Emergency Management Guidelines for Telepsychiatry

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Abstract

Objective— Telepsychiatry, in the form of live-interactive videoconferencing, is an emerging application for emergency psychiatric assessment and treatment, can improve the quality and quantity of mental health services, particularly for rural, remote and isolated populations. Despite the potential of emergency telepsychiatry, the literature has been fairly limited in this area.

Method— Drawing on the combined clinical and administrative experiences of its authors this article reviews the common administrative, legal/ethical and clinical issues that arise in emergency telepsychiatry.

Results— An initial set of guidelines for emergency telepsychiatry is presented to generate further discussion to assist those who are considering establishing general telepsychiatry and/or emergency telepsychiatry services.

Conclusion— The practices and techniques of emergency telepsychiatry are relatively new and require further examination, modification and refinement so that they may be fully utilized within comprehensive mental health service systems.

Keywords

Telepsychiatry; Emergency Telepsychiatry; Rural Mental Health; Emergency Psychiatry

Background

The past decade has witnessed a surge in the use of telepsychiatry, in the form of live interactive videoconferencing for clinical applications (1), and increasingly to assess and treat patients with emergency psychiatric conditions (2–4). The growth nationally of telepsychiatry programs means such providers will more frequently encounter psychiatric emergencies in the course of delivering psychiatric care. Delivery of telepsychiatric care, particularly to rural areas comes with its own unique set of challenges, including greater illness burden, fewer resources, geographic distances, differing systems of care, and cultural differences encountered in populations typically served by telepsychiatry (5–8). Despite the potential of emergency

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telepsychiatry to improve care especially in rural and frontier populations, the literature has been fairly limited in this area.

Although no data exist on rates of psychiatric emergencies in telepsychiatry clinics, there are data about the typical populations served in these clinics. Patients with mental health problems have been shown to be at increased risks for suicide, homicide, and accidents (9) (10). Several studies of rural populations have demonstrated higher suicide rates, particularly for men, when compared with urban populations (11–15). For example in four Northeastern rural California counties suicide rates (19%) are twice the national average.(16) A study examining the gradient of rural-urban suicide between 1970–1997 found suicide rates for rural males to be twice that of their urban counterpoints (20–26 per 100,00) and the adjusted suicide rate for young and working age women 85% and 22% higher in 1995–1997 for rural vs. urban women.(13) Impaired access to care in rural areas is hypothesized to contribute to these increased rates (8,17).

The literature in emergency telepsychiatry has been limited to a case report, and 4 program descriptions. All focused on patient and provider satisfaction assessed by Likert scale instruments, and concluded that videoconferencing was an acceptable means to conduct emergency assessments and treatment (2–4,18,19). Missing in these descriptions is any detailed information about the nature of psychiatric emergencies addressed, the potential impact of the use of telepsychiatry on the assessment and management of these cases, or details and recommendations for modifications of process and procedures in the management of emergency cases over telepsychiatry. Notably absent in the literature is any direct comparison of emergency psychiatric treatment face-to-face vs. telepsychiatry. Furthermore there has been no mention of emergency telepsychiatry in the general mental health literature, including the potential use of this modality in the recent expert consensus guidelines for the Treatment of Behavioral Emergencies 2005 (20).

The impetus for this article was the emerging importance of emergency psychiatric assessments seen in three large telepsychiatry practices, and the dearth of existing information or guidelines. Drawing on the programs' experiences with emergency telepsychiatry, the goals of this article are to 1) Review common issues that arise during the course of emergency telepsychiatry care (administrative, legal/ethical, clinical); 2) Suggest an initial set of guidelines for emergency telepsychiatry; and 3) Recommend areas for future research and direction.

Focus and Clinical Telepsychiatry Emergency Experience

This paper focuses on emergency telepsychiatry defined as psychiatric care delivered over live interactive videoconferencing to assess and treat patients experiencing potential imminent dangerousness to themselves (suicidal or grossly disturbed behavior) or, dangerousness to others (homicidal or other violent behaviors). Other potential safety issues such as domestic violence, child, and elder abuse are beyond the scope of this paper (21–25). Addressed in this paper are models of emergency care that utilize psychiatrist since this represents the major domain of the authors' experiences, although much of the material here has applicability to non-MD clinicians (psychologists, social workers, etc.). Also beyond the specific scope of this paper are other medians of telepsychiatric/e-mental health treatment including email and store and forward technologies,

This paper draws from the combined clinical and administrative experiences of three large programs over the past 14 years, involving over 5000 different telehealth sessions in 6 western states in the US and Australia. The work concerned involves clinics conducted at the American Indian and Alaska Native Programs (AIANP) at the University of Colorado at Denver and Health Science Center's (UCDHSC), the Veterans Administration (VA), the Indian Health Service (IHS), University of California at Davis's Department of Psychiatry, and programs in

Queensland and South Australia. These clinics have all served rural populations including children, adolescents, adults and the elderly. The telepsychiatry activities include consultation with local providers, diagnostic assessment, medication management, case management, family meetings, individual psychotherapy and group psychotherapy. The patients seen represent a wide variety of backgrounds (Caucasians, African Americans, Hispanic, American Indian, and Australian Aboriginal) and range of psychiatric diagnoses (anxiety, mood, psychotic, cognitive and substance use disorders). The services have been provided in various health care systems including federal, state, tribal and private. Additionally the providers have also conducted randomized trials and evaluated program outcomes associated with these services. More detailed descriptions of the general services provided can be found elsewhere (1,19,26–31), and can also be provided by the authors upon request.

We now turn our focus to common issues in emergency telepsychiatry by first presenting administrative issues followed by legal and ethical issues, general clinical issues and issues specific to work with rural populations. Table 1 summarizes the salient points from each of the sections in the form of recommendations.

Administrative Issues in Emergency Telepscychiatry

Administrative issues involve remote site assessment, choice of treatment models, emergency protocols, and determination of roles and responsibilities of involved staff. One of the first steps in developing a telepsychiatric service is to assess in advance the resources available to handle psychiatric emergencies at the patient sites (26). Data needed includes the local mental health services available (outpatient, inpatient, police, other?), the parties' experience/expertise in handling emergency psychiatric assessment, how the different system involved collaborate (or not), the key personnel and the pathways of communication for the systems. Information on the patient site resources can then be organized to see if it is complimentary with a telepsychiatry service. If so, staff can collaborate in creating protocols and procedures to manage psychiatric emergencies. The role of the telepsychiatrist will vary greatly depending upon the model of care in the telepsychiatry clinic. A wide variety of models exist which include consultative vs. ongoing and single provider treatment vs. collaborative/multidisciplinary team treatment.

Once a model of care is chosen a determination will need to be made about who will assume primary responsibility for care in general and psychiatric emergencies. For telepsychiatry consultation services this will probably be the primary team, who is working with the patient. The telepsychiatric consultant has the responsibility to make sure any safety concerns identified are communicated to the primary team in a clear and timely manner. The telepsychiatric consultant may also need to assist and advise the primary team with appropriate treatment linkages across health systems.

In the case of ongoing telepsychiatry treatment, the domains of responsibility for patient safety can be more complex. There is a broad array and diversity of telepsychiatry clinics. Some patient sites are part of a fully integrated healthcare system with full, pre-existing service lines, including local psychiatric emergency services. Others are freestanding without "back-up". Patient sites that are part of a larger health care system may have crisis/emergency psychiatric management teams that telepsychiatric providers can work with directly during a psychiatric emergency. Telepsychiatry clinics part of smaller systems will likely have less emergency resources directly available to them as part of their system. For these clinics protocols need to be developed, based on the resources identified during the needs assessment phase, for contacting and linking with outside organizations to assess with emergency evaluation and management.

During clinic hours the telepsychiatry provider often takes primary responsibility for emergency psychiatric assessment and treatment, helping the patient site to access local or regional resources to render further emergency treatment. For example a telepsychiatric provider may need to enlist the help of local clinic security, as available, or local law enforcement in dealing with an acutely agitated patient. The point at which other clinic personnel and additional systems of care are brought into any specific clinical interaction will vary by provider comfort and experience, patient status, and availability of local resources. Even given case variability, the point of obtaining outside involvement should be pre-determined by clinic staff, and procedures for this should be in place.

Protocols for after hours, emergency coverage for ongoing telepsychiatry clinics need to be clearly delineated. The telepsychiatric provider may be far from the clinic, possibly several states away or even in a different country, depending on the service model (i.e., consultation or treatment). The extent and nature of after-hours clinic coverage will not only be affected by this distance, but also by existing jurisdictional issues (discussed below). Telepsychiatric providers need to consider how they will be involved in after-hours care, the "tipping" point when local emergency services and personnel are utilized and the true availability of local services. There are several models for after-hours coverage, ranging from the telepsychiatric clinician providing emergency phone coverage with referral to local services as needed, to the clinician turning after-hours coverage over to local providers (i.e., local crisis intervention teams). At minimum, it is important to delineate the after-hours coverage, mechanisms for communication between providers, and key contacts.

We recommend the use of shared written protocols and procedures for every active telepsychiatry service. These protocols should specifically describe roles, responsibilities (i.e., daytime and after-hours coverage), communication, and procedures around emergency issues. The degree of involvement of the telepsychiatric provider will vary greatly between patient sites and be determined by legal issues, local resources, and staffing available to the clinic. These protocols should also include basic information on general clinic issues such as prescriptions, relationships with local labs and pharmacies, communications with patient's other providers and access to technical support. The essential components and requirements for general telepsychiatry services have been previously discussed in the literature.(1,26,32, 33) Table 2, presents a sample of emergency protocol successfully utilized in an active telepsychiatry clinic. It is intended as one example of such a protocol the actual details of any emergency protocol will be driven by specific circumstances and resources, and even for this clinic this protocol represent a variant of multiple models available.

Legal and Ethical Issues in provision of Emergency Telepsychiatry

Legal and jurisdictional issues need to be understood for each telepsychiatric service which includes laws concerning involuntary commitments and duty to warn, collaboration with law enforcement and considerations around standard of care. The ability to mandate a person into custody for an evaluation is a legal mechanism that is regulated by each state and usually is granted to medical and emergency personnel (police, social services). Telepsychiatric providers that provide care across state lines need to be licensed in those states of the patients, or in the case of federal organizations (Veteran's Affairs, Indian Health Service) need to make arrangements to work with qualified local personnel to initiate involuntary certifications. Although there is one report of assessments for involuntary commitment preformed via telepsychiatry (19), providers should be prepared to have this modality of certification questioned due to its novelty. Whether working within a state, or across state lines, ideally telepsychiatry clinics should have arrangements with a local entity at the patient site that can initiate involuntary commitment as needed. Indian Tribes in the United States have their own commitment rules and regulations. Providers working with American Indian populations

should be familiar with these processes and issues regardless of the location of the clinic (i.e., even if the clinic is located on state property), and negotiate and work through these issues with tribal partners.

Telepsychiatric providers should also be aware of the "duty to warn" when patients they are caring for make threats towards others. This duty initially established through the well-known Tarasoff rulings varies from state to state with 27 states requiring clinicians to warn potential victims, 11 allowing clinicians to warn and 14 states without definitive laws on a clinician's duty to warn (Alabama, Arkansas, Georgia, Hawaii, Iowa, Kansas, Maine, Nevada, New Mexico, North Carolina, North Dakota, South Dakota, Wyoming and Virginia).(34,35) Providers practicing across state lines should be familiar with their obligations in both the patient and provider site states, and should consider adopting the most conservative regulations (eg. warning) when the two differ.

During acute crises either because of danger to others or danger to the patient the telepsychiatric provider may find themselves contacting local law enforcement (eg. 911). The impulse to contact 911 at times may arise at times from a more medical/legal (eg. clinician anxiety) than a clinical perspective. Telepsychiatric providers need to recognize the different perspectives (enforcement vs. treatment) and roles and obligations (duty to protect public vs. protect individual with disability) law enforcement personnel bring to a given situation. Providers should also be sensitive to potential lack of training in mental health of law enforcement as well as the dual relationships law enforcement personnel may have in small rural communities. (36) Specific recommendations for interacting with law enforcement are discussed in the clinical section.

Finally emergency telepsychiatry raises complicated standard of care issues that have yet to be addressed in the literature. For instance, in terms of emergency management, what should be the "standard of care?" Options include the standard of care of the patient clinic, the telepsychiatric clinic or another national standard? So far the state boards of medical examiners have stated that the standard of care rests at the patient site. This is consistent with actual practice, as care is determined by rural or local insurance coverage, services, formularies, quality improvement standards and other parameters (i.e., rural community via telepsychiatry is not going to have the same resources as a specialized psychiatric emergency room in a major urban center). Limited telepsychiatric care may be better than care as usual (in some case no care at all), and in preliminary trials is equal to in-person care (37). It may be different qualitatively (1), though, and limitations or benefits regarding emergency care over telepsychiatry need to be considered. The standard is most likely different for consultative services (i.e., lower) vs. ongoing care. Two pieces of information that will inform and help to answer these questions are currently missing. The first are data from a developed research base, and the second are legal precedents. If an emergency telepsychiatry case comes before the legal system, as is inevitable eventually, legal precedents will be drawn from other areas of medical case law and applied.

General Clinical Issues in Emergency Telepsychiatry

A number of important clinic issues arise when treating emergencies via telepsychiatry entailing perceptions of control, patient displays of strong affect, contracts for safety and involvement of local law enforcement in crisis management. Providers during telepsychiatric encounters may experience a different perception of control compared with being in the same room with a patient. The telepsychiatry providers' experiences indicate that there is a diminished feeling of control over the clinical encounter. This perception may increase provider anxiety when dealing with an emergency situation but the perception of diminished control may aid the emergency telepsychiatric evaluation if it causes the clinician to become

more attentive, directive, and increase their communication with on-site staff during the encounter. Having emergency procedures and protocols (e.g., a hotline number to call the front of the clinic or security) in place can help to manage provider anxiety. Providers also have to consider the pros and cons of having a staff, security or family member sit in for safety.

A benefit of emergency telepsychiatry is that it increases provider safety when assessing potentially dangerous patients. On several occasions the physical distance afforded by telepsychiatry has allowed patients to express extremely strong affects that may have led the authors to terminate an encounter if in the room with the patient. Often in these cases once the affect has been discharged the assessment can continue. Providers during these situations need to be mindful for the safety of remote site staff. The telepsychiatic provider may need to envision the end of a session and how the patient may react when they leave the room and encounter local staff. Telepsychiatric providers should have procedures to contact staff during a session to warn them of a potentially upset or disruptive patient (e.g., to inform a disruptive patient that you need to discuss scheduling with the remote site staff, mute the microphone, and then call the staff on a telephone to appraise them of the situation). Additionally procedures should be in place on how to handle a situation in which a patient leaves a telepsychiatry session abruptly. If the telepsychiatric provider feels that there is a safety issue then they will need to follow the clinics emergency psychiatric protocol which may include contacting local staff, a local mental health crisis team, or law enforcement to further outreach and assess patient safety.

Although common in some practices we do not recommend the use of "contracts for safety" in telepsychiarty since there is a current lack of evidence concerning their effectiveness.(38) Telepsychiatric providers should educate patients that they treat (either ongoing or consultative) about the emergency protocols, procedures and resources at the patient site. This should be part of any initial interaction with a patient and telepsychiatry clinics should consider providing written summaries of emergency protocols for patients. For patients with chronic safety concerns a more detailed clinical safety plan should be developed, tailored and discussed with the patient.

As discussed in the legal/ethical section at times of crisis telepsychiatric providers may find themselves needing to collaborate with local law enforcement. Depending on a telepsychiatry clinics protocol this contact might be initiated by the telepsychiatric provider or designated staff from the patient site. Regardless of whom from the clinic makes contact they should be prepared to provide the following information to law enforcement on: 1) The current situation; 2) Patient's type of diagnoses and how these could specifically impact interaction with law enforcement; 3) Contact information for "in situ" support and information for law enforcement during interaction with patient; and 4) Information on mental health follow-up, resources and support for patient. Our experience has been that providing this information and offering support as needed is greatly appreciated and helps increase law enforcement personnel's comfort in handling situations involving patients. Providers who are working with small rural communities should take into account the impact of dual roles (discussed further below) on interactions between patients and law enforcement personnel.

Special issues in Emergency Telepsychiatry with Rural Populations

There are several issues unique to telepsychiatry clinics that work with rural populations. These include issues of telepsychiatric provider cultural knowledge, firearm ownership, boundary issues in small communities, and addressing comorbid substance abuse. Many telepsychiatric clinics involve providers in large urban centers treating patients in rural and remote areas. These telepsychiatric providers may not be familiar with rural culture (5). Telepsychiatric providers should be aware of the high rate of firearm ownership in rural communities (39) and the implications of this (12). One study found that that 67% of rural households had firearms, that

farm houses had twice the rate of loaded unlocked guns than in-town (rural) houses, and that the rate of loaded unlocked guns was 4.5 times higher for handguns vs. long guns (39). Providers working with rural populations should ask about firearms at home, the type and number of firearms, and whether they are loaded and unlocked especially with patients endorsing suicidal or homicidal thoughts. Providers need to be sensitive to the potential meaning of firearm ownership (e.g., personal identity, recreational use, and safety/protection concerns) when negotiating firearm disposition (i.e., lock-up, remove or surrender). Enlisting the support of a patient's family members can help to facilitate safely securing firearms. As a last measure a provider may consider contacting local authorities to take possession of a patient's firearms, when concerns of imminent dangerousness are present. This action needs to be weighed against patients' rights and the short and long term effects on rapport and the treatment relationship.

A related and important issue for clinicians providing telepsychiatric treatment in rural communities is an awareness of the size and social networks within the community. Smaller rural communities often create multiple roles and relationships for patients, as well as the local clinic staff in rural communities. These roles need to be considered by the provider in the context of confidentiality issues, involving others in patient treatment (collaterals, family involvement) as well as in situations where there is a duty to warn. Providers should reflect on the impact to the patient and the community of involvement or disclosure of clinical information to outside parties. In cases where a duty to warn exists, providers should seek to balance the protection of patient confidentiality, the safety of the community, and potential consequences of such disclosures on local relationship dynamics.

Often involvement of family members can be extremely helpful in emergency situations. They can obtain collateral information, monitor treatment and patient status, and provide emotional and social support for the patient. Families of patient's who endorse solid family relationships should be contacted and brought into the treatment. Conversely providers should assess where family involvement may exacerbate existing tensions and potentially contribute to a crisis. In these cases providers should consider a more measured approach to involving family, particularly in smaller communities.

Finally as with any psychiatric emergency comorbid substance use issues need to identified and assessed with attention paid to their contribution to increased risk of impulsive or dangerous behaviors. Addressing substance use can be challenging in rural clinics, given at times the lack of access to both diagnostic tools (ie. urine toxicology screens) and treatment resources. Telepsychiatric providers used to working in clinics with greater local resources may need to assume more primary responsibility in the assessment, and treatment of substance use in patients seen in rural telepsychiatry clinics.

Conclusions

The emerging application of telepsychiatry, in the form of live-interactive videoconferencing, for emergency psychiatric assessment and treatment can improve the quality and quantity of mental health services for rural, remote and isolated populations. In our experience emergency telepsychiatry can be undertaken effectively, efficiently and safely. Table 1 presents guidelines for emergency telepschiatry highlighting the major recommendations and themes of this paper.

In addition to videoconferencing several emerging technologies in the field of telemedicine have great potential to help clinicians managing telepsychiatric emergencies, and can be integrated with telepsychiatry services. These include in-home monitoring technologies, email (40), web-based symptom tracking, remote safety support groups, as well as old fashioned telephone management (41). The information presented in this paper has potential limitations.

First, although the patient populations that we have worked with have been very diverse, the specific populations and settings may have limited the generalizability of our observations. Second, the information is based on clinical work performed over many years, is impressionistic and requires more rigorous validation using formal research methodologies.

Future work in the field of emergency telepsychiatry should include: 1) Examination of which emergency situations, and which psychiatric diagnoses are most appropriate to be treated and assessed through videoconferencing; 2) Strengths and weakness of videoconferencing for emergency psychiatric management need to be delineated: 3) Modifications and adaptations in both administrative and clinical process and procedures, to optimize telepsychiatric emergency work needs to be examined; 4) Best practices and models for emergency telepsychiatry need to be developed; and 5) The use of supplementary technology (email, in-home monitoring, etc.) to augment emergency telepsychiatry services should be explored.

The guidelines proposed here are meant to be preliminary. It is the hope of the authors that these guidelines will generate further discussion and interest in the field, as well as assist those who are considering establishing general telepsychiatry and/or emergency telepsychiatry services. The practices and techniques of emergency telepsychiatry are relatively new and require further examination, modification and refinement in order to improve and expand this technologies utility to increase the quality and availability of mental health services for patients everywhere.

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Table 1

Emergency Management Guidelines for Telepsychiatry

Administrative Issues

- Perform a remote site assessment

    – Obtain information of local regulations and resources

    – Identify local collaborators

- Create emergency protocols with clear delineations of roles and responsibilities

- Decide the "tipping point" for psychiatric emergencies when other staff and resources are brought to bare

- Determine after hours emergency coverage procedures

Legal/Ethical Issues

- Know local civil commitment and duty to warn regulations

- Arrange with local staff to initiate/assist with civil commitments

General Clinical Issues

- Be aware of the impact of telepsychiatry on providers perception of control over the clinical interaction, and how this might impact providers management

- Be aware safety issues with patients displaying strong affective or behavioral states upon conclusion of a session, and how patients may then interact with remote site staff

- If involving law enforcement provide information on: 1) The current situation; 2) Patient's type of diagnoses and how these could specifically impact interaction with law enforcement; 3) Contact information for "in situ" support and information for law enforcement during interaction with patient; and 4) Information on mental health follow-up, resources and support for patient.

Rural Issues

- Discuss firearm ownership, safety, and meaning of firearms to patients in rural areas. Be prepared to negotiate with patients over firearm disposition, and consider involvement of patients' families as appropriate

- Be sensitive of impact of disclosures made during emergency management on patient confidentiality and relationships in small communities

- Include families in emergency treatment situations where possible, but assess and be attentive to exacerbation of family tensions in small communities

- Assess substance issues, be familiar with local resources for substance use assessment and treatment, and be prepared to play a more active role in substance use treatment

Table 2

Sample Emergency Protocols

Sample of emergency protocol for ongoing rural telepsychiatry clinic (specific names in **bold** have been changed to preserve clinic, community and provider anonymity)

Note: This clinic involves a model of ongoing telepsychiatric treatment. Agreements have been made with a hospital system near the patient site to provide emergency treatment and after-hours emergency coverage. Other areas of the protocol (not shown) cover use of local services (labs, etc) with this hospital system and sharing of patient information between the telepsychiatry clinic and the hospital system.

EMERGENCIES

For routine issues between scheduled appointments, patients will be informed through the clinic (see patient form) that they need to contact **the local telepsychiatry clinic staff** (patient site) to schedule a walk-in visit or speak directly with the telepsychiatry provider. 30–45 minutes will be reserved each week for walk-in visits to deal with patient issues that they feel cannot wait until their next appointment, such as questions about medications, requests for refills, or other non-emergent matters.

Definition of a Psychiatric Emergency

For the purposes of this service, a psychiatric emergency will be defined as patient reports of;

1   New suicidal thoughts or homicidal thoughts that are causing distress to the patient, or an impulse or plan to act upon any such thoughts.

2   Grossly impaired behavior due to symptoms of mental illness. (Such as being unable to eat, take care of one's basic needs e.g., shelter).

3   A severe reaction to a medication prescribed through the clinic. (such as severe, intractable vomiting). It will be **the telepsychiatry providers's** responsibility to describe severe medication reactions to each patient for each medication prescribe and to educate the patient as to when to seek medical attention for such a reaction.

Emergency coverage will be provided by **Local (patient site) Mental Health Crisis Services.**

Emergency Procedure Outside of Clinic Time

Patients will be instructed that anytime they feel they are in psychiatric crisis outside of telehealth clinic hours to contact the **local Emergency Room** and ask for **Mental Health Services.** They will also be instructed to notify the telepsychiatry provider through a message left at their voicemail that they have contacted the ER. To the extent that the telepsychiatry provider is available, they will attempt to provide information and coordinate care with local ER. If the patient contacts the telepsychiatry clinic staff during a psychiatric emergency, the clinic staff will direct the patient to follow the same emergency procedure, which is to contact the local ER and inform the telepsychiatry provider.

Emergency Procedure During Clinic

If a psychiatric emergency situation is identified during a telehealth clinic then the telepsychiatric provider will work to arrange an emergency evaluation for the patient by the local ER. The telepsychiatric provider will contact the ER and arrange for an emergency evaluation. The telepsychiatry provider will also work with the telepsychiatry staff to arrange patient transportation as necessary. The patient depending on the circumstances may 1) arrange own transportation 2) utilize ambulance services 3) utilize local van services if appropriate and available. Local telepsychiatry clinic staff will not be involved at anytime in transporting patients.

Local staff may help the telepsychiatric provider to coordinate transportation but will not be directly involved in emergency assessment.

If a patient from this service is deemed in need of an inpatient admission by the local ER then **the Regional MH inpatient hospital** will be contacted and the local ER will work with the Regional MH inpatient hospital to coordinate inpatient care at that facility, or another facility if no bed is available. The telepsychiatric clinician and telepsychiatry clinic staff may also work to help facilitate inpatient admission.

Sample of emergency protocol taken from larger information sheet given to patients enrolled in the local telepsychiatry clinic (specific names in **bold** have been changed to preserve clinic, community and provider anonymity)

WHAT IS A MENTAL HEALTH EMERGENCY?

There are several things that may be considered a mental health emergency.

1   Having thoughts of wanting to harm your self or harm others, especially when:

•   These are new thoughts.

•   You feel you may act on these thoughts.

•   You begin to make plans to carry out these thoughts.

2   Being unable to take care of your basic needs (such as food, shelter, clothing) because of the state of your mental health. For example feeling so sad that you are unable to eat.

3   Having a severe reaction to a medicine that Dr. **Telepsychiatrist** has prescribed for you. For each medication that Dr. Telepsychiatrist recommends you take, he will inform you of the signs of a serious reaction, and what you should do about it.

4   ther thoughts or behaviors not described above where you feel that yourself or others maybe in danger or be harmed because of a mental or medical condition. Remember it is always better to be safe, and seek help and advice when you are unsure if you are having an emergent mental health or medical condition than to try and handle a situation by yourself.

WHAT SHOULD I DO IN THE CASE OF AN EMERGENCY?

This clinic is taking place by telehealth (live interactive video conferencing). The clinic staff and Dr. telepsychiatrist will not be available for emergency care except during scheduled clinic hours. The **Local** Hospital will provide emergency services and care for patients involved in this clinic. If at anytime you feel you are having an emergency due to a mental health condition you need to contact the Local Hospital at xxx-xxx-xxxx and ask for the Emergency Room. When connected with the ER, explain your situation and ask for Mental Health Emergency Services. You may also go directly to the Emergency Room. Please remember to tell the Emergency staff that you are receiving treatment through this clinic, and inform them of any medications you are taking. If you have any contact with emergency services, at your earliest opportunity please call Dr. Telepsychiatrist so they are aware of what is occurring.