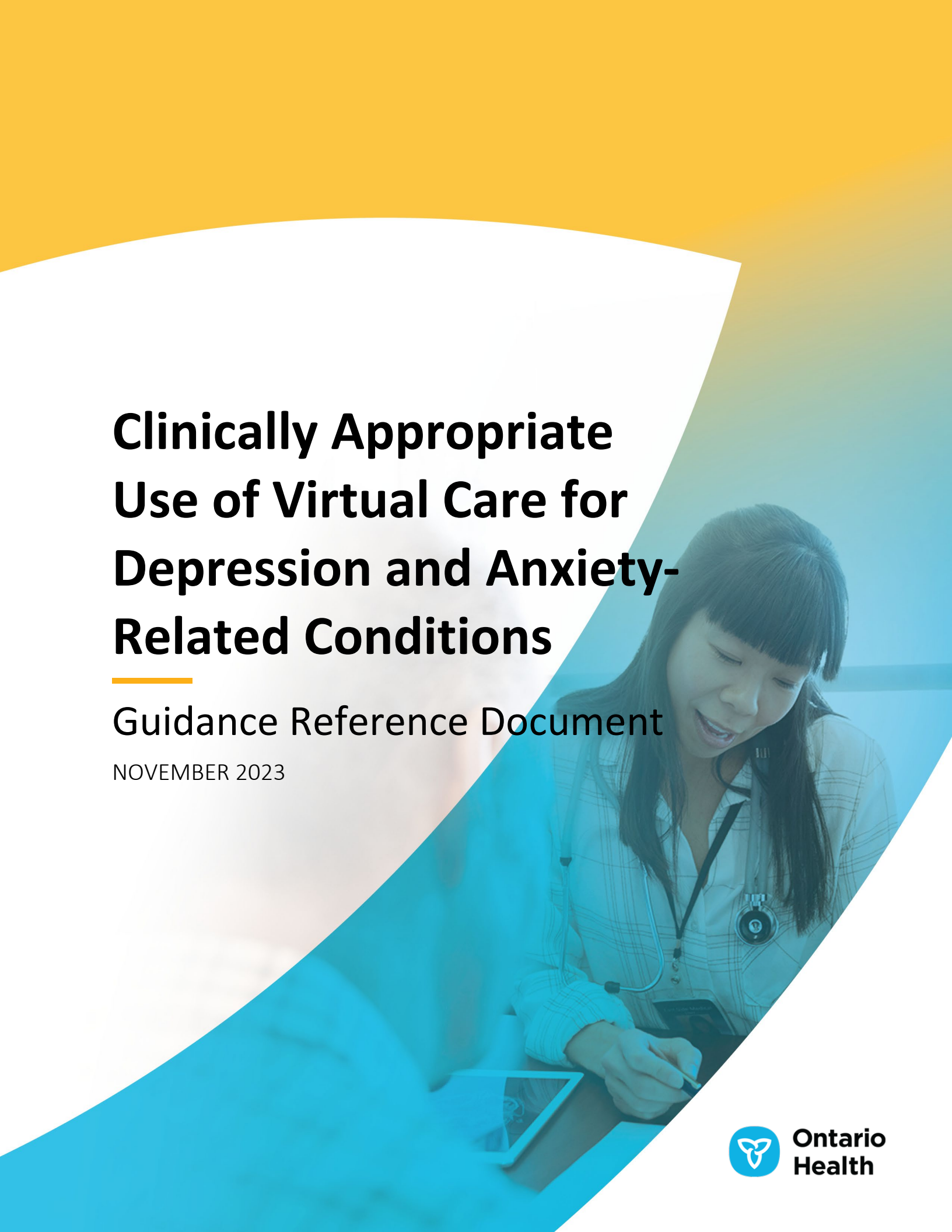
Clinically Appropriate Use of Virtual Care for Depression and Anxiety-Related Conditions

Guidance Reference Document

NOVEMBER 2023



Ontario Health

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This document is intended to provide guidance for the use of virtual care in clinical practice in Ontario. Physicians seeking information on how to bill OHIP for virtual care services are advised to refer to the Health Insurance Act, the regulations thereunder, including the Schedule of Benefits for Physician Services or to contact the Ministry of Health.

About This Document

This document has been developed to help health care professionals make decisions about the use of virtual care modalities (i.e., telephone, videoconferencing) for adults with depression and/or anxiety-related conditions.

This guidance is specific to decision-making regarding the delivery of virtual care for depression and anxiety-related conditions. It supplements – rather than replaces – all related legislation, regulation, regulatory college practice standards, policies, government directives, and public health guidance.

This guidance may need to be adapted to address the unique needs of people receiving care, families, or caregivers, as well as those of organizations or other local conditions. It is acknowledged that developing strong relationships with First Nations, Inuit, Métis and urban Indigenous (FNIMUI) communities and organizations – founded on respect, partnerships and open communication – is critical. Engagement with FNIMUI communities and organizations is an ongoing process and not a one-time event. Continued engagement will be required to more fully articulate the unique considerations when working with FNIMUI within the context of this guidance document. The guidance as set out in this document will be evaluated and through this evaluation, further engagement and iteration of the content will occur with FNIMUI, with support from the Indigenous Health Equity Coordination team at Ontario Health. Further updates will be released as research and clinical evidence develop and as Ontario's long-term strategy for virtual health care evolves.

Intended Audience

This guidance has been designed for regulated health care professionals who provide mental health care (including but not limited to psychologists, psychiatrists, psychotherapists, social workers, registered nurses, and occupational therapists) to adults aged 18 years and older experiencing depression and/or anxiety-related conditions.

It may also be applicable to others providing care, such as Traditional Healers, Elders, Knowledge Keepers, and peer support workers.

Background and Rationale

Throughout the COVID-19 pandemic, the delivery of virtual care for depression and anxiety-related conditions grew significantly and expanded the ways in which people receive and health care professionals deliver care. Virtual care for depression and anxiety-related conditions may enhance access to care in areas of Ontario where there are few specialized mental health care professionals, services, or resources and for those who face other barriers to access, such as limited mobility, geographic location, cost of transportation, needing to take time off work to travel, and childcare. Virtual care can and has been provided in a hybrid format, in which both in-person and virtual care are used, for both individual and group therapy. The delivery of virtual care for depression and anxiety-related conditions may be preferred by the person receiving care or by participating family members or caregivers. The use of videoconferencing may also assist health care professionals in better understanding the home context and environment.

The Ontario Ministry of Health has funded the development of guidance on clinical appropriateness to support health care professional decision-making about the use of virtual care modalities in care for depression and anxiety-related conditions, as guidance at the provincial level is lacking.

Guidance Development

The Guidance for the Clinically Appropriate Use of Virtual Care, Depression and Anxiety-Related Conditions, Expert Panel ("expert panel") was established to inform the development of this guidance. The expert panel consisted of people with lived experience and health care professionals experienced in providing care for adults with depression and/or anxiety-related conditions, as well as for families and caregivers, in hospital and community settings.

The expert panel referred to available mental health–related data, evidence from the literature, and their own experiences to arrive at a consensus on the concepts and guidance statements included in this document. Members participated in 5 meetings and completed 4 post-meeting surveys.

Literature Review: The Role of Virtual Care and Cognitive Behavioural Therapy

Ontario Health conducted a preliminary literature review to better understand the role of virtual care and Cognitive Behavioural Therapy (CBT) in treating depression and anxiety-related conditions, extracting data from both peer-reviewed and grey literature. An Ontario Health senior research associate and members of the guidance content team reviewed titles and abstracts and worked together to determine which studies to include. In total, 73 studies were included (23 randomized controlled trials, 25 review articles, 9 quasi-experimental studies, 9 observational studies, 6 secondary analyses of randomized controlled trial or open trial data, and 1 case study). All randomized controlled trials and review articles reported the efficacy of virtual CBT-based interventions for depression and/or anxiety disorders as effective and/or noninferior to face-to-face CBT.[1] The virtual CBT-based interventions included in the studies were reported as having reduced Beck Anxiety Inventory scores, improving overall health, and improving symptoms of generalized anxiety and depression.[1]

Literature Review: The Needs of First Nations, Métis, Inuit and urban Indigenous Peoples and the Role of Virtual Care

Ontario Health also conducted a preliminary literature review to better understand the needs of First Nations, Métis, Inuit and urban Indigenous peoples and their experiences with virtual care in Canada.[2] Five primary research studies and six review studies were included. All primary research studies used qualitative methods (e.g., participatory research, art-based, interviews, focus groups). These studies examined virtual interventions in Indigenous communities and reported positive perceptions from people receiving care, including youth. Interview and focus group data indicated that a virtual CBT-based game called SPARX (Smart, Positive, Active, Realistic, X-Factor) was a promising tool to support the mental health of young Inuit people.[2] However, the studies noted challenges in the adequacy of online mental health resources for Indigenous youth in certain regions, indicating the need for improvement and tailored approaches. Out of the 6 identified review articles, only one reported outcomes on intervention effectiveness.[3] Findings from a 2023 study indicated that cognitive assessment and health service use appeared to be comparable between virtual and usual-care modalities but that neither was superior.[3] A systematic review identified 4 components of virtual care

interventions that have been found to be effective when supporting Indigenous populations: evidence-based interventions, mobile device–based interventions, intervention duration (i.e., a minimum of 8 to 12 weeks of behavioural and lifestyle interventions), and health professional involvement (i.e., training and employing Indigenous health professionals).[4] Additional reviews reported growing evidence that virtual care solutions show promise in addressing the mental health needs of Indigenous peoples and that they are generally positively perceived by people receiving care.

Key Concepts and Definitions

This guidance addresses the clinically appropriate use of virtual care for depression and anxiety-related conditions and decision-making regarding the use of virtual versus in-person care. The literature offers several definitions of *clinical appropriateness*, but all highlight the importance of equity, evidence-based care, resource use, clinical expertise, and person-centredness.[5]

The expert panel discussed the significance of these elements as they relate to providing clinically appropriate care. Further, several regulatory colleges defer decision-making regarding the clinically appropriate use of virtual care to the judgment of health care professionals.[6] Factors that may influence the clinical appropriateness of virtual care for a person with depression or an anxiety-related condition include the person's access to technology and internet bandwidth and their digital health literacy, personal preference (and that of family members or caregivers as appropriate), perceived cultural safety of and comfort with the proposed virtual care modality, values (and those of family members or caregivers as appropriate), and access to local supports, as well as the clinical context.

Clinically Appropriate Use of Virtual Care

The definition of *clinically appropriate use of virtual care* used in this guidance and agreed upon by the expert panel was adapted from the *Clinically Appropriate Use of Virtual Care in Primary Care* guidance reference document[6]:

> Clinically appropriate mental health care is safe,* timely, effective, inclusive, equitable, confidential, evidence-based,† and person/family-centred.‡ It is provided within the scope of practice of the health care professional in a setting or using modalities that permit appropriate

*_Safe_ refers to ensuring the safety of both the person receiving care and the health care professional during virtual care encounters by minimizing preventable harm, as well as ensuring that the virtual care provided is culturally safe and accessible for individuals from marginalized populations while meeting the necessary standards for safety, privacy, and security.[7]

†"Evidence-based practice involves the conscientious, explicit and judicious use of the best available research evidence to inform each stage of clinical decision making and service delivery." This requires that health care professionals apply their knowledge of the best available research with their clinical experience, data, and feedback gained from each person receiving care in the context of individual characteristics, cultural backgrounds, and preferences, with family members or caregivers being involved as appropriate.[8]

‡Person-centred care is the evolution of patient-centred care, a shift that signals to the system the profound importance of being treated as a person first and a patient second. Use of the term *person* over *patient* is also intentionally inclusive of family members and caregivers and recognizes that a person often experiences the health care system with a support network.[6]

clinical assessment of the presenting condition and/or evidence-based treatment of the presenting condition.

Virtual Care

The definition of *virtual care* used in this guidance and agreed upon by the expert panel was adapted from the *Clinically Appropriate Use of Virtual Care in Primary Care* guidance reference document[6]:

> Virtual mental health care is defined as a clinical interaction (including but not limited to assessment, consultation, check-in, and treatment) between a person receiving care and member(s) of their health care team, occurring where the person receiving care and/or member(s) of their health care team are not physically in the same location, using any form of communication or information technologies, with the aim of facilitating quality, access, and effectiveness of care.

The virtual care modalities included in this guidance are telephone and videoconferencing, which may be facilitated through a smartphone, tablet, or computer.

Although this guidance focuses on telephone and videoconferencing, other virtual care modalities are emerging. Some have varying levels of evidence, whereas others have limited to no evidence. For example, guided internet-delivered CBT (iCBT) has been found to be associated with greater improvement compared with nonguided iCBT.[9]

While other modalities (e.g., self-guided smartphone applications, secure messaging) exist and may be helpful adjunctive tools, these do not fall within the scope of this guidance.

It is acknowledged that a person's treatment may involve both in-person and virtual components and that the choice of virtual modality may vary throughout treatment. It is also acknowledged that group therapy may be delivered in a hybrid manner in which both in-person and virtual modalities are used to support the delivery care.

General Considerations

Context and Considerations for Health Care Professionals

It is important for health care professionals to consider their own competencies in delivering care virtually. Such competencies include the ability to establish a therapeutic relationship, deliver culturally safe and trauma-informed care, technical skills, and awareness of how to deliver evidence-based interventions using virtual modalities.[10] It is also important for health care professionals to recognize the potential impacts of using technology on the therapeutic relationship, confidentiality, and the cultural values, privacy, and safety of the person receiving care.[10]

Context and Considerations for People With Depression and Anxiety-Related Conditions

Each person with depression or an anxiety-related condition is unique, and people vary in terms of their understanding of the use of virtual care modalities, their access to them (and to in-person care options), their preferences in terms of their use, and their ability to effectively use them.[6] When determining a person's suitability for virtual care, the health care professional considers and discusses with the person their clinical, psychosocial, socioeconomic, cultural, and social identity needs and preferences.[10,11] Asking about the person's values, preferences, and beliefs, as well as discussing and considering collaboration with community resources and, where appropriate, traditional care practitioners, healers, or elders may further support cultural safety and the therapeutic relationship.[10,11]

Figure 1 lists some of the potential benefits of virtual and in-person care modalities to consider when determining which modality may be best for a person receiving care and for family members or caregivers as appropriate. Figure 2 lists some of the potential limitations or challenges of these modalities.

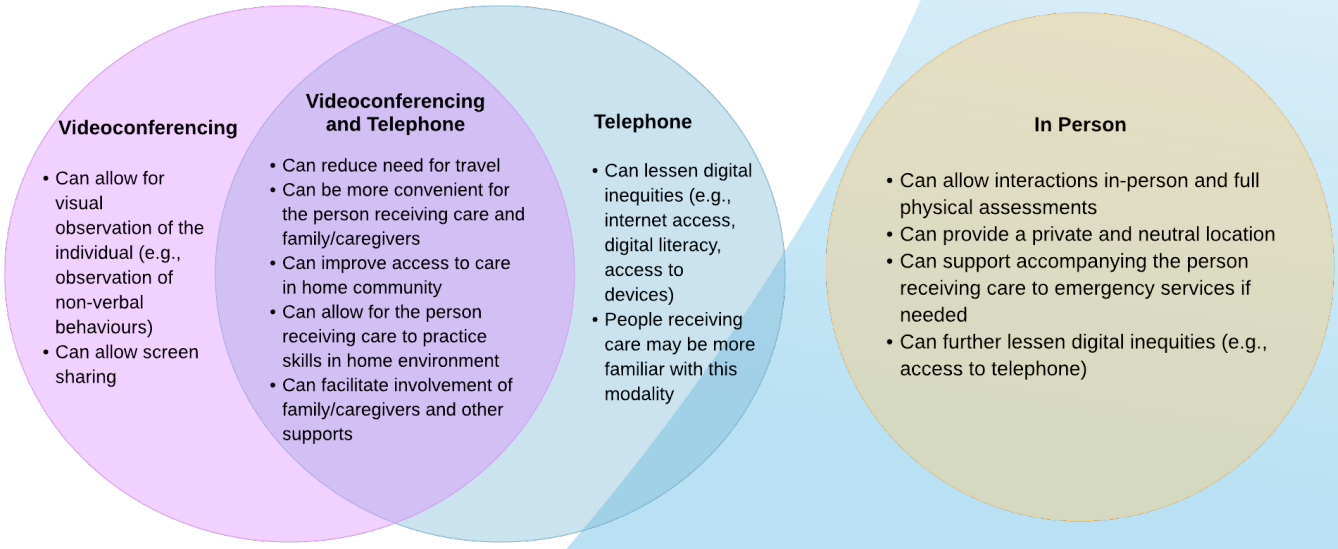

Figure 1. Potential Benefits of Virtual and In-Person Care Modalities

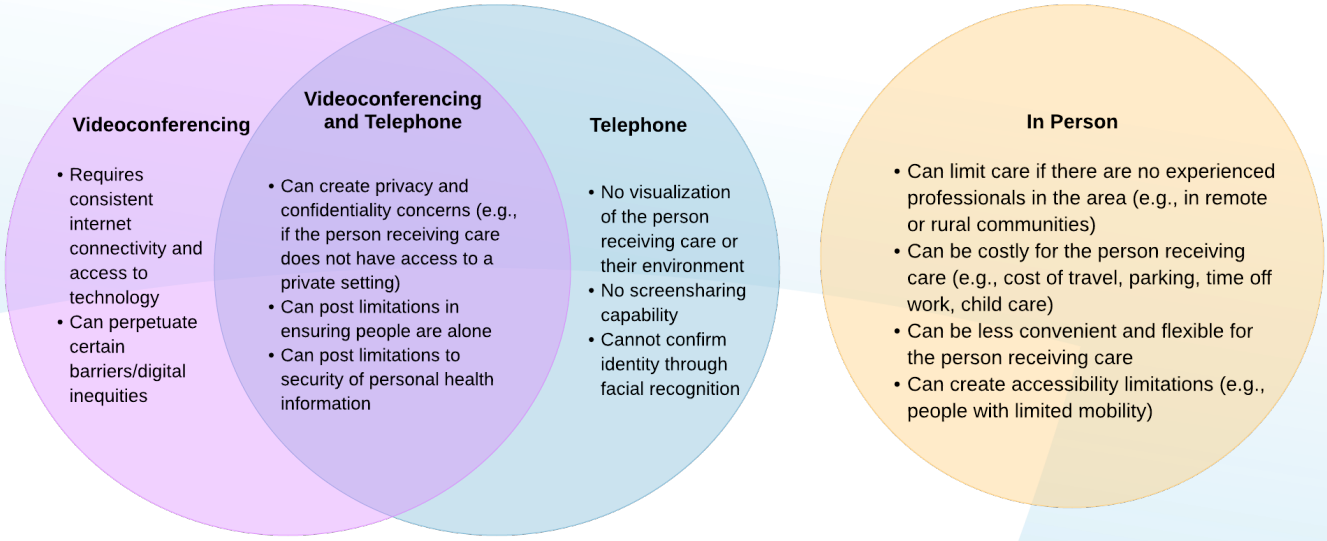

Figure 2. Potential Limitations or Challenges of Virtual and In-Person Care Modalities

Considerations for Indigenous Peoples

First Nations, Métis, and Inuit and urban Indigenous peoples and communities are distinct and constitutionally recognized in Canada, each with their own unique traditions, beliefs, cultural practices, political structures, languages, and histories. Delivering virtual care for depression and anxiety-related conditions to First Nations, Métis, Inuit, and urban Indigenous individuals requires an awareness of the unique strengths of these communities while also recognizing the cultural, historical, and constitutional contexts that affect Indigenous communities and individuals.[11]

A rapid evidence review of virtual primary care delivery for Indigenous populations in Canada discusses the importance of ensuring Indigenous-led and Indigenous-centred services are culturally safe and trauma informed to provide high-quality care to Indigenous clients.[12] Relationality is a core concept in Indigenous-centred care and includes the physical, mental, emotional, and spiritual connections and relationships Indigenous people have with all living things. The authors state, "Taking time to build mutual trust is a crucial step to enhancing relationality."[12] Acknowledging that ongoing relationship-building fosters trust and confidence in the care being provided, the authors suggest that health care professionals consider the person's preferences and discuss with them how relationality can be supported in the planning and delivery of virtual care.[12]

It is acknowledged that there are many considerations and continued engagement required when planning for and delivering virtual care to First Nations, Métis, Inuit, and urban Indigenous populations, including but not limited to the following:

- Culturally safe service delivery
- Cultural accessibility (e.g., access to Traditional Healers, Elders and medicines)
- Support from family and community
- Cultural and spiritual beliefs

- Digital literacy, equity and technology (e.g., access to a computer, laptop, tablet or smartphone)
- Experiences of systemic racism, discrimination, stereotypes, and prejudice
- Housing and safety
- Language and communication barriers (e.g., translation)
- Connectivity and infrastructure challenges
- Poverty, financial barriers, and other socioeconomic factors
- Privacy and confidentiality

Further information and hearing directly from First Nations, Métis, Inuit and urban Indigenous through engagement is required to better understand the gaps and needs of First Nations, Métis, Inuit and urban Indigenous peoples as they relate to seeking and accessing care for depression and anxiety-related conditions.

The following may assist in addressing the cultural and spiritual needs of First Nations, Métis, Inuit and urban Indigenous individuals, thus facilitating "trust, acceptance and use of technology":

- An awareness of Indigenous-led organizations for virtual supports;
- Including Indigenous clinicians, Traditional Healers, or Elders in virtual visits;
- Incorporating traditional practices, values, and beliefs in virtual visits;
- Providing trauma-informed care; and
- Pursuing cultural safety training.[13,14]

Virtual mental health care for First Nations, Métis, Inuit and urban Indigenous individuals can be an option to support certain goals or act as a supplementary service based on personal needs, preferences, and clinical appropriateness.[11] It is one of several care options for Indigenous individuals, including services within their own community, Traditional Medicine, and in-person care. For First Nations, Métis, Inuit and urban Indigenous individuals who would prefer to receive care from a mental health care professional outside their community, virtual care may be advantageous. However, it has been reported that seeking treatment outside a person's community can "place individuals at greater risk for health and wellness problems."[13] Some people may also feel a lack of interpersonal connection when receiving care virtually.

As personal preference varies, it is essential for the health care professional to discuss preferences with the person receiving care and to reflect on how to create a culturally safe digital space for virtual visits. Virtual mental health care "needs to be a community's choice, and an individual's choice; it cannot be something that is imposed."[13] Valuing Indigenous knowledge and recognizing when an Indigenous-focused service or Indigenous clinicians may be better suited to provide care are also important considerations.[13,14]

Benefits and Challenges of Virtual Mental Health Care for Indigenous Populations

According to the literature, virtual mental health care may provide the following benefits for Indigenous individuals and communities[13,14]:

- It can support certain goals and act as a supplementary service to what is already being provided in the community
- It can facilitate support among community mental health workers
- It can facilitate connection to communities and individuals speaking Indigenous languages, allowing for communication and healing in people's own Indigenous languages
- It can provide access to mental health care where it may otherwise be inaccessible
- It can provide access to mental health care within a person's home community
- It may "facilitate disclosure in some clients who might feel more comfortable being more physically distant from the clinician"

According to the literature, virtual mental health care may pose the following challenges for Indigenous individuals and communities[13,14]:

- It may "detract from capacity building within the community"
- It may make it difficult to build trust
- It may "detract from the therapeutic relationship if a sense of connection is lacking"
- Certain mental health work and healing may not be appropriately facilitated via virtual modalities
- It may pose privacy and confidentiality concerns
- The technology and bandwidth requirements may make virtual care inaccessible for some

Considerations for Equity, Diversity, and Inclusion

When planning for and delivering virtual care for depression and anxiety-related conditions, many issues need to be considered for members of equity-deserving populations and populations typically underserviced in treatment for depression and anxiety-related conditions. This includes people who are Black or People of Colour, or members of other racialized populations; people who identify as 2-spirit, lesbian, gay, bisexual, transgender, queer or questioning, intersex, asexual, or another sexual orientation or gender identity (2SLGBTQIA+); people living with disability; people with neurodiversity; older adults; and others.

The use of virtual care may bring health care professionals into contact with people or communities whose unique cultural contexts, intersectional identities, or social determinants of health they are unfamiliar with. It is important for health care professionals to consider each person's specific needs and preferences and to make appropriate modifications, when needed and when possible, to support people's access to care.

Potential considerations to be mindful of include but are not limited to the following:

- Access to health care
- Age

- Cultural and religious influences
- Digital literacy and digital equity
- Education
- Experiences of systemic racism and other forms of discrimination
- Financial barriers, poverty, and other socioeconomic factors, including access to technology
- Housing and safety
- Internet connectivity
- Language (e.g., Francophone)
- Level of trust with health care professionals
- Personal assumptions and biases
- Privacy and confidentiality

Further evidence is required to better understand the gaps and needs of equity-deserving and underserviced populations as they relate to seeking and accessing care for depression and anxiety-related conditions.

Stigma

Stigma may be an area of concern regardless of care modality (i.e., whether in-person or virtual), as people receiving care, families, and caregivers can experience stigma in various ways. The use of virtual care may help address the perceived stigma of seeking care for depression and anxiety-related conditions and in certain situations may promote engagement in care.[15,16]

Potential Risks in a Virtual Context

A 2023 scoping review examined adverse events, risks, and mitigation strategies when delivering virtual mental health services.[17] The unique risks in a virtual context identified in this review included attrition, dropouts, and treatment adherence, as well as privacy and confidentiality. Risks may arise due to various factors, including "the health condition, the mental health care itself, or risks may be due to the modality (i.e., unique due to virtual care) or a combination of these."[17] The review concluded that virtual modalities are a safe way of providing mental health care, even for high-risk patients or clients.[17] While virtual care presents additional considerations for managing safety and potential risks, there is general alignment with what would typically be done for in-person care.[17]

Attrition, Dropouts, and Treatment Adherence

Attrition and dropouts have been cited as areas of concern in the delivery of virtual mental health care.[17] A study conducted in Ontario found that compared with in-person groups, videoconference groups for anxiety and related disorders had slightly higher rates of attendance in some cases, "with functional improvement and treatment dropout rates being comparable across the delivery formats."[15] Further, it has been suggested that virtual care may be more convenient than in-person care for certain people, which may improve adherence to the treatment program.[15]

Privacy and Confidentiality

Health care professionals consider privacy and confidentiality including but not limited to the person receiving care being in a safe, private location; discussing with the person receiving care measures that can be employed to protect the person's privacy (e.g., using headphones, password-protected devices, using a private and trusted internet connection, encryption programs); obtaining consent from the person; and ensuring awareness of the different risks to confidentiality when using different modalities.[18,19]

Potential Risks for People Receiving Care in a Virtual Context

Safety for people receiving care in a virtual context encompasses the objective of minimizing preventable harm to people receiving care and to health care professionals during virtual care encounters. It is also important that virtual care offerings are culturally safe and accessible to individuals from marginalized populations while adhering to the required standards of safety, privacy, and security.[7]

An important component of both in-person and virtual care for depression and anxiety-related conditions is the appropriate assessment and management of the risks of self-harm behaviours and suicide.[20] When delivering care virtually, it may be necessary to ensure a plan is in place for how to proceed should technical issues arise. People receiving care are informed of situations in which local emergency authorities may need to be contacted.[10] To the best of their ability, health care professionals are aware of the location of the person receiving care during a virtual care session, and they have the person's emergency contact information. Familiarity with applicable laws and legislation (e.g., duty to call child protective services, when to call police) and the nearest local resources capable of managing emergencies or crisis situations (e.g., nursing station, emergency services, crisis lines, hospitals) are also important considerations. Additional considerations may include awareness of comorbid conditions (e.g., substance use) and assessing for risks (e.g., suicidal and/or homicidal risk assessments, child protection risks).[21]

Guidance/Recommendations

The following guidance statements have been reviewed, discussed, and agreed upon by the expert panel and are current as of June 8, 2023.

These guidance statements assume the understanding that the standard of care provided in virtual care for depression and anxiety-related conditions should be no different from that provided in in-person care.[22] All references to virtual care for depression and anxiety-related conditions refer to clinically appropriate care that is safe, timely, inclusive, equitable, private, confidential, evidence-based, and person-centred, with family or caregiver involvement as appropriate.

1. Planning Virtual Care for Depression and Anxiety-Related Conditions

A. Health Care Professional Knowledge and Ability

1. Before offering virtual care for depression and/or anxiety-related conditions, the health care professional assesses their competence, limits, risks, and readiness to deliver virtual care[10]
2. The health care professional keeps informed of emerging evidence as it relates to the virtual care modality being used or considered in their particular clinical context and with consideration of the potential benefits, limitations, and challenges of other care modalities, including both virtual and in-person

B. Informing the Method of Care Delivery

1. The health care professional assesses the utility, feasibility, and effectiveness of virtual care in the context of comorbid physical, substance use, or other mental health conditions that may be present
2. When considering virtual care modalities, the health care professional considers the preferences of the person receiving care (and those of family members or caregivers as appropriate), feasibility, and the clinical context
3. The health care professional discusses and considers the specific needs and preferences of the person receiving care and makes appropriate modifications when needed and when possible – especially when they are unfamiliar with the unique cultural contexts, intersectional identities, or social determinants of health of the people or communities with whom they are working – to support access and minimize barriers to care and to create a culturally safe digital space
4. When choosing the best method of care delivery with a person (and with their family members or caregivers as appropriate), the health care professional considers stigma in the discussion, keeping in mind that what may create stigma for a person can vary based on several factors (including but not limited to past experiences, sense of cultural safety, and intersectional identities)
5. The health care professional is familiar with applicable laws and legislation (e.g., duty to call child protective services, when to call police) and the nearest local resources capable of managing emergencies or crisis situations (e.g., nursing station, emergency services, crisis lines, hospitals) in the event that an emergency or crisis arises during a virtual session
6. The health care professional collaboratively discusses with the person receiving care (and with their family members or caregivers as appropriate) privacy and confidentiality considerations as they pertain to the virtual modality being used and measures that can be employed to support privacy and confidentiality

C. Ongoing Assessment of the Virtual Care Offering

1. As with the ongoing assessment of the appropriateness and effectiveness of in-person care, the health care professional assesses the degree to which the use of the virtual care offering meets the needs of the person receiving care and whether this care is resulting in the intended outcomes, and the health care professional discusses this with the person
2. The health care professional discusses the virtual care modality with the person receiving care over the course of the therapeutic relationship or care plan and addresses any changes in preference as appropriate, as preferences may change over time[6]

D. Ongoing Assessment and Management of Potential Risks

1. The health care professional assesses and manages the potential safety, privacy, and confidentiality risks of providing virtual care to the best of their ability and within the scope of their professional regulatory body
2. The health care professional and the person receiving care (and their family members or caregivers as appropriate) discuss potential technical challenges and make a plan for how to proceed in the event of a session disruption
3. The health care professional is familiar with the location of the person receiving care and the emergency or crisis resources nearest to them. The person receiving care (and their family members or caregivers as appropriate) is informed of the types of situations in which emergency authorities may need to be contacted

2. Delivering Virtual Care for Depression and Anxiety-Related Conditions

A. Documenting Virtual Care Encounters

1. The health care professional documents their virtual care encounters as instructed by their organizational policies and/or professional college(s) in the jurisdiction(s) in which they are regulated and in the jurisdiction in which the person receiving care is located
2. Documentation considerations in the context of virtual care may include referencing the technology used, the location of the person receiving care during sessions, and discussions of privacy and confidentiality
3. As with in-person care, the health care professional adheres to standards pertaining to informed consent, privacy and confidentiality, and documentation when delivering virtual care[18]

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Partner Engagement

Ontario Health conducted one or more meetings with the following groups during the development of this guidance:

- Addictions & Mental Health Ontario
- Canadian Mental Health Association, Ontario
- Knowledge Institute on Child and Youth Mental Health and Addictions
- Youth Wellness Hubs Ontario

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Additional Resources

- *Clinician Change Virtual Care Toolkit* (Canada Health Infoway and Healthcare Excellence Canada, 2022)
- *CPA Guidelines on Telepsychology* (Canadian Psychological Association, 2023)
- *Culturally Safe Engagement: What Matters to Indigenous Patient Partners? Companion Guide* (BC Patient Safety & Quality Council, 2022)
- Enhancing Equitable Access to Virtual Care in Canada: Principle-Based Recommendations for Equity (Government of Canada, 2021)
- *Virtual Care Handbook for Residents and Faculty* (University of Toronto Department of Psychiatry, 2021)
- Virtual Visits Verification Standard (Ontario Health, 2021)