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MEMORANDUM

Attn: Brian Erickson, Sen. Deb Soholt
From: Luke Mack, MA
Date: 8//2019
Subject: Supporting evidence on efficacy of Virtual Mental Health

Literature Summary

Abrams, J., et al. (2017). "Practical Issues in Delivery of Clinician-to-Patient Telemental Health in an Academic Medical Center." Harv Rev Psychiatry 25(3): 135-145.

BACKGROUND: In the age of online communication, psychiatric care can now be provided via videoconferencing technologies. While virtual visits as a part of telepsychiatry and telemental health provide a highly efficient and beneficial modality of care, the implementation of virtual visits requires attention to quality and safety issues. As practitioners continue to utilize this technology, issues of clinician licensing, treatment outcomes of virtual visits versus in-person visits, and cost offset require ongoing study. METHODS: This review provides an overview of the topics of technology, legal and regulatory issues, clinical issues, and cost savings as they relate to practicing psychiatry and psychology via virtual visits in an academic medical center. We review the telepsychiatry/telemental health effectiveness literature from 2013 to the present. Our literature searches used the following terms: telemental health effective, telepsychiatry effective, telepsychiatry efficacy, and telemental health efficacy. These searches produced 58 articles, reduced to 16 when including only articles that address effectiveness of clinician-to-patient services. RESULTS: The technological, legal, and regulatory issues vary from state to state and over time. The emerging research addressing diverse populations and disorders provides strong evidence for the effectiveness of telepsychiatry. Cost savings are difficult to precisely determine and depend on the scope of the cost and benefit measured. CONCLUSION: Establishing a telepsychiatry program requires a comprehensive approach with up-to-date legal and technological considerations.

Bailey, K., et al. (2018). "Barriers and facilitators to implementing an urban co-responding police-mental health team." Health Justice 6(1): 21.

BACKGROUND: In an effort to reduce the increasing number of persons with mental illness (PMI) experiencing incarceration, co-responding police-mental health teams are being utilized as a way to divert PMI from the criminal justice system. Co-response teams are typically an inter-agency collaboration between police and mental health professionals, and in some cases include emergency medical personnel. These teams are intended to facilitate emergency response by linking patients to mental health resources rather than the criminal justice system, thus reducing burdens on both the criminal justice systems as well as local healthcare systems. The current study examines the barriers and facilitators of successfully implementing the Mobile Crisis Assistance Team model, a first-responder co-response team consisting of police officers, mental health professionals, and paramedics. Through content analysis of qualitative focus groups with team members and interviews with program stakeholders, this study expands previous findings by identifying additional professional cultural barriers and facilitators to program implementation while also

exploring the role of clear, systematic policies and guidelines in program success. RESULTS: Findings demonstrate the value of having both flexible and formal policies and procedures to help guide program implementation; ample community resources and treatment services in order to successfully refer clients to needed services; and streamlined communication among participating agencies and the local healthcare community. A significant barrier to successful program implementation is that of role conflict and stigma. Indeed, members of the co-response teams experienced difficulty transitioning into their new roles and reported negative feedback from other first responders as well as from within their own agency. Initial agency collaboration, information sharing between agencies, and team building were also identified as facilitators to program implementation. CONCLUSION: The current study provides a critical foundation for the implementation of first-responder police-mental health co-response teams. Cultural and systematic barriers to co-response team success should be understood prior to program creation and used to guide implementation. Furthermore, attention must be directed to cultivating community and professional support for co-response teams. Findings from this study can be used to guide future efforts to implement first-response co-response teams in order to positively engage PMI and divert PMI from the criminal justice system.

Boudreaux, J. G., et al. (2016). "Using Mental Health Outreach Teams in the Emergency Department to Improve Engagement in Treatment." Community Ment Health J 52(8): 1009-1014.
Engagement in treatment for a person having a behavioral health crisis is critical to fully address the concerns of the individual as well as to prevent future crises. This study explored the benefits of establishing outreach visits from a local community mental health provider to psychiatric patients in an emergency department. Using retrospective analysis of data collected by a local mental health agency, the effect of receiving face to face contact in the emergency room with a community mental health worker (and/or telephone follow up) was compared to no outreach interaction. The effect of this intervention was a significant increase in initial appointment attendance at the local mental health clinic in the aftermath of a psychiatric crisis. Community mental health services provided in partnership with community emergency departments may improve patient engagement in aftercare and consequently help alleviate future behavioral health crises as well as return visits to the emergency department.

Bounthavong, M., et al. (2018). "Economic evaluation of home-based telebehavioural health care compared to in-person treatment delivery for depression." J Telemed Telecare 24(2): 84-92.
Introduction Home-based telebehavioural healthcare improves access to mental health care for patients restricted by travel burden. However, there is limited evidence assessing the economic value of home-based telebehavioural health care compared to in-person care. We sought to compare the economic impact of home-based telebehavioural health care and in-person care for depression among current and former US service members. Methods We performed trial-based cost-minimisation and cost-utility analyses to assess the economic impact of home-based telebehavioural health care versus in-person behavioural care for depression. Our analyses focused on the payer perspective (Department of Defense and Department of Veterans Affairs) at three months. We also performed a scenario analysis where all patients possessed video-conferencing technology that was approved by these agencies. The cost-utility analysis evaluated the impact of different depression categories on the incremental cost-effectiveness ratio. One-way and probabilistic sensitivity analyses were performed to test the robustness of the model assumptions. Results In the base case analysis the total direct cost of home-based telebehavioural health care was higher than in-person care (US$71,974 versus US$20,322). Assuming that patients possessed government-approved video-conferencing technology, home-based telebehavioural health care was less costly compared to in-person care (US$19,177 versus US$20,322). In one-way sensitivity analyses, the proportion of patients possessing personal computers was a major driver of direct costs. In the cost-utility analysis, home-based telebehavioural health care was dominant when patients possessed video-conferencing technology. Results from probabilistic sensitivity analyses did not differ substantially from base case results. Discussion Home-based telebehavioural health care is dependent on the cost of supplying video-conferencing technology to patients but offers the opportunity to increase access to care. Health-care policies centred on implementation of home-

based telebehavioural health care should ensure that these technologies are able to be successfully deployed on patients' existing technology.

Daggenvoorde, T. H., et al. (2018). "Emergency care in case of acute psychotic and/or manic symptoms: Lived experiences of patients and their families with the first interventions of a mobile crisis team. A phenomenological study." Perspect Psychiatr Care 54(4): 462-468.

PURPOSE: To explore the lived experiences of patients with a psychotic or bipolar disorder and their families with emergency care during the first contact with a mobile crisis team. METHODS: Open individual interviews were held with ten patients and ten family members. Content data-analysis was conducted. FINDINGS: Communication and cooperation was difficult in several cases. Personal crisis plans were not always used. Stigma was felt, especially when police-assistance was needed. A calm, understanding attitude was appreciated. PRACTICE IMPLICATIONS: Focus explicitly on communication with the patient, despite the acute condition, enhances the chance of cooperation. Taking time for contact is important.

Dham, P., et al. (2018). "Community based telepsychiatry service for older adults residing in a rural and remote region- utilization pattern and satisfaction among stakeholders." BMC Psychiatry 18(1): 316.

BACKGROUND: Evaluation of telepsychiatry (via videoconference) for older adults is mostly focussed on nursing homes or inpatients. We evaluated the role of a community based program for older adults in rural and remote regions of South Australia. METHOD: The utilization pattern was studied using retrospective chart review of telepsychiatry assessments over 24 months (2010-2011). Satisfaction was evaluated through prospective post-consultation feedback (using a 5-point Likert scale), from patients, community based clinicians and psychiatrist participating in consecutive assessments from April-November 2012. Descriptive analysis was used for the utilization. Mean scores and proportions were calculated for the feedback. Mann Whitney U test was used to compare patient subgroups based on age, gender, prior exposure to telepsychiatry services and inpatient/ outpatient status. Feedback comments were analysed for emerging themes. RESULTS: On retrospective review of 134 consults, mean age was 75.89 years (SD 7.55), 60.4% (81) were females, and 71.6% (96) lived independently. Patients had a broad range of psychiatric disorders, from mood disorders to delirium and dementia, with co-morbid medical illness in 83.5% (112). On feedback evaluation (N = 98), mean scores ranged from 3.88-4.41 for patients, 4.36-4.73 for clinicians and 3.67-4.45 for psychiatrists. Feedback from inpatients (14 out of 37) was significantly lower compared to outpatients (37 out of 61) (chi sq. = 0.808, $p < 0.05$), and they were significantly less satisfied with the wait time ($U = 163.0$, $p < 0.05$) and visual clarity ($U = 160.5$, $p < 0.05$). Audio clarity was the most common aspect of dissatisfaction (mean score less than 3) among patients (6, 11%). Psychiatrists reported a preference for telepsychiatry over face to face in 55.4% (46) assessments. However, they expressed discomfort in situations of cognitive or sensory disabilities in patients. CONCLUSIONS: In rural and remote areas, community-based telepsychiatry program can be a useful adjunct for psychiatrist input in the care of older adults. Innovations to overcome sensory deficits and collaboration with community services should be explored to improve its acceptance among the most vulnerable population.

Fendrich, M., et al. (2019). "Impact of Mobile Crisis Services on Emergency Department Use Among Youths With Behavioral Health Service Needs." Psychiatr Serv: appips201800450.

OBJECTIVE: Youths are using emergency departments (EDs) for behavioral health services in record numbers, even though EDs are suboptimal settings for service delivery. In this article, the authors evaluated a mobile crisis service intervention implemented in Connecticut with the aim of examining whether the intervention was associated with reduced behavioral health ED use among those in need of services. METHODS: The authors examined two cohorts of youths: 2,532 youths who used mobile crisis services and a comparison sample of 3,961 youths who used behavioral health ED services (but not mobile crisis services) during the same fiscal year. Propensity scores were created to balance the two groups, and outcome analyses were used to examine subsequent ED use (any behavioral health ED admissions and number of behavioral health ED admissions) in an 18-month follow-up period. RESULTS: A pooled odds ratio of 0.75 (95% confidence interval

[CI]=0.66-0.84) indicated that youths who received mobile crisis services had a significant reduction in odds of a subsequent behavioral health ED visit compared with youths in the comparison sample. The comparable result for the continuous outcome of number of behavioral health ED visits yielded an incidence risk ratio of 0.78 (95% CI=0.71-0.87). CONCLUSIONS: Using comparison groups, the authors provided evidence suggesting that community-based mobile crisis services, such as Mobile Crisis, reduce ED use among youths with behavioral health service needs. Replication in other years and locations is needed. Nevertheless, these results are quite promising in light of current trends in ED use.

Fortney, J. C., et al. (2013). "Practice-based versus telemedicine-based collaborative care for depression in rural federally qualified health centers: a pragmatic randomized comparative effectiveness trial." Am J Psychiatry 170(4): 414-425.

OBJECTIVE: Practice-based collaborative care is a complex evidence-based practice that is difficult to implement in smaller primary care practices that lack on-site mental health staff. Telemedicine-based collaborative care virtually co-locates and integrates mental health providers into primary care settings. The objective of this multisite randomized pragmatic comparative effectiveness trial was to compare the outcomes of patients assigned to practice-based and telemedicine-based collaborative care. METHOD: From 2007 to 2009, patients at federally qualified health centers serving medically underserved populations were screened for depression, and 364 patients who screened positive were enrolled and followed for 18 months. Those assigned to practice-based collaborative care received evidence-based care from an on-site primary care provider and a nurse care manager. Those assigned to telemedicine-based collaborative care received evidence-based care from an on-site primary care provider and an off-site team: a nurse care manager and a pharmacist by telephone, and a psychologist and a psychiatrist via videoconferencing. The primary clinical outcome measures were treatment response, remission, and change in depression severity. RESULTS: Significant group main effects were observed for both response (odds ratio=7.74, 95% CI=3.94-15.20) and remission (odds ratio=12.69, 95% CI=4.81-33.46), and a significant overall group-by-time interaction effect was observed for depression severity on the Hopkins Symptom Checklist, with greater reductions in severity over time for patients in the telemedicine-based group. Improvements in outcomes appeared to be attributable to higher fidelity to the collaborative care evidence base in the telemedicine-based group. CONCLUSIONS: Contracting with an off-site telemedicine-based collaborative care team can yield better outcomes than implementing practice-based collaborative care with locally available staff.

Gentry, M. T., et al. (2019). "Evidence for telehealth group-based treatment: A systematic review." J Telemed Telecare 25(6): 327-342.

BACKGROUND: Interest in the use of telehealth interventions to increase access to healthcare services is growing. Group-based interventions have the potential to increase patient access to highly needed services. The aim of this study was to systematically review the available literature on group-based video teleconference services. METHODS: The English-language literature was searched using Ovid MEDLINE, PubMed, PsycINFO and CINAHL for terms related to telehealth, group therapy and support groups. Abstracts were reviewed for relevance based on inclusion criteria. Multiple study types were reviewed, including open-label, qualitative and randomised controlled trial study designs. Data were compiled regarding participants, study intervention and outcomes. Specific areas of interest were the feasibility of and satisfaction with telehealth technology, as well as the effect of video teleconference delivery on group dynamics, including therapeutic alliance. RESULTS: Forty published studies met the inclusion criteria and were included in the review. Six were randomised controlled trials. Among the studies, there was a broad range of study designs, participants, group interventions and outcome measures. Video teleconference groups were found to be feasible and resulted in similar treatment outcomes to in-person groups. However, few studies were designed to demonstrate noninferiority of video teleconference groups compared with in-person groups. Studies that examined group process factors showed small decreases in therapeutic alliance in the video teleconference participants. CONCLUSIONS: Video teleconference groups are feasible and produce outcomes similar to in-

person treatment, with high participant satisfaction despite technical challenges. Additional research is needed to identify optimal methods of video teleconference group delivery to maximise clinical benefit and treatment outcomes.

Gentry, M. T., et al. (2019). "Geriatric Telepsychiatry: Systematic Review and Policy Considerations." Am J Geriatr Psychiatry 27(2): 109-127.

Telemental health (TMH) for older patients has the potential to increase access to geriatric specialists, reduce travel times for patients and providers, and reduce ever growing healthcare costs. This systematic review article examines the literature regarding psychiatric assessment and treatment via telemedicine for geriatric patients. English language literature was searched using Ovid Medline, PubMed, and PsycINFO with search terms including telemedicine, telemental health, aging, and dementia. Abstracts were reviewed for relevance based on inclusion criteria. Multiple study types were reviewed, including open label, qualitative and randomized controlled trial study designs. Data was compiled regarding participants, study intervention, and outcomes. 76 articles were included. TMH was shown to be feasible and well accepted in the areas of inpatient and nursing home consultation, cognitive testing, dementia diagnosis and treatment, depression in integrated and collaborative care models, and psychotherapy. There is limited data on cost-effectiveness of TMH in the elderly. This article will discuss the current barriers to broader implementation of telemedicine for geriatric patients including reimbursement from the Medicare program. Medicare reimbursement for telemedicine is limited to rural areas, which does not allow for the widespread development of telemedicine programs. All Medicare beneficiaries would benefit from increased access to telemedicine services, not only those living in rural areas. As many elderly and disabled individuals have mobility problems, home-based telemedicine services should also be made available. There are efforts in Congress to expand the coverage of these services under Medicare, but strong advocacy will be needed to ensure these efforts are successful.

Hilty, D. M., et al. (2013). "The effectiveness of telemental health: a 2013 review." Telemed J E Health 19(6): 444-454.

INTRODUCTION: The effectiveness of any new technology is typically measured in order to determine whether it successfully achieves equal or superior objectives over what is currently offered. Research in telemental health-in this article mainly referring to telepsychiatry and psychological services-has advanced rapidly since 2003, and a new effectiveness review is needed. MATERIALS AND METHODS: The authors reviewed the published literature to synthesize information on what is and what is not effective related to telemental health. Terms for the search included, but were not limited to, telepsychiatry, effectiveness, mental health, e-health, videoconferencing, telemedicine, cost, access, and international. RESULTS: Telemental health is effective for diagnosis and assessment across many populations (adult, child, geriatric, and ethnic) and for disorders in many settings (emergency, home health) and appears to be comparable to in-person care. In addition, this review has identified new models of care (i.e., collaborative care, asynchronous, mobile) with equally positive outcomes. CONCLUSIONS: Telemental health is effective and increases access to care. Future directions suggest the need for more research on service models, specific disorders, the issues relevant to culture and language, and cost.

Hilty, D. M., et al. (2018). "Telepsychiatry and other technologies for integrated care: evidence base, best practice models and competencies." Int Rev Psychiatry 30(6): 292-309.

Telehealth facilitates integrated, patient-centred care. Synchronous video, telepsychiatry (TP), or telebehavioural health provide outcomes as good as in-person care. It also improves access to care, leverages expertise at a distance, and is effective for education and consultation to primary care. Other technologies on an e-behavioural health spectrum are also useful, like telephone, e-mail, text, and e-consults. This paper briefly organizes these technologies into low, mid and high intensity telehealth models and reviews the evidence base for interventions to primary care, and, specifically, for TP and integrated care (IC). Technology, mobile health, and IC competencies facilitate quality care. TP is a high intensity model and it is the best-studied option. Studies of IC are preliminary, but those with collaborative and consultative care show effectiveness. Low- and mid-intensity technology options like telephone, e-mail, text, and e-consults, may provide better access for

patients and more timely provider communication and education. They are also probably more cost-effective and versatile for health system workflow. Research is needed upon all technology models related to IC for adult and paediatric primary care populations. Effective healthcare delivery matches the patients' needs with the model, emphasizes clinician competencies, standardizes interventions, and evaluates outcomes.

Lee, S. J., et al. (2015). "Outcomes achieved by and police and clinician perspectives on a joint police officer and mental health clinician mobile response unit." Int J Ment Health Nurs 24(6): 538-546.

Despite their limited mental health expertise, police are often first to respond to people experiencing a mental health crisis. Often the person in crisis is then transported to hospital for care, instead of receiving more immediate assessment and treatment in the community. The current study conducted an evaluation of an Australian joint police-mental health mobile response unit that aimed to improve the delivery of a community-based crisis response. Activity data were audited to demonstrate utilization and outcomes for referred people. Police officers and mental health clinicians in the catchment area were also surveyed to measure the unit's perceived impact. During the 6-month pilot, 296 contacts involving the unit occurred. Threatened suicide (33%), welfare concerns (22%) and psychotic episodes (18%) were the most common reasons for referral. The responses comprised direct admission to a psychiatric unit for 11% of contacts, transportation to a hospital emergency department for 32% of contacts, and community management for the remainder (57%). Police officers were highly supportive of the model and reported having observed benefits of the unit for consumers and police and improved collaboration between services. The joint police-mental health clinician unit enabled rapid delivery of a multi-skilled crisis response in the community.

Loree, A. M., et al. (2019). "Comparing satisfaction, alliance and intervention components in electronically delivered and in-person brief interventions for substance use among childbearing-aged women." J Subst Abuse Treat 99: 1-7.

Electronic delivery of Screening, Brief Intervention, and Referral to Treatment (e-SBIRT) may be a low-cost and high-reach method for screening and brief intervention in health care settings. However, its relative acceptability, ability to build a therapeutic alliance, and delivery of key intervention components compared to in-person SBIRT (SBIRT) is unclear. The association of these factors with intervention outcomes is also not known. We compared SBIRT and e-SBIRT on satisfaction, alliance, and receipt of intervention components, and evaluated the extent to which these intervention dimensions were related to later substance use. Data were collected as part of a randomized clinical trial (N=439) examining SBIRT, e-SBIRT, and enhanced usual care for childbearing-aged women in two reproductive healthcare clinics (see Martino et al. (2018) for main trial findings). Participants receiving SBIRT or e-SBIRT (N=270) rated satisfaction and alliance following a single-session, brief intervention, based on motivational interviewing that targeted hazardous substance use (tobacco, alcohol, illicit drugs and prescribed medications). Trained raters coded audio-recorded SBIRT sessions for the presence of six major intervention components, and evaluated the occurrence of these components in the e-SBIRT software. Overall, participants in both groups reported strong satisfaction (on average, "considerably" to "extremely" satisfied) and perceived working alliance (on average, "very often" to "always" allied). SBIRT participants provided higher overall alliance ratings, felt more encouraged to make their own decisions, and rated the intervention's likely helpfulness to other women higher. Fewer e-SBIRT participants received intervention components focusing on personalized feedback, developing importance of and confidence in making changes to substance use, and developing a plan to change, compared to SBIRT participants. However, e-SBIRT participants were equally or more likely to receive components seeking to help them understand their use, discussing reasons for use, and summarizing and supporting what the patients elected to do. Notably, satisfaction, alliance, and number of intervention components received were not associated with total days of substance use. Although we found no evidence that the intervention characteristics evaluated in this study were associated with outcomes, acceptability and alliance may have other important implications. Findings suggest

areas for improvement with respect to e-SBIRT satisfaction and alliance formation. ClinicalTrials.govregistration number: NCT01539525.

Mahmoud, H. and E. Vogt (2018). "Telepsychiatry: an Innovative Approach to Addressing the Opioid Crisis." J Behav Health Serv Res.

The opioid epidemic faced by the USA is a complex public health crisis, with staggering loss of life and overwhelming social, health, and economic costs. Despite the rising need for medication-assisted treatment, individuals struggling with opioid use continue to face multiple barriers hindering their access to care, particularly in rural areas. Innovative approaches to enhance access to treatment are needed. Telepsychiatry has proven to be effective and economical across multiple settings and psychiatric diagnoses, including opioid use disorder. As the implementation of telepsychiatry continues to expand, this method of healthcare delivery offers significant opportunities to overcome several barriers to access patients with opioid use disorder face. While addressing the opioid crisis will require multifaceted efforts involving multiple stakeholders and different approaches, a comprehensive strategy must incorporate the adoption of telepsychiatry as an innovative approach to overcoming barriers to treatment and enhancing access to care.

Mayworm, A. M., et al. (2019). "School-Based Telepsychiatry in an Urban Setting: Efficiency and Satisfaction with Care." Telemed J E Health.

Background and Introduction: Given the shortage of child psychiatrists in most areas, telepsychiatry may increase accessibility of psychiatric care in schools, in part by improving psychiatrists' efficiency and reach. The current study assessed consumer and provider satisfaction with school-based telepsychiatry versus in-person sessions in 25 urban public schools and compared the efficiency of these service delivery models. Materials and Methods: In total, 714 satisfaction surveys were completed by parents, students, school clinicians, and child psychiatrists following initial (26.3%) and follow-up (67.2%) visits (6.4% did not indicate type of visit). Most of these surveyed visits were for medication management (69.9%) or initiation of medication (22%). Efficiency analyses compared time saved via telepsychiatry versus in-person care. Researchers also conducted focus groups with providers to clarify preferences and concerns about telepsychiatry versus in-person visits. Results: Consumers were highly satisfied with both in-person and telepsychiatry-provided school psychiatry services and showed no significant differences in preference. Providers reported both in-person and telepsychiatry were equally effective and showed a slight preference for in-person sessions, citing concerns about ease of video equipment use. Telepsychiatry services were more efficient than in-person services, as commute/setup occupied about 28 psychiatrist hours total per month. Discussion and Conclusions: Findings suggest that students, parents, and school clinicians perceive school-based telepsychiatry positively and equal to on-site care. Child psychiatrists have apprehension about using equipment, so equipment training/preparation and provision of technical support are needed. Implications of study findings for telepsychiatry training and implementation in schools are discussed.

Peters, D., et al. (2018). "Worker Preferences for a Mental Health App Within Male-Dominated Industries: Participatory Study." JMIR Ment Health 5(2): e30.

BACKGROUND: Men are less likely to seek help for mental health problems, possibly because of stigma imposed by cultural masculine norms. These tendencies may be amplified within male-dominated workplaces such as the emergency services or transport industries. Mobile apps present a promising way to provide access to mental health support. However, little is known about the kinds of mental health technologies men would be willing to engage with, and no app can be effective if the intended users do not engage with it. OBJECTIVE: The goal of this participatory user research study was to explore the perceptions, preferences, and ideas of workers in male-dominated workplaces to define requirements for a mental health app that would be engaging and effective at improving psychological well-being. METHODS: Workers from male-dominated workplaces in rural, suburban, and urban locations took part in an exploratory qualitative study involving participatory workshops designed to elicit their perspectives and preferences for mental health support and the design of an app for mental health. Participants generated a number of artifacts (including draft screen designs and promotional material) designed to reify their

perceptions, tacit knowledge, and ideas. RESULTS: A total of 60 workers aged between 26 and 65 years, 92% (55/60) male, from male-dominated workplaces in rural (16/60, 27%), suburban (14/60, 23%), and urban (30/60, 50%) locations participated in one of the 6 workshops, resulting in 49 unique feature ideas and 81 participant-generated artifacts. Thematic analysis resulted in a set of feature, language, and style preferences, as well as characteristics considered important by participants for a mental health app. The term "mental health" was highly stigmatized and disliked by participants. Tools including a mood tracker, self-assessment, and mood-fix tool were highly valued, and app characteristics such as brevity of interactions, minimal on-screen text, and a solutions-oriented approach were considered essential by participants. Some implementation strategies based on these findings are included in the discussion. CONCLUSIONS: Future mental health mobile phone apps targeting workers in male-dominated workplaces need to consider language use and preferred features, as well as balance the preferences of users with the demands of evidence-based intervention. In addition to informing the development of mental health apps for workers in male-dominated industries, these findings may also provide insights for mental health technologies, for men in general, and for others in high-stigma environments.

Polomeni, P., et al. (2018). "[Consultation/liaison addiction medicine: Tools and specificities]." Encephale 44(4): 354-362.

Since the 1970s, the concept of "consultation/liaison (CL) psychiatry" has pertained to specialized mobile teams which meet inpatients hospitalized in non-psychiatric settings to offer them on-the-spot psychiatric assessment, treatment, and, if needed, adequate referral. Since the birth of CL psychiatry, a long set of theoretical books and articles has aimed at integrating CL psychiatry into the wider scope of psychosomatic medicine. In the year 2000, a circular issued by the Health Ministry defined the organization of "CL addiction services" in France. Official CL addiction teams are named "Equipes de Liaison et de Soins en Addictologie" (ELSAs) which are separated from CL psychiatry units. Though this separation can be questioned, it actually emphasizes that the work provided by CL addiction teams has some very specific features. The daily practice of ELSAs somewhat differs from that of psychiatric CL teams. Addictive behaviors often result from progressive substance misuse. In this respect, the ELSAs' practice frequently involves screening, brief intervention, and referral to treatment (SBIRT) interventions, which are rather specific of addiction medicine and consist more of prevention interventions than actual addiction treatment. Moreover, for patients with characterized substance use disorders substantial skills in motivational interviewing are required in ELSA consultations. Though motivational interviewing is not specific to addiction medicine, its regular use is uncommon for other liaison teams in France. Furthermore, substance misuse can induce many types of acute or delayed substance-specific medical consequences. These consequences are often poorly known and thus poorly explored by physicians of other specialties. ELSAs have therefore the role of advising their colleagues for a personalized somatic screening among patients with substance misuse. In this respect, the service undertaken by ELSAs is not only based on relational skills but also comprises a somatic expertise. This specificity differs from CL psychiatry. Moreover, several recent studies have shown that in some cases it was useful to extend liaison interventions for addiction into outpatient consultations that are directly integrated in the consultation units of certain specialties (e.g., hepatology, emergency, or oncology). Such a partnership can substantially enhance patients' motivation and addiction outcome. This specificity is also hardly transposable in CL psychiatry. In France, addiction medicine is an inter-specialty that is not fully-integrated into psychiatry. This separation is also applied for CL services which emphasizes real differences in the daily practices and in intervention frameworks. Regardless, CL psychiatry units and ELSAs share many other features and exhibit important overlaps in terms of targeted populations and overall missions. These overlaps are important to conjointly address, with the aim to offer integrated and collaborative services, within the hospital settings of other medical specialties.

Roth, D. E., et al. (2019). "Telepsychiatry: A New Treatment Venue for Pediatric Depression." Child Adolesc Psychiatr Clin N Am 28(3): 377-395.

The benefits and acceptability of using telepsychiatry to provide psychiatric treatment to youth in their homes, schools, primary care provider offices, juvenile correction centers, and residential

facilities are well established. Telepsychiatry removes geographic barriers between patients and providers and improves the access to and ease of receiving quality care. Effective telepsychiatrists use strategic room staging, enhanced nonverbal communication, and technical experience to ensure sessions provide an authentic treatment experience and strong provider-patient alliances are forged. When the telepsychiatry venue is used properly, sessions feel authentic and pediatric treatment outcomes meet and sometimes exceed those of sessions conducted in traditional venues.

Van Veen, M., et al. (2019). "Suicide risk, personality disorder and hospital admission after assessment by psychiatric emergency services." BMC Psychiatry 19(1): 157.

BACKGROUND: The main objectives of the mobile Psychiatric Emergency Services (PES) in the Netherlands are to assess the presence of a mental disorder, to estimate risk to self or others, and to initiate continuity of care, including psychiatric hospital admission. The aim of this study was to assess the associations between the level of suicidality and risk of voluntary or involuntary admission in patients with and without a personality disorder who were presented to mobile PES. METHODS: Observational data were obtained in three areas of the Netherlands from 2007 to 2016. In total, we included 71,707 contacts of patients aged 18 to 65 years. The outcome variable was voluntary or involuntary psychiatric admission. Suicide risk and personality disorder were assessed by PES-clinicians. Multivariable regression analysis was used to explore associations between suicide risk, personality disorder, and voluntary or involuntary admission. RESULTS: Independently of the level of suicide risk, suicidal patients diagnosed with personality disorder were less likely to be admitted voluntarily than those without such a diagnosis (admission rate .37 versus .46 respectively). However, when the level of suicide risk was moderate or high, those with a personality disorder who were admitted involuntarily had the same probability of involuntary admission as those without such a disorder. CONCLUSIONS: While the probability of voluntary admission was lower in those diagnosed with a personality disorder, independent of the level of suicidality, the probability of involuntary admission was only lower in those whose risk of suicide was low. Future longitudinal studies should investigate the associations between (involuntary) admission and course of suicidality in personality disorder.

Waugh, M., et al. (2019). "Using Telepsychiatry to Enrich Existing Integrated Primary Care." Telemed J E Health 25(8): 762-768.

Background: Integrated care is characterized by evolving heterogeneity in models. Using telepsychiatry to enhance these models can increase access, quality, and efficiencies in care. Introduction: The purpose of this report is to describe the process and outcomes of adapting telepsychiatry into an existing integrated care service. Materials and Methods: Telepsychiatry was implemented into an existing integrated care model in a high-volume, urban, primary care clinic in Colorado serving patients with complex physical and behavioral needs. Consultative, direct care, educational/training encounters, provider-to-provider communication, process changes, and patient-level descriptive measures were tracked as part of ongoing quality improvement. Results: Telepsychiatry was adapted into the existing behavioral health services using an iterative team meeting process within a stepped care model. Over 35% of the requests for psychiatry services were medication related-and medication changes (type/dose) were the most frequent referral outcome of psychiatric consultation. Forty percent of patients in the service had multiple behavioral health diagnoses, in addition to physical health diagnoses. Discussion: Telehealth will become an increasingly necessary component in building hybrid/blended integrated care teams. Examples of flexible model implementation will support clinics in tailoring effective applications for their unique patient panels. Conclusions: An adapted integrated care model leveraging telepsychiatry is successfully serving the complex deep end of a primary care patient population in Colorado. Lessons learned in implementing this model include the importance of team attitudes.

Attachments


Van Veen-2019-Suicide


Bailey-2018-Barriers and facilitators to in


Scott-2000.pdf


Vanderploeg-2016.pdf


Dham-2018-Community based telepsych

Other Sources

1. Here is the link to "Mobile crisis services for children and families: Advancing a community-based model in Connecticut": https://www.sciencedirect.com/science/article/pii/S0190740916303589
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4. Dr. Peter Yellowlees