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Discussion

Little information is available about the cost-effectiveness and cost-benefit of telepsychiatry programmes; and data need to be collected in a standard, prospective, preferably longitudinal fashion. However, cost-effectiveness could be improved by use of a consultation-liaison model, whereby the telepsychiatrist evaluates the patient and makes recommendations for management by the primary care provider, who thereby gains skills that could benefit patients and the community setting. This educational role of telepsychiatry is especially important for the primary care providers of rural communities, in which 20% of the US population lives.

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THEMATIC PAPER – TELEPSYCHIATRY

Telepsychiatry in Europe

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The uses of videoconferencing included meetings (50%), supervision, training and teaching (31%), clinical consultations (14%) and tests or demonstrations (5%).... The low rate of clinical videoconferencing reflects a reluctance of key professionals to offer services this way.

Telepsychiatry, the use of videoconferencing in mental health care, has been piloted in European settings as diverse as northern Norway and inner London. These studies have been initiated to improve access to services and have been limited in scale. Nevertheless, some common themes have emerged.

Telepsychiatry in Norway

Gammon *et al* (1996) surveyed the use of videoconferencing in mental health services in northern Norway in 1995. Over six months, 1028 persons participated in 140 videoconferencing sessions from 35 institutions. The uses of videoconferencing included meetings (50%), supervision, training and teaching (31%), clinical consultations (14%) and tests or demonstrations (5%). The forms of contact that videoconferencing replaced included travel (59%), no contact (25%), telephone (14%) and mail or fax (2%). No problems were reported in 55% of the sessions. The majority of users reported that they were satisfied or very satisfied with the facility. The low rate of clinical videoconferencing reflects a reluctance of key

professionals to offer services this way. This network has continued to grow.

Gammon *et al* (1998) also reported the use of videoconferencing for psychotherapy supervision, over 384 kbit/s integrated service digital network (ISDN) connections. Trainees had five face-to-face sessions, alternating weekly with videoconferencing. The quality of supervision could be satisfactorily maintained by videoconferencing, for up to half of the 70 hours required for training. A precondition for this estimate was that the supervision dyad should meet face to face and establish a relationship characterised by mutual trust and respect. Major concerns reported by the participants were the loss of non-verbal cues and the effects this had on spontaneity, the expression of personal emotional material, and the experience of social and emotional presence.

Telepsychiatry in Finland

Mielonen *et al* (1998) reported on the use of videoconferencing in Oulu, where videoconferencing at 384 kbit/s was used for family therapy, occupational counselling, clinical consultation and teaching. In 1996, video-

conferencing was used in this area for a total of 249 hours, which increased to 434 hours in 1997. During 1997, 45% of the time was used for teaching, 26% for occupational counselling, consultations and therapies, 23% for training and 6% for administration.

Mielonen *et al* (2000) also reported on the use of videoconferencing for planning discharge from a mental health unit. The majority of participants stated that they would prefer to have their next meeting by video-conference. The most common reasons given were the reduced need for travel and the ease and speed of the consultations. An economic analysis showed that at a volume of 50 care-planning consultations per year, the videoconferencing alternative was about FM2340 cheaper than conventional meetings and the municipality would save about FM117 000 by using the medium. Six hours of travel time could be used for other purposes when the meeting was held by videoconferencing.

Telepsychiatry in the UK

The earliest UK work was reported from Guy's Hospital in London (McLaren *et al*, 1996). A link was established with the Speedwell Mental Health Centre, about six miles away, using a 2 Mbit/s leased line. Of 26 patients approached, 11 refused (five said they were concerned about confidentiality and video-recording, three said they had used it before and three said they did not understand). Patients' perceptions were more positive than clinicians' for every question on the satisfaction instrument and this reached statistical significance. Clinicians were less confident in judging the presence of psychiatric symptoms by videoconferencing than in person.

The Guy's group has gone on to pilot videoconferencing in an inner-London adult mental health service, for a population with high levels of morbidity and social deprivation. Videoconferencing has been used between a general practice and a community mental health centre serving the same area (McLaren *et al*, 2002). This work found high levels of service user acceptance. Information on refusals has been a useful aspect of this urban telemedicine research, where the benefits to service users are more marginal than in areas of low population density. Some service users believed it was an advantage to be seen in the general practitioner's surgery. Others felt they were 'missing out' and preferred to travel to the psychiatrist. Dropout rates were no higher for patients treated by videoconferencing, but patients treated this way may stay in contact with the specialist secondary service longer than those seen face to face.

May *et al* (2000) reported qualitative data from a telepsychiatry referral service for patients being treated by general practitioners for anxiety and depression, using the British Telecom VS1 desktop videophone operating at 128 kbit/s. Twenty-two patients and 13 doctors were interviewed after a videophone consultation. The doctors stated that they did not see a need for videoconferencing where accessibility is not a problem. The most important problem identified was the extent to which communication skills needed to be adjusted to meet the demands

of the medium. In a further qualitative analysis, it was reported that the use of videoconferencing in this way threatened professional constructs about the nature and practice of therapeutic relationships (May *et al*, 2001).

Frier *et al* (1999) described the use of videoconferencing in a psychology service in the Highlands of Scotland, which has one of the lowest population densities in the European Union. This service operated from 1997 and extended over a distance of 200 km between Inverness and the Isle of Skye, using BT VC7000 videoconferencing units connected by ISDN at 128 kbit/s. Twenty-seven adults and seven children were treated with cognitive-behavioural therapy by videoconferencing. Most service users complained of poor sound and picture quality, but were still satisfied with the consultations. A third expressed a preference for face-to-face consultation.

Ball (2003) has reviewed the use and potential of videoconferencing in old age psychiatry.

Pilot studies have begun in several forensic settings to explore the potential of videoconferencing to improve access to services for mentally disordered offenders.

Other projects

Gonçalves & Cunha (1995) described a telepsychiatry component in a telemedicine link between Lisbon and the Azores. Mannion *et al* (1998) in Galway reported on a link established with the island of Inishmore, off the west coast of Ireland. The European Union is currently funding the 'ISLANDS' telepsychiatry project. An international research group is studying the use of videoconferencing to support psychiatric service delivery in the Canary Islands, the Greek Dodecanes, French Guyana and Martinique.

Conclusions

Telepsychiatry has been piloted with a wide range of geographical locations and service models. Service user responses have been generally, but not uniformly, positive and these responses need further clarification. Professionals have embraced videoconferencing for supervision, education and administration, but are still wary of using it for communicating with service users for clinical tasks. This wariness may owe more to prejudice and professional defensiveness than to objective assessment. The costs of equipment and communication links have limited the diffusion of such applications to areas with low population density, where economic benefits are obvious. Costs of both are falling rapidly and the readiness with which service users, even while suffering from acute and severe mental illness, adapt to clinical consultations by videoconferencing suggests that this mode of service delivery could become commonplace, both for accessing scarce national and international tertiary expertise and for improving communication between elements of distributed urban community services.

Mental health services are facing growing demands and struggle to deliver effective treatments in sufficient quantity. Efficient communication between service elements and getting effective treatment to service users in a timely

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fashion are two of the major challenges facing mental health services this century. Telepsychiatry has been shown to have the potential to improve both. Larger-scale economic evaluations are required and professional concerns need to be addressed through studies of the effects of the medium on clinical outcomes and therapeutic relationships. Within two decades videoconferencing could be the preferred medium for contact between professionals and mental health service users in Europe.

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COUNTRY PROFILES

Introduction

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Country profiles provide summary information on mental health policy, services, training and research in the country, along with key references for more details. The aim is to give a bird's eye view of the situation within about 1500 words. It is hoped that this will not only increase the reader's awareness of distant and often forgotten countries, but also provide an opportunity for learning from others' experiences. The profiles can also open possibilities for further dialogue and even collaboration.

This issue of *International Psychiatry* presents country profiles from Sri Lanka, Turkey and Azerbaijan. As well as giving rich descriptions of the situation within the countries, all three profiles clearly bring out the need for comprehensive mental health policies, supported by enhanced training of professionals for improving psychiatric care.

If you wish to make a contribution to the country profile section, please contact Shekhar Saxena (email saxenas@who.int).

Negative attitudes to mental illness, social stigma and a lack of appreciation of the suffering and disability caused by mental illness have resulted in low priority being given to mental health care services in Sri Lanka.

COUNTRY PROFILE

Mental health services in Sri Lanka

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Relative to its economic indicators, Sri Lanka has a high health status. The life expectancy in the year 2001 was 70.7 years for males and 75.4 years for females. Maternal and infant mortality rates have shown a downward trend over the past half century and now are around 2.3 per 10 000 live births and 16 per 1000 live births, respectively.

These trends are mainly due to the high literacy rate and comparatively large investments made in health and social welfare.

The situation regarding mental health care services is very different. As in many developing countries, negative attitudes to mental illness, social stigma and a lack of appreciation of the suffering and disability caused by mental