Title

The effectiveness of telehealth in providing care to people with depression: a critical commentary

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Abstract

The growth in the prevalence of mental health conditions has put further pressure on health and social care services. Although digital technologies are seen as a solution to the challenges faced, uncertainty remains as to their effectiveness. This article critically appraises and evaluates a systematic review that compares the effectiveness of telehealth with face-to-face in-person provision of care for people with depression.

Keywords

Mental health, depression, digital technologies, telehealth, systematic review

Key Points

- The occurrence of mental health difficulties continues to grow, worsened by the effects of global events (e.g. COVID19 pandemic).
- With health and social care services facing unprecedented challenges in providing services within constrained budgets, such additional pressures necessitate difficult decisions concerning the provision of care.
- Digital technologies, including remote access through telehealth, may provide an option that benefits patients, practitioners and the wider NHS and social care service.

CPD reflective questions

- What factors may limit the generalisability of the findings to the provision of care?
- Is the evidence presented compelling in terms of any benefits in managing mental health conditions, whether considering the severity of the condition or a person's quality of life?
- What other evidence would you consider important in deciding whether to implement a change in the provision of the service?

Introduction

Health and social care services continue to face unprecedented challenges (Cooksley et al., 2023; Ham, 2020; Woolnough, 2024). Increasing demands from an ageing population with long-term chronic conditions, the occurrence of new diseases (e.g. COVID19), the emergence of new high-cost health technologies, constrained funding, and growing workforce challenges, necessitate difficult decisions concerning the provision of care (Nuffield Trust, 2024; Rawlins, 1999; Smeeth et al, 2024; The Health Foundation, 2022). The potential benefits of digital technologies have long been

recognised (National Institute for Health and Care Excellence, 2024). It is thought they provide greater convenience, may decrease the inaccessibility of standard care, reduce the number of appointments required and allow the health service to lower its costs (National Institute for Health and Care Excellence, 2021). With the prevalence of mental difficulties, such as depression, continuing to rise above pre-COVID19 pandemic levels, mental health services are looking at innovative ways to manage the increased pressures (Budd et al., 2022; NHS Digital, 2016; Office for National Statistics, 2022). Digital technologies may provide an option to help manage the growing need and demand for mental health services (Li, 2023). Telehealth, a form of digital technology used to deliver care remotely, has been identified as an alternative to in-person, face-to-face care, reducing the possible burdens placed on both the patient and the health service itself (Joshi and Welch, 2024). Although such technologies have continued to evolve and their use grow, some uncertainties remain as to whether they are as effective as usual care (Bulkes et al., 2022; García-Lizana and Muñoz-Mayorga I, 2010). The systematic review by Scott et al (2022) aims to provide an evidence base to assess the effectiveness of telehealth for managing depression.

Aims of the commentary

This commentary critically appraises the methods used within the review by Scott et al (2022) and expand upon the findings in the context of implementing within practice.

Methods

The methods for the systematic review by Scott et al (2022) were outlined in an unpublished protocol, with the review reported following the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) statement. Studies were identified through searches of Medline, Embase and Cochrane CENTRAL (inception to 18 November 2020), backwards and forwards citation analysis in Web of Science (6th January 2021) and searches of clinicaltrials.gov and WHO ICTRP (25th

March 2021). There were no restrictions on language or date of publication, with abstracts included if sufficient details of methods and results were provided. Randomised controlled trials (RCTs) comparing standard care provided via telehealth (i.e. video, telephone or a combination of both), to identical or very similar care (i.e. in terms of provider, frequency, setting and duration) delivered by face-to-face (in-person) format were included. Services had to be provided in a primary care setting by general practitioners (GPs), primary care/community nurses or allied health professionals (e.g. psychologists or counsellors) as single or multiple care visits. Care would be provided to people of any age or gender receiving care for chronic and symptomatic depressive disorder, regardless of formal diagnosis, severity, duration, or comorbidities. Depression severity using symptom severity scales (e.g. Patient Health Questionnaire-9 (PHQ-9), Hamilton Rating Scale (HAMD) and Beck Depression Inventory (BDI-II)) was the primary outcome, with quality of life, therapeutic alliance between client and health provider and satisfaction with care (patient, caregiver and/or care provider) secondary outcomes. Screening of studies for inclusion (i.e. titles and abstracts and full papers of selected papers) was undertaken by paired authors. Data were extracted, and risk of bias was assessed using the Cochrane Collaboration Risk of Bias tool 1.0, independently by two authors. Any disagreements at each stage were resolved through consensus or adjudication by a third author. Studies were synthesised narratively and where appropriate through meta-analyses. Pooling of continuous outcomes were synthesised using mean (MD) or standardised mean difference (SMD) and a random effects model. Sub-group analyses were conducted by time-point at which depression severity was reported. Heterogeneity was assessed using the I^2 statistic.

Results

Nine parallel RCTs conducted in the USA were included in the qualitative synthesis by Scott et al (2022), with seven RCTs in the meta-analysis. RCTs were predominantly among adults (two RCTs in children or youth), evaluated cognitive and/or behavioural therapy and compared telephone (four

RCTs) or video (five RCTs) to face-to-face delivery. Sessions were delivered once or twice a week for up to 18 weeks, with follow-up from none to 18 weeks. Outcome scales included nine self-reported, one clinician reported and one was unclear. Risk of bias was considered generally low or unclear, although blinding of participants and personnel of all RCTs was at high risk, allocation concealment was unclear for most RCTs and attrition bias was high for half the RCTs.

Six of the nine RCTs reporting depression severity were included in meta-analyses by Scott et al (2022), showing no statistically or clinically significant differences between telehealth and face-to-face in-person care immediately (SMD -0.04; 95% CI -0.21, 0.13; p=0.67; I^2=0%), at 3 months (SMD 0.10; 95% CI: -0.08, 0.28; p=0.27; I^2=0%) or at 6 months (SMD 0.05; -0.56, 0.66; p=0.86; I^2=87%) after treatment. A significant comparative benefit was reported by one RCT at 9 months post-treatment that favoured telehealth (SMD -0.39; 95% CI: -0.75, -0.02, p=0.04). Of the three RCTs not included in the meta-analysis, one RCT showed no significant difference on BDI-II at 3 months (MD-3.72; 90% CI -13.86, 6.41) and at 12 months (MD 1.05%, 90% CI: -8.3%, 10.41%) post-intervention. Two studies, a feasibility study and a post-hoc analysis, reported the effects pre- and post-intervention on the Children's Depression Inventory (CDI). The former showed no significant difference between telehealth and in-person care on depression severity, and the latter reported a statistically significant benefit for telehealth and in-person combined.

One RCT showed that following treatment there was no statistically significant difference between telehealth and face-to-face in-person care on a patient's quality of life (Short-Form 36 scores) at 3- and 12- months. In another RCT the therapeutic alliance for both patients and therapists, assessed using the Working Alliance Inventory Short Form, did not differ at 4 or 14 weeks between the interventions. Similarly, two RCTs found no significant difference in treatment satisfaction immediately after (SMD -0.14; 95%CI: -0.56, 0.28, p=0.51), at 3- (SMD -0.18; 95%CI: -0.46, 0.09,

p=0.19) and 12-months (SMD -0.05; 95%CI: -0.33, 0.22, p=0.71) post treatment, with a third RCT reporting that telemedicine was considered as good as face-to-face care parents and children.

Commentary

The continued growth in the occurrence of mental health conditions, exacerbated by the COVID-19 pandemic, has further increased pressures on health and social care services (Budd et al., 2022; NHS Digital, 2016; Office for National Statistics, 2022). With a focus on identifying alternative approaches to delivering services, the benefits of digital technologies have been explored (Li, 2023). Telehealth, including telephone and video, has received attention, potentially overcoming limitations associated with attending appointments in-person (Joshi and Welch, 2024). The systematic review by Scott et al (2022) found evidence of moderate certainty that telehealth is as good as face-to-face in-person appointments on measures of depressive symptom severity up to 3-months follow-up. More limited low to very low certainty evidence showed that it may be as, or more, effective on measures of depressive symptom severity up to 12-months follow-up, as well as on a person's quality of life, therapeutic alliance and treatment satisfaction.

Assessment of the quality of the systematic review

Using the AMSTAR2 critical appraisal tool (Shea et al., 2017), it was evident that there was an overall low confidence in the results of the systematic review (Table 1). Although it appeared to have two critical flaws (i.e. specifically not accounting for risk of bias when discussing study results and assessing publication bias) and should be graded as critically low, with only nine studies formal assessment of publication bias was inappropriate resulting in a revised grading of low confidence. The review was affected by three non-critical weaknesses, lacking explanation of its focus on RCTs, its inclusion of RCTs at risk of bias in some of its meta-analyses and limited consideration of the effects of heterogeneity. Also, there was a failure to publish or register its protocol and contact was not made with experts as part of the search strategy. Despite these apparent limitations, it was

thought that their effects would be limited, with guidance indicating a low overall confidence rating (Shea et al., 2017).

Application to practice

The effectiveness of telehealth compared to face-to-face in-person approaches to managing depression reported by Scott et al (2022) concur with those of other systematic reviews. In most instances the evidence in the systematic reviews was considered of low to moderate risk of bias (Palylyk-Colwell and Argáez, 2018; Schiller et al., 2023; Shih et al., 2023; Wu et al., 2024; Yin-Hwa et al, 2023; Zheng Z et al., 2023), it explored a range of telehealth (or virtual) technologies in people experiencing different health conditions, comparing them to active and non-active interventions delivered by different parts of the health service. Telehealth was shown to be comparable to, and on occasions more effective than, similar active and non-active interventions on the severity of depressive symptoms (Chen et al., 2024; Guaiana et al, 2021; Palylyk-Colwell and Argáez, 2018; Schiller et al., 2023; Shaker et al., 2023; Shih et al., 2023; Yin-Hwa et al., 2023; Zheng et al., 2023; Wu et al.,2024). Although evidence was often limited, reviews reported improvements in quality of life and in satisfaction with telehealth (Shih et al., 2023; Yin-Hwa et al., 2023; Zheng et al., 2023). A systematic review indicated that telehealth could be cost-effective given reduced travel costs for patients, despite initial increased costs associated with establishing telehealth services (Guaiana et al., 2021). Limited new evidence has emerged since the systematic review by Scott et al (2022), with any new RCTs not directly comparable as they assess different telehealth interventions with a range of comparators in various care settings. Despite these differences, their findings concurred with those reported by Scott et al (2022), showing that telehealth appears to be as good as various face-to-face interventions in treating symptoms of depression (Haun et al., 2024; Kishimoto et al., 2024).

Although further research is necessary to address the limitations in the evidence-base, it appears that telehealth is a viable alternative that should be considered for people with depression. It may help to improve access, particularly for people living in remote areas, reduce non-attendance at appointments and help with managing conditions effectively. Such changes could be beneficial to managing waiting lists and allow resources to be used more effectively. Importantly, it promotes patient choice (Haleem et al., 2021). Some service-users may prefer to access care from the comfort and safety of their own home. Others may find remote access through telehealth challenging, which may be due to issues around accessing and using the technology or through finding it too distancing and preferring in-person contact (Ftouni et al., 2022). Some issues may arise around managing the therapeutic environment (e.g. possible interruptions) and maintaining confidentiality, which may be easier to control in an in-person setting (Houser et al., 2023). Whichever option is chosen, it appears that there should be no significant loss of effectiveness in managing depression symptoms, which should be reassuring to both practitioners and those receiving therapy. Issues have been identified around uncertainties in funding digital technologies and the misalignment of local and national priorities that may affect their implementation, which need clarification (Eddison, 2022; NHS England, 2021).

Further research

The generalisability of the findings are more limited in certain respects. Most RCTs were conducted in the US health care system and there were uncertainties as to whether geographical location (i.e. rural vs urban) and population age groups were appropriately represented. It's likely that people in rural locations and the elderly may benefit in different ways from others. Importantly, the effects of comorbidities and other interventions used by patients were not clearly outlined, which may impact on prognosis, efficacy, appropriateness and satisfaction. Further RCTs should consider the clinical- and cost-effectiveness of different types of telehealth using various platforms over the long duration of follow-up. The RCTs should: be within different jurisdictions (i.e. service structure and funding)

and forms of provision (i.e. primary, secondary and tertiary); look at rural and urban settings; consider different participants in terms of their characteristics (e.g. age groups, sex, comorbidities), conditions and co-interventions; and, assess a person's quality of life and treatment satisfaction. The funding of digital technologies and reimbursement of services should also be considered. With increasing use of digital technologies during the COVID19 pandemic, it is likely that studies are on-going and these should be incorporated in updated living systematic reviews.

Conclusion

Moderate certainty evidence indicates that telehealth may provide an alternative option for managing depressive symptoms that is as good as in-person appointments, providing benefit to patients, practitioners and health and social care services. Further research is required to identify which people, with which mental health conditions, receiving care from different settings would benefit most in terms of effectiveness and cost-effectiveness.

Table 1 Critical appraisal of the systematic review by Scott et al (2022) using the AMSTAR-2 tool for assessing systematic reviews (Shea BJ et al., 2017)

AMSTAR 2 items	Responses
Did the research questions and inclusion criteria for the review include the components of PICO?	**Yes** – it is clear that the components of PICO were reported, although the timeframe for follow-up was not stated.
Did the report of the review contain an explicit statement that the review methods were established prior to the conduct of the review and did the report justify any significant deviations from the protocol?	**Partial Yes –** The author stated that they had a written protocol, however there was no evidence that it had been registered.
Did the review authors explain their selection of the study designs for inclusion in the review?	**No –** It was briefly mentioned that RCTs were included. Although no explanation was provided as to why RCTs were selected these are a robust design when undertaken appropriately and should not introduce bias.
Did the review authors use a comprehensive literature search strategy?	**Partial yes** – It was evident that no experts in the field consulted and there is no evidence of search for grey literature.

Did the review authors perform the study selection in duplicate?	**Yes** – paired review authors independently screened titles and abstracts, as well as full-texts of manuscripts. Any disagreements were resolved by discussion or adjudication by a third author.
Did the review authors perform data extraction in duplicate?	**Yes** – two authors independently extracted data. Discrepancies were resolved by consensus or adjudication by a third author.
Did the review authors provide a list of excluded studies and justify the exclusions?	**Yes** – references excluded at full-text screening and reasons for exclusion were provided in an online appendix.
Did the review authors describe the included studies in adequate details?	**Partial Yes** – No justification of the population included.
Did the review authors use a satisfactory technique for assessing the risk of bias in the individual studies that were included in the review?	**Yes** – two authors independently assessed the risk of bias for each included study using the Cochrane Risk of Bias Tool 1.0.
Did the review authors report on the sources of funding for the studies included in the review?	**Yes** – the authors state that they assessed individual study conflicts of interest and funding using the Cochrane Risk of Bias under the 'other sources of bias' domain.
If meta-analysis was performed did the review	**Yes** - the mean difference or standardised mean difference was calculated for continuous

authors use appropriate methods for statistical combination of results?	outcomes, using random effects models. Sub-group and sensitivity analyses were planned a priori.
If meta-analysis was performed did the review authors assess the potential impact of RoB in individual studies on the results of the meta-analysis or other evidence synthesis?	**No –** There is mention of unclear bias, however there is no evidence that the authors have performed analyses to investigate the impact of ROB on summary estimates of effect.
Did the review authors account for RoB in individual studies when interpreting/ discussing the results of the review?	**No** – No evidence of discussion of the likely impact of RoB on the results.
Did the review authors provide a satisfactory explanation for and discussion of, any heterogeneity observed in the results of the review?	**No** – The authors presented I^2 statistics, with only the 6-month post-treatment results showing considerable heterogeneity. No other discussion is undertaken.
If they performed quantitative synthesis did the review authors carry out an adequate investigation of publication	**No –** No funnel plot was produced due to insufficient studies and no discussion.

bias (small study bias) and discuss its likely impact on the results of the review?	
Did the review authors report any potential sources of conflict of interest, including any funding they received for conducting the review?	**Yes** – the authors identify the Department of Health, Canberra, Australia as the funder and that they were only involved in establishing the PICO criteria for the review. The authors report no other actual or potential conflicts.

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