Doctors return to their work, disgruntled but somewhat mollified. The administrators in governmental and municipal offices and the ministers in their palatial cabins heave a collective sigh of relief and return to their perennial machinations.

The cost of strikes is not paid either by doctors and nurses or by secretaries in ministries or by the ministers themselves. It is paid by the poor, who commit the crime of falling sick or getting injured in accidents. During the strike, the unlucky are turned away at the gates of the hospital. Those a little less unfortunate lie in corridors, outpatient departments, emergency rooms or on the beds in their wards. Their pain worsens: they die.

REFERENCE

SUNIL PANDYA

Letter from Ganiyari

MENTAL HEALTHCARE: THE TELEPSYCHIATRY WAY

Introduction: Setting the stage in Ganiyari

It was 2008 when I, as a visiting psychiatrist, first interviewed patients with mental health issues in Ganiyari. I was amazed that in one morning I saw case after case of psychiatric illnesses that matched textbook description. I now realize that session was just a tip of the iceberg.

With a suicide rate of over 43 per 100 000 population (data collected by the community health programme at Jan Swasthya Sahyog [JSS]) in our programme area (versus Germany’s 12.4 per 100 000 population) or rural India’s 22 per 100 000 population (>15 years of age), we have a huge mental healthcare need. In Germany (where I also practise), there is a dedicated mental health workforce. For every 100 000 Germans, there are more than 13 psychiatrists and 40 psychotherapists, who are supported by numerous psychiatric nurses and psychiatric social workers. The situation in Chhattisgarh is soberingly different. In 2014, several months after opening the new mental hospital in the Bilaspur district, all psychiatric posts (including chief of the hospital) were vacant.

Confronted with the burden of mental illness in the outpatient department (OPD) and in the programme villages, we decided in April 2012 to provide regular mental health service without a psychiatrist available on a day-to-day basis. Over the past three-and-a-half years, we have developed a model of mental healthcare in Ganiyari. The time has come to share that model.

Telepsychiatry: Can it work?

Telepsychiatry has been shown to be feasible in a wide range of settings, for a number of psychiatric treatments, in different ethnic groups and populations, and in all age ranges. Psychiatry is ideally suited to videoconferencing: most psychiatric treatments can be adapted to telepsychiatry and the doctor–patient relationship can be developed. Telepsychiatry has no known absolute exclusion criteria or contraindications for any specific psychiatric diagnoses, treatments or populations. Schizophrenia Research Foundation (SCARF) in Chennai has developed a telepsychiatry component of its community outreach programme in rural Tamil Nadu. The service is provided on a custom-built bus that has a consultation room and pharmacy. This sustainable model has served over 1000 people with serious mental disorders over three years.

Our experience

At JSS we started our weekly telepsychiatry clinic in April 2012. This outpatient clinic is run under my supervision via Skype from Germany. Audiovisual consultations are provided using a high speed internet (2 Mbps) connection. The Team Viewer allows all parties to simultaneously see the same results from the electronic medical records (EMR). Besides the patient, a resident doctor or paramedic is present to facilitate the discussion and perform logistic work during the consultation. Diagnosis and treatment plans are made as a team, with occasional emergency consultations.

Challenges

Most of our patients have perhaps never used a computer or the internet. It takes time for both the medical team and the patient to get accustomed to Skype. Imagine a rural Indian patient coming to the telepsychiatry clinic for the first time. The patient enters the consultation room where a few individuals are sitting. They are silent and the computer monitor or iPad starts speaking to the patient. Experience has shown that it is critical to say the patient’s name slowly and deliberately. These changes often come at the expense of modulation of one’s voice, an important aspect of developing a clinical relationship during a psychiatric interview. Longer pauses between statements are necessary because of the small but perceptible delay in transmission. Sometimes it is difficult for me to focus on the patient. The iPad’s microphone amplifies noise and cannot filter it the way the human ear can. These seemingly trivial details—a closed door and a few people in a quiet room—are important to seek a diagnostic impression. For the past one year we have started using EMR during the Skype session. It has the disadvantage of making the picture of the patient small as the bigger part of the screen is used by the EMR window. On the other hand, it is a great help to look directly at the records, document history and findings of examination as well as prescribe medication and treatment.

Psychiatrists believe that there is a strong association between physicians’ communication skills and (i) patients’ satisfaction; (ii) patients’ adherence to treatment recommendations; and (iii) treatment outputs. A large part of this communication is non-verbal, and the situation is different in telepsychiatry. The audio and visual components of the conversation are often not synchronized. Each party views a two-dimensional picture of the other. The symmetry of the psychotherapeutic interview (an equal
partnership) changes with one party on the screen and the other physically present. These differences are noticeable while speaking with a stranger and trying to develop a therapeutic relationship.

The choice of words and use of simple and small sentences are important in establishing a therapeutic relationship with patients. The resident physician accompanying the patient should be familiar with psychiatric illnesses and vocabulary, so that a phrase used by the psychiatrist can be repeated to the patient for clarification.

Similarly, working in different time zones needs creative solutions. I must be available in Germany but at a time when patients can still finish their visit to the clinic and get back home, avoiding the need to stay on the hospital campus overnight or lose an extra day of work.

These challenges can be taxing, especially during technical difficulties. At times, when the internet is not functioning, the session is continued via telephone. Sometimes, the sound is frustratingly low or the picture quality is poor. In spite of these hurdles, Skype is a simple, cheap and widely available option for telepsychiatry and rural mental health.

The patients we serve

During the past 3 years, we have provided longitudinal care to 316 patients through about 1200 consultations. The list of diagnoses looks familiar: depressive disorders 169 (52%), anxiety disorders 37 (11.7%), schizophrenia 24 (7.5%), psychosis, unspecified 19 (6%), and somatoform disorders 14 (4.4%), etc. Our pharmacy’s psychiatric formulary has evolved with our changing case load. It now stocks fluoxetine, sertraline, escitalopram, mirtazapine, venlafaxine, olanzapine, risperidone, clonazepam, and a depot neuroleptic (for non-compliant patients). Patients are referred for telepsychiatry consultation by other physicians in the OPD or by health workers in the health programme villages.

My regular, 6-monthly visits to Ganiyari have included training sessions for these referring professionals. It can be easy even for an untrained eye to spot a psychotic phenomenon and identify a patient of manorog. It can be much harder in a busy OPD. A trained person can ask about mental health aspects of a patient with complaints in multiple body systems, which can lead to the identification of a depressive disorder. Our telepsychiatry clinic gives the resident doctors, who assist in the interview and treatment of patients, a chance to learn and practise their skills in psychiatric management. These skills are critical to primary healthcare and family medicine.

Outside the telepsychiatry clinic

The morbidity of mental illness in rural regions of India is estimated to be 70.5 per 1000 people. We are aware that the burden of unmet mental health needs is much larger than our telepsychiatry clinic. In addition to training health workers about issues in mental health, we must also sensitize the people. We try to accomplish this efficiently through support groups. We run regular group sessions for patients, their family members and the community. In those sessions, everyone is encouraged to narrate their experiences, the difficulties they face, and learn to understand and simply talk about mental illness.

These support groups are critical because of the stigma surrounding mental health, particularly psychoses. Despite stereotypes to the contrary, regular medication can help in containing symptoms in patients and even integrate them back into society. Our new outreach programme aims to identify, diagnose and treat these individuals in villages, and will be equipped with depot neuroleptics (such as fluphenazine), if needed.

Another key area of mental illness that we are working on is substance abuse, particularly alcohol. This area needs an independent discussion, but reference here is to patients of dual diagnoses in whom treatment of a mental illness such as a mood disorder or anxiety disorder is necessary to effectively manage the alcohol problem.

Besides medicines, psychiatric care involves counselling and psychotherapy. These aspects of our rural mental health programmes are just beginning, and our brief clinical experience has shown that people are remarkably open to talk about challenging emotional issues and report great benefit from even brief counselling. One area that needs exploration concerns patients who have attempted suicide. We plan to develop this work via narrative techniques and family interventions.

CONCLUSION

I have personally found this work very moving, particularly when I speak to patients who have travelled for a day for a brief session on Skype. It is humbling as many patients continue to follow-up, knowing I shall probably never talk to them in person. It is equally satisfying to meet some of the patients in person during my 6-monthly visits to Ganiyari.

Teleconsultation: An invitation

Modern technology has made the world a smaller place. JSS is using technology to tackle the lack of skilled psychiatric consultants. Much needs to be done in psychiatric health at the individual, communal and health systems level.

Dear Reader, you are likely to have a specific skill as a consultant. Through telepsychiatry, we have shown that the friends of JSS can be in Ganiyari though physically in another part of the world. Please consider this an invitation.

REFERENCES

1 Available at www.destatis.de (accessed on 10 Jun 2015).

PRASHANT GOGIA

Jan Swasthya Sahyog

Ganiyari