5

Safety Planning and Emergency Management

This chapter provides an overview of safety issues encountered during telemental health (TMH) practice as well as the essential components required for safety plans and emergency protocols for TMH services. Safety planning is a necessary component of competent and ethical telepractice and a must for all practitioners across telepractice settings. Safety planning involves identifying steps and procedures for addressing situations that present a risk to the safety of clients/patients and other persons such as family members or clinical staff members during the course of telehealth services (Knapp, Younggren, VandeCreek, Harris, & Martin, 2013; Luxton, O'Brien, McCann, & Mishkind, 2012). In writing this chapter, we drew from the latest published standards and guidelines from professional organizations (e.g., American Counseling Association [ACA], American Association for Marriage and Family Therapy [AAMFT], American Psychological

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A Practitioner's Guide to Telemental Health: How to Conduct Legal, Ethical, and Evidence-Based Telepractice, by D. D. Luxton, E.-L. Nelson, and M. M. Maheu

Association [APA], American Telemedicine Association [ATA]) and from the existing telehealth literature.

When conducted in accordance with evidence-based protocols (Luxton, Sirotin, & Mishkind, 2010), there is not any evidence that TMH, including home-based TMH, is less safe than traditional in-office services. However, the TMH practitioner's inquiries and interventions may be notably limited. Clinicians may do well to carefully consider the viability of specific techniques to both prevent and handle safety issues when working with distant populations. In some situations, TMH may offer additional safety because of the connections it affords across systems of care, allowing the consenting patient, behavioral health provider, and local health care professionals to work together around safety concerns.

The components of effective safety planning can be classified into the following general categories:

- assessment of the appropriateness for TMH services for the client/patient;
- assessment of client/patient's site factors;
- plan for coordinating with support persons and emergency services at originating sites or their communities;
- development of an emergency contact list to be included in the client/patient record for easy access in the case of emergency;
- assessment of technology issues for safety planning; and
- a plan to review safety plans and expectations with clients/patients (safety plans are the written steps for carrying out safety procedures and emergency protocols define the steps to be followed during emergency situations).

TYPES OF SAFETY ISSUES

The primary safety issues that may be encountered during TMH are generally the same as those experienced in in-office settings. These risks may include harm to self or others, worsening of symptoms that may contribute to heightened risk (e.g., suicidal ideation), and medical emergencies

that could occur during a TMH session. We discuss these in greater detail in the following paragraphs.

Behavioral Emergencies

Behavioral emergencies include threats to harm others that involve duty to warn, and worsening of clinical symptoms, such as those resulting in heightened suicide risk. They require immediate clinical intervention. Although these same risks are present during traditional in-office practice, telepractice introduces additional consideration when safety planning given the geographic separation between the clinician and the client/patient. Effective TMH requires awareness of local emergency services as well as how far the client/patient may be from emergency or other help services in their community. The clinician should also know the average response time of police, fire, and other emergency services in all local areas where clients/patients are seen.

When TMH services are delivered to clinically supervised settings (i.e., hospitals or outpatient clinics), there will typically be on-site clinical staff available to assist and help resolve safety issues. TMH care delivered to an unsupervised setting requires additional planning steps because such staff are not involved. For example, a client/patient could indicate intent to harm himself or herself or another person at the end of a TMH session or while intentionally disconnecting the VC session. These types of situations require the TMH clinician to contact other identified support persons and/or law enforcement to assist at the client/patient's site.

Medical Emergencies

Medical emergencies present another risk, especially with homebound patients and patients with multiple chronic conditions. Behavioral medicine/health psychology services to unsupervised home settings may be particularly appealing to homebound individuals with serious conditions because of travel limitations and need for specific expertise. As these services expand, telepractitioners need to consider risks related to

medical emergencies. For example, a client/patient could suffer cardiac arrest during a session and require notification of emergency services at the client/patient's location. Similarly, a client/patient may disclose to the telepractitioner that he or she had a recent fall or other injury in the home setting, yet had not self-identified the need to seek medical attention or was hesitant because of other barriers. The telepractitioner may provide additional support in completing the same steps the client/patient would follow if a medical emergency occurred separate from the telepractice session.

Risks Associated With Firearms

Access to firearms is another potential safety issue that teleproviders should consider, learning the social norms of the local community ahead of telepractice. ATA (Grady et al., 2011; Turvey et al., 2013) and APA (2013a) TMH guidelines state that clinicians shall discuss firearm ownership, safety, and the culture of firearms in rural areas. Access to firearms may be more of an imminent issue during home-based TMH and is a particular risk if a client/patient is known to have history of self-directed or other-directed violent behavior. Access to firearms should thus be taken into account when assessing the appropriateness of home-based TMH for some patients. However, as Pruitt, Luxton, and Shore (2014) noted, home-based TMH may be a safer alternative than in-office services when a patient has a history of violence or threatened violence toward clinical staff.

Many people who live in rural areas where hunting is common may have firearms in the home. When providing telepractice services with at-risk youth, teleproviders should be aware that it is common for a child may have knowledge of both the location of firearms and location of keys or lock combinations associated with access to ammunition, and also that parents may be unaware of the child's knowledge. Documentation of discussion and planning with children and parents about removal and/or safe storage of firearms in risky situations is important in the telepractice setting. Discussion of firearm access, regardless of setting, when safety is a concern is recommended. Furthermore, discussion of trigger safety lock

devices may provide an additional level of safety precaution by restricting immediate access to firearms (Luxton, O'Brien, et al., 2012).

Risks Associated With Technical Difficulties

Technical problems with telehealth equipment (e.g., computers, monitors, video cameras, audio equipment) or network problems that cause a loss of connection may occur during a critical assessment or crisis situation and thus require an alternate method to contact the client/patient. Technology limitations, such as inadequate bandwidth for videoconferencing communication, insufficient camera resolution, or environmental problems (e.g., adequacy of room lighting and size, background noise or interruptions, room privacy, microphone placement) can also present a safety issue if audio/visual quality is impaired (Luxton, O'Brien, et al., 2012).

In some settings, VC equipment (e.g., laptop, camera or videophone) may be supplied by a care provider and therefore affords a level of control over the technical functioning of the equipment. However, the previously mentioned issues may especially be a risk during home-based TMH because of the potential disadvantage of relying on the network limitations of the patient's location as well as the patient's (or another family member's) personally owned equipment.

Not only should TMH providers have a secondary method for immediately contacting the patient and staff at the originating site in case of equipment failure, but they also should discuss with the patient up front what both parties will do in the event of technical malfunction. For instance, the practitioner may suggest that the client/patient remain off the telephone line so the clinician's efforts to call the client/patient will be successful. Such agreements can be made and documented as part of the informed consent process.

A patient or family in an unstable living situation, such as those going between living situations and homelessness, may not be the best fit for home-based telepractice because of difficulties in finding a consistent secure physical and technical environment to complete sessions. A similar discussion should occur if the client/patient connects from many different

sites because of travel; assessment of whether travel locations will have adequate connectivity and environment to support telepractice sessions should be discussed.

CLIENT/PATIENT APPROPRIATENESS FOR TMH

An essential step is to assess whether providing TMH services is appropriate for each client/patient's circumstance. When patient records are available, it is good practice to review for history of adverse interactions during care, including violence toward family members or health care providers. Assessment of suicide risk prior to initiating and during treatment is also important (Luxton, O'Brien, Pruitt, Johnson, & Kramer, 2014). With the patient's consent, it is advisable to consult with other health care professionals who have been directly involved with treatment of the patient, such as referring providers. As with in-person settings, the individual's or family's preferences need to be taken into account and coercion avoided. For example, a clinician may recommend couple's therapy via a video conferencing platform, but one of the members of the couple may prefer telephone, in-person, or no services. Similarly, a school-based site may recommend TMH services but a parent/guardian may choose to refuse such treatment options for his or her child. In fact, giving priority to client/patient preference regarding TMH services is required by most professional association ethics codes and guidelines (ACA, 2014; APA, 2013a).

Along these lines, it is important to be mindful that clinical contraindications may be discovered during the course of clinical TMH services. At a minimum, telepractitioners should ask clients/patients on intake if they know of any issues that may present a barrier to participation in TMH, such as problems with vision or hearing that may limit the ability of patients to use VC equipment. In some situations, the VC setting may assist with such challenges, such as the ability for an individual with hearing impairment to zoom in on the clinician's face to read lips. It is important to make sure that the VC setting is easily accessible to patients across mobility and other health challenges.

In some situations, a client/patient with a history of adverse reactions to treatment may not be suitable for TMH care, particularly in unsupervised

settings. For example, working with individuals struggling with serious anger management may call for extra caution on the part of the clinician when a client/patient is volatile and vulnerable people are also in the home. Once a client/patient is agitated in a nonclinical environment, it may be impossible for a telepractitioner to intervene effectively to calm the person before he or she interacts with others in the immediate environment. Telepractice sessions differ from in-person sessions in that the client/patient may have different exposure to family members and possibly less opportunity to decompress or "cool down" before heading home. In addition, both supervised and unsupervised TMH settings may have less access to on-site security personnel than in large in-person clinics.

Depending on the situation, clients/patients may require additional time to regain their composure, outside of what is normally allotted for their therapy session. For example, "Amy" was receiving therapy to learn to control her anger and anxiety, especially when dealing with her children. She told her therapist during their videoconference session that her goal was for all the children in her family—from her 20-year-old student to her 3-year-old niece she cared for during the week—to take part in keeping the house clean. While describing this goal, Amy became surprisingly agitated. Her therapist could hear the 3-year-old knocking on the door to Amy's room and calling for her aunt. It was easy to see how her niece's behavior was disruptive to Amy, and how difficult it was for Amy to remain in control of herself. In a situation such as this one, the telepractitioner can ask the patient to calm herself before addressing the children in question and to perhaps take a walk outside before speaking to anyone. In some cases, however, such a suggestion may not be heeded. If good diagnostic workups and related agreements are not in place, telepractitioners may find themselves at a crossroads with the need to make difficult choices about continuing or discontinuing care.

Telepractitioners should take additional safety precautions when working with victims of domestic violence in the home setting by ensuring that the abuser is not lurking out of the camera view. Similarly, child therapists should carefully assess safety in home environments if there is family history of interpersonal violence or if the presenting concern involves a family member (e.g., parent, sibling, other) bullying the child.

It is also common practice to develop verbal signals or code words to be used by the client/patient if something is amiss and the session needs to be terminated without any further verbal exchange. Another commonly used strategy, with the client's knowledge and consent, is for the clinician to scan the room with the camera to show the client/patient that no one else is in the room and to show the locked door. Likewise, the client/patient is then asked to do the same at his or her end of the connection, allowing the client/patient to tell potential lurkers that such scanning is commonplace.

Furthermore, clinicians carefully evaluate clients/patients with substance or alcohol abuse issues. Supervised settings providing these services may consider having breathalyzers or other screening tools available and training telepresenters to administer them. These patients may not be appropriate candidates to be seen in the home setting as clients/patients may have easier access to substances or alcohol in the home or may be more likely to use before or after a session. It also may be more difficult for clinicians to detect intoxication over video because they are not able to smell alcohol on the breath and may be less able to detect changes in voice amplitude, gait, etc. When working with any clinical population, the patient's engagement in a variety of addictive behaviors, including overeating, drinking, drugging, as well as excessive shopping and sexuality may need to be anticipated and addressed quickly by evoking a predefined protocol. Making it a point to explicitly ask patients about behaviors, such as whether they were drinking during the day, is an important part of such a protocol. If a patient endorses these behaviors, the patient and provider then follow the preestablished protocol, which in some cases may mean canceling that day's appointment or referring the patient for on-site services.

It is also important to assess the appropriateness of individuals interested in participating in group sessions over VC, particularly in unsupervised settings. Individuals with risk factors for suicidal concerns or decompensation are unlikely a good fit. Protocols for telepractice group sessions should include well-documented strategies to manage a participant should he or she decompensate within a video session or monopolize the encounter to the detriment of the other group members, including expectations to stop a session in the event a group member requires one-on-one support or direction to emergency services. Protocols, with associ-

ated informed consent processes, should describe how the telepractitioner will follow up with the individual and the other group members should a session be terminated. As in on-site settings, ground rules should be established concerning expectation for the privacy/security of the group sessions over video, as well as expectations for therapist and group member contact outside of sessions.

HOW TO DEVELOP A SAFETY PLAN

As a prerequisite, familiarity with the guidelines and ethics codes of applicable professional organizations is recommended. As outlined in Chapter 3, it is crucial for telepractitioners to be familiar with the jurisdictional requirements of the originating site. Some states have laws specific to telemedicine, and these laws vary from state to state in what type and under what circumstances care can be provided across state lines. It is necessary to be familiar with originating site civil commitment requirements as well as with duty-to-warn/protect requirements. Telepractitioners should also be aware of institutional-level guidance and protocols that may address these issues.

Ideally, safety planning is an ongoing process initiated in advance of difficulties, with protocols/procedures continuously revised as part of practice improvement processes. As in the face-to-face setting, strong team communication skills are crucial in developing and implementing safety plans. Some organizations, such as the U.S. Department of Veterans Affairs, have established standard operating procedures that include safety planning. Practitioners in private practice, however, may not have established safety protocols and thus must develop their own well-considered and written plans.

Review Safety Plans and Expectations With Clients/Patients

It is important for clinicians to discuss safety planning with clients/patients before initiating telepractice sessions as part of the informed consent process (APA, 2013a). The discussion of applicable confidentiality, data security (encryption/Health Insurance Portability and Accountability Act of 1996

[HIPAA] requirements), privacy, and safety procedures as they pertain to the home-based treatment is recommended. The roles and responsibilities of local collaborators, both lay supporters and health care professionals (e.g., telemedicine coordinators/presenters, medical teams), must be clearly defined in writing. In addition, full discussion and documentation of emergency procedures with appropriate family members or other identified local collaborators is advised (see Chapter 3). A setup session that includes such education may be needed prior to the initiation of treatment. When preparing for handling behavioral emergencies, a good diagnostic workup is essential to understanding how to best proceed.

Include Support People

With a solid informed consent agreement in place, the clinician is free to get to know local emergency processes, the availability of collateral services, and response times. The identification and use of a local collaborator, such as a family member or patient's friend, should also be considered as part of home-based TMH safety planning (APA, 2013a; Luxton, O'Brien, et al., 2012; Turvey et al., 2013). Community health workers also have potential to support patients in the home setting (see Chapter 9). Local health care professionals may also be able to provide technical assistance in the event that a connection is lost and, when appropriate, provide support to a client/patient in the event of emergency situations. However, telepractitioners must also remain sensitive to potential tensions in small communities when local supporters (e.g., family, friends, community health workers, health care professionals) become involved.

In some unsupervised VC situations, it may also make sense to consider collaborating with a second local care provider to help with care coordination in the event of psychiatric crises. Relationships and safety plans for clients/patients can be jointly developed with the cooperation of the local care provider to help handle emergencies.

Similarly, when working with people struggling with personality disorders or substance abuse, for example, it often is optimal to involve a team of local community professionals in the care plan, even when practicing in one's own professional community. This well-considered network of

local care providers not only improves care by enhancing care coordination, but also minimizes risk and the practitioner's own anxiety when working with difficult patients. Establishing these relationships between the clinician and professionals in the client/patient's local community is also wise. These collateral services potentially involve not only the range of behavioral health and medical/nursing professionals, but also substance abuse treatment professionals, teachers, allied health professionals (e.g., physical therapists, speech therapists, occupational therapists), and a host of other professionals. Telepractitioners should also consider the risks of involving local collaborators in emergency situations (Luxton, O'Brien, et al., 2012). In particular, the safety of local collaborators must be carefully considered when managing crisis situations. If there is a safety risk to local collaborators, it may be best to rely on local emergency (911) responders. Telepractitioners should weigh the risks of disclosures made during emergency management on patient confidentiality and relationships, especially in small communities (Turvey et al., 2013). Although not always necessary, a physical visit to the community to identify and develop working relationships with local emergency personnel is optimal and, again, can build the local referral base.

ASSESSMENT FACTORS TO BE CONSIDERED AT A REMOTE SITE

Visiting the physical location and getting to know community resources at the remote site prior to engaging with a client/patient is often disregarded by online practitioners, but such relationship building is one of the best risk-management procedures and practice development strategies available (see Chapter 4). Rather than "shotgunning" services to many different communities online, it is suggested, then, that the practitioner identify several key communities to work and thereafter develop referral networks within those communities from which to give and receive referrals. By doing so, telepractitioners mirror traditional therapeutic involvement with community referral sources.

The purpose of such visits is to assess whether the TMH services fit local need. Listening and relationship building are the focus of these early

meetings, allowing the community and future referrers to "put a name with a face," to get a better idea of the scope of TMH services, and to allay potential misperceptions regarding TMH. In many cases, it may allay community fears by clarifying that the telepractice service will fill service gaps, not compete with locally available services. Because many underserved communities have experienced few or no behavioral health providers in the past, few options for providers trained in the latest evidence-based practices, and/or high turnover among the behavioral providers, they may be cautious in embracing the new outreach service. It is advisable to take time in developing the telepractice and to avoid overpromising regarding scope of services (Nelson & Velasquez, 2011). For example, full implementation of telepractice from idea to full clinics often takes 1 to 2 years. It is important to maintain a dialogue with the community about a feasible time frame for the telepractice, often starting with a handful of patients to continuously improve processes ahead of ramping up to full capacity (see Chapter 4). Visits also assist with narrowing the scope of potential services, avoiding duplication of services, and building a referral network. Moreover, the visit and follow-up communication support the development of safety protocols by identifying the community-specific first responders and others who may assist in emergencies. For example, in developing a rural college telepractice, it is important to reach out to campus security services to discuss risk management concerns and procedures.

Particularly in rural areas, primary care providers may be de facto mental health services because of extreme referral shortages as well as the high prevalence of behavioral health conditions among primary care patients, and they are often important partners to cultivate when initiating telepractice. As many primary care practices are pursing patient-centered medical home designation, there is increasing interest in technologies to help coordinate care with behavioral health (Goldstein & Myers, 2014). Periodic visits (every 6 to 12 months) over video and in person with primary care providers and other local leaders will continue to grow these important community connections. Meeting with clients/patients in person can also be valuable. Some providers engage with communities by participating in cultural traditions, such as visiting a sweat lodge associated with rural American Indian veterans served by a TMH clinic (Shore et al., 2012).

As noted by Kramer, Mishkind, Luxton, and Shore (2013), emergency protocols should clearly delineate how two geographically distant sites will collaborate in technical, clinical/psychiatric, and medical emergencies. Ongoing protocol review and staff training are encouraged to support system/team readiness in the event of an emergency. In supervised TMH settings, protocols often take into account local emergency plans, as emergencies are generally handled consistent with already existing emergency protocols at the client/patient's site. Emergency plans should also clearly assign responsibility for contacting emergency and other necessary personnel (e.g., local law enforcement, facility security, emergency medical response teams). Both sites should have immediate access to emergency contact numbers that can respond to the originating (patient) site in the event of an emergency. Further, telepractitioners should obtain the direct phone number for emergency services for the location of patients and also test the nonemergency number for that area to verify that the emergency number is correct. Clinicians should also consider obtaining information regarding medical and psychiatric services that are nearby the patient to make appropriate referrals, to coordinate care across health care providers, and/or to contact the patient's medical team in the event of a crisis situation (Luxton, O'Brien, et al., 2012).

The following information should be collected and readily available to share with emergency personnel: the situation details, the patient's diagnosis and how it could influence interaction with law enforcement officers, and the contact information for local mental health support (Gros, Veronee, Strachan, Ruggiero, & Acierno, 2011; Luxton, O'Brien, et al., 2012; Maheu, Pulier, Wilhelm, McMenamin, & Brown-Connolly, 2004).

OPENING SESSION PROTOCOLS

Well-organized opening protocols for each session, including checklists, can establish the current location of the client/patient to ascertain compliance with legal and reimbursement requirements. Depending on the situation, room setup, locked doors, presence of other people in the room, child-care and eldercare arrangements, who if anyone (e.g., a nurse) is likely to see the patient record, possible interruptions, and

other procedural issues should be reviewed. If it is learned that a client/patient is not in a location for which the clinician has collected required information, time can be taken at the beginning of that session to gather needed information before proceeding or to arrange for alternative care (e.g., reschedule for a later time) if the contact is deemed inappropriate—for example, a college student who is regularly seen over VC through her campus counseling office is visiting her parents for a holiday. Initial session discussion covered the location of her parents' home, location of local emergency resources, and the physical and technical environment. Of course, the clinical decision to see the patient in an alternate location is at the discretion of the practitioner and is based on professional judgment and client/patient condition at the time of each contact. When such decisions are made, the clinician is advised to carefully document rationales.

Uncertainty and fear of TMH, particularly home-based services, can be a barrier to improving access to care and meeting the needs of your clients/patients and the communities you serve. Again, remember that there is not any evidence that TMH, including home-based TMH, is less safe than in-office services when conducted according to evidence-based protocols. With knowledge of the risks, careful preparation, and practice, the TMH professional can ensure that the services they provide are delivered as safely and at the same level of quality as traditional in-office care.