

CASE AND COMMENTARY: PEER-REVIEWED ARTICLE

According to Which Criteria Should Telemental Health Be Deemed Elder Inclusive?

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Abstract

Telepsychiatry offers opportunities to provide better access to and higher quality of psychiatric care for some patients. This commentary on a case considers an analysis of clinical and ethical barriers to equitable telehealth for elders with mental health needs.

Case

Dr JM has just begun working in a telepsychiatry clinic that serves patients from regions with mental health service shortages via an online video conferencing platform. Dr JM is scheduled to evaluate a patient, TT, who is 88 years old and accompanied by her 65-year-old son, who struggles to maintain audio and video call quality from where they are seated in a car outside a restaurant that has wi-fi connectivity in their community. Their home internet access is unreliable, and the instruction they received for enabling the supported smartphone application was not helpful. Due to poor audio and video transmission quality, Dr JM is unable to observe the symptoms (eg, anxiety and irritability) that TT's son worries about. As the appointment time ends, Dr JM remains concerned about the standard of care she just provided and is not at all confident that she learned clinical and diagnostic information that will help her help TT. Dr JM wonders how to follow up. What should be the scope of the health care organization's obligations to ensure equitable access to mental health services? According to which criteria should remote services be deemed equivalent in accessibility and quality to health services delivered in person?

Commentary

The COVID-19 pandemic's influence and effects can be seen not only in the physical health, but also in the mental health of patients. South Korean patients with a history of severe mental health illness were found to be at a slightly higher risk for severe clinical outcomes of COVID-19 than those without such a history, and, in the United States, a recent diagnosis of mental disorder was found to be associated with increased risk of infection.¹ One population that is particularly vulnerable to the impact of the pandemic in its various forms is the older adult population. Older adults are at higher risk of suffering negative outcomes, with 80% of deaths in the United States during February to March 2020 being among adults 65 years and older.^{2,3} Studies suggest that the mental and physical health of older adults was negatively affected by social isolation during the

COVID-19 pandemic, with anxiety, depression, poor sleep quality, and physical inactivity as the main outcomes.² Some factors besides social isolation contributing to these outcomes include the presence of life stressors and the lack of technological expertise, which limited the availability of remote socialization options.⁴

Telemedicine provides access for those who might otherwise be unable to obtain services or have to wait for a long time to access them.^{5,6,7,8} Justice as a principle speaks to the fair and equitable distribution of resources among diverse groups of patients regardless of their age, gender, race, or socioeconomic factors. Upholding this principle entails that access to care for older adults be equitable to that for the younger population. Since telepsychiatry is available to younger patients, it therefore should be available to older adults. This commentary will explore challenges experienced by elderly persons in accessing telepsychiatry and offer potential strategies for addressing these challenges to ensure equitable care.

Difficulties for Elderly Persons

While some studies have argued that there are no significant differences between **telepsychiatry** and in person face-to-face care, others point out that certain aspects of telepsychiatry can be problematic,^{9,10,11} including “the knowledge and capacity to get online ... [and to] operate and troubleshoot audiovisual equipment.”¹² For telemental health care to be deemed elder inclusive, barriers need to be identified and addressed at various levels. These barriers include technology factors, patient factors, and clinician factors. Technology factors include availability of equipment, issues of connectivity, and technological know-how. Even if an older adult has the capacity to get online, there may be limited internet accessibility in rural areas. Patient factors include autonomy, comfort with and acceptability of the treatment modality, and concerns about **safety, privacy, and confidentiality**. Because patients may need others to assist with the technology, their ability to share freely what might be concerning to them may be limited, raising concerns about autonomy and confidentiality. Patients may also struggle with acceptance of the treatment modality and perceived limitations in the establishment of “trustworthy, authentic, and effective patient-clinician relationships.”¹³ Clinician factors include expertise with the older adult population and with the use of relevant technology, comfort with the treatment modality, and knowledge of the legal ramifications of the use of telepsychiatry. Clinicians also need to be aware of the limitations of telepsychiatry and to be open about these limitations with patients. The obligation to be transparent overlaps the principle of fidelity, which requires that clinicians provide accurate information to the patient about the care provided. Among older adults, especially in **rural areas**, barriers posed by technological, patient, and clinician factors may result in a drastic decline in quality of care, rendering care less equitable. It is therefore important to creatively look at options that make telemental health care for older adults more equitable to the care provided to the younger population.

Accommodating Elder Access to Telepsychiatry

For telemental health care to be deemed elder inclusive, accommodations need to be put in place. The elderly have been identified as a group that has difficulty using new telecommunication equipment.⁵ Some authors have argued that training older adults to use telemedicine for mental health may have limited impact.¹⁴ One way to address this concern on an individual level is to have another party assist with the operation of technical equipment. Although this kind of assistance from family and caregivers may be helpful, elderly patients may find it difficult to communicate sensitive concerns in the

presence of their children or caregivers. A potential benefit of having a family member present can be seen in cases in which patients have dementia, hearing impairment, or visual impairment or need repeated setup of equipment or in which a family member is necessary to supply aid or collateral information.

Having a family member present foregrounds the ethical issues of autonomy and confidentiality. While patients are allowed to involve whomever they wish in their care, involvement of others limits their ability to take charge of all aspects of their care, as there is a third voice in the conversation that might influence the visit. A potential solution would be to have someone set up the appointment and exit the room. This approach would be particularly beneficial in cases in which there is concern about potential elder abuse. Keeping in mind the principle of nonmaleficence, the clinician has to be cognizant of the potential for harm if an abuser is present in the room, as studies have shown that elder abuse—including physical, verbal, and emotional harm; financial exploitation; and neglect or indignity—increased tenfold during the pandemic.¹⁵

Institutionally, strategies need to be put in place to improve the clinician's ability to gather sufficient information to make clinical decisions that will not harm the patient, hence satisfying the clinician's need to provide appropriate care to patients who would otherwise have no access to it. Such strategies include providing internet-connected tablets and internet connectivity for appointments, as well as having community partners who can help older adults navigate their virtual world and provide safe and private spaces for consultations when necessary. An argument can also be made for a hybrid model that would require periodic in-person visits after a certain number of virtual visits. Hence, if something were missed during the virtual visits, it could be picked up during the face-to-face visit. In addition, thorough training should be provided for telemedicine practitioners on how to optimize assessing patients and hopefully improve confidence in decisions made with a limited physical exam. Training should also include information on how telemedicine practitioners can protect themselves from legal repercussions that may arise from making decisions based on limited information. Lastly, patients need to have an opportunity to access emergency help if there is a crisis during the encounter and to access prescription management, labs, and the after-visit summary. There is also a need to standardize the platform for providing virtual care to create consistency and reduce the burden for patients and caregivers as applications are updated.

In the case of TT, virtual care was offered. However, due to other challenges, the care might not have been equitable to the care delivered in person due to poor transmission and problems with the technology, as well as possible concerns about TT's autonomy. It is also clear that the clinician did not feel comfortable with the information obtained and utilized in clinical decision making.

Conclusion

In summary, for telemental health care to be deemed elder inclusive, certain boxes need to be checked. First, there has to be adequate technology to fulfil the need; second, there needs to be appropriate infrastructure to foster autonomous decision making and safety; and lastly, there has to be adequate training for clinicians. Satisfying these conditions will ensure that older adults are able to access and utilize telemental health services appropriately.

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Editor's Note

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The people and events in this case are fictional. Resemblance to real events or to names of people, living or dead, is entirely coincidental. The viewpoints expressed in this article are those of the author(s) and do not necessarily reflect the views and policies of the AMA.