Digital technologies and telepsychiatry.

*The following table is divided into four. Table A is short and concise, and is designed for quick reference, with practical advice summarised briefly as a checklist for busy clinicians. Tables B, C and D have full detail and cover the different implications and possibilities for using telepsychiatry in general, in children and adolescents and in older adults.*

*In Tables B, C and D, questions are arranged in groups covering topics listed under headings. Readers can, of course, focus only on areas of interest, but we would suggest that you read the answers to all questions within a group as the answers complement and overlap with each other.*

*The tables were created with the input and guidance of Dr John Torous, Director of the Digital Psychiatry Division at Beth Israel Deaconess Medical Center, and Clinical and Academic Psychiatrist at Harvard Medical School. He is also Editor-in-chief for the academic journal on technology and mental health, JMIR Mental Health (*[*https://mental.jmir.org/*](https://mental.jmir.org/)*), leads the American Psychiatric Association’s work group on the evaluation of smartphone apps, and is an advisor to the smartphone mood study within the NIH's one million person All of Us research program. We thank him for his invaluable contribution and guidance in preparing these tables.*

**Sources searched:** Public Health England (PHE), Royal College of Psychiatrists (RCPsych), Royal College of Nursing (RCN), Royal College of General Practitioners (RCGP), British Medical Association (BMA), The Nuffield Department of Primary Care Health Sciences, The National Association of Psychiatric Intensive Care and Low Secure Units (NAPICU), NICE, Royal College of Physicians (RCP), Healthcare Improvement Scotland, SLAM NHS Trust, NHS Wales, GMC, NHSX, NMC, CDC (Centers for Disease Control and Prevention), US Department of Labor, American Psychiatric Association, American Academy of Child & Adolescent Psychiatry (AACAP), Massachusetts General Hospital Psychiatry, FSMB (Federation of State Medical Boards), CMS (Centers for Medicare & Medicaid Services), WHO, IASC (Inter Agency Standing Committee), The Council of Autism Service Providers, UNICEF, WPA, Singapore Ministry of Health, Singapore Psychiatric Association, Singapore Medical Association, Health Canada (Government department), Canadian Psychiatric Association, Royal College of Physicians and Surgeons of Canada, Regional Geriatric Programme of Toronto, Australian Government Department of Health, Mental Health Online (Australia), Royal Australian and New Zealand College of Psychiatrists (RANZCP).

**Sources used:** PHE, RCPsych, RCN, RCGP, British Medical Association (BMA), The Nuffield Department of Primary Care Health Sciences, NICE, RCP, NHS Wales, GMC, NHSX, NMC, CDC, American Psychiatric Association, AACAP, Massachusetts General Hospital Psychiatry, FSMB, CMS, The Council of Autism Service Providers, Royal College of Physicians and Surgeons of Canada, Regional Geriatric Programme of Toronto, Singapore Psychiatric Association, Mental Health Online, Singapore Medical Association, RANZCP.

**Table A: Practical guidance on telepsychiatry for the busy clinician: a checklist of things to consider before, during and after the consultation.***(For further detail, please refer to the section from Table B listed in brackets).*

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| 1. **Consult relevant national guidance** for your country (*section 2a*). 2. **Consider information governance issues and the IT system** that you and your patient will be using (*section 2b*). 3. **Prepare the patient:** ensure the patient has relevant information before the consultation (*section 3a*). 4. **Prepare yourself:**    * Be familiar with the IT system you will use (*section 3b*).    * Ensure your environment is set up appropriately (*section 3b*). 5. Starting the consultation: **use a written checklist** such as the one shown below, derived from the American Psychiatric Association’s Telepsychiatry Toolkit (<https://www.digitalpsych.org/uploads/1/2/9/7/129769697/session_start.pdf>) (*section 4a*):   **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]”  Alternative checklists are:  <https://www.bmj.com/content/368/bmj.m1182/infographic>  <https://www.cfp.ca/sites/default/files/pubfiles/PDF%20Documents/Blog/telehealth_tool_eng.pdf>  [Best Practices in First Time Telepsychiatry During COVID-19](https://www.psychiatry.org/psychiatrists/practice/telepsychiatry/toolkit/best-practices-in-first-time-telepsychiatry-during-covid-19)   1. During the consultation, focus on: (*section 4b*)    * **Communication**    * **Contingencies/back up plan** in case of difficulties, such as IT or clinical issues    * **Confidentiality**    * **Consent**    * **Confidence** 2. **Physical examination** is possible, but may need to be modified (*section 4c*). 3. Consider **combining with other digital technologies** e.g. apps, websites for information, platforms for recording data such as mood symptoms (*section 4d*). 4. Consider **safety and emergency plans** (*section 4e*). 5. **Document appropriately** – just as you would for face to face contact with additional details relevant to telepsychiatry (*section 5a*). 6. **Are the any special considerations?** (e.g. Older adults, child/adolescent, students, cultural issues, assessments by more than one member of the team) (*section 6a-e*). 7. **Are there any training issues to consider?** (*section 7a*) |

**Table B: Digital technologies and telepsychiatry – full guidance**

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| Clinical question | Guidance | Author Reference/weblink for further information |
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| **1. Background to telepsychiatry and what we know already** | | |
| 1a. What are the differences between telehealth, telemedicine and telepsychiatry? | **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.  **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.  **Telepsychiatry** is a subspecialty of telemedicine and includes psychiatric assessments or follow-up interviews conducted using telephone calls, audio and video digital platforms. | <http://www.wales.nhs.uk/technologymls/english/faq1.html>  <https://www.rcpsych.ac.uk/about-us/responding-to-covid-19/responding-to-covid-19-guidance-for-clinicians/digital-covid-19-guidance-for-clinicians> |
| 1b. Is telepsychiatry a new skill and what do we know about it? | * 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. | <https://www.psychiatry.org/psychiatrists/practice/telepsychiatry/toolkit/history-of-telepsychiatry> |
| 1c. What is the evidence supporting telepsychiatry? | The evidence base is substantial, and outcomes have been measured as follows (<https://www.psychiatry.org/psychiatrists/practice/telepsychiatry/toolkit/clinical-outcomes>):   * **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 inall 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. | <https://www.psychiatry.org/psychiatrists/practice/telepsychiatry/toolkit/clinical-outcomes> |
| 1d. Are there any settings where telepsychiatry might be better than in person care? | * 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 (**<https://jamanetwork.com/journals/jamapsychiatry/fullarticle/2765557>). * **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. | <https://www.psychiatry.org/psychiatrists/practice/telepsychiatry/toolkit/clinical-outcomes>  <https://www.psychiatry.org/psychiatrists/practice/telepsychiatry/toolkit/return-on-investment>  <https://www.ehidc.org/sites/default/files/resources/files/Virtually%20Perfect%20-%20New%20England%20Journal%20of%20Medicine.pdf> |
| 1e. What treatment modalities can I use in telepsychiatry? | * 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. | <https://www.psychiatry.org/psychiatrists/practice/telepsychiatry/toolkit/clinical-and-therapeutic-treatment-modalities> |
| **2. Guidelines and Information governance on telemedicine and telepsychiatry** | | |
| 2a. Are there guidelines I should be aware of? | **In the UK:**  **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 thelimitations 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](https://www.bmj.com/content/368/bmj.m1182) for a useful guide including a [**visual summary for remote consultations**](https://www.nice.org.uk/guidance/ng163/resources/bmj-visual-summary-for-remote-consultations-pdf-8713904797)(https://www.bmj.com/content/368/bmj.m1182/infographic). * **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.   **NHSE (NHS England)** have general guidance on video consultation information for NHS Trusts and Foundation Trusts, at <https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/08/C0638-nhs-vc-info-for-nhs-trusts.pdf>. 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** (https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/good-practice-in-prescribing-and-managing-medicines-and-devices) * 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) <http://www.legislation.gov.uk/uksi/2012/1916/part/12/chapter/2/crossheading/prescription-only-medicines/made>). * **Follow local guidance** for remote prescribing (see <http://oxfordhealthbrc.nihr.ac.uk/wp-content/uploads/2020/05/remote-prescribing-guidelines-Oxford-Health.pdf> 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.   <https://track.govhawk.com/reports/2Nzd2/public> summarises USA legislation related to telemedicine in different states.  The FSMB has waived licensure requirements during COVID-19 – details for each state are contained in <https://www.fsmb.org/siteassets/advocacy/pdf/states-waiving-licensure-requirements-for-telehealth-in-response-to-covid-19.pdf>  A video detailing all changes is available at: [Telepsychiatry Legal and Regulatory Considerations during COVID-19](https://www.psychiatry.org/psychiatrists/practice/telepsychiatry/blog/telepsychiatry-legal-and-regulatory-considerations-during-covid-19)  It is important to note that:   * Flexibilities at the federal and state level are **temporary measures**. Unless there is specific new legislation, these changes **will revert to pre- COVID-19 arrangements**. This currently under discussion. * **Federal and state rules do not always align** and so clinicians should check both for their area of practice. * Licensure waivers are **state specific and therefore will** **lapse at variable time points** – clinicians need to check the updated FSMB website for current status. * **During the COVID-19 emergency, the DEA has allowed a change to its usual prescribing regulations**: controlled substances (such as treatments for ADHD or for addiction) can be prescribed via telemedicine without an in-person examination if:   + This is for a legitimate purpose   + It is prescribed in the usual course of medical practice   + Communication is via live interactive audio-video   + It is in accordance with state and federal law * A separate DEA registration in each state is not required during the COVID-19 public health emergency   **CMS (Centers for Medicare & Medicaid Services) 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 at <https://www.psychiatry.org/psychiatrists/practice/telepsychiatry/blog/apa-resources-on-telepsychiatry-and-covid-19>  CMS has also provided a factsheet for clinicians on telemedicine (including helpful tips and billing information) at <https://www.cms.gov/files/document/telehealth-toolkit-providers.pdf> and for patients and carers at <https://www.cms.gov/files/document/c2c-telehealth-patient-toolkitdigital508c.pdf>  **American Psychiatric Association (Telepsychiatry): does not give specific guidance, but provides an extensive practical ‘toolkit’ of advice for general methods in telepsychiatry (including some COVID-19 specific advice)** (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 (Telemedicine: A Practical Guide for Incorporation into your Practice | Earn CME/MOC | ACP (acponline.org), 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.   Singapore Ministry of Health has also produced a guideline for telemedicine at: <https://www.moh.gov.sg/healthwatch/telemedicine>  **Canada:**  Royal College of Physicians and Surgeons of Canada has specific guidance for each province at : <http://www.royalcollege.ca/rcsite/documents/about/covid-19-resources-telemedicine-virtual-care-e>, 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 (<https://www.ranzcp.org/practice-education/telehealth-in-psychiatry>), Government of New South Wales - Agency for Clinical Innovation (<https://www.aci.health.nsw.gov.au/make-it-happen/telehealth/telehealth-for-nsw-health-clinicians>), NZ Telehealth (<https://www.telehealth.org.nz/>), Medical Council of New Zealand (<https://www.mcnz.org.nz/assets/standards/c1a69ec6b5/Statement-on-telehealth.pdf>)  A practical guide to video consultations is available here (<https://www.mentalhealthonline.org.au/pages/video-mental-health-consultation>) | <https://www.rcpsych.ac.uk/about-us/responding-to-covid-19/responding-to-covid-19-guidance-for-clinicians/digital-covid-19-guidance-for-clinicians>  <https://www.rcpsych.ac.uk/docs/default-source/members/sigs/private-and-independent-practice-pipsig/pipsig-telepsychiatry-guidelines-revised-mar16.pdf?sfvrsn=30d4c605_2>  <https://www.gmc-uk.org/ethical-guidance/ethical-hub/remote-consultations>  [Overview | COVID-19 rapid guideline: managing COVID-19 | Guidance | NICE](https://www.nice.org.uk/guidance/ng191)  <https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/08/C0638-nhs-vc-info-for-nhs-trusts.pdf>  [Joint statement from chief executives of statutory regulators of health and social care professionals - The Nursing and Midwifery Council (nmc.org.uk)](https://www.nmc.org.uk/news/news-and-updates/joint-statement-from-chief-executives-of-statutory-regulators-of-health-and-social-care-professionals/)  <http://www.fsmb.org/siteassets/advocacy/key-issues/telemedicine_policies_by_state.pdf>  <https://track.govhawk.com/reports/2Nzd2/public>  <https://www.fsmb.org/siteassets/advocacy/pdf/states-waiving-licensure-requirements-for-telehealth-in-response-to-covid-19.pdf>  <https://www.psychiatry.org/psychiatrists/practice/telepsychiatry/blog/telepsychiatry-legal-and-regulatory-considerations-during-covid-19>  <https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet>  <https://www.cms.gov/files/document/telehealth-toolkit-providers.pdf>  <https://www.cms.gov/files/document/c2c-telehealth-patient-toolkitdigital508c.pdf>  <https://www.cdc.gov/coronavirus/2019-ncov/hcp/telehealth.html>  [Telemedicine: A Practical Guide for Incorporation into your Practice | Earn CME/MOC | ACP (acponline.org)](https://www.acponline.org/cme-moc/online-learning-center/telemedicine-a-practical-guide-for-incorporation-into-your-practice)  https://www.telehealth.hhs.gov/  [Singapore Medical Association - For Doctors, For Patients (sma.org.sg)](https://www.sma.org.sg/news/year/2020/month/February/leveraging-on-telemedicine-during-an-infectious-disease-outbreak)  <https://www.moh.gov.sg/docs/librariesprovider5/resources-statistics/guidelines/moh-cir-06_2015_30jan15_telemedicine-summary.pdf>  <https://www.moh.gov.sg/healthwatch/telemedicine>  <http://www.royalcollege.ca/rcsite/documents/about/covid-19-resources-telemedicine-virtual-care-e> |
| 2b. What information governance issues should I consider? | **NHSX has published** **pragmatic guidance** on information governance issues during COVID-19: <https://www.nhsx.nhs.uk/information-governance/guidance/tag/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.   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 https://www.nhsx.nhs.uk/information-governance/guidance/covid-19-ig-advice/ .  There are several features common across all platforms that are the gold standard for live videoconferencing in telepsychiatry:   * 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>) | <https://www.rcpsych.ac.uk/about-us/responding-to-covid-19/responding-to-covid-19-guidance-for-clinicians/digital-covid-19-guidance-for-clinicians>  <https://www.nhsx.nhs.uk/information-governance/guidance/tag/covid-19/>  <https://www.bma.org.uk/advice-and-support/covid-19/adapting-to-covid/covid-19-video-consultations-and-homeworking>  <https://www.rcpsych.ac.uk/docs/default-source/members/sigs/private-and-independent-practice-pipsig/pipsig-telepsychiatry-guidelines-revised-mar16.pdf?sfvrsn=30d4c605_2>  <https://www.rcpsych.ac.uk/about-us/responding-to-covid-19/responding-to-covid-19-guidance-for-clinicians/digital-covid-19-guidance-for-clinicians>  <https://www.psychiatry.org/psychiatrists/practice/telepsychiatry/toolkit/platform-software-requirements>  <https://www.psychiatry.org/psychiatrists/practice/telepsychiatry/toolkit/security-issues> |
| 3. Tasks before the consultation | | |
| 3a. What preparations should be made with the patient before the consultation? | * **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 (e.g. with family members, do they order shopping online, book holidays online, or use internet banking?) * **Take any steps needed to mitigate the so-called** **‘digital divide’** ([Telepsychiatry and the Digital Divide](https://www.psychiatry.org/psychiatrists/practice/telepsychiatry/toolkit/digital-divide)), (i.e. lack of access to technology, to internet or telephone access, or access to technology but without sufficient confidence/skills to use this), which can particularly affect mental health patients and may be affected by socioeconomic, ethnic and age-related factors.   Ways to **mitigate these circumstances** might be to ask patients some preliminary questions:   * + What type of technology do you have access to? Do you own a smart phone or another device that can help you to connect, and do you know how to use them? Do you have an e-mail address?   + Does your device let you connect with video, and what is the quality? Is audio-only telepsychiatry an option?   + What sort of telecommunications plan (telephone and internet access) do you have; is this plan limited? * **Explain how the remote consultation will work**. The RANZCP have a webpage for patients and carers on remote psychiatry consultations during COVID-19 (<https://www.yourhealthinmind.org/psychiatry-explained/seeing-a-psychiatrist-online>), with information sheets at <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>. 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. | <https://www.rcpsych.ac.uk/about-us/responding-to-covid-19/responding-to-covid-19-guidance-for-clinicians/digital-covid-19-guidance-for-clinicians>  https://www.psychiatry.org/psychiatrists/practice/telepsychiatry/toolkit/digital-divide  <https://www.mentalhealthonline.org.au/pages/video-mental-health-consultation>  <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-family-and-carers-(telepsyc.aspx>  <https://www.phc.ox.ac.uk/research/resources/video-consulting-in-the-nhs> |
| 3b. What should I do to prepare in advance? | **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). | <https://www.rcpsych.ac.uk/about-us/responding-to-covid-19/responding-to-covid-19-guidance-for-clinicians/digital-covid-19-guidance-for-clinicians>  <https://www.mentalhealthonline.org.au/pages/video-mental-health-consultation>  [Best Practices in First Time Telepsychiatry During COVID-19](https://www.psychiatry.org/psychiatrists/practice/telepsychiatry/toolkit/best-practices-in-first-time-telepsychiatry-during-covid-19) |
| **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:    **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 at handy summary sheet is available at <https://www.digitalpsych.org/uploads/1/2/9/7/129769697/session_start.pdf> and https://www.bmj.com/content/368/bmj.m1182  .  The College of Family Physicians of Canada has also produced a brief guide at: <https://www.cfp.ca/sites/default/files/pubfiles/PDF%20Documents/Blog/telehealth_tool_eng.pdf> | <https://www.digitalpsych.org/uploads/1/2/9/7/129769697/session_start.pdf>  [Best Practices in First Time Telepsychiatry During COVID-19](https://www.psychiatry.org/psychiatrists/practice/telepsychiatry/toolkit/best-practices-in-first-time-telepsychiatry-during-covid-19)  Full details at: <https://www.bmj.com/content/368/bmj.m1182>  <https://www.cfp.ca/news/2020/03/26/3-26-1> |
| 4b. What should I try to do throughout the consultation? | **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.   **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 at:   * [COVID-19 Resource Hub: Remote consultations: Guidance documents and top tips (rcgp.org.uk)](https://elearning.rcgp.org.uk/mod/page/view.php?id=10812) * <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> * <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 (<https://www.rcplondon.ac.uk/education-practice/courses/effective-remote-consultations>) describing practical considerations in delivering remote consultations in general.  **RCGP has produced a guide to remote versus face-to-face assessment and which to use when**.  Key factors include:   1. **Safety first** – you should feel confident you have been able to form a satisfactory assessment and agree a clinically appropriate management plan. Trust your instincts if you feel concerned. 2. **Be vigilant** – consider safeguarding, capacity and confidentiality issues and how you will explore these fully. If you have concerns at any stage, convert to a face-to-face assessment, unless there are compelling reasons why that cannot happen 3. **Consult, don't just triage** – whatever mode of communication is used. 4. **Remain curious** – choose the mode of consultation best suited to gaining sufficient understanding of the problem(s) from a clinician and patient perspective. 5. **Explore to reassure** – find out what the patient is worried about – it can be harder to assess non-verbal cues and emotion remotely, check and confirm with the patient your understanding and the patient’s expectations. 6. **Be clear on next steps. Safety-net explicitly**. If a patient has consulted about the same problem remotely repeatedly have a low threshold for seeing them face-to-face or arrange an onward referral to an appropriate service 7. **Be flexible** – change the mode of consultation if needed 8. **Don’t rush** – spend time building rapport, actively listening and allowing space for questions, information giving and explanation. Experience shows that a detailed telephone or video consultation takes at least as long as a face-to-face consultation. 9. **Heighten your senses** – assess the patient’s home environment and surroundings, check who else is in the room with the patient, can anyone overhear, do they feel safe? Be alert to cues. When consulting remotely with adolescents, establish who initiated the consultation. If a parent is present, consider requesting they leave the room for the last few minutes in order to hear the young person’s perspective and give them the opportunity to talk about any private concerns in a confidential space. 10. **Jointly agree on an acceptable consultation method** with the patient, taking into consideration the patient’s needs, the circumstance and local risks of COVID-19. 11. **Agree wording – or ‘scripts’ – to support reception and other staff with communications with patients** about how they can access services and what to expect, explaining how services are working to keep patients (and others) safe in the COVID-19 context and the methods of consultation available. This may include reassurance that face-to-face care always remains available when clinically appropriate. A remote consultation is not a ‘lesser’ form of a consultation, but it is often different from what patients have previously. | <https://www.rcpsych.ac.uk/about-us/responding-to-covid-19/responding-to-covid-19-guidance-for-clinicians/digital-covid-19-guidance-for-clinicians>  <https://www.psychiatry.org/psychiatrists/practice/telepsychiatry/toolkit/visual-nonverbal-aspects>  <https://www.mentalhealthonline.org.au/pages/video-mental-health-consultation>  <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>  <https://www.phc.ox.ac.uk/research/resources/video-consulting-in-the-nhs>  <https://www.rcplondon.ac.uk/education-practice/courses/effective-remote-consultations>  [Remote versus face-to-face\_Nov 2020.pdf (rcgp.org.uk)](https://elearning.rcgp.org.uk/pluginfile.php/154305/mod_page/content/13/Remote%20versus%20face-to-face_Nov%202020.pdf) |
| 4c. How do I manage examinations which require physical interactions? | **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 (<https://www.youtube.com/watch?v=Pw-Jdy3-T9g>) 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 (<https://www.youtube.com/watch?v=Wrl1T5VRqdw&feature=youtu.be>) | <https://www.youtube.com/watch?v=Pw-Jdy3-T9g>) |
| 4d. How can I integrate telepsychiatry with other digital technologies? | 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 <https://oxfordhealth.truecolours.nhs.uk/www/en/> 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** (<https://www.fda.gov/media/106331/download>). 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** (https://digital.nhs.uk/services/nhs-apps-library) previously contained recommended digital health tools, but did 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. The NHS Apps Library was decommissioned in December 2021. * The **NHS also collaborated with the NICE** to establish credentials for digital health tools or **“Digital Health Technologies”** (DHT) (<https://www.nice.org.uk/about/what-we-do/our-programmes/evidence-standards-framework-for-digital-health-technologies>). 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**: <https://www.gov.uk/guidance/rapid-evaluation-of-digital-health-products-during-the-covid-19-pandemic>.   **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** (<https://www.psychiatry.org/psychiatrists/practice/mental-health-apps>) 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 (<https://www.psychiatry.org/psychiatrists/practice/mental-health-apps/app-evaluation-model>). 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/>). | <https://www.psychiatry.org/psychiatrists/practice/telepsychiatry/toolkit/telepsychiatry-integration-with-other-technologies>  <https://www.jmir.org/2020/1/e15188/>  <https://bmcmedicine.biomedcentral.com/articles/10.1186/s12916-019-1447-x> |
| 4e. What about safety and emergency considerations? | * 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 detailed guidance in <https://static1.squarespace.com/static/5ee0be2588f1e349401c832c/t/5ef4549bae574d50c6650d02/1593070749637/COVID-19+Guidance+-+Health.pdf>  **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 guidance  <https://static1.squarespace.com/static/5ee0be2588f1e349401c832c/t/5ef4549bae574d50c6650d02/1593070749637/COVID-19+Guidance+-+Health.pdf> 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).  1. **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). 2. 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.** 3. 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** (<https://policeconduct.gov.uk/news/if-youre-risk-domestic-abuse-remember-silent-solution>).   **Guidance for nurses** on assessing signs of domestic abuse and/or modern slavery can be found at RCN (<https://www.rcn.org.uk/clinical-topics/domestic-violence-and-abuse/assessment-tools-and-guidance>), also here ([www.rcn.org.uk/clinical-topics/modern-slavery](http://www.rcn.org.uk/clinical-topics/modern-slavery)). | <https://www.psychiatry.org/psychiatrists/practice/telepsychiatry/toolkit/patient-safety-and-emergency-management>  <https://www.mentalhealthonline.org.au/pages/video-mental-health-consultation>  <https://static1.squarespace.com/static/5ee0be2588f1e349401c832c/t/5ef4549bae574d50c6650d02/1593070749637/COVID-19+Guidance+-+Health.pdf> |
| 5. What should I do after the consultation? | | |
| 5a. What do I need to document during and after the assessment? | **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. | <https://www.psychiatry.org/psychiatrists/practice/telepsychiatry/toolkit/clinical-documentation> |
| 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. College/University students | Challenges include:   * Students **split their time** between living in the college/university setting and home setting, which may be in different areas/states. * Difficulties have been exacerbated by COVID-19 as students have ended up in **unexpected settings** (either home or university based) and so plans and continuity were disrupted. * Issues of **adequate clinical and insurance cover** for clinicians when treating patients remotely (especially in the US where insurance is state specific). * In the US licensure requirements have been temporarily loosened but this has differed state by state. * Providing clinical care for a student **out of state or in a different region needs to balanced against possible risks** – for example in the event of an increase in suicidal risk, worsening of physical status in an eating disorder, local crisis service provision may differ.   Areas to focus on particularly include:   * The use of telepsychiatry in college students has not been studied extensively in student populations, but **initial studies support its effectiveness.** * College/University psychiatrists should **practice within their scope of competence and scope of service**, as they would when conducting in-person visits. **The standard of care should remain the same**. * A small number of students may be **under 18** at the start of the course. * In the US, for students who are located in a state where the psychiatrist is not licensed, the psychiatrist should research licensing requirements and follow procedures outlined by the out-of-state medical board. * Psychiatrists will need to make **appropriate referrals for local care and provide sufficient medication** to bridge the time until the student can be connected to the new team/GP. * Psychiatrists should be **clear with the patient about the boundaries and limitations** around continuity of care as the student moves between locations. * The psychiatrist should be attentive to the acute need for **active case management, in partnership with patients,** including advanced scheduling of times when the student is at home, encouraging patients to update the psychiatrist on their status and advising them when and how to seek additional levels of care. * College students may live with their families during the pandemic: **creating a private space can be challenging**. Wifi and smartphones may not be available at home. * **International students** may be on visas with specific regulations which may be affected by unexpected closures or prolonged breaks. Many international students do not have family in the country and unexpected closure can impose social and financial pressures. International students may not be able to obtain the same medicine or same quality of medicine in their home country. It is best to choose a medication that is available in the student’s home country, if a return to that country is likely. * **Telepsychiatry services may not be appropriate for a subset of students**, due to the acuity and severity of symptoms, the nature of the disorder, the need for specialized care or the ability of the student to utilize telemental health services, or because they are studying abroad or international students who return to their home country. | <https://www.psychiatry.org/psychiatrists/practice/telepsychiatry>  <https://www.psychiatry.org/File%20Library/Psychiatrists/Practice/Telepsychiatry/APA-College-Mental-Health-Telepsychiatry-COVID-19.pdf>  <https://www.tandfonline.com/doi/full/10.1080/07448481.2021.1909040>  <https://www.psychiatry.org/psychiatrists/practice/telepsychiatry/toolkit/college-telepsychiatry-during-covid-19> |
| 6c. Are there any special considerations for Older Adults? | See Table D for full details. |  |
| 6d. How should we consider cultural issues? | 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 with 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. | <https://www.psychiatry.org/psychiatrists/practice/telepsychiatry/toolkit/use-of-telepsychiatry-in-cross-cultural-settings> |
| 6e. How do we manage a patient interaction when more than one member of the team is present on the call? | 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://each.international/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/> * Guidance from **the Medical Schools Council** is at: [students-attending-remote-consultations-advice-to-medical-schools-and-students.pdf (Cedschools.ac.uk)](https://www.medschools.ac.uk/media/2788/students-attending-remote-consultations-advice-to-medical-schools-and-students.pdf) | <https://www.psychiatry.org/psychiatrists/practice/telepsychiatry/toolkit/team-based-integrated-care>  <https://www.psychiatry.org/psychiatrists/practice/telepsychiatry/toolkit/team-based-models-of-care> |
| **7. Training and service needs** | | |
| 7a. How can I prepare to be a good telepsychiatrist? | **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. | <https://www.psychiatry.org/psychiatrists/practice/telepsychiatry/toolkit/learning-telemental-health> |
| 7b. How can I prevent videoconferencing (”Zoom”) fatigue? | Symptoms have been widely discussed during the COVID-19 pandemic. Not classified as a clinical syndrome.  Symptoms include feeling sluggish, tired or disinterested in meetings after a long period of videoconferencing.  **Contributing factors** are both specific to videoconferencing and general to sitting in front of a screen:   * Staring at a computer all day is tiring. * Videoconferencing involves a sense of always being "on" and performing for the camera. Constantly ensuring that you look and sound OK to the other party can be fatiguing. * Dealing with technical difficulties can also contribute. * Doing the same activity for many hours in a row can be tiring. Being in front of a camera all day without breaks may exacerbate this.   **Strategies to mitigate this** include:   * Taking **frequent short breaks** including exercise/fresh air. * **Turning-off your self-view image** once you've established that you are appropriately represented on the patient's screen so that it does not preoccupy you during the session; but check it periodically to ensure that it is still a high-quality image. * **Varying tasks** to keep interest up e.g. alternating patient meetings with managerial. * **Using reliable IT /technical support.** | <https://www.psychiatry.org/psychiatrists/practice/telepsychiatry/toolkit/videoconferencing-fatigue> |
| 7c. What is a ‘Hybrid’ telepsychiatry interaction between patient and clinician? | * **“Hybrid care,” incorporates telepsychiatry and other health technologies with traditional in-person care.** * The psychiatrist-patient relationship is mediated through commonly used **communications technologies** (telephone, e-mail, video) in conjunction with **clinical support technologies** (e.g., electronic health record systems, e-prescribing), while still offering **in-person appointments**. * **Digital therapeutics** (dTx, also known as Software as a Medical Device or SaMD) and **self-care technologies** within mental health have applications in this hybrid relationship (e.g. smartphone apps, virtual reality, and web-assisted therapy). * It maximizes the benefits of using a virtual space in conjunction with the traditional familiarity of a physical space.   **Benefits of Hybrid Models of Care:**   * **Virtual Space Benefits**   + Advantage for those with avoidant behaviour, PTSD, and anxiety   + Convenient & immediate   + Provider can observe patient in their environment   + Indirect & off-hours care opportunities   + Modalities include videoconferencing, e-mail, text messaging & telephony * **Physical Space Benefits**   + Traditional in-person is the standard ‘gold standard’ interaction   + Immediacy & trust in interpersonal interaction   + Physical boundaries can be set for therapeutic frame   + Ample research and practice guidelines available for healthcare in the physical space   **Why is becoming adept at hybrid relationships important?**   * Widespread transformation of society and psychiatry using and integrating technology in all aspects of care * COVID-19, Climate Change, and Disaster Psychiatry   + Rapid virtualization of psychiatric services in response to the COVID-19 pandemic   + Increased comfort, experience, and streamlining of technology used by both psychiatrists and patients.   + Accelerated longer-term trends of technology use.   + Growing evidence of effectiveness of many technologies (e.g. videoconferencing).   + Need to adapt clinical style, workflow, interactions and expectations to work effectively with a particular technology   + Increased demand for at-home and flexible treatment options   + Patient satisfaction with hybrid care is generally high, with more flexible access to providers and good attendance rates.   To evaluate and manage technology in psychiatric practice and its impact on hybrid physician patient relationships, **psychiatrists & organizations should consider:**  **Administrative issues:** These include the legal, regulatory and technology requirements of any specific technology. Technology specifics include proper installation & maintenance such as data backups, data security & privacy and efficiency and usability of software.  **Operational issues:** These include the use of standard operating procedures, integrating a technology into a practice setting, addressing onboarding patients, onboarding healthcare providers, and workflow efficiency such as documentation burden and inbox management.  **Clinical issues:** The impact of a technology on clinical process, rapport, and alliance including how to adapt and modify communication, clinical style and approach to maximize effective use and support of engaged and connected psychiatrist-patient relationships  What can a psychiatrist/provider do to be proficient in hybrid physician-patient relationships?   * **Learn about current and future trends in mental health technologies.** This includes evidence for their use and effectiveness; best practices in implementation and clinical use; and administrative, operational and clinical issues (see [Telepsychiatry Toolkit Home](https://www.psychiatry.org/psychiatrists/practice/telepsychiatry/toolkit) and [Telepsychiatry Blog](https://www.psychiatry.org/psychiatrists/practice/telepsychiatry/blog) for essential resources). * **Seek education and training in both specific technology use, but also management of hybrid relationships**. * **Set clear expectations, policies and ongoing communication with patients** on processes for communication and treatment, with each technology used in treatment. * **Stay informed and offer informed decision making around smartphone apps.** Many patients have tried or are already using mental health smartphone apps. Even if you do not want to use them yourself, being able to explain their risks and benefits is critical to offering relevant and timely information. The APA has created a smartphone app evaluation framework and website with information examples, videos, and scheduled office hours, to support virtual care competencies and proficiencies: <https://www.psychiatry.org/psychiatrists/practice/mental-health-app> (see section 4d for more details) | <https://www.psychiatry.org/psychiatrists/practice/telepsychiatry/blog/hybrid-models-of-care>  <https://www.psychiatry.org/File%20Library/Psychiatrists/Practice/Telepsychiatry/APA-Hybrid-Psychiatrist-Patient-Relationships.pdf> |
| 7d. 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 (<https://www.rcn.org.uk/professional-development/publications/rcn-remote-consultations-guidance-under-covid-19-restrictions-pub-009256>).  Nursing staff who need to **initiate challenging conversations** (including end of life care) with patients remotely will find guidance here (<https://www.rcn.org.uk/professional-development/publications/rcn-courageous-conversations-covid-19-uk-pub-009-236>).  **Advice for remote prescribing for nurse prescribers** is contained at RCN’s website (<https://www.rcn.org.uk/clinical-topics/medicines-management/covid-19-remote-prescribing>).  Guidance for nurses on **assessing signs of domestic abuse and/or modern slavery** can be found at RCN, <https://www.rcn.org.uk/clinical-topics/domestic-violence-and-abuse/assessment-tools-and-guidance>, and at [www.rcn.org.uk/clinical-topics/modern-slavery](http://www.rcn.org.uk/clinical-topics/modern-slavery).  **Detailed guidance for health visitors** on delivering different types of remote consultations can be found at <https://www.unicef.org.uk/babyfriendly/guidance-documents/>. |  |
| 7e. Other allied health professionals | Physiotherapists: [Remote consultations top tips v9.pdf (csp.org.uk)](https://www.csp.org.uk/system/files/publication_files/Remote%20consultations%20top%20tips%20v9.pdf) | [Remote consultations top tips v9.pdf (csp.org.uk)](https://www.csp.org.uk/system/files/publication_files/Remote%20consultations%20top%20tips%20v9.pdf) |

**Table C Telepsychiatry and digital technologies in child and adolescent psychiatry**

This table summarises considerations specific to telepsychiatric consultations with children and adolescents. General guidance is also given in Tables A and B and relevant sections are cross referenced within this table for information.

|  |  |  |
| --- | --- | --- |
| Clinical question | Guidance | Author |
| 1. Where can I find general guidance? | Guidance is summarised below, but for more detail, please refer to the [**American Academy of Child & Adolescent Psychiatry**](https://www.aacap.org/AACAP/Clinical_Practice_Center/Business_of_Practice/Telepsychiatry/toolkit_videos.aspx) **and APA** (<https://www.psychiatry.org/psychiatrists/practice/telepsychiatry/toolkit/child-adolescent/>).  **Information for young people and families** on telepsychiatry is available at:  <https://www.aacap.org/AACAP/Families_and_Youth/Facts_for_Families/FFF-Guide/Telepsychiatry-and-Your-Child-108.aspx>  **American Academy of Child and Adolescent Psychiatry (AACAP) Policy statement on Telepsychiatry (2017)** is available at:  <https://www.aacap.org/AACAP/Policy_Statements/2017/Delivery_of_Child_and_Adolescent_Psychiatry_Services_Through_Telepsychiatry.aspx>  **American Academy of Child and Adolescent Psychiatry (AACAP) Committee on Telepsychiatry and AACAP Committee on Quality Issues have issued a clinical update** available at:  <https://jaacap.org/article/S0890-8567(17)30333-7/fulltext>  Please also consult the **guidance on telepsychiatry summarised in Table B, Sections 2a-b.** |  |
| 2. What is the evidence base for telepsychiatry in young people? | * Telepsychiatry services have been successfully used with diverse populations **across diagnoses (e.g. depression/ADHD/tics/OCD/autism/psychosis) and settings (including urban/rural, community/school/home/inpatient/forensic).** * For **children and adolescents on the autistic spectrum, it may be preferable to in-person consultation**. * Multiple studies have demonstrated the **feasibility** of delivering varied treatments to children and families through telepsychiatry. * **Referring providers, psychiatrists and families report high satisfaction** with telepsychiatry services. * **The ability to establish a therapeutic rapport with youth and families through telepsychiatry is well established**. | <https://www.aacap.org/AACAP/Clinical_Practice_Center/Business_of_Practice/Telepsychiatry/Toolkit%20Videos/evidence_based.aspx>  <https://www.psychiatry.org/psychiatrists/practice/telepsychiatry/toolkit/clinical-outcomes> |
| 3. How do I set up and conduct the remote interview? | * **At the beginning, direct the family arrangement** so all members remain visible throughout the consultation. **Use the zoom and wide function** if needed. * **Ensure adequate lighting** – on average you need one more light source than you would for face to face meetings. Make sure you are lit from the front, not from the side or behind you. * Position yourself so your **eyes appear 1/3 down from the top of the screen**. * Arrange the **patient’s picture on your screen as close as possible to your camera** (to allow for ‘relative eye contact’). * **Keep both cameras still** – make sure you and the patient have them placed on a stable base. * **Comment on real features** in the patient’s room so they know you can see and hear them. * **Greet patients;** How are you? Can you see and hear me OK? * **Replace the handshake**, e.g. with a wave or fist bump. * **Use non-verbal communication**: facial expression, gestures, eye contact, tone of voice. **Nod and smile frequently**. * **Ask about physical comfort** – consider factors such as privacy, temperature, lighting. * **Adjust your voice:**    + Speak slowly and clearly.   + Use longer pauses after questions to avoid talking over each other. * **Maintain eye contact** (look at the camera).   Please also refer to **general considerations for setting up a telepsychiatry consultation (Table B, Sections 3a-b).** | <https://www.aacap.org/AACAP/Clinical_Practice_Center/Business_of_Practice/Telepsychiatry/Telepsych_Articles/Roth-Ramtekka-AACAP-News-web.pdf>  <https://www.aacap.org/AACAP/Clinical_Practice_Center/Business_of_Practice/Telepsychiatry/Telepsych_Articles/Roth-Ramtekka-AACAP-News-pt2-web.pdf> |
| 4. How do I develop a therapeutic space and establish rapport? | General advice:   * Telepsychiatrists must immediately engage the patient’s attention and convince them that they are trustworthy, competent, empathic, and will be responsive to their needs.  It is often not what is said, **but how it is said, that matters most to our patients.** * **2/3 of the meaning of a consultation comes from non-verbal communication**, so how we see each other on screen is crucial. * **Use creative ways to establish rapport**: expressions will need to be increased, use picture in picture feature so that patients can see you and themselves, ensure you build rapport with other people in the room including parents and siblings. In general, **control the use of electronics by patients during the interview, but be flexible** – teens may want to share and use as a method of communication.   Set up the rooms at the patient’s and psychiatrist’s sites to establish a typical clinical experience:   * **Clinician’s room:**    + **Minimise detail** (to facilitate the camera’s focus and minimise sources of distraction for the patient).   + **Do a room tour** to show privacy and welcome patient and family.   + **Show the therapist from waist up** (like a news broadcaster) to include all non-verbal communication.   + Include in frame **any tools, or gadgets you intend to use**. * **Patient’s room:**    + **Large enough** for the patient, family and any caregivers/staff attending.   + **Large enough** to assess the patient’s physique, motor skills, behaviour, mental status examination, gross motor and fine motor skills, affect, and rapport.   + If there is only one participant at the remote site, **he/she should sit 2-4 feet away from the camera and screen. For each additional participant, another 2 feet back from the camera** will keep all participants in the screen’s frame.   + Young children move frequently. Place the camera at a sufficient distance **to ensure that they are always in frame, even if they move to play on the floor.**   + Consider **the selection of toys**: useful as a distraction when talking to carers and as a means of assessing behaviour. Avoid toys that are noisy or have lots of pieces. Ideally a small table with paper and crayons can help assess focus, fine motor skills and engagement. Pictures can be reviewed by holding them up to the screen.   + Many **seating arrangements** can work for children. Children can sit next to the parent, between the parents, on a parent’s lap, or in front of the parents in either their own chair or on the floor.   + Sometimes **a hyperactive or autistic child cannot remain in the camera frame**. Consider keeping the parent(s) in the frame and call the child back to the camera when they need to answer a question. If a child’s motor skills, play, exploration, and movements are being assessed, the room should be large enough for this activity to fit within the camera frame.   + Occasionally, anxious or defiant young people **will refuse to sit within the camera frame**. If behaviour management strategies don’t work, then consider asking the parent to turn off the self-monitor image and seat the young person further from the camera but in the frame. Another strategy is to allow the young person to have more privacy for part or all of the session.   Please also refer to **general considerations for how to conduct a telepsychiatry assessment (Table B, Sections 4a-d).** | <https://www.aacap.org/AACAP/Clinical_Practice_Center/Business_of_Practice/Telepsychiatry/Toolkit%20Videos/virtual_therapeutic_space.aspx>  <https://www.aacap.org/AACAP/Clinical_Practice_Center/Business_of_Practice/Telepsychiatry/Toolkit%20Videos/participant_arrangement.aspx> |
| 5. What about school based telepsychiatry? | * **There are many advantages to school-based telepsychiatry**: reduced travel time for psychiatrists, reduced parents’ work leave, reduced child absence from school, increased attendance at psychiatry appointments, facilitation of a team based approach with earlier interventions and better compliance. * **Special considerations include:**    + Finding a **private and secure space**.   + **Understanding and respecting school staff, policies and structures.**   + **Knowledge of existing school support and learning support.**   + Considering **continuity outside school** (evenings, holidays etc).   + Ideally, using a **hybrid approach** with some in person meetings at the beginning.   + Identifying which staff will support with practical arrangements and in the meetings if needed. | <https://www.aacap.org/AACAP/Clinical_Practice_Center/Business_of_Practice/Telepsychiatry/Toolkit%20Videos/school_based.aspx> |
| 6. What about forensic (juvenile justice) settings? | * In this particularly **underserved population,** telepsychiatry can have an important role in providing a service where it may not be possible in person. * Telepsychiatry can be **challenging**: young people may be reluctant to engage, particularly if sessions interfere with their participation in recreational activities, or there is concern about staff being present and confidentiality. * Telepsychiatrists must **define their role** in the young person’s system of care and treatment i.e. clarify a forensic vs direct care role. * **On-site therapists (but not correctional staff) often participate in sessions** to aid the psychiatrist in obtaining pertinent patient information and to facilitate clinical care. * **Background information and reports** **may be available in advance** and these should be used proactively in the interview. * Telepsychiatrists should be **familiar with regulations regarding consent to pharmacological treatment of minors in forensic settings.** * Telepsychiatrists can **ask staff to provide a “virtual tour” of the facility** with a mobile device to assess and ensure privacy, security, management of mental health records, and other concerns. | <https://www.aacap.org/AACAP/Clinical_Practice_Center/Business_of_Practice/Telepsychiatry/Toolkit%20Videos/juvenile_justice.aspx> |
| 7. Behaviour management | * Evidence-based behaviour management training can be offered via telepsychiatry in clinic and home settings. * Psychiatrists can both model and coach parents on the concepts of behaviour management in real time. * In clinic, **staff can clarify subtleties in the child’s behaviour** which may not be evident through videoconferencing. * Treatment can be offered in naturalistic settings such as the home, potentially providing more ecologically valid assessments and interventions. * It is important to **develop a safety and crisis plan at the beginning** (see Section 9) in case the child’s behaviour becomes unmanageable or unsafe during a session. This plan should include **contact lists of trusted family/friends, local GP and emergency services.** | <https://www.aacap.org/AACAP/Clinical_Practice_Center/Business_of_Practice/Telepsychiatry/Toolkit%20Videos/behavior_management_training.aspx> |
| 8. Cultural issues | Consider the following:   * **Do not assume a difference** in social, economic, income, geographic, racial, ethnic or cultural backgrounds, but ask for clarification. * Remember there is **heterogeneity** within minority communities. * **Staff at the patient site can also be helpful**. * Establish **strong working relationships with the local team.** * **Family structure** may differ in different cultures – find out by asking. * Use **professional interpreters**, not family members. * Please also refer to **general cultural considerations for telepsychiatry in Table B, Section 6c.** | <https://www.aacap.org/AACAP/Clinical_Practice_Center/Business_of_Practice/Telepsychiatry/Toolkit%20Videos/telepsychiatry_across_culture.aspx> |
| 9. Assessing those with Autism or Autism Spectrum Disorder (ASD) | **NHS England** identify particular areas for those who are providing IAPT (Improving Access to Psychological Therapies) services, and working with those who may have a learning disability, autism or communication impairment to be aware of:   * Identify any **alternative or augmentative means of communication** that help the patient understand or express themselves. This **may require additional preparation with the patient or their family/carers** to identify the best means of communication and to ensure both you and they have access to it during interactions. For example, you may need to check what kind of vocabulary the patient uses and is familiar with, and whether particular signs, symbols or picture resources can support interaction. * Consider how therapeutic language or specific vocabulary **can be simplified, paraphrased or be represented by symbols or pictures.** * The patient **may need extra time to become familiar with and comfortable in using the technology**. Guidance on its use needs to be supported by the identified alternative or augmentative means of communication. * Consider **pacing the session according to the patient’s needs** and monitoring their concentration level. Using signs, symbols or pictures is likely to slow the pace of the therapeutic intervention; this will need to be considered   In terms of **modifying usual assessment tools to use within telepsychiatry**, there is no formal guidance:   * The **ADOS** (Autism Diagnostic Observation Schedule) is a standardized diagnostic test for Autism Spectrum Disorder (ASD). It is designed to be performed in person by clinician with the patient. Wearing PPE is likely to impact results, and **there is no formal guidance on remote administration.** * However, it is possible to **use some elements of ADOS remotely**. This will not provide an ADOS score but will help evidence gathering in general. * An alternative is to use an **adapted version** of the ADOS for remote assessment:   + One possibility is to use the BOSCC (Brief Observation of Social Communication) as a framework for recording a video where the ADOS items can be scored. Further details are described in <https://www.youtube.com/watch?v=sOGv8vbJeeo>   + The Oxford Virtual Assessment for Autism Tool (OVAAT) is an adapted version of the ADOS for online use. It has not been formally assessed but is being used by Oxford clinicians and services in Buckinghamshire, Swindon, Wiltshire and Bath. (If interested please contact the service for more information: [Maria.Bourbon@oxfordhealth.nhs.uk](mailto:Maria.Bourbon@oxfordhealth.nhs.uk) team manager)   US guidance on the application of **Applied Behavior Analysis for those with autism and how to deliver this remotely during the COVID-19 pandemic** is contained at <https://casproviders.org/wp-content/uploads/2020/03/PracticeParametersTelehealthABA_040320.pdf>  **Advice for patients, families and carers:**   * Advice for patients with autism on remote consultations is available at <https://www.autistica.org.uk/what-is-autism/coronavirus/make-the-most-of-a-telephone-appointment> * Advice from the RCPsych on supporting someone with autism during COVID-19 is available at: [COVID-19 and Autism and Autism Spectrum Disorders (rcpsych.ac.uk)](https://www.rcpsych.ac.uk/news-and-features/podcasts/detail/covid-19-and-autism-and-autism-spectrum-disorders) | <https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/03/Final-C0042-MHLDA-Covid-19-Guidance-IAPT-.pdf> |
| 10. Safety issues | * Clinicians need to **establish at each site what infrastructure and emergency management protocols are in place. These protocols can be adapted** to telepsychiatric care. * In **hospital and community settings** (CMHTs) these protocols will be well established. * **In non-traditional settings,** e.g. shelters for families and children these will need to be developed and established before starting telepsychiatry consultation. * Emergency management during telepsychiatry **is a team effort**. * **Identify on-site staff who can help by physically intervening during an emergency.**  Community resources must be identified to incorporate into **emergency management protocols and the patient’s care plan.** * Safety and mobilization procedures at a patient site should be both **accessible to staff for review and an integral part of their training.** * Psychiatrists need to be able to **manipulate telepsychiatry technology to maximize video and audio quality** to assess signs of agitation, substance use and medication side effects if needed. * If technology falters, psychiatrists should be prepared to **quickly initiate a pre-planned backup emergency management plan,** e.g. calling a named coordinator at site to enter room and ensure safety. * Please also refer to safety issues for **general telepsychiatry in Table B, Section 4e.**   **Where there are concerns about the possibility of domestic violence or abuse, particularly during COVID-19,** see <https://oxfordhealthbrc.nihr.ac.uk/our-work/oxppl/domestic-violence-and-abuse/> (particularly section 2b) for guidance for those working with children and families) | <https://www.aacap.org/AACAP/Clinical_Practice_Center/Business_of_Practice/Telepsychiatry/Toolkit%20Videos/patient_safety.aspx> |
| 11. What are my training needs? | * Official guidelines for training competencies in child and adolescent telepsychiatry have not yet been established. * **Primary skill areas** for competent telepsychiatric care are: technical skills, communication, assessment skills, collaborative and interprofessional skills, administrative skills, medico-legal skills, community psychiatry and community-specific knowledge, cultural psychiatry skills, and knowledge of health systems. All of these have special applications for children and adolescents. * Clinicians need to learn to **increase non-verbal communication by approximately 15-20%** for effective use on screen (e.g. projecting voice, slower response time, bigger expressions). * Be **collaborative with all staff at patient site**, across disciplines. You may never meet them in person, and so you need to integrate into the team remotely. * **Be sensitive to cultural and community issues.** * **Help staff to be comfortable with telepsychiatry**. * **Be flexible in your role** in the child’s system of care and to vary your role depending on the resources available at the patient site. * **Understand legal, policy and regulatory guidelines** (see Table B, Section 2a) (in the US this needs to be at federal/state and county levels) * Please also refer to **general training considerations for telepsychiatry in Table B, Sections 7a.** | <https://www.aacap.org/AACAP/Clinical_Practice_Center/Business_of_Practice/Telepsychiatry/Toolkit%20Videos/training.aspx> |

**Table D Telepsychiatry and digital technologies in Older Adult Psychiatry**

This table summarises considerations specific to telepsychiatric consultations with older adults. General guidance is also given in Tables A and B, and relevant sections are cross referenced within this table for information.

|  |  |  |
| --- | --- | --- |
| Clinical question | Guidance | Author |
| 1a. General guidance for remote consultations in Older adults | * **Outcomes have been positive** in terms of satisfaction, validity/reliability, and preliminary clinical outcomes relative to in-person care. * **Satisfaction has been superior** for patients, families, carers and providers. * A variety of disorders have been effectively treated in this population, including **depression,** **anxiety, dementia/cognitive impairment, and associated behavioural problems.**   Telepsychiatry considerations are similar to those for adult patients, **with a few key modifications**:   * **Pre-visit accounting of general events and the patient’s attitude, comments, complaints, sources of information, and clinician observations** (e.g. olfactory/vision/hearing limitations, gait/balance problems) is helpful. * The clinical examination **may require staff or family assistance**. A modified version of physical examination is possible (see Section 4c in Table B) but may be less extensive than in person assessment.   Benefits include:   * As with standard care, **family (especially carers) are important to include, and are appreciative of services.** * The clinician is part of an **interdisciplinary team who can all be connected through telemedicine**. * **Assessment, cognitive intervention, and clinical outcomes have been similar to in-person care**. * This is a very efficient way to deliver specialty expertise for **nursing home and home outreach**. | <https://www.psychiatry.org/psychiatrists/practice/telepsychiatry/toolkit/geriatric-telepsychiatry> |
| 1b. How can I assess memory/cognitive function remotely? | **Memory clinic assessments:**  **Tasks before the remote cognitive assessment:**   * Use a **triage process** to ascertain whether it is appropriate to use video or telephone consultation. * **Examples where it might not be appropriate to have a remote consultation**:   + The patient is **unable to** use video or other technology and cannot be supported to do so.   + Where there are concerns about a carer or relative dominating the conversation, especially if it raises any **safeguarding concerns**.   + The patient is **unable to communicate** over telephone or video (although some people may be able to lip read and use the chat function of video consultations).   + The patient has **serious anxieties** about using technology   + From the available information it is clear that the patient requires a physical examination or has cognitive difficulties that can currently **only be assessed face to face** e.g. visuospatial deficits. * Services should also **consider if now is the right time for a diagnosis**, compared to waiting for face to face assessment. Will a diagnosis now make a meaningful difference to the patient and their family, and will they be able to access post-diagnostic support? * If they cannot receive a remote assessment and the benefits of assessment and diagnosis outweigh the risks of a face to face appointment, then local policies, procedures and infection prevention control measures such as PPE should be followed. * A **pre-assessment discussion** **on the telephone** may be helpful. * Ask the patient if they would like a **family member or friend to join them**. * Gain **as much collateral information as possible**, including from the GP, other professionals and an informant (perhaps using a validated tool such as the IQCODE which can be delivered on the phone or via video consultation).   **Practical guidance on completing cognitive assessments remotely:**   * Take in account all **general advice** given in Table B on preparation for, activities during and after the meeting. * For cognitive assessments involving visual stimuli, use a device **at least as large** as a standard iPad (9”). * **Landscape format** is recommended over portrait format as it simulates the in-person experience more closely. * **Check sight and hearing** before starting, and ensure the patient is comfortable. * Keep your **vocal cues to a minimum** – a slow nod or a smile is better * Show your interest and attentiveness through **eye contact and facial expressions**. * If you need to interrupt, try a visual signal such as **raising your hand**. * Rapid gestures or body movements can be distracting – try to slow them down. * People with visuospatial misperception and visual hallucinations may find video conferencing particularly challenging (use of headphones/microphone/webcam may be helpful).   **Cognitive tests via telephone:**   * NICE has outlined the tests for which there is an evidence base (<https://www.nice.org.uk/guidance/ng97>). * There are 20 telephone-based assessments of cognition available, most of which have been validated (<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3933813/>). * **MoCA** (Montreal Cognitive Assessment): The blind version of the MoCA can be delivered over the phone and has been validated for mild cognitive impairment (MCI) diagnosis after stroke/transient ischaemic attack (TIA). It is limited in its assessment of visuospatial and complex language tasks compared with a face to face MoCA. * **TICS** (The Telephone Interview for Cognitive Status) and the modified version, TICSM, (which correlates with the Mini Mental State Examination (MMSE)) are widely translated and validated telephone-based screening tools for MCI and dementia. TICS takes 10-15 minutes to complete. Assesses orientation time/place, attention, short-term memory, sentence repetition, immediate recall, naming to verbal description, word opposites and praxis. A score of ≤28 has good sensitivity and specificity for the diagnosis of post-stroke dementia. It has a high diagnostic validity for identification of dementia among ethnically diverse older adults. Some questions may need to be adapted to be country-specific. * **TYM** (Tele-Test Your Memory, <http://www.tymtest.com/>) has 10 tasks on 2 sides of a single sheet of card and correlates with scores on standard cognitive tests. It takes about 5 minutes and the patient can complete it under the supervision of a relative or healthcare professional. It can also be administered by video consultation. * Individual components of cognitive testing can also be completed via the phone. Although this will not give a validated test score it will give an understanding of cognitive deficits to aid clinical decision making. Orientation to time, place and person, arithmetic skills, verbal recall, knowledge of recent news events, single word and sentence repetition, word definitions, verbal fluency and frontal tests (e.g. cognitive estimates and proverb interpretation) can all be assessed over the phone, as well as spontaneous speech and elements of motor speech disorders such as apraxia of speech or dysarthria. * Many of these tools are subject to copyright restrictions (see <https://www.parinc.com/products/pkey/445> for further information). * In primary care, brief tests to detect cognitive impairment can be used over the telephone. For example, the GP Cog (<http://gpcog.com.au/> (with omission of the clock drawing test) or the 6-item Cognitive Impairment Test (6CIT) (<https://patient.info/doctor/six-item-cognitive-impairment-test-6cit>).   **Cognitive tests via video consultation**     * **MoCA**: The full version of the MoCA can be administered via video conferencing (https://www.mocatest.org/remote-moca-testing/). The patient will need a white sheet of paper, a pencil and an eraser. For the visual section, use the screen sharing function where possible as follows:   + Show them the trail and say: “please tell me where the arrow should go next to respect to the pattern I am showing you”   + Show them the cube and say: “copy the cube”   + “Draw a clock. Put in all the numbers and set the time to 10 past 11”   + “Tell me the name of these animals”   + Orientation: “look straight at the camera and tell me today’s date, day of the week, month and year” (to avoid people looking at bottom right hand of screen where the date is shown), “from what clinic/department am I calling you, “what city/borough is our clinic/department located in” * **Addenbrooke’s Cognitive Examination III** (ACE III): can be completed via video. The patient will need several pieces of paper, a pencil and an eraser. Ensure that the camera can view the patient doing the pen and paper placement tasks. Where possible have the pictures, words dots, and broken letters on your computer in PDF or PowerPoint format and share your screen rather than holding pieces of paper up to your camera. * Clinicians will need to **gain adequate practice in the remote administration of these assessments prior to use** even if highly familiar in their traditional administration. * As with in-person tests, none of these tests are diagnostic. They measure cognitive function, and all are subject to error e.g. by sensory impairment, educational level, and culture or language. * Some of these tests may not be appropriate for people with limited education and may not be validated for use in BAME populations or people for whom English is a second language. | <https://www.rcpsych.ac.uk/docs/default-source/members/faculties/old-age/nhs-london-clinical-networks---guidance-on-remote-working-for-memory-services-during-covid-19-v2---july-2020.pdf?sfvrsn=8a3f67df_2>  [www.yhscn.nhs.uk/media/PDFs/mhdn/Dementia/Covid%2019/MAS/2020%2005%2027%20MSA%20-%20A%20New%20Way%20of%20Working%20-%20Remote%20Memory%20Clinics%20FINAL.pdf](http://www.yhscn.nhs.uk/media/PDFs/mhdn/Dementia/Covid%2019/MAS/2020%2005%2027%20MSA%20-%20A%20New%20Way%20of%20Working%20-%20Remote%20Memory%20Clinics%20FINAL.pdf)  <https://canadiangeriatrics.ca/wp-content/uploads/2020/05/Virtual-Approaches-to-Cognitive-Screening-During-Pandemics_FINAL.pdf> |
| 1c. Is there any guidance on neuropsychological testing using telepsychiatry? | **Neuropsychological assessment**     * Acceptability may be lower in older patients, but virtual neuropsychology should be offered and attempted. * Test selection will depend on the technology the patient has access to and can use without imposing additional cognitive burden. * Third party assistance may be required for some tests. * Contact by phone may still be used for screening purposes and is recommended to assess for current risk and vulnerabilities. * The British Psychological Society (BPS) Division of Neuropsychology (DoN) has recently released guidance regarding the remote administration of neuropsychological assessments ([DON guidelines on the use of tele-neuropsychology (April 2020).pdf (bps.org.uk)](https://www.bps.org.uk/sites/www.bps.org.uk/files/Member%20Networks/Divisions/DoN/DON%20guidelines%20on%20the%20use%20of%20tele-neuropsychology%20%28April%202020%29.pdf)). * Consider the risks and benefits. There are significant advantages to using video conferencing rather than telephone. Ensure that you are familiar with the remote administration of the test, and the patient’s is able and willing to engage in remote assessment. There is an encouraging evidence base indicating that valid results can be achieved by remote administration of neuropsychological tests (eg the Repeatable Battery for Assessment of Neuropsychological Status, RBANS, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4718188/>). * For people who are not able to undertake formal assessment at present, a thorough neuropsychological clinical interview by telephone with the patient and informant may be acceptable in starting the assessment process. | <https://www.rcpsych.ac.uk/docs/default-source/members/faculties/old-age/nhs-london-clinical-networks---guidance-on-remote-working-for-memory-services-during-covid-19-v2---july-2020.pdf?sfvrsn=8a3f67df_>2  [www.yhscn.nhs.uk/media/PDFs/mhdn/Dementia/Covid%2019/MAS/2020%2005%2027%20MSA%20-%20A%20New%20Way%20of%20Working%20-%20Remote%20Memory%20Clinics%20FINAL.pdf](http://www.yhscn.nhs.uk/media/PDFs/mhdn/Dementia/Covid%2019/MAS/2020%2005%2027%20MSA%20-%20A%20New%20Way%20of%20Working%20-%20Remote%20Memory%20Clinics%20FINAL.pdf) |
| 1d. How can I give and discuss the diagnosis of dementia using remote consultation? | **Giving a diagnosis of dementia remotely**     * If you feel you have enough clinical information to establish a diagnosis then the patient and their next of kin (where appropriate) should be informed of the diagnosis, assuming consent for this communication has been obtained. * When giving the diagnosis by telephone, it is important to explain to the patient that you can’t see each other and therefore you cannot see their body language. * Explain that you may need to give them some distressing information which would normally be done face to face. * Tell the patient and carer that because you can’t see them, or their reaction, you will pause between giving pieces of information to ask them if they are happy for you to continue. * Royal College of Nursing has guidance on initiating challenging and courageous conversations remotely (<https://www.rcn.org.uk/-/media/royal-college-of-nursing/documents/publications/2020/april/009-236.pdf?la=en>). | <https://www.rcpsych.ac.uk/docs/default-source/members/faculties/old-age/nhs-london-clinical-networks---guidance-on-remote-working-for-memory-services-during-covid-19-v2---july-2020.pdf?sfvrsn=8a3f67df_>2  [www.yhscn.nhs.uk/media/PDFs/mhdn/Dementia/Covid%2019/MAS/2020%2005%2027%20MSA%20-%20A%20New%20Way%20of%20Working%20-%20Remote%20Memory%20Clinics%20FINAL.pdf](http://www.yhscn.nhs.uk/media/PDFs/mhdn/Dementia/Covid%2019/MAS/2020%2005%2027%20MSA%20-%20A%20New%20Way%20of%20Working%20-%20Remote%20Memory%20Clinics%20FINAL.pdf) |
| 1e. Is there any specific advice for occupational therapy assessments? | **Considerations for Occupational Therapists**     * Functional assessments are difficult to conduct remotely; however, it is possible to make observations using virtual technology and this may be useful for assessments of mobility, particularly transfers. * Carers could also send a live stream video indicating difficulties. * Some activities of daily living measures could be administered over the phone, (e.g. the Bristol Activity of Daily Living Assessment, and the Lawton Instrumental Activities of Daily Living). * Where possible continue to order and review equipment (home adaptations and assistive technology) via telephone/video link. * Occupational Therapists can assist in establishing routines and supporting carers to be creative in their caring roles, while still allowing people to have some autonomy and independence. * Occupational Therapists can offer support and advice in managing challenging behaviours (for example the Kingston Standardised Behavioural Assessment can be administered over the telephone) and give ideas regarding meaningful activities for people to engage in while socially isolating (see Section 1g for possible resources). | <https://www.rcpsych.ac.uk/docs/default-source/members/faculties/old-age/nhs-london-clinical-networks---guidance-on-remote-working-for-memory-services-during-covid-19-v2---july-2020.pdf?sfvrsn=8a3f67df_>2  [www.yhscn.nhs.uk/media/PDFs/mhdn/Dementia/Covid%2019/MAS/2020%2005%2027%20MSA%20-%20A%20New%20Way%20of%20Working%20-%20Remote%20Memory%20Clinics%20FINAL.pdf](http://www.yhscn.nhs.uk/media/PDFs/mhdn/Dementia/Covid%2019/MAS/2020%2005%2027%20MSA%20-%20A%20New%20Way%20of%20Working%20-%20Remote%20Memory%20Clinics%20FINAL.pdf) |
| 1f. Are there any specific considerations for remote mental health assessments in care homes? | **Care home considerations, memory assessment and diagnosis**     * People in care homes are likely to have more advanced dementia; a **collateral history** from care staff or family members will be helpful in establishing the diagnosis. For diagnosing advanced dementia in care homes the DiADeM (Diagnosing Advanced Dementia Mandate) tool (<https://www.alzheimers.org.uk/dementia-professionals/resources-gps/diadem-diagnosing-advanced-dementia-mandate>) could be used via video conference with the support of care home staff. * Consider the benefits of a diagnosis at this time and if it is **in the patient’s best interests**; for example, will a diagnosis lead to the resident’s care plan being updated and support the care home staff to look after them? * Where possible, memory services or community mental health teams should support care homes by giving advice and guidance on key challenges such as implementing isolation for people who walk with purpose and supporting people with behavioural and psychological symptoms of dementia (see Section 1g for resources). | <https://www.rcpsych.ac.uk/docs/default-source/members/faculties/old-age/nhs-london-clinical-networks---guidance-on-remote-working-for-memory-services-during-covid-19-v2---july-2020.pdf?sfvrsn=8a3f67df_>2  [www.yhscn.nhs.uk/media/PDFs/mhdn/Dementia/Covid%2019/MAS/2020%2005%2027%20MSA%20-%20A%20New%20Way%20of%20Working%20-%20Remote%20Memory%20Clinics%20FINAL.pdf](http://www.yhscn.nhs.uk/media/PDFs/mhdn/Dementia/Covid%2019/MAS/2020%2005%2027%20MSA%20-%20A%20New%20Way%20of%20Working%20-%20Remote%20Memory%20Clinics%20FINAL.pdf) |
| 1g. What COVID-19 resources can I suggest for patients and carers, or for multidisciplinary staff in supporting older patients, particularly with dementia, and/or self-isolating? | 1. **COVID-19 specific guidance for patients and carers**   **UK specific resources:**   * <https://www.rcpsych.ac.uk/docs/default-source/members/faculties/old-age/dementia_leaflet_coronavirus-(1).pdf?sfvrsn=8d3bf150_4> * <https://www.ageuk.org.uk/scotland/information-advice/health-and-wellbeing/coronavirus/your-wellbeing/> * <https://www.alzheimers.org.uk/get-support/coronavirus/dementia-risk#content-start> * <https://www.alzheimers.org.uk/get-support/coronavirus/about-coronavirus> * <https://www.dementiauk.org/dementia-uk-coronavirus-advice/> * <https://www.dementiauk.org/get-support/coronavirus-covid-19/> * [Getting the most out of a remote consultation - Dementia UK](https://www.dementiauk.org/get-support/diagnosis-and-next-steps/getting-the-most-out-of-a-remote-consultation/) * <https://www.leedsth.nhs.uk/assets/e7843f5988/Dementia-Carer-Pack-A4-Flyers-230420-4.pdf> * <https://www.thehelphub.co.uk/> * [NHS Volunteer Responders](https://nhsvolunteerresponders.org.uk/) * <https://www.giveusashout.org/>   **General resources**   * <https://www.dementiability.com/resources/6-COVID-Book-stay-at-home-UK.pdf> * <https://www.dementiability.com/resources/5-COVID-A-Book-for-Dementia-on-the-Global-Pandemic-of-2020.pdf> * <https://www.alzheimer-europe.org/Living-with-dementia/COVID-19> * <https://www.alz.org/help-support/caregiving/coronavirus-(covid-19)-tips-for-dementia-care>  1. **Advice for staff (multidisciplinary)**  * <http://www.yhscn.nhs.uk/media/PDFs/mhdn/Dementia/Covid%2019/Supporting%20People%20with%20Dementia%20During%20Covid%2019%20NHSCT%20final.pdf> * <http://www.yhscn.nhs.uk/media/PDFs/mhdn/Dementia/Covid%2019/2020.05.20-FINAL1.0-Leeds-walking-with-purpose-guide.pdf> * <https://www.bps.org.uk/sites/www.bps.org.uk/files/Member%20Networks/Faculties/Older%20People/Supporting%20older%20people%20and%20people%20living%20with%20dementia%20during%20self-isolation.pdf> * <https://www.bgs.org.uk/resources/covid-19-dementia-and-cognitive-impairment> * <https://raredementiasupport.org/wp-content/uploads/2020/04/Living-with-dementia-and-COVID-19-an-emergency-kit.pdf> * <https://freedementiatraining.files.wordpress.com/2020/03/useful-resources-if-you-are-supporting-someone-living-with-dementia-or-their-family.pdf> * <https://healthinnovationnetwork.com/wp-content/uploads/2020/04/Maintaining-Activities-for-Older-Adults-during-COVID19.pdf> * <https://www.youtube.com/watch?v=blJjUwBhVpk&feature=youtu.be> * <https://www.england.nhs.uk/publication/dementia-wellbeing-in-the-covid-19-pandemic/> |  |