Telemental Health After COVID-19: Understanding Effectiveness and Implementation Across Patient Populations While Building Provider Acceptance Are the Next Steps

To the Editor: Given the rapid adoption of telemental health (TMH) during the COVID-19 pandemic, we were enthusiastic to read Zimmerman and colleagues'[1] recent work. They found significant clinical and functional improvements among 207 partial hospitalization patients receiving TMH. Perhaps just as important from an implementation perspective, TMH resulted in high levels of patient satisfaction and treatment adherence.

Although TMH has long been heralded as a way to improve access to services, widespread adoption lagged prior to COVID-19. The work of Zimmerman et al[1] established the preliminary effectiveness and patient acceptability of such treatment, even in an intensive psychiatric setting. However, providers are a key stakeholder group who have traditionally limited adoption of TMH with attitudinal barriers, including concerns about ability to establish therapeutic alliance, equivalent effectiveness of in-person versus TMH services, and privacy.[2]

As COVID-19 prompted new urgency in TMH adoption, we have studied provider attitudes and uptake of such services. Unlike Zimmerman et al,[1] who focused on a partial hospitalization treatment setting, our work has centered on primary care as the de facto mental health care setting in the US. We surveyed 104 providers (n = 53 mental health providers [MHPs], n = 51 primary care providers [PCPs]) embedded in primary care clinics across the US using an online survey distributed in December 2020 by a health care market research company (details and survey available from corresponding author on request). The institutional review board deemed the study exempt. Embedded in our larger TMH survey were items asking respondents to rate which disorders they considered most and least appropriate for TMH. Descriptive statistics and χ^2 tests compiled frequencies and compared differences between provider types.

Psychotic disorders were most frequently rated as the least appropriate (n = 68, 65.4%) diagnoses to treat with TMH. MHPs were more likely than PCPs to rate psychotic disorders as least appropriate ($\chi^2_{1,\ 104} = 7.68$, $P = .006$). Almost one-third (n = 32, 30.8%) of providers rated personality disorders as least appropriate for TMH. Depressive and anxiety disorders were most frequently endorsed as the most acceptable (n = 78, 75.0%) for TMH treatment; acceptability did not differ by provider type ($\chi^2_{1,\ 104} = 0.36$, $P = .55$).

Other TMH surveys during the pandemic[3,4] suggest that the majority of providers intend to continue using TMH after the pandemic but perceived poor fit for certain populations, including patients with psychotic disorders. Providers indicated that future use of TMH would be guided by a patient's severity of symptoms.[3] Data such as those presented by Zimmerman and colleagues[1] reiterate the effectiveness and acceptability of TMH, even in high acuity settings and with conditions perceived as less appropriate for TMH. Although TMH for more severe conditions (eg, psychotic disorders, personality disorders) seems promising, research on effectiveness must be coupled with a better understanding of the acceptability, appropriateness, and feasibility of such an approach for these higher acuity populations and settings. Given the potential of TMH to offset access barriers and increase service utilization, future work must then attend to provider perceptions to ensure sustainment of such services across a range of patient populations and settings.

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