Telepsychiatry and Addiction Treatment

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ABSTRACT

The need and the importance of telemedicine has been brought to the forefront during the ongoing pandemic of COVID-19. It has created another viable option for treatment delivery while reducing risks. However, there are major concerns regarding the delivery of services for treatment of substance use disorders using telepsychiatry. We discuss the various concerns and opportunities, the different international practices, and the Indian guidelines. We believe that there needs to be a balance between access to treatment and medication with reasonable checks and call for more patient and provider friendly practices. We also propose certain modifications in the Indian Telepsychiatry Guidelines.

Key word: Addiction, drugs and society, psychiatry, telemedicine/telecare

1. Its purpose is to provide clinical support and education.
2. It is intended to overcome geographical barriers, connecting users who are not in the same physical location.
3. It involves the use of various types of ICT.
4. Its goal is to improve health outcomes at the level of individual patients and/or communities.

Telemedicine offers the potential for enhancing treatment and recovery of people who suffer from substance use disorders (SUD). The use of telemedicine in this field is still limited but growing and is the need of the hour. The coronavirus disease (COVID-19) pandemic has spurred professional bodies, administrations, and jurisdictions to adopt newer technologies for delivering health care services. However, with regard to the treatment of People Who Use Drugs (PWUD), the pandemic and the techniques that could be used to address the challenges present unique problems.
These problems include, but are not restricted to, the following:

- Patients with SUD have greater risk of contracting the coronavirus.
- Comorbid conditions.
- Issues related to misuse and diversion of medications.
- Access and availability of licit and illicit substances and essential medicines.
- Issues related to the protection of patients and health care providers from infection.
- Issues related to privacy confidentiality and, of course, the stigma and discrimination associated with addiction.

As a response to the pandemic, The Ministry of Health and Family Welfare, Government of India, issued the Telemedicine Guidelines in March 2020. Subsequently, the Indian Psychiatric Society and the Telemedicine Society of India, in collaboration with NIMHANS, brought out the Telepsychiatry Operational Guidelines—2020 in May 2020. These documents help to generate wider discussion about telemedicine and legitimize it as a credible method of treatment delivery. However, on closer scrutiny, it is apparent that these guidelines do not adequately address the issues related to the treatment of addiction, as we shall elucidate later.

**Barriers to the Use of Telepsychiatry**

A recent review on the barriers to the use of telepsychiatry by Cowan et al. has extensively discussed the concerns and hurdles in the use of telepsychiatry. While it is not possible to elaborate on all the points, in general, barriers to the use of telepsychiatry can be both from the clinicians’ and patients’ perspectives. These include the following.

- Concerns about satisfaction, alliance, rapport, and comfort: There are concerns raised regarding the efficacy and quality of telemedicine, difficulty in building rapport, and lower therapeutic alliance. However, in general, some of the benefits reported were improved access to care and reduced waiting periods, travel time, and cost. Patients also report increased satisfaction with telepsychiatry.
- Cultural and communication gaps and differences in values, especially in a vast and diverse country like ours: There are cultural, language and regional barriers, and differences in value systems, especially in a vast and diverse country like ours, and that may impact the quality of services.
- Patient privacy, security, boundaries, and safety: These concerns include access to information, health data, network issues, encryption, issues of self-harm, emergency or crisis during sessions, and lack of support or local resources.
- Barriers related to technology: A well-functioning, robust system with good audio-visual quality and technical support is essential for the practice of telepsychiatry.
- Limited evidence base: Telepsychiatry is hampered by the limited research on its effectiveness in clinical practice.
- Financial viability: These include concerns regarding the cost of technology, reimbursement, insurance coverage, etc.
- Issues of licensing and credentialing: Some states and countries may require an exclusive license or accreditation in telepsychiatry before permission to practice.
- Legal/regulatory issues: These include problems related to prescription of controlled medication, differences in specific local laws, jurisdiction in civil commitment, and insurance requirements.
- Concerns of liability, litigation, and malpractice.
- Concerns of tradition, habit, routines, and workflows: These include often neglected problems of loss of efficiency, scheduling outside of regular times, investment of time and energy, special arrangements for telepsychiatry, and changes in protocols and procedures.

In addition, treatment for PWUD presents other unique problems concerning controlled substances such as the validity of the prescriptions within and across jurisdictions (for controlled medicines, different state, and excise laws); establishing identity in clinics and hospitals; registration of premises—old, new, and temporary (some states have special rules for registration of deaddiction facilities); concerns about emergency delivery sites; registration of satellite/community/mobile sites; issues related to supply and transport of controlled medications; concerns regarding dispensing and refill of prescriptions including the dose and duration of prescriptions and refills; diversion, abuse, overdose, relapse, and retention in treatment; and finally, issues related to record-keeping, documentation, and filing of reports and returns. The above concerns are serious since the laws dealing with controlled substances are exceptionally stringent.

As we have discussed, there are challenges at multiple levels in providing services through telemedicine to PWUD.

**Recommendations for Telemedicine During General Practice and During the Pandemic**

Canadian Research Initiative in Substance Misuse (CRISM) has issued general recommendations for telemedicine. We extract the relevant points for our purpose.

1. Telemedicine can be practiced if: (a) the health care provider evaluates that telemedicine is appropriate, (b) the patient provides informed consent, and (c) both the health care provider and patient have the proper technological means to use telemedicine. The risks and benefits of providing care by telemedicine compared to providing care in-person should be assessed.

2. The tools (telephone and video conferencing), platforms, and data used during telemedicine must be secured and confidentiality of the consultation must be maintained. Patient consent can be obtained verbally unless written consent is required at the sign-up of the tool/platform being used.

3. Patient identification must be provided at each telemedicine consultation, including name and at least one of the following: date of birth, address, health card number, or another valid form of identification.
(which can also be displayed on the screen). The health care provider’s documentation should include the same elements as a regular note, while also indicating the reason and method for providing telemedicine.

4. During a pandemic, it is recommended that health care providers always consider using telemedicine to provide care whenever possible. Each patient’s eligibility for telemedicine should be reviewed individually. Prescriptions should be transmitted verbally, electronically, by fax, or via secured electronic medical record to protect pharmacists, patients, and pharmacy employees from the transmission of COVID-19 by reducing visits to the pharmacy.

Telepsychiatry for SUDs: International Practices

It would be worthwhile to elaborate on some of the international practices with regard to the provision of telemedicine services to PWUDs. We would restrict the discussion to practices explicitly related to addiction psychiatry and not to general issues of telepsychiatry (such as tools and privacy).

As far as opioid agonist treatment (OAT) is considered, CRISM has suggested the following guidelines:

• The renewal/re-induction of OAT is allowed by telemedicine when indicated as per standard of care guidelines. OAT can be initiated by telemedicine in situations where the prescriber judges that a delay in the start of OAT would entail a risk for the patient, and if conditions are appropriate. All patients are encouraged to obtain a take-home naloxone kit.

• Health care providers should provide increased support to patients via remote methods and maintain ongoing and open communication. Online resources should be offered to patients, and increased counseling services by phone or other platforms should be offered.

• Pharmacy delivery should be used if available, and authorized/designated agents can be used to pick up or receive carries.

CRISM recommendation for other specific medications are as follows:

• Benzodiazepines and psychostimulants: A health care provider may prescribe benzodiazepines or psychostimulants to a known patient via telemedicine if he ensures follow-up—either in-person or by telemedicine. In the case of a new patient, the health care provider is permitted to prescribe it by telemedicine if they judge and document in the medical file that it is medically indicated, and a delay in initiating treatment will entail a risk to the patient. Appropriate and timely follow-up must be carried out, either in-person or by telemedicine. For all patients, the prescribed quantity must be safe and the patient’s condition and the associated risks must be taken into account.

• Opioids: Opioid prescriptions may be renewed following a telemedicine consultation, according to the professional judgment of the prescriber. While doing so, the following issues may be taken into account: each patient’s needs; the fundamental concerns of stability, safety, and storage; overdose risk; diversion risk; lapse or relapse; the new dangers associated with COVID-19; and current public health advice around physical distancing. The initiation of OAT is authorized by telemedicine consultation only when the health care provider judges that a delay in the start of the treatment would entail a risk for the patient.

The Drug Enforcement Division (DEA) in the US has also issued extensive guidelines for the use of controlled substances during the COVID-19 emergency period. These include detailed instructions for prescriptions, registration of temporary sites, alternate delivery sites, alternative delivery models, increase in drug supply, telemedicine, medication-assisted treatment including buprenorphine and methadone, and record-keeping and reports. A detailed discussion of these are beyond the scope of the article. Suffice to say, a balance has been maintained between ensuring the availability of medicines for such patients while minimizing diversion and misuse. Importantly, waivers have been given to various conditions that would facilitate the supply and use of these medicines to patient benefit. More information can be obtained from the DEA’s Diversion Control Division website.

Similarly, the American Society of Addiction Medicine (ASAM) has issued guidelines called “Supporting Access to Telehealth for Addiction Services” that include access to buprenorphine and methadone, access to telehealth, and access to alcohol use disorder and alcohol withdrawal management services. Again, these guidelines have kept in mind the unique problems faced during this pandemic, and facilitate the treatment and recovery of patients.

The Substance Abuse and Mental Health Services Administration (SAMHSA) in the US has ensured the provision of buprenorphine and methadone for both new and existing patients with certain exceptions. The salient points are as follows.

• For new patients: Exemption from the requirement to perform an in-person physical examination for telehealth for buprenorphine but not for methadone.

• Permitting practitioners to continue to treat existing patients on both buprenorphine and methadone using telehealth meeting applicable standards of care.

• Allowing practitioners outside opioid treatment programs to treat both new and existing patients with buprenorphine using telehealth facilities.

• Permitting OTPs to dispense medication (either buprenorphine or methadone) up to 14–28 days depending on clinical stability.

Recently, a position paper titled “COVID-19 and substance use disorders: Recommendations to a comprehensive health care response” by the International Society of Addiction Medicine (ISAM) Practice and Policy Interest Group has advocated more liberal policies facilitating better access to treatment for patients suffering from SUDs. Specific detailed steps regarding the provision of treatment, medication, and services during different stages and populations have been elucidated.

Indian Guidelines

In India, the Telemedicine Practice Guidelines were issued in March 2020, and the Telepsychiatry Operational Guidelines—2020 were published in May 2020. These documents legitimize telemedicine as a credible option for service delivery. The purpose of these guidelines is “to give practical advice to doctors so that all ser-
vices and models of care used by doctors and health workers are encouraged to consider the use of telemedicine as a part of normal practice.”

The guidelines define teleconsultation methods, types of consultations (first and follow-up consultation), and post-consultation approach by treatment providers. Besides, there is a section that divides medication which can or cannot be prescribed through telepsychiatry practice into certain groups List A, B, and C. Importantly, it needs to be noted that the categories (List O, A, B, and C) of medicines that can be prescribed via teleconsultation are expected to be as notified in consultation with the central government from time to time. It is to be clarified that the Telemedicine Guidelines provide general guidance while the specific list of drugs are mentioned in the Telepsychiatry Operational Guidelines—2020. For the sake of completeness, we will briefly elaborate on the category of the drugs.

1. **List “O” drugs:** Over-the-Counter drugs are those that do not require, by law, a prescription from a doctor to be sold.

2. **List “A” drugs:** List-A medications are those containing relatively safe medicines with low potential for abuse. These medications can be prescribed during the first/new consult via video consultation only, and for tele-follow-up consult, any mode of consultation is allowed (text/audio/video) for refilling the medications.

3. **List “B” drugs:** The List-B includes “add-on” medications, which are used to optimize an existing psychiatric condition. This list is dynamic in nature and depends on central government notification and the introduction of new molecules into the market. The medications under List-B can be prescribed in tele-follow-up consultation only, and it can be in any mode (text/audio/video).

4. **List “C” drugs (prohibited for online prescribing):** These are the psychotherapeutics drugs/medicines which are prohibited to be prescribed during telepsychiatry consultation. They include those which are especially regulated under the following regulations:
   a. Schedule X of Drugs and Cosmetics Act (D&C Act), 1940, and Rules, 1945
   b. Narcotic and psychotropic substance listed in the Narcotic Drugs and Psychotropic Substances Act, 1985 (NDPS Act, 1985)

   In the context of treatment of SUD, the concerns are as follows:
   - The issues of accessibility and availability of medicines for the treatment of SUD have not been addressed adequately. As an example, the duration and take-home doses of medication need to be increased to avoid unnecessary traveling in stabilized patients. Alternative sites can also be provided for dispensing.
   - The distinctive problems faced by patients with dual diagnoses (SUD along with other mental illnesses) also have not been adequately addressed. Such patients have special needs for the treatment of both mental illness and substance dependence. The restricted or differential availability of medications may hamper recovery.
   - The medicines in List A (as per the details in the Telepsychiatry Operational Guidelines—2020) are not exhaustive and are specific for a particular program of the government (District Mental Health Program). These cannot be generalized to all practitioners working in different setups and are unduly restrictive.
   - The distinction between prescription, stocking, and dispensing is unclear. The registered medical practitioners have the right to prescribe, stock, and dispense medications as per law. However, some of these medications are unavailable with chemists despite being permitted. So, the prescriptions may not be honored. Although it has been alluded to in section 7 (Prescribing Medications Online in Psychiatry), but these have been restricted in section 7.2. Although it is mentioned that prescriptions are on the professional discretion and judgment of the practitioner, certain medications are prohibited for a prescription. These are mainly controlled medications used frequently by patients of substance dependence.

   In Section 7.3, the medicines in List B are for “ADD ON” and “FOLLOW-UP” only. These medications may need to be started in the first consultation itself for maximal patient benefit. These may affect the right of the patient to effective treatment.
   - In Section 7.4, List-C drugs are prohibited as they fall under the NDPS Act, 1985, and Rules, 1985, and D&C Act, 1940, and Rules (DCR), 1945.

**Controlled Medications**

We believe that this (prohibiting online prescription of some important medications) is a major area of concern. The NDPS Act has been misunderstood and misinterpreted to construe medications as if they are banned. In fact, the NDPS Act and the Rules not just permit the use of medications for medical and scientific purposes but actually encourage it. It is universally accepted that the supply of these medicines for SUD patients constitutes a medical purpose as defined in the act and rules. The same is true for the medicines listed in D&C, 1940, and Rules, 1945. The inclusion of medicines in various regulations (NDPS Act, D&C Act) also does not prohibit the right of prescription by a psychiatrist. Indeed, this particular right has been bestowed upon the psychiatrists after they obtain the due qualifications and registration under the prevailing Medical Council of India/National Medical Council rules. The telepsychiatry system so envisaged while facilitates the provision of treatment and care for patients with a wide variety of mental health concerns, unfortunately, may inadvertently create many hurdles for those with SUDs. There is an implicit assumption on the Telemedicine Guidelines 2020 that these medications will only be abused or misused while neglecting the important therapeutic uses of these medicines without providing any logic, rationale, or data to back its proposal. This stigmatizes the patients of SUD by doubting their intentions for taking treatment while turning away potential seekers who may wish to start treatment. Also, there is no scope given for a case-by-case evaluation of such patients who may warrant such medications. We believe that a balance needs to be maintained rather than unnecessary and potentially dangerous overregulation. These regulations may cause a risk of relapse and overdose, greater emergency visits, risk of infections due to change of drug/route, and increased crime/violence/other social and legal problems.
We strongly believe that this is a time to think out of the box and not be over-cautious to the extent of restricting care for those in need. This crisis is an opportunity to enhance access to care for all those patients who, for some reason, could never approach a psychiatrist for SUD. The current guidelines appear too restrictive. The explicit prohibition on prescription and dispensing essential life-saving medications without a clear, rational basis may hamper the recovery process in substance dependence patients besides increasing the stigma and discrimination that these patients suffer. Many patients may drop out of the therapeutic network leading to an increase in morbidity and mortality. We should not miss this opportunity to address the major public health burden posed by restricted access to the treatment of SUD.

To achieve this, we put forward the following suggestions:

1. Medicines that are indicated as anticraving agents for SUD may be included in List A, which include oral formulations of baclofen, pregabalin, acamprosate, and topiramate.

2. Tablet naltrexone needs a special place on List A as a medication that can be used as an anticraving agent for alcohol and can be prescribed to patients already on naltrexone therapy for opioid dependence.

3. Tablet disulfiram, after proper informed consent in the first face-to-face consultation, may be allowed to be prescribed for patients with ongoing treatment through telepsychiatry.

4. Oral lorcazepam has been widely used for alcohol withdrawal management. Considering its advantages and efficacy and even though it falls under the NDPS Act, based on available evidence as well as clinical utility and safety profile, we advocate for its use through telepsychiatry from the first face-to-face consultation onwards.

5. A large number of patients suffering from opioid addiction will require buprenorphine and methadone as ongoing Opioid Substitution Treatment regimen. As the whole COVID-19 scenario is also a special circumstance, we as a fraternity should not refrain from any decision or policymaking which can directly benefit our patients. We need controlled, monitored, and documented use of buprenorphine and methadone on an e-prescription basis.

6. Pharmaceutical products for tobacco dependence, including bupropion and varenicline, are neither addictive nor under any legal restriction and should be made extensively available. Such agents will help the patients of nicotine dependence, especially during the ban on tobacco products during COVID-19.

Conclusions

Telemedicine has become a viable method of service delivery, especially in these difficult and testing times. It provides many opportunities while reducing risks for both the patients and the treatment providers. However, there are many unique concerns and challenges in the application of telemedicine in SUD. These concerns, if left unaddressed, may hamper recovery in patients of these disorders. We call for more patient-friendly approaches and urge the policymakers and the regulatory authorities to make amendments in the existing guidelines and laws to facilitate this.

Declaration of Conflicting Interests

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