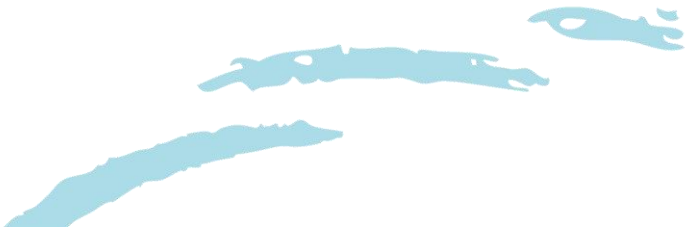
Informing the future of Queensland's Telepsychiatry Services



Results from a consultation with people who access Telepsychiatry to inform work to reform the mental health system and improve outcomes for Queenslanders

Final Report

November 2015

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Executive Summary

The use of telehealth in the provision of health services, including mental health services to people living in rural and remote areas, has in recent years become increasingly routine and widespread across Queensland.

Telepsychiatry has increased the capacity of mental health services to respond to people's mental health needs; there are reduced timeframes to access specialist mental health services and services are able to be provided in the person's own community. There are clear health and social advantages to be gained by those who receive telepsychiatry services, and a reduced cost of service delivery on the part of the service provider.

It is in this context that the Queensland Mental Health Commission (the Commission) has engaged Enlightened Consultants to consult with people who have received telepsychiatry services. The intent is to inform the future use of telepsychiatry in Queensland and ensure future practice and guidelines reflect the needs of service users.

This report to the Queensland Mental Health Commission (QMHC) aims to inform the delivery and improvement of mental health services delivered through telepsychiatry in Queensland. It contains the results of twenty-one (21) naturalistic interviews with people experiencing mental health problems who utilise telepsychiatry in Queensland. The data was collected using both semi-structured and exploratory interviewing, with a focus on the person's own experiences, thoughts and ideas regarding the use of telepsychiatry services. The aims of the consultation were to hear the voice of those who have lived experience of using these services, and their family members and natural supports.

Initially, the consultation focussed on fourteen specific elements that were identified as potentially important to a positive experience of telepsychiatry by a working group established chaired by the Queensland Mental Health Commission. However, it quickly became evident that additional data was emerging that was significant in relation to identifying principles of best practice for use in provision of telepsychiatry services. The data and accompanying recommendations form the two tables included in the summary of recommendations.

The consultation took part within the Darling Downs Health and Hospital Service (DDHHS) area. This Hospital and Health Service has the largest use of telehealth, including telepsychiatry, currently in Queensland. This consultation was not an evaluation of telepsychiatry services but utilised the wisdom of those who access telepsychiatry to inform how telepsychiatry can be improved for the future. Queensland Health clinicians were asked to introduce the consultation project to people who were currently accessing telepsychiatry. Twenty eight (28) people were referred with results from twenty one (21) individual interviews informing this consultation.

From the first interviews conducted, it became apparent that this consultation and its recommendations were considered highly significant to the interviewees. Participants were keen to

be heard, not just about the questions proposed, but about a range of issues, extending from the importance of telepsychiatry and the differences it has made in their lives, as residents of rural and remote Queensland, to their views on the possible future of telepsychiatry. They felt it was important to make comments and recommendations which may not as yet have been considered by service providers but which could inform the development of telepsychiatry services in the future and ensure they are sustainable and more easily accessible where needed.

Almost without exception, participants had clearly given thought to the interview and to their views about telepsychiatry. Four overarching themes emerged from the interviews, which this report has endeavoured to reflect in its commentary and recommendations:

1. Telepsychiatry is a valued and necessary component of mental health care for people living in rural and regional areas of Queensland.
2. Satisfaction with telepsychiatry is strongly influenced by the ability to develop and maintain meaningful and positive relationships with service providers.
3. Continuity of care issues are a significant factor in determining the effectiveness of mental health services delivered through telepsychiatry
4. Telepsychiatry can be utilised to support a range of significant others and relevant service providers participating in the provision of mental health services and support

Enlightened Consultants wishes to thank the QMHC for the opportunity to engage in such a work of significance to the people of rural and remote communities. We also extend our thanks for the support provided by DDHHS and its mental health services community teams and managers, for their support identifying participants and where necessary providing assistance to organise interviews, and also for their hospitality on our various visits.

Finally, we extend our thanks to the project participants, who gave so willingly of their time, their thoughts, and their experiences, in order to benefit other people who use telepsychiatry in Queensland, and improve services for those in rural and remote areas. Without their generosity of spirit this project would not have been possible.

Amanda Greaves
Senior Consultant
enLIGHT'ened Consultants

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ENLIGHTENED consultants

po box 7361
redland bay qld 4165
australia
p +61 7 3206 8921
e info@enlightened.com.au
w enlightened.com.au

SUMMARY OF RECOMMENDATIONS

The following provides a summary of recommendations formed from this consultation to the Queensland Mental Health Commission (QMHC) to inform the future use of telepsychiatry in Queensland.

Table 1 Issues and recommendations relevant to best practice

Issues relevant to Best Practice	Recommendation
A: Frequent changes in medical staff	It is recommended that where possible, measures such as prioritising resource allocation are in place to ensure people receiving telepsychiatry services have access to improved continuity of care and therefore a service which is not only more effective but more acceptable to those in disadvantaged rural and remote parts of the state.
B: Decision to use telepsychiatry	The decision regarding the frequency or necessity of face-to-face appointments should be the result of a number of factors including the preference of those accessing the service. The person should be involved in this decision making in a collaborative way. Clinical pathways developed by HHS's should reflect this collaborative process.
C: Use of telepsychiatry facilities by natural and NGO supports	It is recommended that where possible, videoconferencing facilities be utilised by NGO's and natural supports for the purposes of support, networking and education.
D: Engagement of external services and remote participants in telepsychiatry	It is recommended that significant others and relevant external services be engaged in treatment planning whilst using telepsychiatry, and that HHS's support direct access by those people either in person or the use of multisite videoconferencing from their geographical location. Using software such as Jabber, services could also be accessed directly from the person's home, where the technology exists to do so and the person is living a rural / remote area significant distance from a mental health service.
E: Use of telepsychiatry in acute and emergency situations	Improvements to future practice could include greater collaboration between emergency departments and General Practitioners, and rural and remote mental health services to promote early access to specialist mental health services in order to reduce the need for hospitalisation.

Table 2 Recommendations based specifically on elements identified by telepsychiatry working group

Element	Recommendation
1: The comfort, safety and confidentiality of the room	**1**: In order to facilitate the trust and confidence of people accessing telepsychiatry, it is recommended that issues of confidentiality are discussed prior to use of the telepsychiatry service. This discussion should include: (i) advice regarding the confidentiality of personal information, (ii) the security of written notes or other documentation relating to the videoconference taken by involved clinicians, and (iii) determining whether any part is being recorded, in accordance with existing privacy and confidentiality legislation and HHS policy requirements.
2 That the equipment is working smoothly	**2.1**: Videoconference equipment needs to be checked regularly prior to use, to minimise disruption because of functionality issues. **2.2:** That all staff involved in the provision or support of telepsychiatry services receive training on equipment set up and problem solving.
3: The presence of one of the clinical team before during and after the interview	**3.1**: It is recommended that the case manager be present for the telepsychiatry interview. Additionally, it is recommended that at some point in the telepsychiatry appointment the person should be offered the opportunity to talk privately with the doctor if they wish to do so **3.2**: That the person is offered the option of time with the case manager before and after the interview for preparation and reflection, if they wish.
4: Information about telepsychiatry that is easy to understand and discusses options and risks	**4**: That the person using telepsychiatry receives plain language information discussing options and risks. The person should have the opportunity to ask questions regarding this

Element	Recommendation
	information prior to commencing telepsychiatry
5: Being able to consent and have choice in receiving telepsychiatry	**5.1:** Where alternatives to telepsychiatry exist for face-to-face services, even where this may involve some travel or inconvenience, that these options are outlined and the person has, as far as possible, choice in the mode of service delivery. This should include the option to utilise a mixture of face-to-face or tele modes, particularly in the relationship building phase. **5.2** That standard consent arrangements for mental health services be applied to telepsychiatry, noting the exception to informed consent that may be imposed by the Mental Health Act 2000(Queensland Government, 2000). **5.3** The principle of family involvement be reflected in telepsychiatry practice and guidelines. That the service user is given the choice regarding involvement of specific family members/ natural supports, identified by the person, to participate in telepsychiatry interviews in the event of the person's emergency or acute illness
6: Access to an interpreter if I need one, and having information in my own language	**6.1:** It is recommended that an assessment of the person's language and information needs be undertaken prior to organising telepsychiatry services for that person.
7: Culturally safe and appropriate to my cultural needs	**7**: It is recommended that assessment of the person's cultural preferences and needs be undertaken prior to organising telepsychiatry services for that person.
8: Appropriate for any physical limitations I might have (for example visual or hearing loss)	**8:** It is recommended that the person's physical needs related to the access to and use of the equipment be assessed prior to use of the videoconferencing equipment, and that where possible these needs are taken into account in the setting up and use of the equipment and space.
9 Being able to have a support person present if desired	**9**: The option for the person to have a support person (as well as their case manager) with them at the interview should be offered. This may be a family member or natural support/allied person/peer support worker/Indigenous /

Element	Recommendation
	CALD Worker. If the person accessing telepsychiatry has any concerns, the opportunity to discuss them should be provided. It is recommended that this be offered to everyone who accesses telepsychiatry services.
10 The doctor / clinician who is interviewing me has read the relevant information in my file about me beforehand	**10:** It is recommended that the treating clinician receive the relevant information at least 30 minutes before the telepsychiatry appointment, to ensure it is read prior to the appointment. It is further recommended that for clinics where back to back appointments are held, that telepsychiatry appointments are scheduled with enough space between appointments to allow the clinician to ensure they have read relevant information about the person, including a summary of their treatment plan and last session, before the commencement of the session.
11 An opportunity to discuss my concerns	**11:** It is recommended that time is allocated during each telepsychiatry appointment for the person to raise issues of concern directly to the treating clinician, in addition to providing the opportunity to raise concerns before and after the interview. The person should be made aware of this opportunity in advance (perhaps through brochure or advertising, or through their case manager) so they can prepare.
12 The clinician uses good eye contact, uses my name, and introduces him/herself	**12.1** That clinicians observe the following telepsychiatry etiquette : -All parties are introduced, whether on or off camera -Ensure they speak clearly into the microphone and do not talk over others -Aim for good eye contact -The clinician is to ensure they can multitask – e.g., adjust the

Element	Recommendation
	camera angle or zoom and speak -Minimise unnecessary movements -Mobile phones or pagers must be turned off or in silent mode **12.2** In addition, the consultation identified the following points of etiquette that would assist relationship development and rapport building: -That the treating clinician provide information about his/her qualifications and position, as well as their name -That the manner of the treating clinician supports confidence by the service user through the effective use of rapport building skills -That sufficient time is allowed to ensure the development of effective rapport **12.3** It is further suggested that telepsychiatry etiquette could be a training element for all staff using these services.
13. That I am informed about any changes to my treatment, medication changes, before the interview finishes so I have the opportunity to ask questions	**13:** It is recommended that, in addition to the requirements that treating and receiving clinician take notes, that people utilising telepsychiatry are offered / encouraged to take their own notes, i.e. of treatment changes and questions, during the interview to assist their active participation in treatment planning.
14. That I have the opportunity after the session to discuss the process and outcomes with the clinical team member who is with me	**14:** It is recommended that as standard practice, there should be an opportunity for people utilising telepsychiatry services to discuss the process and outcomes of their telepsychiatry consultation with their case manager, either immediately after the consultation or at a later time

PART 1: CONSULTATION BACKGROUND

1.1 BACKGROUND

The use of telehealth in the provision of health services, including mental health services to people living in rural and remote areas, has in recent years become increasingly routine and widespread. The wellbeing of people living in rural and remote communities can be challenged by social, financial and environmental factors such as limited education and employment opportunities, social and geographical isolation, economic hardship and the stress of extreme weather events. Lack of information and accessible, quality mental health and alcohol and drug services can make people living in rural and remote areas less likely to seek or receive treatment or support.

Telepsychiatry has increased the capacity of mental health services to respond to people's mental health needs; there are reduced timeframes to access specialist mental health services and services are able to be provided in the person's own community. There are clear health and social advantages to be gained by those who receive telepsychiatry services, and a reduced cost of service delivery on the part of the service provider.

It is in this context that the Queensland Mental Health Commission (the Commission) has engaged Enlightened Consultants to consult with people who have received telepsychiatry services. The intent is to inform the future use of telepsychiatry in Queensland and ensure future practice and guidelines reflect the needs of service users.

The Queensland Mental Health Commission (the QMHC) was established in 2013 to drive system-wide reform of mental health and drug and alcohol systems in Queensland. As part of its legislative mandate the Commission promotes the best interests of people living with mental Illness or problematic substance use, as well as their families and support persons. This includes people living in rural and remote communities.

Enlightened Consultants was engaged via a tender process by the QMHC to undertake this consultation process with people who receive services by telepsychiatry, in order to inform the use of telepsychiatry across the HHS Mental Health Alcohol, and Drug Services in Queensland.

PART 2: THE CONSULTATION PROJECT:

2.1 OVERVIEW, PURPOSE, SCOPE

The Queensland Mental Health Commission (QMHC) has engaged Enlightened Consultants to consult with people who access telepsychiatry for mental health treatment, so as to inform the future of telepsychiatry in Queensland. The aims of the project were:

- Learn from the experiences of people in rural and remote areas who have accessed telepsychiatry
- Determine if telepsychiatry practice is meeting consumer and community expectations for accessible and quality care
- Identify ways that the utility and value of telepsychiatry could be improved, from the perspective of consumers living in rural and remote areas.
- Make informed recommendations for enhancing the practice of telepsychiatry.

Consultations aimed to identify the process and elements that are necessary for effective service delivery of telepsychiatry, and engage those who use the services in a conversation about their experiences of telepsychiatry, so that their voices are heard and reflected in practice and in documents which guide the use of this vital service in the in future. The project also included consultations with natural supports, such as family and friends, on their experiences of telepsychiatry.

Originally the Darling Downs (DDHHS) and Central Queensland (CQHHS) Health and Hospital Services were chosen by the QMHC to participate. Relevant paper work[1] including evaluation protocol, Participant Information and Consent Forms, Plain English Statements and Communication strategy were submitted to the Chair, DDHHS Human Research and Ethics Committee (HREC), who formally acknowledged that the work was consistent with a service evaluation, and did not require full ethical review.

CQHHS was forced to withdraw their involvement following the impact of natural disaster across the area. Townsville HHS were subsequently chosen by the QMHC to be involved and following discussions with the Townsville HREC, relevant paperwork was submitted to the Townsville HREC Chair for consideration. However, the Townsville HREC Chair's decision was that the project required full ethical review, an option not possible to pursue in the given time frames for the project. The decision was made by QMHC to proceed with the consultation solely within the DDHHS.

[1] These documents are appendixes to this report

The Darling Downs HHS Mental Health Service has developed its own local processes and guidelines for telepsychiatry, including the DDHHS *"Management of Acute presentations Using Telepsychiatry (Darling Downs HHS Mental Health Service, 2013)"* [i] which have been drawn upon to inform this consultation. According to this report, the Darling Downs Health and Hospital Service (DDHHS) is the most frequent user of telehealth services in Queensland, accounting for 4083 telehealth episodes in 2013-14, and the data for 2014-15 appears to continue this trend. Considering the top ten telehealth service providers for DDHHS, Mental Health is the largest user, with 871 telehealth episodes in 2014,[2] against the nearest competitor, orthopaedics / fracture clinics, which registered only 270 episodes over the same period.

Within the DDHHS, community based mental health services are arranged through three large clinical teams covering separate geographical catchment areas. Each team has a designated team leader who has staff based in several locations in their area. The Southern Team, based at Warwick, includes mental health staff based in, and covering the surround areas of Stanthorpe, Goondiwindi, Inglewood, and Texas. The Western Team covers the two main towns of Dalby and Chinchilla, with staff and services in each town, and also covering Oakey, Miles, and Tara. The South Burnett team is based at Kingaroy, and provides staff and services in Cherbourg, and also covers and services the surrounding areas of Nanango and Murgon.

For the purposes of this project, it was decided that consultations would occur in the areas / townships most likely to host sufficient numbers for the consultations; however, referrals from any part of the MHS were welcomed. The towns chosen for specific focus were Warwick, Stanthorpe, Kingaroy, Dalby, and Chinchilla. There was an attempt to garner referrals from Cherbourg however it was explained that the number of telepsychiatry users in that community is relatively small due to the higher ready availability of visiting face-to-face psychiatric services.

2.2 CONTEXTUL FACTORS – TELEPSYCHIATRY IN DDHHS

Each of DDHHS's three geographic areas utilises telehealth in very different ways, mostly determined by the availability of visiting psychiatric medical staff. In the Southern area, since the most recent psychiatrist left approximately twelve months ago, the area has relied solely on telepsychiatry services. Some clients in the study reported they had not had a face-to-face visit with a psychiatrist in the last 12 months. More recently some face-to-face services have recommenced.

For the Northern (South Burnett) area, telepsychiatry acts as a backup service; face-to-face services from visiting services are usually available, however if temporarily unavailable, telepsychiatry providing occasional services to Kingaroy and in rare cases to Cherbourg. Telepsychiatry services are provided from Toowoomba.

[2] showing a likely underestimate in HBCIS data

The Western area has psychiatric services to Dalby, and occasionally to Chinchilla, and service users rely heavily on telepsychiatry. All three areas run regular monthly Clozapine Clinics on telepsychiatry.

Emergency mental health services for people accessing emergency departments of rural hospitals are also provided via telepsychiatry by acute care units in local areas where possible, then after hours by the Toowoomba Acute Care Team with its designated psychiatric services. These people may be either current services users or be new to the DDHHS MHS. They may be requiring assessment within strict timeframes imposed by the Queensland Mental Health Act 2000 (Queensland Government, 2000), or be self-presenting in a voluntary manner as a result of crisis or deterioration in mental health. Whilst DDHHS has installed a system of regular use of telepsychiatry for these scenarios, it is unknown whether telepsychiatry is used in a similar manner in other HHSs, or whether its clinical use is confined to more regular follow up appointments.

It became clear during the consultation process that telepsychiatry services are the medium for a number of services to those in rural and remote areas, including hearings of the Mental Health Review Tribunal, access to Drug and Alcohol Services, multi-service conferences for legal matters, and multi-service case reviews. For example a person from Chinchilla who is inpatient in Toowoomba Adult Mental Health Unit may link with their case manager who may be in Dalby, their family member or representative in Chinchilla, and the Mental Health Review Tribunal (MHRT) in Brisbane.

2.3 CONSULTATION DESIGN

The consultation was designed to collect qualitative data to inform best practice in telepsychiatry. The consultation involved a semi-structured interview[3] based on participants' experiences of what has worked effectively in their experience of receiving services and support through telepsychiatry, as well as asking participants to rate the importance of different elements of telepsychiatry practice to their overall experience.

The interviewees engaged for the consultation were people who have direct current or past experience accessing telepsychiatry. Eligibility criteria focussed on those people over 18 years of age, currently or in the past receiving telepsychiatry within the DDHHS, who were therefore within an open service episode for the DDHHS Mental Health Service. The consultation also engaged family, friends and natural supports of individuals accessing telepsychiatry for mental health or substance use issues. The project endeavoured to meet requirements for diversity of perspectives. Efforts were undertaken to include the perspectives of people from Aboriginal and Torres Strait Islander backgrounds, people from culturally and linguistically diverse communities with little success. An appropriate balance of gender perspective was obtained.

[3] The semi structured interview protocol is included as an appendix

The consultation design was for data to be collected either by interview or focus groups. The consultations were face-to-face, by phone or using video conferencing, and were recorded for transcribing. Prospective participants were given the choice as to whether they preferred an individual interview or focus group participation as well as the choice of web conference or videoconference. As only two persons who registered to participate in the consultation selected to participate in a focus group consultation, focus groups were not held due to lack of numbers, and all consultations comprised of individual interviews. In two cases sound recording was not possible for technical reasons, so the conversations were typed directly after the interview. The data were examined to identify patterns or themes and impacting factors. These themes were then analysed and coded for the purpose of the report.

OBJECTIVES

The objectives of the project, relevant to the above purpose and aims were to

1. Collect feedback from people who have received services through telepsychiatry
2. Inform best practice for the delivery of telepsychiatry

ELIGIBILITY CRITERIA

- This consultation focused on people receiving telepsychiatry within the Darling Downs HHS
- People aged over 18 who are currently or have used Queensland Health's telepsychiatry services for mental health treatment, or
- People who provide support (non-paid) to those accessing Queensland Health's telepsychiatry (family or friends) were eligible to participate in this consultation.

Children and youth, under 18 years of age, accessing the Mental Health services were not included in this consultation. On the advice of the QMHC the needs of this group are likely to be specialised, and will be considered separately to adults. It is important to note that Child and Youth Mental Health Services (CYMHS) are integrated with the community mental health teams in rural and remote areas, and currently use video-conferencing.

2.4 COMMUNICATION AND ENGAGEMENT STRATEGY

The Queensland Mental Health Commission negotiated with Darling Downs HHS seeking their interest, agreement and support of the consultation project. Enlightened Consultants negotiated with Executive Director (ED) of the DDHHS regarding the scope and logistics of the consultation project. The ED nominated the Director of Nursing as a contact person and local project lead. As Enlightened Consultants did not have direct access to people who previously or currently are accessing telepsychiatry, the assistance of the local project lead was sought to facilitate distribution of information to potential participants, and to support the clinician engagement required to support recruitment.

The Enlightened Consultants project officer met with the Director of Nursing and Manager of Rural Services to collect background information about the service/team structure and use of telepsychiatry. Following this meeting a multi-point video conference was attended, which included the team leaders of the three community mental health teams covering the DDHHS rural areas; Southern Downs, incorporating a small team at Stanthorpe and solo workers and visiting services to Goondiwindi and Texas; Western Downs, including teams based at Dalby and Chinchilla and outreach services to smaller centres; and Wide Bay/Burnett area, consisting of Teams in Kingaroy and Cherbourg, and outreach components. The majority of case managers from Warwick, Chinchilla and Dalby also attended the videoconference. All in attendance received a 15 minute presentation covering the project aims and proposed processes for communication and participant recruitment, which was well received.

Negotiated communications with the DDHHS were:

- Email from Enlightened Consultants acknowledging receipt of the referral and whether or not the person met eligibility requirements;
- Liaise with case managers for support for the interview arrangements if required;
- Regular fortnightly feedback to local project lead, Manager for Rural Services, and team leaders regarding the intake of referrals and adjustment of estimated timeframes for completion, which changed during the project.
- As participants were active within the Mental Health Services of DDHHS, case managers were seen as the primary contact point. Case managers were also requested to pass the project information on to related NGO and support services in the local community.
- At a later stage in the project, the networks developed by the consumer and carer consultants who were based in Toowoomba were used to support the recruitment process.

2.5 PARTICIPANT RECRUITMENT

Case managers were supplied, in both hard copy and electronically, a package[4] to give to potential participants, consisting of The Participant Information Sheet (Plain English Statement), an introductory script, a flyer, and a consent form which gave the case manager permission to release the person's contact details to Enlightened Consultants if they wished to either participate or gain more information. Case managers were also provided with a referral form, which requested additional details including:

(i) the person's preference for interview by phone, face-to-face, web conference or focus group and

[4] These documents are contained within the appendix

(ii) whether participants felt they might require assistance understanding or completing any of the paperwork.

Case managers then scanned the consent and referrals and sent them electronically to Enlightened Consultants, where they were allocated for interview. In some cases the person kept the paperwork they had been given by the Case Manager and self-referred to Enlightened Consultants at a later date.

Once referrals were received they were entered on to a confidential database. The person was contacted by phone and given more information about the project and an opportunity to ask questions. They were advised also of the consent process, verbal consent was obtained and the consent form and Participant Information sheets were put in the mail with self-addressed envelope, or hand delivered in case of face-to-face interview.

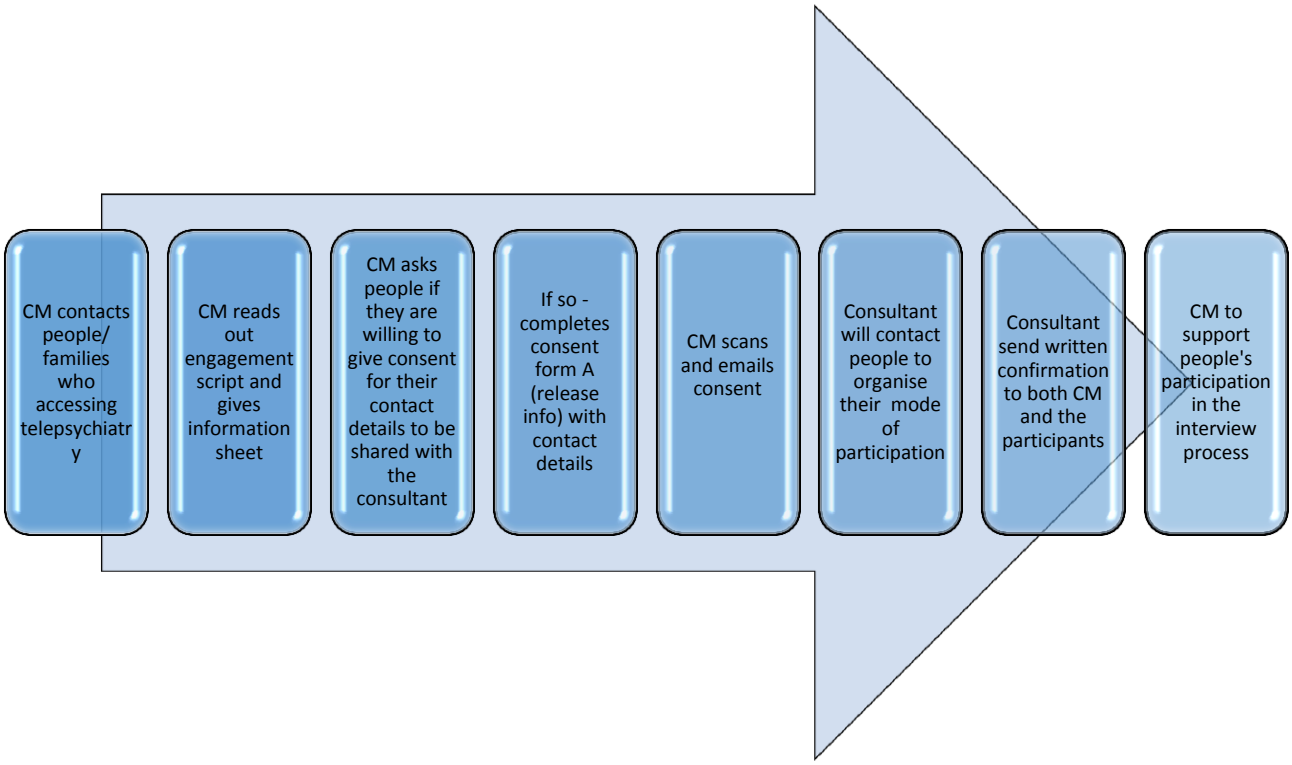


Figure1 Telepsychiatry Study - Case Management and recruitment Process

2.6 THE CONSULTATION: PROCESS AND CONTENT

The QMHC approved two (2) sets of questions to guide the semi-structured interviews with participants. One set was for use in individual interviews; it consisted of open ended questions exploring the person's recovery through telepsychiatry, what challenges the person may have faced in using telepsychiatry, and how the experience compared to that of a face-to-face consultation with a psychiatrist. The second set of questions related to 14 elements that may influence their experience of telepsychiatry, identified by a telepsychiatry working group chaired by the

Queensland Mental Health Commission's consultant psychiatrist. Participants were asked to decide whether each element was essential to a good experience, good but not essential, or may contribute to a negative experience. The questions are attached in the Appendices.

Interviews were conducted by three (3) interviewers and checked for inter-rater consistency in style and coding. Each interview, regardless of format, began with introductions and a verbal description of the project and its aims, as per the information sheet, if the person indicated the time was suitable to continue. The Participant Consent was also read and verbal consent obtained at that time to proceed. All interviews were sound recorded with the person's permission. Confidentiality and the right to withdraw from the project were also outlined. The person was also advised that as per the Participant Information Sheet provided they would receive a $60.00 pre-paid Visa Card. These were delivered by mail to all but face-to-face interviews, where they were usually delivered by hand and signed for. Two interviews, which were unable to be sound recorded for technical reasons, were transcribed from brief notes and typed out in detail immediately after the interview took place. Hard copies of Participant Consent Form and Participant Information Sheet were then sent to all those who had not received them directly via their face-to-face interviews. All participants were advised that they would not be identified in any way in subsequent reports, and they were encouraged to speak freely. Interviews took between forty (40) minutes and seventy-four (74) minutes.

Data were entered into excel spreadsheets and sorted for themes and factors. The items reported were those that appeared as a clear response from the majority of participants, as well as those where there was a significant discrepancy in participant responses. Following this there is discussion of factors that may contribute to these results. Also, some comments have been reported that have been made by one or a small number of participants, but which were seen to have high significance as they highlighted ethical or equity concerns related to the delivery of telepsychiatry services.

2.7 ETHICAL CONSIDERATIONS

There were a number of ethical considerations in the project that should be mentioned, apart from those which have already been presented, such as potential biases in the sample selection.

Confidentiality was extremely important to the success of this project. All original spreadsheets, documents and recordings are being stored in confidential accounts of Enlightened Consultants, in accordance with privacy and confidentiality legislation requirements. Records and documents were shared by the project team at Enlightened Consultants via a confidential Drop Box account. Only de-identified data will appear in project reports and presentations.

The issue of equity of access to the project arose when it became clear that not all those with telepsychiatry experience were being given the opportunity to participate, depending on their case manager's level of engagement in the project, and their consideration of which people would be

likely to engage. The lack of Indigenous and CALD participation in the consultation significantly limits the generalisability of the consultation.

During the initial engagement process, it was noted that Child and Youth Mental Health Services are provided by designated staff integrated within the community mental health teams. Case managers raised initial concerns that the limitation of the consultation to an adult population could be perceived as disadvantaging families of those children and youth who already access telepsychiatry services. This issue was taken to the Commission and clarified, and case managers informed that the needs of children and youth and their families would be dealt with at a future time, and reassured that the matter had been raised with the Commission.

2.8 THE SAMPLE- DEMOGRAPHICS AND LIMITATIONS

Twenty-eight (28) Individual referrals were received. Twenty-one (21) referrals were completed to interview stage. Following referral and contact from Enlightened Consultants but prior to interview, two (2) people decided to withdraw from the project for personal reasons, initial contact was made with three(3) people but were unable to follow through with interviews as they did not attend or recontact; three (3) people were unable to be contacted.

Of the sample, five (5) people identified as either family members or natural supports, four (4) female and one male. Of these, two (2) were a married couple who are both clients of the DDHHS MHS and also identify strongly that they provide mutual care for each other in times of crisis or illness, and require the support of the other to remain living independently in the community.

INTERVIEW TYPES AND LOCATIONS

LOCATION (MHS)	NUMBER OF I/V	FACE-TO-FACE	PHONE	WEB/ VIDEOCONF
DALBY	4	2	2	0
CHINCHILLA	3	2	1	0
WARWICK	4	0	4	0
STANTHORPE	4	0	1	3
KINGAROY	6	6	0	0

Two outreach trips were made by Enlightened Consultants to interview those who preferred face-to-face interviews. These were to Chinchilla and Kingaroy. Face-to-face interviews at those locations were at Chinchilla were at the private residence of the person after the case manager verified there were no current home visiting safety alerts on the Consumer Integrated Mental Health Application CIMHA. At Kingaroy, interviews were held at the Community Mental Health Team rooms, located within the Kingaroy Hospital grounds, due to the fact that participants were located some distance from the centre, requiring significant additional travel time.

SAMPLE LIMITATIONS

There were some clear limitations to the project sample.

(i) There was no successful engagement of indigenous people, despite approaches to the team servicing Cherbourg and also the use of consumer and carer consultants. It was explained that Cherbourg itself has well established and regular visiting psychiatrists, and that use of video conferencing for that community is minimal. The consumer and carer staff contacted people who identified as being indigenous from the other community mental health teams directly, to invite participation but few were able to be contacted and no one accepted. This limitation is unforeseen and there may need to be further consultation with the Cherbourg community regarding the experience of telepsychiatry.

(ii) Similarly with those from culturally and linguistically diverse (CALD) backgrounds; the area covered by the sample tends to be mostly farming communities, and despite requests to case managers to assist with identification of possible CALD participants, none were able to be identified. Initially it was hoped that these sample limitations might be rectified through engagement with Townsville HHS, however this did not eventuate.

(iii) The sample may also lend itself to some bias due to the recruitment process; some case managers were more active in inviting people than others, and it is possible that the offer was more acceptable to those who were more able to respond given their mental state at the time, so perhaps those more highly functioning.

(iv) Another limitation concerns the restrictions imposed by eligibility criteria. As those participating were those with open service episodes to the mental health service, or their family members, recruitment missed people who had used telepsychiatry in emergency departments (ED's) as the result of a Mental Health Act 2000 related acute presentation, but were subsequently not accessing ongoing mental health services. It was felt that this group was not only outside the eligibility criteria, but were unlikely to engage in a project such as this where they may be seen to be in some way associated with mental health services.

PART 3: RESULTS AND DISCUSSION

3.1 THE VALUE OF TELEPSYCHIATRY TO RURAL AND REMOTE QUEENSLANDERS

Analysis of the data collected from participants reveals immediately that the use and acceptance of telepsychiatry in rural and remote areas is related as much to contextual factors in the delivery of the service, and the context of the community to which it is delivered, as to the actual service itself. It is clear that telepsychiatry cannot be considered in isolation in any analysis of user preference or when considering potential improvements to telepsychiatry practice.

This section commences with an overview of comments made by participants that help to establish the relevant contextual factors and thus enlighten further discussion by participants. The report also reflects the views and thoughts regarding telepsychiatry that participants were clear they wanted to express and be clearly heard regarding any possible changes or state-wide recommendations, which may affect the way, their services are delivered.

There was a clear view expressed by many participants that the telepsychiatry services they receive are essential for their wellbeing and recovery. Participants regularly expressed the view that telepsychiatry, regardless of any perceived flaws, was much better than no service or relying solely on services located a long distance away from their home or community. Particular themes included the ideas that:

1) Telepsychiatry makes services much more accessible, and therefore the person is able to get needed help before significant deterioration, and without the stress of having to travel to access psychiatrist services in an unfamiliar town or over great distances. Two participants described using telepsychiatry and avoiding an admission to hospital as the result of early intervention. One woman described her experience after moving from another QLD rural HHS, and becoming unwell - when telepsychiatry facilitated a needed admission.

> *"I have been admitted via telepsychiatry. When I moved here I was really unwell. It only took 2 hours at my local mental health for them to set up the video appointment with a psychiatrist. The acute care person set it up. I was admitted by that afternoon. It's cut down the time it takes to get help a lot. It's so much easier-I only have to go 10 minutes away. And it's much less expense. If I'm unwell, my moods are all over the place, I can see a psychiatrist in a couple of hours, rather than waiting for a face-to-face appointment or traveling to one. So you don't get as sick as if you had to wait. So you recover quicker"*

2) Telepsychiatry services save money for users of this service in financially stressed country areas. An example of comments from many participants:

> *"For me it's been a lifesaver… …It is extremely convenient. For me, if I travel to Toowoomba or Brisbane, I would have to take a bus, because I can't deal with the traffic… its expensive and stressful getting there…. I think all little towns like this should have access to telepsychiatry… it's brilliant. And now, in the country, things are tight,*

there aren't many jobs around. People can't afford the cost of trips to Toowoomba or Brisbane. I think people who can't afford it should always be offered telepsychiatry."

3) Telepsychiatry supports family members in rural areas in multiple ways. A carer described how much the telepsychiatry has meant to her in her role as a carer for two sons with schizophrenia, and also how it impacts on their recovery and wellbeing:

"Telepsychiatry is essential for where we live. It saves enormous amounts of stress and pressure for me as a carer, especially when (my son) is unwell. He can talk to a psychiatrist here in a familiar environment. It's brilliant. I would be driving 2 hours each way, and finding parking, getting to an appointment, waiting- it's the whole day. The drive would also make his mental state worse as well, and going to a big hospital and lots of strangers, which affects how he communicates. For people with mental illness, establishing trust is difficult, so it's essential he has a case manager who knows him, so he comes in for telepsychiatry to our local mental health service feeling safe and in a familiar environment"

4) Another theme expressed by several participants concerned the additional isolation felt by people who live away from country centres:

"It's not really any different to meeting in person. I understand that the doctors are under a fair bit of pressure it makes sense that they do it this way. It's a 130km round trip for me to go and meet with them. It gets a bit lonely out in the bush so after using telepsychiatry I feel better 'cause I have had someone to talk to. Having telepsychiatry means I'm less isolated."

3.2 THE KEY ISSUE OF RELATIONSHIP DEVELOPMENT

This issue was explored in depth with all those interviewed. What became clear in these discussions was that there were many factors impacting on whether the person felt that a good or useful relationship was developed using telepsychiatry.

The first of these and most dominant theme emerging from the consultation was the added difficulty experienced by telepsychiatry users when faced with a different doctor for almost all appointments. Many of the challenges expressed by users of the service centred on the difficulty of establishing rapport, maintaining continuity and consistent direction for their treatment, whilst also using a screen based medium. As one participant put it,

"When they change doctors frequently it gets really hard, and it becomes a second rate service. If they can keep the same doctor as much as possible that makes a big difference."

It is clear that for telepsychiatry to be effective, measures to improve continuity of care must be considered.

Not all of these factors related directly to the telepsychiatry experience, some were more related to the type of use the person was making of it (for example, regular follow up appointments, obtaining acute assistance, or MHRT). Often the view of the success or usefulness of the service was relative to the outcomes of the appointment; if people received a good service, or one that they found beneficial because treatment has been successful, they tended to view the telepsychiatry much more favourably. Also of relevance was the issue of the availability of face-to-face services - some areas did not have a face-to-face psychiatrist service at all and relied solely on telepsychiatry. For these people, the alternative of face-to-face services included significant expense, stress, and disruption to their lives as they would otherwise have to travel to obtain the service. Not surprisingly these participants were more likely to favour the videoconference as a mode of essential service delivery that they would not otherwise have.

Here we have attempted to identify and highlight significant themes emerging that participants using telepsychiatry had felt impacted, positively or negatively, on their view of telepsychiatry experience.

a) Language and cultural issues

b) Continuity of medical care

c) The manner of the doctor

d) User familiarity with telepsychiatry

e) Type of use

f) Local context / organisation of access to telepsychiatry services

g) Technical issues

h) Preference

LANGUAGE AND CULTURAL ISSUES

Twelve (12) participants reported that they had difficulty understanding what was being said by doctors with strong accents. Most of these reported that their case manager acted as somewhat of an interpreter, asking the doctor to restate if necessary and clarifying with the service user what was being said. The following comments are typical of responses in this category

> *"some of the doctors are foreign, it's hard to understand what they've said, it's good to have the case manager there to check what they've said. Subtitles would be great! Even face-to-face, the accent is a problem."*

"Had some doctors with strong accents- same difficulty face-to-face, although face-to-face may give you better body language"

"The foreign accents- they just need to slow down so they can be understood".

"It's important on the video conference to make sure the person can speak English properly"

"Closed captioning would be great"

CONTINUITY OF MEDICAL CARE

Of the services users interviewed, 11 reported having access only to videoconferencing, 3 reported that that they usually saw a doctor face-to-face but used the video link when the person was sick or unable to visit; and 5 reported their services alternated on a more regular basis between face-to-face and video conference. Of all these people, 16 reported that they see a different doctor on most occasions. Some reported that they had seen the same doctor twice recently. Most people reported that this lack of continuity posed significant problems for them in relationship development, and which were made at times more difficult by the medium of telepsychiatry.

"When you're struggling with issues, having a breakdown in front of a camera is different, than having a face-to-face appointment. Having the case manager beside me is really important as support. And usually you get a different doctor each time. I have to re-traumatise myself going over my history every time I meet a new one. And on a TV screen"

Another user described the feeling of hopelessness when a new doctor didn't appear to be prepared with the person's history and treatment:

" You shouldn't have to repeat yourself and your story every time you change doctor, you go back to square one. It makes you feel hopeless. A summary at the end of each session would be good, documented, they can refer to, and the new doctor can start with that"

Most participants reported that having the case manager there was essential to ensure the doctor was informed about pertinent issues related to a person's care, and was able in this way to ensure some continuity.

THE MANNER OF THE DOCTOR

Eleven (11) participants reported incidents where the manner of the clinician interviewing had negatively impacted on the relationship development with the person. Two (2) participants reported a positive event. The significant themes emerging from the discussions were the need for the doctor to take the time to get to know the person, their interests, their life and own ways of supporting their recovery, and have a personable and respectful manner. The second theme reflected the

impact of adverse behaviours such as typing during the interview, talking over the person, rushing through the interview, or reading through the person's notes while they watched. One person reported that her doctor had actually fallen asleep in the appointment.

> *"The more they know about you personally the better they can help you. I have a bird, I have to care for it, it's my responsibility, it helps me stay well. They should know that.*
>
> *"The last two times were really good- I had the same doctor, it worked out better, he looked at my whole history, he was very understanding. I felt comfortable with him I'm not normally comfortable using the video link. His manner– wasn't too serious, even though he hadn't read my notes, he apologised to me, and my case manager filled him in, and made it easier."*
>
> *'The best experience was with Dr K. He asked me questions about my interests, made me feel better. He took the time to get to know me. The others were foreign doctors. I don't think they understood me; not just my accent (I am Scottish) but who I was.*

As one family member commented:

> *"A lot depends on the psychiatrist- how personable, knowledgeable, and respectful of my son. In one such appointment where the doctor was like that, the relationship worked really well."*

The following 2 comments are typical of adverse behaviours identified by several participants:

> *"The psychiatrists tend to rush through via video, it's easier for them to talk over you. Sometimes the Dr is typing while talking to you and you have no idea what they're typing and if they're paying attention. They're more likely to do that on telepsychiatry"*
>
> *"At the last one, the doctor took a phone call in front us during the interview, we couldn't hear what he was saying, it wasn't in English"*

USER FAMILIARITY WITH TELEPSYCHIATRY

All the participants interviewed had prior use of telepsychiatry; the length of this varied from 3 sessions to many sessions over 10+ years. However, many made comment about their initial sessions on this medium that generally indicated that while they had all found it a somewhat strange experience initially, had mostly gone on to find out that they got used to it over time.

> *"It doesn't bother me talking to a TV screen. I love it, it's so easy, it's like they're in the room. It's just the initial part, I get nervous when I meet someone new. But I don't mind either way, as long as you have your case manager with you that's what matters"*
>
> *"When I first started using it, it was pretty daunting but once you get used to it its ok. Takes a few goes before I felt comfortable with it. Saves having to travel. Helps prevent having to go into hospital because I can see someone when I need to"*

TYPE OF USE OF TELEPSYCHIATRY

Participants indicated that a number of different types of service had been delivered to them using telepsychiatry. Seven (7) people identified they had utilised telepsychiatry when acutely unwell. These people generally reported a very positive experience, associated with getting help more quickly and sometimes avoiding hospitalisation. One person who had also had a positive experience if getting help quickly via telepsychiatry compared it to one of her experiences in Brisbane, after she had been discharged from the local MHS and become unwell.

> *"I was in Brisbane, I went to ED, I'd been sick for 2 weeks. The doctor wasn't convinced I was unwell, wouldn't believe me, said my voice was too calm. No wonder people start yelling and screaming and security gets involved. I recommend it be used in ED's- With telepsychiatry you can get straight onto someone who knows about psychiatry, rather than go through ED. Some places in QLD you can go straight to a mental health team, other places, they make you go through ED first. They should use telepsychiatry in all EDs to get specialist mental health help sooner. I've been hurt by security in ED in Brisbane before. A lot of people wouldn't get hurt and misunderstood. To have to go through that when all you want is help. The memories are distressing. Painful."*

> *"I have used telepsychiatry when distressed / depressed- they can still tell, even if I'm trying to hide it. They pick it up just as well. It was more difficult with hearing that time-it was a challenge to communicate, had to ask case manager a lot more. Also if I'm distressed, I find it a bit harder to focus on."*

Two (2) people who identified as hearing voices mentioned that telepsychiatry could be more difficult if the person was hearing voices, and one carer who has twin sons with schizophrenia noted

that even if her son would not use telepsychiatry while very unwell, it could still be utilised by the carer / case manager to obtain needed assistance.

Four (4) people identified they had used telepsychiatry for MHRT hearings. One indicated that an MHRT hearing had been his first experience of telepsychiatry, and he had found it very daunting to know little about the service and suddenly be facing a number of people on the screen. One participant reported receiving drug and alcohol services via telepsychiatry.

THE LOCAL CONTEXT/ ORGANISATION OF TELEPSYCHIATRY SERVICES

Some service users identified that the way the telepsychiatry services were set up locally had a marked impact on the outcomes of services delivered. One person described it this way:

> *"The organisation of it is very important, so people can get access to it quickly. If the mental health team works effectively, that is essential for telepsychiatry to work well. They organise and trouble shoot things. So they need to be educated and have clear processes. They're a really good team here. One day can make a big difference. Gives you some peace of mind."*

TECHNICAL CHALLENGES

While most telepsychiatry users felt their services generally went off without a hitch, others described challenges such as time delay between the picture and sound. One person reported having to reschedule her appointment as the equipment could not be made to work, and 2 others reported being made to wait at the beginning of clozapine clinics while the clinicians attempted to make the link function. One person reported that on one occasion the sound wasn't working properly and she had to wear headphones, which she found very difficult.

PREFERENCE

The issue of individual preference for each person seemed to be formed from a complex interaction of the above factors, added to the general concept that services provided locally, particularly when there was no local alternative, were of clear benefit to the rural or remote service user. Generally those interviewed rated them fairly closely in terms of preference; people found telepsychiatry services no different to face-to-face services. Ten (10) people stated a clear preference for telepsychiatry services. Eight (8) of those consulted stated a preference for face-to-face, but two of those reported the difference was marginal. Three (3) participants were unsure. Of those who expressed preference, the following comments were typical:

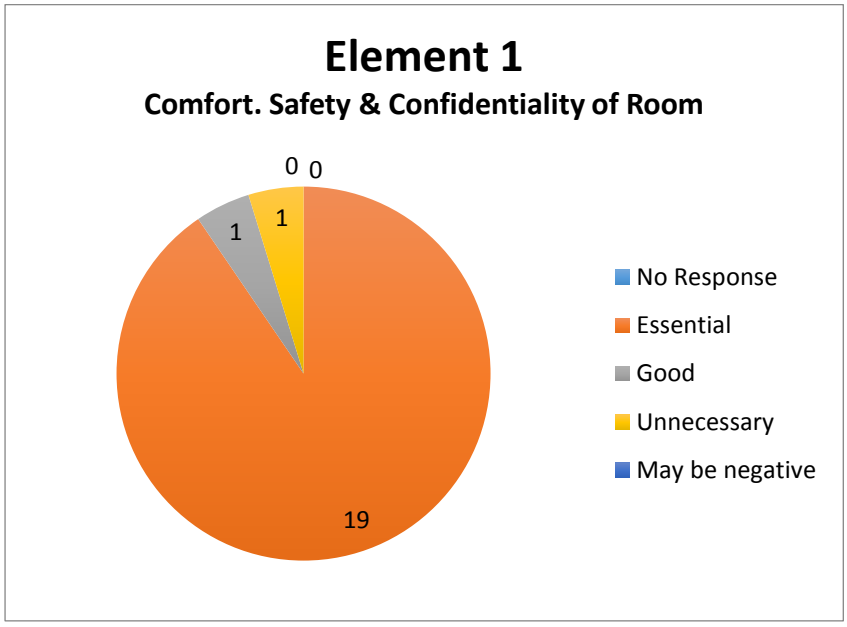
> *"I really enjoy it. When I was very unwell, - it feels like the psychiatrist is there in the room, they can see you. The relationship- same as face-to-face, if not better. If you have to wait for the face-to-face you would be a lot sicker"*

> *"I would prefer face-to-face but once you get used to it, it's no problem, and I much prefer telepsychiatry to travelling to Toowoomba. In fact, in some ways I share more using telepsychiatry because there is a barrier between me and the doctor and so I feel freer to say things that I'd be worried about saying face-to-face."*

3.3 IMPORTANT ELEMENTS IN TELEPSYCHIATRY PRACTICE

Participants were specifically asked to respond to fourteen elements that might influence their experience of telepsychiatry. They are asked to rate the elements as to how essential, or not, they were in creating a positive experience of telepsychiatry. The following outlines the collated responses from people, with associated qualitative responses.

ELEMENT 1: The comfort, safety and confidentiality of the room



Overwhelmingly, (19 of 21) participants felt that the comfort, safety and confidentiality of the room in which the telepsychiatry consultations were held was essential to develop trust and an atmosphere where the person could communicate openly. One participant who rated this good but not essential, commented *"it doesn't need to be that comfortable, you're not there that long."*

The importance of confidentiality was expressed by one person, who related his fear of lack of confidentiality:

> *"I feel like a freak 'because the medication made me grow breasts and if anyone knew I'd feel like my confidentiality had been ruined"*

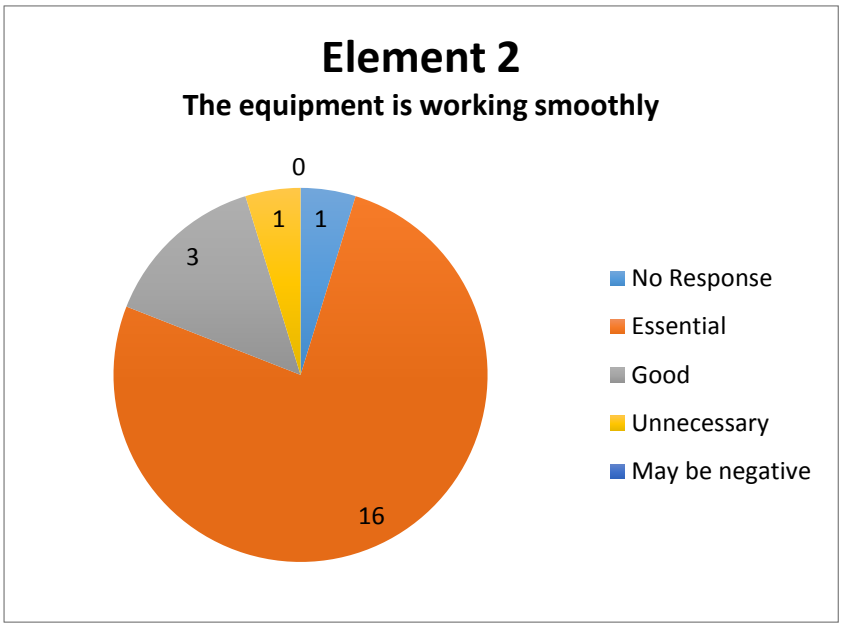
Another person described how his initial concerns about who might be unknown by him sitting in on the videoconference and who might have access to his private information was a significant barrier to using the service initially

> *"In the beginning I had a phobia about people having access to me and my information. You don't know who's there, who's getting that information. But I've gotten used to it over time."*

RECOMMENDATION 1

In order to facilitate the trust and confidence of people accessing telepsychiatry, it is recommended that issues of confidentiality are discussed prior to use of the telepsychiatry service. This discussion should include advice regarding the confidentiality of personal information, the security of written notes or other documentation relating to the videoconference taken by involved clinicians, and whether any part it being recorded, in accordance with existing privacy and confidentiality legislation and HHS policy requirements.

ELEMENT 2: That the equipment is working smoothly



The large majority of those consulted (18 of 23) felt this was essential. Participants related various experiences where equipment had worked well, and many where the main problem was the initial set up. The comments are typified by this one succinct comment from a carer:

> *"There's often been glitches, things like no sound, everyone tries things, and then eventually they call for help. They need to maintain the equipment regularly and also train the staff properly"*

Participants from one centre tended to report that the equipment was checked before use and that there were seldom problems. Others however pointed out the need to ensure staff were trained in using the equipment and the equipment was checked regularly before use. In one instance, it could not be made to work and the consultation had to be done over the phone.

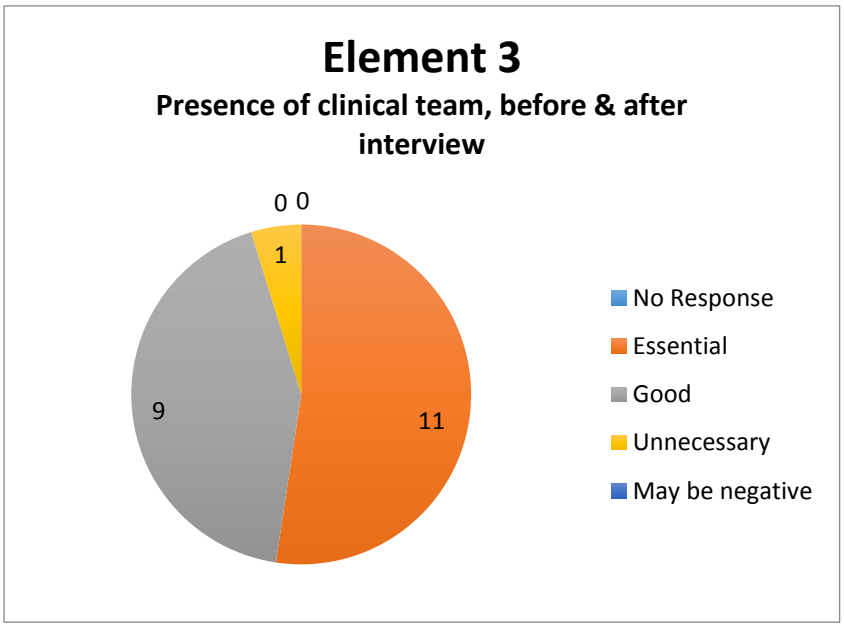
Of the three participants who rated this element as good but not essential, all 3 described other factors such as the manner of the clinician, or the rushed nature of their appointments, as more significant factors. One person did not wish to comment on this item and one felt it didn't matter as they perceived the appointment gave them a welcome break from their workplace.

RECOMMENDATION 2

2.1: That videoconference equipment is checked regularly, prior to use, to minimise disruption due to functionality issues.

2.2: That all staff involved in the provision or support of telepsychiatry services receive training on equipment set up and problem solving.

ELEMENT 3: The presence of one of the clinical team before during and after the interview.



Participants were divided in their responses to this element, however some common themes emerged. One point made by a large majority of participants was that the person with them needed to know them well; many indicated the role of the a case manager as someone who could advocate for them, raising issues they felt unable to raise, clarifying things the doctor has said which were not understandable because of foreign accent or jargon, and providing reassurance and emotional support to the person as needed. It was strongly expressed this person should be the case manager, or a person on the team that the service user feels knows them well, as opposed to a randomly delegated member of the clinical team. Participants were keen that practice and guidelines reflect this.

There was fairly uniform support for the idea that the case manager needed to be at the interview, to handle clinical information such as blood tests results, and also to ensure that the ongoing plan developed with the person was clear, understood, and agreed to by all present.

However, the issue of having time alone with the psychiatrist was raised by a number of participants. Several expressed the view that their case manager did not need to know every detail of their concerns, and that if they were receiving this service face-to-face it was unlikely their case manager would be present. As one participant commented:

> *"I think you should have some one-to-one time with the psychiatrist. Some things are embarrassing to talk about in front of another person. You'd open up more if it was just one-to-one"*

And similarly:

> *"Depends on what you wanted to say to the doctor. Might want to have some privacy"*

These participants suggested that after the interview was set up and underway, that the person is offered some one to one time with the doctor if they wish.

> *"Sometimes I'd like to speak to the psychiatrist alone but haven't asked for that. Would be good if they made that time. Sometimes there's things in my head I feel uncomfortable about them both hearing at the same time. Maybe the first 10 minutes just you and the doctor."*

> *"The case manager might not know every detail or your life, you might want to just talk with the doctor, not someone who doesn't know about that thing. Can be good to have someone, but also have the choice to have time on your own with the doctor"*

The issue of the presence of the clinical team member before and after the telepsychiatry appointment drew much more varied responses. Only 13 of 23 people felt all these parts were essential. 8 felt all parts were good but not essential. It was clear that some people wanted these opportunities, to prepare and to reflect on the interview outcomes and processes. Others, coming in for routine appointments such as Clozapine Clinics, felt that preparation time was not necessary, and also that time after the appointment may not be available or suitable, and that they could catch up with the case manager in a follow up appointment.

> *"The time beforehand with the case manager is not necessary if you are running late; could be good to have some time to ask doctor anything in private. Good to have them (case manager) there during the interview to clarify things and after to reflect, but if that's not possible it would be good to have a follow up appointment in the following couple of days".*

One person felt it was all was unnecessary, saying:

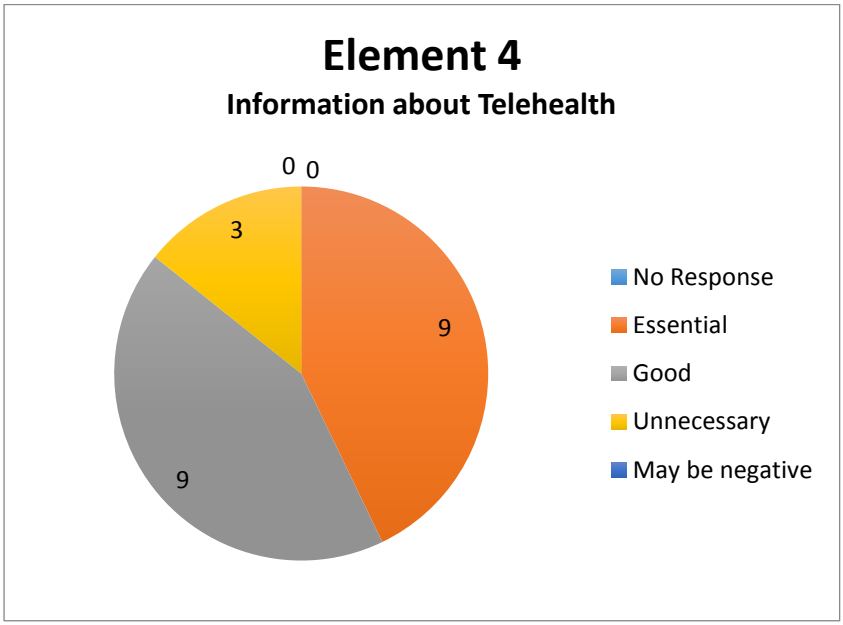
> *"I'd rather have my fiancé there than the case manager". However, there was general support that these opportunities for support be offered to / negotiated with each person.*

RECOMMENDATION 3

3.1: It is recommended that the case manager be present for the telepsychiatry interview. Additionally, it is recommended that at some point in the telepsychiatry appointment the person should be offered the opportunity to talk privately with the doctor if they wish to do so

3.2: That the person is offered the option of time with their case manager before and after the interview for preparation and reflection, if they wish.

ELEMENT 4: Information about Telepsychiatry that is easy to understand and discusses options and risks



The majority of participants noted that they had been given some verbal information about telepsychiatry before they started using it. The information was reportedly of a general nature. Two (2) participants reported that they were not given any instruction prior to using it.

> *"I was not given any explanation the first time, was just sat down in front of the screen and saw this doctor, I didn't know who he was. I was very frightened."*

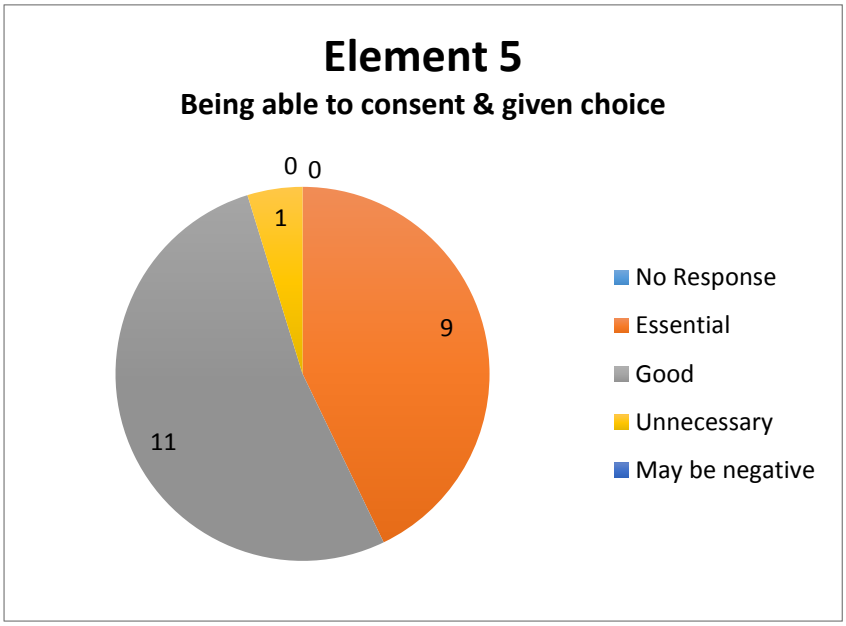
Another person stated that his first experience of telepsychiatry had been in front of the Mental Health Review Tribunal.

Equal numbers of people (18) thought that prior information was essential (9) or good but not essential (9). Five (5) participants suggested that some sort of written information in the form of a brochure outlining the benefits and limitations of telepsychiatry, would be useful. One carer suggested these could be put in mental health waiting areas. One person suggested that verbal information is hard to remember, particularly if feeling nervous or anxious, and that clear written information would be better to refer to.

RECOMMENDATION 4

That the person using telepsychiatry receive plain language information discussing options and risks. They should also have an opportunity to ask questions regarding this information prior to commencing telepsychiatry.

ELEMENT 5: Being able to consent and have choice in receiving telepsychiatry



Eleven (11) participants rated this element as essential. A further ten (10) participants rated this element as good but not essential. In relation to these ten (10) participants, the participants reported that as they were happy with the psychiatry service, choice was not necessary for them. However, in both of these groups, there were 6 participants who identified that some people, perhaps more elderly people, or those wo don't use computers, that may be less likely to feel comfortable with screen based services, and may prefer to travel to access face-to-face services; and that for these people, choice may have greater significance. One participant who has utilised telepsychiatry for a range of service and in other states, made this comment to note that consent should be for good reasons.

> *"Some people find it confronting, I've heard that, about letting a TV tell you what to do. Maybe they have less education or they're just not happy with anything from MHS. It might be hard if you're hearing voices, but I think some recalcitrant say that just so they can get out of the assessment."*

There was however general support for the concept of having choice, while acknowledging the actual choice where there are no local choices is limited for those who do not have transport or can't afford to travel. Most participants either were not offered choice or did not remember if they had been. Only two (2) participants reported they had been told they had a choice about using telepsychiatry.

In most responses, participants did not differentiate choice and consent. However, one family member of twin sons with schizophrenia made this comment related more specifically to the issue of consent as it applied to an emergency assessment situation:

> *"My other son won't go to appointments when he is unwell, when he won't speak into a TV screen, as this is part of his delusional beliefs. I prefer having the telepsychiatry*

service. It's still necessary for urgent situations. Even if the person won't communicate, another person can talk to the psychiatrist and report the behaviours. They need to consult with families as well about whether the person can use telepsychiatry. My sons differ in this regard."

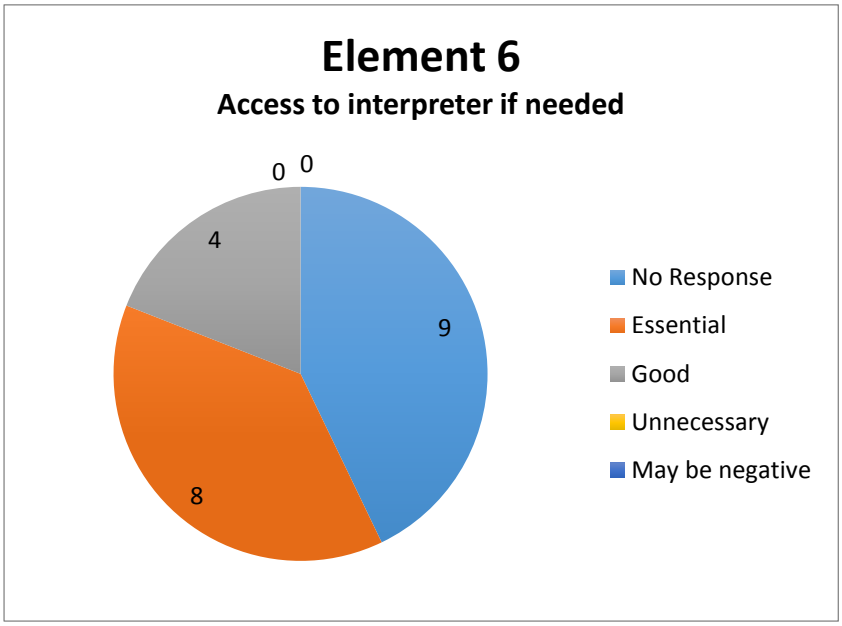
RECOMMENDATION 5

5.1 That where alternatives exist for face-to-face services, even where this may involve some travel or inconvenience, that these options are outlined and the person has, as far as possible, choice in the mode of service delivery including a mix if possible.

5.2 That standard consent arrangements for mental health services be applied to telepsychiatry, noting the exception to informed consent that may be imposed by the Mental Health Act 2000(Queensland Government, 2000).

5.3 That the principle of family involvement be reflected in telepsychiatry practice and guidelines. That the service user is given the choice regarding involvement of specific family members/ natural supports, identified by the person, to participate in telepsychiatry interviews in the event of the person's emergency or acute illness.

ELEMENT 6: Access to an interpreter if I need one, and having information in my own language

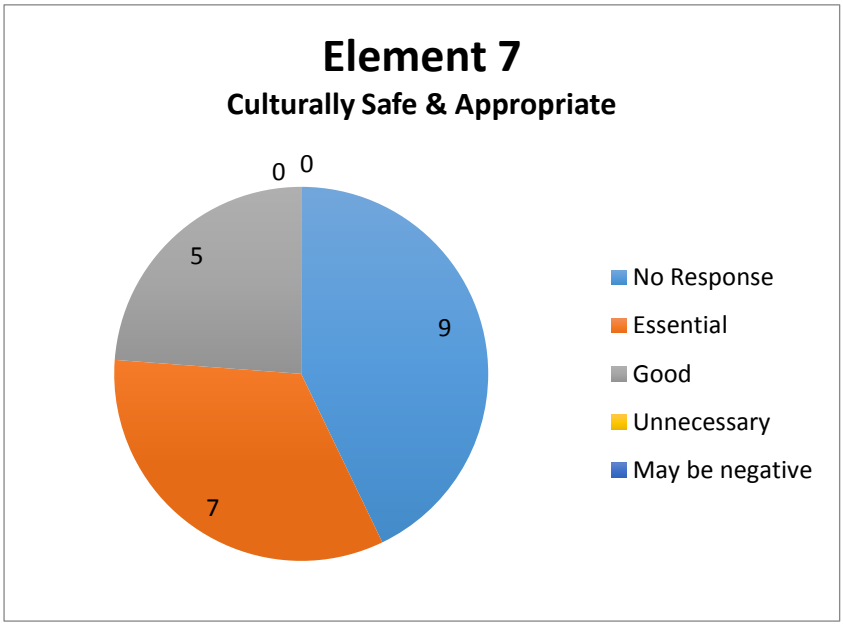


No-one in the participant group had used or needed to use an interpreter, or had a first language other than English. Eleven (11) participants chose not to respond to this question. Six (6) participants felt it would be essential for others who may need it, and three (3) participants felt it was good but not essential. One carer made the suggestion that it may be helpful if prior to using the telepsychiatry, the person's language and information and cultural needs were identified by the case manager, or in emergency through consultation with family members.

RECOMMENDATION 6:

That people accessing telepsychiatry have access to an interpreter, if needed. That assessment of the service user's language, and information needs is undertaken prior to organising telepsychiatry services for that person.

ELEMENT 7: Culturally safe and appropriate to my cultural needs

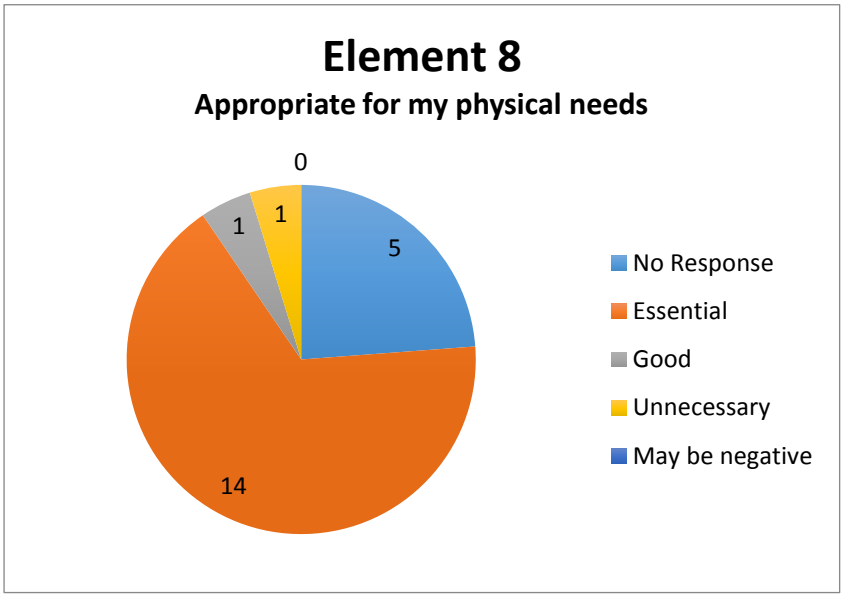


Despite no-one identifying with a specific indigenous or CALD background, those that responded to this element all rated this item as essential or good. Given the broad concept of culture, which includes age, beliefs, family and social grouping, this result is significant and reflects the wishes of participants that telepsychiatry services meet the individual needs of those using them.

RECOMMENDATION 7

It is recommended that assessment of the service user's cultural preferences and needs is undertaken prior to organising telepsychiatry services for that person.

ELEMENT 8: Appropriate for any physical limitations I might have (for example visual or hearing loss)



The majority of participants (16-3) rated this element as essential. Five (5) of those consulted did not make a rating, and comments reveal this is likely to be related to the fact that they didn't themselves have a visual or hearing loss. The comments from those who rated as essential centred on the needs of people who may have poor hearing, and two (2) people requested that the possible of electronica hearing loop for hearing aids be investigated. Two (2) people reported having visual problems affecting their ability to see the video screen, which had not been reported to the case manager:

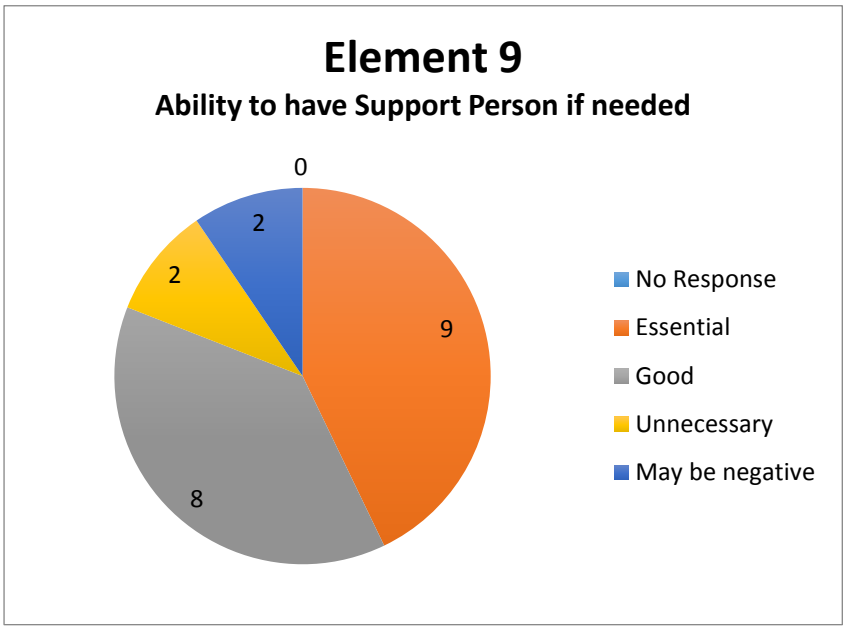
> *"I can't see the screen properly. Sometimes it's a fair way away. They should check people can see and hear the screen before they start."*
>
> *And:*
>
> *"When you get stressed you don't hear well. I have problems with glare, so sometimes I wear sunglasses. These things need to be assessed before and checked on the day if they can see hear it properly."*

One participant reported wearing two hearing aids and sometimes forgetting to bring them to appointments- however appointments went ahead without her being able to hear the discussion properly. Several participants were in agreement that there should be some sort of check of each person's physical needs prior to using telepsychiatry, to enable the room setup to maximise the person's ability to communicate and participate in the session.

RECOMMENDATION 8

That the person's physical needs, related to the use of the equipment, be assessed prior to use of the videoconferencing equipment, and these needs taken into account in the setting up and use of the equipment and space.

ELEMENT 9: Being able to have a support person present if desired

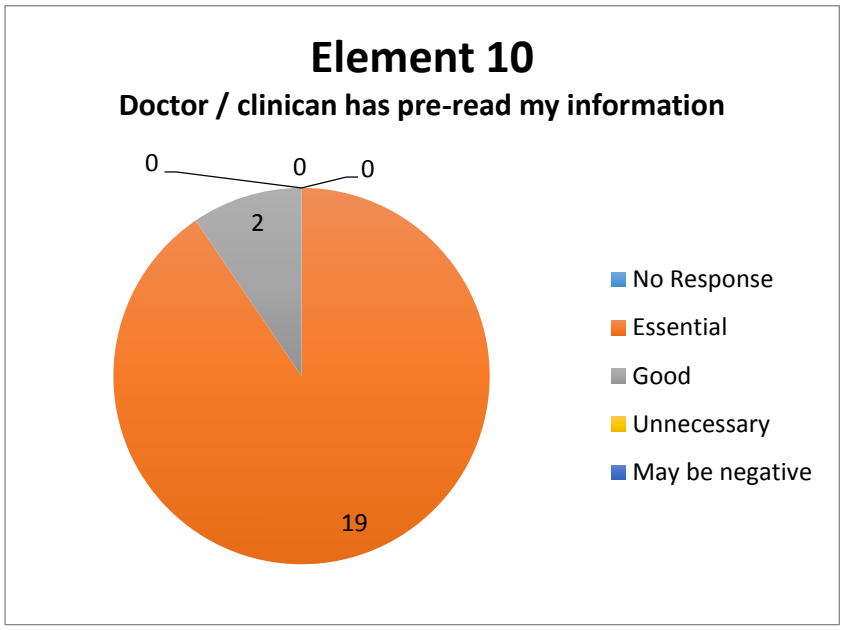


Participants were divided in response to this element. 9 people rated this as essential and 7 as good but not essential. However, there were two (2) people who felt it didn't matter and one who rated this a potentially being negative. Comments for these participants however revealed that their ratings referred to their own desire to not have a family member or support person present. The majority were in favour of this choice being offered. Some people felt it was essential to have their spouse or NGO support worker present at all interviews by videoconference; most did not but felt that choice should be offered to all service users.

RECOMMENDATION 9:

That service users be advised that they can have a support person present in the telepsychiatry consultation if desired. Information about telepsychiatry that is provided to the service user should also be provided to the support person. This may be a family member or natural support/allied person/peer support worker/ indigenous or CALD worker. If the person accessing telepsychiatry has any concerns, the opportunity to discuss them should be provided. It is recommended that this be offered to everyone who accesses telepsychiatry services.

ELEMENT 10: The doctor / clinician who is interviewing me has read the relevant information in my file about me beforehand



This element drew many strongly worded comments from participants. Twenty One (21) of twenty-three (23) people rated this is essential and two (2) rated as good but not essential. Many participants reported that they felt the clinician interviewing them was not prepared. One person related the following experience:

> *"I sat there watching him on the screen read my notes for 5-10 minutes before he spoke to me. I got really pissed off. It's rude." This participant also identified that when seeing a different doctor each time you could tell, when they started asking questions, whether they had any idea about you or what happened previously; sometimes "you just knew, you were back to square one… makes you feel a bit hopeless".*

Another participant noted the added difficulty of frequent changes of doctor combined with limited preparation:

> *"I have had a new doctor who hadn't read my file and I never met them before and I had to tell them my story all over again. There is some instability where the doctor changes all the time and that makes it very hard. "*

One participant commented on the impact that lack of preparation has on the subsequent tone of the interview:

> *"Extremely important. It drives you mad when they ask stupid questions that they'd know if they had read the chart"*

There were two commonly expressed themes for suggestions in relation to this element. The first suggested that there be allowed sufficient time between appointments scheduled to ensure the clinician had read the relevant information. The second suggested that a good summary of the

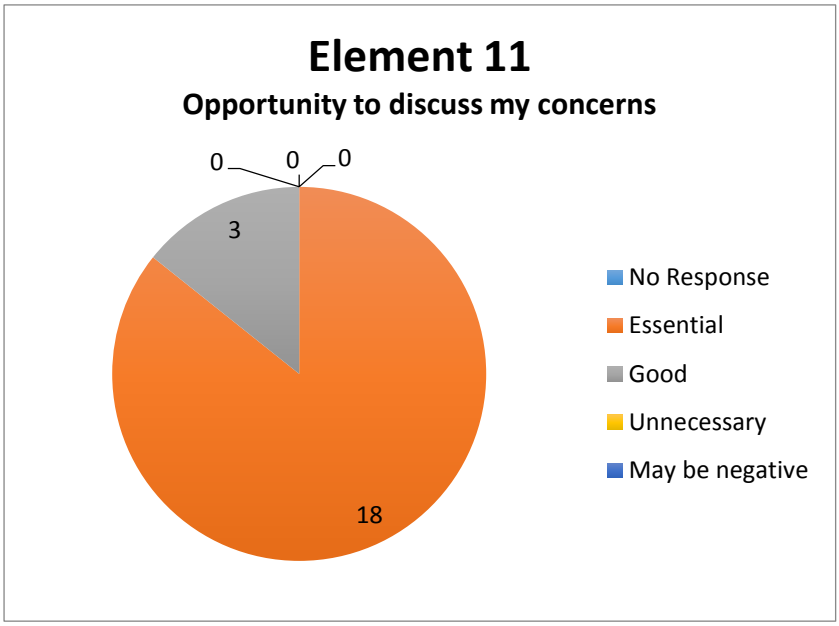
previous session be made available to the doctor before the session so they can be updated as to the treatment plan.

RECOMMENDATION 10

That the treating clinician receives the relevant information thirty (30) minutes before the start of the consultation, to ensure it is read prior to the appointment

We further recommend that for clinics where back to back appointments are held, that telepsychiatry appointments are scheduled with enough space between appointments to allow the clinician to ensure they have read relevant information about the person, including a summary of their treatment plan and last session, before the commencement of the session.

ELEMENT 11: An opportunity to discuss my concerns



Eighteen (18) participants rated this element as essential and two as good but not essential. Comments made by participants indicated it was sometimes difficult to get their point across or ask questions unless they felt very confident.

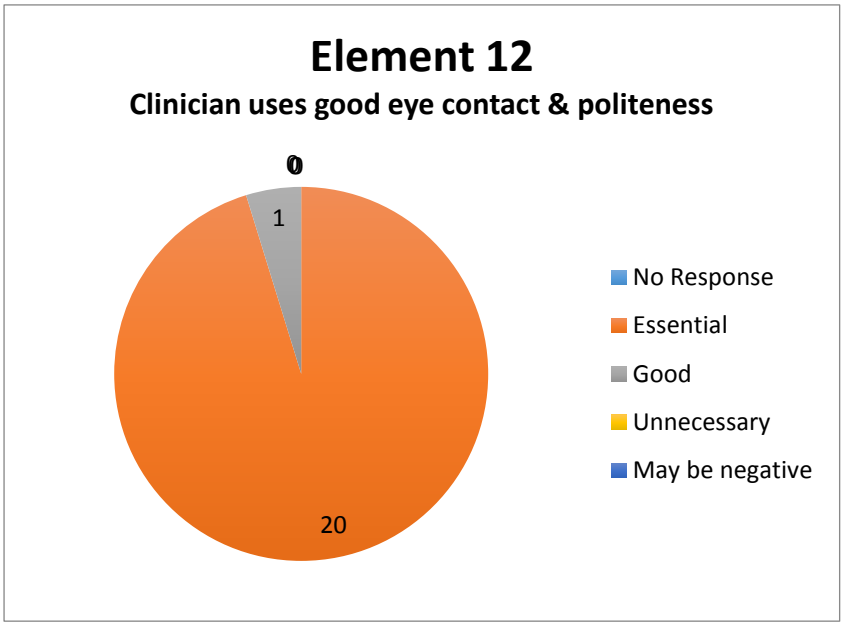
> *"They tend to talk over you and cut you off and so unless you're willing to really speak up you don't get to explain things"*

There was strong support for a designated time in the interview where the person was given the opportunity to raise any concerns they may have. One person felt they would need to have time prior to the interview to prepare for that, they wouldn't be able to do that "on the spot".

RECOMMENDATION 11:

That time is allocated during each telepsychiatry appointment for the person to raise issues of concern directly with the treating clinician. In addition, people should be made aware of this opportunity in advance (perhaps through brochure or advertising, or through their case manager) so they can prepare

ELEMENT 12: The clinician uses good eye contact, uses my name, and introduces him/herself



All participants within the consultation, except one, rated this element as essential. One rated it as good but not essential. The comments in this section reflected perceived issues affecting the subsequent relationship developed through the interview. The concept that this element reflected common courtesy was frequently expressed. Other comments made concerned the clinicians general manner;

"They need to be friendly and find out more about what matters to me"

There were also two significant suggestions about what the clinician's introduction could include:

"The introduction should include a summary of what happened last time so you have confidence they know a bit about you" and

"Maybe they could say a bit about themselves, what their position is, how long they've been practicing, whether you are likely to see them again"

RECOMMENDATION 12:

12.1 That clinicians observe the following telepsychiatry etiquette:

- All parties are introduced, whether on or off camera

- Ensure they speak clearly into the microphone and do not talk over others

- Aim for good eye contact

- The clinician is to ensure they can multitask – e.g., adjust the camera angle or zoom and speak

- Minimise unnecessary movements

- Mobile phones or pagers must be turned off or in silent mode

12.2 In addition, the consultation identified the following points of etiquette that would assist relationship development and rapport building:

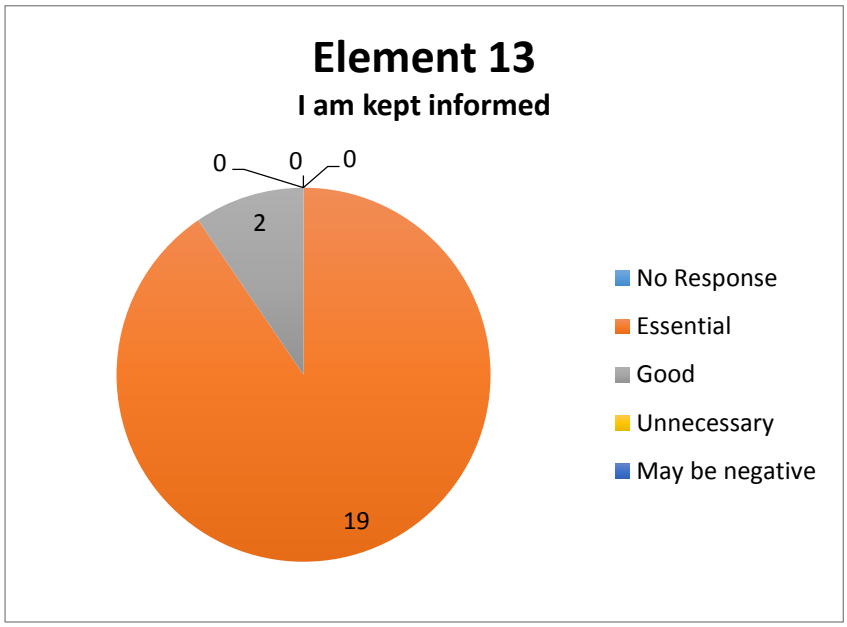
- That the treating clinician provide information about his/her qualifications and position, as well as their name

- That the manner of the treating clinician supports confidence by the service user through the effective use of rapport building skills

- That sufficient time is allowed to ensure the development of effective rapport

12.3 It is further suggested that telepsychiatry etiquette could be a training element for all staff using these services.

ELEMENT 13: That I am informed about any changes to my treatment, medication changes, before the interview finishes so I have the opportunity to ask questions



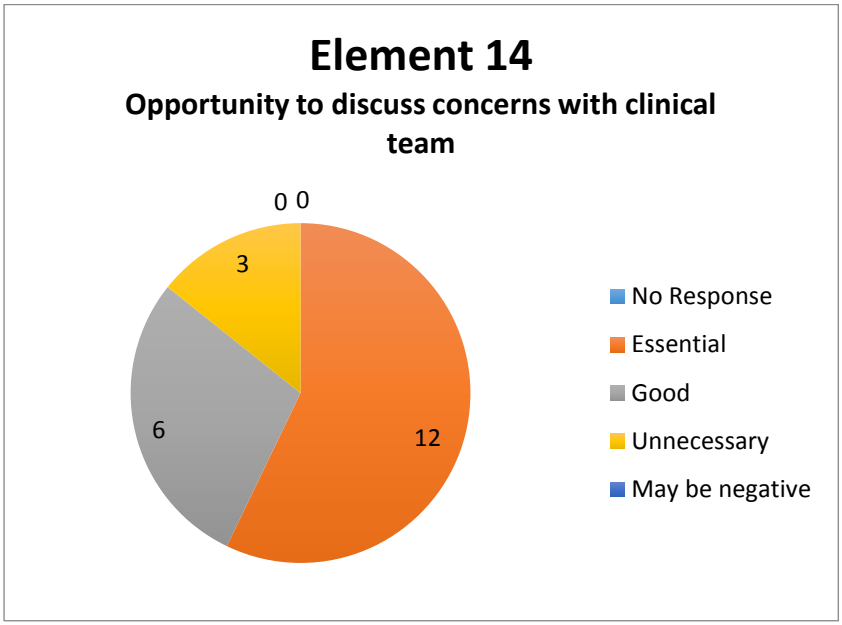
Once again there was overwhelming support for this element. All but one person rated this as essential, and the exception rating was good but not essential. Comments supported the idea that everyone needed to be clear at the end of the session what the plan was, and two suggestions were of significance:

> *"Absolutely. And they should summarise at the end to make sure everyone's clear."*
>
> *"Maybe people should be encouraged to take notes as well, it's easy to forget otherwise"*

RECOMMENDATION 13

That service users are offered / encouraged to take their own notes, i.e. of treatment changes and questions, during the interview to assist their active participation in treatment planning

ELEMENT 14: I have the opportunity after the session to discuss the process and outcomes with the clinical team member who is with me



Participants were more divided on this element. Twelve (12) people rated this as essential, six (6) people rated as good by not essential, and three (3) people rated as not necessary. Considering the comments, most people felt that the case manager could help interpret the results of the interview and clarify anything the person was not sure about. Some felt this was not needed as they had the opportunity to ask questions during the session. One noted the case manager might be busy straight after and they could always catch up later.

RECOMMENDATION 14

That as standard practice, there should be an opportunity for consumers to discuss the process and outcomes of their telepsychiatry consultation with their case manager, either immediately after the consultation or at a later time

PART 4- SUMMARY OF RECOMMENDATIONS

4.1 Recommendations relevant to Best Practice

In addition to the recommendations for specific elements of telepsychiatry practice presented in section 3, the following principles relevant to Best Practice are here summarised and recommendations proposed.

It was apparent from the interview responses that people in rural areas value telepsychiatry and for many it had major advantages over face-to-face consultations. For some, it meant access to services they wouldn't otherwise have. It was also clear that the ability to form relationships is central to peoples satisfaction with telepsychiatry and that this could be affected by many different factors.

There were a number of themes that emerged during the interviews that were not asked about specifically but nonetheless warrant discussion and further consideration given their impact on the person's experience of telepsychiatry.

A Continuity of psychiatric medical care

The first of these and most dominant theme emerging from the consultation was the added difficulty experienced by telepsychiatry users when faced with a different doctor for almost all appointments. Many of the challenges expressed by users of the service centred on the difficulty of establishing rapport, maintaining continuity and consistent direction for their treatment, whilst also using a screen based medium. As one participant put it,

> *"When they change doctors frequently it gets really hard, and it becomes a second rate service. If they can keep the same doctor as much as possible that makes a big difference."*

RECOMMENDATION

It is recommended that where possible, measures such as prioritising resource allocation are in place to ensure people receiving telepsychiatry services have greater access to continuity of care and therefore a service which is not only more effective but more acceptable to those in disadvantaged rural and remote parts of the state.

B Decision to use telepsychiatry

The second area for discussion is that of the relationship of face-to-face appointments and telepsychiatry appointments. It is clear in the feedback from the consultation that the individuals wanted to be able to express their preference for either service, which was based on a number of personal and contextual factors as described above. Some people interviewed clearly stated that they preferred telepsychiatry, and would be happy to receive all their services that way; in addition

to being much easier to access, they felt their impact on their mental state was such that telepsychiatry gave a more accurate picture of their mental state, as they did not have face to stress of face-to-face services.

RECOMMENDATION

The decision regarding the frequency or necessity of face-to-face appointments should be the result of a number of factors including service user preference; the person should be involved in this decision making collaboratively. Clinical pathways developed by HHS's should reflect this collaborative process.

C . Use of telepsychiatry facilities by natural and NGO supports

The third area of consideration is expanding the scope of services delivered through telepsychiatry. Consistent with Queensland Health, Mental Health Services, *Consumer, Carer and Family Participation Framework,(Queensland Health, 2010)* the role of family / natural supports, where it is the person's preference to involve, is pivotal in ensuring holistic care. Family members and natural supporters in rural and remote areas are also often geographically isolated from each other and unsupported. One family member stated that it would be a highly valuable service if it were used to support families; individuals and small groups of family members through their local mental health services could meet for support and education through the linking of videoconference facilities.

RECOMMENDATION

It is recommended that where possible, videoconferencing facilities be utilised by NGO's and natural supports for support, networking and educational purposes.

D. Engagement of external services and remote participants in telepsychiatry

The fourth area for discussion concerns the relationship of external services that form part of the person's clinical team, for example GPs, mental health and other support services. Videoconferencing is routinely used for clinical reviews and case conferences. Inclusion of external parties to the mental health services is limited, in part due to lack of access to Queensland Health videoconferencing network.

It is significant to note that during this consultation, Enlightened Consultants, an external agency, was able to join Queensland Health video-conferencing by taking part in a state wide trial being conducted by the state wide IT support service, of extending access to external services. Cisco Jabber was sent as a free download link, and when installed was able to be used from our personal computers and laptops. This facility is currently available to a range of services; if promoted and continued, the capacity to involve parties that may be geographically isolated or otherwise would find coming to a facility to participate in a case review / treatment planning session, would be dramatically increased. GPs, other health services, mental health support agencies, all could participate from their own base. Similarly the ability of the individual in a rural or remote location to link with other government departments, such as Department of Housing, Department of Veteran's Affairs, and Centrelink, with case manager support would save countless hours of stress and effort and naturally reduce service delivery costs. Some participants in the consultation already identified having been in multisite videoconferences, accessing from their local health centre to case manager in another town, and a doctor in a third location. Feedback was extremely positive about these experiences and the direct benefit on the person's care.

> *"Why don't they give access to videoconference from people's laptops and to their GPs, so access would be even better."*
>
> *"It would be good to have access to telepsychiatry by other agencies that work with people with mental health problems"*

Similarly, direct access to telepsychiatry should be considered for those people who live in remote locations significant distances from the nearest mental health service.

> *"Would be good to have an app to link into telepsychiatry from where you lived, like people on properties and way out, they wouldn't have to travel along way to the MHS, they could have the MHS, case manager, doctor and person all on the screen"*
>
> *It's essential to get this out to remote areas, in in their home/ properties. Men in crisis on remote properties would be more likely to get help over a private video link from home than coming into a mental health service….it could save lives"*

RECOMMENDATION

It is recommended that practice and guidelines reflect the need to engage significant others in treatment planning, whilst using telepsychiatry, and support the direct access of external services either in person or through Jabber, where possible, and the use of multisite videoconferencing, engaging participants from their geographic location. Telepsychiatry services could be accessed directly from the person's home, where the technology exists to do so and the person is living a rural / remote area significant distance from a mental health service.

E. Use of telepsychiatry in acute and emergency situations

The fifth and final area for consideration is the use of telepsychiatry in emergency assessment. At DDHHS, telehealth facilities in emergency departments are now being routinely used to access mental health acute services for acute mental health assessment. One person who reported highly distressing experiences of accessing ED's in Brisbane during exacerbation of her Bi-Polar Disorder, recommended that Telepsychiatry be accessed directly from all ED's to allow more direct access to specialist mental health assessment and reduce the trauma associated the presenting for assistance at an ED.

> *"They should use telehealth in all EDs to get specialist mental health help sooner. I've been hurt by security in ED in Brisbane before. A lot of people wouldn't get hurt and misunderstood that way."*

Similarly, several participants noted that being able to get early, by coming in to the local MHS or to their GP, and receive specialist services by videoconference, they would be able to get assistance sooner and avoid a hospital admission.

RECOMMENDATION

Improvements to future practice could include the collaboration of emergency departments and General Practitioners and rural and remote mental health services to promote early access to specialist mental health services in order to reduce the need for hospitalisation.

A final quote:

The following quote was given by one participant to summarise the importance of investing in telepsychiatry for Queenslanders.

> *"The money they save from not sending doctors out here, they should put that into buying more telepsychiatry facilities, somewhere people can access them, and in their homes. People don't want to go to the city. They live in the country for a reason."*

Enlightened Consultants

On behalf of rural and remote participants, DDHHS

13th August 2015

ENLIGHTENED consultants

po box 7361
redland bay qld 4165
australia

p +61 7 3206 8921
e info@enlightened.com.au
w enlightened.com.au

PART 5 Appendices

1. Consultation Questions
2. Information sheets
3. Consent forms
4. Telepsychiatry working group members

APPENDIX 1 : CONSULTATION QUESTIONS

The Inquiry Focus

The inquiry will be in two parts:

A semi-structured interview process that provides people with an opportunity to share their experience of using telepsychiatry and then identify what processes would be i) essential to good practice ii) desired but not essential iii) unnecessary iv) preferable to be avoided

Invite people to consider the key process elements within and provide feedback on whether they would be i) essential to good practice ii) Desired but not essential and iii) unnecessary iv) preferable to be avoided

Part One

Using open questions, invite participant to share their current or previous experience in using telepsychiatry

- 'Can you share an experience of when you have used telepsychiatry that has worked well?'
- 'What do you think it was about the process of using telepsychiatry that worked well?'
- 'If you have also accessed support through seeing a psychiatrist face-to-face, can you tell me how the experience compares, is it more or less useful and why?'
- 'What challenges have you experienced, how have you overcome these challenges?'
- From these experiences we will ask people to identify:
- What is essential to the telepsychiatry process in assisting my recovery?
- What is good but not essential to be present to assist my recovery?
- What is preferable to be avoided as it would get in the way of my recovery?

Part Two

Participants are asked about several key elements of telepsychiatry (provided in dot points below). It is important that these are explored after the participant has identified what their areas of importance based on their experience.

'There are a number of ideas that have been considered by others as important to the effectiveness of telepsychiatry.' These are provided to the participant, either verbally (phone), in person or web-based:

- The comfort, safety and confidentiality of the room
- Equipment is working smoothly

- Presence of one of the clinical team before, during and after the interview
- Information about telepsychiatry that is easy to understand and discusses options and risks
- Being able to consent and have choice in receiving telepsychiatry
- Access to an interpreter if I need one and having information in my own language
- Being able to have a support person present if desired
- The doctor/clinician who is interviewing me has read the relevant information in my file about me beforehand
- An opportunity to discuss my concerns
- The clinician uses good eye contact and uses my name and introduces him/herself
- That I am informed about any changes to my treatment, medication changes before the interview finishes so I can ask questions
- I have an opportunity after the session to discuss the process and outcomes with the clinical team member who is with me

I am interested in how you consider these points as

1. Essential and important to support your wellbeing- why do you consider this important?
2. Good but not essential-why do you consider it this way?
3. Unnecessary-why do you think this?
4. May contribute to a negative experience- why do you consider this may be the case?

APPENDIX 2: INFORMATION SHEETS

Flyer

You're Invited…

To have your say on Queensland Health's

Telepsychiatry Guidelines

What is it about?

The QLD Mental Health Commission have asked us, Enlightened Consultants, to talk with people who use telepsychiatry and those that support them, to get your ideas and thoughts - to ensure that your experience of using telepsychiatry is the best it can be.

Who are we interested to chat with?

If you are someone who uses telepsychiatry or supports someone that does we would be very interested to chat with you.

You can join in with a focus group or have an individual interview- whichever you prefer.

As an appreciation of your time and contribution we would like to offer you a $60 limited Visa card.

Further information:

Pease contact **Amanda Greaves** to be involved –
Phone 0422138722
OR
Email: amanda@resetservices.com.au OR Chat to your Case Manager about making contact.
We look forward to hearing from you

Invitation to Participate:

What is your experience of Telepsychiatry?

What is the Purpose: of the Consultation?

The Queensland Mental Health Commission (QMHC) has engaged Enlightened Consultants to undertake a consultation with people who have accessed telepsychiatry so that their experiences and ideas can inform the guidelines currently being developed for telepsychiatry for use by Queensland health services.

Your input, based on your experience, will assist to identify the best processes and elements that are necessary for effective service delivery of telepsychiatry. The purpose of this consultation is not to evaluate the existing services but create opportunities for people's voices to be heard regarding their experience of telepsychiatry.

The consultation will be held for people receiving services within the (i) Darling Downs and (ii) Townsville Hospital and Health Services.

The project also aims to facilitate discussion with families of existing recommendations on the extent to which these process recommendations are useful and contribute to a positive experience.

Who can participate?

We are interested to have conversations with you, if you:

- ☐ Are a person, aged 18 or over, who has accessed telepsychiatry services through Queensland Health
  Or
- ☐ Provide support to a person who has accessed telepsychiatry services through Queensland Health
  And
- ☐ Would be interested in sharing your experiences and commenting on guidelines for best practice
- ☐ Agree to participate in an audio-recorded interview or focus group

We are looking to have a good balance of people in the consultation including different age groups, genders, and cultural backgrounds.

Reimbursement and Time Commitments:

Participants will receive a $60 shopping voucher in appreciation of their contribution. The interview or focus group is expected to take approx. 1-1 ½ hrs

Participating in the Consultation:

If you would like to participate in the consultation please contact: Amanda Greaves 0422138722 amanda@resetservices.com.au

Participant Information: Plain English statement

What is the consultation about?

Enlightened Consultants have been funded by the Queensland Mental Health Commission to conduct consultations on the experience of receiving services through telepsychiatry to inform recommendations for best practice guidelines. The consultations are focused on the process of receiving support via telepsychiatry and how this supports your personal recovery. The consultations will also provide feedback to inform guidelines for best practice into how telepsychiatry is delivered in Queensland. The consultation also hopes to hear from families about their experiences of how telepsychiatry has supported their family member.

The consultation has two central aims:

1) Provide an opportunity to hear the experiences of people who have received support through telepsychiatry
2) Provide feedback to inform best practice guidelines

Who is eligible to participate?

- This consultation will focus on people receiving telepsychiatry within the Darling Downs HHS and Townsville HHSs.
- People aged over 18 who are currently or have used Queensland Health's psychiatry services for mental health treatment, or
- People who provide support (non-paid) to those accessing Queensland Health's telepsychiatry (e.g., family or friends) are eligible to participate in this consultation.

If you are unsure about your eligibility for the study, please contact Enlightened Consultants: amanda@resetservices.com.au or Telephone: 33251454 (BH) or mobile 0422138722

What is involved?

The consultations are being conducted either by phone, web conference, or face-to-face. You can decide to participate in either a one on one interview or is a small focus group (up to 8 people). We will ask questions about your experience of telepsychiatry and ask you to comment on some suggestions for best practice guidelines. Participants will also have an opportunity following their interview to provide feedback on the interview summary to ensure that the information provided has been heard correctly. Involvement in this consultation is voluntary and your consent to participate is important.

Possible Benefits

Consultation is crucial so services can increase their knowledge of how they need to provide services in the future. As a participant you are eligible to receive the results from the consultation. Your

participation will provide important information to develop insight and understanding on telepsychiatry in Queensland. In recognition of your time and contribution, you will also receive a $60.00 limited Visa Card.

Do I have to participate?

No. Participation in any consultation process is voluntary. If you do not wish to take part you are not obliged to. If you decide to take part and later change your mind, you are free to withdraw from the consultation at any stage. If you do receive support from telepsychiatry the decision not to take part will not affect your relationship with your service provider or staff. Before you make your decision, a member of the consultation team will be available to answer any questions you have about the consultation. You can ask for any information you want. Sign the Consent Form only after you have had a chance to ask your questions and have received satisfactory answers. The Consent Form seeks your approval to participate in the recorded interview or focus group. Some questions may be of a personal nature but you will be free to skip questions that you feel uncomfortable answering.

Who will see the results?

As a participant in the consultation, unless you choose to share your feedback with others, no one will be able to identify you through the information you have provided. The information provided to others, arising from the consultation, will be provided in such a way that you cannot be identified. Only summarised data will be made available in the final report so as to maintain your confidentiality. Your information will be stored securely in a lockable filing cabinet at Enlightened Consultants office, Redland Bay. Any digital recordings taken during interviews and focus groups will be de-identified, transcribed and destroyed. Information you provide for this consultation will be retained for 5 years. After this time, all information will be destroyed. Contact information that you provide will (i) not be used to contact you after the finish of the project and (ii) be destroyed directly after completion of the project.

Possible Risks

There are no major risks to your participation in the consultation, although you will potentially learn more about, and be able to contribute to quality service provision of the future. All information will be de-identified and your responses will not be revealed to other parties. However, if you disclose anything that may indicate abuse or neglect in terms of your service, we will have an obligation to talk to you about reporting this through appropriate complaints mechanisms.

Ethical clearance

This consultation will be carried out according to the guidelines outlined by Human Research Ethics Committees (HRECs) and in accordance with the National Statement on Ethical Conduct in Human Research (2007). For more information contact Enlightened Consultants 3206 8921

Privacy Statement

The conduct of this consultation involves the collection, access and/or use of your de-identified personal information. The information collected is confidential and will not be disclosed to third parties without your consent, except to meet government, legal or other regulatory authority requirements. Your anonymity will at all times be safeguarded.

APPENDIX THREE: CONSENT FORMS

CONSENT FORM: PART A- to obtain information

Consultation to inform the telepsychiatry guidelines

I have read and understand the Participant Information Sheet regarding my involvement in the consultation. I have had the opportunity to ask further questions and am satisfied that I understand the consultation.

I give permission for my mental health Case Manager / support worker to provide by contact details (Name, phone number, address / email address) to Enlightened Consultants so they can contact me and organise my participation / provide me with further information

My contact details are:

NAME:	ADDRESS:
PHONE	EMAIL

1. I am (please tick as appropriate)

   ☐ Someone who has used / is using / telepsychiatry services

   ☐ Family member or friend supporting someone to access telepsychiatry services

2. If I choose to participate in this consultation, I would like assistance / support with written documentation (If you require assistance, the interviewer will provide 1:1 phone or face-to-face support as needed)

☐ YES

☐ NO

3. If I choose to participate in this consultation, I would prefer to participate in the following ways: (check as many as appropriate)

   ☐ Small group with other service users / family members in your area

   ☐ Individual interview, face-to-face

   ☐ Individual interview, telephone

☐ Individual interview, web conference

I am agreeable for Amanda Greaves from Enlightened Consultants to arrange my participation or to give me more information YES / NO (please circle)

Your Name (Print) _____

Signature _____ Date : _____

Thank you for your assistance with this consultation.

CONSENT FORM: Part B

Consultation to inform Telepsychiatry Guidelines

TODAYS DATE _____/_____/_____

1. I have read and understand the Participant Information Sheet regarding my involvement in the consultation. I have had the opportunity to ask further questions and am satisfied that I understand the consultation.
2. I understand that if I agree to participate in this consultation, I will be asked to participate in an interview or focus group.
3. I have been informed that participation in the consultation is voluntary and I may withdraw at my own request at any time and that this decision will involve no penalty or loss of benefit as a result of my withdrawal.
4. I also understand that if I participate in the consultation, and choose to withdraw before its completion, no explanation is required.
5. I understand that information obtained will be stored in strict security and will not be disclosed to parties outside the consultation team. Confidentiality of the data collected or any personal records identifying myself will be maintained throughout the project and all data will be de-identified prior to sharing information with other bodies. Data collected will be stored securely in a lockable filing cabinet at Enlightened Consultants Redland Bay office. My responses will only be identified by an ID number and will not be stored with this consent form. Any digital recordings taken during interviews and focus groups will be de-identified, transcribed and destroyed.
6. I understand that if I have any complaints concerning the manner in which the consultation is conducted, I may discuss this issue with the Queensland Mental Health Commission on 1300 855 945

Your Name (Print) _____

Signature _____

Date : _____

Thank you for your assistance with this consultation.

Please return this form in the prepaid envelop provided or hand it to the Amanda at the time of the consultations

APPENDIX FOUR: TELEPSYCHIATRY WORKING GROUP MEMBERS

Assoc. Prof Mohan Gilhotra (Chair), Consultant Psychiatrist, Queensland Mental Health Commission

Dr Frances Hughes, Chief Nursing and Midwifery Officer, Department of Health and Australian College of Mental Health Nurses

Assoc. Prof. John Allan, Chief Psychiatrist, Department of Health

Dr David Lie, Statewide Mental Health Alcohol and Other Drugs Clinical Network, Department of Health

Dr Ewen McPhee, Statewide Rural and Remote Clinical Network, Department of Health

References

DARLING DOWNS HHS MENTAL HEALTH SERVICE 2013. Management of Acute presentations Using Telepsychiatry. Toowoomba: DDHHS.

QUEENSLAND GOVERNMENT 2000. Mental Health Act 2000.

QUEENSLAND HEALTH, M. H. S. 2010. Consumer , Carer and Family Partcipation Framework. Brisbane: Queensland Government