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Original Paper

Telepsychiatry pilot-project in Denmark
Videoconference by distance by ethnic specialists to immigrants/refugees

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Abstract *A telepsychiatry service, using broadband (sHDSL), was established in order to provide psychiatric assessments and/or treatment of immigrants/refugees. Mental health care of immigrants/refugees in Denmark is concentrated to specialized centres where treatment is provided via translators. Limited access to clinicians that speak immigrants/refugees` language and understand their background can have influence on speed and accuracy of diagnosis and treatment. Clinicians involved in the project have ethnic background (including the language abilities) which enable providing mental health care on patients` own language, without translators. The main part of the work in the first year of this 3-years project consisted of diagnostic assessment and/or treatment conducted by videoconference in real time. All participants reported a high level of acceptance and satisfaction with telepsychiatry regardless their ethnicity, educational level or mental health state. Clinicians employed in specialized centres reported their attitudes toward the project and telepsychiatry in generally, through semi-structured interview. They express reluctance toward the aim of the project and would prefer to use translators.*

Key words: telepsychiatry, Denmark, immigrants/refugees, ethnic specialists, treatment on own language, translators, video consultations in real time

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INTRODUCTION The term "telepsychiatry" refers to the use of telecommunication technologies with the aim of providing psychiatric services from a distance (Brown, 1998). Telepsychiatry connects patients and mental health professionals, permitting effective diagnosis, treatment, education, transfer of medical data and other activities related to mental health care. Several studies demonstrated high reliability and patient's acceptance of telepsychiatry (Baigent et al., 1997; Hawker et al., 1998; Simpson et al., 2001; Kopel et al., 2001; Bose et al., 2001; Bishop et al., 2001). Telepsychiatry (especially video consultations in real time) can provide access to mental health care that is not available in some areas of the country (e.g. treatment on patients' own language without translator). In such situations it can be used as a substitute for face-to-face contact between provider and client.

It is no secret that mental health system in Denmark did face (and still does) significant barriers in providing appropriate psychiatric care towards immigrants/refugees on their own language. Psychiatric treatment of immigrants/refugees in Denmark is concentrated to several centres all around the country where the treatment is provided via translators.

There are only few "ethnic psychiatrists" in a country where 8,2 % of population consists of immigrants/refugees (Udlaendingestyrelsen, 2004). Limited access to clinicians that speak their language and have similar cultural and ethnic background can have an influence on speed and accuracy of diagnosis and treatment. Mental health care provided via translators is per definition

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time-consuming and affected by high risk of lack of confidence. Consequently, it can affect patient's compliance and make treatment less effective and more expensive.

One solution to this problem is to give immigrants/refugees access to ethnic specialists by using videoconference (telepsychiatry). We assumed that telepsychiatry on mothertongue language could increase level of trust and confidentiality in therapeutic process. Furthermore, by avoiding translators, the specialist time can be used more efficiently.

Behandlingscenter Den Lille Prins, in Copenhagen, is a psychiatric clinic with affiliated clinicians that speak their patients` languages (www.denlilleprins.org). Despite the fact that "Denmark is a little land" it can be time-consuming to travel from distant part of the country and meet "ethnic clinicians" in Copenhagen. For that reason, mental health professionals from ex-Yugoslavia, Middle East, East Europe and Africa use telepsychiatry in order to provide psychiatric care on patients' own language all around the country. Telepsychiatry have been developed and used in the centre since 2001. This paper describes a recent telepsychiatry project started in February 2005.

The key aim of this project is to provide psychiatric service on patients' own language where the access to ethnic clinicians is still limited.

MATERIALS AND METHODS The main part of the work in the first year of the project was providing diagnostic assessment with subsequent treatment suggestions. In few cases we established continuously telepsychiatric psychotherapeutic treatment supported by relevant medication.

Clinicians involved in the project are affiliated to Behandlingscenter Den Lille Prins in Copenhagen, a psychiatric clinic for treatment of immigrants/refugees. They all have ethnic background that make possible to provide psychiatric care on patients' own language.

Participants involved in the project were mentally ill immigrants/refugees and their family members. Furthermore, stuff involved in patient contact have been informed and contributed in coordination of professional efforts within the project. Total number of participants involved in the survey in the first year of the project was 23 (7 women and 16 men). Mean age for males were 38 years (range 20-58 years) and 42 years for females (range 30-55 years). Countries of participants' origin were ex-Yugoslavia (48%), Iraq (30%), Somalia (9%), Lebanon (9%) and Syria (4%).

Duration of participants' education was as followed: 0-4 years (9%); 5-8 years (35 %); 9-12 years (39 %) and over 12 years (17 %).

Most of participants (87%) did not have any contact to mental health system before arrival to Denmark. 61% of participants were in contact with either psychiatrist and/or psychologist in Denmark before being involved in the project.

The mean number of sessions (by 45-60 min) completed for all 23 subjects was six (6).

Five (5) participants had at least one face–to face contact. The rest of the sample received only remote service.

All participants in the project received written information about telepsychiatry. They all undersigned consent before or after the first telepsychiatry session. They were asked to complete the questionnaire after the end of the telepsychiatry-contact in order to determine satisfactory level, advantages and disadvantages by using telepsychiatry. The questionnaire of 10 items was developed for this project (Table 1).

Furthermore, 9-items semi-structured interview have been designed in order to determinate clinicians' attitudes toward the project and telepsychiatry in generally (Table 2). Several specialized centres for treatment of refugees and torture survivors have been contacted and asked to participate in the project. They have been offered technical support and necessary videoconferencing equipment without charge (markets price about 10.000 Eu) in order to

participate in the project where their patients could receive treatment by ethnic psychiatrists. After 1-2 hours of information about telepsychiatry and about the project in Denmark, clinicians answered the semi-structured interview.

Table 1

		YES, in high degree	YES, in some degree	NO, only in less degree	Not at all	Don`t know
1.	Did you get enough information about telepsychiatry?					
2.	Do you perceive "conversation via TV" as unpleasant / uncomfortable ?					
3.	Did you feel safe under telepsychiatry contact?					
4.	Have you been satisfied with sound quality?					
5.	Have you been satisfied with picture quality?					
6.	Did you achieve your goal via telepsychiatry / could you express everything you wanted to?					
7.	Would you recommend telepsychiatry to others?					
8.	Would you prefer contact via translator in future?					
9.	What were you most satisfied with during the telepsychiatry contact?					
10.	What were you most unsatisfied with during the telepsychiatry contact?					

Table 2

1. Do you think that the treatment of refugees/immigrants via translator is optimal?
2. Would you prefer to use ethnic clinicians rather than treatment via translators?
3. Do you have bad experiences with ethnic clinicians? If "yes", which?
4. What do you know about telepsychiatry ?
5. What do you perceive are the advantages of the telepsychiatry ?
6. What do you perceive are disadvantages of the telepsychiatry ?
7. What are you most concern about regarding potential participation in the project ?
8. Do you perceive using of translators as better solution ? If "yes", why ?
9. Have you ever asked your patients whether they would prefer ethnic clinician rather than contact via translator ?

TECHNICAL SET-UP The videoconferencing system links Behandlingscenter Den Lille Prins in Copenhagen, Psychiatric department in Bornholm Hospital, an island about 165 km away, and RevaAktiv-activity centre in Odense, 170 km away from Copenhagen.

Videoconferencing is via sHDSL by 2Mb/s.

The project period is 3 years (2005-2007).

RESULTS Semi-structured interview answered by the specialists employed in specialized centres with experience in treatment of refugees showed generally acceptance of telepsychiatry. Their attitudes toward telepsychiatry as an educational tool were positive. However, they expressed no willingness to participate in the project as it is designed. Specialists did not assume the language as the most important tool in psychotherapeutic work with immigrants/refugees. They express reluctance toward the aim of the project and would prefer to use translators. Their argument was that "the language is not important but the competence of the translator and the clinician". Some of specialists assumed their patients for being "too ill to be involved in telepsychiatry contact". At the same time they express willingness to participate in the project by using the offered equipment "in order to reach as many patients as possible" (e.g. patients referred from remote areas) but not using the ethnic expertise.

Nevertheless, preliminary results regarding patients' satisfaction within the project showed something else. All patients referred to telepsychiatry assessment and/or treatment agreed to participate in the survey. Diagnostic assessments disclosed wide range of psychiatric disturbances (Figure 1). Participants' response to telepsychiatry in the first year of the project have been very positive regardless degree of mental illness. They reported a high level of acceptance and overall satisfaction with telepsychiatry regardless their ethnicity, educational level or previous experiences within mental health system (Figure 2). There were no difference in satisfaction rates between patients that received subsequent face-to-face consultations and the rest of the sample. Participants find telepsychiatry acceptable and considerer it a useful way to express their intimately emotional and existential problems on their mothertongue language. Furthermore, they mentioned reduced need for travel. Participants responded positive when asked if they would recommend telepsychiatry to others (Figure 3). All participants, so far, reported willingness to use telepsychiatry again, as well as they would prefer help by telepsychiatry on own language rather than face-to-face contact with the doctor via translator (Figure 4). The most of participants were satisfied with the quality of the picture and sound.

Only one participant was less satisfied referring to two episodes of lack of connection.

Figure 1 – Diagnose distribution

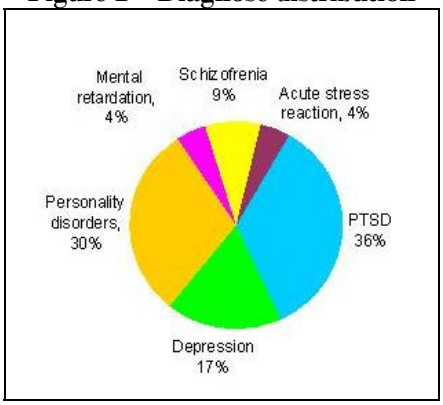


Figure 2

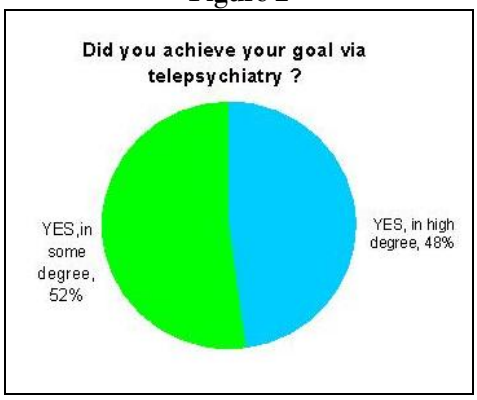


Figure 3

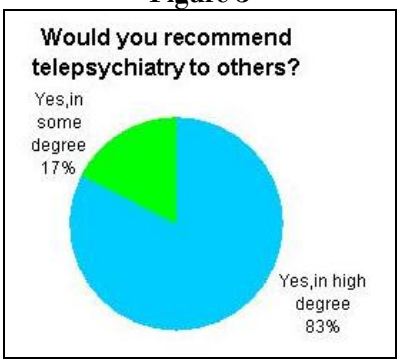
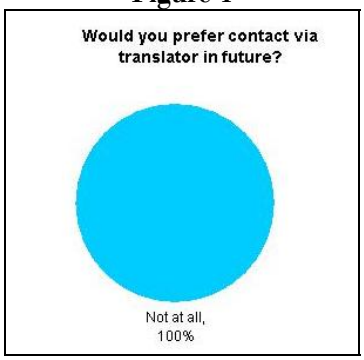


Figure 4



DISCUSSION According to the fact that the most of refugees in Denmark are treated within specialized centres, it seemed obvious to prioritise centres as potential partners in the project. Unfortunately, we did not notice any willingness from specialized centres to be involved in the project as it is designed. Their reluctance was not addressed to telepsychiatry in general, but to the basic idea of the project ("treatment on own language by ethnic specialists"). Danish specialists did not accept the argument that communication via translator could have detrimental effect on doctor-patient relationship. They neither agreed that it could affect patients' compliance and the outcome of the therapy. They expressed "no need for ethnic psychiatrist because of good experiences with translators". At the same time, specialists ignored the fact that nobody ever asked patients if they would prefer translator or ethnic doctor who speaks the language. One possible explanation of massive resistance toward the project could be concurrency and risk of losing a part of the market.

We are certain that these specialists' attitudes are not representative for Danish clinicians in general. Actually, we are about to establish several positive contacts with psychiatrists employed in public hospitals. They do not perceive the project as a threat but as a professional challenge and relevant initiative.

Key predictor of patient satisfaction with telepsychiatry in this survey was possibility to communicate on mothertongue language. Both, participants with or without previous experience by translator provided mental health care, prefer remote contact on own language. Their willingness to receive psychiatric service on motherhood language via telepsychiatry rather than usual contact via translator can be understood as a natural need of confidential relation with the therapist and/or because of possible bad experiences with translators. This mutual need of confidence should not come as a surprise for any professional mental health worker with basic knowledge of the importance of language in the therapeutic process. Bad experiences with translators occur most often because of translators' limited educational level, different national origin and/or political convincing.

Our results also indicate that participants' ethnicity, educational level and degree of illness had no influence in order to choose telepsychiatry versus psychiatric help provided via translator. This is in discrepancy with an earlier published survey, which indicates that individuals with better

physical health and higher adaptive coping scores tended to be more willing to participate in telepsychiatry (Rohland et al., 2000).

The quality of transmission has been satisfactory for the most of the time. One of the participants has noticed single disturbances but it has certainly not affected his willingness to use telepsychiatry in future. Bad experience with the transmission has been explained by change in firewall that has not been reported to us before the session. Written protocol, made over recent projects time, significantly improved coordination of resources and consequently the quality of telepsychiatry service

CONCLUSIONS Telepsychiatry, as suggested by a large number of original surveys through last four decades, is a growing field with the potential to deliver high quality, much needed assistance in a variety of settings to persons in need of mental health services (Monnier et al., 2003). As far as we know, there is no research on use of videoconference in order to provide mental health toward such specific patient population as immigrants/refugees. In a field such as assessment and treatment of immigrants/refugees, often torture survivors, who are significantly underserved on their own language, telepsychiatry could enable access to an appropriate and specialized service. At the same time, telepsychiatry provides opportunities for participation of several individuals involved in work with the patient (family members, social worker, GP, stuff on psychiatric department etc.). So far, this pilot project has demonstrated high acceptance and usefulness of videoconferencing in order to increase accessibility to mental health services on own language for immigrants/refugees population in Denmark. Finally, telepsychiatry used as a supplement to existing system can improve the way of dealing with immigrants/refugees psychiatric problems. It is well known that telepsychiatry is no substitute for direct contact. To specific patient population with limited language abilities, telepsychiatry can be offered as a "possibility to choose or refuse" regarding contact on mothertongue language, whenever mental health service is provided via translators.

At the same time, telepsychiatry brings professional psychiatric expertise to outlying areas with shortage of resources. Consequently, it is able to serve not only immigrants/refugees but also wide range of Danish patient population. Nevertheless, some regrettable attitudes have to be overcome for successful implementation of telepsychiatry in Denmark. However, future evaluation could give an answer whether telepsychiatry has found its niche in Danish mental health system or not.

Detailed final evaluation of the project in the end of 2007 should focus on predictors that can influence satisfaction with and implementation of telepsychiatry in Denmark (e.g. appointment waiting time, travel expenses etc.). Family members` and referring providers` attitudes toward the project and their satisfaction with telepsychiatry contact will be explored as well.

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