

**Draft New Zealand National Telepsychiatry
Clinical Practice Protocols and Guidelines**

On behalf of the
Clinical Users Reference Group
Telepsychiatry Project
New Zealand Mental Health Workforce Development Programme

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TABLE OF CONTENTS

Caveat	3
Acknowledgements and Sources	3
Definitions	3
Introduction	4
Uses of Telepsychiatry	4
Issues of Priority for the Use of Equipment.....	5
Use of Videoconferencing Equipment.....	5
Videoconferencing Etiquette	6
Kinds of Clinical Interview.....	8
Clinical Uses for Telepsychiatry.....	8
System Administration.....	9
Equipment Use	10
Mental Health Service User Consent, Confidentiality and Safety	11
Conducting the Interview.....	12
Pre-interview	12
Before the session starts.....	13
Interview.....	13
Post Interview	14
Documentation, Storage of Information and Statistics Collection.....	14
Contingencies for Equipment Failure	15
Clinical Responsibility and Duty of Care	15
Outstanding Issues / For Debate	16
Registration and Liability	16
Competencies and Training	17
Cultural Issues	17
Mental Health Act.....	17
Conditions.....	17
References	18

Caveat

These protocols and guidelines have not yet been signed off by the Mental Health Workforce Development Programme Steering Committee. Whilst they could be used to shape the clinical use of telepsychiatry in the interim, they are still a draft form. They are being posted on the website to stimulate further discussion.

Acknowledgements and Sources

These protocols and guidelines have been prepared with reference to the

- Royal Australian and New Zealand College of Psychiatrists Position Statement #44 Telepsychiatry ¹
- Clinical Practice Guidelines for Using Videoconferencing Technology Queensland Mental Health Services
- Capital and Coast District Health Board Mental Health Services Videoconferencing Protocols
- Canterbury District Health Board Mental Health Services Telemedicine Policy
- University of Toronto Telepsychiatry Guidelines and Procedures for Clinical Activities ²
- Canadian Psychiatric Association Clinical Guidelines and Position Papers Telepsychiatry ³
- American Psychiatric Association Resource Document on Telepsychiatry Via Videoconferencing ⁴
- Canadian Framework of Guidelines National Initiative for Telehealth Clinical Standards Guidelines ⁵
- Expert input from the New Zealand Mental Health Workforce and Development Programme Telepsychiatry Project Clinical Users Reference Group, Regional Coordinators and selected senior clinicians and mental service managers.

Definitions

- *Videoconferencing technology*: Live, two-way audio and two-way video transmission across distances.

- *Telepsychiatry*: The use of videoconferencing equipment to communicate interactively with mental health service users, their family/whanau/caregivers, clinicians, and clinical supervisors at a distance.
- *Base*: The site at which the more senior mental health professional or consultant is located
- *Remote*: The site, usually a remote, rural or provincial centre, where the mental health service user/family/whanau/caregivers, and the mental health service user's primary clinician are situated.

Introduction

These protocols and guidelines are an output of the New Zealand Mental Health Workforce Development Programme Telepsychiatry Project ⁶.

Telepsychiatry has been used intermittently and in scattered locations in New Zealand for the past 10-15 years, however whilst there have been several start up projects few have gone on to sustainability ⁷.

Whilst most District Health Board mental health services have access to some form of videoconferencing facilities ⁸, most are not used at all and for those that are used usage varies from 1-2 hours to 15-20 hours per week, and the bulk of the time is used for administrative meetings to save staff travelling time (*pers.comm.* S. Macaulay).

Telepsychiatry has been shown to be a clinically reliable and valid way of delivering mental health care, consultation, supervision, education and support to remote mental health professionals, primary care health professionals, mental health service users and their families/whanau/caregivers ^{9,10,11}.

The research on cost effectiveness has not been very reliable largely due to the difficulties of estimating indirect costs. Increasingly the focus is on demonstrating the utility of telepsychiatry in facilitating access to secondary or tertiary mental health services for remote mental health service users and practitioners ⁹.

Uses of Telepsychiatry

To provide increased direct access to clinical advice and consultation, education, and liaison amongst mental health services.

- Enhance the care and treatment of mental health service users and their families/whanau/caregivers

- Increase the efficiency of inter-service mental health care delivery
- Increase the scope and availability of education and supervision for mental health service staff and mental health service users

In determining the particular clinical limitations of videoconferencing, the basic consideration is whether the mental health service user is willing and able to sit in front of a camera and communicate. This is a behavioural and attitudinal consideration rather than a diagnostic one.

Clinical staff and service users must always be satisfied that the standard of treatment provided is in no way diminished by the use of videoconferencing facilities, and that the right to informed consent, privacy, dignity and cultural safety will be maintained at all times. A reasonable standard of care and good documentation are required at all times.

Videoconferencing depends on the transmission of only visual and auditory information across a distance. Any other sensory information, such as observations on the mental health service user's personal hygiene, needs to be obtained from a clinician, present in person. While videoconferencing can provide an effective means of communication for clinical purposes, it is not usually as good as, or preferable to, the clinician being present with the mental health service user.

Issues of Priority for the Use of Equipment

If a mental health service is to have a reliable, responsive telepsychiatry service each telepsychiatry site should have its own dedicated videoconferencing room, and videoconferencing equipment.

However all too often mental health services have had to share rooms and equipment. Usually the videoconferencing equipment is located in a shared conference room which may be heavily booked for conventional meetings. The mental health service should negotiate with other services using the equipment that telepsychiatry for clinical use has the highest priority for booking of both the equipment and the room. If the equipment must be moved it should be mounted on robust, manageable, easily manoeuvrable trolleys to protect the equipment from damage and have adequately labelled connections to facilitate reconnection.

Use of Videoconferencing Equipment

These points can apply both to large screen equipment with steerable and zoomable cameras and to a lesser extent to PC-based equipment with fixed cameras.

Users should have received adequate training on the use of their local equipment. They should have familiarized themselves with the equipment so that its use is near second nature and does not distract from the interview process.

Would-be users should be encouraged to use the equipment using instruction as below to contact colleagues at a remote site for instance to see how reliable and user-friendly modern videoconferencing equipment can be.

At each site there should be a hard copy of local instructions on how to use that equipment. The instructions should include:

- How to turn the equipment on, or if it is always left on how to activate it
- Which buttons to push, switches to switch, what NOT to touch
- How to dial the required other site(s)
- There should be regional directories on the screen listing available sites at which to point and click to contact
- There should be a hard copy of name(s), phone and/or locator number of the local technical help and local experienced clinical users
- A hard copy list of the telephone numbers of the various rooms housing the region's telepsychiatry facilities
- If the camera(s) are steerable, how to steer, zoom, pan them and to use the pre-sets.
- How to use the mutes, picture-in-picture (PIP), etc

The videoconferencing room should be a small air-conditioned conference room seating say up to 12 people in comfort. Characteristically the audio volume used in videoconferencing is louder than normal speech so the room needs to be more than usually adequately sound-proofed so that the audio channel cannot be heard outside the room. The interior should be brightly, but diffusely lit, with no shadows on the participants, with no natural lighting, or adequate drapes to exclude it, and preferably be painted pale blue.

The equipment and furniture should be set up to enable the interview to resemble as closely as possible a face to face encounter.

Videoconferencing Etiquette

- Remember videoconferencing is two way. Monitor your own end using the PIP facility.

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- Do not wear brightly coloured, distinctly patterned clothes, or jingly jewellery, especially earrings. Even at higher bandwidths the patterns and movements can break up the picture and also delay or break up the audio transmission.
- Always turn both end mutes on as you turn on or activate the equipment.
- Make sure that in at least one view all persons can be seen if possible. If not both ends should pan so that both ends can view all the participants at the beginning of a session.
- For one to one, or one to many, interviews the one should sit 2 metres away from the camera to give the other end a head and shoulders portrait view. Check the view with the PIP.
- Generally try to keep camera movements to a minimum. If possible set up the camera presets at both ends before the meeting.
- If PC based equipment is used and the camera cannot be 2 metres away look at the camera while speaking. This is quite difficult to do as the natural tendency is to talk to the person's image. That would result in your talking without eye contact.
- Speak at normal volumes. There is no need to shout, do not mumble and in particular do not speak with your hand in front of your mouth. In some situations there may be a speech delay so pause before replying to ensure that the audio transmission has delivered the last part of the other end's speech.
- Some microphones are very sensitive so avoid extraneous noise; clicking pens, rustling papers. If possible turn cell phones and locators off.
- If PC based equipment is being used in a non-sound-proofed environment discreet earphones should be used and one's voice suitably modulated.
- A chairperson should always be appointed for group meetings. For large meetings it can be useful to appoint a deputy chairperson at the other end. Also it can be useful to have a person other than the chairperson control the equipment
- It is really important that there be no aside conversations as these can render the audio channel unintelligible.
- Ensure that all persons participating are introduced and acknowledged. This can be by a round of names, designations, background and role, or introductions by the chairperson(s) (quicker!).
- In larger meetings start speaking by first giving your name.
- Usually try to have the speaker on screen. However zooming in on the speaker can be distracting and may be embarrassing and unsettling to the speaker.
- Do start and finish on time.

Kinds of Clinical Interview

Direct clinical consultations involve mental health service users being interviewed at a distance by specialist mental health professionals, GPs or other health workers in the community, hospital or from any other site for purposes of assessment, diagnostic, treatment and ongoing management of mental health problems or disorders

and

Indirect clinical consultations are clinical meetings which involve the ongoing management of mental health problems or disorders through case reviews, handovers and ward rounds. A mental health service user may not necessarily participate in this kind of meeting

OR

the *direct treatment model*, or out-patient clinic equivalent, where the mental health professional at the base is the responsible clinician

and

the *consultation model* where the mental health professional at base is responding to a referral from the remote mental health professional for advice on assessment and/or management for a mental health service user who is the clinical responsibility of the remote mental health professional. If the mental health service user is not present the outcome of the consultation should be communicated to the mental health service user by the mental health service user's remote mental health professional.

The consultation model is the model of care delivery most favoured by practically all the telepsychiatry literature⁹. The most successful telepsychiatry services are centred on the provision of specialist support from the base specialist for remotely based primary health care providers (e.g. general practitioner, mental health worker) in their care of mental health service users within the mental health service users' own communities. In this way telepsychiatry is a key means of supporting primary care psychiatry in rural and remote regions.

When using the direct treatment model after hour and/or emergency treatment options must be made clear to the mental health service user and family/whanau/caregivers, and documented at both ends.

Clinical Uses for Telepsychiatry

Mental health service user interviews:

- Follow up after an initial consultation to review treatment/outcomes
- Providing a second opinion
- Emergency assessments

- Gaining information additional to referral form (pre screening)
- Access to cultural and/or translating services and support
- Mental Health Act assessments, reviews, judicial hearings, MHA Tribunal Reviews (see *Conditions* page 16)
- Providing mental health services to mental health service users in institutions e.g. prisons

Conditions (NB see also page 16)

- A staff member must present at all times during use of the videoconferencing equipment. If the videoconference is for clinical purposes the staff member present must be a clinician.

Team/group meetings (where family/whanau/caregivers/support persons may be included with the mental health service user's permission), for:

- Discharge planning
- Family conferences
- Multidisciplinary mental health service user reviews generally
- Maintaining essential mental health service user contact with their family in another area (virtual hospital visits)

Consultation / liaison between clinicians, managers, external agencies, mental health service user groups.

Education and Supervision

- One to one supervision
- Group/peer supervision
- Distance learning for education programmes
- Maintaining up to date practice through information sharing
- Attending meetings relating to regional/national projects, research

System Administration

A designated mental health service administrative staff member should be responsible for the administration of the system at each telepsychiatry site, including:

- Co-ordinate the training of clinical staff in the use of the equipment and maintain records of such training
- Coordinating the telepsychiatry booking
- Arranging access to the equipment
- Monitoring equipment use
- Equipment maintenance and repairs

- System testing
- Providing statistics on system use
- Liaison with other centres when problems arise with communication
- Arranging call charges to cost centres or billing for external users or others using the equipment
- All the above tasks and protocols be adequately documented to ensure continuity of the service should administrative staff change

Equipment Use

(See also *Use of the Equipment and Videoconferencing Etiquette* pages 5 and 6)

- Staff and others will only use the equipment when they have been trained in its correct use and maintenance.
- All requests for use will be referred to the system administrator, unless it is required for use in an emergency, when a telephone call to the administrator will suffice. The system administrator will complete the appropriate booking form (for internal or external requests) and ensure training requirements have been met.
- Equipment will be secured at all times between usages in the soundproofed room designated for its use. Users should ensure the sign which indicates a session is in progress, is in place / turned on.
- For ISDN linked facilities staff should use the appropriate transmitting lines for the purpose of the call:
 - If high resolution is required for a mental health service user interview, use 384kbps
 - 384kbps are required to reliably assess for instance negative symptoms of schizophrenia, fine tremors, pupillary reflexes, tearing in the eyes
 - For other purposes, use 128kbps
 - If the call is to continue when the mental health service user interview is completed, the clinician should hang up and re-dial at 128kbps to reduce cost.
- For IP linked facilities there is a fixed charge for the bandwidth so 384kbps, or better 512kbps if available, can be used for all purposes.
- Any system malfunctions or difficulties must be reported immediately to the administrator on discovery.

Mental Health Service User Consent, Confidentiality and Safety

Informed consent should be obtained from the mental health service user, next of kin or guardian prior to the consultation. A written description of the activity should be prepared and given to those involved before the consents are sought. As many people may be functionally illiterate, the content of the consent should be discussed fully and a note should be placed on the chart that this occurred.

Mental health service users, and where applicable, family/whanau/caregivers and other participants should be provided with clear information on how video conferencing operates, who will be involved in the session and what the alternatives to videoconferencing are for example, travelling to an appointment.

A video-recording on the use of the equipment and a mock interview shown to the mental health service user/family/whanau/caregivers before the telepsychiatry interview can be a very useful adjunct to the above.

The mental health service user, or their representative, will be informed of their right to refuse to participate and the right to withdraw from the conference at any time. This should specifically state that a refusal or withdrawal will not prejudice their continued treatment within the constraints of the service.

The capacity to consent or refuse treatment or consultation is seen as the ability to understand the information that is relevant to making a decision about the proposed intervention, and to appreciate the reasonably foreseeable consequences of a decision or lack of decision.

The important determinant is not only the person's age, but the ability to comprehend and appreciate consequences. When a child or youth is the subject of the consultation, the mental health professionals should involve parents or guardians and have their consent.

A clinical staff member must be present with the mental health service user at all times during a telepsychiatry interview. (See also *Conditions* page 16)

Where possible, mental health service users will be given the option of having a support person present and, if necessary, an interpreter.

For practical reasons the initial discussion of consent and confidentiality and provision of any written documentation is completed by the remote based clinicians. However, the base clinician must ensure that these matters have been adequately organised and actioned.

The interview will not be recorded on videotape or other means other than the conventional written clinical notes without the mental health service user's express written consent.

- For what would the recording be used; clinical, research, teaching?
- How, where, for how long, and for whom would a VHF tape be stored?
- Most medical record systems do not have adequate, reliable means for the storage and retrieval of tapes.
- Until telepsychiatry is readily accepted by mental health service users the asking for permission to record might complicate the obtaining of informed consent.

Whilst the capacity to store audio and video information, using VHS cassettes, may be useful for medico-legal, teaching or research purposes, for most clinical situations it is unnecessary and only increases the burden of securing the information as well complicating the process of obtaining informed consent.

When ISDN linked facilities are used the transmitted data are encrypted and confidentiality is ensured. However IP linked facilities should be within a Virtual Private Network, a conventional E-mail type access is not secure enough.

Non-clinical staff may need to be party to the interview process. For instance information technology staff being called in to deal with an equipment problem in the middle of an interview or setting up and/or maintaining bridge links amongst more than two connected sites. It is important to ascertain that such staff are subject to the organization's confidentiality rules and they be reminded of the obligation for confidentiality. There may need to be a special confidentiality agreement drawn up for these situations. If possible the non-clinical staff should leave before the clinical interview/meeting resumes.

Conducting the Interview

See also *Use of the Equipment Videoconferencing Etiquette* pages 5 and 6

Pre-interview

- Make the bookings, involving the mental health service user, family/whanau/caregivers if appropriate, the other clinician(s) and the system administrator.
- For out-patient clinic equivalent use there should have been regularly scheduled bookings made weeks or even months ahead. It is however prudent to check that the facilities are available as booked.
- Relevant documentation should be obtained and reviewed.

- The remote clinical team must make relevant documentation available to the consulting clinician. In general this includes -
 - a summary letter with brief details of the mental health service user's current clinical details highlighting any problems or other issues and any specific questions to be addressed in the interview.
 - copies of discharge summaries, assessment reports or other reports with detail of history and background
- The base clinician and the remote team must establish a clear mutual understanding of the respective and proportional duty of care and clinical responsibility.

Before the session starts

- Full explanations should be given to the mental health service user and where applicable whanau / caregivers as above.
- They should be informed of the name, position, responsibility/role of the person(s) they will be speaking to as well as details of others who might present.
- They should be told of the purpose and if possible the expected outcome(s) of the interview. They should also be asked about their own expectations of the interview and these discussed.
- Mental health service user consent obtained.

Interview

- Introduction of all people participating in (or observing) the interview.
- If appropriate, the cameras should be adjusted to reassure the mental health service user that there are no persons observing without permission.
- Explanation given of the technical aspects of the sound recording, for example, quality of sound, managing the time delay.
- Explanation of the camera placements:
 - initially viewing the entire room
 - focused on the people when the interview commences
- The interview is conducted
- The interview is concluded with a discussion with clinicians (to include mental health service user and whanau / caregivers wherever appropriate) of the assessment findings and recommended management.

Post Interview

A summary of the interview should be written by the mental health service user's key worker at the remote site and placed in the mental health service user's medical record noting that the consultation was via video conference link, pending the arrival of the letter or report from the base mental health professional.

A written report completed by the consulting base clinician is sent to the relevant clinicians in the remote team. The report should state clearly that the consultation was via videoconference link, the sites that were linked, and who was in attendance throughout the session. There should be a clear statement in the report on whether or not the audiovisual quality was adequate for the requirements of the interview. This information is in addition to the standard documentation for the consultation and any treatment proposals.

The consulting clinician is responsible for appropriate liaison with all the appropriate and involved health care providers to ensure the ongoing safety and care of the mental health service user. If this is not done during the videoconferencing session these separate contacts should be documented along with the documentation of the session.

Documentation, Storage of Information and Statistics Collection

Clinical notes and all related information will be held on the mental health service user's file and at the Health Service site providing the consultation. (This may require the establishment of a new/separate file).

For out-patient clinic equivalent interviews the clinical notes should be faxed to the remote site for inclusion in the mental health service user's file and the notes also filed in a similar record at the base site.

Details of videoconferencing consultations must be recorded in the mental health service user's clinical file by the local clinical team as per usual procedures.

If the quality of transmission was poor details must be documented in the clinical file.

The progress note for an interview should include the following information:

- date and time
- the location of the clinician conducting the interview
- the location of the mental health service user (town, facility)
- who was present, at both sites, during the interview, and what their role was

- any malfunction or equipment failure that may affect clinical care

The consulting clinician is expected to keep all documentation including any progress notes resulting from the videoconferencing interview and must place relevant documentation on the mental health service user 's usual mental health service clinical file (usually in the form of a letter or a report).

The system administrator notes the type and time of the session for usage statistics.

Contingencies for Equipment Failure

Procedures for dealing with equipment failure should be anticipated. The clinician initiating the videoconferencing call is responsible for attempting to re-establish a videoconferencing adequate link or for telephoning the clinician at the other site. (See *Practical Guidelines* page 5).

When equipment failure prevents adequate assessment, diagnosis or treatment it should be documented in the clinical record and appointments made for further attempts or face to face assessment.

If the System Administrator and IT support person have not already been involved they must be informed.

The mental health service should negotiate with the information technology service the highest possible priority of response from IT support staff to deal with any IT problems with the videoconference equipment to minimize disruptions to clinical interviews/meetings.

Clinical Responsibility and Duty of Care

Telepsychiatry services involve the same level of professional responsibility as conventional clinical practice. However, due to the varying roles of all those involved in telepsychiatry services, clinical responsibility and duty of care should be assessed and determined in a case by case manner. There is a need therefore to determine the respective and proportional duty of care and clinical responsibility between the telepsychiatry clinician and the mental health service user's primary care provider, including a mutual understanding of what elements of a mental health service user's care are ascribed to other health care professionals.

The consulting and referring clinicians should identify who is responsible for communicating the results of the consultation to the mental health service user and given the mental health service user's consent the mental health service user's family if the family is not present. Similarly, the mental health service user, and the mental health service user's family, needs to understand who is responsible for care. If the family doctor is not in attendance, it should be decided who is to inform him or her about any recommendations. These responsibilities should be documented.

In consultation, the clinical case responsibility remains primarily with the agency or physician requesting the consultation. The mental health profession providing the consultation does not accept ongoing responsibility for primary care, nor will he or she (usually) prescribe medication or do treatment. Hence, it is important both at the beginning and at the end of the consultation for the consultant to make clear the extent of his or her involvement and to explicitly state that he or she will not continue to have responsibility and that the duty of care or shared care will be terminated at the end of the consultation.

The consultant must be clear that recommendations made are within the competencies of the remote practitioner(s). There needs to be considerable discussion about any recommendations and whether they are feasible. As the consultant is not assuming clinical case responsibility, it must be made clear that he or she is only making suggestions and it is up to the case manager and/or family physician to make decisions. There is no formal delegation of responsibility, as responsibility was never assumed and always resided with the case manager and/or family physician.

Outstanding Issues / For Debate

Registration and Liability

The New Zealand Medical Council informally endorses the use of telepsychiatry saying that it improves access to mental health services and supports and supervises the clinical practise of isolated practitioners. However this has not yet been legally tested. Nurses and other mental health professionals should check with the Nursing Council and other registration bodies and liability carriers to ascertain their positions. Individual medical practitioners requiring advice as to risks in relation to the utilisation of telepsychiatry, should seek advice from their indemnity provider. With this purpose in mind, this document has been provided to the Medical Protection Society.

FRANZCP psychiatrists might very well need to complete the College's on-line telepsychiatry course.

Should individual practitioners inform their registration bodies and malpractice carriers that they are using telepsychiatry?

Competencies and Training

Will individual mental health services develop their own training and evaluation programmes or will these be a District Health Board, Regional or National projects? Consumer group input wants a national approach for consistency.

Cultural Issues

Cultural appropriateness and safety issues should probably be dealt with at a mental health service level, with regional and national support. However again consumer input was for a national approach. There has not been any formal Maori input on this yet.

Mental Health Act

Whilst in some districts Mental Health Act assessments, reviews, hearings, and tribunals are carried via telepsychiatry there are others where the judiciary (and also District Inspectors) are reluctant to use telepsychiatry and are concerned about the audiovisual quality and legality of the proceedings.

Again these problems might be best addressed at a local level perhaps with a demonstration of the clarity and reliability of the medium and reference to the literature on validity, reliability and safety of telepsychiatry interviews^{1,9}.

Conditions

Some telepsychiatry services have stipulated that all first assessments must be face to face.

One of the virtues of telepsychiatry is that it makes access to secondary and tertiary mental health services readily available to remote mental health service users and their families/whanau/caregivers without delay or travel.

Telepsychiatry has been shown to be reliable and valid for all types of psychiatric assessments^{3,4,9,10,11} and added information can be obtained from the remote practitioner who might already know the mental health service user and invaluable corroborative information from family/whanau/caregivers also gathered.

Feedback from the previous draft strongly supports the above.

No Mental Health Act initial assessments should be by telepsychiatry.

As above. A District Inspector has expressed an opinion that if the mental health service user was willing and able to sit in front of the camera and communicate and that the responsible clinician thought the quality of the audiovisual link was adequate for clinical purposes then District Inspectors would be unlikely to object to the use of videoconferencing for MHA hearings and would welcome the possibility of increased corroborative information from local clinicians and family/whanau.

Feedback from the previous draft also supports the above

The RANZCP Position Statement and some other guidelines require that every third interview should be face to face.

This could be very difficult to schedule and very unpopular with remote staff and mental health service users having to travel or having a long delay between appointments. The literature is full of reports of mental health service users' satisfaction with telepsychiatry and in particular some mental health service users preferring the telepsychiatry environment⁹. Certainly most mental health service users who have had access to telepsychiatry much prefer it to long travel or not such ready access to secondary or tertiary mental health care⁹. With briefings of the base clinician about the mental health service user's present state by skilled remote case workers who know the mental health service user well there should be no need for this condition.

Feedback from the previous draft strongly supports the above

There must be a clinician present with the mental health service user during the interview.

If there is a long established mental health service user - mental health professional relationship as in for instance psychotherapy there need/should not be a remote mental health professional present during the interview¹. Indeed the presence of a third party can be inhibitory to full disclosure of sensitive material¹¹. However a remote mental health professional should be available for help with the equipment if required and for mental health service user support during or after a distressing interview for instance.

Feedback from the previous draft supports the above

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