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Research Article

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Telepsychiatry Services During Covid-19 Pandemic: Findings And Learning From A Tertiary Hospital Setting

Anjali Sharma

Department of Psychiatry, Lady Hardinge Medical College, New Delhi, India

Corresponding author
Anjali Sharma, Department of Psychiatry, Lady Hardinge Medical College, New Delhi, India

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ABSTRACT

Background and Aims: The COVID-19 pandemic had a significant impact on the mental well-being of the people and has presented numerous challenges in accessing mental health treatment. Telepsychiatry has been empirically demonstrated to be an efficacious method for providing mental healthcare. We share our experience of using telepsychiatry in providing mental health services in a tertiary hospital in Northern India.

Methods: A retrospective chart review of data that has been recorded for telepsychiatry services during the period April 2020–March 2021.

Results: During the specified period, 188 patients were enrolled, with 112 (59.57%) females and 76 (40.42% males). The majority were aged 21-30 years (29.78%), followed by 31-40 years (26.59%), and over 60 years (17%). 177 patients (94.14%) were from Delhi, while 11 (5.85%) were from outside the city. Bipolar affective disorder was the most common diagnosis among individuals aged 10-20, followed by depression in the 21-30 age group, followed by bipolar affective disorder in the 31-40 age group, depression in the 41-50 age group, adjustment disorder in the 51-60 age group, and finally, depression in the over-60 age group. These findings highlight the diverse age groups and varying levels of mental health issues.

Conclusion: Telepsychiatry has significantly improved mental healthcare and has been viewed as a future option for routine follow-up care, ensuring the maintenance of mental healthcare.

Keywords: Covid-19, Pandemic, Telepsychiatry, Telemedicine, Telecare

Introduction

Using information and communication technology to deliver mental health care remotely is known as telepsychiatry, and it has been used for more than 50 years. In 2001, the Indian Space Research Organization (ISRO) launched a telemedicine pilot project that connected Chennai's Apollo Hospital with its rural counterpart in Aragonda village, in the Chittoor district of Andhra Pradesh. Despite its early beginnings, telemedicine is still relatively new in India [1]. Since then, telemedicine services have been offered by numerous institutions. The Schizophrenia Research Foundation (SCARF) telepsychiatry in Pudukkottai used internet and mobile bus services to connect patients with mental illness in the villages to the psychiatrists in the central hub. Of particular note are the telepsychiatry services offered by the Postgraduate Institute of Medical Education and Research (PGIMER), Chandigarh, which created a computerized diagnostic support system to standardize the diagnosis and treatment of psychiatric disorders, and the National Institute of Mental Health and Neurosciences (NIMHANS), which uses Project ECHO (Extension for Community Healthcare Outcomes, developed in New Mexico) to manage substance use disorders and train counselors about quitting smoking [2,3]. However, these initiatives were unable to bridge the gap between researcher's views on the importance of telemedicine and its actual utilization in India. Insufficient resources, tardy policymaking at the national as well as state levels, poor acceptance among patients as well as medical professionals, and unresolved medico-legal issues, all contribute to this situation [4]. The release of the telemedicine and telepsychiatry guidelines came as a timely measure during this COVID pandemic, as it helped to reach the unreached during the restrictions [5].

Delivery of mental healthcare services during the novel coronavirus disease (COVID-19) pandemic was challenging, particularly in the low- and middle-income countries [6]. Telepsychiatry services proved to be a practical alternative for providing mental healthcare globally, especially during periods

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of travel restrictions, physical distancing, lockdown, and physical isolation [7]. Mental health professionals (MHPs) used technology to assess and treat the patients without increasing the risk of infection to service providers or the patients. This also includes providing assistance to nonpsychiatric clinicians in managing matters related to mental health issues. As an approach to prevent the spread of COVID-19 infection, nationwide lockdown was implemented on March 24, 2020 by the Government of India. To adhere to the physical distancing mandate, routine non-emergency services were stopped by most of the hospitals. Telemedicine Practice Guidelines were issued by the Ministry of Health and Family Welfare, Government of India, on March 25, 2020, enabling healthcare practitioners to manage patients who could not reach the hospitals [8].

Amidst the COVID-19 pandemic, different institutions in India implemented innovative telepsychiatry methods to provide a seamless provision of healthcare services. These techniques included tele-triaging and stepwise telemedicine assistance [9]. The Telemedicine Society of India and the Indian Psychiatric Society, in collaboration with NIMHANS, provided recommendations for the operational approach of telepsychiatry services in India, which helped in their widespread implementation across the country [10]. With the aim to provide accessible, affordable, and quality mental health services to individuals across the nation, Tele MANAS (Tele Mental Health Assistance and Networking Across States) program was launched on October 10, 2022 by Government of India. It offers free, 24/7 mental health support through phone-based services, ensuring that individuals across India can easily access the help they need. We share our experience of using the telemedicine approach in providing mental health services at a tertiary care hospital in India during the COVID-19 pandemic, following the break in routine outpatient services during the national lockdown.

Objectives

Socio-demographic and clinical profile of patients availing of telepsychiatry services in a tertiary care hospital.

Methodology

This was a retrospective chart review of data that has been recorded for telepsychiatry services during the period April 2020–March 2021 where COVID-19 lockdown was imposed and routine hospital consultations were at a halt. As this is a retrospective chart review, the sample size was not calculated. Diagnoses were made based on clinical evaluation and mental status examination as per ICD-10. Existing data were entered in a Case Record Form regarding following domains:

1. Socio-demographic profile
2. Findings of clinical evaluation and mental status examination
3. Diagnosis
4. Pharmacological treatment received or
5. Non-pharmacological intervention advised

Ethical clearance: Ethics permission was taken before the study from the Institute Ethical Committee. The entire process of data was completely anonymous.

Statistical Analysis: All the information related to the above variables retrieved and entered in an Excel sheet, followed by the coding of all the data. The descriptive statistics like mean, median, frequency, and percentages subsequently estimated using Statistical Package for the Social Sciences (IBM Corp., Released 2022. IBM SPSS Statistics for Windows, Version 29.0. IBM Corp. Descriptive statistics provided for socio-demographic and clinical characteristics of the individuals as mean and standard deviation (SD) for continuous variables and frequency and percentages for categorical variables.

Results

Sociodemographics

- **Sample characteristics:** The data was comprised of one hundred eighty-eight patients, out of which one hundred twelve (n=112, 59.57%) were females and the rest were males (n=76, 40.42%). The majority of the participants belong to the age group of 21-30 years (56 (29.78%)), followed by 31-40 years (50 (26.59%)) and 21 (11.17%) belonged to the age group of 41 – 50 years. 177 (94.14%) of patients belonged to Delhi, and rest 11 (5.85%), were from outside of Delhi. (Table.1)
- **Patient profile in telepsychiatry:** One hundred nine patients (42.24%) have been on follow up from online services, 119 (46.12%) are on follow up from offline services, and 30 (11.62%) new patients have enrolled from the telepsychiatry services.

Table 1: Sociodemographic (n=188)

Age	10 – 20 years	13 (6.9%)
	21-30 years	56 (29.78%)
	31-40 years	50 (26.59%)
	41-50 years	21 (11.17%)
	51-60 years	16 (8.51%)
	>60 years	32 (17.02%)
Gender	Female	112 (59.57%)
	Male	76 (40.42%)
Residence	Delhi	177 (94.14%)
	Outside Delhi	11 (5.85%)

Diagnostic profile

- Diagnostic profiles of patient attending services through telepsychiatry has been mentioned in the table 2. Majority number of patients belonged to the diagnostic rubric of mood disorders (n=81), followed by schizophrenia and other psychotic disorders (n=31) and then other disorders. Among the substance use disorders, alcohol dependence syndrome (n=9) was maximum followed by tobacco dependence (n=2).
- The prevalence of patients with a specific diagnosis varied across different age groups. In the age group of 10-20 years, bipolar affective disorder was the most prevalent diagnosis. Among individuals aged 21-30 years, depression was the most common diagnosis. In the 31-40 age group, bipolar affective disorder was the most prevalent diagnosis. Among individuals aged 41-50 years, depression was the most common diagnosis. In the age group of 51-60 years, adjustment disorder was the most prevalent diagnosis. Lastly, among individuals aged over 60 years, depression was the most common diagnosis.

Table 2: Diagnostic profile of the patients (n=188)

No.	Diagnosis (ICD-10)	n (%)
1.	Depressive Disorder [F32]	43 (22.87)
2.	Bipolar Affective Disorder [F31]	38 (20.21)
3.	Schizophrenia and other psychotic disorders [F20/F23/F29]	31 (16.48)
4.	Other anxiety disorders [F41.0/F41.2/F41.9]	19 (10.10)
5.	Obsessive-compulsive Disorder [F42]	14 (7.44)
6.	Adjustment Disorder [F43.2]	11 (5.85)
7.	Mental and behavioral disorders due to use of alcohol [F10]	9 (4.78)
8.	Mental and behavioral disorders due to use of tobacco [F17]	2 (1.06)
9.	Dementia unspecified [F03]	5 (2.65)
10.	Sexual dysfunction, not caused by organic disorder [F52]	5 (2.65)
11.	Non-organic sleep disorders [F51.0]	5 (2.65)
12.	Dysthymia [F34.1]	2 (1.06)
13.	Hypochondriacal Disorder [F45.2]	2 (1.06)
14.	Dissociative Disorder [F44]	1 (0.5)
15.	Mental and behavioral disorders due to use of opioids [F11]	1 (0.5)

Treatment

- Treatment offered to patient: Among the patients who were following through the telepsychiatry services. 120 (63.82%) received the same treatment on which they were on already on, 39 (20.74%) had modifications done in their ongoing regimen, and 29 (15.42%) were started on newer medications.
- Special conditions: For four patients, special arrangements were made as mentioned in table.3.

Table 3: Special treatment arrangements for patients

No.	Sex	Age	Patient type	Address	Diagnosis	Treatment	Special
1.	F	>60 years	Follow up from offline service	Delhi	Schizophrenia	Same	Injection of paliperidone 75 mg monthly in liaison with a nearby General Physician
2.	F	21-30 years	Follow up from offline service	Delhi	Schizophrenia	Modified	Newly pregnant
3.	F	31-40 years	Follow up from offline service	Delhi	BPAD remission	Same	Injection Haloperidol 50 mg 2 weekly in liaison with a nearby General Physician
4.	F	21-30 years	Follow up from offline service	Delhi	BPAD depression	Modified	Advised in person consultation (suicidal ideation)

Discussion

The institute developed standard operating procedures (SOPs) for delivering telepsychiatry services. The patients who were previously registered were contacted via smartphone devices and asked if they were willing to participate in a telepsychiatry consultation. Prior to the teleconsultation, the patient's identification was confirmed by utilizing the distinct identification number associated with the registered mobile phone. An assessment was conducted to analyze the patient's present health requirements, proficiency in utilizing technology, possession of a mobile phone, type of mobile device, and connection to the internet. Patients were assessed using audio or video conversations and short message services, depending on their convenience. Subsequently, digital prescriptions were given via text messages.

Following the resumption of regular outpatient services after the lockdown, telepsychiatry was maintained as an alternative service for patients requiring follow-up. Patients requiring a physical evaluation were advised to go to the hospital. Moreover, telepsychiatry treatments were provided to patients who had concerns about contracting COVID-19, resided in remote locations, and faced difficulties in traveling. The implementation of tele-consultation in routine services involved modifying the interview rooms in outpatient clinics to ensure physical separation during patient interviews. The clinician conducted the interview with the patient and informant using video chat technology, connecting two separate rooms with PCs via a local area network. Though the patients were only 188 but the implementation of telepsychiatry gave a deeper understanding to the accessibility of mental health services that can be done.

A comprehensive analysis of several studies has demonstrated that telepsychiatry is a dependable method for evaluating and diagnosing individuals with mental illness [11]. India has a wireless mobile phone connectivity of 1140.71 million people, resulting in a tele density of 84.38 percent. The rate of internet adoption in India is also on the rise, with a quarterly growth rate of 0.79 percent [12]. Given the wide range of digital resources available in the country, patients were provided with a variety of options for telepsychiatry services. Telepsychiatry services have facilitated the provision of uninterrupted mental healthcare to patients residing in remote areas of the country, thanks to the widespread access to the internet in both urban and rural regions. Prior to this, India has utilized different telepsychiatry service models largely to facilitate the availability of mental health practitioners (MHPs) in distant and underserved regions [13]. Previous models mostly relied on specialized psychiatrists providing feedback to primary care physicians. However, recent advancements have allowed for the integration of these services into regular patient care [14].

On exploring the literature in Indian scenarios, there is a dearth in literature, specifically during the COVID-19 pandemic period. Limited publications are there. One study conducted in a tertiary care hospital in Northern India showed that during the four months of regular outpatient service closure (March 30 to July 31, 2020) a total of 2401 tele-consultations were provided. This covered 64% of the booked appointments during this period. The reasons for the remaining 36% unsuccessful consultations included unavailability of mobile numbers (3.7%), incorrect phone numbers (4.8%), inability to reach the number (14.4%), and unattended calls (12.8%). The

percentage of successful teleconsultations improved from 51.4% in April to 81.9% in July 2020 [15].

In another study conducted from another tertiary care hospital in Eastern India, a total of 109 patients availed telepsychiatry facility and had 168 telepsychiatry consultations during a specified period of six months from April 2020 to September 2020. Males (62.4%) opted for more than females (37.6%). Highest (>20,000 INR/month) (48.6%) and lowest (<5000 INR/month) (21.1%) income groups were two most common income groups among those who availed of telepsychiatry consultations. While the highest income group might be having better access to technology, thereby availing the facility; the lowest income group might use the facility to avoid other costs like travel costs and to save time, which might affect their daily income and productivity [16].

According to Das et al., majority (96%) of the patients regarded telepsychiatry as a satisfactory method for receiving psychiatric consultations as a follow-up. Convenient access to mental health care may be the primary determinant of the acceptability of telepsychiatry. Telepsychiatry is a cost-effective method that reduces indirect expenses, such as time lost from visiting the hospital, travel time, and travel fees [3]. Moirangthem et al., demonstrated that telepsychiatry was more cost-effective than in-person tertiary care services [17]. Thara and Sujit have emphasized the challenge of acquiring psychiatric drugs from rural pharmacies in India [18].

Telepsychiatry services can be more effectively implemented if peripheral centers, such as primary health centers, can ensure the availability of pharmaceuticals by consistently keeping supplies of the necessary psychiatric medications. Telepsychiatry, while recommended as a useful tool during sudden healthcare service lockdowns, still encounters specific challenges that must be addressed in the future. These challenges include the acceptance of technology as a substitute for in-person visits, ensuring a comprehensive virtual assessment of physical and mental health, maintaining professional competence, validating prescriptions, and dealing with inconsistent network connectivity. Future research in this sector should include capacity building in addition to expanding its clinical utility. The telemedicine strategy for mental healthcare services has the potential to be utilized in LAMI nations worldwide, particularly in regions with limited mental health resources and where patients must travel significant distances for in-person consultations.

Conclusion

The demand for telemedicine and telepsychiatry services has increased due to the COVID-19 pandemic, necessitating a comprehensive analysis of their strengths and weaknesses. One should aim to strike a balance between technological innovations and ethical principles to ensure equal access to care for all, regardless of social and financial status. They suggest promoting national legislative initiatives and international sharing of information to optimize and harmonize telemedicine-based care. Addressing the digital divide is crucial for upholding the universal human right to health and ensuring access to care for all patients.

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