The Royal Australian & New Zealand College of Psychiatrists
Tu Te Akaaka Roa
New Zealand National Office

Your Health in Mind
Hauora hinengaro Manatuhia

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By email to: ashley.bloomfield@health.govt.nz

Tēnā Koe Dr Bloomfield

**Re: The Royal Australian and New Zealand College of Psychiatrists - Experience of Telehealth During the COVID-19 Pandemic**

Thank you very much for attending the Council of Medical Colleges' hui on 28 May 2020 and providing an overview of the health sector's response to the COVID-19 pandemic.

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) understands that you are interested in hearing about medical practitioners' experience with telehealth services, particularly any barriers encountered in delivering telehealth services during the pandemic. We welcome the opportunity to provide feedback and were pleased to note that the Ministry of Health (The Ministry) plans to increase the DHB's capacity to deliver telehealth services. We have considered our response against the background of implementing the findings of He Ara Oranga. Telehealth, where used when clinically indicated, should increase access and choice for people living with mental health and addiction issues.

## The Context of Telehealth Relevant to the Practice of Psychiatry

Our experiences during the COVID-19 situation demonstrated the importance of using models of care that offer a hybrid approach of in-person clinics and virtual clinics. In-person engagement is still the preferred option for acute cases, assessment clinics, those with difficulties accessing data or digital devices due either to technological issues or the nature of their clinical condition.

The importance of a mixture of models of care cannot be underestimated when working alongside mental health and addiction consumers with complex presentations e.g. the possibility of a delay in diagnosing a comorbid physical condition due to only having a video consultation, whereas one would have been able to detect signs if the consumer was seen in a face to face consultation. For some of our consumers, particularly individuals with lower intellectual functioning and/or severe and enduring mental illness, psychiatrists need to ensure ongoing regular face to face contact as often these consumers are unable to verbalise their current or ongoing issues.

Aspects of telemedicine are likely to be incorporated into routine practice in many services, especially for the routine follow up of known consumers where access is difficult or it is the

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consumer's preference. New assessments or crisis reviews are still more amenable to face to face assessments where possible. Telehealth was considered less helpful in assessing psychotic individuals but could be used reasonably well for Mental Health (Compulsory Assessment and Treatment) Act 1992 assessments.

**Barriers Identified By RANZCP During the COVID-19 Situation**

The RANZCP identified seven broad areas where there may be challenges to overcome to ensure the effective use of telehealth in New Zealand. Some of these barriers cannot be solved by developing initiatives within the health sector. For example, in some of parts of New Zealand consumers do not have cell phone coverage nor do they own smartphones, therefore consumers are unable to access or choose full telehealth consultations e.g. video consultations. We understand that ACC is working with the Ministry of Social Development to improve people's access to telehealth enabled devices. Issues we identified are:

1. Not having access to suitable technology: devices, data and internet are not available
2. Lacking the confidence to set up telehealth capability ( consumer and health providers)
3. Poor cell phone coverage in some locations
4. Reminding staff about the increased awareness of privacy issues
5. Assisting staff willingness to change practice and use telehealth
6. Developing consistency within the DHBs regarding the use of technology to assist consumers and health providers
7. Tailoring telehealth to meet each consumer group's needs – older people, children and adolescent, Māori and Pacific people are likely to have different experiences of telehealth.

The RANZCP would welcome further discussion on the issues we have identified in the attached document (Appendix 1). We conclude that telehealth can be used very well in those clinical situations – where both the consumer and clinician feel that it is an appropriate model of care. We have outlined in the attached document examples of when telehealth worked well for a numbers of consumers, especially those who feel very anxious about visiting mental health services or individuals who are difficult to find and follow up in the community. In summary, telehealth could be used more broadly within the mental health and addiction environment to increase access and choice but greater training and technological support is required to fully realise the advantages of this modality. Although we have identified several barriers when using telehealth, overall we thought the health system adjusted well to the unpreceded situation where both consumers and health providers had to rapidly adjust to a new method of engagement. There were issues in training health providers to use telehealth, health providers having access to PCs, smartphones and wifi within the DHBs. These issues need to be resolved fairly quickly as Aotearoa is not without COVID-19 cases, albeit new cases are in quarantine, but recent events in Australia demonstrate how quickly the virus can return.

The RANZCP is committed to supporting the enhanced use of telehealth or tele-psychiatry and our professional practice guideline[i] provides comprehensive advice around effectively using this model of care. Thank you for the opportunity to provide feedback and we trust this information will assist the Ministry of Health and National Telehealth Service in updating the telehealth service annual plan[ii].

If you have any further questions regarding this letter please contact the New Zealand National Office - Tu Te Akaaka Roa. Ms Rose Matthews, National Manager, supports our mahi and may be contacted by email rosemary.matthews@ranzcp.org or by telephone on 04 472 7265.

Ngā mihi

Dr Mark Lawrence FRANZCP
**Chair, Tu Te Akaaka Roa - New Zealand National Committee**

## References


[i] The Royal Australian and New Zealand College of Psychiatrists Professional Practice Standards and Guides for Telepsychiatry.2013. Available from: https://www.ranzcp.org/files/resources/practice-resources/ranzcp-professional-practice-standards-and-guides.aspx

[ii] Ministry of Health. The National Telehealth Service Annual plan 2019 / 2020. 2019. Available from: https://www.health.govt.nz/system/files/documents/pages/2019-20-nts-annual-plan-final.pdf

## Appendix 1: RANZCP Feedback on Telehealth During the COVID -19 Situation

### Things that went well with Telehealth

1. In terms of positives, it allowed psychiatrists to provide a different mode to communicate with consumers and many appreciated the choice to use telehealth.
2. When working with children it was useful because the health provider was able to see where the children were actually living to get a better idea of their environments. Could conduct Zoom consultations for both new assessments and follow-ups. It generally worked well, but was better for the latter. Upsides included convenience for families and clinicians, reduced transport costs, delays due to parking and missed appointments
3. It was particularly easy to use telehealth to engage with consumers who were already known to the service or those living in rural areas.
4. There was also a group of consumers where telehealth was preferable to normal treatment. This group included consumers who are usually very difficult to find and follow up (as telehealth could be used by the case managers to link in the doctors when they found them in the community), consumers who usually feel very anxious about visiting mental health services (some of these people do not like waiting in waiting rooms, other people found it easier to speak to clinicians over telehealth), and consumers having routine Mental Health(Compulsory Assessment and Treatment) Act reviews in the community (they often find it inconvenient to have to travel to our community service, wait in the waiting room, have a review and then travel back home again - having a telehealth review saved a lot of inconvenience for these patients).
5. Some information was lost with telehealth, other information was gained. It was interesting having a better understanding of the living situation of many consumers.
6. Improved access for some groups, particularly rural communities when they had the ability to use telehealth.
7. Ability to still monitor vulnerable consumers who needed to isolate at home.
8. Staff gained experience in telemedicine practice, particularly through Zoom.
9. The ability for senior trainees to undertake Mental Health (Compulsory Assessment and Treatment) Act assessments under supervision was a worthwhile educational activity for those registrars, therefore, helping prepare them for this responsibility on graduating.
10. There were benefits in psycho-geriatrics that in-home (as compared to in-clinic) assessment can offer real benefits in terms of acceptability, comfort and validity/effectiveness. Could conduct community outreach for older consumers by phone and if supported by family members they could be contacted by Zoom. The dementia rest home visits via Zoom worked reasonably well and some of the patients appeared rather befuddled and also amused by the process. It is a reasonable option when face to face is impossible, but definitely face to face trumps telehealth.

### Barriers with Implementing Telehealth

The main limitations with telehealth are described below.

1) **Not having access to suitable technology – devices, data and internet**

**a. Health providers** -psychiatrists, RNs, OTs, social workers and clinical psychologists - must be provided with the relevant technology (e.g. laptops and reliable data connections) to use telehealth. There are reports that health providers had to use their own phones and

laptops. More investment is required by the DHBs - small things like making sure the PCs in the offices have webcams or microphones, and issuing staff with smartphones (currently most DHB issued phones can only text and call).

Wifi was also a significant problem with the systems in the DHBs poorly set up e.g. the system could not cope when many clinicians used the internet all at once. We conclude that most DHBs would need a substantial upgrade in wifi systems for telehealth to work well

**b. The main barrier for consumers** was cost – they could not afford data to allow Zoom consults on their phone. Higher Social Economic Status consumers had access to video consultations but remaining consumers only had phone consultations, or alternatively a case manager had to visit them with a phone/laptop and then use Zoom to call their psychiatrist. This is an equity issue as those struggling financially should receive the same service as everyone else. Some consideration needs to be given to how we address the 'digital divide'. For example, DHBs providing phone top-ups to overcome these difficulties. Many consumers don't have smartphones nor data access

**2) Lacking the confidence to set up telehealth capability**
Many patients and staff required 1:1 assistance to get started. Once set up they generally found they could learn to use the technology.

**3) Poor cell phone coverage in some locations**
Large areas of New Zealand have very poor cell phone coverage – mainly rural but some people living in urban areas can also have problems. Not sure how this can be addressed without working with the Telco's.

4) **Reminding staff about the increased awareness of privacy issues**
Psychiatrists must be aware of who else may be in the room that we could not see. This may be particularly important when working with ACC clients who have highly sensitive claims under consideration.

**5) Assisting staff willingness to change practice and use telehealth**
Some staff adapted to the use of technology much more easily than others. Some training and upskilling in technology should be developed by the DHBs and ACC with assistance from the National Telehealth Service. Many health providers had to learn on the job and this could result in frustrations with the technology.

**6) Developing consistency within the DHBs regarding use of technology to assist consumers and health providers**.
Having clear guidance from Ministry of Health (MoH) about which platform to use for telehealth (Zoom, Doxy.me, Microsoft Teams) would be very helpful. If we are to use Telehealth moving forward then it would make sense for all health professionals (across all areas of medicine) are trained in using the same software/telehealth platform to make it easier for consumers (who would then only need to be familiar with one platform).

**7) Tailoring telehealth to meet each consumer group's needs**

**Old Age Psychiatry** - many challenges for telehealth within this consumer group due to cognitive impairment, hearing/vision impairment, and are less familiar with technology. They are also among those most vulnerable to COVID-19 and, therefore, engaging meaningfully with them is of great importance. We recommend that the MoH identifies telehealth solutions that may work better for this group, e.g. larger screens, devices that sync with hearing aids, ability to telehealth to local GP clinics so patients could be seen at their local

clinic but have someone there in-person with them to problem-solve setting up the technology.

Techno-phobia, practical logistic issues setting up the link to the applications and poor quality audio often got in the way when undertaking a telepsychiatry consultation with the elderly. Consumers generally need a younger person to support them during the session; if trying to manage the video meeting solo there is a real risk of anxiety, frustration and miscommunication.

**Child and Adolescent Psychiatry** - Downsides included limited observation of body language, inability to conduct physical examinations, disruptions due to other people and noises at the family's end. Also difficulty finding suitable spaces for private conversations within a busy hospital, DHB wifi issues and clinicians experiencing Zoom fatigue were additional challenges. Some types of therapy such as CBT were easier to deliver than others such as child psychotherapy.

**Māori and Pacific people** – Māori and Pacific people may prefer face to face contact as their cultural norm places a high value on engaging in-person with another individual. However, during COVID-19 Māori communities were particularly vigilant about restricting interactions with the wider society and this meant the only way to receive health services would be via telehealth which may not take into account Māori tikanga.

**Telehealth is not for all consumers** - It became apparent that there were some groups of consumers where telehealth is not an appropriate modality - particularly those with acute risky presentations or diagnostically complicated consumers or consumers who are unknown to the service or consumers with an initial engagement under the Mental Health (Compulsory Assessment and Treatment) Act.

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