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World Psychiatric Association Telepsychiatry Global Guidelines

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Abstract
Telepsychiatry with live interactive videoconferencing and other technologies has improved access, quality, and effectiveness of mental health care for unserved and underserved populations across the world. Clinicians, systems, and organizations took great initiative during the pandemic to help patients via telepsychiatry, calling for an update of existing guidelines and best practices. The World Psychiatric Association (WPA) Telepsychiatry Global Guidelines developed in 2020 are updated and described to serve as a key foundation for growth of telepsychiatry. The Guidelines were developed by the Association's Informatics and Telecommunications (now Digital Mental Health) Section via outreach to, and input from, countries worldwide. The intent was to support all countries with patient care, mental health care practices, available technology, and collaborative health and public health initiatives. It was specifically intended to assist low- and middle-income countries. Methods included a survey with six domains and open-answer questions, a descriptive data charting form, and thematic and qualitative methods. A modified Delphi process was used to incorporate expert feedback from 17 telepsychiatric consultants and sections of the WPA. The Guidelines define telepsychiatry and focus on clinical and administrative practices, including the patient relationship, procedures and protocols, technical requirements, scope of practice, and contextualization to specific populations and settings. The Guidelines also promote health, technology literacy, and cultural safety. The Guidelines provide a foundation of clinical, technological, educational, research, and administrative approaches for many populations and settings, with an emphasis on patient-centered care, ensuring confidentiality and security of patient information, and ongoing evaluation and quality improvement. The Guidelines also offer an appendix with standards, surveys, and other resources. The Guidelines highlight the importance of collaboration between patients, clinicians, organizations, and policymakers for the development and implementation of telepsychiatry programs.

Keywords Global · Guideline · Technology · Telepsychiatry · Video

Introduction

Videoconferencing is commonly used in practice and within the healthcare systems to assess and treat patients. It was first used in psychiatry in 1959. Since then, many services have been developed and primarily serve geographically isolated populations. This is known as telepsychiatry (TP). Over the last three decades, in line with Internet expansion, TP has been applied to the majority of psychiatric patient populations via a variety of applications (see under "Specific Populations and Settings"). TP is defined not only in the literature, but also in professional, legal, policy, and other terms, which created a need for consensus on common issues and which have to be contextualized to local and regional practice settings.

In countries where TP is well-established, guidelines and protocols for use are developed and frequently updated. This WPA guideline aims to provide advice to those wishing to establish or upgrade the use of TP, in general, during the pandemic, and after it. It provides general, high-level advice to be applied to many settings in concert with local, state, provincial, and country laws and regulations. It includes input from experts as well as themes from existing regional (e.g., Europe), country (e.g., USA or American Psychiatric Association), American Academy of Child and Adolescent

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Psychiatry (2017) and organizational (e.g., American Telemedicine Association, 2017) guidelines, with attention to operations (Rina et al., 2021). Overall, TP providers must ensure that the standard of "remote" treatment is equivalent to "in person" treatment — *this applies to all sections of the Guidelines.*

While society typically moves quickly and regulation and law tend to be more static, regulatory frameworks have been made nimbler and more responsive to meet the needs of modern society with regard to technological advances during the pandemic. Therefore, clinicians should check with licensing, board and other regulatory agencies (e.g., the European Union has a common set of norms regarding tort and criminal liability, but fewer legal norms on medical liability) (Leslie et al., 2021). These affect scope of practice, liability since, and other parameters (Raposo, 2016). For example, related to emergency psychiatry services, stakeholders are working towards and requesting change, such that psychiatrists should position themselves to establish and advocate for best-practices in culture, research, clinical care, training, and funding (Huber et al., 2023).

The methodologic approach used for the Guidelines was to collect information about digital mental health (DMH) from clinicians, countries, and others via a survey worldwide, in order to examine patient needs, mental health care practices, available technology, and collaborative health and public health initiatives. It was specifically intended to assist low- and middle-income countries. The open answer survey with 6 domains was developed with the help of consultants (17) of a WPA pandemic committee of psychiatrists with experience in DMH. It was emailed to WPA members with encouragement to collect information by distributing it locally, as well as to states, provinces, and other regions. The six domains were as follows: (1) technology use; (2) trends in use before and during the pandemic; (3) what has worked well, overall, and during the pandemic; (4) what major challenges were experienced for patients, families, clinicians, and administrators (e.g., ease of use, bandwidth, technology availability, issues with regulations, need for training or technology skills, implementation); (5) resources that would be helpful from the WPA both clinically (i.e., working across technologies with patients, workflow models) and administratively (e.g., technology issue training, set-up, bandwidth, availability, implementation, business and funding models, legal, and regulatory); and (6) what format would be most helpful to receive this support (e.g., web-based downloadable documents, webinars, consultation, peer support, or other).

A data-charting form was used to extract data, and notes were organized using a descriptive analytical method; the process was more qualitative than quantitative. The reviewers (DM, DH) compared and consolidated information using a modified content analysis with thematic components (Crowe et al., 2015); a third author (JS) moderated any disagreement and analyzed consistency of the approach. The information was shared with the Digital Mental Health WPA Section and the consultants, with their input summarized, and themes extracted. Results were organized into tables, with key concepts and components outlined and described, partially based on excerpts from published topics. The data varied considerably and therefore were challenging to compare. Qualitative steps to analyze disparate data, populations, and clinical approaches were used (Crowe et al., 2015). Content, discourse, and framework qualitative analysis techniques were used, if needed, to analyze findings, and classify, summarize, and tabulate the behavioral data. The final subject areas were developed by a consensus approach via four videoconferences via a modified Delphi process for the data (Crowe et al., 2015).

Telepsychiatry Explained

In practice, the therapeutic process for TP consultation must be as similar as possible to an in-person meeting. The WPA Telepsychiatry Global Guidelines provide a framework to ensure a quality TP service in addition to high patient and provider satisfaction (Hilty et al., 2013; Moeller et al., 2022; Mucic, 2008, 2010, 2016, 2018). TP requires flexibility and tolerance by professionals and the application of common sense. Competent TP skills, attitudes, and knowledge are necessary (Hilty et al., 2015, 2018, 2020, 2021a, b; Maheu et al., 2018) in order to provide TP that is high quality and equivalent to, or sometimes even more effective than, traditional in-person care (Hilty et al., 2013). In addition to this guideline, an online TP competency course that may help trainees, faculty, and other interdisciplinary clinicians across the world is available through WPA (https://www.wpanet). Many of the recommendations and requirements of TP are similar to the common rules and good practice for in-person consultations. We repeat them here in order to prevent potential misunderstandings and improvisations related to the new communication mode.

TP is the use of videoconferencing for the provision of mental health care. It primarily uses interactive, Internet-based communication technologies, with offline options less frequent and complimenting in-person and online interactive clinical practice. In a broader context, the use of other media, such as email, text messaging (SMS), telephone communication in real time, and chat via web-based platforms, may also be understood as part of TP. These may be used, for example, within a "hybrid model" of care when combined with in-person contact. Setting up a standardized TP service requires a number of prerequisites and considerations that are outlined in Table 1.

Table 1 Basic principles for establishing a standardized TP service

Prerequisites and considerations when setting up a telepsychiatry (TP) service:
1. The need for services and whether TP is an option
2. The sustainability of the service
3. The patient population, model of health service delivery, and services to be offered
4. The required infrastructure
5. Identification and review of legal and regulatory issues
6. Management strategies for the service
7. Appropriate equipment and technological specifications
8. Development of quality and clinical outcome indicators
9. Promotion of rapport, confidence, and collaboration with staff at the patient site
10. Informed consent and assent procedures should be established
11. The physical setting arrangement for the virtual relationship to produce an optimal clinical encounter
12. The method of assessment should be determined and if others should be present with the patient
13. Procedures for prescribing medications should be established
14. Education of patients and families about procedures for care between TP sessions, including procedures for emergency or urgent care
15. An implementation plan, which should include staff training and address long-term sustainability

Administrative Aspects of TP Service Provision

While the needs of the patient should always be the priority, TP providers must also comply with program, professional, and regulatory requirements.

Legal and Regulatory

TP must adhere to the relevant local, state, provincial, and country laws, regulations, policies, and procedures relating to its practice. These include, but are not limited to, licensure and malpractice, mandated reporting, informed consent, documentation, technology-related legal mandates, scope of practice, and requirements for billing and reimbursement. Additionally, TP providers should:

- Practice in accordance with, and educate others on, adherence to TP-relevant legal and regulatory requirements.
- Apply and adapt in-person standards to TP.
- Attend to contextual and overarching jurisdictional issues in a reasonable way.
- Attend to privacy, confidentiality, data protection, integrity, and security.

Licensure and Malpractice

All the requirements of in-person care (i.e., ethical codes or other standards and guidelines) should also be followed when working "remotely" by technology. The clinician is expected to reasonably serve each individual professionally and legally — regardless of the website or technology used — by making adjustments. Challenges in this area are primarily related to different rules and regulations in different states, provinces, and countries; there may also be variation in credentialing and privileging practices. Each patient and provider location must be considered individually. This is of key importance, as the location of both the patient and the practitioner in remote consultation may have an impact on legal aspects of TP. So far, most countries regulate the TP practice depending on where the patient is located (e.g., state, province, or country).

If the TP provider is located in another country, they must be certified in the country where the patient is located. Accordingly, the provider must be aware of the regulations valid in the country where the patient is located; there may be local, state, provincial, and country laws and regulations, as well. Within these laws and regulations, it is important to see if there are obstacles to international expansion of the scope of the services or collaborations.

There is a growing tendency for patients to reach out to TP providers located in other countries. Language, the doctor's specialty, and cost associated with the service are the main parameters that influence a patient`s choice of the provider. For example, if a practitioner speaks the same language, has the required expertise, and is cheaper than those locally, he/she/they may be chosen even when located in another country. A broader international framework may need to be established that operates globally. The first step may be the creation of regional licensure regulations, which could pave the way for globalized legislation enabling expanded international collaboration and increased access to care regardless of national borders.

In general, some countries allow for the storage of video sessions in TP, but others do not without specific consent and other procedures. However, the specific regulations and guidelines for storing these sessions may vary between jurisdictions. It is important for mental health professionals and organizations providing TP services to familiarize themselves with the relevant regulations and guidelines governing the storage of video sessions in their respective jurisdictions

to ensure compliance with data protection laws and maintain the privacy and confidentiality of patient information.

It is important to note that the recording and storage of TP sessions is not a default procedure, as the patient's consent must be obtained prior to recording and storing the session. This ensures that the patient's privacy and confidentiality are respected and that their rights are protected throughout the TP process.

Scope of Practice

TP providers should be aware of local, state, provincial, and country laws and regulations related to online services and, if necessary, incorporate them in their guidelines for clinical TP practice. Professionals need to keep up to date with technologies, research, and legal issues in the following areas:

Prescribing Medication

Standards for prescribing medication should be maintained by following the local, state, provincial, and country regulations.

Written and Spoken Information Followed by Informed Consent

The information about the TP service must be simple and easy to understand for patients, caregivers, and family members. The patient information as well as the informed consent should emphasize that participation in remote consultations is voluntary sessions, and it will not be recorded or stored, unless there is a purposeful and acceptable exception. Patients have the freedom to discontinue the consultation at any time they desire. This will ensure the service meets expectations and that therapeutic service is delivered in a manner that is supportive of evidence-based care.

The consent process should include discussion of circumstances around session management, so that if a patient can no longer be safely treated through distance technology, he/she/they are aware that services may be discontinued and alternative arrangements made.

Billing and Reimbursements

Billing and reimbursements are dependent on the local regulations and vary from country to country. For more details, refer to specific regulations.

Operating Procedures and Protocols

Clear consensus related to roles, responsibilities, and communication between the sessions and procedures around emergency issues is necessary when establishing a TP service. The following aspects of the standardized TP service are important to maintain the same level as one might expect from "in-person" services:

Culturally Competent Care

Cultural competency is an important prerequisite in the establishment of standardized TP services. Providers should familiarize themselves with the cultures and environments in which they are working and may use site visits and cultural facilitators to enhance their local knowledge when appropriate and practical.

Quality Improvement and Performance Management

Effective quality and performance management processes aim to collect data about the activities, characteristics, and outcomes of the TP service. These data are used to answer questions about the acceptability, participation levels, and the short- and long-term impacts of the proposed service(s). Recommended evaluation areas include:

- Patient satisfaction, provider satisfaction, and process of care (e.g., no-shows, coordination, completion of treatment).
- Communication (e.g., rapport).
- Reliability and validity (e.g., assessment and treatment vs. in-person).
- Specific disorder measures (e.g., symptoms).
- Cost (e.g., length of service, travel, hard, and software).
- Administrative factors (e.g., facility management and team staffing).

Patient-Provider Identification

At the beginning of a TP session:

- All participants of the videoconference must be presented and identified to each other.
- The following information must be verified and documented:
    - The name of the patient.
    - The name and credentials of the provider.
    - The location of the patient during the session.
    - Contact information for the patient, provider, and other relevant support people (both professional and family).
    - Expectations of potential "between-session-contact" and other alternative arrangements.
    - Management of mental health emergencies, both during and outside sessions. It is crucial to establish

protocols related to collaboration with patient site staff to either assist or initiate commitments.

Clinical Settings for TP Provision

Clinically Supervised Settings

These are patient locations where other medical or support staff are available in real time to support the TP sessions. These include hospitals, elderly homes, prisons, general practice (GP) clinics, rehabilitation institutions, and other settings. They typically have staff or health professionals introduce or accompany the patient, provide clinical information, provide information on vital signs or a component of physical examination (e.g., check for medication side effect), and facilitate ancillary services as needed (e.g., laboratory services). It is crucial to create emergency protocols, including an explanation of roles and responsibilities in potential emergency situations. Patients should be informed of emergency coverage and guidelines outside clinic hours regarding available staff and other resources. Clinicians should be aware of safety issues related to any patients displaying strong affective or behavioral states and, upon conclusion of a session, must understand how patients might then interact with remote site staff.

Clinically Unsupervised Settings

These are patient locations where other medical or support staff are not readily available in real time to support the TP sessions (e.g., private home, working office). When providing a TP service in clinically unsupervised settings, it is critical to identify where the patient is located in case the following situations occur:

- Patient requires referral to the nearest mental health and/or health institution for medical, ancillary, and other services or to a local psychiatrist for in-person consultation.
- An emergency intervention is needed to save a patient's life (i.e., attempted suicide) or someone else's life (i.e., homicidal attempt), requiring local police, ambulance, or other services.
- Mandatory reporting of certain diseases is required by law in the jurisdiction where the patient is receiving services.

Common Requirements

The following prerequisite requirements are applicable to both clinically supervised and clinically unsupervised settings:

Clinicians TP professionals shall uphold or ensure the following:

- Professional clinical standards, protocols, policies, and procedures to deliver care of equal quality as provided through in-person care.
- Ethical norms and laws similar to those applied to in-person care, which includes credentialing and privileging practices.
- Requisite skills, attitudes, and knowledge — adapted from in-person care and specific to the technology used (e.g., video, mobile health, other asynchronous). Involved clinicians should receive preliminary training in the operation of the equipment, such as the WPA online TP competency course.

Patients Patients must voluntarily participate in TP consultation(s) after undergoing a consent process that explains the use of TP and the service and clinic procedures and processes for during and after session communication.

- Technology. Any technology used must fulfill requirements related to the safety of patient data and privacy according to local, state, provincial, and country laws and regulations.
- Care coordination. Providers should establish appropriate processes for coordinating patient care internally within their services and to external organizations and providers.

Technical Requirements

Videoconferencing

- TP providers and organizations should select videoconferencing equipment, applications, and platforms in line with its required verification, confidentiality, and security parameters.
- Sufficient bandwidth and screen resolution are required to ensure the quality of the image and/or audio received is appropriate to the services being delivered.
- A backup plan or set of plans (e.g., telephone) must be established prior to the TP session commencing in case of technical disruption to the session, such as a power outage or network issues.

Videoconferencing Applications

- Intercompatibility of the video equipment, software, and/or platform is of utmost importance when choosing the equipment. Lack of intercompatibility limits the communication possibilities between all potentially involved parts;

information technology staff may help assess this and a pilot before clinical use is suggested. Awareness and ongoing efforts may result in workflow improvements without compromising patient and data safety and security.

- Peer-to-peer technology is a recent technological advance that is increasingly being used in TP consultations. This technology allows mental health professionals and patients to communicate directly without the need for server interference, which may enhance the privacy and security of TP sessions, if both ends are private and secure. Moreover, peer-to-peer technology does not require cloud-based storage, which can address concerns related to data privacy and confidentiality. The simplicity of this technology also makes it accessible to individuals with little or no computer expertise, improving access to TP services for those who may be hesitant or unable to use more complex technology solutions or which use substantial bandwidth.

Integration of Videoconferencing Equipment into Other Systems and Technology

- Organizations should ensure the technical readiness of the TP equipment and the related environment. They should also have policies and procedures in place to ensure the physical security of TP equipment and the electronic security of data.
- In case of the use of a video platform or app, it is recommended to incorporate it into the existing electronic patient journal (EPJ), electronic health record (EHR), or electronic medical record (EMR) system (Appendices 1 and 2).
- In case of offline TP consultations, the interviewer must be appropriately trained, and if the session is recorded, it should be stored and/or shared following local, state, provincial, and national standards to protect individuals' medical records and other personal health information.

Physical Location and Room Requirements

- The location of the patient and the TP professional is considered as clinical space.
- Both locations must ensure privacy and be a safe and comfortable space.

Clinical Considerations

Patient Selection

There are no absolute contraindications to patients being assessed or treated via TP. However, providers should always assess and consider how best to provide care and services across a range of technologies and settings (in-person vs. virtual) based on the individual's case needs. The key is quality and safe care; even paranoid patients with false beliefs about technology have done well.

Providers should also consider whether there are any medical aspects of care requiring physical examination. If the provider cannot manage the medical aspects for the patient without being able to conduct initial or recurrent physical exams, this should be documented on the record and arrangements made to perform physical examinations onsite as clinically indicated. The examination can be performed by a general practitioner at a GP clinic or during a home visit to the patient. The doctor's name must be registered in the patient journal.

Setting Selection

Providers should assess and consider how best to provide care and services across a range of technologies and settings based on the individual case needs.

- Clinically unsupervised settings:

  In professionally unsupervised settings, the patient must take a more active and cooperative role in the treatment process than in other settings. Patients need to be able to set up the videoconferencing system, maintain the appropriate computer or device settings, establish a private space, and cooperate for effective safety management. Healthcare professionals should be aware of the following disadvantages and limitations related to clinically unsupervised settings:

  - Limited opportunity for somatic examination
  - Limited ability to read the body language
  - The risk of the patient recording the sessions and publishing them on the Internet
  - Poor bandwidth or an unstable Internet connection that may have an impact on the sound and picture quality

  Given these limitations, it is important that TP providers consider the appropriateness of the TP service for each individual patient. Factors to consider include the patient's:

  - Cognitive capacity.
  - History regarding cooperativeness with treatment professionals.
  - Current and past difficulties with substance abuse.
  - History of violence or self-injurious behavior.
  - Geographic distance to the nearest emergency medical facility.
  - The efficacy of support system.

  - Current medical status.
  - The location.

- Clinically supervised settings:
  The provision of TP services in professionally supervised settings has the same requirements as in-person consultations.

Management of Hybrid Patient-Provider Relationships

The TP interview can be the only mode of contact between the patient and the psychiatrist. This is more prevalent in rural areas due to distance. A TP interview can supplement an in-person contact. All communication with the patient should follow clear policies describing the boundaries around ways in which patients can communicate with a provider and which content is appropriate to share over different technology platforms.

Ethical Considerations

TP professionals are expected to uphold the same professional and ethical standards as those followed in in-person care while providing services through TP. This means that they must follow these principles:

- Maintain confidentiality: TP professionals should ensure that the patient's privacy and confidentiality are protected. This includes using secure communication channels, safeguarding any electronic records, and adhering to relevant privacy laws and regulations.
- Obtain informed consent: TP professionals must acquire informed consent from patients before initiating remote consultations, ensuring they understand the nature, risks, and benefits of the services provided through TP.
- Ensure competence: Professionals should be adequately trained and competent in both the therapeutic interventions they offer and the technology used to deliver TP services. They should stay up-to-date on best practices and developments in the field.
- Establish boundaries: TP professionals need to establish and maintain appropriate boundaries with patients, just as they would in face-to-face consultations. This includes being mindful of the potential for dual relationships and managing any issues that may arise due to the remote nature of the care provided.
- Address emergencies: Professionals must have a clear plan in place to handle emergencies or crises that may arise during a TP session. This may involve coordinating with local emergency services, family members, or other support networks.
- Cultural and linguistic sensitivity: TP professionals should be aware of and sensitive to cultural and linguistic differences that may impact the therapeutic relationship and adapt their approach as needed to ensure effective communication and understanding.
- Continuity of care: Professionals should strive to provide continuity of care to their patients, ensuring that follow-up sessions, referrals, and coordination with other healthcare providers are seamlessly managed.

Specific Populations and Settings

Child and Adolescent Populations and TP

The procedures for the assessment and treatment of youth must be modified to address the developmental status of the patient. The examination room should be set up with age-appropriate equipment required for specific levels of interaction (e.g., game, book). It should be of adequate size to enable activities that allow the child to engage with the accompanying person and provider.

When providing TP services to young patients, it is critical to conduct an assessment of the appropriateness of "remote" care. This includes the safety of the patient, the availability of supportive adults (and their mental health status), and their ability to respond to any urgent or emergent situations.

Geriatric Populations and TP

Interviewing techniques should be adapted for patients who may be cognitively impaired, find it difficult to adapt to the technology, or have visual or auditory impairment, yet sometimes, settings can actually help with patient. Cognitive testing may be provided via videoconferencing but might need to be modified for use via video. The inclusion of staff, nurses, other mental health clinicians, and social workers is often helpful. Inclusion of family members should be undertaken as clinically appropriate and with the permission of the geriatric patient.

Substance Use Disorder Populations and TP

Local, state, provincial, and country laws and regulations around prescription of controlled substances involved in substance use disorder treatment must be followed. Collaboration with onsite staff is necessary to monitor ongoing treatment as clinically indicated.

Inpatient and Residential Populations and TP

TP enables integration of the mental health professionals into inpatient and residential care settings. Remote providers should optimize use of patient site staff for help with

TP consultations and case coordination, as clinically indicated. In addition to clinical care, it is helpful to participate in treatment team, quality, or process improvement and other meetings by video.

Primary Care Settings ("Shared Care Model") and TP

A patient may receive the treatment from a remote mental health specialist while located at a local GP. The TP "shared care" model refers to the provision of mental health care from a distance and includes clinical work with the patient, educational (i.e., supervision) and administrative activities. Using this model with technology, general practitioners and TP specialists discuss patient treatment, which increases the information and knowledge available to each participant. TP is used for collaborative, stepped an integrated care models.

Rural Populations and TP

Rural hospitals may connect to behavioral and mental health specialists through TP. Accordingly, a remote-located psychiatrist can assess and/or treat patients in rural hospitals or GP clinics. Some rural programs provide case management services through TP to improve patient outcomes.

Cross-cultural Populations and TP

Ethnic minorities access assessment and treatment via interpreters or via a third language that is common for both the patient and the professional. Use of TP may eliminate the need for an interpreter and enable remote connection between the patient with limited abilities in one language and a bilingual professional with a similar cultural and/or ethnic background. This is known as the "ethnic matching" model. It may lead to more precise and detailed description of patient symptomatology (as the patient feels at ease and better shares the story), minimize risk for misinterpretation or misunderstanding, and enable better diagnostic and subsequent treatment.

International Populations and TP

Bilingual resources are precious in assessment and/or treatment of ethnic minorities (i.e., refugees and migrants with limited language proficiency). If or when the bilingual resources are not readily available within the country borders, technology may help to build the bridge over geographical as well as cultural boundaries. International collaboration via TP may also be used to get a qualified "second opinion" from colleagues with a relevant cultural and linguistic background. Further, international expertise may be brought via TP to local health workers as a part of education, supervision, and scientific collaboration.

Considerations related to international TP are primarily based on licensure and local, state, laws, and regulations related to the location of the patient and the professional, respectively. Generally, the patient needs to be located within the same state (e.g., USA; American Psychiatric Association, 2014, 2017) or country boundaries as the professional; that does not apply for one-time or ongoing consultations without treatment, of course. There are few exceptions, if any, to this, though periods of turmoil (e.g., war or conflict with evacuation or refugees) have challenged this, as a patient may not feel comfortable to engage in treatment with a professional of the same country due to political or other influences. As care evolves, conceptualization of the visit with the doctor "up in the cloud" then may cause future changes in these regulations.

Team-Based Mental Health Care (TP Consultation Between a Healthcare Worker and a Psychiatrist)

Healthcare workers, such as nurses and allied health professionals, can initiate TP consultation for both independent and supported assessments.

The collaborative TP consultation initiated by the healthcare worker can also be part of the assessment of persons to assist law enforcement agencies or other institutional administrators in the evaluation of persons with mental illness.

Correctional Facilities and TP

Considering the high vulnerability of the prison population, health care in prisons represents a special challenge primarily due to the shortage of psychiatric staff. TP has proven to be a practical and effective way of providing care for patients or inmates in jails and prisons. TP is an attractive option for psychiatrists who want to avoid the personal safety risks and other unpleasant aspects of working in correctional facilities, let alone the daily commute to and from prisons or jails. Also, TP offers unique advantages in the way care is provided. However, this way of providing health care requires that the systems enable the prerequisites for the physician to be best integrated into the treatment team and the institution in general.

Discussion

The WPA Telepsychiatry Global Guidelines help practitioners and researchers to stay informed about ongoing developments in the field and are consensus-based, with input from clinicians, researchers, and policy-makers worldwide. The consensus process in this case is a bridge between a very good evidence base with studies with best practices to adapt to all of the diverse settings and practices worldwide, in which it would be difficult to do

these studies. The consensus process helps to interpret data and observations, which are theory-laden (i.e., theoretical understandings) to application for patients based on shared sets of values (Djulbegovic & Guyatt, 2019). All clinical practice guideline recommendations require both a judicious consideration of the relevant evidence and consensus from professionals regarding both the interpretation of the evidence and tradeoffs (i.e., benefit versus the harm or burden of the recommended health intervention). This applies whether the available evidence is considered as being of high quality or very low quality.

To promote the Guidelines, WPA has launched its first online continuing medical education (CME) courses annually at worldwide and regional WPA conferences to increase awareness and knowledge of TP among mental health professionals (e.g., latest developments from research, best practices, changes in regulations). CME can help to address the potential knowledge gaps and skill deficits, as well as improve attitudes. This can lead to increased confidence and competence in providing TP services, which can improve patient outcomes and satisfaction. Finally, offering courses in TP can signal to mental health professionals and the broader healthcare community that TP is a legitimate and important mode of delivering mental health care, which can ultimately lead to greater access to mental health care for patients. By taking a leadership role in this area, psychiatric associations can help to ensure that mental health professionals have the knowledge and skills necessary to provide safe, effective, and culturally responsive TP services to patients. There are arguments against making education or training in TP mandatory, (e.g., imposing additional demands on mental health professionals who are already facing time and resource constraints). But at a minimum, perhaps a certification should ensure that the introduction to such services is carried out in a safe and effective manner.

There are limitations to this set of Guidelines and the existing database on which it is based. First, more studies are required to determine the efficacy of TP in diverse clinical settings and patient populations. This could include more efficacy trials (e.g., randomized controlled trials), but more importantly further investigation to identify the most effective approaches for implementing and assessing TP programs, emphasizing the importance of continuous innovation and adaptation (Shore, 2014, 2018). Second, there may be inferences and bias in the process of trying to help clinicians and systems chart the optimal course of action based on values and preferences, and data would be preferable if available. Population studies (e.g., younger, geriatric, diverse patients) would provide evidence that is more compelling with obvious courses that would be beyond dispute. Third, ensuring that all patients have access to high-quality mental health care will require the development of culturally sensitive and contextually appropriate TP programs, as well as adapted to meet the specific needs of different countries and regions. Fourth, the Guidelines can be further developed with specific, weighted recommendations. Fifth, the Guidelines could have further investigated ethical standards to meet the unique needs and cultural contexts of different regions. Sixth, a more detailed reliable and valid survey on the use of WPA Telepsychiatry Global Guidelines could provide important insights into how the guidelines are being implemented and their impact on TP programs. Seventh, the WPA did not use a formal tool like Appraisal of Guidelines for REsearch & Evaluation (AGREE) I (10 items) or II (23 items) and available at https://www.agreetrust.org/practice-guidelines/, but could do so in future editions. Eighth, these Guidelines did not ask direct questions about billing, reimbursement and economic matters; while not much feedback was given in reply, economic issues bear on sustainability. Lastly, these Guidelines incorporate input from experts as well as themes from existing regional (e.g., Europe), country (e.g., USA or American Psychiatric Association) and organizational (e.g., American Telemedicine Association) guidelines, but do not include the list of all the studies which serve as the foundational evidence base.

Conclusion

TP has emerged as a promising approach to improve access to mental health care, particularly in underserved populations, partly due to a shift in attitudes for patients, providers, and others overseeing care during the pandemic. This widespread adoption of TP has highlighted both the opportunities and challenges to make services more robust, accessible, and efficient. The WPA Telepsychiatry Global Guidelines can play a significant role in facilitating this transformation. More research is needed related to effectiveness, culturally diverse populations, and best practices related ethical challenges, economics, and other areas that may vary widely across the world.

Summarized General Recommendations

Regardless of settings and/or patient populations, it is recommended to:

1. Adapt best practices for in-person care and make adjustments for the technology used to ensure quality of care and the therapeutic relationship.

2. Assess a patient's previous exposure, experience, and comfort with technology and videoconferencing. The TP provider should be aware of how this might impact initial TP interactions.
3. Create emergency protocols, including explanation of roles and responsibilities, in potential emergency situations.
4. Conduct an ongoing assessment of the patient's level of comfort with technology over the course of treatment. (Refer to Appendix 3: "Patient Satisfaction Questionnaire".)
5. Conduct an ongoing assessment of the other users' level of comfort with technology over the course of treatment. (Refer to Appendix 4: "Users TP Satisfaction Questionnaire".)

Appendix 1. Standards of remote consultation clinical practice and professional behavior

General

- The following should be available to each participant of the telepsychiatry session:
    - Concise and easy-to-understand printed protocols on operating the video equipment.
    - A list of dial-in numbers for virtual call rooms and relevant IP addresses.
    - Contact information for the technical support person and/or "Helpdesk" must be readily available in each video room.
- When booking the patient in the electronic patient journal (EPJ), electronic health record (EHR), or electronic medical records (EMR) system, remember to include the purpose of the consultation.
- Test the equipment and become familiar with the use of remote control (if using a stand-alone camera) or command buttons on the video platform prior to the first video call.
- If you are using a video platform with another health worker (i.e., without the patient), make sure you have two monitors for the purpose of easy access to EPJ, EMR, or EHR.

Before the TP Session

Consent will vary to some degree from state to province and between countries, so these components are the essential components. Consent pertains to the following: choice with reasonable access or alternatives and an opportunity to decline (or autonomy), a conducive setting, matters of privacy and confidentiality including data protection, avoidance of conflicts of interest, and other standard features in alignment with in-person care.

- Inform the patient both verbally and in written form about TP before the initial remote interview.
- Prior to commencement of the first TP session, the patient must give written consent, which states that he/she/they may at any time interrupt the remote session, and have the opportunity to meet the doctor in person.
- The patient's explicit consent is required to record the remote consultation for educational purposes (supervision or clinical case presentation) or an asynchronous TP session aimed for diagnostic clarification/second opinion.
- Consider the background that will be captured by the camera. Personal photos and other items you would not display in an office should be relocated out of the camera's view. You may need to remove books from the camera's view. Some titles on the bookshelf behind you may create a distraction for patients.
- Sit in the center of the picture with a neutral background so this does not interfere with the consultation. The patient's view of you should be similar to that of a seated news anchor on television.
- Ensure the room is well lit and the video image is clear. Avoid backlighting. This will create a shadow on your face.
- Establish a video connection 5 min before the session commences to adjust the picture on both sides and exchange information with medical staff related to the patient interview.
- Mute your microphone until the session starts.

Preparation

- Maintain professionalism at all times prior, during, and after the appointment.
- The purpose of the meeting should be clear.
- Ensure you have the necessary materials to record notes during the meeting.

- The duration of the TP consultation should be the equivalent to any other in-person session, whether it is an initial assessment, medical follow-up, psychotherapy, or another type of meeting.

Beginning of the TP Session

- Remember to un-mute your microphone.
- All participants on both sides of the videoconference must be presented and identified to each other.
- Introduce any additional people in the room to both the patient and the provider.
- Confirm the patient's identification (name, national insurance, social security, Medicare number, etc.).
- Confirm the location of the patient during the session using local, state or provincial or country standards.
- Confirm the patient's sound and picture quality.
- Exchange contact information for the provider, the patient, and any other relevant support people, both professional and personal.
- Discuss and verify expectations of potential 'between session contact'.
- Establish provisions for management of mental health emergencies for the session and also how to handle any emergency between sessions.
- Ensure the room is quiet and private:
    - Test the noise level of the room in a practice session.
    - Sometimes unnoticeable noises, such as the air conditioner running, can be amplified by microphones.
    - Others in the area may need to be asked to keep the noise level down.
    - Silence all phones and other devices prior to starting a session.
- Privacy should be afforded by the location. Sessions should be conducted behind closed doors.
- Provide an overview and purpose of the video meeting and confirm the time allocated.

During the TP Session

- Attempt to maintain eye contact with the patient throughout the consultation.
- When taking notes during the consultation, explain this and the reasons for it to the patient.
- It can be difficult to read patient body signals over video. Observe the body language of the patient and also pay attention to your own body language.
- Keep track of time. Allow time at the end of the meeting for the patient to ask questions.

End of a TP Consultation

- Discuss and agree on the next steps.

After the TP Session

- Provide the patient with the opportunity to provide feedback on the session (i.e., questionnaire). Address any technical issues encountered during the instant session right away.
- Note any follow-up appointments with the patient.
- Remember to turn off your equipment, close your telepsychiatry platform, or at least mute your microphone after a session concludes.
- If required, and if in line with local laws and regulations, medicines may be prescribed online.

Recommendations for TP Sessions Within Clinically Unsupervised Settings

- Use the computer or device's built-in microphone function rather than headphones, unless those help with privacy. This will ensure the session is as similar to an in-person consultation as possible.
- Remind the patient that no recording of the session is allowed.
- Have the emergency plan ready.

Appendix 2. List of abbreviations

TP	Telepsychiatry
EPJ	Electronic patient journal
EHR	Telepsychiatry
EMR	Electronic medical records
ID	Identity, identification
ID	General practice

Appendix 3. Telepsychiatry patient satisfaction questionnaire

Name: _____

Diagnosis: _____

No. of telepsychiatry sessions: _____

Medicine:

☐ Antipsychotic

☐ Antidepressant

☐ Tranquilizers

☐ Other

Earlier psychiatric treatment *(circle):* YES NO

Earlier telepsychiatry experiences *(circle)*: YES NO

	Question	YES *(to a high degree)*	YES *(to some degree)*	NO *(only to a less degree)*	NO *(not at all)*	Don`t know
1.	Did you receive enough information prior to commencing telepsychiatry?					
2.	Do you perceive ‘contact via TV’ as uncomfortable?					
3.	Did you feel safe under telepsychiatry contact?					
4.	Were you satisfied with the sound quality?					

5.	Were you satisfied with the picture quality?					
6.	Did you achieve your goal via telepsychiatry or could you express everything you wanted to?					
7.	Would you be interested in continuing with telepsychiatry contact if possible?					
8	Would you recommend the method to others (e.g., if direct contact is not possible)?					
9	Would you prefer contact via a translator in future?					
10.	What telepsychiatry related benefit(s) do you perceive?					
11	Is there something you would change or improve?					
12	Further comments or suggestions.					

NOTE: Question 9 is only for Cross-cultural TP participants that otherwise will be assessed and/or treated via translator assistance.

_____

(Date and place)

_____

(Signature)

Appendix 4. Telepsychiatry professional's satisfaction questionnaire

Name: _____

Function: _____

No of telepsychiatry sessions within the current course of treatment: ____

Previous telepsychiatry experience *(please circle)*: YES NO

		YES *(to a high degree)*	YES *(to some degree)*	NO *(to a less degree)*	NO *(not at all)*	Don`t know
1.	Did you receive enough information before commencing telepsychiatry?					
2.	Did you have concerns or reservations when you were first introduced to telepsychiatry?					
3.	Has your attitude towards telepsychiatry changed after completing treatment?					
4.	Do you perceive 'contact via TV' as uncomfortable?					
5.	Is the video equipment user friendly?					
6.	Were you satisfied with the sound quality?					

7.	Were you satisfied with the picture quality?					
7.	Could you assess the patient as in-person?					
8.	Could you provide the treatment to the same level as in-person?					
9.	Would you be interested in continuing telepsychiatry contact with the patient?					
8	Would you recommend the telepsychiatry to the colleagues?					
10.	What telepsychiatry benefit(s) do you perceive?					
11	Is there something you would change or improve; any potential disadvantages?					
12	Further comments or suggestions.					

_____

(Date and place)

_____

(Signature)

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We trust that the WPA Telepsychiatry Global Guidelines will be a useful source of information for practitioners, policy makers, and communities. We hope this document will also pave the way to increased international collaboration in this work and inspire a movement towards easier collaboration and access to care within and between countries across the world.

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