the conversation, through to issues of privacy.

The psychiatrist should also consider with the patient a contingency plan if the patient becomes unwell, such as access to emergency face-to-face care and agreements about contacting other supports.

Booking appointments, billing and correspondence are also an important consideration. If you are practising from your office, you may wish to continue with secretarial and administrative support for billing. Otherwise, psychiatrists will need system for booking, correspondence and billing from home, and there are web and software programmes that provide such facilities, but the cybersecurity of these digital options will need to be verified before use. The cybersecurity of private practice as a small business warrants caution during Covid-19.[14]

The RANZCP has updated guidelines for telepsychiatry consultations[15] and there is another comprehensive guide for video mental health consultation from Swinburne University.[12]

Future developments

The uptake by patients and private psychiatrists of metropolitan telepsychiatry augurs a potential shift in practice that may increase flexibility of the options for appointments through ongoing broad telepsychiatry access after the Covid-19 crisis. Face-to-face consultations, which allow for the experience of being physically present with another person are not likely to be replaced, since telephony and

videoconferencing cannot presently reproduce the interpersonal fidelity of face-to-face – indicating the need for research into comparisons of the effectiveness of these consultation modalities.

While there presently seem to be no specific problems with exploitation of telepsychiatry to date with Covid-19, concern about the risk of exploitation of telehealth in general practice has already been articulated. This has included concern about the development of online only, call-centre based general practice telehealth that is not associated with a physical practice and thus cannot provide comprehensive medical care.[16] Similarly, telepsychiatry needs to be provided by psychiatrists based in practices to allow for face-to-face assessments, including where needed cognitive, neurological and other relevant examination is required.

Research into metropolitan private telepsychiatry usage during Covid-19 should inform the development of much needed private sector mental health policy and services. Feedback from patients is also essential to further improve telepsychiatry provision.

Research into cybersecurity for telepsychiatry videoconferencing and telephony will assist with provision of safe and secure services. Private psychiatric practices should investigate business continuity options to deliver psychiatric care in future pandemic contingencies, for example, the ability to move all business functions to working from home in the event of quarantine for a virus outbreak in the practice (P.Viljakainen, personal communication).

Research into private practice telepsychiatry must be contextualised by broader research into the coordination of telepsychiatry with other mental health services as part of a population mental health approach.[17] This includes investigation of potential synergies between private telepsychiatry and public mental health services, for example, private psychiatrists providing locum services via telepsychiatry.

Other digital technology interventions are worth brief mentioning, though this paper focuses on telepsychiatry that is regarded as synchronous telehealth (i.e. patient and psychiatrist interact simultaneously in real time).[6,7] There are proposals for asynchronous telehealth and apps for wellbeing and health, as well as yet to be developed digital technologies.[7]

Conclusions

Among the lessons to be learned from the rapid expansion of telepsychiatry in the Covid-19 era is that technology can be used to facilitate the temporary provision of psychiatric care, albeit short of the interpersonal richness of face-to-face consultations. The comparative effectiveness of videoconferencing, telephony and face-to-face consultation warrants further investigation. There are benefits and risks with any technological adaptation. Retention of telepsychiatry for metropolitan as well as rural/remote patients after Covid-19 measures will allow for increased flexibility of appointments. Psychiatrists fundamentally practice through being present and directly interactive with patients, not virtually. The likely role of telepsychiatry after Covid-19 will be as a flexible complement to face-to-face consultation, requiring coordination with mainstream and other innovative mental healthcare.

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