A technology-based future for psychotherapy

Despite suffering from high rates of depression, homebound older adults often have limited access to clinic-based psychotherapy. Professor Namkee Choi from the University of Texas has been investigating how videoconferencing can be used to deliver cost-effective mental health care for low-income homebound older adults suffering from depression.

Homebound older adults suffering from chronic medical conditions, mobility impairments and financial stress are particularly susceptible to social isolation and often experience depression. Recent studies have found that these older adults suffer from clinically significant depressive symptoms at rates two to three times higher than their mobile peers. Despite their high rates of depression, these older adults face significant barriers to accessing effective, evidence-based psychotherapy or other psychosocial interventions due to their homebound state, financial hardship and lack of transportation.

THE BARRIERS TO TREATMENT
Psychotherapy treatments available at present are largely clinic-based. This limits low-income homebound older adults’ access given their mobility impairment and transport limitations. Other systemic access barriers include difficulties in scheduling appointments around existing primary care commitments, a notable shortage of licensed psychotherapists for older patients, and treatment cost. Personal barriers include the perceived stigma of mental health issues, denial of depression, lack of motivation and reliance on religious faith as health issues, denial of depression, lack of motivation and reliance on religious faith as a primary means of coping.

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IN-HOME VIDEOCONFERENCE PROBLEM-SOLVING THERAPY
Dr Choi’s research between 2009 and 2012 tested videoconferenced problem-solving therapy (tele-PST). Originating from the cognitive-behavioral theory, PST is a short-term, structured treatment based on the idea that people who struggle with problem-solving skills are less able to cope with high levels of stress and are therefore more susceptible to depression. PST is focused on providing practical, ‘here and now’ problem-solving skills and behavioural activation and is therefore particularly well suited to helping older disadvantaged sufferers of depression to cope with daily stressors. Dr Choi’s research, funded by the US National Institute of Mental Health, investigated whether five–six sessions of PST could be tele-delivered for homebound older adults in their own homes.

Although tele-therapy has been growing in popularity over the last decade, it has generally been confined to office–clinic-based videoconferencing or telephone-administered care. Dr Choi’s research took this approach one step further, implementing home-based tele-therapy. In a randomised controlled trial, Dr Choi compared the acceptance and efficacy of home-based tele-PST to those of in-person PST (i.e., therapists conducted PST sessions face-to-face at older adults’ homes) and care call (regular telephone calls providing support and monitoring of depressive symptoms). The participants in this study were referred by case managers of ageing service agencies that served low-income disabled/homebound older adults. The study found that tele-PST was more acceptable than in-person PST. An absolute majority of tele-PST participants were highly satisfied with tele-sessions’ convenience. 12-week follow-up assessments showed that compared to care calls, both tele-PST and in-person PST were more effective in reducing depressive symptoms. However, at 36 weeks, compared to both in-person PST participants and care call participants, tele-PST participants had significantly lower levels of depressive symptoms (measured with the 24-item Hamilton Rating Scale for Depression) and disability (day-to-day difficulties due to health conditions, other mental or medical, measured with the 12-item World Health Organization Disability Assessment Schedule).

According to Dr Choi, tele-PST’s higher long-term effectiveness can be attributed to a combination of factors. Firstly, patients were found to experience a high sense of achievement at mastering a new, previously unknown technology and took pride in ‘joining the technical age’. Secondly, patients enjoyed the comfort and convenience of in-home tele-sessions. Thirdly, therapists reported that patients were often more focused during tele-sessions than in-person sessions. Distractions that commonly occur during in-person, in-home therapy, such as answering the phone, getting a drink etc. were rare during tele-PST sessions, suggesting that the use of technology facilitated higher engagement in the therapy while allowing the same benefits of face-to-face therapy sessions.

Alongside enhanced patient outcomes, Dr Choi also stresses the additional benefits of tele-delivery that eliminates the need for older adults to travel to see a therapist or the need for a therapist to travel to see homebound older adults. Savings from travel time and costs mean reduced treatment costs and also allow one therapist to see more patients. Thus, tele-therapy offers a sustainable, economic and effective alternative to in-person therapy.

TRAINING THE WORKFORCE FOR A SUSTAINABLE MENTAL HEALTH CARE DELIVERY MODEL

While Dr Choi’s research clearly indicates the acceptance and efficacy of tele-PST for underserved older adults, the access to this mode of psychotherapy is still ultimately limited in real-world settings due to the current and projected shortage of licensed geriatric mental health clinicians. In the United States, most states have strict licensing laws allowing only licensed master’s- or PhD-level clinicians to practise psychotherapy. However, in other countries, lay mental health workers have been proven to deliver effective interventions for underserved population groups.

An absolute majority of tele-PST participants were highly satisfied with tele-sessions’ convenience.
Dr Choi demonstrates a mental health care delivery model that can improve access to evidence-based treatment for underserved population groups

Your research focuses on low-income, homebound older adults. Why is this group particularly susceptible to depression? Low-income homebound older adults contend with multiple life stressors on a daily basis, which increases their vulnerability to depression. They have to deal with physical, functional, and psychological effects of chronic medical conditions and disability. Their homebound state caused by disability also means that they are more socially isolated than their mobile peers. Most low-income homebound older adults lack means of transportation and have to rely on formal and informal support systems to get around. Financial strain is also a significant stressor contributing to these older adults’ depression.

Why is problem solving therapy (PST) particularly effective for treating depression in low-income, homebound older adults? PST is a short-term (i.e., five to six sessions in our studies), structured talk therapy. It focuses on “here and now” stressors and problem-solving coping skills. It aims at behavioural activation through this problem-solving skills training and daily pleasant activity scheduling. Most older adults who have participated in our study like PST because it is a structured and practical approach to solving problems and its immediate positive effect on their daily lives. As they learn how to better deal with stressful situations, they feel more empowered. Sense of self-efficacy is a powerful antidote to depression.

Your recent studies have been investigating the use of Skype and other videoconferencing platforms to deliver PST to homebound older adults. What sort of feedback have you received? In our pilot to test PST through Skype, because it is a free programme used by millions of people. In our current study, we are using a videoconferencing platform that is compliant with HIPAA’s Health Insurance Portability and Accountability Act of 1996 US legislation that provides data privacy and security provisions for safeguarding medical information. With technological advances, most tele-therapy platforms are low-cost and the cost is likely to go down further.

Many older adults initially expressed reluctance towards videoconferenced sessions, because they had never done them. However, after their first sessions, almost all of them felt comfortable with their tele-sessions and accepted tele-delivery as a great way to engage in treatment. Because a large proportion of low-income older adults, especially those in their 70s and 80s, do not have their own computers and Internet connection (due mostly to the cost of Internet subscription), we have been providing a laptop and wireless card for tele-sessions. The laptops were set up in ways that are easy to use even for those without any prior experience. The problem that we have encountered with videoconferencing is not because of older adults’ lack of technological savvy but because of faulty Internet transmissions. When audio and/or video transmissions are not optimal, we have to reschedule tele-sessions and in some cases have to switch to telephone or telephone sessions. With continued advancement in telecommunication technology, transmission problems are expected to become fewer in the future. However, wider dissemination and implementation of tele-therapy in the real world requires universal access to an Internet-connected computer without cost, as a right, not a privilege, regardless of economic status.

Many case managers have reported low patient uptake. What, in your opinion, are the main steps required to increase patient engagement in tele-therapy? Older adults in their 70s and 80s have had limited experience of discussing their mental health issues and treatment other than with pharmacotherapy. Many in these age cohorts often feel stigmatised about their depression. They also often misinterpret psychotherapy sessions as “my grocery list” or psychotherapy and do not want to “dig up the past” especially with a stranger (therapist). Thus, we need to do more work to normalise depression as a treatable medical condition that is different from other health conditions. We also need to provide more education about short-term, evidence-based psychotherapeutic interventions that focus on “here and now” stressors and behavioural activation.

Also because of our history of institutional racism and mismanagement of mentally ill people, racial/ethnic minority older adults often mistrust mental health providers. Integration of mental health services into ageing service agencies is an important step to reduce their mistrust, as older adults tend to trust their ageing service providers more than mental health providers.

Younger cohorts of older adults in their 50s and 60s are more open to evidence-based psychotherapy; however, low-income individuals are often concerned about treatment cost. Even those with health insurance often cannot afford co-pay given their already high out-of-pocket medical spending. To improve access to mental health care in the real world, we need more funding for mental health services.

Throughout your trials you have received positive feedback from both case managers and patients. What needs to be done to encourage more healthcare providers to use tele-therapy? I believe most healthcare providers accept tele-therapy as a resource- and time-saving alternative to in-person therapy. However, both public and private health insurance programmes currently have some restrictions about the types of tele-therapy that can be reimbursed. Reimbursement policies for in-home tele-therapy for homebound older adults need to be instituted for wider implementation.

The Older Americans Act (OAA) has some funding available for OAA-funded agencies to directly provide or purchase mental health services. However, this funding is often not adequate. Federal and state funds for mental health services are often misused. There is a need for better coordination of mental health services into existing ageing agencies. Moreover, the shortage of geriatric mental health service providers is a major challenge especially in health-behind-the-mental health - professional shortage areas. That is why I set out to test tele-SCM by lay mental health workers.