

Connect

the newsletter of the computers in psychiatry special interest group



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Welcome

The Mental Health Information Strategy published in March 2001 set out the pathway towards the adoption of the Integrated Mental Health Electronic Record (IMHER - the mental health equivalent of electronic patient records, or EPR) by all Trusts by 2007. In Trusts where clinicians still do not even have access to a PC this seems like a tall order.

The serious lack of funding for IT in mental health over many years has led to learned helplessness and NHS staff accepting extremely poor standards. A friend of mine who works in IT in the City talks about support response times of *up to* 2 or 3 hours. My experience has often been more like 2 or 3 weeks. To access my patient's history or look up a lithium level from any site within a Trust 24 hours a day, is merely to practice good and safe psychiatry but it does require adequate hardware, infrastructure and support services. Let's hope that the Wanless Report's recommendation of a doubling of IT spending will impact on this.

I'm afraid we can't suggest any immediate solutions to these problems but we do have words of advice in the 'library' section of our website (www.rcpsych.ac.uk/cipsig). We also have an online discussion board where the aim is to provide an informal arena for the exchange of ideas, whether it be "how do I get rid of that annoying toolbar when my computer starts" or "my recommendations for level 6 EPR". CIPSIG has for some years run computer workshops at the College Annual Meeting and this year is no different (see below for our selection from Cardiff). We

are also planning future meetings including a conference in 2003.

So what can be found in this issue of Connect? There is practical advice from Stuart Leask on the clinical uses of email as well as a review of psychology provision to remote areas by video-conferencing written by Susan Simpson. Fionnbar Lenihan reminds us that despite the government's apparently cosy relationship with a major software company, we do have alternative and free software options - a point also touched on in Conor D'Arcy's article on databases. Whilst I urge you to consider the need to backup your computer data, Adrian Blaj provides a new suggestion for ICD10; a humorous article with a serious point - technophobia is a significant barrier to the adoption of the IMHER.

If you are looking for a little extra reading you may have noticed a new series on Informatics in *Advances in Psychiatric Treatment*. Prof Cornelius Katona's editorial in May 2002 explains what the series will cover and Dr Alex Lewis kicks the series off with a look at coding systems & EPR.

We are currently seeking contributions for future issues of Connect. We aim to cover topics such as electronic prescribing, the Data Protection Act & EPR systems. Details may be found on our website. Finally, we will be based in the CyberCafé at Cardiff this year and we're keen to meet our members so please drop by for a chat!

Matthew Evans
Chair, CIPSIG

Cardiff 2002

CyberCafé
Free Internet access in the Green Room

Monday June 24th
Getting the most out of the Internet
Dr Martin Baggaley & Dr Martin Briscoe

Tuesday June 25th
Getting the most out of the Internet
Dr Trevor Hicks & Dr Martin Baggaley

Wednesday June 26th
Creating web pages on the Internet
Dr Martin Briscoe & Dr Sudhir Kaligotla

Wed. cont.

Getting the most from the College's online journals
Mrs Lucy Alexander

Thursday June 27th
Creating web pages on the Internet
Dr Sudhir Kaligotla & Dr Martin Briscoe

12.30 - 1.20pm CIPSIG Business Meeting

Clinical Information Systems: It's not what you say:- the future of clinical communications
Prof Roy McClelland & Dr Martin Elphick

Building Web Pages with HTML
Miss Lynn Reynolds



Dr Stuart Leask
Duncan Macmillan
House
Nottingham

**" young
people
speaking
Martian,
wearing
short-
sleeved
shirts and
loud ties"**

clinician.com

In this giddy world of ever-expanding information technology a lot is written about the value of these developments to the jobbing clinician. However, much that is described about online databases, web-based user forums and search engines is perhaps of much more use to a patient with time on their hands than to a psychiatrist juggling meetings, research commitments, clinics, ward-rounds and emergencies. I therefore felt it would be useful to describe a recent experience I had working in a real job with real academic commitments and with a real community team, and how IT made it all much more doable.

My confession is that I am an enormous fan of email, used properly, and check my email hourly most days. With wireless email devices fitting in a shirt pocket nowadays (eg. www.handspring.co.uk), this can be true even for colleagues who cannot bear to stop pacing swiftly down corridors holding some papers and a sandwich.

The first thing I noticed was a real commitment to IT. The community team had their own software support engineer and their own network, which immediately gave everyone a sense of ownership - IT wasn't beige boxes being delivered to team bases by young people speaking Martian, wearing short-sleeved shirts and loud ties, it was something their team did better than anyone else. As a consequence, even the meekest team member, barely able to type with one finger, felt that this was something that empowered them. And empower it did.

Despite my contract clearly describing only four face-to-face clinical sessions a week, patients actually had the nerve to develop problems at other times. Normally this would either leave keyworkers having to buttonhole one of my colleagues, or track me down by telephone and spend 25 minutes off-loading the minutiae of the situation (as, wherever I was I invariably would not have access to my last clinic letter). With this system, however, the 25 minutes could be spent by the keyworker composing a message containing the facts, the risks and what needed doing from their perspective. We all read much faster than we type, so I could then digest such a message in 90 seconds or less. A brief reply usually sufficed, such as "Go ahead!", or "Put them in clinic on Friday morning" or "I can visit them with you on Thursday at 1.30", or even "I have no flexibility today - the duty doc will have to deal".

The team found that this degree of access to RMO opinion was worth the effort of typing the email, as matters could be moved on without interminable anxiety-ridden discussions after hours of trying to track folks down.

The advantages of clinical team email over that ghastly monster of modern life the cellphone seem to be:

- ◆ Emails do not interrupt research meetings or patient consultations. They do not need 'right this second' attention the way a 'phonecall does. The way even a 'phonecall about something utterly trivial does...
- ◆ Emails can cope with the "Just to let you know" type of communication with no interruption at all.
- ◆ Email contents can be noted without having to reply immediately - very useful if thinking time, or communication with someone else before replying, is worthwhile.
- ◆ Typing an email is slow, which concentrates the mind; a useful discipline for those of us in this most prolix of specialties.
- ◆ Putting together an email gives much more scope for prioritising, both information and demands for input.
- ◆ Most email systems will report if there is a problem delivering the message, and can be configured to send a reply confirming that the message has been opened, which are both improvements over sticking a post-it note to someone's door.
- ◆ Emails make the whole system 'self-documenting', exchanges being readily printed out and filed in the notes.

There are however several important rules to make email in the clinical environment work:

1. DO NOT set the 'Priority' flag. Everyone thinks their email is important, that's why they're sending it, but the importance to the recipient will inevitably differ from the importance to the author. Just don't use them, they impart no useful information in my experience.
2. Use the Subject field for what it says, the subject, for example "KG needs sectioning NOW". Resist the temptation to see it as a "Order:" field ("READ NOW!"), or even that delightful "Critique:" field ("Important message"). How terribly informative that last one is. Again, the recipient must be allowed to triage, which is much quicker if the Subject fields are informative.
3. Have a second account for 'circulars', so the only incoming email is that which is being sent to you in person. Alternatively, ask that your main email address is left off all group lists, have a second one and then put these into a different mail folder. And promise that this other folder isn't called 'Trash'...

Number 3 is the most important clinically - if

you're checking your email for stuff of clinical importance several times a day you do NOT want to have to wade through "Invite to a Nite Out" and "Report needed for Monday" etc. Administrators and Managers often take umbrage at the suggestion that their emails are not important, but I would suggest that they are invariably less of a priority to a clinician than "PB says he wants to come into hospital now - or he'll strangle his cat".

(Finally, before you move to wholesale use of clinical email, check that your system is secure. Email between users on an internal network is usually OK. Email between different networks or to people's home accounts usually isn't. If in doubt, check. Either way, use of eg. patient

initials only, leaving out patient addresses and 'phone numbers helps, as information then becomes only meaningful to those involved with that case anyway. Numerous encryption methods are also available.

So, there we have it. Email, used responsibly by a whole team, can change your life. It can increase your perceived (but not immediate) availability, while actually being far less of an intrusive burden than bleep or 'phone.

I have seen it work, and it wasn't even California, it was Nottingham...

[Declaration of Interest: The author does not own a Handspring Treo. Yet.]

The use of Videoconferencing in Mental Health

Although the treatment of mental health problems has traditionally taken place in a face-to-face setting within the clinician's office, this model of treatment delivery discriminates against patients living in remote and rural areas. In countries such as Scotland, access to mental health services is impeded by vast distances between communities, and other geographical barriers such as severe weather conditions and remote islands. Most specialist mental health services are based in major cities, as working in remote communities can often lead to professional isolation and a reduction in training opportunities. Patients are therefore required to travel to gain access to treatment, which is often expensive and disruptive to their daily work and family commitments. For patients who are frail, or who have physical disabilities the prospect of travelling long distances for treatment is even more problematic.

What is known about video-therapy?

To date, most research has focused on the feasibility and acceptability of providing psychological services via videoconferencing, focusing on subjective measures of self-report from health professionals and clients. Little has been conducted to investigate the effectiveness of interventions for specific psychological disorders. Various studies have reported high levels of reliability for psychiatric assessments and rating scales conducted via videoconferencing with patients with schizophrenia (Zarate et al., 1997), and obsessive compulsive disorder (Baer et al, 1995). McLaren et al. (1996) reported that clients with schizophrenia were satisfied with videoconferencing psychiatric consultations, and some found that this actually facilitated communication (McLaren et al., 1996). A recent study in the Highlands of Scotland offered

videotherapy to both adults and children, and results showed that they were satisfied with the service, although a third indicated that given the choice they would prefer face-to-face sessions (Freier et al., 1999).

Recent studies have found therapeutic alliance to be similar for both face-to-face and videoconferencing psychotherapy sessions (Simpson, 2001; Ghosh, McLaren & Watson, 1997). Nagel and Yellowlees (1995) reported that empathy and warmth can be transmitted via videoconferencing, and Allen et al. (1996) found that clients often feel that they have a greater sense of control than with face-to-face therapy due to being able to move out of the view of the camera or even out of the room, and being able to switch off the equipment if they wished. Another advantage of videotherapy sessions is that they tend to be more task-oriented and structured, better prepared, and are less likely to be interrupted than face-to-face sessions (Gammon et al, 1998).

Although clinicians are often more apprehensive about communicating via videoconferencing than clients, this initial reluctance tends to recede with practice and experience (Nagel and Yellowlees, 1995). Clinicians can learn to use additional helpful skills such as the process of turn-taking, but mostly find that they can continue to use their usual therapy techniques whilst consulting via videoconferencing (Omodei & McLennan, 1998).

The development of the 'Remote Psychological Therapies Service' in Aberdeen

A videoconferencing link was established between the Psychology Department of Royal Cornhill Hospital in Aberdeen and the Mental Health Department in the Lerwick Health Centre in Shetland in 1998 to facilitate consultations. Evaluation of this link for use with psychological therapies was undertaken and published (Simpson, Deans & Brebner, 2001). Patients were seen for an initial face-to-face assessment by the Psychologist in Lerwick and

**"I have seen
it work, and
it wasn't
even
California"**



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those considered suitable were offered a course of videoconferencing therapy sessions. Preliminary findings of this study suggest that the psychologist and the majority of patients were highly satisfied with using videoconferencing for therapy. Some patients expressed a preference for videoconferencing sessions over face-to-face contact, as they perceived it to be less confrontational. Initial results suggest that therapeutic interventions provided by videoconferencing were effective (as measured by validated measures) for all conditions, and that a strong and positive therapeutic alliance could be developed between clinician and patients via the video-link (Simpson, 2001).

This service has recently expanded to include the provision of supervision sessions for the Shetland Community Psychiatric Nurses, and consultancy sessions with GP's and other healthcare professionals on a regular basis via videoconferencing. Additional innovations include a pilot study which looked at the feasibility of conducting hypnosis sessions with patients by teleconferencing (Simpson et al., 2002), and a new project which is evaluating the benefits of providing a tele-visiting service for inpatients at Royal Cornhill Hospital who come from Shetland and Orkney.

The Eating Disorder service also offers regular videotherapy sessions to Shetland. Funding has recently been secured from STAF (Scottish Telemedicine Action Forum) to support a pilot project which will examine the effectiveness of videotherapy for patients with eating disorders who live in rural and remote locations in the North East of Scotland, Shetland, and Orkney.

Recommendations for using videoconferencing in the provision of psychological therapies (from Simpson, S., Deans, G., & Brebner, E. (2001))

- It is invaluable for clinicians to practise using the videoconferencing equipment prior to setting up clinics, in order to familiarise themselves with the system. Learning to focus the camera to maximise the clarity of the image on the screen, and to time speech patterns to allow for delays in lip synchronisation are key tasks. Clinicians also need to learn to convey empathy in more overt ways as gestures often taken for granted (e.g. offering a box of tissues) are not feasible with videoconferencing.
- It is important to anticipate the time required outside videoconferencing sessions for administration and indirect clinical work. In this study, patients benefited from being sent handouts and formulation summaries between appointments. These were a useful reference point for sessions, and gave patients valuable materials to work on between sessions. (McGinn, Young, & Sanderson, 1995, Beck, 1996)
- Patients with highly avoidant or para-

noid personality traits may be wary of video-therapy due to difficulties trusting and fears that others may have access to viewing their sessions.

- Patients with long-term, entrenched difficulties may require more sessions, as well as additional contact and support between sessions.
- If secretarial staff are going to take responsibility for "managing" the videoconferencing equipment at the remote site, it is vital that adequate training and practice is provided before the service begins.
- When technical difficulties or breaks in communication occur, in the first instance hang up and redial, as this can often sort out the problem without the need for further action. It is essential to have technical support at least at one of the two sites. Telephone sessions can be used as a short-term interim if technical problems prevent videoconferencing link-up.
- Using the lower bandwidth videolink can occasionally make it difficult to detect changes in patients' facial expressions and to identify signs of distress. If there is access to a higher bandwidth videolink (e.g. ISDN 6) and the extra funding is available, this should be used whenever possible.
- To maximise the picture clarity, ensure a solid colour background in videoconferencing rooms, avoid wearing highly patterned clothing, and keep fast or extravagant gestures to a minimum (especially at lower bandwidth).
- Manual-based treatments can be particularly well suited to working in videotherapy, as it gives patients and the clinician a common reference to work with, and homework tasks and handouts are included, obviating the need for these to be sent out to patients each week.
- Ensure that a supply of tissues and notepads/pens is kept at the remote videoconferencing system for patients' use.
- Ensure that the videoconferencing room is soundproof, and that the sound is not turned up to such a volume that others in the waiting room can hear the sessions

A full list of references for this article is available on our website:

www.rcpsych.ac.uk/cipsig/olrefs.html

For more information see the Telemedicine Information Exchange (TIE) at tie.med.org

Forthcoming texts to be released in Spring 2003:

Wootton, R., Yellowlees, PM, McLaren, P. (eds.) *e-Mental Health and Telepsychiatry*. Publishers: Royal Society of Medicine Press.

Anthony, K. and Goss, S. (eds.) *Technology in Counselling and Psychotherapy Practice: A Practitioners' Guide*. Publishers: Palgrave Macmillan Ltd. UK.

Introduction to Free Software

In this article I want to define free software both as product and philosophy. Over the last few years the profile of free software has been raised by the commercial and technical success of the Linux operating system (a free operating system produced by a coalition of volunteers around the world) and for the first time it is seen by many as being a plausible competitor to proprietary offerings (www-1.ibm.com/linux/). In October 2000 the BMJ devoted an editorial to free software (BMJ 2000 Oct 21;321 (7267):976). There remains however, some confusion over what constitutes free software and it is this confusion I hope to dispel.

Every computer user is used to getting software for nothing. When you bought your computer it probably came with lots of stuff like web browsers, media players, maybe some office programs. Is this free software? Not really. The cost was hidden in the overall cost of the computer. Even the preinstalled copy of windows cost you a (sizeable) percentage of the total system cost.

There are other types of free software. Every now and then you download a freebie after filling in a few pages worth of personal information. This isn't really free either as you have paid in the coin of personal information. The full price will soon become apparent as your email in-box begin to fill up with "SPECIAL, UNMISSABLE, ONCE IN A LIFETIME OFFERS!!!". Many of these "free" programs also introduce so called "spyware" software to your system (grc.com/optout.htm) without your knowledge or consent. This may have implications for sensitive patient information you keep on your system (e.g. reports, summaries).

The most common kind of "free" software is the kind that wears an eye-patch and a parrot. Many people have copies of various packages that they brought home from work and installed on a home machine. Conversely it may be a favorite piece of software from home that you can't live without at the office. Or perhaps it's a CDROM "on loan" from a friend. This is not free software either. Even if you are not convinced by the moral claims of the software industry a conviction for software piracy would be a professional and financial disaster.

Free software is not just "free" in the monetary sense (though it usually is). It is also "free" in the sense that you are free to study it, modify it and pass the modified versions along (on the same terms as you received it). Some members of the quarrelsome sects that comprise the free software movement use the terms "free beer" and "free speech" to distinguish between the

two types of freedom.

Normal commercial software is released in binary form only (readable by computers but not people), making it extremely difficult to modify. Free (as in speech) software is usually released as both binary and source code (the human-readable text file which is converted into the binary). For this reason free software is sometimes called "open source" software.

Why use free software?

Well it's free. Sort of. If you have a broadband connection then both the executable program and the source code are available for download. For the majority of people in dial-up land the cheapest way to sample the joys of free software is to order a CD from somewhere like the linux emporium (www.linuxemporium.co.uk/) or at a computer fair. You will pay a few pounds for the costs of CD and packaging but you won't tie your phone up for three days!

Home users tend not to be aware of the costs of the software they use but for an institution like your hospital or a medical school with dozens or hundreds of users the cost of software licenses can rival or exceed the hardware costs.

As well as having a monetary cost, compliance with software licenses can have large "transaction costs" which are usually borne by the buyer. Innocent mistakes are easily made which can expose the organization to financial and legal penalties.

In an academic environment the availability of the source code can be of educational value. This has led to the widespread use of Linux and other free software packages in academia. While most medical educators will not be interested in delving through source code there may be advantages in using the same software base as the scientists and engineers across the corridor.

Free software is easily customized, again because of the availability of the source code. A hired programmer can easily tweak free software to produce an exact fit to your organizational needs. Doing this with commercial, proprietary software would usually be both impractical and illegal.

Free software is considered by many (www.theregister.co.uk/content/4/21853.html) to offer better security than proprietary alternatives. The availability of the source code makes it more likely that security flaws which could endanger patient confidentiality and service availability are detected early and corrected.

Proprietary software usually, though not always, makes use of proprietary data formats to store information. Free software, in contrast, generally uses well documented, open formats for data storage (e.g. ASCII, HTML, Postscript, XML). These usually have a better shelf-life



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"Free software is considered by many to offer better security..."

and do not lead to dependence on a single software vendor. Paper is always readable but for a variety of reasons it is being increasingly supplanted by electronic formats. If we allow these electronic formats to be dictated by a few large corporations there is a danger that in a decade or so we will be unable to pull old case-notes or

conduct retrospective research and audit.

It costs nothing, literally, to try free software. In a later article I will try to review some popular free software packages that you can try yourself.

Database or Databoss?



Conor D'Arcy

works in a senior IT audit capacity for a major Irish financial institution. He has many years experience in the IT industry and was awarded an MSc in Health Informatics

Introduction

Have we become slaves to the data that is intended to support us in our work? So much time is spent on data entry, data verification and attempting to extricate useful information from unwilling data storage mechanisms, that recourse to Post-It® s and spiral notebooks are attractive even to the most enthusiastic technophile. On these occasions, the database designers seem to have no idea what we, the users, want or what the aim of the information system is.

In many cases, this is entirely true. The system may have been commissioned so long ago that the current usage was entirely unforeseen (how many twenty-year-old applications were internet enabled from the start?). Thus labour-intensive workarounds are necessary to get information to the user.

User requirements may have been translated into functional specifications and then to technical specifications through a disjointed series of 'Chinese Whispers', leading to an end result that does not solve the original problem. Or if user is in direct contact with the database developer, they may end up with many discrete systems that cannot communicate with each other, so time is wasted daily re-entering data.

Understanding the cause is only the first step in inverting the user/database relationship from servant/master to master/servant. In this article, we'll look at three levels of achieving this:

1. Understand some of the technical choices, so we are in a better position to know what to ask for, or respond to our supplier or developer.
2. Understanding more of the technical aspects of each choice means that we may not have to ask a developer, rather we can ask the database itself for the information we need.
3. Be clear on what the aims of the database are, to ensure we get what we need

Unstructured or Relational

Post-Its are good examples of unstructured databases. Data can be written anywhere on the

sheet, in any format, about anything. But given a list of random sheets, it would be very difficult to index them, or quickly search through them for an answer to a specific question. Transposed to the electronic arena, simple text files are good analogies for unstructured data. They are not an efficient system for managing a large set of data.

Most database management systems (DBMSs) today are based on the relational model, hence are termed RDBMSs. These are fast, efficient and allow easy data storage, data retrieval and creation of powerful searches using Structured Query Language (SQL).

SQL is a global standard that is supported by a huge number of RDBMS vendors. In theory, this means that it should be easy to switch from one RDBMS vendor to another. In practice, many vendors add in 'extensions' that facilitate execution of certain tasks, but also tie in the buyer to that vendor. SQL allows both definition of data (create tables, alter tables etc) and manipulation of data (select, insert, update and delete data). This combination, with a well-designed database, can empower the user to do anything! Thus users should look for an RDBMS and as far as possible ensure that the SQL used is standard. For those who do wish to bypass developers and go direct to the database, www.sql.org is a great source of SQL information.

Pros and Cons of some RDBMSs: Oracle, DB2, MySQL, Access, Cloudscape

Oracle claims to be the RDBMS market leader. Certainly, there are many developers who are familiar with the product, so finding a Database Administrator (DBA) is always possible. Oracle provides a language, PL/SQL, that allows the developer to use powerful non-SQL-standard features of the database. However, both the product and Oracle DBAs can be expensive for a small project.

DB2 is IBM's RDBMS offering. While not as popular on smaller platforms such as NT, it is fully SQL compliant and has the world's largest computer company backing it. It is available on a huge number of platforms and finds favour in very large organisations. Like Oracle, it is scalable, reliable, fast and very configurable.

MySQL is a free database (see www.mysql.org) which has evolved from limited functionality on a UNIX environment to a stable offering on

many UNIX and Microsoft platforms. As it is free, it is great for experimenting on a single machine or in a small department but also works well in production.

Microsoft Access is only available on Microsoft Platforms (i.e. Windows). It is popular as it comes as part of some Microsoft Office variants and has tools that allow easy development of attractive user screens or using Microsoft VisualBasic. However, it is not regarded as being as stable as those above, nor scale to as many users concurrently, nor does it support anything other than Microsoft platforms. Compatibility between versions of Access can raise issues.

Cloudscape is another free database, installed with Java® 2 Enterprise Environment (java.sun.com/j2ee/) It is free and available on as many platforms as Java itself. It allows both standard SQL queries and integrates well with Java programs. This is also a good choice for experimenting with and testing your SQL queries.

Application Aims

In choosing an RDBMS, take account of who will be using the system and how long you expect to be using it for. All of the above have some mechanism for data manipulation through a web browser (fast uptake and reduced training costs). A free system might suit for a small 6 month survey, where only summary results are needed at the end, rather than an industrial strength RDBMS. For any production healthcare system, be aware that both Oracle and DB2 have very strong security features, including full audit trails. We can be sure that this will still be a strong selling point for healthcare applications in twenty years time.

Armed with this information, we can be sure that we are making the best RDBMS choice for the aims of our database. Where that choice has already been made, SQL knowledge helps us specify exactly the information we need, when needed...without searching for Post-Its and pens!

Packups & Backups

If you are like most people, you are unlikely to have given much consideration to backing up the data sitting on your PC. If you *had* thought about it, you may have assumed that your IT department dealt with it automatically. Whilst this is true for major system data e.g. PAS, PiMS, email servers etc., it is unlikely to be true for individual PCs in NHS offices.

The common causes of data loss include: user error ("oops, I think I just deleted your document"); computer viruses; theft & loss (particularly common with laptops); flood, fire & impact damage; sabotage; and hard drive failure. The latter is surprisingly frequent - a major hard drive manufacturer is currently being sued for a recent top-end drive having a failure rate which some estimate to be in excess of 20%. That would potentially mean the loss of years worth of clinic letters, discharge summaries, archived emails etc. - very bad news!

The good news on this front is that there are some specialist data recovery firms that are able to retrieve data from physically damaged disks (try a search in www.google.com using the keywords 'uk data recovery'). Also check out the museum of successfully recovered hard drives (www.drivesavers.com/museum/museuma.html) from computers that have melted in fires or even sunk to the bottom of the Amazon! These services come at a price however (e.g. £40 for floppies, £800 for large hard drives) and your data may not be sufficiently valuable to justify spending this amount of money.

A full description of how to backup your files is beyond the scope of this article. A google search with something like 'backup strategy' as keywords will bring up a multitude of detailed online resources. What follows is a brief outline of what you need to consider when planning your own backup strategy.

First you need to decide what you should back up. Word processor, database and spreadsheet files are obvious. Also think about address books, 'internet favorites', program customizations (e.g. macros, .ini files & the registry), archived emails and any other files you may need to get your hands on. Clinical teams should consider all letters and summaries sitting on the secretary's computer. For most work computers it is only necessary to back up these 'user created' items as main program files can generally be re-installed by your IT department.

Depending on the size of this data you might consider backing up to (in order of generally increasing capacity): floppy, Zip Disk, CD, DVD, tape drive, a second hard drive (make sure these are physically separate rather than partitioned to appear as additional drives) or a USB hard drive (I think these are great for modern PCs). Internet backup drives are not suitable for confidential personal data such as patient letters.

The process of backing up your files will depend on your operating system. Some come with adequate utilities for the job but often you will have to resort to an alternative shareware or commercial program. The simplest backup method is to copy folders and files to your chosen storage medium, preferably in a compressed format to save space. This is fine for a few fold-



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My personal strategy is automated weekly backups to a second hard drive and monthly to a portable USB drive which doubles as an MP3 player (see www.archos.com). I also keep a CD backup of really vital files off site.



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Chair:

Dr Matthew Evans

Committee:

Dr Martin Baggaley

Dr Martin Briscoe

Dr Trevor Hicks

Dr Sudhir Kaligotla

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ers but it is not a very efficient method for more complex backups. In these circumstances it may be necessary to use an incremental or differential backup type. These work by selectively backing up only the files that have altered since the last incremental backup or the last full backup. Using these techniques, backups can be made much more quickly and using less storage than repeated full backup methods, although it can be more complicated to restore the data in the event of an 'accident'. If at all possible, make your backups automated and review your plan regularly in case a new program starts storing your personal files in a folder that is not included in your backup plan.

The problem with all of these strategies is that they require a reasonable understanding of computers and are actually quite complicated to set up. They also require considerable discipline to

ensure backups are regularly made and that the backup disks are stored off-site (it's no good religiously backing up to a CD if it is left sitting on your desk to be stolen at the same time your PC is pinched).

I am of the opinion that it is unrealistic for an NHS IT department to oversee backups on individual PCs across an entire Trust. I therefore advocate a different strategy - my preference is that all Trust PCs are networked and that users store all of their clinical information and some of their personal information on a network drive (that is a hard drive elsewhere on the network). In the second part of this article I will describe the tremendous clinical benefits that networks can bring to our working practices and will explain why networks offer a far superior backup solution. Until then - don't forget to develop your own backup strategy!

F40.2 Technophobia ICD 10-R (2002)

This is a phobia restricted to highly specific situations such as proximity to computer terminals. Although the triggering situation is discrete, contact with it can evoke panic as in agoraphobia or social phobias. Technophobia usually arises in the early and middle adult life and can persist for decades even until the final exit if it remains untreated. It is usually uncommon in children and adolescents if they get an early exposure to computer terminals via schools/homes. Most of the patients suffer from a simultaneous fear of change, rigid and inflexible behaviour. The seriousness of the resulting handicap depends on how easy it is for the sufferer to avoid the phobic situation. Fear of the phobic situation tends not to fluctuate, in contrast to agoraphobia.

Diagnostic guidelines

All of the following should be fulfilled for a definite diagnosis:

- (a) the psychological or autonomic symptoms must be primary manifestations of anxiety, and not secondary to other symptoms such as delusion or obsessional thought;
- (b) the anxiety must be restricted to the presence of the computer terminal or related situation; and
- (c) the phobic situation is avoided whenever possible

Includes: phobia of technology, computerphobia, internet phobia, mail-box phobia

Differential diagnosis. It is usual for there to be no other psychiatric symptoms, in contrast to agoraphobia and social phobias. If the conviction of disease reaches delusional intensity, one should seriously consider retirement/redeployment.

Notes: A well known phenomenon is people running away from terminals. If they overcome their phobia, there is little doubt that even those sufferers - mostly people with PhD, MD, etc after their names - would ever go back to paper charts. When successfully treated, there are only two problems that arise with any regularity (from Gilbert¹):

1. If the power goes out, you end up with a lot of expensive people walking around with their hands in their pockets, waiting for the local utility company to get the power turned on again.
2. If the power is out >15', the emergency preparedness plan calls for notes and other medical records to be written on paper. Most people do nothing, rather than resort to that option.

Reference: Francis S. Gilbert - [CIMH2000] MH EPR, yahoogroups.com, 11/12/01

Connect is published in June & December. We invite contributions in the form of letters (up to 200 words), notices and articles (300 to 700 words). Longer articles should be discussed with the editors prior to submission. The deadline for submission is October 15th for December & April 15th for June. Full details can be found on our website. Editors: Matthew Evans & Fionnbar Lenihan. The opinions expressed in Connect are those of individual authors and do not necessarily represent the views of the college.

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