

Editorial

Telepsychiatry: The Bridge across the Access Gap in Child and Adolescent Mental Health

Pratap Sharan, MD, PhD; Savita Malhotra, MD, PhD

Address for Correspondence: Professor Pratap Sharan, Department of Psychiatry, All India Institute of Medical sciences, Ansari Nagar, New Delhi-110029. Email: pratapsharan@gmail.com

Epidemiological studies demonstrate that child and adolescent mental health problems are very common, distressing, disabling and persistent. Children and adolescents' mental illnesses differ in terms of psychopathological patterns, comorbidities and response to treatment in many ways from those of adults; hence specific training and interventions are required for managing them properly. However, the WHO Atlas on Child and Adolescent Mental Health Resources has documented an almost total failure of countries, especially low-income countries, in providing adequate policy, training and services for child and adolescent mental health.¹ Geographic and economic barriers (the majority of relevant professionals are concentrated in large cities either at university centers or inside the private system) further render access to the limited services difficult.

In a low-income country like India, where just about 100-125 psychiatrists are devoting time specifically to child and adolescent mental health (approximately 20 are trained in child and adolescent psychiatry and about 100 have developed it as an area of special interest), it is extremely important to develop alternative approaches to deliver mental health services to children and adolescents as the gap between demand and supply seems impossible to bridge in the foreseeable future with the contemporary Western models of specialist labour-intensive child and adolescent mental health practices. The alternatives to be considered must match the existing realities and systems prevalent in such countries.

Integration of child mental health with school, social services and primary care is necessary for provision of child and adolescent mental health services in low- and middle-income countries. Different professionals could be targeted in diffusing efficacious interventions for mental health problems, e.g. teachers and school counselors could be specifically trained in preventive strategies and psychological triage. Similarly, pediatricians and the general practitioners can be trained to give adequate support to children and adolescents presenting with emotional and behavioral problems, to screen for psychiatric disorders, and to identify children and adolescents at high risk. However, pediatricians and other primary care workers would need support from specialized professionals to carry out the above responsibilities effectively. Telepsychiatry and the internet could help in providing such support.

Telepsychiatry or E-Mental health, is generally defined as the use of communications technology (e.g. telephony, internet) to provide psychiatric services across distances.

Such services are usually for treatment or educational purposes and have been used successfully to provide mental healthcare to rural areas in many high-income countries.² A systematic review of child and adolescent telepsychiatry showed that videoconferencing seemed to improve the accessibility of services and served an educational function.³ Some papers also mentioned savings in time, costs and travel and perceived benefit of service provided within the user's own community. Problems with non-verbal communication and the audiovisual quality of the videoconference were mentioned as drawbacks by some authors, but these concerns have lessened with improvement in technology and greater experience with the medium.⁴ Telepsychiatry therefore seems to offer several benefits, at least in underserved regions. Hilty et al found that primary care consultee satisfaction and utilization of telepsychiatry and clinical skills improved with continued use of telepsychiatry services.⁵ Boydell et al documented the successful implementation of recommendations made during teleconferencing in a sample selected randomly from a paediatric telepsychiatry programme serving rural communities.⁶ Telepsychiatry has been used in the provision of emergency services, and it may be preferred by some patients/ caregivers waiting for a consultation or those having to travel to see a mental health professional in a face-to-face meeting.⁷ Freuh et al have also described the provision of group therapy from an accredited counselor.⁸ However, it is possible that telepsychiatry may not produce equivalent outcomes when used to deliver psychotherapy, which is more dependent on the therapist-patient relationship.⁹

Videoconferencing seems to be the best technology for clinical care at a distance,³ while internet may be the more cost effective method for training.³ Rahman et al have shown that it is feasible to provide training and supervision in child and adolescent mental health (by a child psychiatrist) to mental health (psychiatrist, psychologist) and general health (medical officers) professionals practicing in a low-income country (Pakistan) using the internet.² This was achieved at no additional equipment and running costs to the existing system.

Consultation to front-line workers like physicians and paraprofessionals available in the community (in comparison to direct consultation to patients/clients) seems to be a more efficacious model for service and program consultation.¹⁰ The advantages of working as a consultant rather than as a therapist are that this model addresses the issue of duty of care, does not assume responsibility that would be impossible to carry out and provides support to front-line workers. To apply telepsychiatry for child and adolescent mental health services, it will be necessary to develop software packages with codified medical knowledge as an aid to assessment, diagnosis and management by frontline workers; and also a model of logical decision support system (for diagnosis and management) with facilities for real time as well as store forward (web based) video recording, teleconferencing, and creation of electronic medical records. Issues related to cost (e.g. availability of appropriate hardware and software), training (needed to operate the equipment) and technology (e.g. the speed of the internet service) may be seen as impediments in the use of videoconferencing in many low- and middle-income countries.

However this may not be the case in India, which is a recognized global leader in information technology and thus has the potential to provide leadership in developing models for tele-health. These models could gradually be implemented in other low- and middle-income countries as broadband technology becomes more widely available. To provide quality services, we would also have to work out issues related to informed standards (e.g. ethical issues like informed consent) and guidelines (e.g. regarding emergency contact),^{10,11} that are relevant to our communities. Training mental health professionals to carry out telepsychiatric responsibilities would also be a priority. As services mature, we could mount comparative studies on reliability, efficacy, and cost-effectiveness of telepsychiatry for providing mental health care for children (services provided by telepsychiatric as against services provided as usual in comparable regions).

Finally it should be emphasized that telepsychiatry should be integrated into a system of care that meets children and adolescent's overall needs. To achieve this, it may be critical to understand the nuances of the local communities, e.g. parenting methods, social expectations and demands, societal norms and values; for whom the service is being developed. Eventually we should be able to empower the patients and their families to access health care effectively (and when appropriate even directly from their homes). It is doable and there are steps in this direction already underway

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Professor Pratap Sharan, Department of Psychiatry, All India Institute of Medical sciences, Ansari Nagar, New Delhi-110029.

Professor Savita Malhotra, Department of Psychiatry, Postgraduate Institute of Medical Education and Research, Chandigarh-160012.