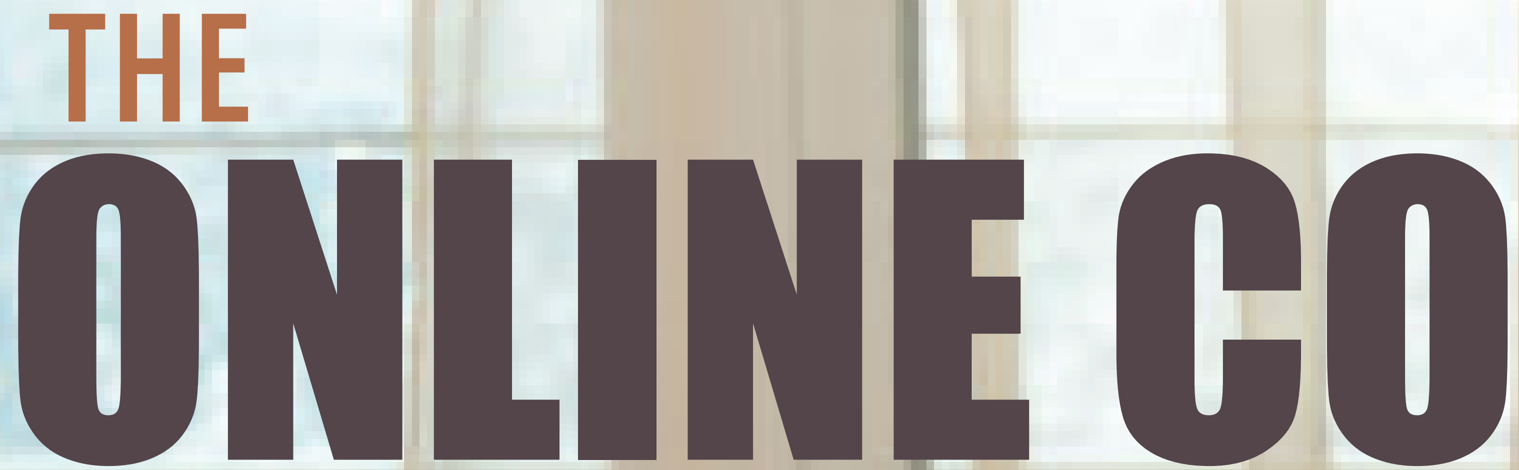

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## MENTAL HEALTH CARE IS GO

*by Jane Sarasohn-Kahn*

This article summarizes the white paper, *The Online Couch: Mental Health Care on the Web*, published in June 2012 by The California HealthCare Foundation. The full paper can be accessed via the CHCF website at http://www.chcf.org/publications/2012/06/online-couch-mental-health.

There is growing demand for mental health services that help people with mild to moderate depression and anxiety. For this expanding patient base, mental health care is moving outside of the therapist's office, via virtual and online modes. An undersupply of mental health professionals, the adoption of communication and information technologies by both consumers and professionals, patient demand for access and convenience, and value-based payment in health care underlie this emerging trend.

Payors of health services recognize the economic burden of depression. More days of work are lost due to depression than any other medical condition. For this reason, depression is considered "the common cold of mental illness" by employers, for whom depression is the #1 financial line item in employee assistance programs (EAPs).

Thus, enlightened employers and public sector plan sponsors (eg. Medicaid, Veterans Administration) are targeting depression as a population health challenge among employees, dependents and enrollees. In response, health plans have begun to serve up innovative programs, such as computerized cognitive behavioral therapy (CCBT). One such health plan, The University of Pittsburgh Medical Center's UPMC Health Plan (with 1.5 million members) researched CCBT programs from all around the world, deciding on Beating the Blues (BtB). BtB originated in the United Kingdom and has a substantial evidence base to support its efficacy: the landmark publication presenting early evidence for BtB was published in 2003, and since then BtB has amassed the largest evidence base available for a CCBT program. Beyond BtB, other CCBT programs are available on the market in 2012, with several in development at the time *The Online Couch* went to print in June 2012.

In addition to CCBT, other service are expanding options for people seeking treatment for mild to moderate

depression outside of the therapist's office such as:

- ***Online therapy, a fast-growing segment.*** This category of technology-enabled mental health can be described as "safe Skyping," whereby secure videoconferencing connections support therapeutic encounters between patients and therapists. Some programs develop networks of therapists who contract independently with patients (in a direct-to-consumer model) for services. Other programs have networks of providers and offer a comprehensive service to self-insured employers, health plans and specialty mental health companies.
- ***Online social networks.*** Patients support other "people like me" in online social networks, where people with depression are often managing other co-morbidities such as multiple sclerosis, diabetes, heart disease, HIV/AIDS, and other medical issues. In these networks, patients who opt into the communities can benefit from a peer-to-peer support system.
- ***Mobile platforms for self-tracking.*** The adoption of the mobile phone (especially the smartphone) and tablet computing (notably, the iPad) by both consumers and clinicians enables patients to manage depression on-the-go – where they live, work and play. Many programs launched on mobile platforms are focused on self-help and self-tracking, such as MedHelp's MoodTracker and What's My M3, developed by psychiatrists from Columbia University, Georgetown University, and the Bipolar Collaborative Network. Beyond these health apps, simple SMS texting has also been found to be useful in managing behavioral health outcomes (Fjeldsoe, Marshall and Miller, 2009).[1]
- ***Games for behavioral health***. Gamification has come to health care, but games in the sphere of mental health haven't been tested to the extent they have in other areas of health care. Existing research on therapeutic computer games suggests that some clients are more cooperative with therapists when using games, that session attendance rates can be improved due to reduced stigma, and that children and adolescents who require therapy benefit from games (Lewinson, Rohde & Sealey, 1998).[2] The SPARX program in New Zealand targeted adolescents seeking help for depression, and resulted in clinically significant reduction in the condition among young patients using a gamified CCBT program (Merry et al, 2012).[3]
- ***Virtual reality.*** VR uses computers, visual immersion devices, and artificial created environments to give patients simulated experiences that can be used to diagnose and treat psychological conditions. There is a growing evidence base supporting VR for mental health applications coming through the Veterans Administration (VA) health system. With a growing number of veterans returning to the U.S. following service in Afghanistan and Iraq war theatres with post-traumatic stress, the VA has initiated programs based on VR to help this population: Virtual Iraq and BusWorld, among them. These applications are

all in the investigative stage, with the VA a trailblazer in exploring the potential for virtual reality and telehealth, writ large, to deal with challenging mental health problems among veterans and families.

Across all of these technology platforms dealing with mental and behavioral health, there are many barriers that can slow adoption in the U.S. While many U.S. health citizens lack access to mental health services in general, these and other people in the U.S. also lack access to the infrastructure technologies that have the potential to expand services to the under-served – especially, broad bandwidth in areas lacking the so-called "last mile." In addition, there are therapists who are entirely committed to the traditional face-to-face model of therapy, and are reticent to experiment with virtual/etherapy. For some of these more techno-conservative clinicians, privacy is seen as a barrier to providing care at a distance. However, most of the new Skype-type platforms for distance therapy offer secure (some make the claim of "HIPAA-compliant") environments. One of the inducements offered by some of the etherapy companies to attract therapists to join their service is electronic health records systems, among other benefits.

The most significant barrier which could slow the adoption of mental health care online is payment. The fact is that telehealth, in general, is more advanced in other parts of the world outside of the United States because their health care payments are tightly budgeted and feature strong primary care "backbones" at the front line of health care. This can be the case in the UK, home of Beating the Blues, which today often functions as first-line therapy prescribed for British health citizens diagnosed with mild to moderate depression – tried out before an antidepressant is prescribed.

In the U.S., Medicaid is the largest payer of mental health services, accounting for 26% of total mental health spending in the nation. Medicaid covers mental health services delivered in a broad range of settings: home, school, and workplace, through the full complement of mental health professionals. With the expected influx of at least 30 million newly-insured people expected to enter the U.S. insured population in 2014 will come dramatically expanded demand for mental health services which cannot be delivered based on the current face-to-face model.

The Affordable Care act could, therefore, impact payment for mental health services

even more dramatically than the Mental Health Parity Act of 2008 did. The ACA's model for integrating care through accountable care organizations and patient-centered medical homes would offer compelling motivation for primary care providers to bring mental health into the primary care practice, enabling earlier detection and treatment of people with mild to moderate mental health conditions. Accountable care financing would incentivize providers to channel patients to the most cost-effective form of mental health care. For patients with mild-to-moderate depression, CCBT could be a cost-effective alternative, in addition to tele-mental health.

Technology can help bridge the gap between pent-up demand for and undersupply of face-to-face behavioral health services. With technology costs falling and broadband and mobile platforms penetrating the U.S., technology-enabled mental health care can improve access for more people needing behavioral health interventions. The drivers of demand, patient and technology are converging for this market to grow. What could ultimately hold back the growth of this market isn't the technology – it's provider willingness to embrace a new model of care delivery.

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## About the Author

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