

B: Digital technologies and telepsychiatry – full guidance.

| Clinical question | Guidance |
|--|---|
| 1. Background to telepsychiatry and what we know already | |
| <p>1a. What are the differences between telehealth, telemedicine and telepsychiatry?</p> <p>[link1] [link2]</p> | <p>Telehealth is the delivery of health care from a distance using technologies such as telephone, email, computer, interactive video, digital imaging, and health care monitoring devices. It is a broad term that covers many different types of healthcare including not only clinical but also non-clinical medical services such as education, research, and administrative functions. For example, surfing the Internet for information about cancer, telephoning a nurse hotline, emailing a physician, and sending data from a heart monitor via the telephone to a cardiologist are all applications of telehealth.</p> <p>Telemedicine is a subset of telehealth. It includes many medical subspecialties, e.g. telepaediatrics, telepsychiatry, teleradiology and telecardiology. It describes the use of technology to provide clinical medical services when the healthcare provider and patient are separated by a geographic distance.</p> <p>Telepsychiatry is a subspecialty of telemedicine and includes psychiatric assessments or follow-up interviews conducted using telephone calls, audio and video digital platforms.</p> |
| <p>1b. Is telepsychiatry a new skill and what do we know about it?</p> <p>[link3]</p> | <ul style="list-style-type: none"> • Videoconferencing in psychiatry began during the 1950s. • By the 2000s, it was seen as effective as, but slightly different from, in-person care, and research in outcome studies provided a platform for practice guidelines (e.g. the American Telemedicine Association In the US). It has been applied successfully to many cultures and international settings. • Telepsychiatry is equivalent to in-person care in diagnostic accuracy, treatment effectiveness, and patient satisfaction; it often saves time, money, and other resources. • Patient privacy and confidentiality issues parallel in-person care. • Telepsychiatry uses specialty expertise effectively, which facilitates patient-centred and integrated care. |
| <p>1c. What is the evidence supporting telepsychiatry?</p> <p>[link4]</p> | <p>The evidence base is substantial, and outcomes have been measured as follows (refer to this document for further details):</p> <ul style="list-style-type: none"> • Feasibility rating: outstanding (based on satisfaction and usability). Technical issues are rare and usually related to low bandwidth. • Validity rating: outstanding. In comparison to in person treatment, the clinician can provide the majority of usual medical services with only minor exceptions, which can often be delivered by a staff or family member if needed. • Reliability rating: outstanding. Diagnoses have been made with good inter-rater reliability for a wide range of psychiatric disorders in patients of all ages. |

- **Satisfaction rating: outstanding among patients, psychiatrists, and other professionals** and in all clinical services, populations, and contexts.
- **Cost and cost-effectiveness rating: similar to in person or better.** Descriptive studies indicate savings in time, travel, and money to patients and providers.
- **Clinical measures:**
 - **Interviewing, assessment, cognitive testing, and others: outstanding.** Dozens of clinician scales have been shown as reliable and valid.
 - **Disorders include depression, anxiety, psychosis, substance misuse, cognitive/attentional/behavioural (assistance for those with learning disabilities or dementia), personality/behavioural, and many others: outstanding.**
 - Settings well-studied include **outpatient, primary care/medical: outstanding.** Settings less well studied include **Accident and Emergency (A and E), prisons, inpatient units and schools: similar to in-person care.**

Good outcomes are dependent on **high quality clinicians, organisation** (including leadership, clinical, technical, and administrative teamwork) and **technology** which allows good engagement, clarity, and is reliable.

1d. Are there any settings where telepsychiatry might be better than in person care?

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- For children and adolescents on the autistic spectrum, telepsychiatry may be preferable to in-person contact.
- For adults with disabling anxiety, telepsychiatry is preferred (and often coupled with telephone and e-mail options).

A growing body of evidence suggests that telepsychiatry may have **significant added value** compared to psychiatric services delivered in traditional settings:

- **Telepsychiatry used in A and E can improve liaison with outpatient mental health services** as well as access to care.
- **Telepsychiatry in A and E may reduce transportation costs, inpatient and A and E utilisation, and overall hospital costs.**
- **Telepsychiatry within primary care settings and specialty care clinics** has shown substantial benefit to patients' overall health status.
- Telepsychiatry can also improve care **within prisons and nursing homes.**

Use of telepsychiatry in public health emergencies:

- Previous work (before the COVID-19 pandemic) has described **effective strategies for using telemedicine in disasters and public health emergencies.**
- **In some countries such as Italy during the COVID-19 pandemic, provisions for telepsychiatry have rapidly been made available in some, but not all, areas** (see [this document](#) for further details).
- **Consider using telemedicine as a strategy for health care surge control using "forward triage"** to sort patients before they arrive in A and E or at the hospital (and reduce the number who need to be seen in person).
- **Respiratory symptoms (as an indicator of early signs of COVID-19) can be evaluated by telemedicine along with detailed travel and exposure histories. Automated screening algorithms** can be built in with local epidemiological information to standardise screening and practice patterns. For example, more than 50 U.S. health systems already have such programmes, which could be adopted for use during the current pandemic.

1e. What treatment modalities can I use in telepsychiatry?

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- Telepsychiatric interventions have demonstrated clinical utility **within a variety of treatment modalities, including group, individual, and family therapies.**
- Modalities using evidence-based treatments have yielded positive outcomes. Such treatment approaches include **CBT, IPT, Exposure Therapy, Psychodynamic Psychotherapy, and DBT.**

- **Evidence-based pharmacological interventions** can be prescribed electronically after appropriate assessments are completed via telepsychiatry.

2. Guidelines and Information governance on telemedicine and telepsychiatry

2a. Are there guidelines I should be aware of?

UK

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RCPsych ([COVID-19 guidance](#)):

- During the COVID-19 pandemic, **remote consultations should be encouraged where safe and appropriate.**
- Ideally remote consultation should be **an adjunct to, rather than a substitute for, face-to-face consultation**, but this may not be possible in the current situation.
- For **initial consultations** (where the patient and clinician are unknown to each other), **remote consultations may be even more challenging, but should go ahead where possible.**
- Clinicians and professionals should **show sensitivity to the patient's comfort level with technology** and determine early in the consultation what objectives can be reliably achieved.
- Those with lack of digital literacy or no access to digital platforms **must not be disadvantaged**, nor should those who are unconfident about using the technology.
- **Use of telephone consultations may be sufficient** for lower risk conversations or to ensure engagement with those who lack digital technology or skills.

RCPsych and PIPSIG (Private and independent practice special interest group of the RCPsych) guidelines ([general guidance on telepsychiatry](#)):

- A qualified doctor is required to **deliver safe, ethical care.**
- The **standards expected of doctors by the GMC apply equally to digital and conventional consultation settings.**
- Consideration should be given to **any potential limitations** of the medium used: GMC guidance is that **a doctor MUST satisfy her/himself that they can undertake an adequate assessment, establish dialogue with the patient and obtain the patient's consent, including consent to the remote consultation process.**
- Consider the **security of the system used** (see section 2b below).
- **Consent:** Although it could be assumed that provision of contact details etc. by the patient provides implicit consent, **explicit consent should also be sought.** Include the **right to withdraw from the process at any time.** If the consultation is **recorded, consent is essential** and a GMC requirement.
- **Legal issues:**
 - **Consider the limitations** of telepsychiatry including those around physical examination.
 - **The GMC does not permit disclaimers regarding the quality of a consultation:** you must be satisfied that you have been able to undertake an adequate assessment and have adequate knowledge of the patient's health at the conclusion of the assessment.
 - You **may not be indemnified if you are consulting with or prescribing for patients who are not in the UK.**
- **General areas to consider:**
 - Remote video consultation **may not be suitable for everyone.**
 - **When telepsychiatry would be used**, e.g. should the first consultation be face-to-face.
 - **How will you assess suitability of the client** for telepsychiatric consultation?
 - **How will you assess suitability of the equipment** used in terms of video and sound quality?

- How often **suitability would be re-assessed**.
- **Consider patient safety**. Discuss and agree on supplying the contact information of a family or community member if needed.
- Whether you are **indemnified**.
- **Confidentiality issues**.
- The **right of the patient to withdraw** from teleconsultations at any time.
- The **taking and storage of clinical notes and correspondence**.

GMC ([general guidance](#)):

Ensure that the medium you are using does not affect your ability to follow the law and our guidance. Consent and continuity of care are key issues to remember when you are advising or prescribing treatment for a patient via remote consultation.

Consent:

- **Give patients information about all the options available to them** (including the option not to treat) in a way they can understand.
- **Tailor the information you give**, and the way you give it, to patients' individual needs, and **check that they've understood it**. If you're not sure a patient has all the information they want and need, or that they've understood it, consider whether it is safe to provide treatment and whether you have valid consent.
- You must **ensure you can assess a patient's capacity**. If a patient lacks capacity to make a decision, consider whether remote consultation is appropriate, including whether you can meet the requirements of mental capacity law.

Continuity of care:

- **Ask the patient for consent to get information and a history from their GP and to send details of any treatment plan**.
- **If the patient refuses**, explore their reasons and explain the potential impact of their decision on their continuing care.
- **If the patient continues to refuse**, consider whether it is safe to provide treatment.
- **Make a record of your decision and be prepared to explain and justify it if asked to do so**.

If you are providing services remotely, remember to:

- **Follow GMC guidance on consent and good practice in prescribing**.
- **Work within your competence**.
- **Check you have adequate indemnity cover** for your remote consultation activities.
- Discuss this element of your practice **with your responsible officer at appraisal**.

Face to face treatment may be preferable when:

- The patient has **complex needs or is requesting higher risk treatment**.
- You **do not have access to the patient's medical records**.
- You **don't have a safe system in place to prescribe**.
- You **need to complete a physical examination** (see section 4c for possible modifications in remote assessment).
- You **can't give the patient all the information** they want or need to decide about treatment via remote means.
- You are **unsure about the patient's capacity** to decide treatment.

NICE ([COVID-19 rapid guideline](#): managing symptoms (including at the end of life) in the community):

Minimise face-to-face contact by:

- offering telephone/video consultations (see [BMJ guidance on Covid-19: a remote assessment in primary care](#) for a useful guide including a [visual summary for remote consultations](#)).
- reducing non-essential face-to-face follow up.
- using electronic prescriptions.
- using different methods to deliver medicines to patients, e.g. pharmacy deliveries, postal services, NHS volunteers, drive-through pick-up points.

(NHS England) have [general guidance on video consultation information for NHS Trusts and Foundation Trusts](#). Further resources are at <https://www.phc.ox.ac.uk/research/resources/video-consulting-in-the-nhs>.

The advice covers general NHS and GP practices and so is not mental health specific but covers how you can prepare your patient (see also section 3a for more details) and yourself as a clinician (see also section 3b) for a successful video meeting.

UK guidance on remote prescribing:

- Follow [GMC guidance on prescribing](#).
- Follow UK legislation on prescribing (Human Medicines Regulations 2012 part 12, Chapter 2 Sale and Supply of medicines describes the legislation for prescribing, including prescribing electronically (section 219), see [this document](#) for further details).
- Follow local guidance for remote prescribing (see [this document](#) for an example of the advice from Oxford Health NHS Foundation Trust).
- Additional prescription requirements may be required for certain drugs e.g. controlled drugs.
- Consider other licensing restrictions that may influence how prescribing is completed (e.g. clozapine may be dispensed from specific dispensaries only).

USA

FSMB (Federation of State Medical Boards) (provides [general guidance](#) on licensing and payment regulations which differ across states in the USA):

- 49 state boards (plus the medical boards of District of Columbia, Puerto Rico, and the Virgin Islands) require physicians engaged in telemedicine to be licensed in the state in which the patient is located.
- 12 state boards issue a special purpose license, telemedicine license or certificate, or license to practice medicine across state lines to allow for the practice of telemedicine.
- 6 state boards require physicians to register if they wish to practice across state lines.
- Payment arrangements vary across states for telemedicine.

[This website](#) summarises USA legislation related to telemedicine in different states.

The FSMB has waived licensure requirements during COVID-19 – details for each state are contained [here](#).

CMS (Centers for Medicare & Medicaid Services) recently broadened access to Medicare telehealth services in the context of COVID-19 on a temporary and emergency basis.

Under this change, Medicare can pay for office, hospital, and other visits via telehealth across the country and including in patient's homes starting March 6, 2020, provided by doctors, nurses, clinical psychologists, and social workers. Prior to this change, Medicare could only pay for telehealth on a limited basis (e.g. in a designated rural area). Updates are provided [here](#).

American Psychiatric Association (Telepsychiatry): does not give specific guidance, but provides an extensive practical 'toolkit' of advice for general methods in telepsychiatry (not COVID-19 specific) (Sections are also referenced in relevant sections of this table).

CDC ([general guidance](#)):

Explore alternatives to face-to-face triage and visits. For example:

- Instruct patients to **use available advice lines, patient portals, on-line self-assessment tools, or to telephone staff** if they become ill with symptoms such as fever, cough, or shortness of breath.
- Identify staff to **conduct telephonic and telehealth interactions** with patients. **Develop protocols** so that staff can triage and assess patients quickly.
- Determine **algorithms to identify which patients can be managed by telephone** and advised to stay home, and which patients will need to be assessed in person.
- Patients **with respiratory symptoms must call before they leave home**, so staff can be prepared to care for them when they arrive.

American College of Physicians ([general guidance](#)):

Has produced an online course (open access without certificate) on the use of telemedicine, and also guidance on both video conferencing and telephone assessments with patients, including specific US advice.

Information for both patients and clinicians on provision of telemedicine and telehealth during COVID-19 is provided at <https://www.telehealth.hhs.gov/>

Singapore

Singapore Medical Association ([general guidance](#)):

- **Assess the patient's profile for suitability**, including age, education level, social support, functional abilities (including cognitive), technological capabilities and their comfort level and willingness to use this modality.
 - **Limitations of telemedicine should be explained** before consent to proceed.
 - **Recognise the challenges and limitations** in evaluating the patient's symptoms and conditions without a physical examination.
 - Take reasonable steps to **verify patient identity before proceeding and include the steps taken in clinical documentation**.
 - Take a **thorough and comprehensive history**.
 - Be reasonably confident that any physical examination of the patient is unlikely to add critical information that could change the opinion or course of clinical management.
 - Be aware of the **clinical "red flags"** which may trigger the need for a referral, an in-person consultation or urgent medical attention.
 - **Clinical documentation for tele-consultation should be maintained at the same standard** as an in-person consult.
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Canada

Royal College of Physicians and Surgeons of Canada has published [specific guidance for each province](#), and a guide to remote consultations at <http://www.royalcollege.ca/rcsite/documents/about/virtual-care-playbook-e.pdf>.

Australia and New Zealand

Resources and guidance are available on several websites: [RANZCP](#), [Government of New South Wales - Agency for Clinical Innovation](#), [NZ Telehealth](#), [Medical Council of New Zealand](#) and [Australian Government – Department of Health](#).

A practical guide to video consultations is available [here](#).

2b. What information governance issues should I consider?

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NHSX has published [pragmatic guidance on information governance issues during COVID-19](#).

This covers all areas including patients use of mobile devices in hospital, volunteers, the social care sector and using videoconferencing for communication between colleagues.

For communications between clinicians and patients:

- **Videoconferencing** to carry out consultations with patients and service users is encouraged.
- It is fine to use video conferencing tools such as Skype, WhatsApp, Facetime as well as commercial products designed specifically for this purpose.
- The **consent of the patient or service user is implied** when they accept the invite and enter the consultation.
- **Safeguard personal/confidential patient information** in the same way you would with any other consultation.
- **Public Health England strongly advise the use of remote access of NHS and essential services for anyone who is over 70 years old, has an underlying health condition or is pregnant.**

Further information is available at <https://www.bma.org.uk/advice-and-support/covid-19/adapting-to-covid/covid-19-video-consultations-and-homeworking>.

RCPsych and PIPSIG [suggest also](#) considering:

- Is the **application suitable for the purpose of a confidential psychiatric interview?**
- **Use a secure system**, ideally one which will link with electronic records.
- Have a **dedicated clinical account** if you use the platform socially as well as professionally.
- Make sure **both parties have the necessary technology**.
- Make sure **both parties have the skill to use the system**.
- Ask if an **advocate or carer is present**.
- **Take contact details early** in the proceedings, so that you can re-establish contact if the connections or technology fail.
- Agree **who will contact whom in the event of a lost connection**.
- **Consider the environment** beyond your video camera – avoid using the system outside an office, e.g. in your living room or bedroom.
- **Is there anyone else in the room** who cannot be seen (such as a student)? If so, introduce them and explain.

- **Does the patient have anyone else present in the room** (such as a relative/carer/advocate)? If so, allow them to introduce themselves and clarify the purpose of the interview with them. Ask them to move in front of the camera if they are taking part in the interview (otherwise they may not be audible).
- Consider the **volume of loudspeakers** and suggest that the patient does the same, emphasising confidentiality.
- Consider the **use of headphones**: they can look professional and emphasise that you are taking confidentiality seriously.

Your local IT training/support team can help.

Please also refer to [this document](#).

There are several features common across all platforms that are the gold standard for live videoconferencing in telepsychiatry (refer to these documents on [software requirements](#) and [security issues](#) for further details)

:

- Use a **broadband internet connection** that, at minimum, has a transmission speed of **at least 5 MB** upload/download (Higher speeds might be required for newer technologies that use HD capabilities).
- Choose a software solution that is **compliant with your local and national guidance** (including HIPAA-compliant in the USA) as many popular, free products are not. Use a **secure, trusted platform** for videoconferencing.
- Make sure your **audio and video transmission is encrypted** (follow local and national guidance).
- Make sure your device uses **security features such as passphrases and two-factor authentication**. Your device preferably will not store any patient data locally, but if it must, it should be encrypted. In the USA, compliance with HIPAA (Health Insurance Portability and Accountability Act of 1996) is essential.
- Be sure your devices and software **use the latest security patches and updates**. **Install the latest antivirus, anti-malware, and firewall software** to your devices. If you're part of an institution with IT staff, they should **approve of and manage your device**.

(For further discussion of the issues around **recording video consultations**, see: https://www.youtube.com/watch?v=h-HAZ5H5_i8&feature=emb_title).

3. Tasks before the consultation

3a. What preparation should be made with the patient before the consultation?

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- **Ensure the patient has access to the technology they require, including internet access, as well as the skills to use it** – if an administrator is setting up the call they can check this and whether the patient has done video calls before with family members, do they order shopping online, book holidays online, or use internet banking?
- **Explain how the remote consultation will work**. The [RANZCP](#) have a webpage for patients and carers on remote psychiatry consultations during COVID-19, with information sheets at [https://www.ranzcp.org/files/resources/practice-resources/ranzcp-information-for-patients\(telepsychiatry\).aspx](https://www.ranzcp.org/files/resources/practice-resources/ranzcp-information-for-patients(telepsychiatry).aspx) and [https://www.ranzcp.org/files/resources/practice-resources/ranzcp-information-for-family-and-carers-\(telepsyc.aspx\)](https://www.ranzcp.org/files/resources/practice-resources/ranzcp-information-for-family-and-carers-(telepsyc.aspx)). A guide, FAQ sheet and videos for patients explaining video consultations in the NHS are available at <https://www.phc.ox.ac.uk/research/resources/video-consulting-in-the-nhs>.
- **Consider any problems with accessibility**, (e.g. hearing loss, difficulties with dexterity). If you can choose the platform which addresses these difficulties as well as possible. The patient using a headset may help depending on their needs.
- **Do they have a carer who can facilitate** the video consultation where they may have difficulties?
- Be aware of any generalisation about any specific group, so **consider on a case by case basis**, using your current understanding of the patient's needs and circumstances.
- Agree a **back-up plan** in case contact cannot be made in the first instance (e.g. who will call whom, landline or mobile number etc).

- Obtain **key details for risk management** (see section 4e for further details) including: phone number or other means of contacting the patient, their home address (to identify local services, or to send help in the event of imminent risk), existing mental health practitioner/s and/or GP details, other contacts such as informal carers if relevant.

3b. What should I do to prepare in advance?

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Acquire competence with the IT system you are planning to use:

- **Specific guidance** on the platform available to you in your organisation should be available through **your internal website or IT training team**.
- **Familiarise yourself** with the video consultation platform available to you, and ensure you understand what all the "buttons" or options do.
- **Test the use of the platform and its features with a colleague**.
- **Make a note of the features you might want to use** and have a summary sheet available to you in case you need to refer to it quickly.

Preparing your Computer/Device:

You can use almost any PC, Mac, or mobile device as long as it has a high-quality camera, microphone, speakers and strong internet connection.

1. It is best to **restart your computer every day** (or at least every few days) for it to run as efficiently as possible.
2. **Close any unnecessary programs and applications**. These take away from resources needed for your computer to run efficiently.
3. **"Edit" what is visible on your computer**, by exiting, or minimising, programmes not needed during your session especially if you plan to screen share. This will aid your navigation in-session and protect privacy.
4. **Prepare resources you may use during the session in advance** e.g. document-sharing or screen sharing functions. Upload your resources before your session, ideally in an easy to access folder.
5. **Consider disabling your email alerts and other notifications** to reduce distractions.
6. **Install recommended updates from sources you trust**, such as Microsoft and Apple. Keeping software up to date will help ensure the performance and compatibility of your device (remember to do this well in advance of the consultation as it may take some time, and also familiarise yourself with any changes in functions generated by the update).
7. Locate the volume control on your device. **You may need to adjust the volume or mute/unmute your speakers**. If possible, use a wired network connection instead of Wi-Fi to ensure the best connection possible.

Preparing your Environment:

- **Sit a comfortable distance from the camera** so your patient can see and hear you clearly.
- Sit in a location **without windows or bright lights behind you**.
- Place your device **on a table or desk facing you** to stabilise the camera and to prevent the speakers/microphone from being blocked. Do not hold your device during the visit.
- To keep background noise to a minimum, **close any doors and shut any windows**.
- **Set up your environment** to create a private and comforting space that the client will see behind you.
- **Check how your attire will work on screen** (dress professionally but also remember some cameras can have difficulty with striped or patterned clothing that can create some optical illusions).

4. During the consultation

4a. How should I start the consultation?

At the beginning of a video session with a patient, verify and document essential information, for example using the [prompts](#) below:

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[link25]
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1. Name of clinician and patient

e.g. "Hello, I am Dr AB. Am I speaking to Mrs CD? Is there anyone else in the room you want me to be aware of?"

2. Location of the patient

e.g. "Can you let me know where you are right now? It is important for me to know this before each session"

3. Immediate contact information for clinician and patient

e.g. "If we get cut off for any reason, how else I can I reach you? If there is an emergency, you can also reach me at ..."

4. Expectations about contact between sessions

e.g. "Although we are connecting in real time here and now, I want to review how we will communicate outside of these video visits. [Insert plan and note you cannot respond in real time outside of these visits]"

5. Emergency management plan between sessions

e.g. "Should an emergency happen between visits, the plan that we have made is for you to [Insert plan]"

Use a **prompt sheet if needed** to make sure you cover all these areas.

Useful summary/prompt sheets are available [here](#) and [here](#).

The College of Family Physicians of Canada has also produced a [brief guide](#).

4b. What should I try to do throughout the consultation?

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Communication

- Try to **allow as much non-verbal communication to be captured as possible**. Include your head, neck, upper body and arms in the video screen. Encourage your patient do the same.
- **Slow the rate of speech** to allow for problems with slow connections and **pause between sentences** longer than you might do face-to-face.
- **Use clear language** to ensure clarity of expression across the video call.
- **Look at the camera, not at the patient's eyes**. This will give the patient the impression of direct eye contact.
- **Use any features, such as a shared "white board" function, you are familiar with** to help with sharing of information.
- **Lighting and background are important** – plain, darker static/uncluttered background with light directly on your face may help, particularly where the connection is of lower quality.
- Where the patient is new to you - **take more time over the introduction and signpost what is going to happen next**.
- **Adjust your position before you start** and use a video system that includes an image of how you appear to the originating site.
- **Avoid looking away** from the camera.
- Be sure to **give ample time for a patient to hear your question or statements**.
- Be sure to **give ample time for a patient's reply**.
- **If taking notes** (electronically or writing) during the session, this will be obvious on the screen. Tell the patient you are doing this. Remember to resume eye contact and active listening. Keyboard noise can be very prominent when using a computer microphone, so using a separate headset microphone may be better. Screen sharing/ whiteboard functions can be used for making notes together with the patient.
- **Dealing with lag**: this is usually because of a lack of bandwidth. Upload speed is slower than download speed, so it is more noticeable to the other parties on the call. If you receive notifications about poor connectivity, check in with the patient about whether the quality is okay for them. Options include: reducing the quality of your video call (or moving to audio only), closing any other programmes using the Internet, switching to a different connection, slowing the pace of your conversation to reduce talking over one another, switching to your back-up plan.

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Contingencies

Have a clear understanding of what to do when the consultation is not going well for technical or clinical reasons:

- Have a **back-up plan for managing any technical difficulties** (e.g. loss of connection) and **provide this via email to the patient ahead of the session or in the first few minutes of the call**. Check you have the **right mobile telephone number to call them as a back-up**. Agree who will contact whom in the event of a lost connection.
- Brief the patient that **if you don't feel able to complete an adequate assessment you will discuss what steps to take next**. This will include reviewing the risks of a face to face contact in the current context and the delay in care that might result.
- Ideally **have this process mapped out in front of you** until you are familiar with it.
- **Practise the "script"** that you might want to use for managing contingencies and ensure that the description of how to manage the "what ifs" are clear.
- Make sure the technology (laptop, phone) is **charged or plugged in and advise, where possible, the patient does the same**. **If possible, have a back-up device available**.

Confidentiality

- **If the patient is new to you, verify they are the right person**, and check they are expecting the appointment **for their mental health**.
- **Check who is in the room with the patient** (such as a relative/carer/advocate), ask for them to be introduced to you, and if possible that they remain in view.
- **If the patient is in a public place**, consider with them whether it is appropriate to continue, or to rearrange.
- **Manage your own environment and avoid sensitive, personal details in the background**. Lock the door to the room if possible, to avoid disruption.
- Some platforms have a function that will **blur the background behind you** - be familiar with how to enable this.
- Have a **dedicated clinical account**, if you use the video platform socially as well as professionally.

Consent

- Be clear with the patient on the **limitation of the assessment or review**, and whether they have any concerns.
- Ensure that you are **clear about the security of the platform you are using and that it is fit for purpose**. **Be able to discuss this with the patient if they require (see above for more details)**.
- Ensure that you **discuss with the patient about recording the session** - the use of this recording, agree what might be useful for them to be able to take away and that it will only be for private use.

Confidence

- Being confident about using the technology, including its limitations and having a clear plan of what to do if something goes wrong, will help you develop a confident approach.
- If it is not possible to complete an adequate review or assessment, acknowledge and communicate this to the patient, and **develop a clear plan of what you need to do next with the patient**.

Guidance specifically for General Practice/Family Practice consultations is outlined: <https://www.rcgp.org.uk/about-us/rcgp-blog/top-10-tips-for-successful-gp-video-consultations.aspx>, <https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/03/C0479->

[principles-of-safe-video-consulting-in-general-practice-updated-29-may.pdf](#) and at <https://www.phc.ox.ac.uk/research/resources/video-consulting-in-the-nhs>.

A quick guide and FAQ sheet for NHS staff on video consultation is also available at <https://www.phc.ox.ac.uk/research/resources/video-consulting-in-the-nhs>.

The Royal College of Physicians has a [short video](#) describing practical considerations in delivering remote consultations in general.

4c. How do I manage examinations which require physical interactions?

[\[link28\]](#)

Although physical examination may be restricted, a significant amount of information can be obtained remotely.

For example, a [good representation of a neurological exam](#) can be obtained including:

- Cranial nerves: pupillary light reflex, eye movements, face sensation, face movement, hearing/presence of nystagmus, palate elevation, shoulder shrug, tongue movements.
- Upper and lower limbs: motor (pronator drift for arms, standing on one leg for legs), sensation, coordination, gait.
- Some aspects may also require a family or staff member to help.

A guide to telephone assessment of some physical features is available [here](#).

4d. How can I integrate telepsychiatry with other digital technologies?

[\[link29\]](#)

[\[link30\]](#)

[\[link31\]](#)

Just as in face to face psychiatry, **clinicians can integrate a wide range of associated technologies as educational platforms or even as adjunctive therapies**, for example, health information websites, connecting with others through chat rooms or social media, using mental health mobile apps, e-mail, or other technologies.

General considerations when integrating other technologies into a telepsychiatry practice:

- Set aside some time to assess **patients' use of other technologies**.
- Ask them about **what they use, how often they use it, and why they prefer certain types**. Think of a standard way to screen for this information with all patients.
- **How does their use of technology in general influence their life or affect their understanding** of their presenting problem?
- How does **it affect the therapeutic relationship**? For example, does it make it easier to get to know an adolescent patient, or does it reveal a side of them that has not been so evident?
- **Is it safe?** For example, does a patient know to talk in-person instead of on-line about suicidal ideation.

Key considerations about **website health information, texting (SMS) and e-mail**:

- Health information on the internet for the public is rarely regulated. **When possible, seek out information from organisations, institutions and/or businesses that have some oversight/expertise** (e.g. the National Institutes of Health; specific disorder agencies like the Depression and Bipolar Support Alliance in the USA, NICE guidance, Bipolar UK in the UK).
- **Remember to verify the identification of the person on the other end of the receiving technology** (i.e. if using secure e-mail or messaging applications).
- **Be cautious about privacy/confidentiality issues**, as well as about the use of new digital communication from one user to another user (e.g. e-mail, SMS text messaging, multiple messaging service (MMS) messaging, instant messaging, Twitter direct messages, Facebook Messenger), which are not secure.

- **Requests for other contact between visits** (e.g. texts, e-mails) are good for some things (e.g. answering yes/no questions, trading a piece of information), but not other things (i.e., emergencies, complex decisions).
 - **Use e-mail, text etc. only for patients who maintain follow-up.**
-

Social media and professionalism:

- Be mindful of **privacy, professional image, confidentiality, and expectations**. Follow recommendations about professionalism and **social media** (e.g. The American College of Physicians, Canadian Medical Association, and British Medical Association).
 - **Consider the pros and cons of gathering information about patients via search engines and social media**. Understand implications for intentionality and use.
 - For physician-produced blogs, microblogs, and comments: **“pause before posting” and “step back”** to consider what is conveyed to the public about the physician and the profession.
 - **Separate personal and professional life** to the extent that it can be done.
-

Apps and other digital technologies may be used in association with telepsychiatry, for example [True Colours mood monitoring](#) and/or apps focussed on wellbeing in general.

In general, consider **which apps may be appropriate**:

Mobile health apps **have many potential advantages**:

- **easily accessible** (with the increasing prevalence of smartphones).
- **increasing precision**.
- **therapeutic potential**.
- **unique insights into physical and cognitive behaviour**.

There are also possible **disadvantages**:

- developed and shared at a fast rate, so it is **hard to assess clinical efficacy, safety, and security**.
- **apps depend on the user and those that appear effective in research settings may not be equally effective in clinical settings**.

How can clinicians and patients distinguish helpful tools from harmful ones?

Regulatory bodies

- The US Food and Drug Administration (FDA) regulates [mobile medical apps](#). However, it **prioritises monitoring and approval of mobile apps that directly control medical devices or function as these**. This **excludes most mental health-related resources** from evaluation. The FDA revised its approach and introduced a **“Pre-Certification” program** in 2017 for pilot in 2019 to “pre-certify” digital health developers who have already shown credibility/excellence in software design and exempt them from standard testing and an accreditation review. This speeds up the process, but may introduce bias. In response, the FDA has piloted a program that accredits developers and software companies, not the technology itself.

- The [NHS Apps Library](#) contains recommended digital health tools, but does not regulate development or enforce data security standards. The initial version in 2013 was withdrawn in 2015 after criticism (e.g. that 20% did not have a privacy policy posted, and 78% of information-transmitting applications with privacy policies did not specify what data was shared). The library was relaunched in 2017, evaluating resources with a 3-step process and a set of Digital Assessment Questions (DAQ), with an end-to-end evaluation software that automatically tests for inclusion criteria. However, it is important to note that the website offers advice (rather than regulation) only.
- The NHS also collaborated with the NICE to establish credentials for digital health tools or “[Digital Health Technologies](#)” (DHT). NICE assesses the evidence base as well as its financial footprint. These standards encourage developers to test software and build medical technologies with their economic impact in mind.
- Public Health England has also produced [guidance for developers on evaluating digital health products during COVID-19](#).

Evaluation websites

- Such as Psyberguide, MindTools.io, and ORCHA generally show a lack of concordance between ratings of the same apps and are often out of date as there are a large number of new apps to assess. Assessment measures are often qualitative, e.g. “subjective quality” and “perceived impact.”
- [American Psychiatric Association \(APA\) app evaluation framework](#) suggests that users (patients and clinicians) ask questions across four areas, in order of descending importance: safety and privacy, evidence, ease of use, and interoperability (refer to [this document](#) for further details). This could also be supplemented with a self-certification checklist completed by developers or volunteers on a frequent basis. Ideally, this could be a public, interactive approach, so that a patient could filter categories for app choices that meet their standards in terms of privacy, level of evidence, usability based on peer reviews, and clinical integration (e.g. <https://apps.digitalpsych.org/>).

4e. What about safety and emergency considerations?

[\[link32\]](#)

[\[link37\]](#)

[\[link39\]](#)

- Management of elevated clinical risk **follows the same principles as in-person work**, with additional considerations for (a) the risk of losing contact with the client when they are not physically present, and (b) the possibility that the client is in a distant location where the practitioner may be less familiar with services.
- Ensure that **all details are recorded for each patient in advance** of the consultation, in case of any risk concerns (see section 3a or details).
- When evaluating patient safety, **assess the level of agitation, the potential for harm to self or others, as well as any safety hazards** that might be accessible by the patient during the session.
- Be familiar with where the patient is located, including any immediate staff who will be available in case of a clinical crisis, emergency procedures; and ways to obtain collateral information about the patient.
- Technology can be used to manipulate the image and sound quality of the video during the session to allow for the inspection of the patient for verbal and visual cues of agitation or other possible factors related to patient safety.
- Consider the use of a support person (family, friend, etc) in sessions, and/or as an emergency contact.
- Please refer to Table C, Section 9, for safety issues relevant to child and adolescent psychiatry, which are also relevant in wider settings.

Domestic violence and abuse

For general guidance on assessing and managing the risk of domestic violence and abuse during COVID-19, please see <https://oxfordhealthbrc.nihr.ac.uk/our-work/oxppl/domestic-violence-and-abuse/> (particularly section 2f for mental health professionals).

Where there may be the possibility of domestic abuse (DA), follow [this detailed guidance](#).

If you have a concern that the person is being subjected to domestic abuse, escalate to your manager/safeguarding lead to create a plan of action as a matter of urgency.

If domestic abuse is raised during a telephone/video call the following points may be helpful (see [this guidance](#) for details):

1. **Confirm whether you speak the same language as the patient.** If needed, use an independent phone interpreting service (female if possible, not a friend or family member).
2. **Check the patient is alone and confirm their current location** (full address) before asking any questions. If not alone, let the patient know you will call them at a later date and do so within 48 hours.
3. **Establish a code word or sentence**, which they can say to indicate that it's no longer safe to talk so they can end the call.
4. **Enquire safely about domestic abuse** if the patient is safe to speak.
5. **Follow these steps to enquire safely:** explain confidentiality and information sharing procedures, frame the question to explain rationale for asking, ask a direct question to clearly enquire about whether they are a survivor, validate their experience and reassure the survivor that you believe them and the abuse they are being subjected to is not their fault.
6. **Gather the following information:**
 - Ask how you can safely check in with them next.
 - Is it safe to send text messages/emails?
 - Find out what the person is frightened of and/or worried about could or will happen.
 - Check that they have access to basic items e.g. prescriptions/medication.
 - Do they have any concerns about their children (if applicable) or other people?
 - Check if they are safe to remain at home and feel safe to call 999 in an emergency.
 - Find out what they want to happen and want to do next.
 - Let them know what essential shops remain open (as they may become safe places to flee to during an emergency).
7. **Check if it is safe to offer information about specialist domestic abuse services**, and for them to store the National Domestic Abuse Helpline number (e.g. under a different name, like hair salon or GP practice).
8. If there is an **immediate risk of harm** to the patient it is important to remind them that **they should call the police or leave their home to access a place of safety regardless of the COVID-19 isolation measures in place. Their place of safety may be their local A and E Department and they can still attend here if they feel at risk, regardless of COVID-19 restrictions.**
9. If survivors feel afraid of further danger or escalation of harm if they are overheard calling 999, they can access emergency services using [Silent Solutions](#).

Guidance for nurses on assessing signs of domestic abuse and/or modern slavery can be found at [RCN](#), also [here](#).

5. What should I do after the consultation?

5a. What do I need to document during and after the assessment?

[\[link33\]](#)

Clinical documentation is as important as with any clinical encounter. In addition, also document:

- The **time, date, remote site location**.
- The duration of **time spent face-to-face** with the patient in interview and examination.
- The **location and personnel**.
- The **full clinical history, mental state examination, diagnosis, and treatment plan** as you would in a face to face meeting.

6. What about subspecialties and special situations?

6a. Are there any special considerations for children and adolescents?

See table C for full details (including guidance for patients with autism/ASD in section 9 and forensic/juvenile justice settings in section 6).

There is as yet, no specific guidance on telepsychiatry in learning disabilities or forensic/justice settings in adults.

6b. Are there any special considerations for Older Adults?

See Table D for full details.

6c. How should we consider cultural issues?

[\[link34\]](#)

Telepsychiatry has been used with different populations and communities and can improve access to, and quality of care for diverse populations. For cross-cultural settings, psychiatrists should:

- Be **knowledgeable and educated about the culture(s) and environments** in which they are providing care.
- Be aware that **cultural differences can be highlighted** by the patient and provider locations.
- Assess and monitor **how a patient's cultural background influences their comfort and use of technology**.
- Consider **how best to adapt** their communication style and clinical processes.

Also please refer to Table C, Section 8, for cultural issues relevant to child and adolescent psychiatry, which may also be useful in wider settings.

6d. How do we manage a patient interaction when more than one member of the team is present on the call?

[\[link35\]](#)

When different team members are involved in a session, it is important to incorporate each member in the process:

- Each member of the team present at the originating site and remote site should **introduce themselves with their name, title, and role**.
- Be sure that **the patient understands** the nature of the encounter.
- After interviewing and examining the patient, **check in with each team member** for their input.
- **Clarify the diagnostic impression and feasibility of a treatment plan with each team member**.

This also applies to **students** (medical, nursing, allied professionals), who may be observing patient consultations.

There is so far **little formal guidance for incorporating students in telepsychiatry**:

- <https://meds.queensu.ca/ugme-blog/archives/4943> summarises experiences of **including students in a remote consultation**
- Top tips for **delivering communications skills teaching online** are at: <https://www.each.eu/wp-content/uploads/2020/05/Top-Tips-for-Delivering-Communication-Skills-Teaching-Online-FULL.pdf>
- General advice for students and teachers for **using online learning effectively** are at: <https://www.mastersdegree.net/distance-learning-tips-covid-19/>

7. Training and service needs

7a. How can I prepare to be a good telepsychiatrist?

[\[link36\]](#)

Useful previous experience includes, but is not limited to: public speaking, acting, coaching, videoconferencing meetings, and media experience. These involve basic communication skills with adjustments for the setting, audience and objectives of the event.

General Considerations

- **Practice and self-observe** (perhaps with use of recording, with the consent of the patient).

- Focus on **patient-centred, respectful, active listening; expressing empathy; being culturally sensitive; use of non-verbal behaviour** (e.g. eye contact); and **replacing physical contact (e.g. handshakes) with welcoming statements**.
- In team assessments, **remember introductions, engaging others to get involved, and giving directions or ground rules to provide structure**.
- Use **elements of good public speaking**: message preparation, presentation style, and content, methods of engaging audiences, written information if helpful.
- **Prepare by planning the session** (e.g. goals, pre-reading notes and summarising knowledge), **managing the session** (e.g. people, room set up, dress, behaviour style, voice projection, limited moving) and **feeling organised**. **Consider an opening script for new assessments**.

Clinical Considerations

- **Maintain the standard of care and quality of service**.
- **Document informed consent**, but also **engage the patient and put them at their ease**.
- **Pre-visit preparation** is helpful including, for example, hearing limitations, patient attitudes or complaints and sources of information.
- **Allocate enough time: video interviewing takes longer** than face-to-face and requires more concentration; add 5 minutes and consider what minor parts can be subtracted.
- **The setting/room**: both ends private/secure, announce anyone who is unseen to the patient, check lighting and check equipment.
- **Check in with the client at the end of the session** to see if they are happy with the format.
- **Minimise interruptions and reduce the amount of information** dispensed.
- **Dress appropriately** (i.e., no stripes that cause dizziness), and **project your voice and other gestures about 15% greater** than in-person.
- **Adjust to age** (e.g. toys and table for kids; support person for older adults).
- **Adapt your clinical examination where needed**: e.g. cognitive examination may require item substitution if clock drawing or sentence writing cannot be uploaded to see or held visually in the camera. Physical examination may need the use of camera control at the far end for wide angle, close-up, and focused viewing to detect tremors, micrographia, and other abnormalities.
- **Encourage family members to attend if possible** and the patient agrees.

Also please refer to Table C, Section 10, for training issues relevant to child and adolescent psychiatry, which may also be useful in wider settings.

7b Specific advice for nursing staff

Guidance in **remote consultation for nursing staff including health visitors, midwives and nursing support workers** is available from the [Royal College of Nursing](#).

Nursing staff who need to **initiate challenging conversations** (including end of life care) with patients remotely will find guidance [here](#).

Advice for remote prescribing for nurse prescribers is contained at [RCN's website](#).

Guidance for nurses on **assessing signs of domestic abuse and/or modern slavery** can be found at [RCN](#) and [here](#).

Guidance for health visitors on delivering remote consultations can be found at <https://www.unicef.org.uk/babyfriendly/guidance-documents/>.

