Kimberly Adams

This is an updated Spotlight on Virtual Mental Health Care from Call to Mind at American Public Media. I'm Kimberly Adams.

As the COVID-19 pandemic continues to shift through variants, the strain on our collective mental health continues to climb. Shutdowns move in waves around the country as serious case numbers resurge - making people more reliant on technology to connect with therapy.

Phones, PCs and internet connections have become lifelines to coping strategies for managing this ongoing, historic stress.

One government analysis found paid insurance claims for telehealth services under Medicare, for example, jumped from 102 thousand to 8.4 million in the first two months of the pandemic. And in December, the U.S. Department of Health and Human Services reported Medicare visits increased to more than 52 and a half million (52.7 m) in 2020.

But, mental health care took an especially large step into the virtual space, where people sought treatment for conditions like anxiety, depression, and bi-polar disorder.

The overwhelming public need led the nonpartisan Government Accountability Office to send a warning to Congress this December of a potential mental health crisis on a national scale. The GAO confirmed demand for treatment services were expected to increase because of the pandemic, but access was also expected to get worse.

So, Call to Mind is updating Spotlight on Virtual Mental Health Care from August, examining how well the mental health sector managed it's forced shift to virtual care during the pandemic.

And we now dive in by turning back to our conversation with Dr. Peter Yellowlees. He's a Professor of Psychiatry and Chief Wellness Officer at UC Davis Health. And, is an expert in telepsychiatry and past president of the American Telemedicine Association.

Welcome to Call to Mind's latest Spotlight.

Peter Yellowlees

Thank you very much indeed, Kimberly. It's a real pleasure to be here.

Kimberly Adams

So how did the delivery of mental health care change in 2020?

Peter Yellowlees

Well, it was really very dramatic. Literally, here at UC Davis, for instance, in our psychiatric outpatient division, we changed from being about 97 or 98% of patients being seen in-person to

100% of patients being seen online, mainly at home within a three day period of time. So you really can't get more dramatic than that.

Kimberly Adams

That is astonishing, that much change in three days. What was that like on the ground?

Peter Yellowlees

Well, we were very fortunate in that as a system, we've done a lot of telemedicine, and in psychiatry, we had already trained our residents and our attendings how to do telepsychiatry, and we had the technology in place. The big issue with COVID was clearly contacting all the patients. Explaining to them, you know, many hundred patients a week, that they were not going to be able to come in and see us in person anymore. And, they were going to have to see us either on video or on the phone**.** The other group that had to change dramatically, of course, were the physicians. Because, suddenly the physicians on the whole couldn't actually stay at work with COVID. And, whilst the more senior physicians, you know, who were established had homes, usually with a spare room that they could use to see their patients in -- a lot of the residents, you know, literally share apartments with other people. And, for them actually finding the space to suddenly be working full-time at home, overnight, was actually really difficult.

Kimberly Adams

Use of virtual mental health care exploded during the pandemic. What policy changes happened to allow this rapid expansion?

Peter Yellowlees 2:30
I think there's no doubt that this expansion could not have happened without major policy changes. There were a lot of regulations in place that, quite honestly, people like me have been arguing against for many years that restricted telemedicine prior to COVID. So, there were three big changes that were made by the federal government instantaneously with the outbreak of COVID. The first is that they changed the rules around physician and other provider licensing, allowing us to see patients in any states. That wasn't possible previously. The second big change was around prescribing for physicians. We were allowed, suddenly, to prescribe controlled substances, which had previously been restricted. In mental health that's really important because it means that we can prescribe, for instance, drugs like Ritalin and stimulants for children for attention deficit disorders, and also potentially narcotics when we're seeing patients with substance use disorders. And, then the third big change was a change to geographic rules about where your patients could be sited. Prior to COVID, patients had to be in a rurally defined geographic area in most states. That rule went away. So suddenly, we could see patients who lived in metropolitan areas, which of course is where most patients actually live.

Kimberly Adams

Since our conversation with Dr. Yellowlees, a number of these pandemic changes have become standardized by the Centers for Medicare and Medicaid Services. But, we want to let Dr.

Yellowlees make one last point about how well mental health care providers were actually able to deliver therapy and assess how well his sector did more than a year into the pandemic.

Peter Yellowlees

You know, there's two ways of looking at that. I think the first way is to say, we actually did make a lot of very successful changes and have provided care, I think, reasonably well overall. And, in fact, have had less no show rates on the whole, because patients have been able to access mental health providers more easily. The alternative approach is to say, well actually, COVID itself, as we know, has been a huge stressor and has actually highlighted the shortage of mental health professionals. And also, particularly certain patient groups, patients from diverse racial and social backgrounds for instance, that we know have unfortunately tended to find it least easy to access care during COVID, and that's been a huge problem. And, there's something that I think most mental health providers are very aware of, and we need to improve that going forward.

Kimberly Adams

We'll hear more from Dr. Yellowlees later in the show, but the point he just made about access to these new tools is also a business issue.

Part of the enthusiasm around telehealth has to do with all the new digital tools available on smartphones and online. From apps that set up text, video, or audio connections with providers for depression treatment, to wellness and meditation guides that can help manage stress.

According to digital health venture capital firm Rock Health, digital mental health companies in the U.S. saw investments more than double to $2.4 billion between 2019 and 2020.

All that attention translates into a lot of apps, 10-20 thousand of them. But, only about three to five percent of those are evidence-based, or have science-backed solutions behind them.

That's according to Dr. Stephen Schueller. He's an Associate Professor of Psychological Science and Informatics at the University of California Irvine. And, he's Executive Director of One Mind PsyberGuide, a website that evaluates mental health apps.

Dr. Schueller, thanks for joining Call to Mind.

Stephen Schueller

Happy to be here.

Kimberly Adams

What's the difference between, sort of a wellness app and a mental health care app?

Stephen Schueller

Yeah, well, I think that a wellness app is not intended to treat a medical condition. So, they're not meant to sort of support clinical levels of, like, anxiety or depression, for example. Another difference is that wellness apps are not regulated. Clinical apps are regulated by the FDA. If it's meant to be a medical treatment, it's a software as a medical device. But, these wellness apps are not regulated.

Kimberly Adams

And, if someone is feeling like they need some extra support, but maybe they're not ready to look for or find a therapist or don't have the resources to do so - how can they wade through those 10-20 thousand and actually find something that will help them?

Stephen Schueller

Well, I think that the first thing I'd say is that these apps are not meant to be replacements for therapists. I think they might be good resources as you're trying to figure out, you know, what therapy might be like and what types of benefits you might be able to gain or if you're searching for a therapist. I know that especially during the pandemic, wait lists and wait times to find a therapist have increased. And, so they might be a good, sort of, initial resource as you're in that sort of searching out period.

I'd also note in terms of trying to find those products, it really is useful to find things that align with what are evidence-based practices that we see from science-based studies and practices that are done commonly in therapy. So, words such as “cognitive behavioral therapy” are words I would look for.

I'd also look for products that are associated with universities or have done research studies in partnerships with academic partners. So, apps like Talkspace and BetterHelp that provide some opportunities to text or chat or video session with a licensed provider.

I think we've also seen, as I mentioned, you know, different things that are sort of fully automated.

So, apps like Woebot, or apps like Calm. You know, Woebot is a chatbot app that replicates some of the skills that you might learn in therapy and teaches that to you by kind of texting back and forth with this, you know, this chat bot, this artificial intelligence agent. And, Calm is a meditation app. And, meditation apps are actually extremely popular. If we actually look at all the downloads for mental health apps, 90% of those downloads are Calm or Headspace. So, what we see consumers want, or at least what they're downloading, are these mindfulness apps.

Kimberly Adams

And, for transparency, you are a member of the scientific advisory board at Headspace.

Stephen Schueller

That is correct.

Kimberly Adams

With people turning to all of these apps in this context, is there a risk that they're actually looking for therapy, but instead turning to these sort of wellness or mindfulness apps?

Stephen Schueller

Yeah, I think my biggest concern in this space is that someone might download one of these products, not get better and think - like, you know - well, I tried that therapy stuff or I tried that treatment, it didn't work and - so, you know - it's not worth me going and doing something more. Delaying treatment.

And, what we see in all of the science is that these tools, when used in conjunction with some form of human support or human component, are as effective as traditional face-to-face therapies. But, when used by themselves in a self-guided way, are still effective, but not as effective.

Kimberly Adams

I also talked to Dr. Schueller about health systems where these apps are used to support other forms of mental health care. And, I asked if there were other models that show apps really working.

Stephen Schueller

I think if we look around the world, we've seen a lot of other countries use these tools as frontline treatments for people seeking care. So, the idea is that if someone presents to care, they might present a digital treatment as a first round, sort of low-intensity treatment, to see if someone gets better after that. And then, if that doesn't work, then they provide subsequent care.

We actually did a research study where we looked at these, what's called Stepped Care Models. And, what we found is that both conditions were equally effective. People got equally better, whether they started with the internet treatment and moved to the telephone treatment, if they needed to. But, not surprisingly, the stepped care model, starting with the internet treatment, was much more cost effective. It actually took about half the cost and half of the time of the therapist to start people on those low-intensity treatments, which makes it much more scalable. If we can provide, you know, twice the services to a population, we're able to reach many more people. So, we've seen this in Australia, we've seen this in Canada, we've seen this in the U.K., across Europe.

I think the challenge here in the U.S. is we don't have a - we don't have a mental health system. We don't have, sort of, a national system to be able to do this. And, so, we have a lot of fragmented systems that are trying to look at, you know, some of them, trying to look at how these tools might be able to be used to scale care. But, we're really far behind a lot of other

countries, in thinking about how we can use these tools to extend services to those who need them.

Kimberly Adams

Talk to me about privacy on these apps. Going for mental health care in person or using an app, it's such a private thing. How well do these apps protect people's privacy?

Stephen Schueller

Well, I think the majority of them do not do a very good job, or at least we don't know.

We did a study a couple years ago where we evaluated about 120 different depression apps, and we found that half of those didn't even have a privacy policy. They didn't tell you what they were doing with their data. And, of the half that did, half of those apps were not acceptable in their privacy policy, based on the transparency metric that we use at One Mind PsyberGuide. So, you know, either they were giving their, your data over to third parties or they were not protecting it through encrypted servers.

So, I think a majority of these apps are not doing a very good job protecting your, your data. And, what was also concerning with even those apps that had privacy policies, a lot of them would not tell you your, their privacy policies until after you set up an account and gave them your email address and, you know, a password. So, you didn't actually even get to know what was happening with your data until you already gave them some information.

I think privacy, it's really critical. It's one of the things that we hear from consumers, that's one of their biggest concerns about apps.

And so, I think one of the things that I really recommend to people, when you look at and consider adopting this product, a product is: A - first look if it has a privacy policy. If it doesn't, that's a very serious red flag. And then, read the privacy policy to look for things such as, you know, do they get to share your data? Is your data leaving the device? What are some of the protections around encryption, passwords, things of the sort? I know we get a lot of privacy policies and terms of services thrown at us in this, when we're using technologies. But, I do think even a cursory review of these privacy policies can raise some, you know, pretty quick red flags that lead you to some products that you should avoid.

Kimberly Adams

And, what about accessibility? And I'm thinking of the term accessibility, I guess, in a couple of ways - both who has access to use these apps in terms of economic access, disability access, and even language access, tech savviness?

Stephen Schueller 15:36
Yeah, I think it's a big concern and it's an unmet promise of this field. Many of these products are developed only in English and they reflect, you know, the cultural and representation mostly of the white majority. So you know, the pictures and the images and the videos, and the cultural examples are mostly, you know, white individuals. And so, I think we've done a very poor job in

terms of creating products that are tailored for, you know, Spanish speaking Latinos, or Black, you know, populations, or LGBTQ populations, which are actually very likely to go online to seek mental health support. And so, I think we need to do a better job making products that reach those people and represent a very, a variety of different, you know, cultural groups and, you know, backgrounds. Because, that's one of our failing, failings right now of the field is we don't have enough therapists that are Black and Latino and speak Spanish and, you know, meet the needs and understand, you know, working with LGBTQ individuals. And so we, we should and could be doing a better job at this in technologies.

Kimberly Adams

What do you see as the future for the way that these apps are going to be part of a continuum of care?

Stephen Schueller

Yeah, you know, I really think 10-ish years from now, we're not going to be talking about digital health, we're going to be talking about health and digital will be a part of it. So, I think we'll see less, you know, discussion about digital mental health, because technology will be better integrated into the workflow. I think that one of the things that we really need to understand is, you know, what works for whom, under what circumstances. And, who are the people, we should be starting on a digital treatment? Who are the people that we should be starting on, you know, therapy. Who are the people who should start with medication? To hopefully make this less of a trial and error, and more of a targeted personalized sort of care process. And really, shortening the window between when a person presents for care, or needs care even, and when they're actually able to receive something that's going to be the best treatment for them.

Kimberly Adams

Dr. Schueller, thank you so much.

Stephen Schueller

Thanks so much for having me. It was great to talk about this.

Kimberly Adams

Stephen Schueller is an associate professor of psychological science and informatics at the University of California-Irvine. And, he’s executive director of One Mind PsyberGuide.

In planning for that future he mentioned, many mental health care providers and researchers are busy trying to assess just what does and doesn’t work when it comes to telehealth and virtual mental health care.

Dr. Juliette McClendon is a clinical psychologist and researcher, who spent a few years working with the Veterans Administration.

In early 2020, she was running a therapy group at the Boston VA and collecting data to measure its effectiveness. The specific approach, or intervention, addressed the effects of discrimination on participants' stress and trauma. And then, just two sessions in, the pandemic shut down in-person visits.

In just over a month, mental health services delivered over video at the VA nationally grew 556 percent, and Dr. McClendon's intervention was a part of that transformation.

Dr. McClendon, welcome to Spotlight.

Juliette McClendon

Thank you. I'm really excited to be here.

Kimberly Adams

So how far did you make it into this eight week intervention before the pandemic started affecting what you could do?

Juliette McClendon

So we made it two weeks. And then, the VA basically, I mean, everything shut down. So at that point, I had to essentially stop the study and turn the study into a virtual study.

Kimberly Adams

What then were some of the things that didn't work out so well, or elements of this that you think restricted access?

Juliette McClendon

So there were a number of individuals who ended up not being able to participate in the virtual groups or chose not to. And, those were often individuals who had a hard time understanding or navigating the online platform that we used, or who preferred in-person care. And so, there were a number of individuals who dropped out of the study because of the move to virtual.

Kimberly Adams

I asked Dr. McClendon about what she learned about virtual care during the study, and she talked about how it helped patients who therapy might not have been designed for.

Juliette McClendon

So, mental healthcare was really designed as a white-collar solution. It was, you know, we deliver care during business hours, typically, and focus on people with disposable incomes and flexible schedules. Right? And so, we saw here how virtual care could help with some of that.

But, telehealth works within the same mental health system that's always existed. There still can remain financial and cultural barriers to accessing that mental health care whether it's in person or whether it's virtual, and that's really exacerbated in minoritized communities.

Kimberly Adams

Much of what we've been discussing is around your work at the VA, but you also work for a digital therapeutics company called Big Health, which sells mental health software to individuals and companies. And, I wonder about how you see those two worlds and the way that they have responded to this transition, the public versus the private sector. What did you notice?

Juliette McClendon

I was actually very, very pleasantly surprised by how quickly the public sector was able to adapt to this change. In terms of the work I do with Big Health, which is where I work full time now, is that we're really focused on this, now, third generation of mental health care, is how I think about it.

So, that first generation is in person. The second generation is telehealth and virtual care. And, I think this third generation is digital therapeutics, which are these types of, this type of care that is fully automated and actually doesn't need a therapist, but can still be very personalized to the individual.

For example, we only have 30 licensed psychologists per 100 thousand people in the United States. That's just not enough professionals to meet the need, especially now post-pandemic, when many people have been suffering from a number of mental health concerns, and are more willing to seek help. And so, I see digital therapeutics as this next generation, because they're able to overcome some of those additional barriers that even virtual care still cannot overcome. Things like stigma. Right? This fear of being associated with negative stereotypes if you have a diagnosis. And then, there's been historical and ongoing injustices within the healthcare system against marginalized populations that sort of make people sort of shy away from seeking out, especially, mental health care.

Kimberly Adams

You've laid out how digital therapeutics can expand access to mental health care. But, in some ways, doesn't this also create a bit of a tiered system of care - where, you know, you still have a mental health system where the wealthy white-collar folks with disposable income can get that one-on-one clinical care with a human being; maybe that second generation has access to virtual health, still with the real person; and then other groups that maybe have already traditionally lacked access, rely on digital therapeutics, which although they can be customized to some extent, it's not the same?

Juliette McClendon

Yeah, absolutely. There are issues related to, like, the digital divide, where minoritized communities, underserved communities are also less likely to have access to things like Wi-Fi and smartphones. And so, that is a really important thing that we have to keep in mind and think about as we're creating these digital therapeutics. For example, is there a way that we can have

therapeutics that people don't need Wi-Fi for? Is there a way that we can get these therapeutics into the hands of people without them having to have a smartphone? Those are things we have to think about within our industry, to really make sure that we're not actually just perpetuating the inequities that we've seen in the traditional mental health care systems.

Kimberly Adams

From your experience going through this process at the VA, what did you learn that you think we need to carry forward post-pandemic?

Juliette McClendon

So one thing I'll share about my experience running these groups, is that I ran groups for about a year. I think I did about 50 sessions and by the end of it, I have to be honest, I was burnt out. And, that's a big problem within the mental health field. There is a lot of burnout and a lot of turnover.

And so, I think we need to think about how can we leverage virtual care, and this combination of virtual and in person care, as well as digital care to reduce the burden on mental health professionals and reduce their burnout, so that they can continue to stay within the field and continue to offer their services to individuals. As well as offering solutions to mental health care professionals so that they can be able to build up their resilience and address mental health problems that they themselves may be experiencing.

Kimberly Adams

I really appreciate your time, Dr. McClendon. Thank you so much for sharing your expertise.

Juliette McClendon

Absolutely. Thank you for having me.

Kimberly Adams

Juliette McClendon is a clinical psychologist and researcher. She spent a few years working with the Veterans Administration and is now director of medical affairs at Big Health, a digital therapeutics company.

You’re listening to Spotlight on Virtual Mental Health Care, from A-P-M.

In the next half hour, we’ll talk about improving access to virtual mental health care, including some new models to get more people the right care, more quickly.

More from Call to Mind after this break.

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Kimberly Adams

This is Spotlight on Virtual Mental Health Care from Call to Mind at American Public Media.

I'm Kimberly Adams.

Before the break, our guests talked about the promise of digital tools, like virtual visits and smartphone apps. But, they also emphasized shortcomings and unmet needs.

I asked Dr. Peter Yellowlees, professor of psychiatry and chief wellness officer at UC Davis Health about some of those gaps. Specifically, the long-standing shortage in mental health care providers.

Even before COVID, the federal government documented this, finding that more than a third of Americans live in a provider shortage area.

So, as an expert in telepsychiatry, I asked Dr. Yellowlees how virtual care might increase access to providers.

Peter Yellowlees

I think there are two obvious ways. The first is that we can be beamed in and can synchronously see people using video or the phone, and can clearly work across lines and different county boundaries like that.

The second, more important long term way, is actually to think about providing more care asynchronously. In other words, to have patients in the long run actually make their own videos of how they are and talk about their, their concerns, and then send those videos or pictures or, or streams of them having certain behaviors to their physicians or to their experts.

We already do this, for instance, in helping to diagnose children with autism early in life. We send videos of the kids because we know we're not going to work or behave in a way that is perhaps useful in the clinic.

Kimberly Adams

That's one of the ways that virtual care, you know, affects and maybe helps access for patients. What does it mean for providers?

Peter Yellowlees

You know, for providers asynchronous care is wonderful, because we don't have the problem of no-shows. In a normal clinic, in most clinics in this country, about 10-20 percent of patients don't show for various reasons. It's partly due to the nature of mental illness. And, and so providers actually have time on their hands.

Now the beauty of providing asynchronous virtual care, e-consults essentially, is that we can do those consultations during that downtime. So, we can actually use our time better and more efficiently and, as a result, actually scale up the number of patients we see in the average week.

Kimberly Adams

We also heard about some of the more fundamental issues with expanding access to mental health services. Here's what Dr. Stephen Schueller explained:

Stephen Schueller

I think a lot of the rhetoric around here is that, you know, we can create these technologies and they'll be scalable, and we can overcome access barriers for people. And, I don't think we've done a great job in this field of doing that. Many of these products are developed only in English. And they reflect, you know, the cultural and representation mostly of the white majority.

Kimberly Adams

What's your response to that?

Peter Yellowlees

I think he's absolutely right. In fact, we've been working over the last several years now on implementing automated translation into some of our video apps. We've just been working in Spanish, because in California there's a lot of Hispanics. But, it's a huge problem. We know that people with limited English proficiency get much worse care, because they're not so well understood.

If we want to change how we actually work in a big way, I think with underserved communities, the biggest single change we can make is actually to start using the phone quite honestly, more frequently than we do now. The phone prior to COVID was not reimbursable. So, you couldn't do consultations on the phone. During COVID, we've been able to use the phone. And, there's been a really interesting paper out from a large New York group recently, showing how they have actually just used the phone during COVID to replace case management visits from therapists, and how that has been particularly helpful for patients who are very poor or, or who come from disadvantaged backgrounds.

Kimberly Adams

Lastly, I wanted to ask Dr. Yellowlees about access. Who in the US struggles the most to connect with mental health care, and virtual mental health care?

Peter Yellowlees

In terms of other disparities around our system, I mean, clearly there are still huge disparities that are geographically based. And there are many, many counties around this country that have no psychiatrists, for instance. I think it's something like 55% of the counties in America have no psychiatrists, some extraordinary number. And so, for those places, the only way to get a psychiatrist is either to travel to see one or to have one beamed into you. But I mean, the third category we must not forget about is, still, there's still a sort of technological and health literacy category. For some people who just either don't or can't use technology because of other

disabilities, people who are blind or deaf, for instance, are big communities. And so, we have to not forget about those people as well.

Kimberly Adams

More from Peter Yellowlees in just a bit.

Now, Americans face all sorts of barriers to getting the mental health care they need. Almost a quarter of Americans say they don't have internet at home, according to Pew Research. More than a third live in an area without enough mental health providers to meet the need. Some people may avoid care if they are worried those around them might judge them for it.

Now, virtual options can knock down some of those barriers, but reinforce others. This can be especially tricky to navigate in remote areas, the majority of which do have a shortage of mental health care providers.

Dr. Jay Shore is a professor of psychiatry at the University of Colorado and the chair of the American Psychiatric Association's telepsychiatry committee. He's here to talk with us about how the transition to virtual mental health care plays out in rural communities.

Dr. Shore, good to have you with us.

Jay Shore

Thank you for having me today.

Kimberly Adams

What happened during the pandemic was such a sudden shift to virtual care. I wonder if you can compare how you saw organizations and clinics, adapting to virtual care, pre-pandemic and what that looked like on the ground during the pandemic.

Jay Shore

Yeah, it was a little more chaotic and less strategic. Often, doing an implementation approach, that can be a two to three month to six to 12 month process of needs assessment, educating the staff, getting the technology set up, billing and coding - all of that. And, when the pandemic hit in March, I was involved and witnessed organizations literally turning on virtual care in two hours to six hours, 24 hours, a couple days. So, it was a very rapid set of implementation. And, I can't think of an organization of a provider over the past year that wasn't involved in some offering of video conferencing.

Kimberly Adams

What were some of the challenges and barriers that the last year and a half kind of showed us when it comes to virtual mental health care?

Jay Shore

So, I think the one that concerns me the most is we knew prior to the pandemic, that there are disparities in digital health care in terms of access, and many people have heard the term the digital divide.

But to me, that digital divide has multiple components. So to access healthcare in a digital manner, you need not only broadband access, but you need a computer, a mobile phone that has adequate software, and is up to date that can run it. You need ongoing, real time tech support. The patient has to have a minimal level of comfort and ease of being able to use the technology. And, in terms of funding, you would hope that, you know, patients' insurance or have some access to to cover the care and that and that's not always true. So, those are five factors, and then they were certainly prominent before COVID. But during COVID, they were significantly highlighted.

Kimberly Adams

In many communities, there are still social barriers to getting mental health care. And, you know, I'm imagining in some rural communities, people may all know each other, and maybe they don't want to bare their soul to somebody who they know or who they will see around town. How does remote care improve access for people who maybe feel social pressure not to seek help? I'm thinking, LGBTQ+ folks living in smaller communities, in particular.

Jay Shore

It certainly could help decrease stigma and barriers in small communities. Obviously, if you're in a small rural clinic and you, you end up showing up, you might walk by someone at the reception desk who's a relative, or you may, and you may see a friend, and you're probably going to know the physician. And so, the nice thing about video conferencing, when you're going directly to a patient's home, right, you enhance the privacy in some respects.

Kimberly Adams

What policy changes need to happen in order to make it easier for the workforce that we do have to actually deliver the mental health care that's needed, especially with so many more people looking for mental health care in light of everything?

Jay Shore

During COVID, we saw some loosening of the regs that, to facilitate telehealth. I think another key issue is billing, and what can be reimbursed, which drives what happens.

So, for those patients in rural, remote areas that are restricted because of the quarantine and could not access virtual care, the phone became a lifeline for getting behavioral health services. We're sort of emerging into a different health care system.
So for telehealth, I think the exciting thing is to really solidify and understand the best practices around this hybrid care. How do we leverage telehealth and technology to preserve the best things about a patient-provider relationship? I think, really, that hybrid care is going to be the future of telebehavioral health and medicine in general.

Kimberly Adams

Dr. Shore, thank you so much. I appreciate your time.

Jay Shore

Thank you for having me. It was delightful.

Kimberly Adams

Jay Shore is a professor of psychiatry at the University of Colorado and chairs the American Psychiatric Association's telepsychiatry committee.

So far, we've spoken with psychiatrists, psychologists, and researchers about their experiences treating conditions like depression and anxiety online and over the phone.

But, there's another group of providers who deliver a huge portion of mental health services in this country, social workers. In 2017, the latest numbers available, the federal government estimated there were about 240 thousand social workers. That's nearly double the number of psychiatrists and psychologists combined.

Social workers often serve people with the most serious needs, and they faced unique challenges in the rapid shift to virtual mental health care.

Heather Ladov saw that first hand. She's a social worker now based in North Carolina. But, she spent the majority of her career, and most of the pandemic, in Oakland, California working at La Clinica de la Raza's community mental health department, Casa del Sol.

Welcome to Spotlight...

Heather Ladov

Thank you so much for having me.

Kimberly Adams

What experience did you and your colleagues have with telehealth prior to the pandemic?

Heather Ladov

Hardly any experience.

Kimberly Adams

Wow.

Heather Ladov

Yeah, we, all of our work was in person. We had never used video or any of the things that we learned during this last year and a half was, were all new for us as we went into the pandemic.

Kimberly Adams

What was that experience like for you? I mean, you've been doing this for decades, you know these people and you're part of that community. What was it like making that shift for you?

Heather Ladov

I think for so many of us that go into the field of mental health, or social work, our heart is in sitting with people and making that one-to-one connection or family connection in the room, and really feeling what are nonverbal cues, what is happening, what's the energy in the room that we really read and use in order to do our work effectively. And, I think for so many of us, we said, like, 'this isn't why we went into this field, to be on a screen all day and to not have that personal connection with our clients.' So that was, that was a shift.

And, the part of bringing our clients along. You know, I think sometimes we both underestimate and overestimate our clients' ability to use technology. Some of our clients adapted really quickly and really benefited from using Zoom or telehealth. The accessibility piece was really, really amazing that people could really catch us where they were. And, it didn't require three buses, walking 20 blocks…

Kimberly Adams

In the heat…

Heather Ladov

...taking their kids out of school, with their two other kids along for the ride, while their other child was in therapy. All of those kinds of access pieces, in some ways, were addressed by just, sort of, you can take the call wherever you were.

Kimberly Adams

Can you talk a little bit more about the types of clients that maybe had particular difficulties with telehealth you think you wouldn't have encountered, if you were sitting in a room with them?

Heather Ladov

I would think for the, for our clients that have severe and persistent mental illness, one. People that have psychotic disorders are quite disorganized. We had a hard time throughout the pandemic with reorienting them with what was going on and why they needed to stay home, because our clinic really is an anchor for so many people that come through physically, and need that physical grounding with us to let them know where they are, who they are, what their activities for the day are, how to keep themselves safe, those kind of very basic needs. And so oftentimes, those clients don't have access to a cell phone or to a computer. So that really impacted our ability to engage and provide them with a full range of services.

Another population, I think, that was hard are teenagers that never turn on their cameras. That engagement is much different than sitting in a room with someone and sort of building social skills and building coping skills and connecting to feelings.

And, I would say that, another group are just younger kids, because play therapy is the way that we engage with, with kids. Really all, all children and adolescents. But, using materials, art, puppets, dollhouses, sandtrays, these are all really active ways that we engage with our clients to try to access feelings. Because, a child that's six isn't really able to tell you in the same way, what's going on, as an adult that's 21 that can say, 'this is why I'm depressed.' Kids play that out in much more symbolic ways.

Kimberly Adams

This has been such a period of transition in the mental health care space in response to the crisis. But, how do you think the pandemic's pivot to virtual care will carry forward? What will it mean for the future of mental health care?

Heather Ladov

I think there's a lot of room for growth here as far as access goes. I talked to a supervisee that, a client who's a day laborer does his session at his lunchtime. And, so he can step away when his other colleagues are eating their lunch and he does his therapy session, you know, on the construction site or on the job site, and then goes back to work. And so, that would not be possible in the previous model and has been made possible because of flexibility due to telehealth. And other people have said, 'I did so much better when I saw you in person, it feels so much better to see you, I want to be in the room.' And, those are the people that are begging to come back.

Kimberly Adams

Social workers provide so much of the frontline mental health care in this country. How has the work that people in your field specifically, changed as a result of this shift to telehealth?

Heather Ladov

We are very hands-on as social workers. And, we are with clients in the community, in their schools, in their homes, in the grocery store, in the Walmart, where we go to help them buy their clothes, because they don't really know what to wear or how to use their money. And so, that has impacted our ability to be with them to the extent that we had been in the past.

Kimberly Adams

Thank you so much for sharing your experiences of what this has been like.

Heather Ladov

You're welcome.

Kimberly Adams

Heather Ladov is a Licensed Clinical Social Worker, formerly of La Clinica de la Raza in Oakland, California. She now practices at El Futuro in Durham, North Carolina.

Over the last hour, we've thrown a lot of terms at you: telehealth, virtual mental health care, digital mental health care, and others. As these new delivery methods grow, providers themselves are trying to get a grip on this language. But they all agree that, in some form, virtual care is now a key component of mental health care..

The group FAIR health looked at insurance claims from April 2021 and found that mental health accounted for 58 percent of all diagnoses over telehealth.

So, we're going to wrap things up, bringing back Dr. Peter Yellowlees, professor of psychiatry and chief wellness officer at UC Davis Health, and a top expert in telemedicine. Earlier, Jay Shore and Heather Ladov use terms like hybrid, personalized, and targeted when talking about the future of mental health care.

So, I asked Dr. Yellowlees what he thinks about this concept of hybrid care.

Peter Yelllowlees

I think it's clearly the way we're going to be working in future. It's the way that patients find much more convenient. It allows them to choose how they're seen at a particular point in time. It's actually also easier on the whole for the clinicians, because we can also choose where we get to see our patients from and aren't necessarily stuck having to go to a particular clinic at a particular time.

And I think, what it, what it says is that in the long run, we will actually have better relationships with our patients, because our relationships won't be based only on one type of meeting in an artificial environment in our clinics. Our relationships will actually be based primarily on the patient's home or where the patient chooses to meet us.

And I, when I see patients at home, which I do all the time now, I get them to show me around the house. I get them to take a walk in the garden, to show me the kitchen. I meet their pets, I meet their kids. And, I actually look at their pictures on the wall. I want to find out which, which sports team they support to see if in fact, you know, they have the same interests that I do or see whether I need to give them a hard time for that.

Kimberly Adams

Very important components indeed. But also, I imagine gives you better insight in how to formulate your treatments.

Peter Yelllowlees

That's exactly right. I mean seeing people in the home is really like an extension of their mental state. Because you get to see, in all seriousness, you know, what they do, how they live, what

their passions are, and particularly what they actually do rather than what they tell you that they do.

Kimberly Adams

Heather Ladov called for more research into what does and doesn't work and what did and didn't work during the pandemic.

Heather Ladov

We needed to do what we could do in the moment, but now we have to look back and see how effective it's been for engaging new clients, for healing and health, for meeting the objectives and goals that we set in therapy, and to be able to look at in-person versus telehealth and video health appointments and really try to understand who needs what, why they need what they need, and how we can use, sort of, a model that's not all one thing.

Kimberly Adams

How much focus should there be on moving towards a more personalized system? That's not all one thing, as Heather puts it?

Peter Yelllowlees

I think, a tremendous emphasis on that. And, what I would add to what Heather said, is that the one of the problems with our current research system is that they tend to want everything to be perfect. And have, you have one group compared with another group.

Now, in fact, if we're talking about moving to a hybrid mental health system, whereby we're using both groups, you actually need to do studies that are called pragmatic clinical studies, rather than necessarily fully randomized and, and perfect research studies. We need to do pragmatic studies that look at real world experiences, and how are patients best helped in the real world. And we need, we need to have a much bigger move in that direction, away from some of our more idealized research studies. And I can say that, as someone who's done idealized research studies for many years.

Kimberly Adams

So those are the needs from the research component, if we're talking about moving towards a new mental health paradigm. But, what about policy? What policy changes will allow us to shift the way that mental health care is delivered in the country moving forward? There are dozens of bills related to telehealth introduced this year in Congress. Do some of those offer solutions?

Peter Yelllowlees

I think some of them do. I think there are very clearly, is a huge need for, for policy changes. To me, the most important single thing is actually getting patient groups and patient advocates more involved in the policy decisions. And, looking at how do we help people, you know, who've got the lived experience of mental illness, and who really understand from their perspective,

what the issues are. And, let them actually give us some guides as to the technologies they find most useful.

Kimberly Adams

If you had to give a grade to the mental health sector's pandemic pivot to virtual care, what's your honest assessment compared against the best practices that you would hope for in the field?

Peter Yelllowlees

You know, my honest assessment is an A. And, that may sound self-serving, but it's not. Because, I was genuinely surprised by how, particularly my colleagues, other psychiatrists actually took to using video. I've spent the last 20 years trying to persuade them to use video, and only a small number have changed. Given the, the motivations around COVID, it was quite remarkable to see how many people both changed, and were prepared to say, 'Hey, you know, it's not that bad. Actually, I might continue doing this.'

Kimberly Adams

What makes you the most hopeful with this pivot, although it took longer than you wanted, and had happened a bit faster and under more tragic circumstances than anybody might have wanted. What makes you most hopeful about this pivot to virtual care?

Peter Yelllowlees

I think the U.S. in particular has done so much better than most other countries in this. You know, I was involved writing a paper with colleagues from 17 other countries, looking at what changes occurred in those countries around the globe. And actually, the U.S. came out number one, by a long way, in terms of the pivot it made the change in its health service services, the preparedness to actually cut back discriminatory regulations overnight. And so I think that's a really good cause for hope. I mean, the US absolutely went in the right way, during COVID. What we've now got to do is continue down that path.

Kimberly Adams

Dr. Yellowlees Thank you so much.

Peter Yelllowlees

Thank you very much indeed, Kimberly.

Kimberly Adams

That's Dr. Peter Yellowlees, professor of psychiatry and chief wellness officer at UC Davis Health from our conversation last summer. He's also past president of the American Telemedicine Association.

And, thanks again to him and all of our guests this hour.

This has been Spotlight on Virtual Mental Health Care, updated as part of our national series from Call to Mind - American Public Media's initiative to foster new conversations about mental health.

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Thanks for joining us for Call to Mind - Spotlight on Virtual Mental Health Care - from A-P-M, American Public Media.