Implications

“Our experience may provide lessons for psychiatry training programs seeking to include telepsychiatry in their practices during the current pandemic, and during future crises that are sure to occur,” the authors conclude. “Beyond such pragmatic clinical and service-related lessons, our experience demonstrates an inspiring collaboration between psychiatry and community to aid efforts to reduce the severity of a pandemic while meeting patients’ needs, as well as to show the way to innovate in the future.”

It was helpful that the Department of Psychiatry and Behavioral Medicine at Seattle Children’s Hospital had an existing TMH infrastructure on which to build HB-TMH services, the authors write. But 6 weeks is both a fast response and a slow one — the clinical staff was ready, but the technology failed.

“The good news is that it took only 6 weeks for a large training program to move from beginning considerations to actual implementation of a stable HB-TMH program. The bad news is that it took 6 weeks to do so.

“The Department had several psychiatrists and psychologists already using TMH for clinical care and teaching and an administration familiar with the needed protocol modifications needed to convert the outpatient faculty to HB-TMH. All were able to mobilize quickly to teach other faculty and problem-solve needed next steps to convert to a virtual clinic.”

It should not have been surprising that the technology failed, the authors write. “Most distressing and delaying to full HB-TMH implementation was the failure of our videoconferencing platform.” Although there were many clues that the system wasn’t adequate for outpatient, psychiatry was the “major complainer” because it was the main user, and the hospital focused instead on the inpatient platform used across the WWAMI region for consultation.

“The primary platform was InTouch, which our department had been using for telepsychiatry services clinic-to-clinic,” lead author Aditi Sharma, M.D. told CPU. “We had difficulties with InTouch when we transitioned to home-based services and the number of users across the department increased. We initially used WebEx as a backup – this was a platform we used for much of our meetings anyway so all had access to it.” The secondary backup option was Zoom. “Initially a handful of us were using Zoom that was provided through the University of Washington to UW faculty, but then Seattle Children’s also obtained Zoom accounts for Seattle Children’s employed providers and it became the primary platform,” said Sharma.

Another problem was the many administrative steps needed to convert services from clinic to home. “Possibly these steps could be less complex than described here,” the authors write, noting that the department is large, with multiple clinics, trainees, sites, and support staff. “Community medical centers or small training programs likely could streamline some of these processes to expedite the process — but maybe not as this option has not yet been tested,” the authors conclude. “The important issue is to develop a reliable process and role designations that contain anxiety for faculty, staff, and patients during an already anxiety-provoking time. Cross-training is recommended.”

Finally, there were serious financial implications, with the hospital’s census falling dramatically as patients were transitioned from clinic to home. Phone appointments yielded far less revenue per appointment than either in-clinic or HB-TMH appointments, although the phone appointments required the same amount of time and almost the same amount of documentation.

A note: Psychiatry is probably at lower financial risk than other medical specialties, where cancellation of elective procedures was a threat to existence. Psychiatry doesn’t depend on procedures, and needs escalate during crises. In the future, the authors write, HB-TMH can overcome barriers to treatment such as distance, transportation, and scheduling. However, rapid mobilization is necessary.

Limitations

The authors warn that their system was in a better place to start telemedicine — because it was already under way — than others. “It is difficult to know how to get started,” they write. On the other hand, small private practices may find it much easier to contract with videoconferencing vendors, based on the authors’ personal communications with the AACAP and APA telepsychiatry committees. But, they worry about quality. “How familiar these providers are with issues affecting HB-TMH practice is not known. Implementation during a crisis does not mean compromising clinical and technological training.”

Sharma A, Sasser T, Gonzalez ES, et al. Implementation of home-based telemental health in a large child psychiatry department during the COVID-19 crisis. J Child Adolesc Psychopharmacol 2020 Jul 8. doi: 10.1089/cap.2020.0062. Epub ahead of print.

What’s New in Research

Children need school, but under pandemic, how?

For some answers to this question, see the July 9 JAMA letter from Rita Rubin, “School Superintendents Confront COVID-19—There Are No Good Options for Next Year,” and recommendations from the American Academy of Child and Adolescent Psychiatry (AACAP) and the American Psychiatric Association (APA) on how schools should open safely, if they do, during the pandemic.

“There are no good options for next year,” Susan Enfield, superintendent of Highline Public Schools, tells Rubin. “There is no scenario in the fall that doesn’t break your heart.” Students could fall behind academically, or, if they don’t stay home, become infected or transmit the virus.

“If you talk to any pediatrician … we are getting inundated by calls from school districts,” says general and behavioral developmental pediatrician Nathaniel Beers, M.D., who helped craft the American Academy of Pediatrics’ (AAP’s) school reopening guidelines (https://services.aap.org/en/pages/2019-novel-coronavirus-covid-19-infections/clinical-guidance/covid-19-planning-considerations-return-to-in-person-education-in-schools/).

Common questions are whether the schools should test for SARS-CoV-2 and what to do about sports. Beers spent more than 7 years working for the District of Columbia Public Schools, the last 15 months as chief operating officer. So he knows the quandaries superintendents are dealing with.

The very students who are the most adversely affected when classrooms close continued on next page
are also the ones who are struggling academically, whose families may not have access to the technology needed for remote learning, and whose parents can’t stay home with them.

“We all did the best we could over March, April, May, June, but we’re going to have to do better in the fall if this is a long-term scenario,” Enfield says.

Besides interrupting supportive services, school closures have made it difficult for schools “to identify and address important learning deficits as well as child and adolescent physical or sexual abuse, substance use, depression, and suicidal ideation,” the AAP school reopening guidelines state. In addition, the AAP notes, “there has been substantial impact on food security and physical activity for children and families.”

Worldwide, about 1.6 billion students — 91.3% of all enrolled — had been shut out of school by the end of March.

Children with mild or no symptoms of influenza or measles, for example, can still transmit a virus. “Kids shed much more influenza virus, and they do that for much longer periods of times than adults,” Vanderbilt University infectious disease specialist William Schaffner, M.D., says.

It’s unclear whether this is true for SARS-CoV-2. But it is known that older adults can be much more affected than children.

President Donald Trump wants the schools to be open, but most voters aren’t comfortable with this, according to a Politico/Morning Consult poll.

“One thing that is clear is that little is clear,” Rubin writes.

The Centers for Disease Control and Prevention recommends schools “space seating/desks at least 6 feet apart when feasible,” but the AAP guidelines note that in many schools, that much distancing is feasible only by limiting the number of students in the classroom.

APA and AACAP guidelines

The American Academy of Child and Adolescent Psychiatry and the American Psychiatric Association recognize that education, including school attendance, is an essential component of successful and healthy development for all children and adolescents, so if schools will open, they recommend that they do so with these precautions:

• Public health agencies must make recommendations about returning to school in the classroom, based on scientific evidence and local community circumstances, devoid of politics, with careful and thoughtful decision-making, and with the best interest of students, teachers, and staff. One size cannot fit all.

• The return to school must include appropriate protections for all children, families, school personnel, and other members of the community.

• When classroom-based education is not possible, techniques that optimize social interactions alongside educational objectives should be prioritized.

• The education of children with special needs requires additional resources to adapt instructional techniques. This vulnerable population includes children with emotional, learning, and physical disabilities, as well as those in foster care, in poverty, and for whom English is a second language, to mention but a few.

• The mental health of students must be continually addressed because mental health is an intrinsic part of overall health and well-being. This includes the opportunity for mental health care for all educators, and school staff, as well as parents who are teaching at home.

• Fairness and equity require that sufficient access to equipment, services, and technology, to address systemic and/or cultural disadvantages in educational and mental health supports, amplified by COVID-19, are provided.

• Additional financial support to schools and the community is needed for a safe and supportive educational process. This increase in funding should address the structural requirements necessary to create safe environments to ensure a full array of education and mental health supports.

• All necessary components must be in place to ensure effective systems for the early identification of and intervention for the increased number of high-risk students as a result of the pandemic.

“In these uncertain times, making educational decisions based on science and community circumstances ensures the mental health needs of our children and adolescents are being addressed, allowing them to feel engaged, safe, secure, supported, and loved,” the APA and AACAP conclude.

Rubin R. School superintendents confront COVID-19 — “There are no good options for next year.” JAMA 2020 Jul 9. doi: 10.1001/jama.2020.12575. Epub ahead of print.

Treatments for substance use disorders for teens and young adults

Parents can often be completely confused by the array of treatments for young people with substance use disorders (SUDs). This puts them at the mercy of the internet, where there may or may not be evidence-based treatments available but a toll-free call will link you to someone willing to take your money if you have it, and where desperate parents may not know how to choose between treatments.

This is not about the difference between residential and partial hospitalization and outpatient therapy. When people refer to “evidence-based” treatment, they mean treatment that has been proven to be effective and has been incorporated into strict protocols via manuals, so they can be replicated. The National Institute on Drug Abuse (NIDA) has been tracking the many treatment models for general substance use disorders, as well as for specific substances. Motivational interviewing (MI), medication-assisted treatment (MAT), contingency management (CM), and cognitive behavioral therapy (CBT) are all evidence-based modalities, explained Ruben Baler, Ph.D., NIDA health scientist, in an email to CPU.

But there are many more. The following is not an exhaustive list, but it does include “most behavioral therapies that are generally acknowledged to have comparatively strong empirical support, and which have been specified (and manualized) adequately (including MI, CM, and CBT),” said Baler.

He added, “It is important to note that, unlike pharmacotherapies, many behavioral therapies can be used across a range of substance use disorders with fairly little adaptation.”

And some are particularly good for young people and families.

• Brief strategic family therapy.

Originally developed for Hispanic