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Remote care for mental health: qualitative study with service users, carers and staff during the COVID-19 pandemic

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ABSTRACT

Objectives: To explore the experiences of service users, carers and staff seeking or providing secondary mental health services during the COVID-19 pandemic.

Design: Qualitative interview study, co-designed with mental health service users and carers.

Methods: We conducted semi-structured, telephone or online interviews with a purposively constructed sample; a peer researcher with lived experience conducted and analysed interviews with service users. Analysis was based on the constant comparison method.

Setting: NHS secondary mental health services in England between June and August 2020.

Participants: Of 65 participants, 20 had either accessed or needed to access English secondary mental healthcare during the pandemic; 10 were carers of people with mental health difficulties; 35 were members of staff working in NHS secondary mental health services during the pandemic.

Results: Experiences of remote care were mixed. Some service users valued the convenience of remote methods in the context of maintaining contact with familiar clinicians. Most participants commented that a lack of non-verbal cues and the loss of a therapeutic 'safe space' challenged therapeutic relationship building, assessments, and identification of deteriorating mental wellbeing. Some carers felt excluded from remote meetings and concerned that assessments were incomplete without their input. Like service users, remote methods posed challenges for clinicians who reported uncertainty about technical options and a lack of training. All groups expressed concern about intersectionality exacerbating inequalities and the exclusion of some service user groups if alternatives to remote care are lost.

Conclusions: Whilst remote mental healthcare is likely to become increasingly widespread in secondary mental health services, our findings highlight the continued importance of a tailored, personal approach to decisions about remote mental healthcare. Further research should focus on which types of consultations best suit face-to-face interaction, and for whom and why, and which can be provided remotely and by which medium.

Key words: mental health services, remote care, COVID-19, peer research, qualitative.

Word count: 6271

ARTICLE SUMMARY

Strengths and limitations of this study

- Strengths include its qualitative approach in speaking to a large sample of participants with varied mental health difficulties, carers, and a diverse range of mental healthcare staff.

- Its novelty lies in a deep exploration of the views and experiences of remote mental healthcare during a pandemic.
- The methods are strengthened by the involvement of experts-by-experience and the use of peer research methods.
- We did not adopt a narrative method; the interviews were one-off conversations so we could not explore change as the pandemic progressed and people may have become accustomed to remote care.
- The study used remote methods to comply with UK lockdown regulations; this will have excluded some groups without the ability to engage remotely.

INTRODUCTION

Difficulties in mental health are very common; they bring long-term challenges for individuals, families, carers and society.¹ People with significant mental health needs may use secondary health services for specialised healthcare including acute in-patient services and community-based approaches such as early intervention, crisis resolution or specific therapeutic interventions for particular concerns. During the COVID-19 crisis in the United Kingdom (UK) and elsewhere, the number of people in need of mental healthcare increased. Besides those who suffered physically with COVID-19 itself, fear of infection, worry about those unwell and bereavement have been widespread, while measures such as lockdowns and other interventions to reduce transmission increased social isolation, loneliness and domestic strains; all create adverse conditions for mental health.²⁻⁷ Yet, as need increased, the capacity of mental healthcare provision was severely restricted due to distancing measures, extra hygiene precautions, abrupt changes to care pathways and reduced staff availability⁸. These changes saw provision and use of mental healthcare decrease^{4,9} in the face of increased need and risk for service users.¹⁰

In response to these challenges to the entire healthcare system, many services switched to different forms of remote care as a way of increasing capacity and reducing face-to-face contact. Telehealth, where telephone and other technology-based methods are used to provide care,¹¹ has increased rapidly following years of inertia or slow growth.¹² Accompanying this rise has been a rapid expansion in research, evaluation, guidance and commentary on remote care in a range of fields. This body of literature is largely positive about the potential of telehealth during, and beyond, the pandemic,¹³ and is leading some to suggest that it may, at least in part, replace in-person interaction as a mode of healthcare delivery for many service users.¹⁴

The COVID-19 pandemic forced the introduction of remote care across secondary mental health services in a matter of weeks. The bulk of research to date, however, has taken place in primary care and/or physical health. Of 543 papers identified by Doraiswamy et al. in their rapid scoping review of articles relating to telehealth during COVID-19, for example, only 42 focused on psychiatry and related disciplines.¹³ Both the advantages and the challenges of remote care delivery in physical healthcare settings may differ substantially from those faced in secondary mental healthcare. The use of remote care in mental health has invited debate for decades.¹⁵ Though some have highlighted the potential of telehealth in addressing mental health difficulties during and beyond the pandemic,¹⁶ remote care may also have important downsides; some are more readily anticipated than others.

Rigorous qualitative studies examining the experiences and needs of service users, carers and clinical staff involved in remote mental healthcare are needed to understand its impacts, and guide short and long-term changes to services. This is not only to mitigate problems but also to take advantage of opportunities to address long-standing concerns about access that have been exposed by the pandemic. In this article, we respond to this challenge. We report on a large, interview-based study involving people with direct experience of seeking

(including carers) and providing mental healthcare in England during the first wave of the COVID-19 pandemic.

METHODS

The study was designed and developed with six experts by experience (three service users and three carers) and a peer researcher from the McPin Foundation, a mental health research charity.

Between June and August 2020, we undertook a qualitative study involving remote interviews with 69 adults including:

- 24 people with mental health difficulties under the care of secondary mental health services in who either accessed support, including inpatient and community mental health services, during the pandemic, or who needed services but did not access them. The interviews (all telephone) of four service users were excluded from this analysis because they did not fulfil the criterion of accessing the English NHS for secondary mental healthcare.
- 10 carers of people who accessed, or needed to access, secondary mental healthcare during COVID-19.
- 35 point-of-care staff working in NHS secondary (inpatient and community) mental health services – particularly those more likely to be involved in critical and time-sensitive decisions. They included psychiatrists (trainees and consultants), care coordinators, mental health nurses, clinical psychologists and psychotherapists; some had managerial as well as clinical roles.

We recruited people with experience of mental health services in England only. We did not include individuals seeking to access mental healthcare for the first time through their general practitioner or staff working in primary mental health services such as GP practices, community pharmacists, and Improving Access to Psychological Therapy (IAPT) services.

To comply with the UK lockdown regulations, all interviews were conducted remotely. Participants could choose between being interviewed over the telephone or using online video-supported secure software:

- 19 service users were interviewed over the telephone, 5 were interviewed by video-conference.
- 8 carers were interviewed over the telephone, 2 carers by video-conference; all cared for a family member with mental health difficulties.
- 21 members of staff were interviewed over the telephone, 14 by video-conference.

Participants who opted for video conference interviews had the option to turn their camera off. In both cases (video-conference or telephone call) only the audio was recorded, either online or using an encrypted audio recorder for telephone interviews. Interviews lasted between 22 minutes and 95 minutes. Using peer-research methods,¹⁷ a researcher from the McPin Foundation carried out and analysed the service user interviews, drawing on her own experiences of accessing secondary mental healthcare both before and during the study period.

We recruited individuals using online network-based approaches: some participants engaged in response to information circulated through dedicated networks, whilst others became involved as a result of colleagues or friends alerting them to the study (a technique

known as snowball sampling). Multiple channels were used to publicise the study, including the networks of THIS Institute and the McPin Foundation, Health Education England's Heads of Schools of Psychiatry, NIHR Applied Research Collaborations, specialty clinical networks, and mental health charities including Rethink Mental Illness.

Across participant groups, our recruitment strategy was informed by efforts to maximise diversity. We adopted a purposive sampling strategy,¹⁸ aiming to identify a variety of experiences related to our research questions. As data collection and analysis progressed in parallel, the size of the sample was adapted to the variety of experiences captured, in line with the principle of information power.¹⁹

Invitations were circulated through an expression of interest form, and people who wished to take part were asked to indicate their ethnicity, the gender they identified with, and the first half of their postcode. We then prioritised invitations accordingly, seeking to increase the number of those from a minority background, and to achieve balanced gender representation and widespread geographic cover in England (Table 1).

Table 1: Participants' demographic information

	Service Users	Carers	Staff
Number of eligible interviews	20	10	35
Gender	<ul style="list-style-type: none"> 8 Female 7 Male 2 Non-binary 3 people did not provide this information 	<ul style="list-style-type: none"> 6 Female 2 Male 2 people did not provide this information 	<ul style="list-style-type: none"> 19 Female 11 Male 5 people did not provide this information
Ethnicity	<ul style="list-style-type: none"> 8 White 3 Black 2 Asian 4 Mixed ethnicity 3 people did not provide this information 	<ul style="list-style-type: none"> 7 White 1 Asian 2 people did not provide this information 	<ul style="list-style-type: none"> 24 White 3 Asian 2 Mixed ethnicity 1 from 'any other ethnic group' 5 people did not provide this information
Region	<ul style="list-style-type: none"> 1 North West 5 East Midlands 6 Greater London 2 East of England 1 South East 2 South West 3 people did not provide this information 	<ul style="list-style-type: none"> 1 West Midlands 4 East of England 2 South East 1 South West 2 people did not provide this information 	<ul style="list-style-type: none"> 4 North East 7 North West 2 East Midlands 5 West Midlands 4 Greater London 2 East of England 3 South East 3 South West 5 people did not provide this information
Additional information	Services accessed or contacted: <ul style="list-style-type: none"> Acute hospital wards Community Mental Health Teams (CMHT) Crisis Teams 		<ul style="list-style-type: none"> 17 Psychiatrists (13 trainees and 4 consultants) 10 Mental health nurses (including care coordinators, matrons, non-clinical prescribers) 8 Clinical psychologists (including CBT therapists and systemic family therapists)

	<ul style="list-style-type: none"> Specialist services (self-harm, personality disorder) 		<p>Services covered:</p> <ul style="list-style-type: none"> Community Mental Health Teams (CMHT) Early intervention for psychosis (EIP) Crisis Teams Acute hospital wards Secure Forensic services
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Potential participants were contacted by the researchers via telephone or email, depending on people's preferred contact method. Eligible potential participants were provided with a link to register via Thiscovery, a secure citizen-science platform developed by THIS Institute according to the AA Web Content Accessibility Guidelines that assure accessibility standards. Once registered on Thiscovery, potential participants were given further information and invited to complete the informed consent form. On completion of the consent form, participants were then able to schedule an interview, with the choice of video-conference (on Thiscovery) or a telephone call. Service users and carers were compensated £25 for taking part in an interview. EL, NR, JW and JP conducted semi-structured interviews; JP is a peer researcher with lived experience of accessing secondary mental healthcare before and during the pandemic. The interview topic guide covered a range of themes we sought to explore; the guide was deliberately non-directive to allow participants to discuss areas they perceive as relevant such as feelings of abandonment for service users or moral injury for staff.

Interview audio files were securely transferred to a third-party transcription service subject to the University of Cambridge data protection regulations. Anonymised service user, carer and staff interviews were analysed separately. Analysis of anonymised interview transcripts was based on the constant comparative method.²⁰ The coding scheme was developed based on a subset of initial interviews. The initial codes were revised, expanded and collapsed as analysis progressed, and through whole team discussions. Codes were then organised into categories in a thematised coding scheme. Data was processed using NVIVO software by five coders (four females and one male, DS). JP and NB analysed service user interviews, EL analysed carer interviews, DS, NB and NR independently analysed staff interviews.

During the process of write up and dissemination, some interview excerpts were edited further to protect the identity of participants.

Ethical approval for the study was obtained from the University of Cambridge Psychology Research Ethics Committee on 15 June 2020. All participants were provided with information about the study and gave consent. We followed the Standards for Reporting Qualitative Research recommendations²¹.

Patient and public involvement (PPI)

We consulted a panel of mental health service users and carers convened by the McPin Foundation. Members helped us shape the research questions, methods, and risk management plans for the study. We also gathered the views of these experts-by-experience on the study materials, including the research protocol and our participant-facing documents. We shared the study documents with these experts-by-experience requesting their comments and recommendations. We also held a series of online meetings to give participants a further opportunity to share their views and suggestions for improvement, providing individual online meetings or a telephone call according to preference. Experts-by-experience provided advice on how best to include carers in the study and suggestions for

1
2
3 specific networks for recruitment. They also guided how best to compensate participants for
4 their time, as well as emphasising the need for an accessible summary of the research to be
5 made widely available.
6
7

8 9 **RESULTS**

10 Our interviews with service users, carers and staff confirmed a widespread move to remote
11 care in response to the pandemic. Telephone consultations were, initially at least, reported
12 to be the most commonly offered form of remote care; setting-up secure video-conferencing
13 systems took time due, in part to uncertainty as to which, if any, platforms and systems were
14 allowed by information governance policies of different trusts, and staff and service users
15 being unfamiliar with how to use them. Initially, it was assumed by service providers that
16 telephone would be the most widely available to service users, with fewer barriers to access
17 than online methods. Towards the end of our recruitment period (August 2020), interviews
18 were beginning to indicate that secure video-supported platforms were in place in various
19 NHS community mental health services across the country.
20
21

22 **Service user choices about remote care**

23
24 Service users had mixed experiences. Most reported that remote care was adequate or
25 tolerable, but that face-to-face was much better. Some felt that the use of remote methods
26 made it more likely that appointment times would be altered or not followed through. This
27 often led to a sense of uncertainty and frustration. Several reported that trying to build a
28 therapeutic relationship remotely with a member of staff who they did not know was
29 problematic, and that they preferred being able to build on pre-established rapport.
30
31

32 *I suppose if the AttendAnywhere works... actually, it doesn't take as long out of your day.
33 It takes exactly an hour rather than travelling to the appointment. So, it's an option. But I
34 still feel that the face-to-face has it for me. (Service user)*

35
36 *I can't deal with uncertainty and inconsistency and I think they literally did...oh, we'll call
37 at 3:00, and then they'll call at 4:00 and it was, yes, we can, no, we can't. Then in the
38 end they discharged me with a letter and then...it was in a way, you know when they
39 discharge you as well, you don't know whether to say, yes, that's a good idea or no
40 because you're worried that actually tomorrow I might have a really bad day (Service
41 user)*

42
43 *I think it's a very poor service that make an agreement they'll ring somebody every
44 week, and then suddenly to fall off a cliff like that, I think it's a really bad service, I'm
45 sorry. I think someone should handover and say, well, I've got a vulnerable client
46 that's actually been working with the [service name] as well, and then just to be
47 dumped like that for nearly seven weeks, I'm sorry I think it's really poor. (Service
48 user)*

49
50 Positive experiences generally came from service users who had a prior relationship
51 with a clinician.
52

53 *[The psychiatrist] was really great across the phone... I was quite worried that the phone
54 appointment was going to be terrible because I've always had it in person, but he was
55 really good. It was almost like he was in the same room as me. (Service user)*
56

57
58 Some service users and carers chose not to receive remote care, particularly for
59 psychological interventions, because they believed that face-to-face consultations
60 would be reintroduced soon. Others did not feel that remote consultations would be as

1
2
3 helpful or meaningful as face-to-face ones; they made clear that remote care was their
4 only option during the pandemic, and was not a choice they would otherwise have
5 made:

6
7 *I thought it would be doubly frustrating... doing everything on the telephone and [that*
8 *you'd] end up with endless telephone conversations that got nowhere. (Service user)*
9

10
11 *I certainly feel that I haven't made the progress with the psychologist... I was getting a lot*
12 *more out of the appointments when they were face-to-face, I think. I don't come away*
13 *feeling as if I've really taken on board what he's said to me in the same way. (Service*
14 *user)*

15 Staff expressed concerns that breaks in therapy might negatively affect service users'
16 and families' mental health during the pandemic. They recognised the challenges in
17 providing remote care and understood service users' choices not to engage with it,
18 some offering face-to-face when allowed:

19
20
21 *I did have quite a few drop out... [Some] chose not to continue because they didn't want*
22 *to do remote working... Some people had an idea that [the pandemic] would be short*
23 *lived... That was a concern for me because we were in the middle of therapy and I'm*
24 *struggling now to get them back. (Family therapist)*
25

26
27 *I think that people have missed face-to-face contact... I've rung and said 'I'm going to go*
28 *back to some places for contact... Do you want to see me, or do you want to just do it*
29 *over the phone?' And everybody has said 'Yeah, would really love to see you.'*
30 *(Care co-ordinator)*

31 Some staff shared the view of many service users that remote care was more suitable for
32 maintaining continuity in existing relationships than for meeting people who were newly
33 referred. Conversely, some clinical psychologists and psychotherapists reported that remote
34 care was more likely to be accepted by service users who had not experienced face-to-face
35 therapy before, because they did not endure the 'shock' of a change in access mode.

36 37 **The embodied dimension of therapeutic encounters**

38
39 The move to remote care helped to maintain some form of connection between service
40 users and services during the pandemic. However, participants reported that remote care
41 changed the character and depth of clinical encounters and, in turn, their relational quality.
42 Uniting the accounts of service users, carers and staff was the loss of the embodied
43 dimension of therapeutic interactions, including the physical space where these used to take
44 place. Many described remote consultations as 'not the same', noting that even where they
45 were able to see someone's facial expressions (in online consultations), not being together
46 in a room meant that building and maintaining a connection was problematic. For example,
47 when eye contact was mediated by a camera, it hampered the reciprocity normally
48 experienced in face-to-face interactions, as did the emphasis of verbal communication over
49 body language. These factors compounded many service users feeling socially isolated
50 during the pandemic, while for others, the loss of a particular, even sacred, therapeutic
51 setting undermined the quality of care:

52
53
54 *[Remote consultations with psychiatrist] just felt more perfunctory, somehow, and I felt*
55 *less like opening up about stuff. It tends to be quick discussions about my medication*
56 *and that's it... It felt like there was a barrier and I was just less inclined to open up.*
57 *(Service user)*
58
59
60

1
2
3 *You can't have simultaneous eye contact with someone. When you look at the camera,*
4 *they have the experience that you're looking in their eyes but you don't have that*
5 *experience because you're looking at the camera... It just creates a really weird*
6 *asynchrony so it's just not like being in the room with the person... I just find that quite*
7 *disconcerting.* (Clinical psychologist)
8

9 Service users reported not feeling able to make full use of therapeutic interactions in an
10 environment they shared with other people (commonly, family members). Others felt that
11 video consultations were 'invading' their own private space:
12

13 *In our home, we have three generations of families who live in a two-bedroom house.*
14 *So, picture eight people in a two-bedroom house – you know, it's quite hard.* (Service
15 user)
16

17 *There's something that... has that sacredness about the [consultation] room.* (Service
18 user)
19

20
21 The loss of the journey to and from services was another aspect of remote care that required
22 adjustment. Some service users felt they were deprived of the opportunity to process the
23 content of the sessions and gently transition back to their home lives.
24

25 *After the phone call, he said 'Bye' and he put the phone down. I was just like 'Oh.' It just*
26 *felt slightly surreal.* (Service user)
27

28 *The trip... would at least get me into the headspace of 'Okay, I'm going into therapy.'*
29 *And then, leaving, I would then get on a bus and just chill and let it sink.* (Service user)
30

31 Similarly, some staff members reported less opportunity to reflect and process after
32 consultations due to back-to-back appointments. Several therapists also emphasised the
33 importance of therapy taking place in a safe and bounded physical space (the therapeutic
34 setting). They saw remote consultations, often being delivered from their homes as removing
35 a boundary between private life and therapeutic work, compromising the safety of these
36 consultations. They found some types of therapeutic work, such as trauma processing, to be
37 so ill-suited to remote care that they paused it.
38

39 *And I don't have any car journeys anymore. I really appreciated time in the car because it*
40 *gave me time to reflect and time to process and time for myself. And in an office, home*
41 *office with Microsoft Teams, you get a lot of appointments just back-to-back.* (Family
42 therapist)
43

44 *I had a girl... who started online, and, probably, about six sessions in, she got quite*
45 *emotive... and then she suddenly shut down, and I was like 'What's that about?' And she*
46 *said, 'Well, my mum's next door and I can't do that. This isn't safe.'* (CBT therapist)
47
48

49 Remote assessments and identifying risks

50
51 A particular area of concern for all participants related to the effectiveness of remote forms of
52 care in conducting assessments and identifying risks. Service users reported that the lack of
53 face-to-face contact made it more challenging for staff to identify – and help them recognise
54 – signs that their mental health was changing. This was important when, for example, the
55 nature of their mental health difficulties meant they could transition rapidly from depression
56 to mania, without being able to understand that this was happening and that a crisis
57 requiring inpatient admission might follow. In interviews, service users and carers described
58 video consultations as going some way towards addressing these issues compared with
59 telephone calls, but mostly they saw them as a poor substitute for face-to-face contact:
60

1
2
3 *In the run-up to my becoming very unwell I didn't see them face to face, and I think that I*
4 *was becoming (I have bipolar) increasingly hypermanic [sic]. But, because I was still*
5 *functioning at my job, I didn't really recognise it. (Service user)*
6

7 *Before COVID, probably in face-to-face meetings there [was] more of an opportunity to*
8 *observe body language and assess mood from the physical presence of somebody that*
9 *you're sitting with. I don't think that can be really captured over the phone. (Carer)*
10

11 Some carers felt that the shift to remote care exacerbated a pre-pandemic problem of their
12 being excluded from assessments, such that risk may not be assessed properly. One carer
13 felt that the person they supported did not find remote consultations beneficial and tried to
14 end the interactions quickly. Because the carer was not included in the consultations, some
15 issues were not recognised, recorded or addressed:
16

17
18 *My [family member] just wants people off her back... [She] will say 'I'm fine' until she's*
19 *blue in the face. It's much easier to do that on a half-hour phone call than it is possibly*
20 *sitting face-to-face with somebody for an hour, who might actually be able to read further*
21 *into things. (Carer)*
22

23 Staff tended to agree on the inherent limitations of remote consultations for conducting
24 assessments and identifying mental health risks – especially in the context of COVID, where
25 service users presenting to community services were more acutely unwell. It appeared that
26 specific aspects of assessments were particularly compromised by remote contact. For
27 example, staff and carers said remote consultations made it difficult (or, in the case of
28 telephone consultations, impossible) to pick up important non-verbal cues, such as body
29 language and levels of tension. These difficulties were exacerbated for service users who
30 struggled to verbally communicate how they were feeling. Acknowledging the limitations of
31 remote consultations for risk assessment, some services used telephone consultations to
32 evaluate the need for face-to-face contact. Yet sometimes this introduced other problems:
33 delaying fuller assessments, for example:
34

35
36 *What a lot of doctors did was... a short assessment on the phone just to basically check*
37 *for risks: it was more of an in-depth triage than a proper assessment. And then they*
38 *would say, 'It is urgent that I see this person'. And they would do face-to-face*
39 *assessment. I think what it did was just slow down the process from the point of referral*
40 *to the point of deciding that we would take the person on to the caseload. (Care co-*
41 *ordinator)*
42

43 Other factors that limited the depth and appropriateness of remote assessments included an
44 inability to evaluate service users' home circumstances. Staff had to rely much more on
45 service users' self-report of their mental health without, in addition, picking-up subtle, non-
46 verbal clues that are available during an interview. Staff acknowledged the importance of
47 carers, family members or friends being physically present at the point of assessment,
48 reporting that service users who did not have this support (for example, those living in care
49 homes during the pandemic) may have been particularly disadvantaged. Remote working
50 and lockdown restrictions also meant that service users in compromising home life
51 situations, such as those facing domestic abuse, may not have felt comfortable disclosing
52 how they were coping:
53

54 *Domestic violence assessments – usually we would go out to the home and try and get a*
55 *sense of how things were, whereas obviously on the phone you're only getting one side*
56 *of the story. (Senior clinical psychologist)*
57

58 *Our team would [normally] go to patients' homes and check their weight... but because*
59 *of COVID we had to ask patients to do that. But our patients with anorexia, they have a*
60

tendency to falsify their weight. So, in that way, it would be difficult to give them quality care. (Trainee psychiatrist)

Inequities in access

Participants across the service user, carer and staff groups reported multiple concerns about the potential for remote care to have disproportionately negative effects for some groups of service users and carers through intersectionality, thus creating or further amplifying inequities. These groups included those with hearing difficulties and communication impairments; people for whom interacting through a screen or a telephone was particularly challenging (e.g. because of anxiety or autism); people who were unfamiliar with or reluctant to use technology, including some older people and those experiencing paranoia or delusions about technology; people who could not afford devices or internet access; and people who needed support with the English language, often impacting on whole communities (Table 2).

Table 2: Groups identified as particularly at risk of disadvantage from remote care

<p>Individuals with sensory (e.g. hearing) difficulties and communication impairments.</p>	<p><i>We work with over 65s, so we know that a lot of those are people who have hearing difficulties and it can be incredibly difficult for them to get the same out of the telephone session as they do in person. (Senior clinical psychologist)</i></p> <p><i>I was working with a family that the [family member] had a stroke and can only write, and the family do a lot of her communicating in the family sessions. And they said there's just no way we can do that online, it's going to all... it's just going to stress her out completely. So people who have got additional needs that don't get met by the online platform. (Family therapist)</i></p>
<p>Individuals for whom interacting through a screen or via telephone may be particularly challenging.</p>	<p><i>I felt really not looked after in the community, the way they were proposing to help us was just calling, which is not very adequate for me because I have Asperger's and I really need something physical. (Service user, early July 2020)</i></p> <p><i>I assessed a person with autism, and it was challenging. 'Cause I think if you struggle with human interaction in person, you probably struggle even more online. (Trainee psychiatrist)</i></p>
<p>People who may be unfamiliar with, or unwilling to use, technology ('digital exclusion'), including older adults and individuals experiencing phobias or delusions regarding IT.</p>	<p><i>Ours is an older population generally speaking, and not to stereotype, but a lot of the older population are not technology savvy, a lot don't have smart phones, a lot don't have iPads or computers. So, we haven't video called most of them, or a lot of them. It tends to be that we're just making lots and lots of telephone calls. (Care coordinator)</i></p> <p><i>[Family member] won't Zoom. Part of his schizophrenia is he can't look at live television so, Zoom, he couldn't do. This is him personally I'm talking about rather than in general. But (...) I get to know about a lot of other cases... and we are unanimous [it's] not just schizophrenia (...)... Face to face is invaluable. (Carer)</i></p> <p><i>There's one person who I'm still in contact with over the phone but she's phobic about technology, partly due to a previous trauma issues. (Clinical Psychologist)</i></p>
<p>People who may not have access to technology or telephone/ internet contracts (including those without a secure accommodation)</p>	<p><i>I have people who don't have internet access, don't have mobile phones, so if I don't go to their house, I'm not going to engage with them. (Care coordinator)</i></p> <p><i>Well, I guess people in social economic kind of situations where they don't allow them to have the devices, so families that don't have devices or Wi-Fi, that might be more difficult. (Family therapist)</i></p>
<p>Non-native English speakers (and those needing a language interpreter) for whom</p>	<p><i>But [remote access] is limited, it relies on people having good English, whereas we have quite a high Turkish population here. (Trainee psychiatrist)</i></p>

relaying only upon verbal communication may constitute an obstacle to mutual understanding.

A lot of our patients, because of the demographic, English may not be their first language or they may have an accent if they've grown up abroad, which can add to the difficulties in understanding people on the phone. (Trainee psychiatrist)

Some participants emphasised the need to identify and address the inequalities created by new, as well as traditional, ways of providing support. One carer noted that in evaluating the appropriateness of remote care, it is important to account for remote consultations that are missed or cancelled as well as those that do take place, to avoid self-selection bias:

I'm just very fearful that [services] will take from this 'Oh, we can do it all on Zoom, we can do it all online, we can do it all on the phone. We don't need to actually see people.'... And that would be a very negative [thing] for an awful lot of people.... but those people would vanish quite rapidly. And then... the people who would be left would be those who are comfortable with that. And [services] would be able to say, 'Oh, look, it's working fine for these people.' Well, who have you lost on the way? (Carer)

I hope it doesn't go the other way and we end up cutting the face-to-face services too much. I do fear that in a way. I think the technological things would be the main positive change. I just hope that it doesn't come at the expense of saying, oh well, the face-to-face doesn't matter, or you can cut that, which in the context of older people is especially important. (Trainee psychiatrist)

Conversely, remote care appeared to have some role in addressing some inequalities associated with face-to-face only. For example, during the pandemic, it enabled people who were shielding or particularly vulnerable to the virus to continue accessing services, reducing transport costs and logistical difficulties for service users and carers, and benefitted people with physical impairments who were challenged by having to travel. That said, it did not benefit all.

For a long time, service users asked us 'Do we have to come all the way into a site with no parking, or could you see us by video?' And the answer's always been 'No.' So I think some of them are a little bit annoyed because they've been asking for this for years and never received it, and now we've said 'It is possible, after all – who knew?' So, it'll be funny after [COVID-19] to see what people are happy to go back to... My consulting rooms are on the first floor [with no] parking space, which is hideous for older people with mobility problems. So, I think a lot of them would prefer telephone or video rather than having to come in. (Senior clinical psychologist)

The future of remote care

Service users, carers and staff had varying views on the appropriateness of remote care for secondary mental health services, but generally concurred that shared decision-making about access modes (face-to-face versus remote care) needed negotiation. As the use of remote care became more common during the pandemic, such consultation and shared decision-making became even less commonplace, albeit largely through force of circumstances. Service users, carers and staff, alike, felt strongly that organisations should take a tailored approach to introducing remote care once more flexibility returns to the system. It should take into account the differences between different types of clinical encounter (for example, psychotherapy, psychiatric reviews, monitoring or changing medication, or regular care coordinator encounters) and the range of options for remote contact (including telephone calls, video-supported calls, text messages, emails). They also highlighted that, in the future, mental health services should attempt to acknowledge the

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2
3 unfamiliarity and potential 'strangeness' of accessing services remotely and recognise that
4 people's preferences around remote access may shift in response to their changing
5 circumstances and experiences of mental health:
6

7
8 *There wasn't anything about, 'You might find this strange initially; it's going to feel*
9 *different'... Something like that would have been really nice, like 'It's going to feel*
10 *different and maybe these are some of the ways that you and your psychiatrist can*
11 *manage that.'* (Service user)

12
13 Participants described technology-related and connectivity issues as other key factors to
14 consider in relation to remote access. Wi-Fi and signal problems could affect sound and
15 video quality and sometimes prevented consultations from happening altogether. These
16 issues seemed to be more substantial in rural areas, thus disproportionately affecting
17 services in specific geographical locations.
18

19
20 *I know a lot of people who've had technical and/or IT-related issues with [remote care] –*
21 *largely due to connectivity or lack of. So that seems to have been the biggest barrier.*
22 (Trainee psychiatrist)

23
24 *There was one appointment when we tried and tried to get the AttendAnywhere to work*
25 *and it just wouldn't, and it was really frustrating because we could see each other but*
26 *either I could hear my psychologist, or he could hear me, but we couldn't hear each*
27 *other. So, we gave up in the end... It does rely on you having a good internet*
28 *connection.* (Service user)

29
30 When staff were asked about the future of remote care, most saw it as having a role in
31 *supplementing* face-to-face contact. Its advantages included avoiding unnecessary or
32 burdensome travel, giving healthcare staff more time to maintain regular contact with service
33 users, allowing the flexibility to offer shorter, more frequent sessions, and perhaps enhanced
34 ability to follow up service users who did not attend their scheduled appointments, although
35 this was not the experience of the service users we interviewed. Staff also reported some
36 remote sessions as being more intense than face-to-face so they brought them to a close
37 earlier. Finally, staff emphasised that if remote care was going to be more widely used in the
38 future, they would need specific and tailored training for delivering psychological
39 interventions remotely:

40
41 *Our DNA [did not attend] rate has probably fallen... the standard thing, if somebody*
42 *doesn't turn up to clinic you just mark that down as did not attend. Although a care*
43 *coordinator might go out and say to the person... Whereas now what I would do is just*
44 *phone them up, and I think that's what I will be doing in future. Obviously, you won't*
45 *always be able to get through, but sometimes you can. And you can learn useful stuff on*
46 *the phone even if it might not be the same as what you'd see face to face. It's still better*
47 *than nothing.* (Consultant psychiatrist)

48
49 *I think the telephone consultations have been good. I think it's nice, it offers flexibility to*
50 *the patients as well as the clinicians. Reduces the need for travel if a patient had to take*
51 *time off work, et cetera, to come to an appointment, because before we were quite rigid*
52 *where we would want them to actually come in.* (Trainee psychiatrist)

53
54 *I was never trained in online therapy... Overnight, you're having to change your practice*
55 *and it's quite different online... I would always have a piece of paper between me and*
56 *the client. Well, that was immediately taken away. So, sharing thoughts and formulations*
57 *became more difficult.* (CBT therapist)
58
59
60

DISCUSSION

This qualitative study of the accounts of 65 service users, carers and healthcare staff about their experiences of remote care during the COVID-19 pandemic offers much rich learning (Box 1), including indications of how to optimise service provision in the future and where evidence and guidance is needed. Participants reported both advantages and disadvantages to remote care as a means of sustaining capacity and enabling access to secondary mental health services. Some participants, including both service users and service providers, valued the flexibility offered by remote care, particularly in the context of reduced access to face-to-face service provision.²² Nevertheless, there were significant downsides. Participants found that consultations by telephone and video restricted therapeutic relationships compared with in-person contact, particularly where service users and staff could not build on a bond already formed face-to-face. This finding underscores the limitations of the current evidence on video-based consultations as a substitute for in-person healthcare that, as Greenhalgh and colleagues note, relates almost exclusively to “highly selected samples of hospital outpatients with chronic, stable conditions.”²³ Our study further challenges the transferability of the findings of this body of evidence to the mental health context, particularly for service users whose difficulties are fluctuating or who may find themselves in crisis.

Our study has strengths and weaknesses. As a qualitative study, it relies on accounts of behaviours, practices, experiences and opinions as reported by participants, cannot take into account the clinical or personal outcomes of remote care, or infer causal relationships between these and the various features of remote care identified. Furthermore, we did not recruit people attempting to access mental healthcare for the first time. Among the study’s strengths are its large and varied sample and its novelty in exploring remote care for mental health during a pandemic from the perspective of service users, service providers and family carers. We acknowledge that the methods of online recruitment and engagement used in the study will have created some barriers for some groups; the approach favoured those to whom we could reach out with information about the study, as well as those with the necessary resource and capacity to decide whether or not to take part in the interview and to complete the informed consent process. For this reason, our findings may underplay the problems. On the other hand, remote methods may also have facilitated involvement of some people who would not have chosen to take part in a face-to-face study. Further strengths include the study’s involvement of experts-by-experience and use of peer research methods, which arguably facilitated more authentic understanding of people’s views and experiences, valuing the expertise of all those involved while equally valuing difference.

The study is helpful in identifying the distinctiveness of the mental health context compared with remote care for physical health conditions. Staff and service users alike noted that many features of a consultation that are taken for granted in face-to-face care become problematic in remote consultations. From clinicians’ perspectives, the essential non-verbal cues that are important to their questions, assessments and advice were missing. They sometimes doubted whether service users were willing or able to disclose all relevant information. Similarly, service users and carers felt that important aspects of consultations could be missed or misconstrued, especially by telephone, and even during video consultations. Both service providers and service users lamented the loss of the ‘sanctity of the consulting room’, as a space reserved for highly personal, confidential conversations. Neither the psychological nor the physical features of this space could be replicated in remote consultations. The lack of boundaries between domestic life and the clinical encounter could be immensely stressful, and challenges around privacy that have been noted in relation to physical health may be particularly difficult in remote care for mental health.^{24 25} For some service users, aspects relating to their mental health magnified the challenges that have been noted in remote consultations about physical health.^{22 26} Sensory difficulties, communication impairments, digital exclusion and aversion to screen-mediated contact

made remote care especially problematic for some service users, and might be caused or exacerbated by some mental health difficulties.

Though remote care in secondary mental health services is likely to become increasingly common, perhaps routine, our findings suggest that a blanket approach is not a suitable long-term solution once the exigencies of the COVID-19 pandemic have passed. While enhancing access for some groups, it may impede it for others, and the differential impact of remote care requires careful evaluation, accounting for impacts on those who withdraw from remote care as well those who engage. This also points to the need to develop tailored, personalised approaches to remote care that cater for the preferences and needs of individual service users, as well as for changes in their mental wellbeing. Our data show that many service users – and indeed professionals – had limited influence or choice about how care was provided. Identifying the appropriate balance of in-person and remote support for individuals and for different service user groups requires the input of frontline clinicians, service users and families who may be involved in their care, and the adoption of rigorous co-production methodologies that will take careful development. Future research should aim to provide guidance on exactly which type of clinical consultations best suit in-person presence, and for whom and why, and which can be offered remotely, and through which medium, taking into account intersectional challenges regarding access that contribute to the continuing ‘digital divide’ in mental health^{27 28}. Training and development might focus on enabling staff, service users and carers to make the most of the advantages offered by remote care, while identifying and mitigating its challenges. Equally important is to consider the risks of remote working for members of staff: reduced contact with colleagues in the structured environment of a shared working space may hinder the kind of informal knowledge sharing and mutual monitoring that is key to maintaining safety in healthcare teams. If we can define what good looks like, shared decisions about the option of remote approaches could support a tailored, personal approach to mental healthcare.

Box 1: Learning points for remote care

Box 1: Learning points and priorities for improvement for providing remote mental healthcare

- While remote consultations allowed secondary mental health services to continue working at a time of unprecedented crisis, refinement is definitely needed in how these will be offered in the future.
- The availability of remote access technologies does not mean that direct substitutions are appropriate.
- Conducting mental health assessments remotely may be particularly problematic and could hinder the identification of risks and use of shared decision-making.
- Training for staff in leading or supervising clinical interventions remotely is needed; this must be targeted to the specific remote platform used and be based upon co-production principles with service users and carers in delivery.
- There is a specific need for guidance on use of remote access mental healthcare, which would be best based upon further research and consultation.

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AUTHOR CONTRIBUTIONS

Elisa Liberati was lead researcher and managed the project with Natalie Richards. Peter Jones, Mary Dixon-Woods, Jennie Parker and Vanessa Pinfold contributed to the design of the study, analysis, and writing-up. EL, NR, JW and JP conducted the interviews. DS, JW and NB contributed to the analysis and writing-up.

Competing interests

The authors declare they have no competing interests.

REFERENCES

1. McDaid D, Park A-L, Wahlbeck K. The Economic Case for the Prevention of Mental Illness. 2019;40(1):373-89. doi: 10.1146/annurev-publhealth-040617-013629
2. MIND. The mental health emergency. How has the coronavirus pandemic impacted our mental health? London: MIND. Available at: mind.org.uk.
3. Public Health England. COVID-19: mental health and wellbeing surveillance report. Available at: <https://www.gov.uk/government/publications/covid-19-mental-health-and-wellbeing-surveillance-report>, 2020.
4. Rethink Mental Illness. Rethink Mental Illness COVID-19 briefings: Access to NHS mental health services for people living with severe mental illness. Available at: <https://www.rethink.org/media/3793/access-to-mh-services-final-040220.pdf>, 2020.
5. O'Connor RC, Wetherall K, Cleare S, et al. Mental health and wellbeing during the COVID-19 pandemic: longitudinal analyses of adults in the UK COVID-19 Mental Health & Wellbeing study. *The British Journal of Psychiatry* 2020:1-17. doi: 10.1192/bjp.2020.212 [published Online First: 2020/10/21]
6. Krishnamoorthy Y, Nagarajan R, Saya GK, et al. Prevalence of psychological morbidities among general population, healthcare workers and COVID-19 patients amidst the COVID-19 pandemic: A systematic review and meta-analysis. *Psychiatry Res* 2020;293:113382-82. doi: 10.1016/j.psychres.2020.113382
7. Johnson S, Dalton-Locke C, Vera San Juan N, et al. Impact on mental health care and on mental health service users of the COVID-19 pandemic: a mixed methods survey of UK mental health care staff. *medRxiv* 2020:2020.06.12.20129494. doi: 10.1101/2020.06.12.20129494

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8. BMA. Pressure points in the NHS: BMA,; 17 November 2020 [Available from: <https://www.bma.org.uk/advice-and-support/nhs-delivery-and-workforce/pressures/pressure-points-in-the-nhs> accessed 09 December 2020.
9. NHS Reset. Mental health services and COVID-19: Preparing for the rising tide. Available at https://www.nhsconfed.org/-/media/Confederation/Files/Publications/Documents/Report_Mental-health-services-NHS-Reset_FNL.pdf, 2020.
10. Iob E, Steptoe A, Fancourt D. Abuse, self-harm and suicidal ideation in the UK during the COVID-19 pandemic. *Br J Psychiatry* 2020;217(4):543-46. doi: 10.1192/bjp.2020.130
11. Doughty K. From red buttons to smart technology support: part 1: Independently published, 2018.
12. Fisk M, Livingstone A, Pit SW. Telehealth in the Context of COVID-19: Changing Perspectives in Australia, the United Kingdom, and the United States. *Journal of Medical Internet Research* 2020;22(6):e19264.
13. Doraiswamy S, Abraham A, Mamtani R, et al. Use of Telehealth During the COVID-19 Pandemic: Scoping Review. *Journal of Medical Internet Research* 2020;22(12):e24087.
14. Hollander JE, Carr BG. Virtually perfect? Telemedicine for COVID-19. *New England Journal of Medicine* 2020;382(18):1679-81.
15. Chakrabarti S. Usefulness of telepsychiatry: A critical evaluation of videoconferencing-based approaches. *World journal of psychiatry* 2015;5(3):286-304. doi: 10.5498/wjpv.v5.i3.286 [published Online First: 2015/10/02]
16. Zhou X, Snoswell CL, Harding LE, et al. The role of telehealth in reducing the mental health burden from COVID-19. *Telemedicine and e-Health* 2020;26(4):377-79.
17. Sweeney A, Beresford P, Faulkner A, et al. This is survivor research: PCCS Books 2009.
18. Palinkas LA, Horwitz SM, Green CA, et al. Purposeful Sampling for Qualitative Data Collection and Analysis in Mixed Method Implementation Research. *Adm Policy Ment Health* 2015;42(5):533-44. doi: 10.1007/s10488-013-0528-y [published Online First: 2013/11/07]
19. Malterud K, Siersma VD, Guassora AD. Sample Size in Qualitative Interview Studies: Guided by Information Power. *Qual Health Res* 2016;26(13):1753-60. doi: 10.1177/1049732315617444 [published Online First: 2015/11/29]
20. Charmaz K. Constructing grounded theory: A practical guide through qualitative analysis. London: Sage 2006.
21. O'Brien BC, Harris IB, Beckman TJ, et al. Standards for reporting qualitative research: a synthesis of recommendations. *Academic Medicine* 2014;89(9):1245-51.
22. The impact of COVID-19 on telemedicine utilization across multiple service lines in the United States. Healthcare; 2020. Multidisciplinary Digital Publishing Institute.
23. Greenhalgh T, Wherton J, Shaw S, et al. Video consultations for covid-19: British Medical Journal Publishing Group, 2020.
24. Kronenfeld JP, Penedo FJ. Novel Coronavirus (COVID-19): telemedicine and remote care delivery in a time of medical crisis, implementation, and challenges. *Translational behavioral medicine* 2020
25. Bokolo AJ. Exploring the adoption of telemedicine and virtual software for care of outpatients during and after COVID-19 pandemic. *Irish Journal of Medical Science (1971-)* 2020:1-10.
26. Kichloo A, Albosta M, Dettloff K, et al. Telemedicine, the current COVID-19 pandemic and the future: a narrative review and perspectives moving forward in the USA. *Family medicine and community health* 2020;8(3)
27. Robotham D, Satkunanathan S, Doughty L, et al. Do we still have a digital divide in mental health? A five-year survey follow-up. *Journal of medical Internet research* 2016;18(11):e309.
28. Greer B, Robotham D, Simblett S, et al. Digital exclusion among mental health service users: qualitative investigation. *Journal of medical Internet research* 2019;21(1):e11696.

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Page/line no(s).

Title and abstract

<p>Title - Concise description of the nature and topic of the study Identifying the study as qualitative or indicating the approach (e.g., ethnography, grounded theory) or data collection methods (e.g., interview, focus group) is recommended</p>	Page 1
<p>Abstract - Summary of key elements of the study using the abstract format of the intended publication; typically includes background, purpose, methods, results, and conclusions</p>	Page 2

Introduction

<p>Problem formulation - Description and significance of the problem/phenomenon studied; review of relevant theory and empirical work; problem statement</p>	Page 3
<p>Purpose or research question - Purpose of the study and specific objectives or questions</p>	Page 3

Methods

<p>Qualitative approach and research paradigm - Qualitative approach (e.g., ethnography, grounded theory, case study, phenomenology, narrative research) and guiding theory if appropriate; identifying the research paradigm (e.g., postpositivist, constructivist/ interpretivist) is also recommended; rationale**</p>	Page 6
<p>Researcher characteristics and reflexivity - Researchers' characteristics that may influence the research, including personal attributes, qualifications/experience, relationship with participants, assumptions, and/or presuppositions; potential or actual interaction between researchers' characteristics and the research questions, approach, methods, results, and/or transferability</p>	Page 6
<p>Context - Setting/site and salient contextual factors; rationale**</p>	Page 4
<p>Sampling strategy - How and why research participants, documents, or events were selected; criteria for deciding when no further sampling was necessary (e.g., sampling saturation); rationale**</p>	Page 5-6
<p>Ethical issues pertaining to human subjects - Documentation of approval by an appropriate ethics review board and participant consent, or explanation for lack thereof; other confidentiality and data security issues</p>	Page 6
<p>Data collection methods - Types of data collected; details of data collection procedures including (as appropriate) start and stop dates of data collection and analysis, iterative process, triangulation of sources/methods, and modification of procedures in response to evolving study findings; rationale**</p>	Page 4

1 2 3 4 5	Data collection instruments and technologies - Description of instruments (e.g., interview guides, questionnaires) and devices (e.g., audio recorders) used for data collection; if/how the instrument(s) changed over the course of the study	Page 6
6 7 8	Units of study - Number and relevant characteristics of participants, documents, or events included in the study; level of participation (could be reported in results)	Page 5
9 10 11 12	Data processing - Methods for processing data prior to and during analysis, including transcription, data entry, data management and security, verification of data integrity, data coding, and anonymization/de-identification of excerpts	Page 6
13 14 15 16	Data analysis - Process by which inferences, themes, etc., were identified and developed, including the researchers involved in data analysis; usually references a specific paradigm or approach; rationale**	Page 6
17 18 19 20	Techniques to enhance trustworthiness - Techniques to enhance trustworthiness and credibility of data analysis (e.g., member checking, audit trail, triangulation); rationale**	Page 6

Results/findings

23 24 25 26	Synthesis and interpretation - Main findings (e.g., interpretations, inferences, and themes); might include development of a theory or model, or integration with prior research or theory	Page 7-13
27 28 29	Links to empirical data - Evidence (e.g., quotes, field notes, text excerpts, photographs) to substantiate analytic findings	Page 7-13

Discussion

32 33 34 35 36 37	Integration with prior work, implications, transferability, and contribution(s) to the field - Short summary of main findings; explanation of how findings and conclusions connect to, support, elaborate on, or challenge conclusions of earlier scholarship; discussion of scope of application/generalizability; identification of unique contribution(s) to scholarship in a discipline or field	Page 14-15
38 39	Limitations - Trustworthiness and limitations of findings	Page 14

Other

42 43 44	Conflicts of interest - Potential sources of influence or perceived influence on study conduct and conclusions; how these were managed	Page 16
45 46	Funding - Sources of funding and other support; role of funders in data collection, interpretation, and reporting	Page 16

*The authors created the SRQR by searching the literature to identify guidelines, reporting standards, and critical appraisal criteria for qualitative research; reviewing the reference lists of retrieved sources; and contacting experts to gain feedback. The SRQR aims to improve the transparency of all aspects of qualitative research by providing clear standards for reporting qualitative research.

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**The rationale should briefly discuss the justification for choosing that theory, approach, method, or technique rather than other options available, the assumptions and limitations implicit in those choices, and how those choices influence study conclusions and transferability. As appropriate, the rationale for several items might be discussed together.

Reference:

O'Brien BC, Harris IB, Beckman TJ, Reed DA, Cook DA. **Standards for reporting qualitative research: a synthesis of recommendations.** *Academic Medicine*, Vol. 89, No. 9 / Sept 2014
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Remote care for mental health: qualitative study with service users, carers and staff during the COVID-19 pandemic

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ABSTRACT

Objectives: To explore the experiences of service users, carers and staff seeking or providing secondary mental health services during the COVID-19 pandemic.

Design: Qualitative interview study, co-designed with mental health service users and carers.

Methods: We conducted semi-structured, telephone or online interviews with a purposively constructed sample; a lived experience researcher conducted and analysed interviews with service users. Analysis was based on the constant comparison method.

Setting: NHS secondary mental health services in England between June and August 2020.

Participants: Of 65 participants, 20 had either accessed or needed to access English secondary mental healthcare during the pandemic; 10 were carers of people with mental health difficulties; 35 were members of staff working in NHS secondary mental health services during the pandemic.

Results: Experiences of remote care were mixed. Some service users valued the convenience of remote methods in the context of maintaining contact with familiar clinicians. Most participants commented that a lack of non-verbal cues and the loss of a therapeutic 'safe space' challenged therapeutic relationship building, assessments, and identification of deteriorating mental wellbeing. Some carers felt excluded from remote meetings and concerned that assessments were incomplete without their input. Like service users, remote methods posed challenges for clinicians who reported uncertainty about technical options and a lack of training. All groups expressed concern about intersectionality exacerbating inequalities and the exclusion of some service user groups if alternatives to remote care are lost.

Conclusions: Though remote mental healthcare is likely to become increasingly widespread in secondary mental health services, our findings highlight the continued importance of a tailored, personal approach to decision-making in this area. Further research should focus on which types of consultations best suit face-to-face interaction, and for whom and why, and which can be provided remotely and by which medium.

Key words: mental health services, remote care, COVID-19, peer research, qualitative.

Word count: 6699

ARTICLE SUMMARY

Strengths and limitations of this study

- Strengths include its qualitative approach in speaking to a large sample of participants with varied mental health difficulties, carers, and a diverse range of mental healthcare staff.
- Its novelty lies in a deep exploration of the views and experiences of remote mental healthcare during a pandemic.

- The methods are strengthened by the involvement of experts-by-experience and the use of peer research methods.
- The interviews were one-off conversations, so we could not explore change as the pandemic progressed and people may have become accustomed to remote care.
- The study used remote methods to comply with UK lockdown regulations; this will have excluded some groups without the ability to engage remotely.

INTRODUCTION

Difficulties in mental health are very common; they bring long-term challenges for individuals, families, carers and society.¹ People with significant mental health needs may use secondary health services for specialised healthcare including acute in-patient services and community-based approaches such as early intervention, crisis resolution or specific therapeutic interventions for particular concerns. During the COVID-19 crisis in the United Kingdom (UK) and elsewhere, the number of people in need of mental healthcare increased. Besides those who suffered physically with COVID-19 itself, fear of infection, worry about those unwell and bereavement have been widespread, while measures such as lockdowns and other interventions to reduce transmission increased social isolation, loneliness and domestic strains; all create adverse conditions for mental health.²⁻⁷ Yet, as need increased, the capacity of mental healthcare provision was severely restricted due to distancing measures, extra hygiene precautions, abrupt changes to care pathways and reduced staff availability.⁸ These changes saw provision and use of mental healthcare decrease^{4 9} despite growing need and risk for service users.¹⁰

The COVID-19 pandemic forced the introduction of remote care across secondary mental health services in a matter of weeks. Many services switched to different forms of remote care as a way of increasing capacity and reducing face-to-face contact. Telehealth, where telephone and other technology-based methods are used to provide care,¹¹ has increased rapidly following years of inertia or slow growth.¹² Accompanying this rise has been a rapid expansion in research, evaluation, guidance and commentary on remote care in a range of fields. This body of literature to date has offered largely positive accounts of the potential of telehealth during, and beyond, the pandemic,¹³ leading some to suggest that it may, at least in part, replace in-person interaction as a mode of healthcare delivery for many service users.¹⁴ The bulk of research to date, however, has taken place in primary care and/or physical health. Of 543 papers identified by Doraiswamy et al. in their rapid scoping review of articles relating to telehealth during COVID-19, for example, only 42 (7.7%) focused on psychiatry and related disciplines.¹³

Both the advantages and the challenges of remote care delivery in physical healthcare settings may differ substantially from those faced in secondary mental healthcare. The use of remote care in mental health has invited debate for decades.¹⁵ Though some have highlighted the potential of telehealth in addressing mental health difficulties during and beyond the pandemic,¹⁶ remote care may also have important downsides; some, such as difficulties with access to high-speed internet connections required to support videoconferencing, are more readily anticipated than others – such as the multiplicity of online platforms for mental healthcare and uncertain quality control.

Rigorous qualitative studies examining the experiences and needs of service users, carers and clinical staff involved in remote mental healthcare are needed to understand its impacts, and guide short and long-term changes to services. This is not only to mitigate problems but also to take advantage of opportunities to address long-standing concerns about access that have been exposed by the pandemic. In this article, we respond to this challenge. We report a large, interview-based study involving people with direct experience of seeking (including

carers) and providing mental healthcare in England during the first wave of the COVID-19 pandemic.

METHODS

The study was designed and developed with six experts by experience (three service users and three carers) and a peer researcher from the McPin Foundation, a mental health research charity.

Between June and August 2020, we undertook a qualitative study involving remote interviews with three groups: first, adults with mental health difficulties under the care of secondary mental health services who either accessed support, including inpatient and community mental health services, during the pandemic, or needed services but did not access them. We recruited people with experience of mental health services in England only. We did not include individuals seeking to access mental healthcare for the first time through their general practitioner or staff working in primary mental health services, such as GP practices, community pharmacists, and Improving Access to Psychological Therapy (IAPT) services. Second, we interviewed carers of people who accessed, or needed to access, secondary mental healthcare during COVID-19. Our third group of participants were drawn from those working in NHS secondary (inpatient and community) mental health services – particularly those likely to be involved in critical and time-sensitive decisions.

Across participant groups, our recruitment strategy was informed by efforts to maximise diversity using a purposive sampling¹⁷ to access a variety of experiences related to our research questions. We did not seek to achieve statistical representation of the population under study, but instead to reflect diversity. As data collection and analysis progressed in parallel, the size of the sample was adapted to the variety of experiences captured, in line with the principle of information power.¹⁸

We recruited individuals using online network-based approaches: some participants engaged in response to information circulated through dedicated networks, whilst others became involved as a result of colleagues or friends alerting them to the study (a technique known as snowball sampling). Multiple channels were used to publicise the study, including the networks of THIS (The Healthcare Improvement Studies) Institute and the McPin Foundation, Health Education England's Heads of Schools of Psychiatry, NIHR Applied Research Collaborations, specialty clinical networks, and mental health charities including Rethink Mental Illness.

Information about the study was circulated via email. People who wished to take part in the study completed an online expression of interest form, which included questions about their ethnicity, the gender they identified with, and the first half of their postcode. In line with our sampling approach, we reviewed responses to ensure diversity of experience, geography, minority background, and gender identity. For staff participants, we also prioritised diversification of staff roles and levels of seniority.

To comply with lockdown restrictions, all participants had to be conducted remotely. Potential participants were contacted by the researchers via telephone or email, depending on their preferred contact method. Eligible potential participants were provided with a link to register via Thiscovery, a secure citizen-science platform developed by THIS Institute according to the AA Web Content Accessibility Guidelines that assure accessibility standards. Once registered on Thiscovery, potential participants were given further information and invited to complete the informed consent form. They were then able to schedule an interview, with the choice of video-conference (on Thiscovery) or a telephone call.

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2
3 EL, NR, JW and JP conducted the interviews; JP is a lived experience researcher. The
4 interview topic guide (supplementary file) covered a range of themes we sought to explore;
5 the guide was deliberately non-directive to allow participants to discuss areas they perceive
6 as relevant such as feelings of abandonment for service users or moral injury for staff.
7 Participants who opted for video conference interviews had the option to turn their camera
8 off. In both cases (video-conference or telephone call) only the audio was recorded.
9 Interviews lasted between 22 minutes and 95 minutes. Service users and carers were
10 compensated £25 for taking part in an interview.
11

12 Interview audio files were securely transferred to a third-party transcription service subject to
13 the University of Cambridge data protection regulations. Anonymised service user, carer and
14 staff interviews were analysed separately. Analysis of anonymised interview transcripts was
15 based on the constant comparative method.¹⁹ The coding scheme was developed based on
16 a subset of initial interviews. The initial codes were revised, expanded and collapsed as
17 analysis progressed, and through whole team discussions. Codes were then were organised
18 into categories in a thematised coding scheme. Data was processed using NVIVO software
19 by five coders (four females and one male, DS). JP and NB analysed service user
20 interviews, EL analysed carer interviews, DS, NB and NR independently analysed staff
21 interviews.
22

23 During the process of write up and dissemination, some interview excerpts were edited
24 further to protect the identity of participants. We followed the Standards for Reporting
25 Qualitative Research recommendations²⁰.
26

27 Ethical approval for the study was obtained from the University of Cambridge Psychology
28 Research Ethics Committee on 15 June 2020, reference: PRE.2020.075. All participants
29 were provided with information about the study and gave consent.
30

31 **Patient and public involvement (PPI)**

32
33 We consulted a panel of mental health service users and carers convened by the McPin
34 Foundation. Members helped us shape the research questions, methods, and risk
35 management plans for the study. We also gathered the views of these experts-by-
36 experience on the study materials, including the research protocol and our participant-facing
37 documents. We shared the study documents with these experts-by-experience requesting
38 their comments and recommendations. We held a series of online meetings to give
39 participants a further opportunity to share their views and suggestions for improvement,
40 providing individual online meetings or a telephone call according to preference. Experts-by-
41 experience provided advice on how best to include carers in the study and suggestions for
42 specific networks for recruitment. They also guided how best to compensate participants for
43 their time, as well as emphasising the need for an accessible summary of the research to be
44 made widely available.
45

46 Using peer-research methods,²¹ a researcher from the McPin Foundation carried out and
47 analysed the service user interviews, drawing on her own experiences of accessing
48 secondary mental healthcare both before and during the study period.
49
50
51
52
53

54 **RESULTS**

55
56 In total 69 people took part in the study (Table 1). We interviewed 24 people with mental
57 health difficulties under the care of secondary mental health services (19 by telephone, 5 by
58 video). Of these, four interviews were excluded as they did not meet the eligibility criteria, so
59 analysis was based on 20 interviews. We interviewed 10 individuals who cared for people
60 with mental health difficulties (8 by telephone, 2 by video). We also interviewed 35 point of

care staff (21 by telephone, 14 by video), including psychiatrists (trainees and consultants), care coordinators, mental health nurses, clinical psychologists and psychotherapists; some had managerial as well as clinical roles.

Most service users and carers who expressed interest in the study completed an interview. However, a large proportion of staff who expressed interest did not book an interview, likely because of pressures associated with the pandemic and job role moves. Reasonable diversity of participants was achieved (Table 1), in line with our sampling strategy.

Table 1: Participants' demographic information

	Service Users	Carers	Staff
Number of people who expressed interest in the study	60	18	142
Number of people invited to interview	30	18	91
Number of eligible interviews	20	10	35
Gender identity	<ul style="list-style-type: none"> 8 Women 7 Men 2 Non-binary 3 people did not provide this information 	<ul style="list-style-type: none"> 6 Women 2 Men 2 people did not provide this information 	<ul style="list-style-type: none"> 19 Women 11 Men 5 people did not provide this information
Ethnicity	<ul style="list-style-type: none"> 8 White 3 Black 2 Asian 4 Mixed ethnicity 3 people did not provide this information 	<ul style="list-style-type: none"> 7 White 1 Asian 2 people did not provide this information 	<ul style="list-style-type: none"> 24 White 3 Asian 2 Mixed ethnicity 1 from 'any other ethnic group' 5 people did not provide this information
Region	<ul style="list-style-type: none"> 1 North West 5 East Midlands 6 Greater London 2 East of England 1 South East 2 South West 3 people did not provide this information 	<ul style="list-style-type: none"> 1 West Midlands 4 East of England 2 South East 1 South West 2 people did not provide this information 	<ul style="list-style-type: none"> 4 North East 7 North West 2 East Midlands 5 West Midlands 4 Greater London 2 East of England 3 South East 3 South West 5 people did not provide this information
Additional information	Services accessed or contacted: <ul style="list-style-type: none"> Acute hospital wards Community Mental Health Teams (CMHT) Crisis Teams 		<ul style="list-style-type: none"> 17 Psychiatrists (13 trainees and 4 consultants) 10 Mental health nurses (including care coordinators, matrons, non-clinical prescribers) 8 Clinical psychologists (including CBT therapists and systemic family therapists)

	<ul style="list-style-type: none"> Specialist services (self-harm, personality disorder) 		<p>Services covered:</p> <ul style="list-style-type: none"> Community Mental Health Teams (CMHT) Early intervention for psychosis (EIP) Crisis Teams Acute hospital wards Secure Forensic services
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Participants reported that a widespread switch to remote care for secondary mental health care occurred in response to the pandemic. They described an evolving context where telephone was initially the most widely used technology (owing to its perceived wide accessibility), giving way, towards the end of our recruitment period (August 2020), to increased use of video-supported platforms. These platforms were introduced as issues about what was allowed by information governance policies began to be resolved, and as familiarity with the technology grew. In what follows, we report the accounts of participants in relation to: service user choices about remote care; the embodied dimensions of therapeutic encounters; remote assessments and identifying risks; and inequities in access.

Service user choices about remote care

Service users had mixed experiences of remote care. Most reported that it was adequate or tolerable, but that face-to-face was much better. Where people did have positive experiences, they tended to be reported by service users who had a prior relationship with a clinician.

[The psychiatrist] was really great across the phone... I was quite worried that the phone appointment was going to be terrible because I've always had it in person, but he was really good. It was almost like he was in the same room as me. (Service user)

Several reported that trying to build a therapeutic relationship remotely with a member of staff who they did not know was problematic, and that they preferred being able to build on pre-established rapport.

I suppose if the AttendAnywhere works... actually, it doesn't take as long out of your day. It takes exactly an hour rather than travelling to the appointment. So, it's an option. But I still feel that the face-to-face has it for me. (Service user)

Service users often expressed dissatisfaction with the modality of remote care offered, particularly at the beginning of the pandemic when only telephone was mostly available. They reported feeling frustrated by the lack of choice they had in how to stay in contact with services, an experience that was also shared by staff during the early stages of the pandemic.

It's like, oh, Zoom's not allowed because of privacy, confidentiality, then they tried to launch something and then it was rubbish. It took them like six or seven weeks and they still don't have their act together. Whereas I've heard [other] people... and they said that they can do it online so why is that [this Trust] can do it and you can't get your act together... (Service user)

1
2
3 Some service users reported that the use of remote methods made it more likely that
4 appointment times would be altered or not followed through, leading to uncertainty and
5 frustration.
6

7 *I can't deal with uncertainty and inconsistency and I think they literally did...oh, we'll call*
8 *at 3:00, and then they'll call at 4:00 and it was, yes, we can, no, we can't. Then in the*
9 *end they discharged me with a letter and then...it was in a way, you know when they*
10 *discharge you as well, you don't know whether to say, yes, that's a good idea or no*
11 *because you're worried that actually tomorrow I might have a really bad day (Service*
12 *user)*
13

14 *I think it's a very poor service that make an agreement they'll ring somebody every*
15 *week, and then suddenly to fall off a cliff like that, I think it's a really bad service, I'm*
16 *sorry. I think someone should handover and say, well, I've got a vulnerable client*
17 *that's actually been working with the [service name] as well, and then just to be*
18 *dumped like that for nearly seven weeks, I'm sorry I think it's really poor. (Service*
19 *user)*
20
21

22 Some service users and carers chose not to receive remote care, particularly for
23 psychological interventions, because they believed that face-to-face consultations
24 would be reintroduced soon. Others did not feel that remote consultations would be as
25 helpful or meaningful as face-to-face ones; they made clear that remote care was their
26 only option during the pandemic, and was not a choice they would otherwise have
27 made:
28

29 *I thought it would be doubly frustrating... doing everything on the telephone and [that*
30 *you'd] end up with endless telephone conversations that got nowhere. (Service user)*
31

32 *I certainly feel that I haven't made the progress with the psychologist... I was getting a lot*
33 *more out of the appointments when they were face-to-face, I think. I don't come away*
34 *feeling as if I've really taken on board what he's said to me in the same way. (Service*
35 *user)*
36

37 Staff expressed concerns that breaks in therapy might negatively affect service users'
38 and families' mental health during the pandemic. They recognised the challenges in
39 providing remote care and understood service users' choices not to engage with it,
40 some offering face-to-face when allowed:
41

42 *I did have quite a few drop out... [Some] chose not to continue because they didn't want*
43 *to do remote working... Some people had an idea that [the pandemic] would be short*
44 *lived... That was a concern for me because we were in the middle of therapy and I'm*
45 *struggling now to get them back. (Family therapist)*
46
47

48 *I think that people have missed face-to-face contact... I've rung and said 'I'm going to go*
49 *back to some places for contact... Do you want to see me, or do you want to just do it*
50 *over the phone?' And everybody has said 'Yeah, would really love to see you.'*
51 *(Care co-ordinator)*
52

53 Some staff shared the view of many service users that remote care was more suitable for
54 maintaining continuity in existing relationships than for meeting people who were newly
55 referred. Conversely, some clinical psychologists and psychotherapists reported that remote
56 care was more likely to be accepted by service users who had not experienced face-to-face
57 therapy before, because they did not endure the 'shock' of a change in access mode.
58
59
60

The embodied dimensions of therapeutic encounters

The move to remote care helped to maintain some form of connection between service users and services during the pandemic. However, participants reported that remote care changed the character and depth of clinical encounters and, in turn, their relational quality. Uniting the accounts of service users, carers and staff was the loss of the embodied dimension of therapeutic interactions, including the physical space where these used to take place. Many described remote consultations as 'not the same', noting that even where they were able to see someone's facial expressions (in online consultations), not being together in a room meant that building and maintaining a connection was problematic. For example, when eye contact was mediated by a camera, it hampered the reciprocity normally experienced in face-to-face interactions, as did the emphasis on verbal communication over body language. These factors compounded many service users feeling socially isolated during the pandemic, while for others, the loss of a particular, even sacred, therapeutic setting undermined the quality of care:

[Remote consultations with psychiatrist] just felt more perfunctory, somehow, and I felt less like opening up about stuff. It tends to be quick discussions about my medication and that's it... It felt like there was a barrier and I was just less inclined to open up.
(Service user)

You can't have simultaneous eye contact with someone. When you look at the camera, they have the experience that you're looking in their eyes but you don't have that experience because you're looking at the camera... It just creates a really weird asynchrony so it's just not like being in the room with the person... I just find that quite disconcerting. (Clinical psychologist)

Service users reported not feeling able to make full use of therapeutic interactions in an environment they shared with other people (commonly, family members). Others felt that video consultations were 'invading' their own private space:

In our home, we have three generations of families who live in a two-bedroom house. So, picture eight people in a two-bedroom house – you know, it's quite hard. (Service user)

There's something that... has that sacredness about the [consultation] room. (Service user)

The loss of the journey to and from services was another aspect of remote care that required adjustment. Some service users felt they were deprived of the opportunity to process the content of the sessions and gently transition back to their home lives.

After the phone call, he said 'Bye' and he put the phone down. I was just like 'Oh.' It just felt slightly surreal. (Service user)

The trip... would at least get me into the headspace of 'Okay, I'm going into therapy.'
And then, leaving, I would then get on a bus and just chill and let it sink. (Service user)

Similarly, some staff members reported less opportunity to reflect and process after consultations due to back-to-back appointments. Several therapists also emphasised the importance of therapy taking place in a safe and bounded physical space (the therapeutic setting). They saw remote consultations, often being delivered from their homes as removing a boundary between private life and therapeutic work, compromising the safety of these consultations. They found some types of therapeutic work, such as trauma processing, to be so ill-suited to remote care that they paused it.

1
2
3 *And I don't have any car journeys anymore. I really appreciated time in the car because it*
4 *gave me time to reflect and time to process and time for myself. And in an office, home*
5 *office with Microsoft Teams, you get a lot of appointments just back-to-back. (Family*
6 *therapist)*
7

8 *I had a girl... who started online, and, probably, about six sessions in, she got quite*
9 *emotive... and then she suddenly shut down, and I was like 'What's that about?' And she*
10 *said, 'Well, my mum's next door and I can't do that. This isn't safe.' (CBT therapist)*
11

12 **Remote assessments and identifying risks**

13
14 A particular area of concern for all participants related to the effectiveness of remote forms of
15 care in conducting assessments and identifying risks. Service users reported that lack of
16 face-to-face contact made it more challenging for staff to identify – and help them recognise
17 themselves – signs that their mental health was changing. This was important when, for
18 example, the nature of their mental health difficulties meant they could transition rapidly from
19 depression to mania, without being able to understand that this was happening and that a
20 crisis requiring inpatient admission might follow. In interviews, service users and carers
21 described video consultations as going some way towards addressing these issues
22 compared with telephone calls, but mostly they saw them as a poor substitute for face-to-
23 face contact:
24
25

26 *In the run-up to my becoming very unwell I didn't see them face to face, and I think that I*
27 *was becoming (I have bipolar) increasingly hypermanic [sic]. But, because I was still*
28 *functioning at my job, I didn't really recognise it. (Service user)*
29

30 *Before COVID, probably in face-to-face meetings there [was] more of an opportunity to*
31 *observe body language and assess mood from the physical presence of somebody that*
32 *you're sitting with. I don't think that can be really captured over the phone. (Carer)*
33

34 Some carers felt that the shift to remote care exacerbated a pre-pandemic problem of their
35 being excluded from assessments, such that risk may not be assessed properly. One carer
36 felt that the person they supported did not find remote consultations beneficial and tried to
37 end the interactions quickly. Because the carer was not included in the consultations, some
38 issues were not recognised, recorded or addressed:
39

40
41 *My [family member] just wants people off her back... [She] will say 'I'm fine' until she's*
42 *blue in the face. It's much easier to do that on a half-hour phone call than it is possibly*
43 *sitting face-to-face with somebody for an hour, who might actually be able to read further*
44 *into things. (Carer)*
45

46 Staff tended to agree on the inherent limitations of remote consultations for conducting
47 assessments and identifying mental health risks – especially in the context of COVID, where
48 service users presenting to community services were more acutely unwell. It appeared that
49 specific aspects of assessments were particularly compromised by remote contact. For
50 example, staff and carers said remote consultations made it difficult (or, in the case of
51 telephone consultations, impossible) to pick up important non-verbal cues, such as body
52 language and levels of tension. These difficulties were exacerbated for service users who
53 struggled to verbally communicate how they were feeling. Acknowledging the limitations of
54 remote consultations for risk assessment, some services used telephone consultations to
55 evaluate the need for face-to-face contact. Yet sometimes this introduced other problems:
56 delaying fuller assessments, for example:
57

58 *What a lot of doctors did was... a short assessment on the phone just to basically check*
59 *for risks: it was more of an in-depth triage than a proper assessment. And then they*
60

would say, 'It is urgent that I see this person'. And they would do face-to-face assessment. I think what it did was just slow down the process from the point of referral to the point of deciding that we would take the person on to the caseload. (Care co-ordinator)

Other factors that limited the depth and appropriateness of remote assessments included an inability to evaluate service users' home circumstances. Staff had to rely much more on service users' self-report of their mental health without, in addition, picking-up subtle, non-verbal clues that are available during an interview. Staff acknowledged the importance of carers, family members or friends being physically present at the point of assessment, reporting that service users who did not have this support (for example, those living in care homes during the pandemic) may have been particularly disadvantaged. Remote working and lockdown restrictions also meant that service users in compromising home life situations, such as those facing domestic abuse, may not have felt comfortable disclosing how they were coping:

Domestic violence assessments – usually we would go out to the home and try and get a sense of how things were, whereas obviously on the phone you're only getting one side of the story. (Senior clinical psychologist)

Our team would [normally] go to patients' homes and check their weight... but because of COVID we had to ask patients to do that. But our patients with anorexia, they have a tendency to falsify their weight. So, in that way, it would be difficult to give them quality care. (Trainee psychiatrist)

Inequities in access

Participants across the service user, carer and staff groups reported multiple concerns about the potential for remote care to have disproportionately negative effects for some groups of service users and carers through intersectionality, thus creating or further amplifying inequities. These groups included those with hearing difficulties and communication impairments; people for whom interacting through a screen or a telephone was particularly challenging (e.g. because of anxiety or autism); people who were unfamiliar with or reluctant to use technology, including some older people and those experiencing paranoia or delusions about technology; people who could not afford devices or internet access; and people who needed support with the English language, often impacting on whole communities (Table 2).

Table 2: Groups identified as particularly at risk of disadvantage from remote care

Groups at risk of disadvantage from remote care	Example quotations
Individuals with sensory (e.g. hearing) difficulties and communication impairments.	<p><i>We work with over 65s, so we know that a lot of those are people who have hearing difficulties and it can be incredibly difficult for them to get the same out of the telephone session as they do in person. (Senior clinical psychologist)</i></p> <p><i>I was working with a family that the [family member] had a stroke and can only write, and the family do a lot of her communicating in the family sessions. And they said there's just no way we can do that online, it's going to all... it's just going to stress her out completely. So people who have got additional needs that don't get met by the online platform. (Family therapist)</i></p>

<p>Individuals for whom interacting through a screen or via telephone may be particularly challenging.</p>	<p><i>I felt really not looked after in the community, the way they were proposing to help us was just calling, which is not very adequate for me because I have Asperger's and I really need something physical. (Service user)</i></p> <p><i>I assessed a person with autism, and it was challenging. 'Cause I think if you struggle with human interaction in person, you probably struggle even more online. (Trainee psychiatrist)</i></p>
<p>People who may be unfamiliar with, or unwilling to use, technology ('digital exclusion'), including older adults and individuals experiencing phobias or delusions regarding IT.</p>	<p><i>Ours is an older population generally speaking, and not to stereotype, but a lot of the older population are not technology savvy, a lot don't have smart phones, a lot don't have iPads or computers. So, we haven't video called most of them, or a lot of them. It tends to be that we're just making lots and lots of telephone calls. (Care coordinator)</i></p> <p><i>[Family member] won't Zoom. Part of his schizophrenia is he can't look at live television so, Zoom, he couldn't do. This is him personally I'm talking about rather than in general. But (...) I get to know about a lot of other cases... and we are unanimous [it's] not just schizophrenia (...)... Face to face is invaluable. (Carer)</i></p> <p><i>There's one person who I'm still in contact with over the phone but she's phobic about technology, partly due to a previous trauma issues. (Clinical Psychologist)</i></p>
<p>People who may not have access to technology or telephone/ internet contracts (including those without a secure accommodation)</p>	<p><i>I have people who don't have internet access, don't have mobile phones, so if I don't go to their house, I'm not going to engage with them. (Care coordinator)</i></p> <p><i>Well, I guess people in social economic kind of situations where they don't allow them to have the devices, so families that don't have devices or Wi-Fi, that might be more difficult. (Family therapist)</i></p>
<p>Non-native English speakers (and those needing a language interpreter) for whom relying only upon verbal communication may constitute an obstacle to mutual understanding.</p>	<p><i>But [remote access] is limited, it relies on people having good English, whereas we have quite a high Turkish population here. (Trainee psychiatrist)</i></p> <p><i>A lot of our patients, because of the demographic, English may not be their first language or they may have an accent if they've grown up abroad, which can add to the difficulties in understanding people on the phone. (Trainee psychiatrist)</i></p>

Some participants emphasised the need to identify and address the inequalities created by new, as well as traditional, ways of providing support. For example, in evaluating the appropriateness of remote care, participants suggested that it is important to account for remote consultations that are missed or cancelled as well as those that do take place, to avoid selection bias:

I'm just very fearful that [services] will take from this 'Oh, we can do it all on Zoom, we can do it all online, we can do it all on the phone. We don't need to actually see people.'... And that would be a very negative [thing] for an awful lot of people.... but those people would vanish quite rapidly. And then... the people who would be left would be those who are comfortable with that. And [services] would be able to say, 'Oh, look, it's working fine for these people.' Well, who have you lost on the way? (Carer)

I hope it doesn't go the other way and we end up cutting the face-to-face services too much. I do fear that in a way. I think the technological things would be the main positive change. I just hope that it doesn't come at the expense of saying, oh well, the face-to-face doesn't matter, or you can cut that, which in the context of older people is especially important. (Trainee psychiatrist)

Conversely, remote care appeared to have some role in addressing some inequalities associated with face-to-face only. For example, during the pandemic, it enabled people who

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3 were shielding or particularly vulnerable to the virus to continue accessing services, reducing
4 transport costs and logistical difficulties for service users and carers, and benefitted people
5 with physical impairments who were challenged by having to travel. That said, it did not
6 benefit all.
7

8 *For a long time, service users asked us 'Do we have to come all the way into a site with*
9 *no parking, or could you see us by video?' And the answer's always been 'No.' So I think*
10 *some of them are a little bit annoyed because they've been asking for this for years and*
11 *never received it, and now we've said 'It is possible, after all – who knew?' So, it'll be*
12 *funny after [COVID-19] to see what people are happy to go back to... My consulting*
13 *rooms are on the first floor [with no] parking space, which is hideous for older people with*
14 *mobility problems. So, I think a lot of them would prefer telephone or video rather than*
15 *having to come in. (Senior clinical psychologist)*
16

17 **The future of remote care**

18
19 Service users, carers and staff had varying views on the appropriateness of remote care for
20 secondary mental health services, but generally concurred that shared decision-making
21 about access modes (face-to-face versus remote care) needed negotiation. As the use of
22 remote care became more common during the pandemic, such consultation and shared
23 decision-making became even less common, albeit largely through force of circumstances.
24 Service users, carers and staff alike felt strongly that organisations should take a tailored
25 approach to introducing remote care once more flexibility returns to the system. They
26 proposed that such an approach should take into account the differences between different
27 types of clinical encounter (for example, psychotherapy, psychiatric reviews, monitoring or
28 changing medication, or regular care coordinator encounters) and the range of options for
29 remote contact (including telephone calls, video-supported calls, text messages, emails).
30 They also highlighted that, in the future, mental health services should attempt to
31 acknowledge the unfamiliarity and potential 'strangeness' of accessing services remotely
32 and recognise that people's preferences around remote access may shift in response to their
33 changing circumstances and experiences of mental health:
34
35

36 *There wasn't anything about, 'You might find this strange initially; it's going to feel*
37 *different'... Something like that would have been really nice, like 'It's going to feel*
38 *different and maybe these are some of the ways that you and your psychiatrist can*
39 *manage that.'* (Service user)
40

41
42 Participants described technology-related and connectivity issues as other key factors to
43 consider in relation to remote access. Wi-Fi and signal problems could affect sound and
44 video quality and sometimes prevented consultations from happening altogether. These
45 issues seemed to be more prominent in rural areas, thus disproportionately affecting
46 services in specific geographical locations.
47

48 *I know a lot of people who've had technical and/or IT-related issues with [remote care] –*
49 *largely due to connectivity or lack of. So that seems to have been the biggest barrier.*
50 (Trainee psychiatrist)
51

52 *There was one appointment when we tried and tried to get the AttendAnywhere to work*
53 *and it just wouldn't, and it was really frustrating because we could see each other but*
54 *either I could hear my psychologist, or he could hear me, but we couldn't hear each*
55 *other. So, we gave up in the end... It does rely on you having a good internet*
56 *connection. (Service user)*
57

58 When staff were asked about the future of remote care, most saw it as having a role in
59 *supplementing* face-to-face contact. Its advantages included avoiding unnecessary or
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3 burdensome travel, giving healthcare staff more time to maintain regular contact with service
4 users, allowing the flexibility to offer shorter, more frequent sessions, and perhaps enhanced
5 ability to follow up service users who did not attend their scheduled appointments, although
6 this was not generally the experience of the service users we interviewed. Staff also reported
7 some remote sessions as being more intense than face-to-face, so they brought them to a
8 close earlier. Finally, staff emphasised that if remote care was going to be more widely used
9 in the future, they would need specific and tailored training for delivering psychological
10 interventions remotely:
11

12 *Our DNA [did not attend] rate has probably fallen... the standard thing, if somebody*
13 *doesn't turn up to clinic you just mark that down as did not attend. Although a care*
14 *coordinator might go out and say to the person... Whereas now what I would do is just*
15 *phone them up, and I think that's what I will be doing in future. Obviously, you won't*
16 *always be able to get through, but sometimes you can. And you can learn useful stuff on*
17 *the phone even if it might not be the same as what you'd see face to face. It's still better*
18 *than nothing. (Consultant psychiatrist)*
19

20 *I think the telephone consultations have been good. I think it's nice, it offers flexibility to*
21 *the patients as well as the clinicians. Reduces the need for travel if a patient had to take*
22 *time off work, et cetera, to come to an appointment, because before we were quite rigid*
23 *where we would want them to actually come in. (Trainee psychiatrist)*
24

25 *I was never trained in online therapy... Overnight, you're having to change your practice*
26 *and it's quite different online... I would always have a piece of paper between me and*
27 *the client. Well, that was immediately taken away. So, sharing thoughts and formulations*
28 *became more difficult. (CBT therapist)*
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33 DISCUSSION

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35 This qualitative study of the accounts of 65 service users, carers and healthcare staff of their
36 experiences of remote care during the COVID-19 pandemic offers much rich learning (Box
37 1), including indications of how to optimise service provision in the future and where
38 evidence and guidance is needed. Participants reported both advantages and
39 disadvantages to remote care as a means of sustaining capacity and enabling access to
40 secondary mental health services. Some participants, including both service users and
41 service providers, valued the flexibility offered by remote care, particularly in the context of
42 reduced access to face-to-face service provision.²² Nevertheless, there were significant
43 downsides. Participants found that consultations by telephone and video restricted
44 therapeutic relationships compared with in-person contact, particularly where service users
45 and staff could not build on a bond already formed face-to-face. This finding underscores the
46 limitations of the current evidence on video-based consultations as a substitute for in-person
47 healthcare; as Greenhalgh and colleagues note, the current literature relates almost
48 exclusively to "highly selected samples of hospital outpatients with chronic, stable
49 conditions."²³ Our study further challenges the transferability of this literature to the mental
50 health context, particularly for service users whose difficulties are fluctuating or who may find
51 themselves in crisis.
52

53
54 Our study has strengths and weaknesses. As a qualitative study, it relies on accounts of
55 behaviours, practices, experiences and opinions as reported by participants. It cannot take
56 into account the clinical or personal outcomes of remote care, or detect causal relationships
57 between these and the various features of remote care identified. Among the study's
58 strengths are its large and varied sample and its novelty in exploring remote care for mental
59 health during a pandemic from the perspective of service users, service providers and family
60 carers. Further strengths include the study's involvement of experts-by-experience and use

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3 of peer research methods, which arguably facilitated more authentic understanding of
4 people's views and experiences, valuing the expertise of all those involved while equally
5 valuing difference. However, some important groups we not included in our study, including
6 people attempting to access mental healthcare for the first time and some key professional
7 groups, including those who work in social care and primary care. The methods of online
8 recruitment and engagement used in the study will have created some barriers for some
9 groups; the approach favoured those to whom we could reach out with information about the
10 study, as well as those with the necessary resource and capacity to decide whether or not to
11 take part in the interview and to complete the informed consent process. For this reason, our
12 findings may underplay the problems. It is possible that inequalities in access to technology
13 may have influenced how participants were able to take part in this study, with 40% of staff
14 taking part in an interview using video methods compared with 20.8% of service users and
15 20% of carers. Technical difficulties, personal preferences and concerns about confidentiality
16 may account for some differences too. On the other hand, remote methods may also have
17 facilitated involvement of some people who would not have chosen to take part in a face-to-
18 face study.
19

20
21 The study is helpful in identifying the distinctiveness of the mental health context compared
22 with remote care for physical health conditions. Staff and service users alike noted that many
23 features of a consultation that are taken for granted in face-to-face care become problematic
24 in remote consultations. For clinicians, the essential non-verbal cues that are important to
25 their questions, assessments and advice were missing. They sometimes doubted whether
26 service users were willing or able to disclose all relevant information. Similarly, service users
27 and carers felt that important aspects of consultations could easily be missed or
28 misconstrued, especially by telephone, and even during video consultations. Both service
29 providers and service users lamented the loss of the 'sanctity of the consulting room', as a
30 space reserved for highly personal, confidential conversations. Neither the psychological nor
31 the physical features of this space could be replicated in remote consultations. The lack of
32 boundaries between domestic life and the clinical encounter could be immensely stressful,
33 and challenges around privacy that have been noted in relation to physical health may be
34 particularly difficult in remote care for mental health.^{24 25} For some service users, aspects
35 relating to their mental health magnified the challenges that have been noted in remote
36 consultations about physical health.^{22 26} Sensory difficulties, communication impairments,
37 digital exclusion and aversion to screen-mediated contact made remote care especially
38 problematic for some service users, and might be caused or exacerbated by some mental
39 health difficulties.
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41
42 Though remote care in secondary mental health services is likely to become increasingly
43 common, perhaps routine, our findings have important implications for policy, clinical
44 practice, and the future development of research in this area. In particular, our work makes
45 clear that a "one-size-fits all" approach is not a suitable long-term solution once the
46 exigencies of the COVID-19 pandemic have passed. While enhancing access for some
47 groups, remote care may impede it for others, and the differential impact of remote care
48 requires careful evaluation, accounting for impacts on those who withdraw from remote care
49 as well those who engage. This also points to the need to develop tailored, personalised
50 approaches to remote care that cater for the preferences and needs of individual service
51 users, as well as for changes in their mental wellbeing. Our data show that many service
52 users – and indeed professionals – had limited influence or choice about how care was
53 provided. Identifying the appropriate balance of in-person and remote support for individuals
54 and for different service user groups requires the input of frontline clinicians, service users
55 and families who may be involved in their care, and the adoption of rigorous co-production
56 methodologies that will take careful development.
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59 Training and development might focus on enabling staff, service users and carers to make
60 the most of the advantages offered by remote care, while identifying and mitigating its

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3 challenges. Professional development for staff must evolve, accordingly, as must novel
4 approaches to supporting service users who, presently, are given little information if any as
5 to how best to make the most of remote consultations. While curricula (or a joint curriculum
6 for staff and service users) require further research and pedagogical input, we expect key
7 components to include confidence in use of IT platforms and the means to practise
8 communication skills in virtual settings, consideration of age and cultural contexts, and legal
9 and governance requirements. Equally important for staff is to consider the risks of remote
10 working for members: reduced contact with colleagues in the structured environment of a
11 shared working space may hinder the kind of informal knowledge sharing and mutual
12 monitoring that is key to maintaining safety in healthcare teams. If we can define what good
13 looks like, shared decisions about the option of remote approaches could support a tailored,
14 personal approach to mental healthcare.
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17 In conclusion, the widespread and unavoidable pivoting from face-to-face to remote mental
18 healthcare during the pandemic was an unplanned natural experiment. It is clear from our
19 work is that guidance is needed on exactly which type of clinical consultations best suit in-
20 person presence, and for whom and why, and which can be offered remotely, and through
21 which medium, taking into account intersectional challenges regarding access that contribute
22 to the continuing 'digital divide' in mental health.^{27 28}
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26 Box 1: Learning points for remote care

28 **Box 1: Learning points and priorities for improvement for providing remote** 29 **mental healthcare**

- 30 • While remote consultations allowed secondary mental health services to continue
31 working at a time of unprecedented crisis, refinement is required in how these will
32 be offered in the future.
- 33 • The availability of remote access technologies does not mean that direct
34 substitutions for face-to-face care are appropriate.
- 35 • Conducting mental health assessments remotely may be particularly problematic
36 and has potential to hinder the identification of risks and use of shared decision-
37 making.
- 38 • Training for staff in leading or supervising clinical interventions remotely is
39 needed; this must be targeted to the specific remote platform used and be based
40 upon co-production principles with service users and carers involved in delivery.
- 41 • There is a specific need for guidance on use of remote access mental healthcare,
42 which should be based on further research and consultation.
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AUTHOR CONTRIBUTIONS

Elisa Liberati was lead researcher and managed the project with Natalie Richards. Peter B Jones, Graham Martin, Mary Dixon-Woods, Jennie Parker and Vanessa Pinfold contributed to the design of the study, analysis, and writing-up. EL, NR, JW and JP conducted the interviews. DS, JW and NB contributed to the analysis and writing-up.

Competing interests

The authors declare they have no competing interests.

ETHICS STATEMENT

Ethical approval for the study was obtained from the University of Cambridge Psychology Research Ethics Committee on 15 June 2020, reference: PRE.2020.075. All participants were provided with information about the study and gave consent.

PATIENT CONSENT FOR PUBLICATION

Not required.

DATA SHARING STATEMENT

All data relevant to the study are included in the article or uploaded as supplementary information.

REFERENCES

1. McDaid D, Park A-L, Wahlbeck K. The Economic Case for the Prevention of Mental Illness. 2019;40(1):373-89. doi: 10.1146/annurev-publhealth-040617-013629

- 1
- 2
- 3
- 4 2. MIND. The mental health emergency. How has the coronavirus pandemic impacted our mental
- 5 health? London: MIND. Available at: mind.org.uk.
- 6
- 7 3. Public Health England. COVID-19: mental health and wellbeing surveillance report. Available at:
- 8 [https://www.gov.uk/government/publications/covid-19-mental-health-and-wellbeing-](https://www.gov.uk/government/publications/covid-19-mental-health-and-wellbeing-surveillance-report)
- 9 [surveillance-report](https://www.gov.uk/government/publications/covid-19-mental-health-and-wellbeing-surveillance-report), 2020.
- 10
- 11 4. Rethink Mental Illness. Rethink Mental Illness COVID-19 briefings: Access to NHS mental health
- 12 services for people living with severe mental illness. Available at:
- 13 <https://www.rethink.org/media/3793/access-to-mh-services-final-040220.pdf>, 2020.
- 14
- 15 5. O'Connor RC, Wetherall K, Cleare S, et al. Mental health and wellbeing during the COVID-19
- 16 pandemic: longitudinal analyses of adults in the UK COVID-19 Mental Health &
- 17 Wellbeing study. *The British Journal of Psychiatry* 2020;1-17. doi: 10.1192/bjp.2020.212
- 18 [published Online First: 2020/10/21]
- 19
- 20 6. Krishnamoorthy Y, Nagarajan R, Saya GK, et al. Prevalence of psychological morbidities among
- 21 general population, healthcare workers and COVID-19 patients amidst the COVID-19
- 22 pandemic: A systematic review and meta-analysis. *Psychiatry Res* 2020;293:113382-82. doi:
- 23 10.1016/j.psychres.2020.113382
- 24
- 25 7. Johnson S, Dalton-Locke C, Vera San Juan N, et al. Impact on mental health care and on mental
- 26 health service users of the COVID-19 pandemic: a mixed methods survey of UK mental
- 27 health care staff. *medRxiv* 2020:2020.06.12.20129494. doi: 10.1101/2020.06.12.20129494
- 28
- 29 8. BMA. Pressure points in the NHS: BMA,; 17 November 2020 [Available from:
- 30 [https://www.bma.org.uk/advice-and-support/nhs-delivery-and-](https://www.bma.org.uk/advice-and-support/nhs-delivery-and-workforce/pressures/pressure-points-in-the-nhs)
- 31 [workforce/pressures/pressure-points-in-the-nhs](https://www.bma.org.uk/advice-and-support/nhs-delivery-and-workforce/pressures/pressure-points-in-the-nhs) accessed 09 December 2020.
- 32
- 33 9. NHS Reset. Mental health services and COVID-19: Preparing for the rising tide. Available at
- 34 [https://www.nhsconfed.org/-](https://www.nhsconfed.org/-/media/Confederation/Files/Publications/Documents/Report_Mental-health-services-NHS-Reset_FNL.pdf)
- 35 [/media/Confederation/Files/Publications/Documents/Report_Mental-health-services-NHS-](https://www.nhsconfed.org/-/media/Confederation/Files/Publications/Documents/Report_Mental-health-services-NHS-Reset_FNL.pdf)
- 36 [Reset_FNL.pdf](https://www.nhsconfed.org/-/media/Confederation/Files/Publications/Documents/Report_Mental-health-services-NHS-Reset_FNL.pdf), 2020.
- 37
- 38 10. Iob E, Steptoe A, Fancourt D. Abuse, self-harm and suicidal ideation in the UK during the COVID-
- 39 19 pandemic. *Br J Psychiatry* 2020;217(4):543-46. doi: 10.1192/bjp.2020.130
- 40
- 41 11. Doughty K. From red buttons to smart technology support: part 1: Independently published,
- 42 2018.
- 43
- 44 12. Fisk M, Livingstone A, Pit SW. Telehealth in the Context of COVID-19: Changing Perspectives in
- 45 Australia, the United Kingdom, and the United States. *Journal of Medical Internet Research*
- 46 2020;22(6):e19264.
- 47
- 48 13. Doraiswamy S, Abraham A, Mamtani R, et al. Use of Telehealth During the COVID-19 Pandemic:
- 49 Scoping Review. *Journal of Medical Internet Research* 2020;22(12):e24087.
- 50
- 51 14. Hollander JE, Carr BG. Virtually perfect? Telemedicine for COVID-19. *New England Journal of*
- 52 *Medicine* 2020;382(18):1679-81.
- 53
- 54 15. Chakrabarti S. Usefulness of telepsychiatry: A critical evaluation of videoconferencing-based
- 55 approaches. *World journal of psychiatry* 2015;5(3):286-304. doi: 10.5498/wjp.v5.i3.286
- 56 [published Online First: 2015/10/02]
- 57
- 58 16. Zhou X, Snoswell CL, Harding LE, et al. The role of telehealth in reducing the mental health
- 59 burden from COVID-19. *Telemedicine and e-Health* 2020;26(4):377-79.
- 60
17. Palinkas LA, Horwitz SM, Green CA, et al. Purposeful Sampling for Qualitative Data Collection and
- Analysis in Mixed Method Implementation Research. *Adm Policy Ment Health*
- 2015;42(5):533-44. doi: 10.1007/s10488-013-0528-y [published Online First: 2013/11/07]
18. Malterud K, Siersma VD, Guassora AD. Sample Size in Qualitative Interview Studies: Guided by
- Information Power. *Qual Health Res* 2016;26(13):1753-60. doi: 10.1177/1049732315617444
- [published Online First: 2015/11/29]
19. Charmaz K. Constructing grounded theory: A practical guide through qualitative analysis. London:
- Sage 2006.

- 1
- 2
- 3
- 4 20. O'Brien BC, Harris IB, Beckman TJ, et al. Standards for reporting qualitative research: a synthesis
- 5 of recommendations. *Academic Medicine* 2014;89(9):1245-51.
- 6 21. Sweeney A, Beresford P, Faulkner A, et al. This is survivor research: PCCS Books 2009.
- 7 22. The impact of COVID-19 on telemedicine utilization across multiple service lines in the United
- 8 States. Healthcare; 2020. Multidisciplinary Digital Publishing Institute.
- 9 23. Greenhalgh T, Wherton J, Shaw S, et al. Video consultations for covid-19: British Medical Journal
- 10 Publishing Group, 2020.
- 11 24. Kronenfeld JP, Penedo FJ. Novel Coronavirus (COVID-19): telemedicine and remote care delivery
- 12 in a time of medical crisis, implementation, and challenges. *Translational behavioral*
- 13 *medicine* 2020
- 14 25. Bokolo AJ. Exploring the adoption of telemedicine and virtual software for care of outpatients
- 15 during and after COVID-19 pandemic. *Irish Journal of Medical Science (1971-)* 2020:1-10.
- 16 26. Kichloo A, Albosta M, Dettloff K, et al. Telemedicine, the current COVID-19 pandemic and the
- 17 future: a narrative review and perspectives moving forward in the USA. *Family medicine and*
- 18 *community health* 2020;8(3)
- 19 27. Robotham D, Satkunanathan S, Doughty L, et al. Do we still have a digital divide in mental
- 20 health? A five-year survey follow-up. *Journal of medical Internet research* 2016;18(11):e309.
- 21 28. Greer B, Robotham D, Simblett S, et al. Digital exclusion among mental health service users:
- 22 qualitative investigation. *Journal of medical Internet research* 2019;21(1):e11696.
- 23
- 24
- 25
- 26
- 27
- 28
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Appendix 1

Interview topic guides for service users, carers, and staff

1 Service users

Mutual introductions.

Thank you for taking the time to speak with me today. Our conversation will be transcribed and anonymised and any identifiable data removed to protect your privacy.

You can stop the interview at any time if you would like a break or no longer wish to continue. If you were to become distressed or uncomfortable during the interview, what would be the best way for me to help? (*If appropriate, let interviewee know we can signpost to NHS or listening services*)

I will be available for a debrief after the interview if you feel you may benefit from it.

1. What motivated you to participate in this research? (*Warming up question – building rapport*)
2. *Researcher to ask participants how they are feeling about taking part in the interview – explore mood conversationally.*
3. Have you had to, or chosen to, self-isolate?
 - *If yes – how has this been for you?*
 - *If not – are you able to go out and how have you found this?*
4. Can you tell me about how mental health services usually support you?
 - *What services do/did you access/ what treatment did/do you receive?*
 - *How often do/did you receive treatment?*
 - *When did treatment start (and potentially end)?*

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5. What access to care have you needed since the COVID-19 outbreak started?
 6. [*If needed services could not be accessed*] Could you tell us what happened when you tried to access the service? What reasons were you given for the service being unavailable?
 7. [*If needed services were accessed*] What changes in care have you experienced due to the COVID-19 outbreak, if any?

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Notes for researcher:

- *Explore any change in usual treatment*
- *Explore any change in frequency of treatment*
- *Explore any interruption or delay of your usual treatments*
- *Explore impact on the person*

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8. How were these changes communicated or explained to you?
 9. Were you offered a choice in how to communicate with services? If so what options were you given (for example via phone, video-calls email, text)?
 10. If you now meet with your clinician online, how has this been for you? How are you finding these consultations?

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Notes for researcher:

- *Explore how this change felt, what they did to support themselves through it (or others did)...*

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11. Have you contacted support services that you would not normally use?
 - *Note for researchers: for example, NHS services (crisis support, 111, mental health out of hours support lines, home treatment team), non-statutory support (Samaritans, SANE, etc.), online support and forums.*
 12. *If yes* – how have you found them? Do you think you will continue to use them?
 13. Overall (*researcher to recap changes experienced*), how have these changes impacted you?
 14. Is there anything you are finding particularly challenging?
 15. Have any of the changes been positive for you?
 - Could they be maintained when the COVID-19 pandemic has passed?
 16. Did you have any involvement in, or were you consulted on any changes in the provision of your care during the pandemic?
 - If yes – what worked well in the consultation

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- If not – how might this have been done at the moment?

17. Who do you think should be prioritised for secondary mental health treatment during the COVID-19 pandemic?

Notes for researcher:

- *Explore why, what should guide decisions about prioritisation.*

18. Do you have any suggestions on how your care needs during the pandemic could be better met?

19. Is there anything that we haven't discussed that you think we should know in relation to this topic?

Ask interviewee how they feel after the conversation – explore mood conversationally.

Reminder of payment modality – a member of the research team will contact you via email.

2 Carers

Mutual introductions.

Thank you for taking the time to speak with me today. Our conversation will be transcribed and anonymised and any identifiable data removed to protect your privacy.

You can stop the interview at any time if you would like a break or no longer wish to continue. If you were to become distressed or uncomfortable during the interview, what would be the best way for me to help? (*If appropriate, let interviewee know we can signpost to NHS or listening services*)

I will be available for a debrief after the interview if you feel you may benefit from it.

1. What motivated you to participate in this research? (*Warming up question – building rapport*)
2. *Researcher to ask participants how they are feeling about taking part in the interview – explore mood conversationally.*
3. Can you tell me about your usual role as a carer?
 - Do you live with [*the person they care for - person name*]?
 - What mental health difficulties does [*person name*] experience?
 - What secondary mental health services do they usually access/ what treatment do they receive?
 - When did they start (and potentially stop) accessing services?
4. Have you and [*person name*] had to, or chosen to, self-isolate?
 - *If yes* – how has this been for you?
 - *If not* – are you able to go out and how are you both finding this?
5. Has your role as a carer changed during the COVID-19 pandemic, and if so how? How did you experience this change?
6. What access to care has the person you care for needed since the COVID-19 outbreak started?
7. [*If needed services could not be accessed*] Could you tell us what happened when you and the person you care for tried to access the service? What reasons were you given for the service being unavailable?
8. [*If needed services were accessed*] What changes in the care offered to [*person they care for*] have you noticed during the COVID-19 pandemic? How have they affected you? How have they been experienced by the person you care for?

Notes for researcher:

- Explore any change in usual treatment
- Explore any interruption or delay of your usual treatments
- Explore impact on the carer

9. How were these changes communicated or explained to you and [person name]?
10. Has [person name] received online consultations and, if so, how has this impacted your caring role? What do you think about online consultations?

Notes for researcher:

- Explore how this change has felt, what carer did to support this, what adjustments were needed

11. Overall (researcher to recap changes experienced), how have these changes impacted you?
12. Have you had to make any adjustments and, if so, how have these affected you?
13. Is there anything you are finding particularly challenging?
14. Have any of the changes been positive for you and/or the person you care for?
- Could they be maintained after the COVID-19 pandemic has passed?
15. Did you have any involvement in, or were you consulted, on any changes to the provision of mental healthcare during the pandemic?
- If yes – what worked well in the consultation
 - If not – how might this have been done at the moment?
16. Who do you think should be prioritised for secondary mental health treatment during the COVID-19 pandemic?

Notes for researcher:

- Explore why, what should guide decisions about prioritisation.

17. Do you have any suggestions on how your needs as a carer during the pandemic could be better met?
18. Is there anything that we haven't discussed that you think we should know in relation to this topic?

Ask interviewee how they feel after the conversation – explore mood conversationally.

3 Members of staff

Mutual introductions.

Thank you for taking the time to speak with me today. Our conversation will be transcribed and anonymised and any identifiable data removed to protect your privacy.

You can stop the interview at any time if you would like a break or no longer wish to continue. If you were to become distressed or uncomfortable during the interview, what would be the best way for me to help? *(If appropriate, let interviewee know we can signpost to NHS or listening services)*

I will be available for a debrief after the interview if you feel you may benefit from it.

1. Can you give me a quick background to your role? What kind of things would you typically do on a day-to-day basis?
2. How has the COVID-19 pandemic affected your role? *(Including whether they have been working from home)*
3. What pressures are you experiencing as a result of the COVID-19 pandemic?
4. How has the pandemic affected referrals into your service, in particular for service users that were known to the service before?
 - Have you noticed any changes about *how* people are coming into contact (via A&E, crisis teams, etc.)?
5. *[For hospital staff]* Have decisions about hospital admissions or discharge of service users been affected by the COVID-19 pandemic, in your opinion? How so?
 - Who makes these decisions?
 - How are these decisions affecting you?
6. How is COVID-19 affecting decisions on which service users to prioritise?
 - How are these decisions affecting you?
 - Do you feel that any particular patient groups may be particularly compromised?
7. How are decisions about what type of treatment to offer (including a shift to online consultations) being affected by the COVID-19 pandemic?
8. If some of your work has shifted to online consultations, how are you finding these?
9. How do you support mental health patients displaying COVID-19 symptoms?
 - How is it the decision made to refer them to acute healthcare settings?

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10. Have the processes for referral to specialist services (e.g. occupational therapy) changed? How so?
 11. Considering the changes we have discussed, are you facing any ethical or moral dilemmas which you were not confronted with before? (*Explore how these are experienced*)
 12. How is this new way of working affecting you and your wellbeing? How is it affecting your life outside work (e.g. family arrangements, lifestyle, etc.)?
 13. Has there been any changes to the support you are able to access in relation to your wellbeing and ability to provide support to others?
 - Has the COVID-19 pandemic affected your access to supervision and reflective practice, and if so how?
 - Are there processes in place to report or ask for support about the concerns you may be having?
 14. How do you feel that service users are finding to the new ways of receiving care?
 15. Has any change in the service introduced due to COVID-19 had a positive impact?
 - Would these changes be maintained in the aftermath of the acute phase of the pandemic?
 16. Is there anything that I haven't asked you that you feel we should know in relation to this topic?

Standards for Reporting Qualitative Research (SRQR)*

<http://www.equator-network.org/reporting-guidelines/srqr/>

Page no(s).

Title and abstract

<p>Title - Concise description of the nature and topic of the study Identifying the study as qualitative or indicating the approach (e.g., ethnography, grounded theory) or data collection methods (e.g., interview, focus group) is recommended</p>	Page 1
<p>Abstract - Summary of key elements of the study using the abstract format of the intended publication; typically includes background, purpose, methods, results, and conclusions</p>	Page 2

Introduction

<p>Problem formulation - Description and significance of the problem/phenomenon studied; review of relevant theory and empirical work; problem statement</p>	Page 3
<p>Purpose or research question - Purpose of the study and specific objectives or questions</p>	Page 3

Methods

<p>Qualitative approach and research paradigm - Qualitative approach (e.g., ethnography, grounded theory, case study, phenomenology, narrative research) and guiding theory if appropriate; identifying the research paradigm (e.g., postpositivist, constructivist/ interpretivist) is also recommended; rationale**</p>	Page 5
<p>Researcher characteristics and reflexivity - Researchers' characteristics that may influence the research, including personal attributes, qualifications/experience, relationship with participants, assumptions, and/or presuppositions; potential or actual interaction between researchers' characteristics and the research questions, approach, methods, results, and/or transferability</p>	Page 5
<p>Context - Setting/site and salient contextual factors; rationale**</p>	Page 4
<p>Sampling strategy - How and why research participants, documents, or events were selected; criteria for deciding when no further sampling was necessary (e.g., sampling saturation); rationale**</p>	Page 4
<p>Ethical issues pertaining to human subjects - Documentation of approval by an appropriate ethics review board and participant consent, or explanation for lack thereof; other confidentiality and data security issues</p>	Page 5
<p>Data collection methods - Types of data collected; details of data collection procedures including (as appropriate) start and stop dates of data collection and analysis, iterative process, triangulation of sources/methods, and modification of procedures in response to evolving study findings; rationale**</p>	Page 4

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2	Data collection instruments and technologies - Description of instruments (e.g.,	
3	interview guides, questionnaires) and devices (e.g., audio recorders) used for data	
4	collection; if/how the instrument(s) changed over the course of the study	Page 5-6
5		
6	Units of study - Number and relevant characteristics of participants, documents,	
7	or events included in the study; level of participation (could be reported in results)	Page 5
8		
9	Data processing - Methods for processing data prior to and during analysis,	
10	including transcription, data entry, data management and security, verification of	
11	data integrity, data coding, and anonymization/de-identification of excerpts	Page 5
12		
13	Data analysis - Process by which inferences, themes, etc., were identified and	
14	developed, including the researchers involved in data analysis; usually references a	
15	specific paradigm or approach; rationale**	Page 5
16		
17	Techniques to enhance trustworthiness - Techniques to enhance trustworthiness	
18	and credibility of data analysis (e.g., member checking, audit trail, triangulation);	
19	rationale**	Page 5
20		

Results/findings

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22		
23	Synthesis and interpretation - Main findings (e.g., interpretations, inferences, and	
24	themes); might include development of a theory or model, or integration with	
25	prior research or theory	Page 5-14
26		
27	Links to empirical data - Evidence (e.g., quotes, field notes, text excerpts,	
28	photographs) to substantiate analytic findings	Page 5-14
29		

Discussion

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31		
32	Integration with prior work, implications, transferability, and contribution(s) to	
33	the field - Short summary of main findings; explanation of how findings and	
34	conclusions connect to, support, elaborate on, or challenge conclusions of earlier	
35	scholarship; discussion of scope of application/generalizability; identification of	
36	unique contribution(s) to scholarship in a discipline or field	Page 14-16
37		
38	Limitations - Trustworthiness and limitations of findings	Page 14-15
39		

Other

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41		
42	Conflicts of interest - Potential sources of influence or perceived influence on	
43	study conduct and conclusions; how these were managed	Page 17
44		
45	Funding - Sources of funding and other support; role of funders in data collection,	
46	interpretation, and reporting	Page 17
47		

*The authors created the SRQR by searching the literature to identify guidelines, reporting standards, and critical appraisal criteria for qualitative research; reviewing the reference lists of retrieved sources; and contacting experts to gain feedback. The SRQR aims to improve the transparency of all aspects of qualitative research by providing clear standards for reporting qualitative research.

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**The rationale should briefly discuss the justification for choosing that theory, approach, method, or technique rather than other options available, the assumptions and limitations implicit in those choices, and how those choices influence study conclusions and transferability. As appropriate, the rationale for several items might be discussed together.

Reference:

O'Brien BC, Harris IB, Beckman TJ, Reed DA, Cook DA. **Standards for reporting qualitative research: a synthesis of recommendations.** *Academic Medicine*, Vol. 89, No. 9 / Sept 2014
DOI: 10.1097/ACM.0000000000000388

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