VA Telemental Health: Suicide Assessment

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The Department of Veterans Affairs (VA) encompasses one of the largest telemental health networks in the world, with over 45,000 videoconferencing and over 5,000 home telemental health encounters annually. Recently, the VA designated suicide prevention as a major priority, with telehealth modalities providing opportunities for remote interventions. Suicide risk assessments, using videoconferencing, are now documented in the literature, as are current studies that find telemental health to be equivalent to face-to-face treatment.

Remote assessment of suicidality, however, involves complex legal issues: licensing requirements for remote delivery of care, legal procedures for involuntary detainment and commitment of potentially harmful patients, and liability questions related to the remote nature of the mental health service. VA best practices for remote suicide risk assessment include paradigms for establishing procedures in the context of legal challenges (licensing and involuntary detainment/commitment), for utilizing clinical assessment and triage decision protocols, and for contingency planning to optimize patient care and reduce liability. Published in 2008 by John Wiley & Sons, Ltd.

The Veteran Health Administration (VHA) is the largest integrated healthcare network in the United States and among the largest in the world. The Department of Veterans Affairs (VA) has been a major force in mental health innovation for nearly a century (Godleski, Vadnal, & Tasman, 2001). Subsequently, its leadership role in telemental health since the 1960s has established the VA as one of the largest telemedicine delivery systems in the world.

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In fiscal year (FY) 2007, over 45,000 telemental health visits occurred, primarily with clinicians at 76 VA hospital facilities, delivering care to over 24,000 mental health patients at 242 remote Community Based Outpatient Clinics (CBOCs). In addition, over 1200 patients received home telemental health care delivered through the use of home videophones and in-home messaging devices in approximately 5,000 encounters.

VA clinicians and researchers have been instrumental in establishing the evidence base for telemental health as a modality for the delivery of mental health treatment. Remote video care has been studied and funded extensively in the VA in the last ten years, including tele-treatment for multiple mental health diagnoses (e.g. depression, PTSD, substance abuse, schizophrenia), multiple mental health treatment modalities (e.g. individual therapies, group therapies, medication management), multiple sites of care (e.g. health care facility, patient’s home, homeless shelters), and multiple telemental health approaches (e.g. high-speed videoconferencing, home videophones, in-home messaging devices, and integrated voice response) (Fortney et al., 2007; Frueh et al., 2000; Frueh, Monnier, Elhai, Grubau, & Knapp, 2004; Frueh, Henderson, & Myrick, 2005; Frueh et al., 2007; Grob, Weintraub, Sayles, Raskin, & Ruskin, 2001; Jones & Ruskin, 2001; Menon et al., 2001; Monnier, Knapp, & Frueh, 2003; Morland, Pierce, & Wong, 2004; Nieves, 2006; Nieves & Stack, 2007; Noel, Vogel, Erdos, Cornwall, & Levin, 2004; Ruskin et al., 1998, 2004; Ryan, Kobb, & Hilsen, 2003; Shore & Manson, 2005; Shore, Savin, Orton, Beals, & Manson, 2007; Shore, Savin, Novins, & Manson, 2006; Simpson, Kivlahan, Bush, & McFall, 2005).

In 2007, the VA initiated a major suicide prevention campaign, in response to one of the primary goals identified in President Bush’s New Freedom Commission on Mental Health and the VA Mental Health Strategic Plan. The need for suicide prevention became further highlighted by Kaplan, Huguet, McFarland, and Newsom (2007), whose study indicated that veterans were twice as likely to die of suicide when compared with non-veterans in the general population. This is of particular concern given the current influx of veterans from combat in Afghanistan and Iraq, in addition to the already identified high-risk groups from previous wars (e.g. male, elderly, medically impaired, dual substance abuse diagnoses). As a result, several VA initiatives have been implemented, including establishment of suicide prevention centers, funding for suicide prevention counselors at each facility, and a 24/7 veteran suicide prevention hotline.

When VA telemental health began, there was uncertainty as to what role it could play in suicide risk assessments. Legal issues regarding licensure and involuntary detainment/commitment proceedings impact these assessments when carried out remotely. In addition, concerns initially existed about the effectiveness of telemental health in general and about liability issues with suicide risk evaluations in particular.

Over the past five years, however, the evidence base continued to establish telemental health as comparable to face-to-face treatment, and successful remote videoconferenced suicide risk assessments have been documented in the literature. Subsequently, the VA has moved to develop best practices and clinical paradigms for use of videoconferencing in suicide risk assessments, addressing the legal implications. Currently, the VA offers opportunities for evaluations for suicidality to remote sites via videoconferencing and to the home via videophone and in-home messaging devices.
VA TELEMENTAL HEALTH OVERVIEW

Telemental health was first documented in the United States in 1959 at the University of Nebraska, with the first published report in 1961 of remote group therapy (Wittson, Affleck, & Johnson, 1961). The University of Nebraska went on to develop the first VA connection to the Omaha, Lincoln, and Grand Island VA Hospitals in 1968 (Wittson & Benschoter, 1972). The VA in Bedford also began a telemental health connection with Massachusetts General Hospital in 1968 (Dwyer, 1973).

Telemental health, however, was too expensive and cumbersome for large-scale development in the VA until the computer age flourished in the 1990s. Since 1997, the VA has implemented substantial telemental health services nationally.

The typical VA high-speed (384 kbits/sec) videoconferencing scenario delivers care from a clinician at the main hospital to the patient at the remote community based outpatient clinic (CBOC). The pattern of telemental health growth, especially over the past five years, has been rapid. Since FY 2003, VA videoconferencing telemental health visits and patients served have both more than tripled, to the current level of over 45,000 visits to over 24,000 patients.

In addition to videoconferencing between two healthcare facilities, the VA utilizes telemental health technologies to connect directly to the patient’s home. In 2007, approximately 5000 VA telemental health encounters occurred to the home using videophones and in-home messaging devices.

Videophones insert into traditional telephone lines and provide small screen images over low bandwidth (typically 24–48 kbits/sec). While not considered equivalent to a high-speed videoconferencing encounter in quality of transmission, the videophones provide additional information for the clinician’s remote assessment beyond what is available through a sole telephone contact (e.g. facial expression, grooming and affect). Approximately 500 videophones were deployed in FY 2007 by the VA for mental health care connecting from patients’ homes to clinicians’ offices. Videophones are also being used at other “place of residence” settings such as homeless shelters and halfway houses.

Additionally, over 700 in-home messaging devices are deployed in the VA with telemental health protocols for depression, substance abuse, PTSD, schizophrenia, and bipolar disorder. In-home messaging devices are small technological units that are placed in the patients’ homes and connected by traditional phone lines. They generate questions and transmit data from the patient to the clinician, including triage information (e.g. clinical alerts), cumulative clinical data (e.g. daily rating scale scores), and patient educational materials. The VA Mental Illness, Research, Education, and Clinical Center (MIRECC) in Denver, CO has developed specific in-home messaging device protocols that address suicide risk assessment and intervention in depressed patients.

VA telemental health clinicians and researchers have made major contributions to the telemental health evidence base. The work of Ruskin and colleagues over the past ten years yielded one of first randomized controlled articles comparing telepsychiatry treatment for depression to face to face (Grob et al., 2001; Ruskin et al., 1998, 2004). Most recently, Fortney and colleagues (2007) published a much more extensive randomized trial of telemedicine based care for depression. Other significant VA telemental health researchers include Frueh and colleagues, who published a number of definitive review articles and later randomized controlled...
studies of remote treatment for PTSD (Frueh et al., 2000, 2007; Monnier, Knapp, & Frueh, 2003). Shore combined work with the VA and remote American Indian locations in demonstrating diagnostic reliability in rural telepsychiatry (Shore et al., 2006, 2007; Shore & Manson, 2004, 2005). Morland et al. (2004) demonstrated effective use of remote mental health groups held on different Hawaiian islands. Finally, telehealth to the home has been documented in the VA by the use of videophones (Nieves, 2006; Nieves & Stack, 2007), in-home messaging devices (Noel et al., 2004; Ryan et al., 2003), and integrated voice response (Simpson et al., 2005).

VA SUICIDE PREVENTION INITIATIVES

Suicide is the 11th most frequent cause of death in the U.S., with one person dying from suicide every 16 minutes. The study by Kaplan et al. (2007) further concluded that veterans were twice as likely to die of suicide compared with non-veterans in the general population. Daily life limitations were found to increase suicide risk, which was of particular concern given the influx of returning Iraqi war veterans with injuries. In addition, the elderly male veteran population from previous wars already possesses high demographic risk factors, especially with co-morbid psychiatric disorders and substance abuse.

Brig. Gen. Michael J. Kussman, M.D., US Under Secretary for Health for the Veterans Health Administration, designated suicide prevention as one of the primary goals of the VA’s Mental Health Strategic Plan. In 2007, the VA implemented a comprehensive program to address suicide prevention. It is based on the concept that prevention requires adequate capacity and ready access to a high quality mental health system, as well as activities that target suicide more specifically. Suicide Prevention Coordinators were funded for each medical center and a 24/7 veteran suicide hotline was established. The Under Secretary for Health designated March 1, 2007, as Veteran Suicide Prevention Awareness Day, with staff training to increase suicide awareness and response to suicide risk. This was followed by a coordination of effort with National Suicide Prevention Awareness Week September 10, 2007.

The VA national initiatives established a Mental Illness Research, Education and Clinical Center in Denver, CO, to focus on suicide prevention, under the direction of Lawrence Adler, M.D. The National Center for Excellence for Suicide Prevention was likewise established in Canandaigua, NY. Under direction of Kerry Knox, Ph.D., it provides education, dissemination, and implementation of suicide prevention and has become the hub for suicide coordinators and hotline. Both centers coordinate the VA suicide prevention research, education, and training for the field consistent with prevention policy to enhance the health, well-being, and quality of life of veterans.

THE ROLE OF TELEMEDICINE IN SUICIDE ASSESSMENTS

The use of remote management for mental health emergencies such as suicide evaluation and “emotional crisis” can be traced back to 1953 when “The Samaritans
Service” began offering telephone counseling for those in emotional distress in the United Kingdom and Ireland. The first U.S. suicide prevention telephone service, “Call Bruce,” originated in San Francisco in 1963 to provide accessible telephone interventions for those patients experiencing a “suicidal crisis” (San Francisco Suicide Prevention, 2007). Since then these services have expanded to most U.S. cities, with local emergency mental health services often offering a “crisis hotline” where patients in distress could access a counselor. Even more focused than the crisis intervention services, a national suicide prevention hotline was established to target specific individuals with suicidal ideation and intent. The national toll-free number 1-800-SUICIDE was sponsored by the United States Substance Abuse and Mental Health Services Administration (SAMHSA), with a specialized veteran component added in July 2007.

In addition to these telephone suicide intervention services, which are widely used today for triage, image telemedicine applications are now being reported for emergency psychiatry evaluations. Years ago, there was reluctance on the part of clinicians to conduct video suicide risk assessments remotely, given uncertainty about the effectiveness of telemental health in general and liabilities associated with suicide evaluations in particular. Now that there is a growing evidence base to support telemental health as equivalent to face to face, clinicians increasingly engage in remote suicide risk assessments.

With telephone hotlines, suicide risk is triaged without seeing the patient. Videoconferencing provides an additional dimension to the evaluation by adding a “backchannel” (Cukor et al., 1998) that allows for the visual observation and evaluation of the patients’ emotional state. From a clinical standpoint, remote videoconferencing also opens up access to suicide evaluations in remote areas while minimizing the cost and need to travel. Additionally, it can prevent hospitalization if successful treatment interventions can be implemented as a result of the remote video visit. Finally, it could provide culturally appropriate and competent care in an increasingly multicultural clinical environment, especially if language barriers are a factor.

With the increasing evidence base establishing comparability of remote and face-to-face visits, and documentation in the literature of successful remote suicide assessment, the VA began using telemental health for this purpose. Expanding on the 24/7 veteran telephone triage hotline, the VA now provides widespread opportunities for high-speed videoconferencing suicide assessments between healthcare facilities, with additional opportunities available using home video-phones, and in-home messaging devices.

LEGAL ISSUES RELATED TO SUICIDE ASSESSMENTS

The three main legal arenas intersecting remote suicide assessments involve licensing, involuntary detainment/commitment, and liability. Licensing law requirements for remote clinicians can limit their ability to practice across state lines, and in some states there are even more specific licensing regulations regarding the practice of telemedicine itself. Furthermore, legal regulations become even more important if, in the course of the suicide assessment, the clinician must petition for
the involuntary detainment or commitment of the patient. Finally, liability issues related to suicide assessments should be considered.

**Licensing**

While remote videoconferencing technology provides numerous advantages for the delivery of suicide evaluations, licensing regulations can limit its use. Clinicians often need to be licensed in the state of the patient, just to be able to deliver the care legally across state lines, and almost always to be recognized as “experts” able to give legal testimony regarding dangerousness.

Unlike the regulatory structure that governs the practice of medicine, telemedicine is not bound by geographic state boundaries. The issue of licensing in the practice of medicine has long been recognized in the United States as the purview of individual states (Jacobson & Selvin, 2000). This presents a potential barrier for deployment of telemedicine in mental health (Cwiek, Rafiq, Qamar, Tobey, & Merrell, 2007).

State telemedicine licensing regulations vary greatly, from Alabama, which has a “special purpose license” for telemedicine, to many states that have no specific telemedicine laws. The majority of states, however, do require that a license in their state is necessary if a physician is conducting more than a minimal consultation with regard to a patient located in said state (e.g. reading or interpreting medical records, conducting regular telemedicine encounters with a remote patient). Some states specify the exact interpretation of consultation. In Massachusetts, for example, consultation equals no more than a single visit/year.

Licensing is a globally important issue for telemental health, but it is even more important when assessing suicidality because specific licensing requirements often restrict clinicians from conducting these evaluations if involuntary detainment becomes necessary. Though the VA as a federal agency only requires clinician licensure in a single state, the VA must still abide by the states’ licensing laws that govern state involuntary detainments and hospitalization.

Several alternatives have been proposed to overcome state-limited licensure laws for telemedicine. An expansion of the current licensure models could allow endorsement, reciprocity, and consultative privileges among states. Alternatively, two national licensing models may provide an alternative for the practice of telemedicine (Jacobson & Selvin, 2000). One includes a full federal pre-emption on all laws related to the licensing of telemedicine. The other would provide partial federal pre-emption, whereby the federal government would grant licenses for the practice of telemedicine, while individual states would maintain authority over the practice of medicine and practice standards. This partial pre-emption model already exists in the United States with the Drug Enforcement Agency, which regulates the prescription of controlled substances by physicians already licensed to practice medicine in a state or territory, while the individual state or territory retains authority and regulates standards of practice (Jacobson & Selvin, 2000).

A national licensing model has significant implications for telemental health, especially in the area of expert testimony and standard of care in suicide assessments. In the case of expert testimony, a national licensing model would offer
the opportunity for a clinician who may live in another state or territory to provide his expert opinion in a suicide assessment or commitment proceeding. Expert opinion may not be limited to the area of involuntary commitments, but could also be available in the case of expert opinion in medical malpractice cases related to suicide.

The need for interstate licensing has already received attention in other arenas, which may carry over to telemental health. Local and state disasters, such as Hurricane Katrina and the Virginia Polytechnic University massacre, have raised the importance of an interstate licensure procedure in case of national mental health emergencies. The Southern Governors Association (SGA) held interstate public emergency drills and several states are reviewing the issue of interstate licensure (Cwiek et al., 2007).

Involuntary Detainment/Commitment

In the United States, patients who are considered a danger to themselves or others can be detained and committed to involuntary hospitalization if they meet criteria established by state law, generally determined by an evaluation with a mental health clinician. These evaluations of dangerousness have traditionally been conducted in person, but telemental health offers opportunities for remote assessment. This is particularly important if the patient is geographically distant from the nearest qualified evaluator.

In Virginia, for example, the mental health code requires that patients deemed dangerous to self or others must have a hearing “at the nearest convenient facility” (Commonwealth of Virginia Mental Code 37.2-820) in the presence of a representative from local outpatient mental health services by a court judge or special justice. This has led to the practice of face-to-face court hearings in inpatient units. However, the code also allows for the hearing to be held at “another place open to the public if he (the judge) deems advisable” (Commonwealth of Virginia Mental Code 37.2-820). This presents the possibility of connecting the court judge or special justice through videoconferencing to the originating site and eliminating the need for travel.

Videoconferencing in psychiatric involuntary commitment hearings has been upheld in U.S. Federal Court since 1993 (U.S. v. Baker, 1993). Leroy Baker, an inmate at a the Federal Correctional Facility in Butner, NC, petitioned that his due-process rights were violated by use of videoconferencing in the evaluation leading to his involuntary commitment to a psychiatric hospital. Mr. Baker alleged that the “quality” of information available to the court through videoconferencing was limited and increased the “risk of erroneous result,” thus violating his right to due process under the Fifth Amendment. Instead, the appropriateness of using videoconferencing equipment for legal evaluation was upheld by the district court (U.S. v. Baker, 1993) and later affirmed by the Fourth Circuit Court on appeal (U.S. v. Baker, 1995). In its decision, the court found that videoconferencing allowed for the patient interview to be conducted “in a normal fashion,” where “facial expression and demeanors were easily observable” and the use of video equipment was determined to be equal to face-to-face evaluation “and did not increase the risk of erroneous result” (U.S. v. Baker, 1993).
In 1998, the American Psychiatric Association approved the use of telepsychiatry as appropriate for commitment hearings (APA Resource Document, 1998). Since then clinicians have reported successful videoconferencing deployment for involuntary commitment hearings. Price and Sapci (2007) at the University of Michigan linked medical center conference rooms to the local civil court for involuntary commitment hearings. This approach reduced violence and escape risk liability by eliminating the need and cost to transport the patient out of the hospital. Other related legal issues were addressed locally, including patients’ rights to privacy, confidentiality of video recorded court proceedings, and responsibility for maintenance of records.

Thus with legal precedents (U.S. v. Baker, 1993, 1995) and national professional organizations (APA Resource Document, 1998) upholding the use of telemedicine in involuntary detainments, the potential to build on successes such as the University of Michigan program (Price & Sapci, 2007) offers great opportunities for remote testimony within the legal arena.

Liability

Liability for remote suicide evaluations falls into two major categories: abandonment and negligence.

Issues of abandonment could arise if the technical transmission failed during the patient interview. These could readily be addressed with contingency plans, e.g. providing for back-up telephone connections, access to other clinicians, or other options to address technical interruption in care.

Issues of negligence in remote video suicide evaluations begin with a discussion of negligence for suicide in general. While English common law initially viewed suicide as a crime, punishable by forfeiture of estate and consequences for heirs, the legal attitude has changed dramatically. Since the acknowledgment that mental illness may lead to suicide, laws have been implemented throughout the world to protect individuals from endangering themselves. United States’ courts have repeatedly ruled that failure to furnish medical attention to a suicidal patient may be considered negligent, and that clinicians have a duty to safeguard a patient from danger to self caused by mental state. Once a clinician determines that a patient presents a high risk of endangering him- or herself, each state defines the level of duty the clinician has to try to prevent this, with involuntary detainment and commitment to hospitalization if need be. The criteria for “dangerousness” and the subsequent responsibilities of the clinician vary considerably from state to state.

Telemental health suicide assessments would be bound by the same duty of reasonable care provision that face-to-face visits require. The remote suicide assessment should complete the same comprehensive clinical components of an in-person visit for suicide evaluation.

The increasing evidence base in the literature supports the mental health videoconferencing modality itself as “reasonable care.” Frueh and colleagues reviewed numerous telemental health manuscripts that supported the notion that telepsychiatry assessments produce reliable results, leading to improved clinical outcomes with good patient and clinician satisfaction (Frueh et al., 2007; Monnier et al., 2003). More recently, a number of randomized controlled studies have
concluded that telemental health visits are comparable to face to face (De Las Cuevas, Arredondo, Cabrera, Sulzenbacher, & Meise, 2006; Fortney et al., 2007; Frueh et al., 2005, 2007; Modai et al., 2006; O’Reilly et al., 2007; Ruskin et al., 2004; Shore et al., 2007).

A number of these randomized controlled studies actually treat two conditions most closely associated with suicide: depression and alcohol dependence (Frueh et al., 2005; Ruskin et al., 2004). Depressed patients with history of prior hospitalizations may have a suicide mortality rate up to 20% (Boswick & Pankratz, 2000). Depressed patients treated with telehealth showed treatment adherence, symptom improvement, and satisfaction level equal to patients treated face to face (Ruskin et al., 2004). Treatment of depression through videoconferencing was also as effective in preventing re-hospitalization (14.8%) in patients treated through telehealth compared to 13.6% in patients treated face to face (O’Reilly et al., 2007). These results were obtained with the same rates of patient satisfaction. Patients with alcohol dependence showed the same level of satisfaction and treatment adherence with relapse prevention groups offered through videoconferencing. Their treatment dropout rates were also similar to those of face-to-face groups (Frueh et al., 2005).

Specifically, videoconferencing equipment has been used successfully in suicide evaluations and other high-risk situations. In a recent report, Jong (2004) demonstrated successful outcomes as well as cost efficiency with suicidal patient evaluation using videoconferencing equipment in a remote rural area. A total of 71 patients were evaluated successfully, with three patients being referred to a secondary hospital for further assessment and care. There were no suicides.

Sorvaniemi and Santamki (2002) documented the successful use of videoconferencing for acute high-risk initial psychiatric evaluations for emergency hospital admissions. Depression was the admitting diagnosis for 64.4% of these patients, following a typical suicide assessment evaluation component. There was a strong patient preference for videoconferencing over travel for face-to-face evaluation. As in the previous study, there were no suicides.

A review of the LexisNexis Legal database did not reveal any precedent cases of telemental health liability regarding suicidality. This may be a result of the significant substantiation of remote video evaluation providing the same reasonable care as face to face. In addition to the extensive and increasing evidence base in the literature, the appropriateness of video assessments has also been upheld in the United States legal system (U.S. v. Baker, 1993, 1995) and approved by national professional organizations (APA Resource Document, 1998). The United States Congress even proposed legislation to fund telecommunication technology specifically to prevent and treat suicide in the Indian and Alaska native population (S.2245: Indian Youth Telemental Health Demonstration Project Act, 2006).

**LESSONS LEARNED/BEST PRACTICES**

Given the extent of telemental health in the VA, its use in suicide risk assessments has yielded a number of lessons learned and best practices, which address the legal challenges. These consist of four basic areas: (a) practicing within local legal...
regulations, (b) using clinical judgment in patient selection, (c) utilizing accepted suicide assessment parameters, and (d) addressing contingency plans.

Practicing within Local Legal Regulations

Before deciding whether or not to offer suicide assessment using videoconferencing to a remote location, local legal regulations must be taken into consideration.

Awareness of the state laws regarding telemental health assessment is important if the encounter crosses state lines, and especially if it involves licensure and involuntary detainment and commitment procedures. The majority of states do require at least licensure in their state if a physician is conducting more than a minimal consultation with regard to a patient located in that state. Some states such as Alabama have additional telemedicine licensing requirements, e.g. a special purpose license. Clinicians can access most definitively the exact statutes governing any telemedicine encounter by contacting the governing healthcare board of the applicable state (e.g. Board of Medicine, Board of Nursing, etc). These statutes are also usually available on the internet by searching the name of the state and “telemedicine statutes,” or through accessing the websites of national telemedicine organizations, which often provide composite state legislation data (e.g. American Telemedicine Association, Telemedicine Information Exchange). Caution must be taken in that website information may not always be as accurate or up to date as the professional state governing boards, however.

Even in the VA, where only a single state license is required to practice, VA clinicians must abide by state mental health codes if involuntary detainment/commitment is necessary. If local laws or regulations restrict the use of the clinician in remote videoconferenced evaluations, suicide assessments would need to be done elsewhere or back-up plans for involuntary detainment should be in place. If the patient is in a remote healthcare setting with other clinicians on site, another clinician may be used in this case. Many states do not require that the clinician be in the mental health field in order to petition for involuntary detainment. In the VA, a primary care physician at the patient site can often be called upon to obtain such petitions. In some states, the police can be called to the patient site to determine whether the patient should be detained, if the remote clinician is not legally able to petition for involuntary restraint. This would involve coordination with local law enforcement. Ultimately, knowledge of the local laws at a VA site helps determine whether remote suicide assessments can be conducted at a particular site and with what procedures. Information regarding each state’s mental health laws can be accessed from the state judicial system, and is usually available on the internet when searched under “mental health laws” and the name of a particular state. In most cases, the exact statutes regarding legal standards and procedures for civil commitment are posted on the internet, and the clinician could obtain the information necessary to know whether or not they would be qualified to petition. Relevant laws regarding liability and specific duties in situations of dangerousness are similarly accessible on the internet or at the state judicial system. Again, the clinician should be cautious that the information on the internet may not be as accurate or up to date as that available directly from the judicial system.
Using Clinical Judgment in Patient Selection

In order to provide optimal patient care as well as minimize liability, clinical judgment is key to patient selection for remote video suicide assessments. Factors taken into consideration at the VA include distance, patient acuity, clinician familiarity with the patient, likelihood of imminent hospitalization, or probability that suicide and hospitalization could be prevented with a remote video intervention. Suicide behavior protective factors such as strong spiritual beliefs, strong family bonds, life satisfaction, and ability to handle stress can readily be evaluated through videoconferencing equipment. If it is known that the patient will require hospitalization based upon the history even prior to the assessment, then it may make more sense to try to transport the patient directly to the hospital. However, even in this case, geographic distance may preclude ready access to a hospital (e.g. on an island), in which case getting the patient to a telemental health encounter may be desirable until transportation can be arranged. If the patient’s clinician is familiar with him and is available remotely, the clinician may be able to help the patient avoid hospitalization based upon knowledge of his course. In sum, a number of factors impact the clinical judgment decision about whether to perform a suicide assessment remotely, as there are generally neither absolute indications nor contraindications.

Utilizing Accepted Suicide Assessment Parameters

Once it is decided that the legal regulations allow for remote video suicide assessment, and the clinical judgment determines that it should occur, the use of established suicide assessment techniques is helpful. The VA has initiated extensive suicide prevention training as described earlier. Use of standardized accepted decision trees with comprehensive elements for suicide assessment seeks to provide optimal patient care while minimizing liability risk in face-to-face as well as remote assessments. While not specific to telemental health, VA suicide prevention training includes dissemination of VA Suicide Assessment cards (VA Suicide Prevention Day Pamphlet, 2007) based upon the American Psychiatric Association Practice Guidelines for Assessment and Treatment of Patients with Suicidal Behaviors and the work of Rudd and colleagues (2006). VA suicide assessment tools for clinicians and patients are posted regularly on the internet and can be searched by “VA suicide prevention.” There are also a number of other reports that could be used to simplify and provide easy-to-follow guidelines for suicide risk evaluations (Muzina, 2007), including predisposing risk factors and how to determine intervention level and safety needs.

Addressing Contingency Plans

It is helpful to establish contingencies for emergencies during the suicide assessment, such as equipment failure and on-site need for security/police back-up. At the VA there is generally telephone back-up if the video connection is interrupted so the patient and clinician are able to continue contact through a landline telephone. In addition, when the care is being delivered to a remote VA clinic, there are other
clinicians present, albeit not always mental health, who can resume care of the patient if the connection fails. Though the focus of this article is primarily video conferencing, any telemental health intervention to the home generally delineates emergency procedures for the patient at the onset (e.g. call 911), when videophone contact with the clinician and in-home messaging follow-up is not available at all times. Liaison between law enforcement at the clinician and patient sites is necessary in the case of an on-site suicide attempt, a need for involuntary detention, or to remove any access to suicidal means, e.g. remove a firearm, or secure and safe transport to another location for hospitalization or further care.

**TRAINING CASE VIGNETTE**

In the VA’s extensive telemedicine training module series, we include this hypothetical case vignette to illustrate some of the above outlined principles:

A 58 year old Viet Nam War veteran, with a 30-plus year history of post-traumatic stress disorder, lives on the Island of Maui. His mental health clinician is based on the Island of Oahu, separated by the Pacific Ocean and over 100 miles. The veteran calls his clinician stating that he has been more depressed over the past week, getting into arguments with his family, missing work, and thinking about ending his life.

The clinician will ultimately determine whether the patient should fly to the main VA facility on Oahu for evaluation and hospitalization, or whether a telemental health suicide assessment and intervention could be done first from the VA outpatient primary care clinic in Maui with the hope of avoiding transport and hospitalization.

The clinician would first ensure the immediate safety of the patient, determining clinically whether the patient had the means and likelihood to harm himself at a level of urgency necessary to invoke immediate transport to the nearest medical facility or immediate involvement of the police. If the situation was not at that level of emergency, the clinician would proceed to consider a remote suicide risk assessment as follows.

**Practicing within Local Legal Regulations**

The clinician would take into consideration the relevant legal regulations in Hawaii. While this patient and clinician are on two different islands, they are in the same state, so there is no concern about interstate licensing regulations. Since Hawaii allows for verbal orders from clinicians for temporary detention, the clinician on Oahu knows he or she could obtain such orders remotely if it became necessary during the course of the evaluation. Also, in Hawaii, obtaining detention orders is not limited to mental health professionals, so any licensed physician or health or social service professional may petition for the orders at the primary care clinic site of
the patient if this becomes necessary. In addition, the clinician is aware that in Hawaii if a police officer, in conjunction with a mental health worker, has reason to believe that a person is imminently dangerous to self or others, or is gravely disabled, or is obviously ill, that person may be detained. So local licensing regulations allow for a conducting a telemental health assessment, and state involuntary detainment laws allow several options for this clinician.

**Using Clinical Judgment in Patient Selection**

The clinician would take into consideration a number of clinical judgment issues before determining that a video suicide risk assessment is appropriate for this patient. In this hypothetical training vignette, the patient’s wife is with him, the patient is familiar to the clinician, and the patient agrees to voluntary evaluation and can contract not to harm himself through the time of the evaluation. The clinician proceeds to consider remote telemental health suicide risk assessment, based upon these factors and the history of the patient, which is immediately available to the remote clinician by VA electronic medical record. Given the geographic distance between the clinician and patient, and logistical travel issues requiring air or nautical transport for a face-to-face visit, the clinician determines that it would be clinically preferable to engage in a timely video assessment in the hopes of preventing hospitalization, before arranging transport to Oahu.

**Utilizing Accepted Suicide Risk Assessment Parameters**

When conducting this remote suicide risk assessment, this clinician would use the same parameters and tools as if the assessment were being done face to face (e.g. using VA Suicide Prevention Cards and APA Practice Guidelines for Assessment and Treatment of Patients with Suicidal Behaviors, APA, 2004). This clinical would question the veteran during the video assessment about suicide specifics that include ideation, history, intent, plan, access to means of execution, impulsivity, support systems, and additional risk factors such as substance abuse. Should the clinician determine that the patient does not need hospitalization, the clinician would document the factors leading to this decision in the same way as if it were a face-to-face visit.

**Addressing Contingency Plans**

Should the patient become agitated and imminently dangerous during the course of the video assessment, the clinician would likely first follow any contingency plans of the Maui primary care clinic for dangerous circumstances. The remote clinician would likely also be knowledgeable about the options available. For example, the Maui police could be contacted directly or the Honolulu police could be contacted to connect with the Maui police. The remote clinician could contact the police, or could alert the primary care clinic staff at the site of the patient to handle the situation from there. If detainment is necessary, the remote mental health clinician can determine who would petition for the order. Additional equipment failure
contingency plans in the case would address instructions to the patient to await a
phone call from the remote clinician if the video failed, or to seek an on-site clinician
for further instruction.

In this training vignette, the patient’s suicidal risk is assessed remotely using
videoconferencing and his medications are adjusted, which successfully ameliorate
his depression and suicidal ideation. Both transport to Oahu for evaluation and
hospitalization are prevented.

CONCLUSION

Remote suicide assessments are viable options using videoconferencing techno-
lologies, with the increasing evidence base demonstrating the equivalency of telemental
health and face-to-face visits, the support of professional organizations (e.g. The
American Psychiatric Association), and judicial precedents upholding videoconfer-
encing as viable modalities in the legal arena. Legal implications present challenges
to the clinician to attend to local regulations regarding licensure and involuntary
detainment/commitment proceedings. Liability can be minimized by using sound
clinical judgment regarding patient selection, by conducting the suicide assessment
using established elements of face-to-face suicide assessment, and by planning for
contingencies in the case of technological interruption or dangerousness of the patient.

Future directions should include careful analysis and research regarding the
outcomes of, and the systemic impact on, telemental health evaluations of suicidal
patients. The VA is working with its National Center for Suicide Prevention to
establish a database to track the volume and disposition of suicide assessments done
remotely by videoconferencing. Outcome analysis will help delineate the clinical
factors leading to successful remote assessment, for example whether or not there are
specific diagnoses or clinical indicators that lend themselves well to remote
assessment or contra-indicate it. Finally, the impact of systemic issues should
be carefully analyzed, particularly those resulting from the differing legal statutes in
place. For example, future research should discern whether clinicians are more or
less likely to engage in remote videoconferencing in states with more specific
telemedicine licensing requirements (e.g. Alabama); whether clinicians are more
likely to engage in telemental health suicide evaluations in states that allow for verbal
orders for temporary detention; and whether there are more telemental health
assessments in national systems such as the VA with no interstate licensing
requirements.

With the advances in technology and diminution of costs, telemental health
assessments will become increasingly accessible. Using the information obtained
from careful outcome analysis and research, we will be better able to understand and
lobby for the optimal legal environment to support telemental health.

REFERENCES


Common wealth of Virginia, Mental Health Code, Section 37.2-820.


