**EDITORIAL**                                                   **OPEN ACCESS**

# E-Mental Health: The future is now

## Davor Mucic

## THE IMPLICATIONS OF THE USE OF TECHNOLOGY

Traditional image of doctor-patient relationship implies *physical presence* i.e., direct face-to-face contact (or rather called "in-person" contact). However, the use of telecommunication technology brings us to a different type of "presence". The issue of "presence" is particularly important in psychotherapy, where the technology mediated interaction between patient and therapist introduces new parameters more relevant to consideration about the setting [1–3].

Clinicians' concerns regarding "presence" and virtual environment should not be underestimated as these are common arguments against the use of video conference in clinical settings. A virtual environment created in audio-video sessions might indeed increase the risk that some information cues present in the physical environment are not available in the virtual environment [4].

Commonly, professionals prioritize direct contact with the patient referring to a number of potential obstacles that might occur during video conference ("what about body language?", "I miss a smell", "what about the internet connection problems?", etc ). Mental health professionals' attitudes towards e-mental health (eMH), factors that affect the frequency with which they use the technology, and their perceptions of individual characteristics that make patients more or less suitable candidates for eMH has been explored and discussed.

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Findings suggest that mental health workers have overall positive attitudes towards the use of eMH; particularly for clients in remote and rural locations [5].

It sounds logical that increased acceptance of eMH is associated with more frequent use. In contrary, clinicains' reluctance is commonly explained by the fact that "some patients are unsuitable candidates for telemental health". There is no doubt that some patients will prefer remote consultations due to controlling the presence of the psychotherapist, so as to feel less influenced by him/her i.e., having the opportunity to "switch off" the therapist. In contrary, regarding counter transference issues, it has been noticed that some psychiatrist are reluctant to carry on technology mediated psychotherapy, which might deter the patients from asking or exploring for this possibility [6] .

Narratives from clinical practice may contribute to further understanding of the implications of technology on doctor-patient relationship. Clinical cases may significantly increase the understanding and acceptance of telepsychiatry among professionals with no eMH experience or professionals that are still in doubt.

That is why the following story is particularly interesting:

A 28-year-old female, refugee from my Bosnia-Herzegovina, ex-Yugoslavia (home country of DM). In Bosnia, during the war, She was unfortunately raped several times while her husband was in the army. After immigrating to Denmark, the patient was refered to a psychiatrist due to occurred post traumatic stress disorder symptomatology. As her Danish language abilities were poor, the communication was provided via an interpreter. Consequently, she received psychiatric treatment with medication and psychotherapy via interpreter for around three years prior to our first telepsychiatry session. The video equipment was installed at psychiatric department where the patient used to come and speak with her psychiatrist in-person. I was in Copenhagen while she was located 245 km away in outskirts of Denmark. At the first consultation via telepsychiatry, the first question she asked was, "Can all of Denmark see us now?" When

assured that no one follows our conversation and the session will not be recorded, she replied, "Then I have a secret I would like to disclose" and so she started her story about traumatic events in home country.  The patient cried while speaking in a stream without a break except to wipe her tears and blow her nose.  She said that it was not possible for her to speak about it with her past psychiatrist as all communication runs via the interpreter. The presence of the interpreter for her changed the dynamic of the interview and more tangibly, it increased the risk that her husband would find out about the rape and consequently divorce her. While speaking about her painful experiences the Internet suddenly disconnected. When that happens, the last frame remains on the screen as a frozen picture.  So she could see me as a still image and I could see her frozen in the middle of a movement and of course we could not hear each other. I panicked, thinking what she would say to this, or fearing that she probably would never come again (i.e., use the video). My technician was in the office next door, so he restored the connection.  The break varied about 30 seconds in total, but it felt like much longer.  To my surprise, when the connection was restored, I could see and hear her who spoke in a stream and cried at the same time.  She did not even notice that I was gone for a while.

**Lesson learned:** Prior to every use of the eMH, it is crucial to inform the patients about the technological setting, safety and confidentiality related issues. These informations provides by the referring doctor, both verbally as well as in written form, so that the patient have opportunity to read it carefully and understand what it is about. Further, written consent requires prior to the first remote session. The consent clearly underlines that the involvement in remote consultation is voluntarily and that the patient may discontinue the contact whenever he/she wants.

Updated guidelines for behavioral emergency management have been published recently and clinicians practicizing eMH have to be familiar with it [7] .

For me, personally, the story mentioned above was an experience that marked over the last 15 years of dedicated work on developing of the "cross-cultural telepsychiatry" concept where the treatment of ethnic minorities provides with no use of interpreters [8].

Telepsychiatry assessments of hospitalized suicidal patients are particularly interesting and even to recommend especially when it comes to patients that had a telepsychiatric contact prior to unvoluntarilly admission, as the next clinical case describes:

A, 38-year-old male, refugee from Bosnia-Herzegovina, diagnosed with PTSD and treated via telepsychiatry for 1 year prior to involuntary hospitalization caused by increased suicide risk and suicidal threats that he presented for his general practitioner who decided to send him to psychiatric emergency department located on the island where the patient lives. There he was assessed by a Danish psychiatrist via Bosnian interpreter and involuntarily hospitalized. A day after, he was seen by the psychiatrist who treated him via telepsychiatry approximately once in a month. It was very convenient for psychiatric department located on isolated island to call the psychiatrist that speak the same language as the patient and who knew the patient best in order to assess the patient's mental state, including the current risk of suicide. Despite the fact that the consultation had been done remotely where the patient could disclose much more via TV on native language than via interpreter under face to face consultation the day before.

*After telepsychiatry consultation the patient remained on the ward for the observation but was discharged the following day.*

**Lessons learned:** Continuity achieved and remained by seeing the same doctor no matter where the patient is located is probably one of eMHs most important advantages compared to traditional mental health care provision. Further conclusion is that emergency situations in psychiatry are not an obstacle for the use of eMH [9,10].

## WHY EMH ?

There is no doubt that eMH is capable of increasing the quality of care in many ways because of two main reasons:

The first is, the trend of increasing rates of mentally disorders and the heavy burden that these conditions place on individuals and their families as well as on communities in general worldwide. And second, the necessary care is not available to all who may need it. A simple and very well-known example is depression. eMH applications offer qualified help and consultations to those who need it, no matter where they are and at what time of the day or night they need help.

Patients entering traditional mental health care system,  cannot "personalize" the experience but rather have to cater to the system timing and information flow. Patients per default do not have control over appointment times with therapists, or access to their own lab info or health records. eMH offers potential solution that improves attendance and increase feeling of personalized experience by simply sending text messaging reminders [11].

When referred to a specialist via own family doctor, the patient do not have opportunity to be "represented" in person by his general practitioner that could explain and argue why did the patient was referred for the assessment.

On the other hand, specialists work mostly isolated from each other while their communication is paper-based typically via referrals and written answers to these. Much more of connectivity/communication is rarely

sighted. Consequently, each specialist might get only partial insight in the patient's treatment and difficulties overall. At the same time, the patient is rarely able to get unified impression of care integrated and interpreted equally by all actors in the mental health system.

Further problem is the lack of continuity due to lack of resources where the patient changes the therapist depending on current status of resources at the psychiatric hospital.

With increased access to internet the patients become more knowledgeable and are coming to doctor's office prepared with both questions and recommendations that fits to their very specific problem.

The extent to which different healthcare professionals work well together can affect the quality of the health care which they provide. If there are problems in how healthcare professionals communicate and interact with each other, problems in patient care can occur as consequence hereoff [12].

Efficient use of telecommunication technology might support the collaboration between professionals within health care system [13]. The geographical distance between health care workers can be overcome by the help of technology building virtual team and facilitate better communication between professionals for the best of the patients. At the same time the "partnership" between the professionals and the patients via validated information, coaching and both individual and family support, seem to be crucial task to achieve in order to promote excellence in mental health and effective health outcome for the patients [14].

**To summarize:** While traditional mental health care worldwide remains "traditional" in service delivery and implementation overall, eMH on the other hand offers personalization, connectivity/continuity, social networking and co-creation where the user is no longer a passive receiver but is coming to be seen as an active and knowledgeable participant. When it comes to mental health providers, eMH applications offer opportunities for both clinical and educational growth.

Finally, eMH may offer regular and continuous as well as competent supervision of staff and younger colleagues according to common accepted rules and references [15], no matter where the participants in such seances are physically located.

Within clinical practice, we have never been presented to the tool which requires so little investment while it in turn gives us so much, as is the case with eMH.

When eMH becomes accepted and adopted as a supplemental tool which enhance the quality of care and ease the daily clinical work, then it will probably bring us a step closer towards the use of technology in larger scale.

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Davor Mucic – Substantial contributions to conception and design, Acquisition of data, Analysis and interpretation of data, Drafting the article, Revising it critically for important intellectual content, Final approval of the version to be published

### Guarantor
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Authors declare no conflict of interest.

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