

Implications of increased telehealth use on organisations providing mental health services during COVID-19

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Demand for non-psychiatry telemental health services (NPTHS), especially telehealth services, continues to grow in Australia and overseas as a result of the coronavirus disease 2019 (COVID-19) pandemic.¹ It is well recognised that a sound business case is required to successfully establish and routinely deliver telehealth services.^{1–3} In this letter, we describe the results of a national survey comprising 229 mental health professionals who provide NPTHS services and attended the Mental Health Academy training webinar in February 2021.

The majority of respondents were psychologists (54%, $n = 123$), or counsellors (12%, $n = 28$). The majority of participants were from rural and remote communities (MM3–7) (69%, $n = 159$) and treated adult mental health clients (83%, $n = 190$).

Telehealth during the COVID-19 response

In March 2020, the Australian Government introduced additional Medicare Benefits Schedule (MBS) items to increase the uptake of telehealth during the COVID-19 pandemic; however, out-of-pocket fees were not allowed to be charged for these services until October 2020. Of the 133 respondents who provided information about their business' charging practices, 50% (66) routinely charged non-concession clients out-of-pocket fees. Respondents claimed that the initial bulk billing restriction resulted in a decrease in their earning capacity. For example, the reimbursement rate for a psychologist was A\$267 for a 60 min consult while the MBS reimbursement for that same consult is A\$152.40.

Many respondents were able to provide telephone consultations using their existing resources; however, 28% reported needing additional hardware (i.e. headsets). In some instances, telephone consultations even required less office space to conduct (22%) and were shorter than equivalent in-person consultations (15%). Alternatively, the resource requirements to offer videoconsultations were greater in all aspects; 41% of respondents needed more administrative support, technical support (63%), videoconsultation software (88%) and hardware (72%). A limitation of this survey was that these resource costs were not quantified. Other research has reported that many providers transitioning to videoconsultations report an initial resource-intensive time period;⁴ and many clinicians report a steep learning curve.⁵

Of the 204 respondents who provided information about the efficiency of their consultation services with telehealth, 26% reported increased efficiency because they were able to perform more consultations when using telephone compared to pre-COVID-19 in-person services. A total of 32% of respondents felt that engagement with patients by videoconference helped increase efficiency. This increased efficiency and therefore income, has the potential to offset the initial output on resources; however, many respondents reported that their efficiency was similar regardless of their consultation modality.

Using telehealth for mental health consultations is perhaps one the most commonly reported service examples of telehealth, because NPTHS do not require physical examination

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and can be successfully managed virtually.⁶ Despite its popularity in this field, overall delivery of NPTHS in Australia has, until 2020, been minimal.⁷ Other research focusing on NPTHS during the COVID-19 pandemic has demonstrated increased service volume, efficiency, and overall adoption.^{8–10}

Our study provides additional insight into the business challenges faced by service providers when delivering services by telehealth. Further understanding the business impact of increased costs for phone compared to videoconsultations in relation to business efficiency gains or losses would be valuable.

Our research has demonstrated that a mental health clinician's business can remain sustainable by offering NPTHS in addition to in-person appointments. Although a business model is an enabler of successful telehealth, it is not the only aspect that a provider needs to consider when normalising telehealth.¹¹

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