Editorial

Nursing Home Telepsychiatry

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Practicing psychiatry by remote access (telepsychiatry) is not a new development. Two-way interactive television has been used on an experimental basis since 1959 in Nebraska, and it has spread to other states as well. Its acceptance and efficacy was evaluated in several studies. In a study using questionnaires, patients' evaluations of the interview was the same in control and experimental groups, and evaluation of consultants and consultees was only slightly lower in the experimental group than in control group.1 In a study using the Brief Psychiatric Rating Scale investigators compared patient verbal reports and observational items using 2-way computer system. They found that although there was good agreement in both rating, the agreement was higher for verbal reports than for observational items.2 They ascribed the lower agreement between observational items to low quality of the computer image. A randomized study compared face-to-face and telepsychiatry consultation in 495 patients. Clinical outcomes were equivalent in both groups, and patients expressed similar levels of satisfaction with the service.3 A recent literature review concluded that telepsychiatry appears to be a viable option that is well accepted by patients, including those having dementia.4

Telepsychiatry may be especially suitable for nursing homes, which do not have a geriatric psychiatrist on their staff. Prevalence of mental disorders in nursing home residents is higher than prevalence of mental disorders in community dwelling individuals of the same age.5 This is caused by a high percentage of nursing home residents with cognitive impairment because at least 1 neuropsychiatric symptom was found in 82% of the residents with dementia.5 However, individuals with severe mental illness without dementia, including patients diagnosed with schizophrenia, other psychosis, personality disorder, and bipolar disorder are also admitted to nursing homes.7 Thus, nursing homes need psychiatric services for their residents. However, although nursing home populations is increasing and is expected to reach 3.2 million people by 2030, the number of geriatric psychiatry fellows is steadily declining and in 2010 was only one half of the number of fellows in 2005.8 Therefore, many nursing homes will not have available on-site services of a geriatric psychiatrist.

General acceptance of telepsychiatry is indicated by existence of several companies offering telepsychiatric services.9–11 Most of them offer services of both psychiatrists and psychiatric nurse practitioners who are licensed in the state in which they provide services. One of them even lists on their Web page results of their work in Georgia and claim that in a population of 300 patients there was reduction of [antipsychotics] by 45% with no upswing in substitute drugs.14 Successful use of telepsychiatry in rural nursing homes was reported to deal mostly with depression or dementia-related behavior problems15 and resulted in considerable cost savings compared with face-to-face encounters.16

An article by Catic et al.17 published in the December issue of JAMDA provides another evidence for usefulness of telepsychiatry. Although the authors do not use this term, their consultation involved mostly behavioral symptoms of dementia and changes in psychoactive medications. It is interesting that they based their activity on a medical telemedicine model [Extension for Community Healthcare Outcomes], but the only medical issue for which they provided results of their consultations was hypertension. However, they required very detailed information about the case before its presentation and were, therefore, able to detect also other medical issues. Catic et al17 selected consultation model instead of direct medical care that is provided in most telepsychiatry programs. This model avoids problems with licensure but results in some recommendations not being followed. The recommendations were not followed mostly because of family and patient preferences. Involvement of family and patient (if appropriate) in consultations might have clarified these barriers and have allowed modification of recommendations. Despite that, the consultations prompted nonpharmacologic management of behavioral symptoms and decreased antipsychotic use.

This article, together with other evidence for beneficial use of telepsychiatry, challenges every nursing home that does not have a geriatric psychiatrist to implement such a program. If the cost of commercial programs is found to be prohibitive, a program in connection with a medical school or a hospital may be developed. Because distance is not a factor, there may be many choices to explore. However, it may not be possible to find a provider who would include so many experts as mentioned in Catic et al.17

References