



UNIVERSITY OF
STIRLING



joint improvement team



The Dementia Services
Development Centre



Telehealthcare and mental health

Using telehealthcare effectively in the support
of people living with mental disorder

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Preface

This practice guide explores the ways in which telehealthcare can contribute to the support, protection, and quality of life of people with a mental disorder. It also considers the importance of telehealthcare in providing support and reassurance to carers. It should be of particular interest and value to community psychiatric nurses (CPNs), mental health officers (MHOs), and staff such as occupational therapists in community mental health teams.

As well as providing information about existing telehealthcare services (and the research that has been carried out into their effectiveness), it encourages readers to consider why telehealthcare equipment, including SMS messaging (texting), smart phones, the internet and social media are not used more widely to help people recovering from mental illness.

This is one of a number of publications funded by the Scottish Government's National Telecare Development Programme¹, in pursuit of the strategic goal of raising awareness of the importance of telehealthcare in contemporary health and social care services². The other books in this series are:

- Telecare and dementia – using telecare effectively in the support of people with dementia
- Telecare and physical disability – using telecare effectively in the support of people with severe physical disabilities and long-term chronic conditions
- Telecare and sensory impairment – using telecare effectively in the support of people with sensory impairments
- Telecare and learning disability – using telecare effectively in the support of people with learning disabilities
- Telehealthcare and falls – using telehealthcare effectively in the support of people at risk of falling

The books are written for assessors, care and support staff and their managers, telecare service managers and development staff. Senior managers should also find them useful in informing service planning, and they should help raise awareness, expectations and generally advance understanding among service users and carers.

Each book also contains case examples and a training programme designed to help trainers when designing both awareness-raising and skill-development programmes. Programme directors responsible for basic and post-basic programmes for nurses, housing staff, social workers or occupational therapists should consider these as a sound basis for a module on telehealthcare.

Examples of equipment are featured in each book. The aim is to support readers to make sound decisions by providing information on some of the wide range of telehealthcare products available – as well as on the ways in which mobile phones, social media, and computer software and hardware can be used. The books do not endorse any specific product or supplier, but provide examples of what is currently commercially available or emerging on to the market. Where possible, details of suppliers/manufacturers have been provided at the end of each book.

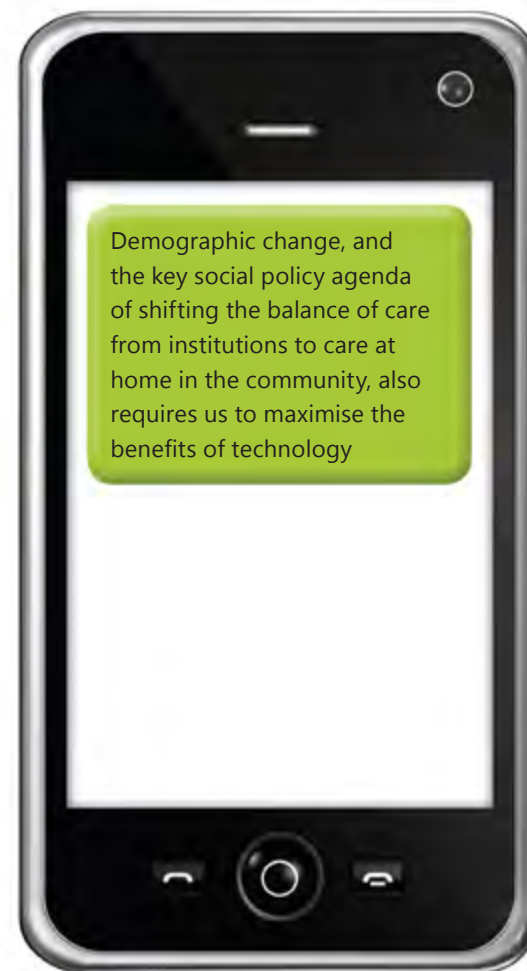
1: Introduction

We all rely increasingly on technology in almost every aspect of our lives. Within our homes, devices such as microwaves, DVD players and TVs enhance the quality of our lives and reduce the amount of time we spend on the drudgery of housework. We use the internet for news, information, social contact and entertainment, and to help us make informed choices about purchases and services. 73 per cent of the adult population now have individual access to the internet at home; 84 per cent now use mobile phones³; 42 per cent use 'smart phones'; and 10 per cent use social networking sites⁴.

Mobile phones have transformed the ways we communicate with each other. Away from home, technologies such as GPS (global positioning systems) and satnav (satellite navigation) – often incorporated into our mobile phones – have the potential to guide us, keep us in touch, and keep us safe. Mobile phone applications ('apps') can now provide as full a range of information and access to services as personal computers. In the health sphere, there are apps which can enable self-diagnosis of colds, flu and pneumonia, and which allow doctors to study X-rays and analyse ECGs remotely.

Good mental health is underpinned by good communication, strong and rewarding relationships, and meaningful and frequent interaction. If a major consequence of a mental illness is miscommunication or social isolation – and if a major source of help is talking therapies of one sort or another – then surely we must maximise the potential of every sort of communication device that modern technology offers. This guide therefore looks at the potential and practical use of the internet, social media, texting, mobile phones and videoconferencing – as well as telecare and telehealth equipment – in supporting people with mental health problems. In addition, it provides practical guidance on how to introduce technology to potential service users.

Demographic change, and the key social policy agenda of shifting the balance of care from institutions to care at home in the community⁵, also requires us to maximise the benefits of technology. There is now plenty of evidence to show that telehealthcare can release significant resources from within health and social care systems and facilitate changes in the balance of care⁶. The Scottish Government's policy is to ensure that high-quality mental health services are available for everyone who needs them at all



levels of need. An access target for mental health services will be included in HEAT in 2011/12⁷ and this guide also includes examples of how telehealthcare can improve access to mental health services.

Telehealthcare evolved from community safety services which use pendant or push button alarms to enable people to summon help remotely. As such, it has been associated with older people, and people with physical disabilities. Advances in the technology, combined with wider experience of its use, have confirmed that telehealthcare is not only useful for older people. It has significant potential value for people with all sorts of difficulties – including those associated with mental illness – as will be illustrated in later chapters. The guide will also illustrate the personalisation concept – namely that we should focus on how best to meet the needs of an individual, irrespective of their age, diagnosis, ‘label’, or the category to which they are allocated.

In summary, the following chapters will outline how telehealthcare can contribute

to improved outcomes for users of mental health services. There are sections on:

- definitions of telehealthcare (along with the related concepts of telecare and telehealth)
- the importance of good needs and risk assessments
- ethical dilemmas and how these can be resolved
- how needs may be met using telehealthcare as part of a package of care and support
- issues particular to carers
- case examples and an outline training programme

Definitions: what is telehealthcare?

There are no universally agreed definitions of terms such as telecare, telehealth, and telehealthcare. In this guide the term telehealthcare is used to describe equipment

within and outwith the home that remotely monitors changing needs and risks, and provides alerts and information that enable improved and informed responses to those needs and risks. The term ‘equipment’ encompasses community alarms, alerts and monitors within the home; tracking and communication devices linked to GPS; mobile and landline telephones; and computers, including interactive software packages, the internet and social media platforms such as Facebook and Twitter.

The distinctive feature of telehealthcare is that the equipment used enables a response or service to be delivered to someone remotely – that is from a distance and at a separate location (hence the prefix ‘tele’, as in telegram, telephone and television). In Australia and New Zealand the term telopsychiatry is used. This is defined as ‘the use of communication technology to provide psychiatric services from a distance’⁸.

Readers may be more familiar with terms such as telecare and telehealth than with this

relatively new umbrella term. The definitions below are taken from the Education and training strategy published by the National Telecare Development Programme, and the Scottish Centre for Telehealth, in 2010⁹.

Telehealth is the provision of health services at a distance using a range of digital technologies. Examples of telehealth include video consultations to support diagnosis and management, clinical networks and health professional education.

Telecare is the remote or enhanced delivery of care services to people in their own home or a community setting by means of telecommunications and computerised services. Telecare usually refers to sensors and alerts which provide continuous, automatic and remote monitoring of care needs, emergencies and lifestyle changes, using information and communication technology (ICT) to trigger human responses, or to shut down equipment to prevent hazards.

Telehealthcare is the convergence of telecare and telehealth to provide

a technology-enabled and integrated approach to the delivery of effective, high-quality health and care services. It can be used to describe a range of care options available remotely by telephone, mobile phone, broadband and videoconferencing. There is accelerating convergence between telecare and telehealth technologies, with the introduction and expansion of long-term conditions monitoring as part of the 'telehealthcare' package available in a person's home, and as part of falls prevention and management.

Telecare has historically been associated with social care – as distinct from telehealth and telemedicine. Use of two separate terms can encourage a separate classification of needs, and with it arguments about whose responsibility it is to meet these needs. This is particularly damaging and distracting in services for people with mental illness, where the focus should be on the needs of the person, hence the importance of the newer term, telehealthcare.

Telehealthcare as part of a personalised service

Telehealthcare should not be seen as the *solution*, a single one-dimensional response to needs or risk. It is not an alternative to direct care by carers, although it can reduce the need for check visits, 'supervision', or visits to clinics for routine medication monitoring (such scenarios will be explored later in this guide). Telehealthcare is effective when it forms part of a personalised programme or package of care and support, and is accepted as such by the service user, their informal carers and other staff/services.

Telehealthcare is the convergence of telecare and telehealth to provide a technology-enabled and integrated approach to the delivery of effective, high-quality health and care services.

To be effective, telehealthcare requires:

- informed, skilled and personalised outcomes-focused assessment of needs and risk
- resolution of ethical dilemmas around capacity, informed consent and choice (for each individual in each situation)
- training and education for the service user, carers, personal care and support staff in how the equipment can be used or misused and how it should be tested and maintained (for example, battery replacement)
- robust call management response protocols
- regular review

Telehealthcare services

So far, this introduction has only discussed equipment. The term ‘telehealthcare services’ sets the use of equipment in the wider context of health and social care services. In a

practical sense, this means efficient, up-to-date monitoring or call centres with trained staff who have access to personal health and social care data and response protocols. These staff may need to be available every day of the year, and will be skilled in making judgements about the information and alerts sent by the equipment, and in facilitating the most appropriate response possible. Where the service user’s needs arise from physical or mental health conditions, call handlers will require protocols which clearly set out appropriate responses, along with training in how to use and interpret them – and possibly access to a nurse or clinician for advice or consultations. Different agencies or services are likely to organise their response service in different ways. In all cases, the presence of someone who can evaluate a situation quickly, interpret information accurately, provide reassurance, follow detailed individual protocols, and understand the basics of how equipment works is essential to ensure the maximum benefit to the service user.

Appropriate response arrangements must also be in place, incorporating individualised response protocols which ensure the best possible response to the immediate need or situation. Traditionally this has relied on key-holders – relatives or neighbours who, when contacted by the call centre, would call on the service user and solve the problem or contact services as necessary. Increasingly, in response to higher levels of dependence, more complex needs and new technology, agencies are deploying teams of trained carers who can respond to an emergency and provide personal care, reassurance, or contact other emergency services as necessary.

In order for telehealthcare services to have maximum impact on wider policy goals such as shifting the balance of care, they need to be conceived as part of, and located within, local health and social care strategies for different client and patient groups. Service planners need to articulate how telehealthcare developments will enhance home care

and housing support services not as an 'add-on', but as an integral part of health and social care service options.

Risk and reliability

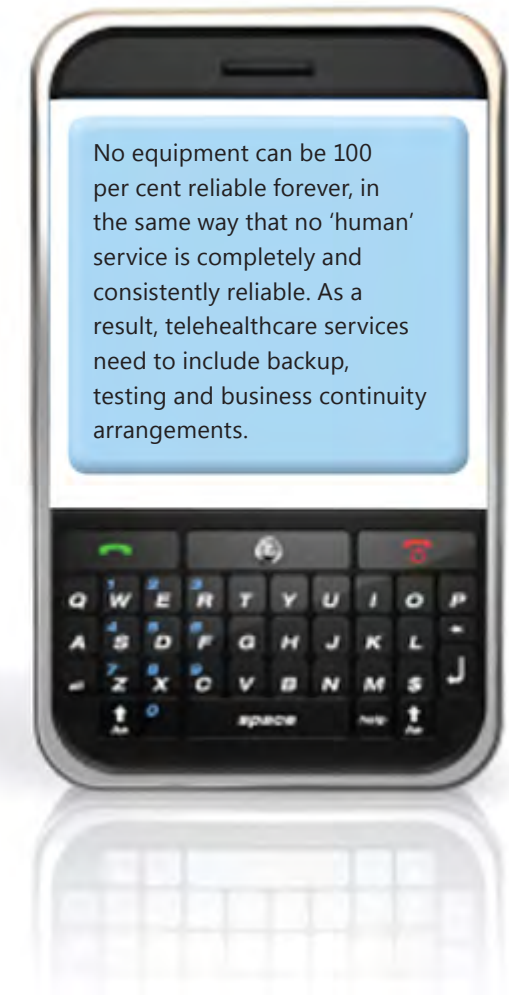
No equipment can be 100 per cent reliable forever, in the same way that no 'human' service is completely and consistently reliable. Equipment will come with a manufacturer's guarantee, but in the event of a fault an engineer will need to be called out, and there may therefore be gaps in service provision, even when monitoring is required '24/7'. Psychiatric intervention via videoconferencing requires a secure communications link and a high quality of visual interface to enable clinicians and assessors to pick up the subtler nuances of behaviour and non-verbal communication. Equipment which relies on mobile phone signals, internet access or landlines to transmit information will, on occasion, experience the lapses in service that affect these systems. To counter these risks, telehealthcare services need to include backup, testing and business continuity arrangements (although of course equipment purchased privately may not have these safeguards as standard).

'Interoperability' is a significant issue. This refers to the problems that arise when equipment developed by one manufacturer is not compatible with the call-handling or monitoring system(s) which are already in place, and which were made by another company. Significant progress has been made in resolving this issue following the introduction of a new British Standard¹⁰. Much still depends on the willingness of providers and manufacturers to adopt this standard and share protocols, as well as awareness among purchasers and commissioners of the right questions to ask.

It is very important that these issues are taken into account when care packages are being put together through the use of proper risk assessments and appropriate risk management arrangements.

Access and availability

Many of the services described in this guide are delivered using equipment that is already in day-to-day use by many people, such as mobile phones, smart phones, laptops and PCs. Other services rely on more specialist equipment, such as pendant alarms, carbon monoxide detectors and electronic pill dispensers. The



examples have not been selected to promote the products of any particular company, but instead to raise awareness of what can be done and what is (or will soon be) available. Where a specialist product is featured, details of the company that sells or manufactures it have been included (see page 57)

Companies specialising in telehealthcare equipment are increasingly able to personalise their products to meet the needs of individual users. Furthermore, they recognise the importance of developing new applications from this starting point. Manufacturers would argue – with some justification – that the scope of what telehealthcare equipment can do is limited only by our imagination, rather than by the technology. The cost of equipment is falling, and public bodies now have procurement arrangements in place which should further reduce this cost. In addition, companies welcome contact with service users and professionals to help them understand needs which might be met through new applications.

Currently the major providers of telehealthcare services are local authorities – increasingly in partnership with health authorities. Purchasing budgets may be available to enable practitioners to access equipment as part of a care and support package. Alternatively, service users should be able to purchase equipment using their individual budgets (self-directed support or direct payments).

One consequence of the development in telehealthcare services over recent years is that many authorities have recruited coordinators, or have designated ‘champions’ within local services. These staff can advise on availability and access, and should find these books helpful in their task of promoting the use of telehealthcare among different client and patient groups.



2: Assessment

An effective and efficient outcomes-focused needs assessment is essential if the potential of telehealthcare for people with a mental illness is to be maximised. Telehealthcare should always form part of an individual (personalised) package of care and support. To achieve this, individual needs must be identified and telehealthcare then considered as part of the potential personalised response.

General and specialist assessment of need

Throughout the United Kingdom, community care needs assessment is now conceived of as a multidisciplinary process^{11 12 13 14}. In Scotland, much work has been done to encourage the use of 'shared assessments'¹⁵ which gather core data on each individual (such as their name, age and ethnic group) along with information on physical, psychological, spiritual and physiological needs. The process involves skilled interviewing

to establish what the person's needs are, and what their perception of those needs is at that time. There is an opportunity for a relative or close friend who is a carer to contribute – with the permission of the person. The assessment concludes with a summary of needs, followed by proposals for meeting them immediately (where necessary) and/or as part of a planned programme of care. (This will be dependent on resources being available and on eligibility criteria.)

The possibility of utilising telehealthcare should be introduced during the assessment phase. Just as the person's need for home support, social activities, counselling or day services is considered, questions in the assessment form ought to trigger a discussion of telehealthcare. During the assessment itself, it is essential to explain what telehealthcare is, using language the person will understand and can relate to. One approach is to start by asking if the person uses a mobile phone, and if they regularly use text messaging. The discussion

might then lead to the use of texts to confirm or change appointments, before considering texts as a means of providing support or asking for help in a crisis.

In the case of patients who are moving from hospital into supported accommodation, a general discussion about environmental monitoring equipment (flood and smoke detectors, for example) could lead on to a conversation about personal safety and health monitors, where appropriate. At this stage the assessor will be considering the potential contribution of telehealthcare in general terms, as well as introducing the concept to the person and their carer(s).

It is very important to link discussions about what particular equipment can offer to the needs that the service user is expressing. For example, someone who is anxious at night is likely to appreciate the potential of a simple community alarm system to provide reassurance. Equally, someone who is very preoccupied – or so depressed that

everyday tasks such as running a bath or turning off the cooker appear overwhelming – is likely to perceive the value of a flood alarm, smoke alarm, or safety device that can shut off the cooker. Subsequent discussion of devices such as medication dispensers and monitors may then seem less threatening.

In some areas of Scotland, a 'core package' of technology is offered to anyone with community care needs. This might consist of a community alarm and smoke and flood detectors, along with a security device for the front door. Increasingly, in new or refurbished supported housing schemes, such equipment is installed routinely, although opinion is divided as to whether such an approach is cost-effective. In the case of service users who have a mental illness, systems have not yet been available for long enough to determine whether a universal approach is best for this group. Be that as it may, it does not obviate the need for individual needs assessments which will ensure that any additional equipment will meet identified needs, and that the response to any technology alerts will be identified.

All assessment documentation should therefore include a section prompting the assessor to consider

telehealthcare as part of the total response. It is also important that the assessor has access to information leaflets detailing the range of telehealthcare that is available locally, what it is for and who is eligible – along with any costs which need to be met by the service user.

If the assessor believes that telehealthcare equipment can form part of the response and the person agrees, a more detailed assessment is then required. This should include the precise combination of devices which can best meet (in combination with other services) the person's needs, as well as a clarification of issues around installation and response. This stage is often referred to as the 'specialist assessment'.

Specialist assessments

This secondary assessment stage is designed to personalise the provision of telehealthcare by identifying items of equipment that appear to best meet the person's needs. At this stage additional factors – such as the design of the property and the availability of telephone lines, wireless networks and mobile phone signals – will need to be considered. The person's familiarity



with electronic equipment will also be taken into account, along with any other telecare equipment already installed. In addition, their routine (for example when they like to go to bed and their sleeping pattern) will also be recorded to ensure that the equipment supports the lifestyle and degree of independence they want. Finally, the integration of the equipment with the rest of the support package, and the need for and availability of a response, will all have to be detailed.

There is no 'best' way of carrying out a specialist assessment. How it is carried out, and by whom, is likely to depend on local arrangements. In some areas, a telehealthcare 'champion' will have been identified within the community care or mental health team. This person will have received additional training in telehealthcare and regular updates on the range of equipment available. One of their responsibilities will be to undertake this specialist stage of the assessment, or perhaps to supervise and guide other team staff when such an assessment is needed.

In other areas this task is carried out by a dedicated service. This group will include staff who carry out the call handling, monitoring and installation functions, and they will have links to any response service. The manager of the service, or a designated person, will be asked to take forward the specialist assessment and carry out any installation that is necessary.

Risk assessment

Risk assessment is a critical component of a good needs assessment. It takes into account the degree of risk experienced by the person, thereby identifying ways in which telehealthcare can assist in the management of risk (by the person themselves, as well as by services). It includes risks in the home as well as outside. These may include risks:

- of fire if the cooker is left on
- of flood if the bathwater is left running
- of scalding in over-hot bathwater

- of unwelcome visitors
- of getting lost
- of harassment
- of hate crime

Risk assessment and risk management are very important in the support and care of people with a mental illness. There is a statutory duty to assess any risks to the health, safety and welfare of the person – and to others – when applying for compulsory powers under the Mental Health (Care and Treatment) (Scotland) Act 2003. As well as those listed above, risks may include:

- relapse, for example if there is non-compliance with medication
- inappropriate approaches to or responses from strangers
- self-neglect or suicide arising from delusions or other symptoms

The most basic equipment, such as flood alerts, smoke alerts and carbon monoxide

detectors, reduces risk in obvious ways. For people with mental illness, medication dispensers, tracking devices, automatic reminders and security devices can contribute to the effective management and reduction of risk. If the nature of such risks is identified through careful, regular risk assessments, then appropriate equipment can be selected. Examples of this are provided in later sections of the guide.

While telehealthcare can be important in the management of risk, it cannot eliminate risk completely. No equipment yet devised is 100 per cent reliable. Routine testing and maintenance (for instance battery changes) are essential to maximise reliability. Even so, malfunctions can occur. Service users – or more often their friends, children or grandchildren! – may inadvertently trigger or disable alarms, and monitoring centres will not always be aware of this. It is therefore important to allow for reliability and human error in any risk management plan.

Using telehealthcare to enhance assessment

Some companies have developed equipment which can log detailed information about a person's movement, lifestyle and routines within their home. This is used for needs and risk assessment purposes. An example is Just Checking¹⁶ (figure 1), a portable activity-monitoring system designed for people with dementia (although not necessarily limited to that group). Small wireless movement sensors are triggered as the person moves around their home. These generate an activity chart which can be accessed via a secure website. This very detailed timed data can provide a much more accurate picture of a lifestyle than is possible from conversation with a person who experiences thought disorders, or who is keen to reassure carers and support staff of their ability to care for themselves. It also offers significant benefits over descriptions provided by carers who do not live on-site.



Support, protection and care arrangements can then be targeted more accurately in a person-centred way.

In addition to these home-based systems, 'tracker' devices¹⁷ are available which will provide details of a service user's location at any time. Depending on the system, the information can be accessed by phone, via text or online. Some have a 'fencing' facility which enables limits to be set around a specific boundary area. If the service user goes beyond that boundary, a monitoring centre is alerted. Such devices can provide information that may be valuable during assessments – for example when passes are

being used in preparation for a discharge, or a variation to a hospital-based compulsory treatment order is being considered.

Videoconferencing can be used to provide assessment and diagnostic services more quickly and effectively to remote communities. The example from Shetland (see page 47) is an illustration of this.

When considering this kind of monitoring equipment there are, of course, very significant ethical issues, as well as issues around consent – even where compulsory measures are in place. These are considered in chapter 3.

Carers' assessment

In Scotland there is now a statutory duty to offer informal carers an assessment of their needs arising from their caring responsibilities. This focuses on how they can be helped to sustain their contribution to the care of a person in need¹⁸. Research has confirmed the extent to which telecare can reduce

pressure on carers; support them in their caring role; increase peace of mind about the safety and wellbeing of the person they care for; and enable them to sleep better¹⁹. It follows that a good carers' assessment will include consideration of the potential of telehealthcare to indirectly benefit carers by helping them continue to care.

Recent research confirms, however, that many carers are unaware of the availability of telehealthcare. It cannot be assumed that carers – especially 'new' carers – will be aware of the possibilities telehealthcare offers. Equally, carers will have their own anxieties, and perhaps guilt, about using technology. They may be concerned about its reliability or whether they will understand it and be able to make it work. The suggestion that contact via social media or mobile phone may be a positive alternative treatment mode will not always be well received, given public concerns about cutbacks to services and the risks around social media. At this point it is important to emphasise that information needs to be

made available to carers, and that where a carer's views are sought at the needs assessment stage their perspective should be included and recorded²⁰.

Telecare can reduce pressure on carers; support them in their caring role; increase peace of mind about the safety and wellbeing of the person they care for; and enable them to sleep better.

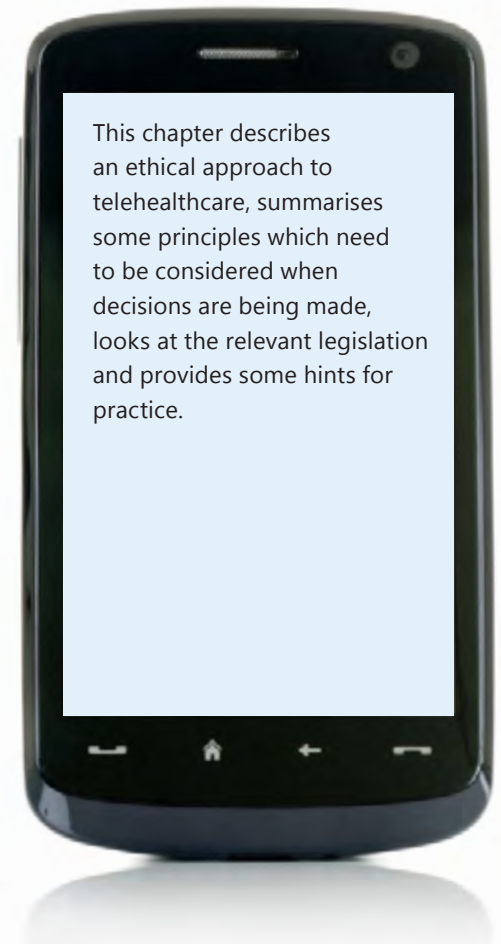
3: Principles, rights and ethics

The previous chapter described the importance of carrying out a careful needs and risk assessment before introducing telehealthcare. However, while good assessment should ensure that the use of telehealthcare is person-centred and needs-led, it will not necessarily answer the question of whether it is 'right' for an individual. The purpose of this chapter is to briefly describe an ethical approach to telehealthcare, summarise some principles which need to be considered when decisions are being made, look at the relevant legislation and provide some hints for practice.

As an example, consider the needs of a person with bipolar illness whose condition is stable as a result of medication. Her history shows that long-term compliance is problematic, and if she reduces her dosage or stops taking one or more tablets (either consciously or because she simply forgets) then a relapse is very likely. A medication dispenser could help her remember which drugs she needs to take at what times. If it is linked to a call centre or clinic, then support staff will know immediately if she fails to take her medication. A CPN can visit that day or the day after to reassess her and possibly discuss a change in her care plan or programme. This enables

a more timely and proactive response than simply assessing the person reactively during their routine appointment, which may be several weeks away. The question is, does the positive outcome justify the degree of monitoring or surveillance that is carried out in the person's home? Is this a justified invasion of their privacy?

Take the example of someone with schizophrenia, who, after a period of treatment in hospital, is ready for discharge home. In the past, episodes of illness have been associated with self-neglect and disappearance from his home for quite long periods. There have been incidents involving members of the public – including children – which have been distressing and frightening for all involved. The assessment process may indicate that a GPS-enabled device²¹ could reduce the person's exposure to risk when he is away from home. It will enable his carers – and a call centre – to pinpoint him at any time so that they can organise help if he becomes lost or experiences harassment – perhaps avoiding police intervention and all that that can entail. A home monitoring system such as Just Checking²² can keep the care team informed about the person's routine and lifestyle in his own



home, and provide very early warning of any changes which may indicate a recurrence of symptoms. This intervention could take place early enough to reduce the distress of another compulsory admission to hospital, or the risk to others.

But such devices could also be used to restrict the person's freedom to make his own choices and go where he pleases, and these are fundamental rights. The devices could be perceived as a kind of electronic tag, with associations of surveillance and the criminal justice system. Certainly, his privacy would be compromised.

Similar dilemmas arise with the use of systems such as Betavista²³. These enable audio and visual communication between a call centre, hospital or clinic and a patient in their own home. They enable either the control centre operator or carer(s) to see the person in their own home – albeit when an alert is triggered – as well as to talk to them via a phone line. This example and the ones above highlight the ethical issues associated

with telehealthcare sharply. Although the use of technology may mean the resulting assessments are very well-informed, the enhanced treatment or support they lead to is not necessarily justified by setting aside the person's fundamental rights.

It is important to stress four things at the outset:

- each person's needs, choices and beliefs must be a fundamental consideration in any decision
- there are few absolute 'rights and wrongs' which can be universally applied to every situation
- ethical issues are not unique to telehealthcare. Indeed, the principles, values and legal obligations discussed here apply to other care and support settings
- no one acts in a value-free or value-neutral way – we all have our value positions. The important issue is understanding these, articulating them

as necessary (particularly to service users and carers) and understanding and thinking through any conflict that may emerge with the values of others, particularly service users and carers

Personal value systems

We all take up value positions and have opinions on issues like the smoking ban, how children should be disciplined and capital punishment. Some people consider these issues to be 'common sense' or 'obvious', but in practice they are complex. Our personal values are influenced by the way we were brought up, our education, the apparent values of our community and by our life experiences. For those working in care and support services, there are also our professional values. These are often expressed through codes of practice²⁴ and feature prominently in our professional education at every level (the *Guidelines for online counselling and psychotherapy*²⁵ are

particularly relevant to this guide). Through such codes of practice we learn – and try to integrate into our practice – core values such as a commitment to confidentiality; treating people with respect; maintaining dignity and individuality; and challenging racism, discrimination and injustice.

It is important that practitioners are aware of these values, and how they come to be part of their own value system. It is also important to appreciate that they may not always be shared by individual service users and carers, with the resultant need to resolve conflicts that arise from different value positions.

Principles

Some writers have developed statements of principles, or ethical theories, which can help ensure that the use of telehealthcare is ethically sound. For example, Bjørneby et al (1999)²⁶ have proposed these principles:

- **autonomy** – people should be able to decide what they want to happen or be done to them
- **beneficence** – we should try to do good to the people we care for
- **non-maleficence** – we should try to avoid doing people harm
- **justice** – people should be treated fairly and equally

In addition to these principles, Bjørneby suggests that the perspectives and views of all those involved in the service should be sought in relation to both its implementation and the likely impact of its non-implementation.

Kemshall and Pritchard (1997)²⁷ highlight the values and rights which they believe underpin community health and social care services. These include:

- a commitment to ensuring that all users and carers enjoy the same rights of citizenship as everyone else

in the community, with equal access to service provision, irrespective of gender, race or disability

- a respect for the independence of individuals and their right to self-determination, including taking risks, and minimising any restraint on that freedom of action
- a regard for the privacy of the individual, intruding no more than necessary to achieve the agreed purpose



- respect for the dignity and individuality of every user and carer
- to maximise individual choice in the type of services on offer and the way in which those services are delivered
- a responsibility to provide services in a way that promotes the realisation of an individual's aspirations and abilities in all aspects of daily life

In work commissioned by the Social Care Institute for Excellence, the Welsh Centre for Learning Disabilities identified similar principles and ethical issues and described a series of 'practice points' in the assessment, consent, installation and review phases of a service²⁸.

The law

In Scotland, three important Acts of Parliament have been passed since 2000: the Adults with Incapacity (Scotland) Act 2000; the Mental Health (Care and Treatment) (Scotland) Act 2003; and the Adult Support

and Protection (Scotland) Act 2007²⁹. In addition to sharing a common purpose of protecting the rights of vulnerable people, these uphold a common set of principles:

- that any intervention must be intended to provide a benefit to the person which could not be reasonably obtained without that intervention
- that this is the 'least restrictive' option available
- that the views of the person are considered, along with those of significant others, like carers and family

The Adults with Incapacity Act and the Mental Health (Care and Treatment) Act are particularly relevant to this guide because of their focus on the rights of people with significantly impaired capacity to make decisions. They also provide safeguards in situations where the person is considered unable to make decisions about their own care and treatment.

Capacity and consent

There will be many occasions when the introduction of telehealthcare raises issues of capacity and consent. The assessment process may indicate the presence of significant risk that telehealthcare (in conjunction with other services) has the potential to reduce. Despite this, the person may refuse the service or be reluctant to accept it. This might be because they disagree with the perception of the risk and/or they want to retain the right to choose the way they live. Their right to refuse has to be recognised and accepted (as well as recorded), unless a lack of capacity can be established³⁰.

When working with people who may benefit from telehealthcare but also lack sufficient capacity to make decisions about risk and quality of life, there may be justification for overruling these fundamental human rights. However, these are very significant judgements which must be made carefully and legally. It may transpire that

a person's capacity is not impaired after all, but instead their means of communication, or ability to communicate, has not been properly considered. This is generally apparent when the person has a hearing or speech impairment, or perhaps has had a stroke, but may be less obvious when the person has a mental illness.

Where decisions are made on behalf of an individual who lacks the capacity to make choices for themselves, the course of action should be time-limited, regularly reviewed and limited to the particular services and decisions under consideration. Such decisions should never be considered as final or permanent.

There are provisions in the Mental Health (Care and Treatment) (Scotland) Act 2003 which allow for this kind of intervention to be used without the consent of the service user. For example, the use of telehealthcare could form part of the 'nursing support' which the service user is obliged to accept in their own home under a community-based treatment order. Like any other intervention, this would need to be carefully and clearly detailed in the person's care plan, and linked to their needs and risk assessment.

Even if all the criteria for compulsory measures are met, it is still important to explain the reasons for the interventions,

and to seek as informed a consent as is possible. In a situation like this, preparation of an 'advance statement' can prove useful. This provides an opportunity for a person with experience of mental illness to state clearly their position on the use of a particular treatment, should a relapse occur and their or ability to make decisions be severely affected³¹.

Confidentiality

People with a mental illness have the same right to confidentiality as anyone else. This right is protected under common law; through the Data Protection Act 1998; via Article 8 of the European Convention on Human Rights; through professional codes of practice; and by government guidance³². The protection prevents information about the person's health, diagnosis and circumstances being disclosed to anyone else – whether relatives, or professionals who have a concern or responsibility for them – without

When working with people who may benefit from telehealthcare but also lack sufficient capacity to make decisions about risk and quality of life, there may be justification for overruling their fundamental right to decline treatment. However, these are very significant judgements which must be made carefully and legally.

their consent. Because of the related issues of capacity and consent which can arise in mental illness, and because of the nature and risks associated with mental illness, there are some circumstances in which data can be shared without the person's consent.

This is relevant to telehealthcare for two reasons. First, some equipment may enable or facilitate the electronic exchange of information between professionals, either as part of the management of the patient's care, or to reduce risks to the patient or others. Second, text messages or email communication between a clinician and a patient may be intercepted or misaddressed, so that other people become aware that the patient has an illness, or is under treatment. Some health authorities are sufficiently concerned about the latter risk to forbid the use of any such methods of communication with patients.

It is therefore very important to again stress that telehealthcare equipment should only be introduced into a patient's care plan with their consent. Where that consent is

overridden, it must be done legally. Procedures that have been developed to protect service users must be followed. The risk of inadvertent breaches of confidentiality must be assessed and managed.

Policy and procedures

Individual agencies will have policies, procedures and guidelines in place which ensure that staff remain within the law when delivering services – including telehealthcare services. Implicit in these are the values of the agency, and of the community that it seeks to serve. For instance, there will be commitments to equal opportunity, privacy, dignity and confidentiality, alongside procedural commitments to legality, cost-effectiveness and quality.

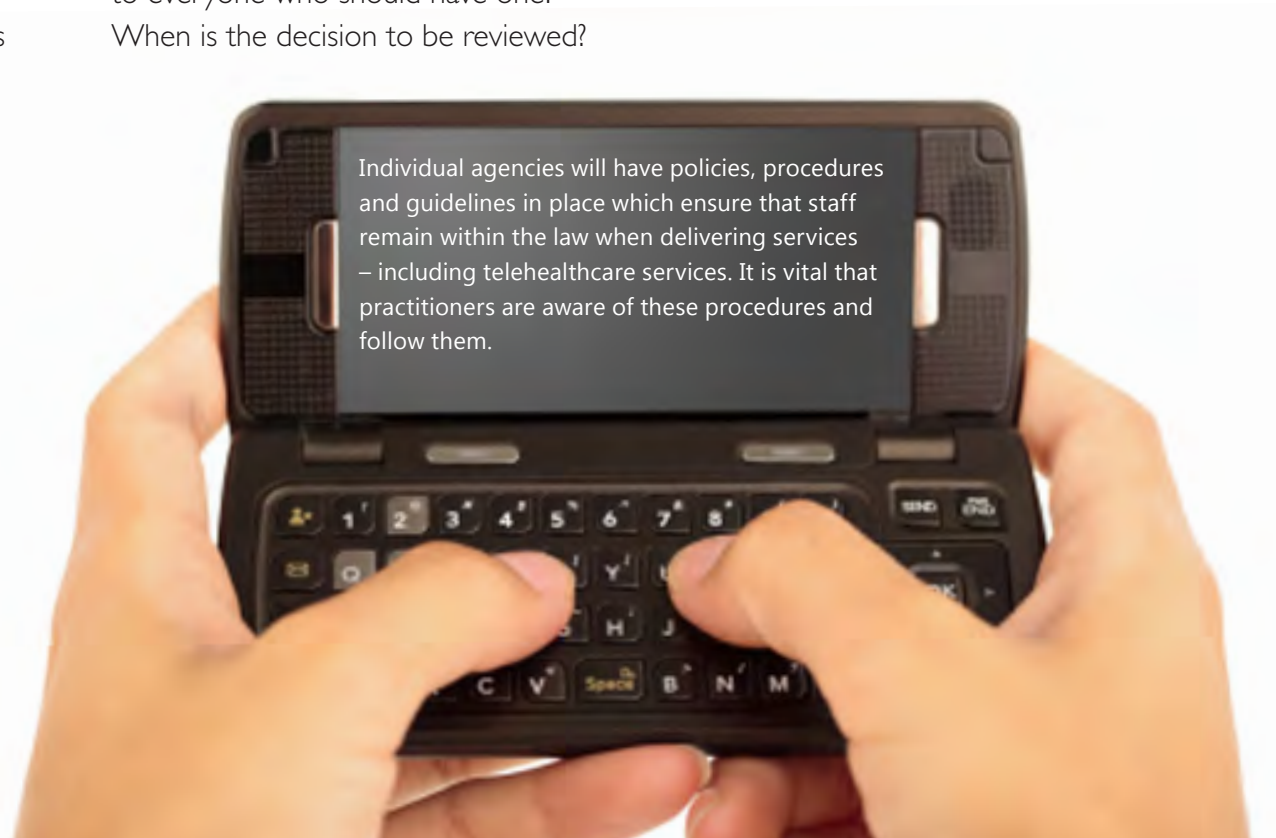
It is vital that practitioners are aware of these procedures and follow them. In the context of this chapter, practitioners should also be alert to conflicts between the values of users and carers and the values of their

agency. These issues are often encountered in the area of risk and personal safety. Agencies have a duty of care, and in some cases their policies and procedures may conflict with the aspirations or expectations of the user, or their carer. For instance, procedures may prioritise the reduction of risk, as distinct from the freedom of someone to take risks and to make their own decisions. Practitioners need to be alert to these conflicts, and to make them explicit to users, carers and their own agency management. They must also ensure that the resolution of the conflict is recorded accurately and transparently.

Practice guidance

In summary, the following guidance is suggested:

- be aware of your own personal and professional value systems – and how these might conflict with the person you are working with and their carers
 - be aware of the procedures of your agency, particularly those which are designed to protect the person's right to choose, to dignity, to privacy and to confidentiality
 - ascertain as fully as possible the views of the person, their carers and other staff working with them. Do you understand what they are saying to you?
 - are there issues of capacity to consent? If so, what are the legal issues around overriding their right to choice and consent?
- in what ways might the telehealthcare solution limit this person's freedoms and rights? Is there an alternative which does not challenge their right to choose?
 - how are the decisions to be made recorded? Has a record been provided to everyone who should have one? When is the decision to be reviewed?



4: Telehealthcare and mental health

This chapter explores the potential and value of telehealthcare to people with a mental illness. It begins by talking about the common needs of people with a mental illness, then goes on to describe telehealthcare equipment and services that can help meet or alleviate those needs. Where possible, sources of additional information about existing services have been included, along with photographs of the pieces of equipment. Numbers identifying pictures also link in to manufacturers' contact details on page 57.

Definitions: whom are we talking about?

Mental illness

In this guide, the term mental illness includes psychotic disorders, such as schizophrenia; obsessive-compulsive disorders; anorexia nervosa; and disorders of mood such as depression and bipolar disorder. However, the emphasis here is not on the precise definition of these illnesses – nor indeed

on the typical symptoms or medical treatments – but on the common needs that people with these illnesses are likely to have, particularly when living at home, with or without outpatient treatment.

A distinction is often made between patients with 'severe and enduring' illnesses, and 'the worried well' (or similar terms). Patients who experience severe and enduring illness have more acute symptoms, and more frequent recurrences or relapses. The majority of resources are targeted at this smaller group because of the level of distress they experience, and the disruption this causes to the patient, their carers and the community. Conversely, preventive measures and support services for patients with reactive or less severe conditions – however chronic and disabling – tend to receive fewer resources. Telehealthcare is sometimes perceived as being more relevant to the latter group, although experience suggests otherwise. With this in mind, it is important to focus

on the needs of individuals that telehealthcare can help address, irrespective of the severity of symptoms.

Mental illness in Scotland

It is estimated that one in four people in Scotland experience mental health problems of some sort at some point in their adult lives. Nine per cent of the Scottish population take an antidepressant on a daily basis. The annual cost to the health service is estimated at £8.6 billion. NHS boards in Scotland spent £928 million on mental health services in 2007/8.

Common needs

Common needs are likely to include:

- a carefully planned and monitored programme of drug treatment and/or therapy that is regularly reviewed
- a safe and secure environment (leading to a consequent reduction in anxiety)
- good physical wellbeing

- social wellbeing, including support from informal networks as well as professionals
- emotional wellbeing, derived from a stimulating and varied lifestyle and positive social relationships
- opportunities for further education, leisure and employment

Treatments

Treatments for mental illness can be categorised into drug therapies, talking therapies (which include different forms of counselling, psychotherapies and approaches to behaviour modification), and social support. As the following examples illustrate, telehealthcare can contribute to each:

- compliance with medication can be improved using medication monitors and dispensers
- access to counselling and CBT/DBT (cognitive behavioural therapy/digital behavioural therapy) can be

enhanced using mobile phones, skilled use of video counselling, and online applications

- emergency support and intervention can be improved through landline and mobile phone communication, and through the use of videoconferencing (providing support in crisis in remote areas)
- a range of home safety and monitoring devices can reduce the need for sleepover support and check visits, releasing time and resources for additional social support, education and interaction

It is sometimes suggested that telehealthcare equipment is unlikely to be helpful in cases of thought disorder and paranoia. There is a view that devices such as door security systems which provide spoken warnings or advice, and alarms or alerts which can trigger a spoken response from a call centre, might exacerbate symptoms among patients

who hear voices or believe that they are in some way under the control or guidance of external forces. Experience suggests that the use of these devices to support people with thought disorder and paranoia does not exacerbate their symptoms. Furthermore, if the person is shown how to switch them off, the possible negative effects can be overcome, without necessarily losing all the benefits.

The emphasis here is not on the precise definition of mental illnesses, but on the common needs that people with them are likely to have, particularly when living at home, with or without outpatient treatment.

Examples of telehealthcare for people with a mental illness

Compliance with medication³³

Most mental illness can now be treated with medication – very often in pill form. Many patients will be prescribed a combination of medications, either to ensure the right balance of treatment, or to reduce or eliminate any possible side effects. Different pills may need to be taken at different times, or on different days. Medication for mental illness may be combined with medication for other conditions.

Compliance with the prescribed medication regime is very important. Treatments may well require time to take effect, and both benefits and side effects may not become apparent straight away. If treatment is taking place in the community, where daily or even weekly supervision is difficult, it can be hard to establish the best possible regime. This may necessitate recall or readmission to hospital for no other reason

than supervision of medication.

Failure to comply with medication is likely to lead to relapse, with the associated distress of readmission, reassessment, and disruption to both the patient's lifestyle and that of their carer(s). Lack of compliance is a significant cause of relapse or recurrence in schizoaffective and bipolar disorders, and re-establishing the appropriate regime can take some time. Patients may make a decision not to comply – perhaps because of perceived side effects, or, ironically, because their mental health has improved. But lack of compliance can also occur because of forgetfulness, confusion over whether or not a pill has been taken, and similar more mundane reasons. For some people, knowing what medication to take and when can become overwhelming and they may 'give up'. Alternatively, they may feel the regime is socially restrictive.

Failure to take one pill or a day's dosage will seldom have immediate consequences. Just as it may take some time to establish



the appropriate dose, the consequences of non-compliance can take a while to show. If a patient sees a consultant every three months, and a community psychiatric nurse perhaps only every fortnight, then a significant period may elapse before symptoms arising from non-compliance are seen, and with the passage of time these are likely to have become more acute. In such circumstances, automatic pill dispenser may have a role to play in both enabling and monitoring compliance.

Automatic pill dispensers (figures 2 and 3) can be programmed to dispense medication in the prescribed dose and at the prescribed times. When medication is due to be taken, an alarm sounds and/or a light flashes, and the correct dosage comes into view through an opening in the lid. That dosage – and only that dosage – is easily available to the patient, and it is immediately

obvious that the dose has been taken. The alarms can be programmed to sound for varying durations, and different sounds are available for different times of day or night. The dispenser is lockable, and has a battery life of 12 months. Some are designed to be portable and are small and discreet enough to be carried by the person when they are away from home.

Current models of medication dispenser can be programmed online with the times and correct dosages. In addition, the dispenser can be set to alert a CPN, family member or carer by email or text when medication has not been taken. It can also flag up when there has a dispensing error, when the unit needs to be refilled, or when the battery is low. This makes it practical to check compliance promptly and enables better monitoring of compliance over a medication cycle.

This model of pill dispenser can be used with a tipping device for patients who lack the manual dexterity to tip the pills out themselves.

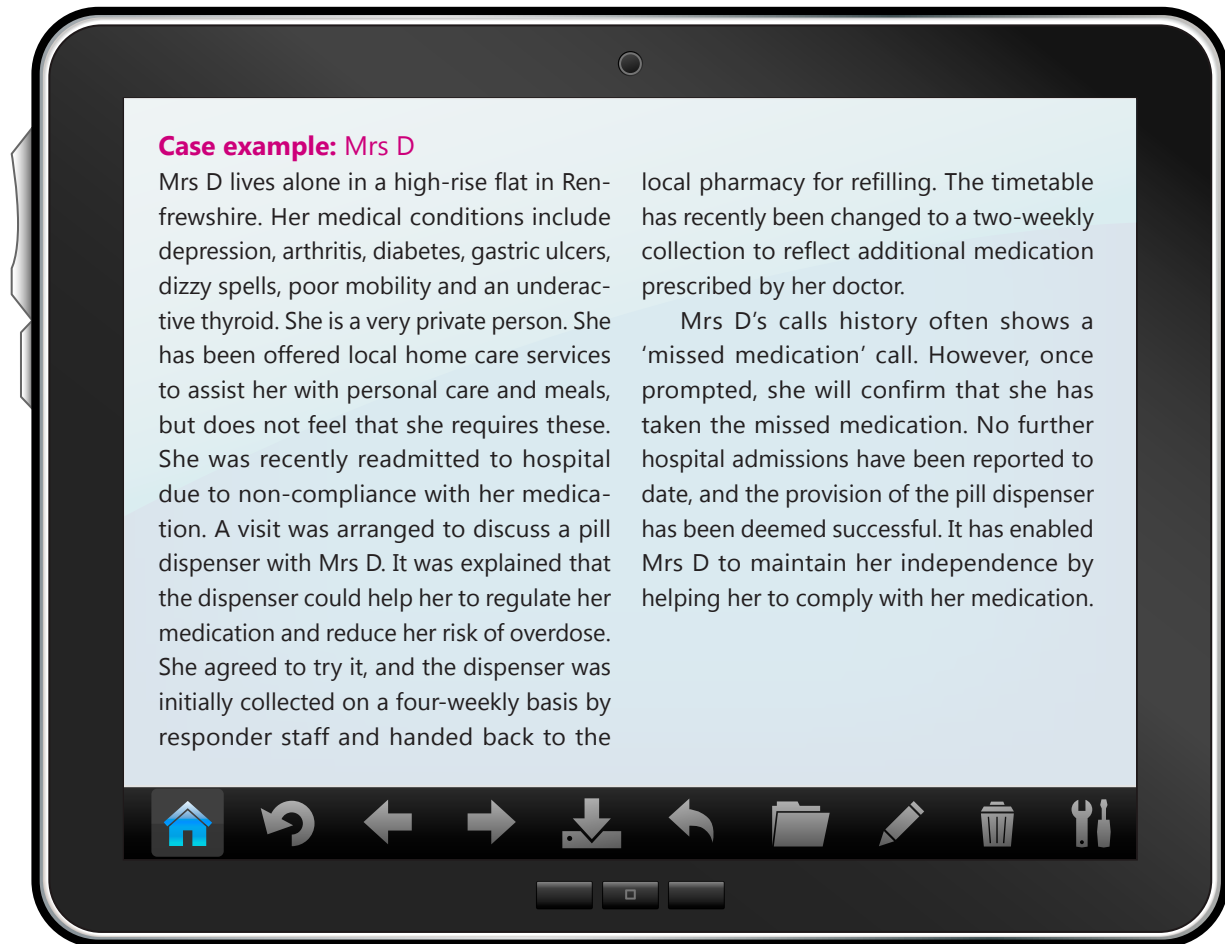


Renfrewshire Care 24³⁴

In 2007 a joint working group was set up involving Renfrewshire Community Health Partnership, Renfrewshire Social Work, the primary care development pharmacist and NHS Greater Glasgow & Clyde to evaluate the potential benefits of medication dispensers. Renfrewshire's Care & Technology Project agreed to fund a pilot involving ten service users for a period of six months. Two independent pharmacies, identified by the primary care development pharmacist, agreed to assess and fill the dispensers. The pilot used the Pivotell MDS unit, which was linked through an alarm unit to Renfrewshire's control centre (currently operated by Hanover Telecare). Chubb Community Care provided the equipment.

Ten service users were identified through the community alarm service and were selected to reflect a varying range of medical conditions. This allowed the appropriateness of the pill dispenser to be assessed for specific conditions. These

included mild to moderate dementia; schizophrenia; depression; and alcohol abuse. A joint assessment was arranged involving the service user, their family, their case manager, the pharmacist and the telecare service coordinator. This was carried out in the service user's home so that the pharmacist could access all the medication in the home, providing an opportunity for a comprehensive pharmaceutical review (if the review had been carried out in the pharmacy, the pharmacist would only have had access to the medication history on their own pharmacy computer system). Once all the information had been collected, the service user's details were entered on to the information system with the relevant protocol for activation of the pill dispenser.



Using telehealthcare to support safety and security at home

Treatment for mental illness generally takes place in the community. Admissions to hospital for assessment, diagnosis or establishment of treatment regimes is kept to the minimum period possible. This is in marked contrast with earlier times when long stays in mental hospitals (asylums) were the norm.

One feature of this change has been the gradual closure of long-stay hospitals and the discharge of patients into their own homes in the community. Specialist support organisations have been established to ensure that such patients have an appropriate programme of care and support as they relearn the skills of independent living. Many patients have found themselves returning home after spending many years in hospital.

Careful assessment of all the needs of these patients is essential before discharge. The assessment process often identifies

significant issues relating to safety, reassurance (particularly at night) and support with the practical tasks associated with daily living, such as cooking, cleaning, shopping, further education and leisure. Support to meet these needs is often initially provided by staff. As the patient relearns or learns new skills, telehealthcare equipment can carry out the monitoring or security roles previously fulfilled by staff, freeing up their time for other more complex support tasks, such as social interaction, counselling and leisure. For example, some patients need waking night staff or sleepover staff in the first months after discharge while they adjust to the different sounds and routine of life outside a hospital ward, and to the uncertainties and unknowns of independent living. Other patients may be at risk of leaving the cooker on, flooding the bathroom or being exposed to low temperatures, simply because they were never responsible for managing these things in hospital. Staff need to be present to reduce and manage such risks. At a later

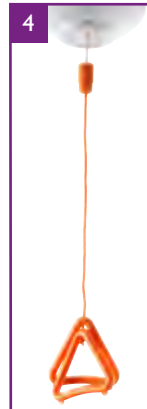
stage, a review may identify that alarms and passive sensors connected to a call centre can reduce levels of staff supervision. Introducing these devices can enhance the person's privacy and independence, while freeing up staff to spend more quality time with the person, developing their social and personal skills, as well as reducing costs.

The following telehealthcare devices can help meet needs of people learning to live independently in the community. They fall into two categories. 'Active' devices such as pull cords need to be activated by the person or their carer. 'Passive' alarms or sensors automatically detect a risk or emergency and send an alert to the call or monitoring centre.

The following environmental monitors and alerts can all be linked to a call or monitoring centre, or to a staff base.

Pull cord alarm (4, 5). This can be pulled by the person to activate an alarm which alerts staff nearby or in a call centre. It is only useful if the person is near enough to the cord or able to move to pull it.

Pendant alarm trigger. Community alarm equipment which can be worn around the neck or wrist. When the button is pressed, the devices shown in figures 6, 7, 8 and 9 trigger an alarm. The model shown in figure 10 can also be used to summon assistance (in this case by pressing a combination of two buttons) but in addition operates as a very small cordless telephone. This can be used to take all incoming calls and make emergency outgoing calls to family, neighbours or a call centre. Modern pendant alarms are smaller than earlier versions, so they are less stigmatising. Pendant alarms link to a base station within the person's home (11), and some models are styled to look like standard phone or modem units (12 and 13).



Temperature monitor (14, 15, 16, 17). This detects extremes of temperature (hot or cold) in the room where it is placed. The high temperature function can detect a fire or if the cooker has been left on. The low alert can flag up a risk of hypothermia or indicate if a door has been left open.



Flood detector (18, 19, 20). This is activated when the floor becomes wet, and is useful in kitchens as well as bathrooms. It can be connected to a control or call centre, or it may be self regulating.



Smoke detector (21, 22). This will pick up even small amounts of smoke, although it can be very sensitive to sources of smoke such as burning toast or candles. It needs to be positioned carefully to avoid false alarms.

Carbon monoxide detector (23). This can either alert a call centre or automatically shut off the gas supply.

The following devices can be useful if someone is experiencing harassment from neighbours, or is simply anxious about meeting strangers at their front door:

Door contact (24, 25). This two-part device is fitted to the door and its frame. Staff or a call centre are alerted when the door is not closed or if it is opened and shut frequently.

Safe door entry system (26). This enables the user to see or hear who is outside before they open the door. Some systems are connected to a television so that the person can see the caller before they decide to open the door. Others can record conversations that take place before the door is opened.



Case example

Telehealthcare has been used in Renfrewshire to support people with mental health problems for some years. Of 850 current clients, 60 are identified as having a mental health problem. These include patients who have been discharged from a psychiatric hospital which has closed a number of wards over the last three years. This example describes six former patients who moved into a supported accommodation complex.

The accommodation is a large sandstone building which has been converted into six flats, with a separate staff flat. All six tenants have been diagnosed with schizophrenia, and had previously been in hospital for continuous periods of between four and ten years. Two also had problems arising from substance and alcohol abuse. Other physical

conditions included diabetes and poor mobility. Limited daily living skills, awareness of risk and anxiety were also problems. All were smokers.

Following assessment, linked smoke alarms were fitted to address the risks associated with dropped cigarettes. Linked temperature monitors were fitted above all the cookers to reduce the risks caused by cookers being left on. Flood detectors were also installed in case taps were left running, and each tenant was provided with a trigger/pendant for their own use. The tenants also had a key safe fitted outside each of their flats which they agreed could be opened to allow access in the event of an emergency.

Telehealthcare equipment provided as part of individual support programmes has enabled these

tenants to lead independent lives within the community and develop daily living skills after prolonged periods within a long-stay hospital ward. They are able to call staff if they need help, rather than the staff having to programme frequent monitoring or check visits throughout the day and evening. These tenants have been in their homes for more than two years, and comment positively on the equipment and security it provides.



Monitoring devices

Sometimes, during a planned programme of recovery and rehabilitation, it is important to know what kind of lifestyle a person is creating or recreating – but without the distorting effect of having support staff or carers in constant attendance, living in or sleeping over. It can also be important to know whether a person is choosing a lifestyle – however unconventional – or whether it is the symptoms of an illness which constrain lifestyle choices and reduce quality of life. Observing the person's lifestyle and behaviour can help staff understand what is taking place when the person's own account doesn't 'add up'. The following telehealthcare devices can provide information for assessment or monitoring purposes (see chapter 3 for details of important ethical issues relating to these systems).

Passive infrared (PIR) beam (27, 28). This detects movement or lack of movement. It can activate an alarm if there has been no movement when there should

be – for example if someone is unable to get out of bed or out of their chair. Alternatively it can be activated if there is movement during the night when this is not expected.

Just Checking³⁵ (figure 1, page 14) is a system which monitors the movement of a person in their home and generates a chart of activity that can be viewed online. Although designed for people with dementia, it can also be used when it is important to understand how someone is living, and how far they are feeling in control of their routines and lifestyle. This can facilitate better decisions about when and how to offer support, and when to make social rather than 'check' visits. Care professionals use the system both for assessment and planning care. Just Checking highlights what a person is able to do for themselves in the familiarity of their own home, and the effect of care services. The system uses wireless movement sensors, a single power socket, and the mobile phone network. Just Checking also provides a multi-person kit



for supported living houses for adults with learning disabilities. It is likely that this would also be beneficial in supported living houses for people with mental health problems. The kit helps establish the need (or lack of need) for night sleeping staff, and highlights opportunities for more efficient

deployment of staff, and greater independence for service users.

While Just Checking works within the home, **buddi**³⁶ (29, 30) provides similar functionality outside the home. It uses GPS technology to provide instant, accurate information on the location of a person who is carrying the device. It can be used



to help them find their way home, or to check where they are (without the need for constant staff accompaniment). A 'safe zone' can be created around an area so that an alert is sounded at a contact or call centre when the person crosses the boundary. Any necessary intervention can then be initiated. This may be important to protect the person, other people, or both. Safe zones or boundaries can be named and designated as full- or part-time. They can be programmed to operate on specific days or at specific times of day.

Securing the person's agreement and understanding issues relating to informed choice are vitally important if this kind of equipment is to be used effectively and ethically. The descriptions above immediately evoke thoughts of Big Brother, and the concept of tagging has connotations of criminal justice and surveillance. However, there will be times when this degree of monitoring – and loss of privacy – offers an alternative to a longer period of admission to hospital,

or to constant accompaniment by a support worker. In other words, such systems might be considered as the least restrictive alternative, or least restrictive option³⁷.

Telehealthcare for support and treatment

Telephones and mobile phones

The telephone was invented in 1876, and around 100 years later the first portable or mobile phone was developed for commercial use. By 2009, 81 per cent of households in Britain had access to a mobile phone, and 88 per cent had access to a landline³⁸. 70 per cent of households in Scotland have both.

The prevalence of landlines and mobile phones means that they have become as significant a means of communicating as face-to-face conversation. Of course there are differences – non-verbal communication (apart from the use and interpretation of silences, and sounds which are not words) and body language are not available by

phone. Nonetheless, if talking therapies are an important part of mental health services – and if access to them in person is limited by cost, geography or availability – then it is important to make sure that the potential of fixed line and mobile phones for mental healthcare is maximised.

The following examples describe some of the ways in which landline and mobile phone technology is being used to support people with mental health problems.

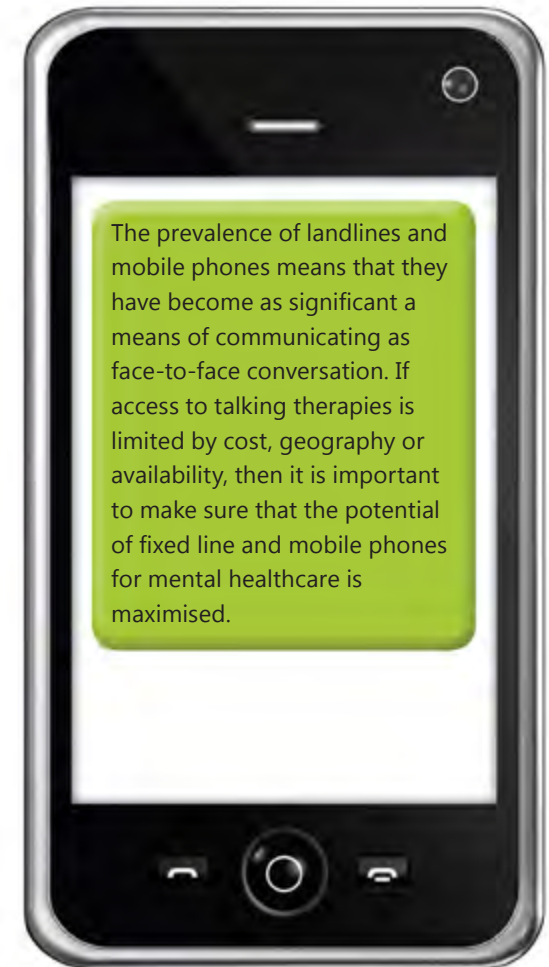
The Samaritans provide confidential, non-judgemental, emotional support 24 hours a day for people who are experiencing feelings of distress or despair, including those which could lead to suicide. Although primarily an emergency telephone service associated with people considering suicide, The Samaritans now offer help by email and text message. This is delivered by trained volunteers and is a listening service – it does not offer counselling or advice as part of its core service.

In Scotland **Breathing Space**³⁹ is a free and confidential phone line available to any individual who is experiencing low mood or depression, or who is unusually worried and in need of someone to talk to.

The service was launched in Glasgow in 2002, and became national in 2004. It was initially targeted at young men, and a high percentage of callers continue to be men. The service is staffed by trained specialist advisers, and now responds to 7,000 calls per month. On average calls last 20 minutes, and there is a 50 minute 'boundary' after which a call is brought to a conclusion. Breathing Space's core services are listening, advising, supporting and signposting. GPs and CPNs are encouraged to refer their patients to Breathing Space as a way of complementing the conventional support and treatment services they provide.

Living Life is a newer telephone service based on cognitive behavioural therapy (CBT). It offers two options: supported self-help (speaking directly with a self-help coach), and CBT (speaking directly with a qualified therapist).

These are just three examples of services which have developed the therapeutic potential of the phone to support people with mental health problems. Both of them target groups who are less likely to be reached by conventional services.



Text messaging as part of a mental health service

A recent dramatic change in communication has been the development of the short message service (SMS) or texting by mobile phone. In just a few years this channel of communication has become as familiar and universal as the telephone call. Within some mental health services it is now being used to confirm or alter appointments, or to exchange other short items of information. Texting is rapidly becoming as well established as other more formal ways of exchanging information. Some services are beginning to expand on text messaging and explore its therapeutic potential.

Penumbra⁴⁰ is an organisation which aims to promote mental health; prevent mental illness among people who are at risk; and provide support to people with mental health problems. In the Scottish Borders, it provides a service for younger people. Here, staff simply started to use texts more routinely when they found that

they were the preferred method for young people to stay in touch with workers. Initially they had some concerns about how this was working as some staff (at that time) did not have work mobiles and were therefore using their own phones. Now all staff are issued with mobiles, both as a means of communication and to access the lone working system check-in/-out process. Texts are also used for the following:

- to arrange and rearrange appointments
- for ad hoc support if mood levels drop or an issue has occurred
- to check if someone is in a better place since the last text
- to ask how an agreed action or approach went
- to find out if someone still wants or needs support after a period of no contact

Staff report that young people routinely text 'to tell us good news, to say hi after a period of no contact, to let us know they are still out there, when they need extra support in between appointments ... or to check things out'.

In **West Lothian**⁴¹ the Social Work Addictions Team routinely uses text messaging to keep in touch with service users, reminding them of appointments, checking on wellbeing and encouraging communication. Service users find that texting is a cheap and easy way of keeping in touch, and it has led to a significant increase in attendance at appointments.

Text messaging is rapidly becoming as well established as other more formal ways of exchanging information. Some services are beginning to expand on texting and explore its therapeutic potential.

Florence – the simple telehealth service

Florence⁴² is a service developed in the West Midlands of England which uses SMS technology to enable patients to send information about their condition and situation, and to receive advice, prompts or reassurance by text. All the information sent is recorded, and an individual programme and protocol is developed to suit the patient's particular circumstances, symptoms and needs. Their consent is essential, and patients can choose to opt out at any time (although few do). Most report significant benefits in terms of their control over their own treatment and their ability to self-manage their condition. This is complemented by a reduction in anxiety about sudden change in circumstances or symptoms.

In the past text messaging has been more typically associated with chronic physical conditions and illness (such as diabetes and chronic obstructive pulmonary disease), but the first 50 patients with which Florence

was trialled had chronic multifaceted mental health problems. It is now being offered to a much larger group with mental health conditions including dementia, schizophrenia, bipolar disorder and depression/anxiety.

Regular text messages are sent which may prompt the person to take their medication; remind them of a routine or exercise requirement; or simply make contact to encourage them. Significant improvements have been reported in attending appointments and in compliance with medication when patients are sent reminders by text. Patients report feeling that they are more in control and engaged with their treatment. This leads to a consequent improvement in confidence and self-esteem.

The example illustrated in the newspaper clipping overleaf describes the experience of someone who benefited from using Florence⁴³ in practice.



In the past text messaging has typically been associated with chronic physical conditions (such as diabetes and chronic obstructive pulmonary disease), but it is now being offered to a much larger group with mental health conditions including dementia, schizophrenia, bipolar disorder and depression/anxiety.

It is just a simple text message, but it plays a vital role in the life of a mental health patient in Stoke.

Cheryl receives messages twice a day to remind her to take her medication. And that basic use of technology is enabling the once suicidal 36-year-old from Stoke-on-Trent to stay out of residential care and get back on her feet.

She is utilising the telehealth service operated by North Staffordshire Combined Healthcare NHS Trust. The Trust is the first in the country to adopt assistive technology for use in mental health services.

Two years ago she was in a council-run residential care home in Hanley, called The Hollies, which caters for mental health patients and people with

learning disabilities. But, with the help of telehealth, Cheryl has now been able to move into the nearby Hillcrest Hostel, which provides rehabilitation for adults with mental illness.

She says: 'I used to live in Devon where I was diagnosed with depression, personality disorder, and suicidal thoughts around 1987. I had hit rock bottom and started taking overdoses to try to kill myself. I was on drugs and drink and it got to the point where I had had enough.'

Fortunately, three years ago, Cheryl was able to turn to her sister Julie for help.

'She came and picked me up but, with me being ill and Julie having five children, it was difficult for her to look after me.'

A planned family holiday to France resulted in Cheryl, who has a son she is not in contact with, becoming 'panicky and paranoid'. She was admitted to The Hollies for a week of respite care but ended up staying for around nine months. But a combination of telehealth and a general improvement in her condition led to Cheryl making the all-important move to the hostel last year.

She adds: 'When I went into Hillcrest I was scared to death, but they were able to help me with things. I am 100 per cent better, which is helped by the text messages.'

Texts are sent twice a day by community psychiatric nurse care coordinator Donna Cantrell to remind her to take her medication.

Adds Cheryl: 'I used to get confused and either take too many pills or not take any at all. That wasn't helping my

condition, but now in the morning and at night I get text messages from Donna to remind me to take my medicine. I will then text her back saying 'Morning Donna, meds again', or 'Night Donna, see you tomorrow'. It's very nice to have this contact because you know you are not alone.'

Donna, who also sends texts to notify Cheryl of appointments, said: 'Residential care was felt to be the most suitable placement for her. But we reassessed her rehabilitation needs and introduced her to telehealth, and she is now living independently. While she's taking her medication her mental health condition remains stable. It does have a massive impact and it's just fantastic and lovely to see her improve.'

Cognitive behavioural therapy by mobile phone

Cognitive behavioural therapy (CBT) is a talking therapy. It encourages and enables patients to talk about how they think about themselves, the world and other people; and how their behaviour affects their thoughts and feelings:

CBT can help you to change how you think ('cognitive') and what you do ('behaviour'). These changes can help you to feel better. Unlike some of the other talking treatments, it focuses on the 'here and now' problems and difficulties. Instead of focusing on the causes of your distress or symptoms in the past, it looks for ways to improve your state of mind now.

CBT has been shown to help with many different types of problems. These include: anxiety, depression, panic, phobias (including agoraphobia and social phobia), stress, bulimia, obsessive compulsive disorder,

*post-traumatic stress disorder, bipolar disorder and psychosis. CBT may also help if you have difficulties with anger, a low opinion of yourself or physical health problems, like pain or fatigue.'*⁴⁴

Given the current interest in CBT and the growing demand for it (traditionally delivered face-to-face), it is significant that it is now readily available and easily accessible via alternative media such as text messaging and the internet. Also, where distance is an issue, these alternative forms of delivery offer significant and obvious advantages. People who access CBT in this way can participate in their own way and at their own pace. This flexibility and self-management may compensate for any perceived disadvantage because there is no face-to-face contact.

Dialectical behaviour therapy (DBT) using mobile and landline connections

This highly focused approach to behavioural therapy combines phone and text contact with regular face-to-face counselling. The concept of 'mindfulness' underpins a contractual arrangement with patients, through which they commit to ways of dealing with their problems and crises with the support of their therapist. It has been found to be very effective with people with complex and long-standing mental health issues, described as 'borderline personality disorders' and associated with frequent suicide attempts, self-harm, substance abuse and chaotic lifestyles.⁴⁵

Case example

Claire Lamza, specialist DBT worker in Forth Valley, is part of a mental health team that works with more than 20 patients in this way. The following (anonymised) case example illustrates how the process works:

Ms R is in her early thirties and lives alone in her own tenancy. She has no housing support. She has had contact with mental health services over a period of ten years or so, and is a frequent caller at social work and her GP surgery.

The DBT programme includes detailing various crisis situations in which Ms R will experience panic, extreme anxiety, or other feelings that threaten to overwhelm her,

along with guidance or instruction on what exactly she should do. This includes ways of making immediate contact with her CPN, who has committed to respond within a certain time frame. As an example, Ms R has made an agreement that if she finds herself in the chemist, in front of the paracetamol, wishing to buy (which in the past has preceded a suicide attempt) she will text her CPN knowing that she will receive a response which will help or guide her to a healthier outcome. Similarly, if she begins to feel suicidal, she has been helped to learn to text or phone the CPN to seek immediate support. If she

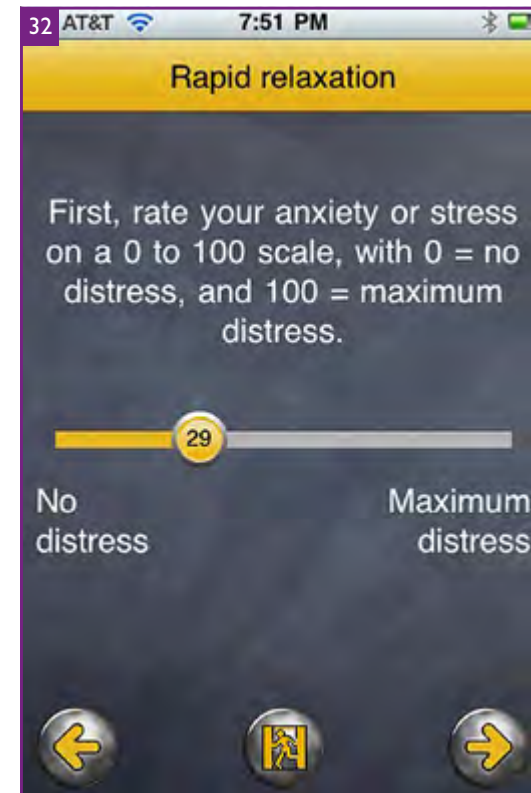
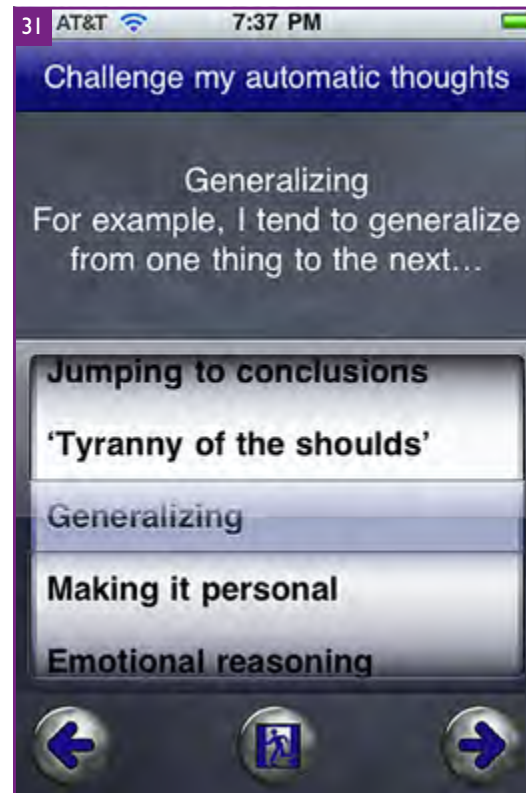
is planning a night out, she can use her mobile to make contact and be reminded of the coping and healthy strategies that have been discussed and agreed in conventional sessions. All of this is part of a carefully constructed and agreed programme of DBT treatment.

After 18 months on this programme, Ms R has established a healthier and less self-destructive lifestyle. She is undertaking voluntary work and has achieved some qualifications. Her treatment relies on her use of her mobile phone – as well as formal counselling.



Cognitive behavioural therapy as a mobile phone application:

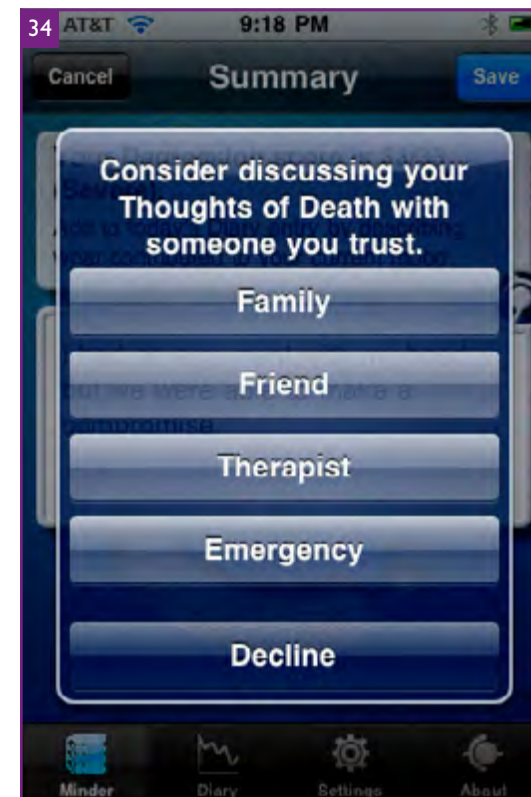
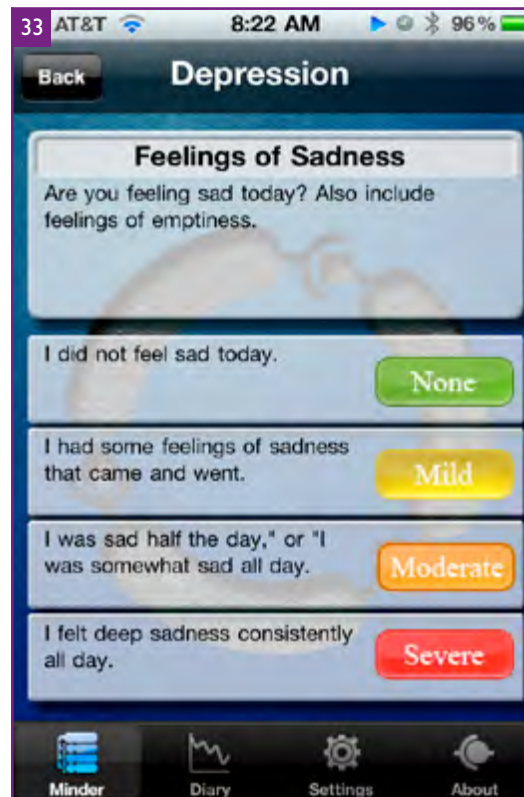
eCBT Mood (31), **eCBT Calm** (32) and **eCBT Trauma** are iPhone/iPod Touch applications that help people who suffer from anxiety, depression or post-traumatic stress disorder (PTSD), respectively. These applications can be used both as an adjunct to traditional psychotherapy (involving a therapist and patient), and as stand-alone interventions to address their problems. They aim to help people learn how to first identify and then challenge the distorted thinking that fuels their problems. By systematically tracking daily and weekly symptom severity, it is possible to track progress over time, and also to share those results with loved ones or professional caregivers.



For more information visit <http://www.mymindapps.com>

Similarly, the **Moodifi** app (figures 33, 34) (not available at the time of going to press in March 2011, but expected to be available soon) helps the user to track their daily mood and ability to function. It tracks dozens of symptoms in three different clusters: depression, mania and anxiety, encouraging the user to produce a self-rating in each cluster before writing a diary page to describe how they are feeling at the time⁴⁶.

Such applications are already available, and although their use may currently be limited, they provide examples of what is emerging on to the market. A randomised controlled trial of Moodifi is currently underway in Oxford, and discussions have begun to develop something similar in Scotland⁴⁷. Those working in the field of mental health need to be aware that patients will increasingly be accessing applications like these for themselves, and they are likely to experience benefits if access to and use of such apps complements conventional service delivery. The applications may also improve access to therapies such as CBT.



For more information visit <http://wellifi.com>

Online therapy

75 per cent of households now own a computer and a similar number of households have internet access⁴⁸. These figures represent a significant increase over recent years. In addition, mobile phones with internet access (smart phones) are beginning to out-sell personal computers and laptops. With this level of internet access and computer usage across the population, it is important to exploit the potential such access offers people with mental health problems. The following examples describe services which have either been developed online, are supported through a website, or are provided via interactive websites.

Cognitive behavioural therapy online

The **Living Life to the Full**⁴⁹ course is a life skills course that aims to provide access to high-quality, user-friendly training in practical approaches to living. It is based on cognitive behaviour principles.

The course teaches key skills in tackling and responding to issues widely encountered in everyday life. It is designed as a series of modules using video, cartoons and text to set a number of steps and challenges for the user. These help them work their way to a greater understanding of and improvement in how they manage their life, feelings, relationships and emotions. The introductory module is carefully worded to ensure that expectations of the course are not inflated, and people experiencing more serious mental health problems are encouraged to seek assistance from their general practitioner and other services. Advice is also provided on using medication while undertaking the course, and those who are already in touch with psychiatric services are encouraged to advise their clinician that they are undertaking this programme.

According to its website, Living Life to the Full was 'supporting 136,708 people' in December 2010. NHS 24 has completed a pilot project which provided telephone

support for users of Living Life to the Full in five pilot areas in Scotland – Borders, West Dunbartonshire, Lothian, Shetland and Western Isles. Initial findings show both strong and positive responses from patients, and significant economic benefits⁵⁰.

Depression Alliance Scotland is another organisation which offers telephone support to people who want to undertake the Living Life to the Full course. They advertise the programme as being suitable for people with 'mild to moderate depression'. While previous discussion with or referral by a GP or CPN is encouraged, the alliance emphasises that this is not a requirement.

Glasgow Steps

(www.glasgowsteps.com) is the website of the NHS primary care mental health team in South East Glasgow. The site provides information about all sorts of common stress problems, as well as ideas on how to tackle them. It features a 'stress wheel' on the home page. In addition to the online directory of services, the team offers a

call-back service by telephone – guaranteeing a call-back from a clinician to phone messages, offering assessment and advice on a range of therapies that Steps and other agencies offer.

Information on the home page also explains that the approach is based on CBT principles, and identifies three stages involving information, assessment and self-help.



Beating the Blues

(www.beatingtheblues.co.uk) is another computerised cognitive behavioural therapy programme. It is recommended by the National Institute for Health and Clinical Excellence (NICE). It consists of eight separate sessions, and is completely confidential.

Social media

The term social media is used here to refer to the range of internet-based social communication tools which have developed in recent years. These include social networking sites such as Facebook, blogging websites and microblogs – of which Twitter is the most familiar.

It is difficult at this time to be confident about the overall impact that social media are having on communication and relationships. The pace of development makes it hard to be certain of their effects, but what is undeniable is the extent of their use. Facebook now has more than 500 million users who between them upload 2.7

million photos and 10 million comments every 20 minutes.

With this growth in prevalence there is also an increased awareness of the risks involved – for instance of young people being harassed and bullied on social networking sites, even to the point of suicide. Further risks are associated with sites where people are encouraged to ask for help, but where they may meet repeated indifference or contempt from registered ‘friends’. The following examples focus on social media channels that have been developed specifically to help and support people with mental health problems. Notwithstanding this, it is important to be alert to the need for safeguards and protection when considering the role of social media in delivering mental health services.



Big White Wall (www.bigwhitewall.com) uses the ideas behind social networking to create a safe online zone where people can talk, share their feelings and use clinically designed psychological interventions and techniques to improve wellbeing. It was set up in 2007 as a social enterprise company in partnership with the Tavistock and Portman NHS Foundation Trust. Psychiatrists and clinicians from the trust helped devise the interventions and train the site's staff. These form a team of 'wall guides' (on duty 24 hours a day) who ensure that users remain safe and anonymous. Further protection is provided by a time lag on postings to prevent inappropriate or offensive messages appearing.

More than 3,500 people have signed up in the past two years. According to an independent survey, they were most commonly looking for help with stress, loneliness, anxiety and depression. A quarter of users were experiencing suicidal feelings, and a fifth were self-harming. More than 90 per cent of respondents reported improved mental

wellbeing. They said they felt able to speak because of the anonymity; trust in the online community; and safety of the service⁵¹.

Mood Cafe (www.moodcafe.co.uk) is a website designed to promote good mental health in Fife. It features practical information about different services and resources in the area, along with a page on interactive sites like the Big White Wall, Living Life to the Full and the Mood Gym (an Australian site) with direct links to each.

Depression Alliance Scotland have developed a site called Look OK ... Feel Crap (www.lookokfeelcrap.org). This features an online forum and provides opportunities for users to share their stories, along with links to information about other sources of help. It is aimed at people with depression

YouthNet UK runs a website called TheSite.org which provides information to younger people on a range of issues, including self-harm (www.thesite.org/selfharm). It includes the option of joining or browsing

an anonymous online discussion forum.

MoneySavingExpert.com now offers a comprehensive guide to mental health and debt, offering 'help, info, guidance and support for individuals and carers'. The site acknowledges the contribution of Dr Rob Waller and Eilidh Brown from the University of Dundee; as well as 'real people' – members of the MoneySavingExpert.com forums.

75 per cent of households now own a computer and a similar number of households have internet access. With this level of computer usage across the population, it is important to exploit the potential such access offers people with mental health problems.

Videoconferencing

In 2009, the Scottish Centre for Telehealth published a review of the use of videoconferencing in mental health services in Scotland⁵². The author of the review, Dr Harry Millar, focused on the use of videoconferencing for clinical mental health services in Scotland. He described videoconferencing as 'potentially the most powerful modality which most closely resembles face-to-face work'. It can take a number of forms.

1. *Direct clinical work with patients and/or families. This has been used for individual assessment and therapy with adults and with children and their families.*
2. *Case discussion and case-conferencing involving groups of clinical staff, patients and relatives in more than one location. In mental health work this kind of clinical case discussion is central to routine clinical practice to an extent which might not be found in other medical specialties. It is particularly important in more highly*

specialised services such as the State Hospital and the national child psychiatry inpatient service, which are not readily accessible to large numbers of patients, their families or local clinicians.

3. *Clinical supervision. This is partly educational in nature but may involve very direct individual case management discussion between supervisor and supervisee, and is thus integral to clinical care.*

He also includes a literature review which reveals (for example) that:

- videoconferencing has been extensively used in mental health services across the world, notably in the USA, Canada and Australia
- clinical applications encompass the entire patient age range and a very broad range of clinical settings. These include emergency and mental health act assessments, standardised

psychological testing and a variety of therapies and treatments

- there is a substantial body of literature but few high-quality, randomised controlled trials. Feasibility and acceptability ratings (among both clinicians and patients) are high
- other things being equal, most patients would choose face-to-face contact, but some prefer video consultations which seem to give them a greater sense of control and empowerment
- if there are significant savings in factors such as travel time, childcare costs and time off work, many patients prefer video to face-to-face
- clinicians worry more than patients about the possible limitations of videoconferencing

Service examples

The Shetland memory assessment service

uses videoconferencing to enable a consultant in old age psychiatry on the mainland to diagnose and treat at a distance. A specialist dementia nurse coordinator is based on the islands full-time and receives all referrals, whether from general practitioners or other sources. The coordinator carries out an initial assessment in all cases and discusses them in a weekly videoconference with the clinician. A video assessment is arranged as appropriate. Emergencies can be dealt with similarly, as the clinician now has a secure laptop and webcam for ad hoc consultations. The service gives the people of Shetland access to clinical services which they may otherwise have to wait a significant time for. It avoids the need for transport by air ambulance, with all the associated trauma for the individual and their family. Anecdotal evidence suggests high levels of satisfaction with the service among all those involved, particularly patients and carers, and significant cost- and time-savings combined with increased quality of care and treatment. A formal evaluation of the service is under discussion⁵³.

'Telecounselling' in Arran

Since December 2003, the clinical and psychological service in NHS Ayrshire and Arran has offered person-centred counselling to patients via video link. Initially this was only available to patients on the island of Arran during the winter months. Now it is also being offered to patients in Largs and on the island of Cumbrae. Counsellor Carol Holtom evaluated the experience of 11 patients in 2004⁵⁴. Her research suggested that they were able to overcome any perceived disadvantages of not being in the same room as their counsellor, and they identified some advantages that the video link offered:

'A typical discovery of participants was that, once they had adapted to the experience of engaging in counselling via the medium of videoconferencing, the therapeutic process took place. They discovered that there were no barriers to connection and relationship with the counsellor, or to being able to make progress, and generally no barrier to the content they could bring to a session.'

Videoconferencing has been extensively used in mental health services across the world, notably in the USA, Canada and Australia. Clinical applications include emergency and mental health act assessments, standardised psychological testing and a variety of therapies and treatments.

The article also includes some direct quotations from patients:

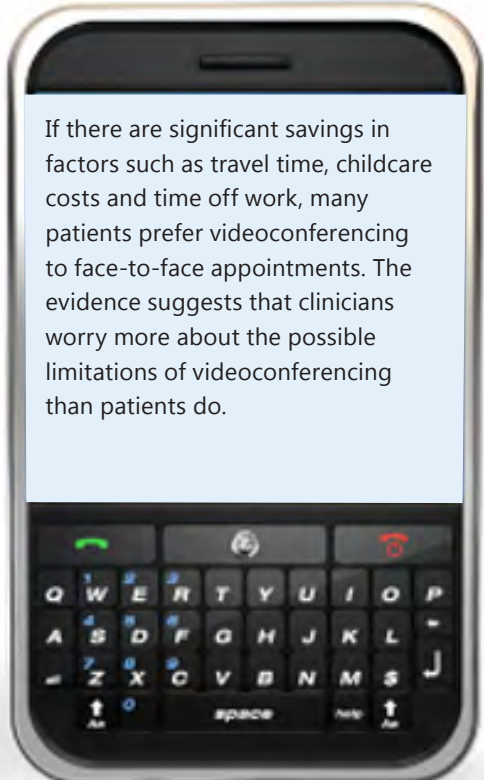
'The link has been so helpful and each session that I've had I feel has been more positive. I mean I just think it's absolutely wonderful, you know. I can't, you know ... and I really sincerely mean that. I mean, the whole experience has been very positive.'

*'It isn't just that I'm sort of putting up with it in order to maintain the counselling link, it's just ... it works really well.'*⁵⁵

**A neuropsychology clinic via videoconfer-
ence**⁵⁶ went live in January 2011. This is delivered from the Institute of Neuroscience at the Southern General Hospital in Glasgow to hospitals in the Western Isles. It provides patients who have neurological conditions with direct access to a range of neuropsychological services. Not only has this significantly reduced waiting times, but it reduces the costs and time involved in travelling. It has been very well received by patients who have used it.

The Grampian Eating Disorder Service⁵⁷

has been established for many years, and has been making use of videoconferencing for both patient consultations and clinical meetings and conferences for more than ten years. It provides assessment and treatment to patients from across Grampian, Orkney and Shetland using videoconferencing. Up to 20 consultations per month take place using this method. It is a specialist, multidisciplinary service for patients which operates as frequently as weekly, a level of access which could not otherwise be resourced. There is a managed clinical network for eating disorders which covers the whole of the north of Scotland, and relies on videoconferencing.

A smartphone is shown with a light blue text box on its screen. The text inside the box discusses the benefits of videoconferencing, such as reduced travel time and childcare costs, and notes that many patients prefer it to face-to-face appointments. It also mentions that evidence suggests clinicians worry more about the limitations of videoconferencing than patients do. The phone's keyboard and navigation buttons are visible at the bottom of the screen.

If there are significant savings in factors such as travel time, childcare costs and time off work, many patients prefer videoconferencing to face-to-face appointments. The evidence suggests that clinicians worry more about the possible limitations of videoconferencing than patients do.

5: Training programme

This section contains content and a suggested timetable for a one-day training programme on how telehealthcare can contribute to the care and support of people with a mental health problem. It is an outline programme which skilled trainers will need to adapt to the particular training needs and circumstances of local groups.

Aim

To support participants in the development of their knowledge, skills and understanding required to introduce telehealthcare into individualised care and treatment programmes and plans.

Objectives

- to learn how telehealthcare can contribute to the support of people

- with a mental disorder and their carers
- to develop practice in needs and risk assessment, and care planning, so as to maximise the benefits of telehealthcare
- to increase knowledge of the legal and ethical framework for good practice
- to understand the wider policy and strategic context for telehealthcare

Timetable

9.00 Welcome and introductions

- domestic arrangements
- introductory warm-up exercise:

This could take the form of a quiz, a brainstorming exercise or a five-minute paired discussion with feedback. The aim is to get people talking about their current use, dependence on, irritation with and fears

about technology such as mobile phones, email and Facebook. Light-hearted questions such as the following will set the tone:

- how did we cope before email? Better or worse?
- how many mobile phones do you have/need?
- what do young people never go out without?
- how many Facebook friends do/should you have?
- discuss the agenda and clarify expectations of the course. Refer to the aims and objectives to confirm what the course can and cannot provide. Invite participants to discuss, briefly, with each other; their current knowledge and understanding of telehealthcare; their perceptions and anxieties; their current reliance on technology

in their work and non-work lives; their expectations of the day; and their individual training needs

10.00 Definitions: telehealthcare and mental illness

This could be a 'teaching' session with a presentation and handout based on the definitions provided in the introduction to this guide. Key learning points are:

- the meaning of terms such as telehealthcare, telehealth, telecare
- the lack of commonly accepted standard definitions, and the extent to which terms are interchangeable, and changing
- the speed with which technology is developing in all areas of our lives
- the effect of this on service user and carer expectations

In this session it will also be important to remind participants about the nature and

impact of different sorts of mental illness, and so begin to explore the ways in which technology can support people with both severe and enduring – as well as milder – conditions. Preconceptions (for example that community alarms and the like are only for older and physically disabled people; or that alarms which provide spoken alerts are unlikely to be used by people who 'hear voices') should be aired and challenged. Assuming that participants will already be working in the field of mental health, the key learning points will include:

- being aware that the successful introduction of telehealthcare depends on understanding the individual nature of the patient's illness and related needs. It is important to find out where the person is in relation to technology, and not to make assumptions. For example, do they already use a mobile phone or have a laptop?

- being open to new and changing ways of providing support and treatment. Talking therapies that are delivered face-to-face may not be the only way and may not always be the best way

Gather together any thoughts and initial reactions at this stage without looking for conclusive ideas. Some of the definitions may be new to participants, and time is available to ask questions about these throughout the day. Reassure participants that they will have the opportunity to apply these to practice later.

10.45 Break

11.00 How can telehealthcare help support people who have a mental illness?

This should be an opportunity for participants to see pictures or DVDs of equipment, and if possible to actually touch and feel different examples. It is important to explain

the kind of support needs for which pieces of equipment may be useful, and to talk through the kinds of therapies that can be delivered using other media, such as via mobile phones and the internet. Also describe services or applications which have been trialled, but are not yet in the mainstream.

Local providers and suppliers may offer to put on a display of equipment, at no charge. If there is a local 'smart house' or videoconferencing facility it may be possible to hold the training session there – or to organise a visit at the end of the day or during the lunch break. It may also be possible to arrange computer access to some of the online services described earlier. Participants with smart phones can download relevant applications.

Ask the group to look at the illustrations of equipment and apps featured in this guide and to share their ideas about each item's uses and limitations. Participants may have additional valid suggestions based on their own experiences. Ask the group to

split into pairs and think about a person they know who may benefit from some of these adaptations or interventions, along with someone who would be unlikely to benefit from them. What might the risks be?

12.00 Case examples: telehealthcare in practice

In this session, participants may look at a variety of different scenarios in pairs and think further about what options would be useful. It is also important that they think through the implications – for example:

- what is the need that is to be met (the importance of careful assessment; avoiding simplistic solutions; not 'just giving out bits of kit')
- the different perspectives of the service user; their family and support staff
- differing attitudes to risk

- how telehealthcare can supplement other kinds of support but is not intended to replace them
- the importance of maximising levels of independence and retaining personal skills
- promoting proactive self-management of long-term health conditions or learning disabilities
- encouraging/enabling individuals to remain in their own homes/communities for as long as is safely possible
- fostering a feeling of security for individuals and their families
- improving quality of life
- providing greater choice

Ideally, participants will share their own experience and cases with colleagues. This guide also contains some case examples which can be used as an alternative, or in conjunction with participants' own experience. The trainer will need to decide how

best to use some or all of these – perhaps giving the initial scenario first, then comparing the solution suggested in the guide with the group-members' own ideas.

The importance of good assessment

Encourage debate about how telehealthcare contributed to the support of the individuals in the case examples in the following ways:

- draw out the importance of good assessment. Refer to the section on assessment in this guide. If necessary, develop a handout or use an example of a local assessment tool
- make sure risk is considered, as well as need
- highlight the differing concerns and benefits as seen from different points of view
- bring any difficult issues into the open, such as staff reluctance or how carer concerns should be addressed

- highlight what the problem is and who the telehealthcare is intended for. Are there consent issues, or differing perspectives on risk, need, capacity or consent?

13.00 Lunch

14.00 Telehealthcare may be the solution ... but is it 'right'?

This is an opportunity to discuss with participants the rights and wrongs of using telehealthcare, looked at from their own perspective, as well as their employer's and professional perspectives. Chapters 2 (Assessment) and 3 (Principles, rights and ethics) may provide the basis for a short introductory talk. Alternatively, this could be an interactive session in which the following kinds of questions are posed:

- telehealthcare can involve the monitoring of people's private lives. Is that 'right'?

- some equipment restricts people's freedom to do as they want or go where they want in order to 'protect' them. What is the right balance between risk and protection and how do we achieve it?
- telehealthcare can be used to support a 'normal' lifestyle – getting up in the morning, going out during the day and going to bed at night. Is telehealthcare being used to 'impose' a conventional lifestyle?

Participants need to be clear about the legal constraints on this (and any other) part of their support service. They have a responsibility to make decisions that are both ethically defensible and legal. An approach based on individual assessed needs will always present ethical dilemmas which need to be resolved.

15.00 Policies, procedures, and strategy to support the use of telehealthcare

This session provides an opportunity for participants to explore and gain a better understanding of local policy and procedures. It should include discussion of local assessment tools to ensure that participants understand when and how telehealthcare can be introduced into the assessment process. Local procedures for accessing telehealthcare, as well as for installation, testing and responding to call-outs, should be discussed and explained, along with charging policies and budgets.

It may also be useful to discuss local strategy. How does the use of telehealthcare fit with local joint strategies for people with mental health problems? If time is available, it will be helpful to look at the national strategy too and discuss how telehealthcare can contribute to national policy goals such as Shifting the Balance of Care. (Resources are available on the National Telecare Development

Programme website – www.jitscotland.org.uk/action-areas/telecare-in-scotland/)

16.15 Conclusions and evaluation

Ask the group if the discussions they have had during the afternoon have influenced the way they would now approach the case examples introduced earlier in the day. Do they now feel more confident about making a recommendation and supporting a person with mental health problems to make an informed choice about telehealthcare?

Summarise and ask what the participants will take away from the day. The discussion could include areas of new technology and the potential for the future use of telehealthcare as a way of supporting people with mental health problems.

Additional resources

For further information about telehealthcare and the National Telecare Development Programme in Scotland, please contact the Joint Improvement Team via their website: <http://www.jitscotland.org.uk/action-areas/telecare-in-scotland/>

Telehealthcare services online

Websites

www.edspace.org.uk is a website designed to provide information about local and online resources for people experiencing mental health difficulties, their carers, professionals and anyone with an interest in mental health and wellbeing.

www.needs-scotland.org. Based in Aberdeen, NEEDS Scotland offers information about eating disorders, including support and encouragement in a safe, caring and confidential environment. It aims to help ease the isolation many people with eating disorders and their carers feel.

Information and general advice from the Disabled Living Foundation: <http://www.livingmadeeasy.org.uk/telecare-167/>

Telehealthcare in Scotland (NHS Education for Scotland):

<http://www.knowledge.scot.nhs.uk/telehealthcare.aspx>

Consumer reports on telehealthcare equipment: http://www.ricability.org.uk/consumer_reports/at_home/;

http://www.hft.org.uk/What_we_do

http://www.hft.org.uk/What_we_do

The AT Dementia website brings together information about assistive technology that has the potential to support independence and leisure opportunities for people with dementia: <http://www.atdementia.org.uk/>

Telecare Services Association (TSA):

<http://www.telecare.org.uk>

Centre for Usable Home Technology:

<http://www.cuhtec.org.uk/>

Centre for Accessible Environments:

<http://www.cae.org.uk/>

Enable: <http://www.enableproject.org/>

www.alvolution.co.uk Alvolution's technology finder is an independent, unbiased, comprehensive product comparison website, developed by health and social care commissioners to help with the selection of assisted living technologies for their service users patients

Scottish Centre for Telehealth :

<http://www.sct.scot.nhs.uk/>

Money Saving Expert:
www.moneysavingexpert.com/mentalhealth

DVDs

Telecare – supporting Scotland: a different approach.
DVD which includes seven 'digital stories' illustrating, in the words of users and carers, the impact of telecare.
Available through <http://www.jitscotland.org.uk/action-areas/telecare-in-scotland/>
Telecare for unpaid carers: 'A Weight off my Mind'
<http://www.carersscotland.org>
Telehealth in Action. Scottish Centre for Telehealth:
<http://www.sct.scot.nhs.uk>

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Supplier contact details

The images of equipment featured in this guide represent a small subsection of the range currently available. The contact details below have been included to assist purchasers in assessing what is available from whom, but in many cases the same device is available from more than one supplier. The publishers in no way endorse any particular supplier or product. The lack of inclusion of a particular product does not imply that it is inferior to any device featured. Purchasers are responsible for researching the full range of products available and reaching their own conclusions about what is most suitable for them or their clients.

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