Mobile telepsychiatry in India

It was interesting to read B. Grady's article (1) in the October 2012 issue of *World Psychiatry* and draw parallels to our own experience in delivering telepsychiatry services to rural parts of Tamil Nadu in India.

Schizophrenia Research Foundation (SCARF) began experimenting with telepsychiatry in 2005 as part of its psychosocial intervention program for Tsunami victims and has since developed it into a full-fledged component of its community outreach program. The services were initially delivered through Integrated Services Digital Network (ISDN) lines and subsequently, with the availability of increased bandwidth, we shifted over to broadband. In 2010, with support from the Tata Education Trust, we expanded our service to cover the district of Pudukottai and pioneered the delivery of telepsychiatry services on a mobile platform.

The mobile service covers 156 villages with a population of about 300,000. At present the service focuses only on those with serious mental disorders and we estimate that about 1,000 people will avail of the service over three years.

SCARF's mobile telepsychiatry service is provided on a bus that has been custom-built to contain a consultation room and a pharmacy. In the consultation room, communication takes place between a psychiatrist based in Chennai and the patient and caregivers through flat screen TVs and state-of-the-art high-resolution cameras using a wireless Internet connection.

After a teleconsultation, a prescription is advised by the psychiatrist to the telepsychiatry clinic facilitator in the bus and dispensed by the on-board pharmacy. A follow-up appointment date is also given for review. The medication is provided free of cost. This is an essential component of the program considering the patients' financial limitations and also the fact that psychiatric drugs are rarely stocked in rural pharmacies.

Each patient receives a patient-held record designed to facilitate continuity of care and information sharing between health care professionals. It details their diagnosis, prescription, and any relevant investigations that the patient must get done independently, such as an EEG or blood tests.

Apart from teleconsultations, the package provides psychosocial interventions including psychoeducation for caregivers delivered by community health workers. There is also an emphasis on getting jobs for patients through existing schemes of government and in the voluntary sector. The health workers are supervised through videoconferencing and periodic onsite visits.

Improving awareness about mental illness is another important element of the package. Poor understanding of the illness delays early identification and treatment and thereby adds to the stigma experienced. The villagers themselves are targeted by awareness campaigns, which include street plays, the distribution of posters and pamphlets, and the screening of films. These are broadcast on a TV screen fitted to the rear of the bus, and were created specifically to educate people about the signs and symptoms of psychotic disorders. The film also explains the process of telepsychiatry and the objective of the program.

While the program has been by and large successful in demonstrating the feasibility of delivering a mobile telepsychiatry service, a major challenge has been managing an increasing patient load, as well as bringing into sharp focus Grady's view (1) that telepsychiatry redistributes resources rather than creating additional capacity.

Overall, our experience has been extremely positive and it encourages us to broaden the reach of the program. Integrating this strategy into the district mental health program could prove to be hugely beneficial especially in reaching out to remote areas. With the recent advances in telecommunication facilities in India, this is the ideal time to exploit the immense potential of telepsychiatry.

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Reference

1. Grady B. Promises and limitations of telepsychiatry in rural adult mental health care. World Psychiatry 2012;11:199-201.

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