Kent Academic Repository

Hotham, Sarah, Osborne, James, Mikelyte, Rasa, Walker, Susie, Barnes, Abbie, Callis, Jerri, Cooper, Emma, Cowe, Richard, Dunleavy, Tara, Goodearl, Elizabeth and and others (2021) *The Implementation of Video and Telephone Psychological Therapy for Adults Accessing Secondary NHS Community Mental Health Services A mixed-methods Evaluation to Understand What Works, for Whom and In What Circumstances.* Centre for Health Services Studies and Kent and Medway NHS and Social Care Partnership Trust, 68 pp.

The version of record is available from

This document version

Publisher pdf

DOI for this version

Licence for this version

Additional information

Versions of research works

Versions of Record

If this version is the version of record, it is the same as the published version available on the publisher's web site. Cite as the published version.

Author Accepted Manuscripts

If this document is identified as the Author Accepted Manuscript it is the version after peer review but before type setting, copy editing or publisher branding. Cite as Surname, Initial. (Year) 'Title of article'. To be published in *Title of Journal* , Volume and issue numbers [peer-reviewed accepted version]. Available at: DOI or URL (Accessed: date).

Enquiries

The Implementation of Video and Telephone Psychological Therapy for Adults Accessing Secondary NHS Community Mental Health Services

A mixed-methods Evaluation to Understand What Works, for Whom and In What Circumstances

Principal Investigators

Dr Sarah Hotham, C.Psychol. Senior Research Fellow, Centre for Health Services Studies (CHSS), University of Kent

Dr James Osborne, Consultant Psychologist, Lead for Psychological Practice, Secondary Care Psychology & Specialist Personality Disorder Services, Kent & Medway NHS Partnership Trust

Research team
CHSS: Dr Rasa Mikelyte, Susie Walker

KMPT: Abbie Barnes, Jerri Callis, Emma Cooper, Richard Cowe, Tara Dunleavy, Elizabeth Goodearl, Arti Makwana

Experts by Experience: David Cousins, Darren Foot, Natasha Theophilus, Carolann Thornett

CHSS University of Kent

NHS Kent and Medway NHS and Social Care Partnership Trust

Table of Contents

Tables

Figures

1. Acknowledgements

We would like to extend thanks to the service users, KMPT staff and other healthcare professionals who took the time to speak with the evaluation team to offer their views on the implementation of virtual consultations. This evaluation was commissioned and funded by KMPT. Analysis and interpretation of the qualitative data was conducted by CHSS. KMPT provided analysis of the CORE-OM data.

2. Executive Summary

Background

The urgent response to the COVID-19 pandemic has precipitated many changes in the delivery of health services. One such change is the introduction of telemedicine (i.e. virtual consultations) at pace and in services that had previously relied on face-to-face interaction. NHS mental health services are at the forefront of this change, with the delivery of therapeutic interventions transitioning to virtual consultations rapidly. Healthcare innovation is rarely a simple linear process; accordingly, it is crucial evaluation approaches focus on **how contextual factors influence implementation success or failure**. The discipline of **implementation science** provides this approach, defined as the scientific study of methods to promote the systematic uptake of research findings into routine practice.

Aim

The study used an **implementation science** to evaluate the **implementation** of **virtual therapy consultations** and asses **impact on service user outcomes**.

Primary research questions

1. What impact are virtual consultations having on service user outcomes and quality of care?
2. What has been the impact on the therapeutic relationship of moving to virtual consultations?
3. Are virtual consultations acceptable, feasible and appropriate for the target populations?
4. Do healthcare professionals view virtual consultations as acceptable, feasible and appropriate?

Methodology

There are different evaluation approaches within the discipline of Implementation Science. For the current study we used the RE-AIM framework (http://www.re-aim.org). This framework facilitates collecting evidence of impact across five dimensions (Reach, Efficacy, Adoption, Implementation and Maintenance). Evidence gathered will illustrate what works, for whom, in what circumstances and with what outcomes.

A mixed-method approach combined qualitative data collected through semi-structure interviews with service users, clinicians and key informants with quantitative data from a routinely collected outcome measure (i.e., CORE-OM scores).

Participants

- **23 service users** who accessed either individual or group therapy were interviewed.
- **21 clinicians**, purposively recruited to ensure a diverse sample in terms of geography, therapeutic modality, seniority/position and delivery (group vs. individual).
- **5** individuals identified as key informants provided their perspective on the implementation of virtual consultations.

Results

Under the RE-AIM evaluation framework, Reach refers to the extent to which an intervention or service is accessed by the intended population. This entails understanding how individual circumstances (e.g. condition/symptoms, living arrangements, age) influenced engagement with virtual therapy. In service user interviews, perceived barriers to engagement were discussed in terms of worries about moving to virtual therapy. These conversations illustrated some common concerns:

- Maintaining a consistent broadband connection, uncertainty about how interruptions would be dealt with in therapy and more generally how it might affect quality of therapy.
- Coping with technical difficulties on the computer or with the Lifesize programme.
- Access to computer or smartphone. Costs associated with lengthy telephone calls and broadband data usage.

- Paranoia about someone else being present in the room and listening to the conversation. Uncertainty about who would be present in the virtual waiting room. Also more general concerns about internet and server security and who can access the Lifesize therapy room.
- Living conditions, specifically lack of privacy where individual circumstances led to difficulties in accessing a suitable space.
- Reluctance to see own image on the screen
- Perception from service users who had experienced face-to-face therapy that the virtual offer was 'not proper therapy'.

When clinicians and wider informants were asked about trends in who had declined or ceased virtual therapy they frequently articulated it was too early in the transition to formulate firm conclusions. Nevertheless, interviewees articulated some tentative patterns observed within their own services. For example, older adults and those with additional needs due to a cognitive impairment (e.g. Dementia) or hearing difficulties reported either a reluctance to start virtual therapy or difficulties in participating. However, feedback from clinicians suggest that telephone therapy was typically accepted as an alternative by service users to ensure continuation of services. Some interviewees noted that individuals with more complex diagnoses- for example individuals with personality disorders- may have difficulties adapting to virtual therapy, although outcome data to support this assertion is not yet available.

Feedback also illustrated factors that could facilitate uptake and engagement with virtual therapy. Both clinicians and service users spoke to how in some cases a virtual offer may be preferable to face-to-face. For example, individuals with agoraphobia and mobility difficulties may find virtual therapy easier to access. Some service users spoke about the convenience of a virtual offer, reducing travel time and costs, alongside increased ease of scheduling therapy appointments around work commitments.

A frequently expressed view from service users was that virtual therapy provided an opportunity to receive crucial support and was preferable compared to remaining on the waiting list or having support paused until reinstatement of face-to-face therapy. Feedback articulated the importance of maintaining a relationship with the therapist, with continuation of support in some form often cited as motivation for accepting virtual therapy. Alongside, some service users felt that while they were presented with a choice, none of the options appealed to them but 'something was better than nothing'.

Service users who described themselves as computer literate and confident using technology remarked how this eased anxieties whilst also acknowledging that individuals not as knowledgeable may struggle with the medium.

Interview questions focused on the role of virtual consultations in supporting treatment and recovery. From a service user perspective findings were mixed, with few consistent patterns emerging from the data in terms of effectiveness. Experiences shared were often unique to the individual, influenced by diagnosis, personal circumstances and type of therapy (i.e. group vs. individual).

Focusing on disadvantages, main themes emerging from the interviews were:
- Increased anxiety due to worry about accessing and engaging in online session
- A feeling that therapy is 'impersonal'. A lack of personal connection and the sense they were 'speaking to the computer' as opposed to an individual or therapist.
- Service users in group therapy had specific concerns about being given adequate chance to speak and felt turn-taking was more difficult online.
- Sense that virtual delivery prevented some individuals from exploring topics – reluctance to open up and speak about emotional memories when not in the same room as the therapist.

- Alongside a reluctance to fully open-up, feedback articulated concerns about accessing immediate support post-session if this is needed from wider team (e.g., duty worker) who would be normally be available onsite when therapy delivered face-to-face.
- Although recognition that for individuals with agoraphobia virtual therapy may be seen as a convenient alternative, service users and clinicians were also cognisant that leaving the house and travelling to a face-to-face appointment was itself an important part of therapy.

Service users also articulated how the virtual offer had been of benefit to them:
- Provided a mechanism of having contact with someone, especially those at risk of loneliness and social isolation.
- Group therapy offered an opportunity to engage with others who have similar diagnosis
- Helped to provide a routine and structure to life- some normality in a time of uncertainty.
- Ensured continual engagement with the recovery process. Some service users felt it was still an opportunity to move forward and make progress

Findings from analysis of CORE-OM data suggested that delivery method of psychological treatment when comparing face-to-face treatment, to virtual consultation, had no statistically significant effect on service users change scores. The mean change score in both groups represent an improvement in clinical outcomes observed by the CORE-OM for service users, providing evidence that transitioning to virtual delivery of psychological treatment did not appear to have a negative impact on service users treatment outcomes.

Both service users and clinicians spoke extensively about how the change in delivery impacted the therapeutic relationship. Responses articulated a number of key observations:

Trust: For those service users who moved to virtual consultations mid-way through therapy some report that the therapist relationship is maintained, the trust built during face-to-face therapy helping facilitate the switch. From the interview responses, it is not clear if the process of building trust differs for new patients (i.e. assessment and therapy all delivered through virtual). There was an acknowledgement in some service user interviews that building a new relationship is perceived to be harder when online; however this was also noted by individuals who had be in receipt of face-to-face therapy. Clinicians and service users spoke about the negative impact of not being able read others' body language, micro expressions or engage in direct eye contact.

Place and emotional memories: Some service users reported how being in their own home promoted a sense of safety, enabling them to feel more comfortable and leading to honest and open conversations. Conversely, a number of service users also reflected on the difficulties of reliving trauma in a home environment and this subsequently infiltrating what had previously been seen as a safe space. A number of service users identified how receiving therapy in what was perceived to be a contained space, outside of their home, often helped separate the trauma from day-to-day life and this had now been removed with the introduction of virtual therapy.

Boundaries: A frequently articulated point was in regard to how virtual consultations removed opportunities to prepare for, and subsequently reflect on, therapy. For example, service users spoke about how the process of travelling to and from face-to-face sessions became an important part of therapy and, without this structured time, it has become trickier to engage in this work outside of the virtual session. Often service users would describe their experience of ending a session and then immediately going back to work or doing a household task. Clinicians were aware of this behaviour and described strategies offered to service users to facilitate the space to reflect (e.g. sitting in the garden, going for a walk).

Implementation

Regards the acceptability of virtual consultations, responses from clinicians were mixed. Continuing some form of therapy service was unanimously welcomed by clinicians but the depth of engagement by service users, richness of their experience and quality of interactions with the therapist were queried. Some clinicians expressed how over time how their scepticism had reduced; however all clinicians spoke of the desire of a return to face-to-face therapy in the long-term. Some spoke about the potential of a blended approach, with virtual options included for specific types of therapy and diagnoses.

There was a sense from some clinicians that certain approaches *may* be better suited to online delivery- for example, CBT or ACT; however it was also noted that additional work was required before these sessions to send the necessary handouts and worksheets. Differences in acceptability was also noted according to modality, with group therapy viewed as more challenging to deliver online.

Clinicians sought out additional professional training on the delivery of virtual consultations from external organisations and would welcome a KMPT-wide training offer to further develop these skills.

Clinicians frequently spoke about the impact on workload. Overall, an increase in work was noted although this was not necessarily aligned to caseload but attributed to the additional demands of delivering therapy online. Clinicians felt they were often '*holding a lot more material*' and working harder to make connections and build trust with service users. As one interviewee articulated: *"you are working a lot more actively to try and offer some containment from across a screen."* Coupled with these concerns was a general sense of fatigue due to increased screen time.

3. Background

Before COVID-19 digital innovations were already an NHS priority. The Topol Review (Topol, 2019) declared digital technology critical for meeting the challenge of "increasing demand [on NHS health care] in the context of financial constraints" and a supplementary report looking specifically at the 'Digital Future of Mental Healthcare and its Workforce' (Foley and Woollard, 2019) listed telemedicine as one of the key technologies poised to impact mental health care over the next 20 years.

The March 2020 implementation of a national lockdown in response to the COVID-19 pandemic has led to the dramatic acceleration of digital change. NHS mental health service providers such as Kent and Medway NHS and Social Care Partnership Trust (KMPT) have had to mobilise at scale and pace to continue delivery of safe and effective mental health support to a vulnerable population.

Within KMPT, traditional 'in person' interactions have been replaced with live video or telephone services – a provision commonly known as 'telemental health', with 'tele' meaning 'distanced'. Within psychological services, telepsychology (APA, 2013) is considered the closest replication of 'in person' intervention for conditions such as depression (Osenbach, O'Brien, Mishkind, & Smolenski, 2013).

4. Brief overview of relevant literature

A review of telepsychotherapy evidence by Poletti et al. (2020) found that people with mental ill health were unlikely to choose teletherapy when 'in person' sessions were an alternate option, but when only teletherapy was offered effectiveness was reported to be comparable to 'in person' treatment (Catarino et al., 2018; Egede et al., 2015; Zerwas et al., 2016). Service users in both teletherapy and in-person therapy groups reported similar perceived quality of life, satisfaction, and credibility of the treatment (Egede et al., 2016). However, improvement in mental health might be slower with teletherapy (Egede et al., 2015; Zerwas et al., 2016). In addition to service user experiences, barriers to the optimal use of telepsychotherapy have previously been identified, including a lack of appropriate equipment (e.g. adequate internet connection and device ownership) and a lack of a suitable location to conduct the therapy from (Van Daele et al., in press).

Service provider opinions are also important in teletherapy utilisation. Pierce et al. (2019) reported that therapists' own perception of teletherapy usefulness and ease of use was strongly associated with others' attitudes and expectations, which then affected likelihood of use. Pierce suggested that specific training, clear policies and regulations may help foster positive attitudes. A systematic review by Connolly et al. (2019) also highlighted the importance of considering the attitudes of the provider of tele-mental health video conferencing, as well as those of the service receivers. They found that often the advantage of being able to increase access to care outweighed the disadvantages of technical problems, increased hassle and perceptions of impersonality.

Research into telepsychology specifically within secondary NHS mental health provision, however, is sparse. Emerging findings demonstrate that telemendicine may be as effective as in person treatment regardless of diagnosis. Miu et al. (2020) compared teletherapy use between serious and common mental illness populations during the pandemic and found no difference in the rates willing to convert from 'in person'

therapy to teletherapy, nor any differences between new service users beginning therapy via video or telephone methods.

While little is known about the mental health consequences of living through a pandemic, a recent systematic review by Vindegaard and Eriksen Benros (2020) found that individuals with pre-existing psychiatric disorders have so far reported worsening of psychiatric symptoms during the Covid-19 outbreak, while the general population revealed lower psychological well-being and higher scores of anxiety and depression. This highlights the need for an urgent health care response, with an increase in health care capacity necessary to support both pre-existing and newly presenting service users.

It is crucial to ascertain whether the new method of virtual service delivery is benefiting service users. Inadequate psychological intervention could lead to sustained, and in some cases, escalating mental ill-health and a detrimental effect on an individuals' quality of life. Therefore, a robust evaluation of the impact of telepsychology (subsequently referred to as 'virtual consultations') on KMPT service user outcomes and quality of care is proposed.

It is also important to establish whether virtual consultations is a feasible and acceptable method of providing safe and beneficial mental health support to service users in the long-term. The current model of providing virtual consultations may become the 'new normal' and, as this rollout allows an opportunity to understand what works best, for whom, and under what circumstances The results of this project should be well timed to guide practice during the COVID recovery phase.

5. Evaluation Questions

1. What impact are virtual consultations having on KMPT service user outcomes and quality of care?
2. What has been the impact on the therapeutic relationship of moving to virtual consultations? How have therapeutic approaches been adapted?
3. Is the KMPT virtual consultation offer acceptable, feasible and appropriate for the target service user populations?
4. Do healthcare professionals delivering the KMPT service view virtual consultations as acceptable, feasible and appropriate?

6. Methodology

6.1 Evaluation approach

6.1.1 Implementation science

Implementation Science is a robust, pragmatic approach that focuses on the perspective of beneficiaries', stakeholders and the context the intervention is delivered. An evaluation following the implementation approach has a number of important benefits - it promptly identifies success and failures, creates knowledge through rapid learning cycles with stakeholders, supports the suitability of initiatives, and can accelerate the integration of research in to practice.

This implementation science approach is based on a learning cycle. Key learnings and good practice are captured from the early stages of a project and shared amongst project partners and relevant stakeholders to inform delivery of future iterations (i.e. delivery in recovery phase of COVID-19).

It enables the capturing and analysis of individual-level outcomes aligned with the aims of virtual consultation - for example, improved mental health outcomes. It also exemplifies a mixed-method approach to evaluation, triangulating quantitative data routinely collected by KMPT and qualitative data collected by the research team via interviews. It also facilitates a process evaluation to capture organisational implementation and adaptation. Through interviews with KMPT staff and wider stakeholders the evaluation explored the challenges, barriers and opportunities faced when delivering video consultations. In the current evaluation, the RE-AIM framework (http://www.re-aim.org/) was used.

6.1.2 RE-AIM framework

The RE-AIM framework (Glasgow et al., 1999) guided collection of evidence across five dimensions (Reach, Efficacy, Adoption, Implementation and Maintenance) relevant to the translation of research to effective practice. Table 1 illustrates how each RE-AIM dimension influences the formation of the research questions and evidence collected. This evaluation consisted of both qualitative and quantitative elements. Qualitative data collection consisted of semi-structured interviews with three groups: service users, clinicians and key informants not directly responsible or involved in delivery of virtual consultations but based organisations who have knowledge or expertise in delivery of mental health services (e.g. mental health commissioners, administrative support staff, IAPT providers). Quantitative data were service user clinical outcome scores collected by the KMPT.

TABLE 1 RE-AIM DIMENSIONS AND RESEARCH QUESTIONS

RE-AIM Dimension	Research question	Qualitative	Quantitative
Reach	What proportion of the target population are accessing virtual consultations?	Interviews with: • Patients • Mental health professionals • Key informants	

Efficacy	What impact are virtual consultations having on patient outcomes and quality of care? What defines 'quality' in a virtual consultation and what are the barriers to achieving this? What has been the impact on the therapeutic relationship of moving to virtual consultations?	Interviews with: • Patients • Mental health professionals • Key informants	KMPT routinely collected patient outcome data (CORE-OM scores).
Adoption	How are virtual consultations adopted and rolled out?	Interviews with: • Mental health professionals • Wider stakeholders (especially wider HCPs)	
Implementation	Are virtual consultations acceptable, feasible and appropriate for the target patient populations? Do healthcare professionals view virtual consultations as acceptable, feasible and appropriate? Are there unintended consequences (positive or negative) of the change to virtual consultations?	Interviews with: • Patients • Mental health professionals • Wider stakeholders	
Maintenance	What changes, brought about because of the COVID-19 response, might be usefully sustained?	Interviews with: • Patients • Mental health professionals • Wider stakeholders	

6.2 Experts by Experience

Four members from the KMPT Expert by Experience group were collaborators on the project. These individuals were involved in a number of activities:

1. Participated in regular research group meetings to discuss progress of evaluation, offer advice on challenges
2. Advised on design of information sheets and service user/decliner consent procedure
3. Led on the design of service user 'what to expect' leaflet to steer content, ensure readability and decide on format (i.e. paper/online)
4. Contributed to guidelines for clinicians on how to engage in successful virtual consultations (what do service users/decliners feel is useful for clinicians to know)
5. Contributed to content of the final report

6.3 Qualitative data collection

6.3.1 Participants

6.3.1.1 Service users

The study sought individuals whose service use can be defined by each of the categories listed below.

1. Service Users who are receiving individual video and telephone psychological therapy services now, but started with face-to-face contact
2. Service Users who have been receiving individual video and telephone psychological therapy services only (i.e. new referrals)
3. Service Users who a receiving virtual group treatment
4. Service Users who are having telephone contact only (declined video consultations)
5. Service Users who declined video and telephone psychological therapy services

Inclusion criteria:
- Aged 18 years or over
- Has capacity to provide informed consent
- Have been offered virtual check-ins and/or virtual treatment from a psychologist or psychotherapist (even if offer not taken up)

Exclusion criteria:
- Aged < 18 years
- In acute distressed

Service users were recruited via their relevant locality; verbally consenting to contact from Assistant Psychologists (n=59). Of those who consented, Assistant Psychologists had telephone contact with a total of 46 service users (see Appendixes 11.9-11.10 for recruitment pathway and flyer). From this, 91.3% (n=42) expressed an interest in participating and 28 (66.6%) service users signed up to the study through the online form, which contained the information sheet and consent form (see Appendixes 11.1-11.2 for information sheet and consent form respectively). From this sample, 23 service users completed an interview (n=2 could not be contacted, n=3 cancelled or did not answer their scheduled call.

The recruiters (Assistant Psychologists and researcher) made three attempts to contact service users, each contact attempt being at different times of the day, on different days, aiming to provide as much opportunity for contact as possible. Voicemail messages were left wherever possible. If a service user did not answer a scheduled telephone call, three additional contact attempts were made. There was no limit on interview rescheduling. Within the sample (n=23), 5 rescheduled up to four times each whilst the 2 of the 3 who cancelled or did not answer a scheduled call, rescheduled at least once.

The 23 service user participants (70% female, 30% male) were aged between 23 and 62 years old (Mean = 39.5 years,) and were completing or had recently completed an individual (n=15) or group (n=8) therapeutic intervention (see Figures 1 and 2).

FIGURE 1: SERVICE USER RECRUITMENT BY STAGES
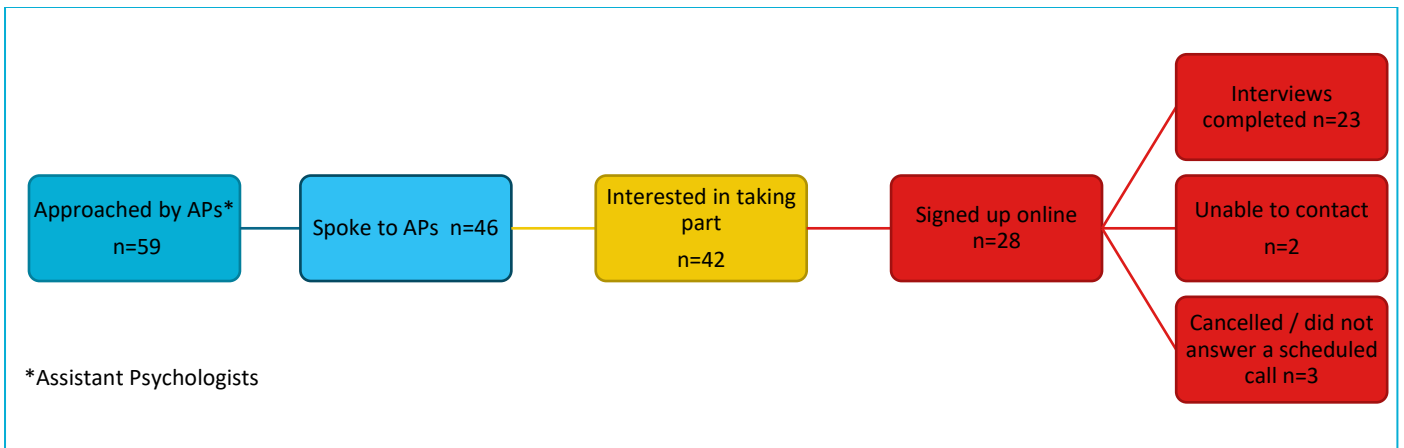
FIGURE 2: BREAKDOWN OF THERAPEUTIC INTERVENTIONS OFFERED TO PARTICIPANTS (SERVCE USERS)
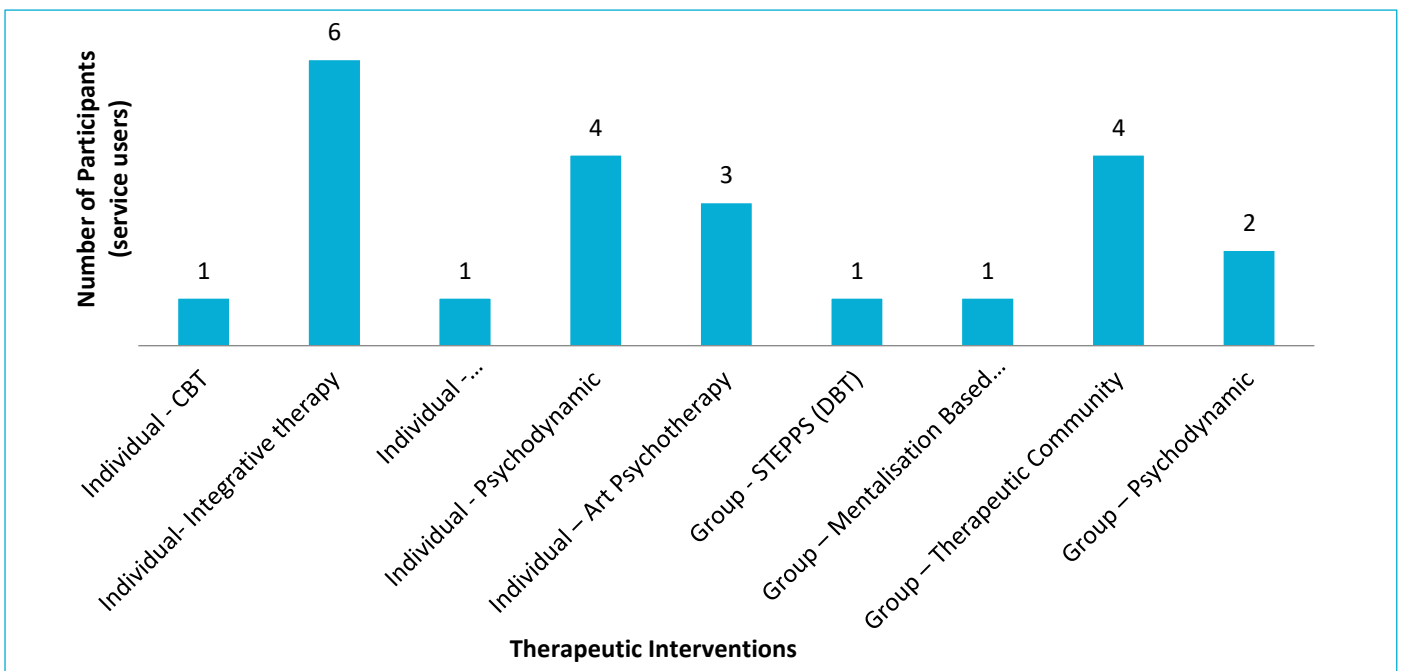
The delivery of intervention varied with some participants having face-to-face contact initially (n=16) whilst others experienced virtual delivery only (n=7). The sample also represented a range of KMPT service locations (see Figure 2).

FIGURE 3: PARTICIPANT (SERVCE USER) SPREAD BY KMPT SERVICE LOCATION
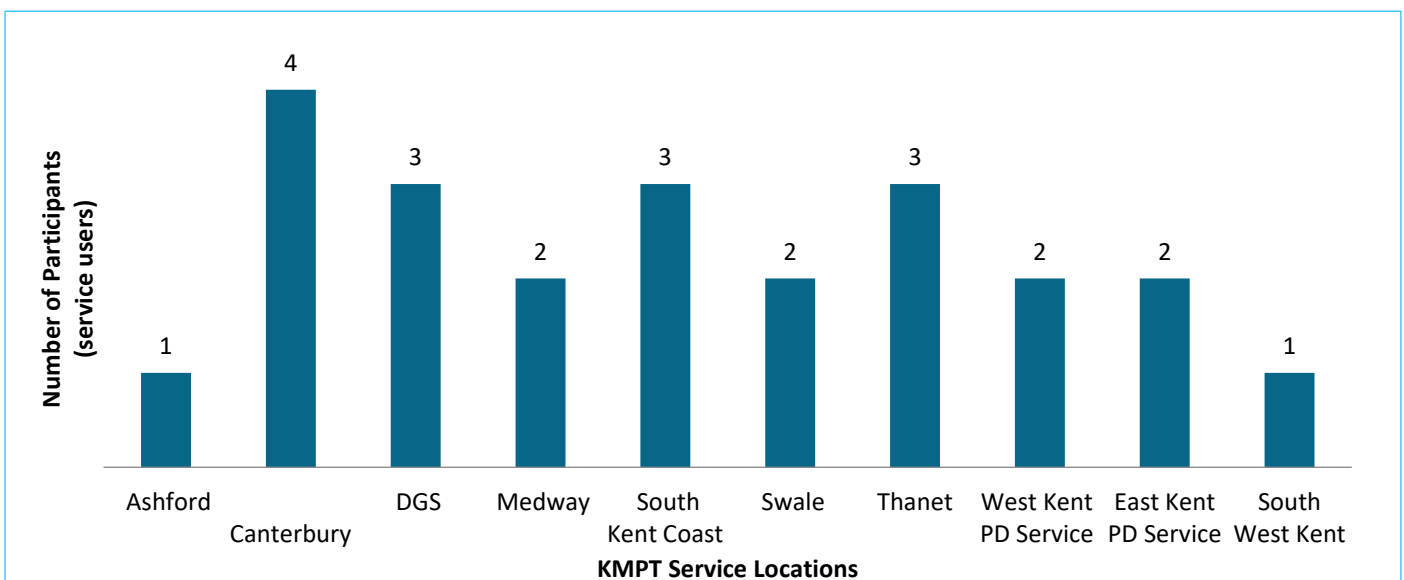
6.3.1.2 Clinicians

Clinicians were made aware of the study by their locality Assistant Psychologist. The contact details of clinicians who expressed an interest in participating (n=34) were shared with the research team. 22 of the 34 interested clinicians were contacted. This group of 22 were selected to ensure an optimally diverse sample in terms of: geography/clinical team, therapeutic modality, group/individual delivery, seniority, length of time working for the service and length of time since switching to virtual delivery. Recruitment resulted in a 95% participation rate (n=21) with 1 clinician unable to participate as replied outside of the timeframe for responses. The clinician sample represented all localities within the Kent area (see Figure 4) and reflected a variety of therapeutic modalities, included clinicians delivering virtual group therapeutic interventions and team leads. All participating clinicians were provided an information sheet and signed a consent form before taking part in the interview (see Appendixes 11.3 and 11.5).

FIGURE 4: PARTICIPANT (CLINICIAN) SPREAD BY KMPT SERVICE LOCATION
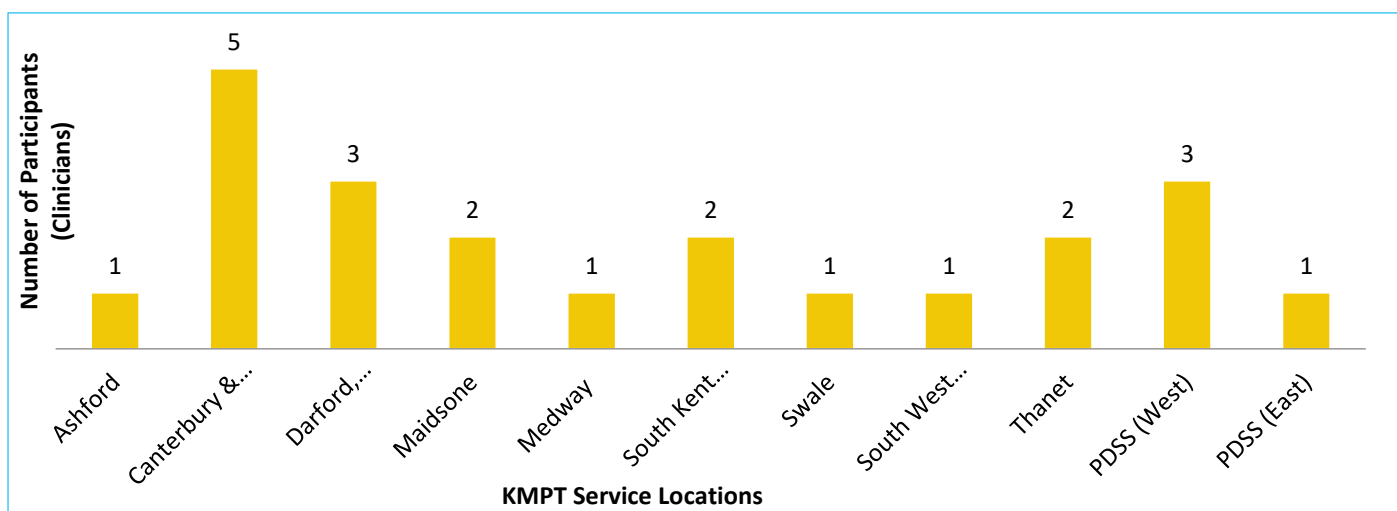
6.3.1.3 Wider Stakeholders

Convenience sampling was applied to wider stakeholder recruitment. Email invitations were sent to wider stakeholders who have knowledge of KMPT psychological therapy services but are not directly involved in telepsychology delivery (e.g. KMPT staff external to the CMHTs and health and social care commissioners in relevant CCGs). The stakeholders were identified by the clinical members of the evaluation team.

20 individuals of various roles were invited to participate in the study as wider stakeholders. Of these, 5 took part in the interviews including, Covering Operational Manager (n=1) a staff member of the Community Mental Health Team – Older Adults Service (n=1), Administrator (n=1), Service Commissioner (n=1) and IAPT Service Lead (n=1). All wider stakeholders were provided an information sheet and signed a consent form before taking part in the interview (see Appendixes 11.4 and 11.5).

6.3.2 Semi-structured interviews

Semi-structured interviews, designed around the five RE-AIM dimensions were conducted with the three target groups:

1. Individuals that have been offered video or telephone psychological therapy services (whether accepted or declined) by clinical staff from adult Community Mental Health Teams across the NHS Trust.
2. Clinical KMPT staff delivering video or telephone psychological therapy services.
3. Wider stakeholders, including senior managers and allied health professionals who do not deliver video consultations, but are part of community mental health teams which offer video and telephone psychological therapy services.

A semi-structured interview guides were developed in collaboration with clinicians and experts by experience; separate guides were designed for service user, clinician and wider informant groups (see appendixes 11.6-11.8).

6.3.3 Analysis

Qualitative data were analysed using framework analysis (Srivastava and Thompson, 2009). The five stages of framework analysis are:
i. familiarisation;
ii. identifying a thematic framework;
iii. indexing;
iv. charting;
v. mapping and interpretation.

A deductive approach was used to analyse the data to help to generate findings but were open to inductive analysis to uncover any unexpected emerging themes (see Appendix 11.10 for the coding framework used). Research team members SH, RM, JC, AB, EC, EG, TD and RC coded all transcripts using Taguette online coding software. JC, AB, EC, EG, TD and RC received specially-tailored training on qualitative coding from SH and RM, had one coded transcript reviewed by a university researcher each, and had an opportunity to ask questions related to coding throughout the coding process.

6.4 Quantitative Data

6.4.1 Routine data

Routinely gathered on entry and exit (typically 6 months) of the service using the **CORE-OM tool**. CORE-OM stands for "Clinical Outcomes in Routine Evaluation - Outcome Measure" and is used to monitor change and outcomes in routine practice in psychotherapy, counselling and any other work attempting to promote psychological recovery, health and wellbeing (coreims.co.uk, 2020). Data were analysed for service users who entered and exited KMPT services between January to October 2020.

6.4.2 Analysis

Quantitative data were analysed by team members JC and AB using SPSS Statistics (Version 26) software package. Routinely collected service user outcome data (**CORE-OM** scores) were analysed using repeated measures designs (i.e., ANCOVA) to establish differences between time points (baseline, 6 months).

The change in CORE-OM scores at the end of treatment determines the effectiveness of treatment in relation to the four domains - wellbeing, problems, functioning, and risk using a frequency Likert scale. We were interested to know whether a change in delivery method of psychological treatment due to the COVID-19 pandemic had an impact on the change in CORE-OM scores. We compared data from the following groups;

1) 'Change scores' for service users who had completed psychological treatment before the COVID-19 pandemic (01/04/19-31/12/19). Their delivery method of psychological treatment was only face to face during this period. Group 2=F2F

2) 'Change scores' for service users who had completed psychological treatment during the COVID-19 pandemic (01/04/20-31/12/20). Their delivery method of psychological treatment transitioned from face to face to virtual methods such as video or telephone during this period. Group 1=F2FVirtual

There was a small sample (n=6) of service users whose delivery method of psychological treatment was virtual only, 4 had video, and 2 had telephone. Due to the small sample size in comparison to groups 1 and 2 we did not include this group in the analysis.

6.4 Quantitative and Quantitative Data Synthesis

Qualitative and quantitative data were triangulated to both cross-validate findings from different data, and also to capture different dimensions around virtual consultation delivery that can only be achieved by utilising multiple methods. Data synthesis was informed by the research questions to understand what works best and in what circumstances, to enable the safe and rapid implementation of virtual consultations, with methodological triangulation occurring during analysis and interpretation of results.

7. Findings

7.1 Reach

This RE-AIM dimension captures the extent to which the target population (i.e. service users across KMPT services) participated in virtual consultations, alongside identifying barriers and facilitators to engagement. This was explored by asking service users to identify factors that both encouraged and hindered uptake of virtual consultations.

Looking first at facilitators, responses from across the sample illustrated three recurrent factors that influenced openness and readiness to accept the offer of a virtual consultation- easier access compared to face-to-face, strong desire to continue therapy and increased ease to fit of appointments around existing commitments (i.e. work, education).

7.1.1 Facilitators

7.1.1.1 Ease of access

A number of service users articulated how physical disabilities or limited mobility had previously made attending face-to-face therapy sessions challenging. With the introduction of virtual therapy, attending appointments became less demanding and increased accessibility for these individuals.

> I think, for me with my physical health problems, it has made it easier. And even in the future, if we go back to face to face, then I now there is now that option that we can do online. If I can't travel because I'm not well I can still have the sessions. Whereas before I would have to stop them because not been well enough to travel. So from that point of view, it has been beneficial. I guess." (SU05)

> "I do have a lot of difficulties with my physical health. So actually, in some respects, being home is a lot easier." (SU12)

In addition, interviewees with agoraphobia or anxiety expressed how the switch to virtual offered some benefits as this change removed the need to leave home:

> "I personally, I see it as an advantage, I have a lot of difficulties with leaving the house, I have a lot of anxiety. I am unable to leave the house a lot of the time. So for myself, it's a positive that isn't that worry of going to location, there isn't a worry of public transport, you know, there are few stresses associated with it." (SU17)

> "In my case because I have anxiety around travelling, it's already a more relaxed situation. The more relaxed I am in a situation easier for me to open up. For example, going to the bipolar group, I'd arrive at KMPT location and then I go in the waiting room, and then it's just anxiety there, you just sitting there waiting, waiting. And then you go in and then there's all these people you don't know. Then you have open up to those people in some ways. It was much more traumatic experience, actually, the group." (SU23)

> "I was struggling to get out to appointments and they were able to offer me over the phone support. And actually, it was really, I found it so helpful, not having the pressure and added strain of getting to somewhere." (SU26)

The benefit of accessing individuals who might otherwise be reluctant to attend face-to-face sessions was also recognised by clinicians:

"I think in terms of the client work, it's been incredibly useful for some people. So I've been able to engage some people in therapy that otherwise wouldn't have engaged or their health concerns. For example, [their condition] meant that they wouldn't be able to leave the house regularly. So that's been invaluable." (Clinician 004)

"I think one of the things that I think has been quite exciting about this is that patients who may be confined to their own home due to the nature of their difficulties, whether that's mental health or physical health we've have many hours of video. The intervention becomes more accessible to those patients. So I would say, going forward that there will be patients who can receive a service who otherwise might not have. There's patients who would struggle to access specialist services. So there was patient who was non-English speaking and there are speciality services in London, that she could have access that wouldn't historically have access and due to anxiety around travelling. If she could access those services remotely and speak to someone in their own language, that would be a huge improvement for someone in her position." (Clinician 003)

7.1.1.2 Continuation of therapy

A common motivation articulated by service users highlighted, although there was a strong desire to return to face-to-face, there was recognition that the virtual offer enabled therapy to continue. Thus providing an opportunity to build on the work already undertaken by services users.

*"I wasn't really gonna put myself in a position where I could potentially miss out and have to wait even longer to get the help that I wanted". (*SU04)

"If I hadn't already participated and built relationship up with the therapist I wouldn't have felt compelled to go through with it. Because it was ultimately that I trusted her." (SU16)

"…having the platform to openly talk to somebody just as you would therapy. And in terms of one to one, face to face, it's having that same experience, just because you're doing it virtually doesn't take anything away from the actual therapy side of things. As long as your therapist is doing exactly the same as what they would do face to face. Yeah, then that, for me is a good session. "(SU17)

"It has absolutely pushed me forward in my life in so many ways. Having face-to-face therapy versus virtual therapy, who knows, it could be better with face to face. Just to the fact that, especially if you've got anxieties about being outdoors and think deeply actually forces you out of your comfort zone, but actually having any therapy at all is so vital." (SU23)

*"Sometimes I did, and sometimes I needed it. Like, it was a battle of not wanting to do and needing it. And, and the thing that made me do it was I needed to do this. And I needed it.**" (**SU24)

"What made coming on to lifestyle? Yeah. I'm really committed. And I think I want to try and get as much about out of it as I can. So that's why I do it. I committed to it." (SU25)

"I know this is all new to everyone. So in that situation. So as much as it was difficult. I needed as much offers of help, I think, especially at such an uncertain time. And I was worried about my mental health declining. And I thought I need to, you know, take the help that's offered." (SU26)

"I think the main reason [for accepting offer of virtual] was just the severity of how ill I've been feeling. Really desperately wanting to start to get well. In the sense of everything being on hold, I'm just wanting to make sure that I'm connected into everything so as soon as things are not on hold anymore, being able to get access to the therapy that I see could help." (SU27)

"I think it has made a difference. Maybe because the therapy is not stopped. That has been an extreme benefit of that." (SU28)

There was also a sense from clinicians that acceptance of virtual therapy was influenced by how the relationship with service user had developed when face-to-face

"I think if that therapeutic alliance, is there, that relationship is there, more, you start off with a therapy of relationship maybe there is a bit more acceptance to change the format." (Clinician 008)

Alongside this desire to continue some form of therapy, service users sometimes framed the motivation for maintaining therapy as 'having no choice'. Examples of how this was articulated by service users are provided in the quotes below:

"I wasn't giving any option to be totally honest. I had the one face to face and then I was told I couldn't have any more face to face. To which I was going to turn around and say, well, don't bother, then that's the end of it."(SU08)

"There wasn't really much of an option. I knew that if I keep going in, and having that contact that I would be almost come out of the thing." (SU16)

"It's because there wasn't really any alternative. I knew I had to do therapy at some point that wasn't... We're going to be in this for a while and I can't keep delaying it or going back onto the waiting list." (SU18)

"I think because it was it was offered, and there was no alternatives at that time. So I either accepted and made inroads into something helping me hopefully, or to stay on a waiting list and not be guaranteed of being on something for I mean, it could be up to a year." (SU21)

7.1.1.3 Convenience

There was recognition from some service users that virtual delivery was a more convenient way of engaging with mental health support as removed the time needed for travel and could be accessed from any location. For example:

"It's actually more convenient for me to do it this way. With my situation-working a lot and doing all that I would choose to do it virtually." (SU19)

"Because I'm a student I can fit around my study schedule, I can fit things around it. Whereas before it would take a good two hours to travel alone. And then the hour therapy, that was a good three hours chunk. If I had other appointments, might have had to have had some delays or rearrange because timing didn't work out. Whereas now that it's remote, I'm not going anywhere." (SU28)

This aspect was reiterated in the clinician and wider informant interviews:

"Just being able to access the treatment, and a time and a space that is more convenient. That doesn't require them to have to do an hours round trip or find some parking or that that's been across the board." (WI05)

"They say that it's because it's convenient, that they can sort of join the group and they can be in their house and they have to worry about travelling or sort of paying to get there and I don't know they just something about convenience." (Clinician 009)

7.1.2 Barriers

Alongside highlighting factors that facilitated engagement, service users also spoke about aspects of virtual consultations that discouraged uptake. The most frequently discussed concerns were related to technical aspects of virtual delivery, worries about interpreting non-verbal behaviour, suitability considering mental health diagnosis and age of service user.

7.1.2.1 Technical aspects

The role of technology, and specifically the impact of unstable internet connections, traversed a number of RE-AIM dimensions in addition to Reach (i.e. Effectiveness, Implementation and Maintenance). When discussed in relation to Reach service users articulated how loss of internet connection affected quality of therapeutic relationship and this could act as a deterrent for engaging with the virtual offer. As the quote below illustrates:

"When you're going through something, and you're discussing something - for the screen to freeze, or issues go on, that takes your attention away from what you were discussing, and you concentrate on getting that problem fixed, rather than dealing with the issue that you supposed to be dealing with." (SU03)

Access to technology and costs associated with participating in virtual and telephone therapy were also raised as a potential barrier for engagement:

"If you don't have a smartphone can do it by telephone. I know one member she was very concerned about that because of costs. A lot of landline companies only give you the first hour for free. You have to disconnect to reconnect." (SU09)

Finally, confidence to use the Lifesize platform, and with using IT more generally, was mentioned as a contributory factor influencing hesitancy to engage with virtual delivery. This was raised a number of times in service user interviews and usually through individuals who themselves were confident with IT, but appreciated that others with a lack of similar experience may struggle.

"With virtual delivery, when it first started back in March, I was obviously a bit concerned about it. Because in the community not everyone is young. And not everyone is obviously technical. So there are some people that weren't very good with smartphones or laptops. So there are a couple of members that didn't have that sort of technology." (SU09).

"I can navigate myself around Lifesize, quite easily. But other people in the group, you know, not necessarily, as well equipped to fix bugs. I would say they're simple things but for people that haven't used software like this before, navigated their way through a zoom call or whatever-to them, it's

completely new. So things like people knowing how to mute and unmute. Or people not understanding that if you use headphones, it helps with feedback." (SU14)

"I feel that not everyone is necessarily used to using video platforms. I use it for work so I'm kind of used to doing stuff, but I'm aware that some people might have a bit more difficulty with it**." (**SU19)

7.1.2.2 Non-verbal communication

A frequently expressed reason for hesitancy or dislike of virtual therapy related to the challenges associated with reading and reacting to non-verbal communication cues. A number of service users expressed concerns regards difficulties reading body language of the clinician and peers when in group-based therapy.

"I was very resistant to beginning because I prefer being able to read body language and be in the same room with somebody." (SU18)

"I sometimes feel that what I'm saying isn't relevant or somebody else wants to say something, or I shouldn't be saying something at that time, or I'm sharing too much. But when you're in that room, you can pick up on that a lot more through people's body language. But virtually, that's nigh-on impossible to apart from their facial expressions."(SU21)

7.1.2.3 Mental health diagnosis

Through interviews with service users, clinicians and wider informants a narrative emerged about how uptake and acceptance of virtual delivery may be influenced by mental health diagnosis. As highlighted in the previous section, some service users articulated how acceptance of virtual therapy was eased because it was perceived to be helpful in terms of their overall recovery. An alternative view was offered by some service users who expressed how for certain diagnoses virtual delivery might exacerbate the illness. Quotes below exemplify this concern:

"I think if it comes down to seriousness of my condition. As far as I'm concerned that can't be done [via] Lifesize, that's got to be done face. I hated having the assessment sessions on Lifesize. It's one thing to have a Lifesize with your GP, I think I've got a cold or I've got a blister. But I think, especially when you're talking about mental health stuff you need to be physically face to face with that person to interact properly."(SU08)

"I get really bad paranoia. And when it's really, really bad I have a fear, like if someone else is sitting in the room with her or she's recording me on the video and other people are listening in then it doesn't feel safe. Then when I'm okay, and I'm in a better place, I'm just anxious because I can see my own self on the video." (SU24)

Wider Informants and clinicians also recognised how diagnosis may play a role in the uptake of virtual therapy. Highlighting individuals with cognitive difficulties (i.e. Dementia), Personality Disorders, dissociative disorders and concerns about self-image as groups who may find the switch from face-to-face therapy more challenging:

"In the cognitive impairment dementia service I know that the majority of those, apart from a handful of high risk patients, virtually all of them were seen by telephone…..I suspect a large element of it was that demographic patient population." (WI01)

"Going back to complexity, I do think that perhaps the clients were with kind of cluster eight diagnosis-people with a diagnosis of personality disorder, perhaps have struggled to come on to life

size more. For other clients where the diagnosis of personality disorder, it may be that it I think, perhaps the, you know, the intensity of, you know, working over video, and the fact that you're looking at someone, you know, constantly perhaps you can't see their whole body." (WI04)

"I imagine and patients, perhaps, who may be more along the psychotic spectrum that connecting via video might be less helpful…it might kind of feed into delusional systems for them in some way." (Clinician 003)

"It's tough to generalise, I'm sure that there are some that worked very well. Working with clients with severe dissociation. I find them much more likely to dissociate over video and telephone. Again, having that physical containment can often be safer to work with dissociative states." (Clinician 004)

"So if you do have troubles in unstable self-image, it is quite a difficult thing to ask people to do to be this close to a camera." (Clinician 016)

7.1.2.4 Age

Comments on how age may affect acceptance of virtual delivery were mainly drawn from the interviews with clinicians and wider informants. Service users rarely discussed this as a factor, which may be a consequence of our participants being predominately under 60 years of age. When discussing age as a potential influencing factor, clinicians and wider informants were tentative about forming firm conclusions in the absence of monitoring data but expressed inclinations based on their own experience and discussions at team meetings. Quotes below exemplify the feedback:

"It's quite hard, I think, to sort of separate out, but I guess I would say that, in general, the older population. So I see clients from 65 [years]. Plus, the older clients are probably much more familiar with working over the phone than they are working over video. So that's a particularly that's an area of clients that I think that I would like to see more kind of investment in trying to, because I really worry about them feeling very excluded from services." (WI04)

"I have a lot of the older adults and I found, you know, we're really not engaging on either telephone or remote. So it wasn't just about kind of modern technology, it was about kind of just really wanting that face to face contact. And whereas perhaps, you know, others have been more able to kind of adapt or be more receptive and open. To give you accurate data, try to look at my case notes, but any over 50 and kind of either had telephone reluctantly-so preferred telephone while waiting to be offered face to face"(Clinician 007)

"As a real rough rule of thumb, the older clients tend not to want to do your virtual. The younger the 20s and 30s are much more amenable to using it because they've grown up with these systems a bit more been doing or practicing with them. I've got a couple of clients in their late 50s and 60s. I just think that's the biggest defining thing is the older the older clients want to tend to stick with the phones." (Clinician 014)

There was also a sense from some clinicians that while at the start of the virtual delivery there had been an expectation that older adults may find access to virtual therapy more challenging, in practice this turned out not always to be the case. Barriers to engagement with older adults were more frequently framed in terms of how a co-existing health condition, and not age, might generate a barrier- for example, individuals with a hearing impairment or Dementia.

"Actually, I thought there would be more to be honest. I thought, , quite wrongly that it would perhaps be some of the older clients that would find this technology go but it hasn't followed any sort of shape-been a bit random." (Clinician 021)

7.1.3 Summary

When clinicians and wider informants were asked about trends in who had declined or ceased virtual therapy they frequently articulated it was too early in the transition to formulate firm conclusions. Nevertheless, interviewees spoke about some tentative patterns observed within their own services. For example, older adults and those with additional needs due to a cognitive impairment (e.g. Dementia) or hearing difficulties reported either a reluctance to start virtual therapy or difficulties in fully participating. However, feedback from clinicians suggest that telephone therapy was typically accepted as an alternative by service users to ensure continuation of services. Some interviewees noted that individuals with more complex diagnoses- for example individuals with personality disorders- might have difficulties adapting to virtual therapy, although data to support this assertion are not yet available.

Feedback also illustrated factors that could facilitate uptake and engagement with virtual therapy. Both clinicians and service users spoke to how in some cases a virtual offer may be preferable to face-to-face. For example, individuals with agoraphobia and mobility difficulties may find virtual therapy easier to access. Some service users spoke about the convenience of a virtual offer, reducing travel time and costs, alongside increased ease of scheduling therapy appointments around work commitments.

A frequently expressed view from service users was that virtual therapy provided an opportunity to receive crucial support and was preferable compared to remaining on the waiting list or having support paused until reinstatement of face-to-face therapy. Feedback articulated the importance of maintaining a relationship with the therapist, with continuation of support in some form often cited as motivation for accepting virtual therapy. Alongside, some service users felt that while they were presented with a choice, none of the options appealed to them but 'something was better than nothing'.

Service users who described themselves as computer literate and confident using technology remarked how this eased anxieties whilst also acknowledging that individuals not as knowledgeable may struggle with the medium.

7.2 Effectiveness

7.2.1 Quantitative data

The calculation of 'change scores' was as follows; *change score = end of treatment total score mean (sum of all items/34) – beginning of treatment total score mean (sum of all items/34)*. A negative change score indicates an improvement in the frequency of difficulties for the service user. Table 2 shows the descriptive statistics for the mean difference in pre and post mean scores in each group.

TABLE 2 MEAN DIFFERENCE IN PRE AND POST CORE-OM SCORES FOR FACE-TO-FACE DELIVERY AND VIRTUAL DELIVERY

Group	N	Mean difference in the mean of Total score	SD
F2F	164	-0.6273	0.72933
F2FVirtual	221	-0.6199	0.74337

An independent t-test was conducted on the change scores to see if delivery of treatment had an impact on clinical outcomes for service users. There was no significant difference in the change scores between Face

to Face Delivery and Face to Face to Virtual Delivery of treatment, t(383)=-0.098, p=0.092, 95% CI [-0.157,0.142], d=-0.01, 95% CI [-0.212,0.192].

We also explored whether delivery method had an effect on the different domains of difficulties in the CORE-OM. The descriptive statistics for this analysis are displayed in Table 3.

TABLE 3 MEAN CHANGE IN DOMAINS OF CORE-OM FOR FACE-TO-FACE AND VIRTUAL

Group	N	Mean change score in Wellbeing	SD	Mean change score in Problems	SD	Mean change score in Functioning	SD	Mean change score in Risk	SD
F2F	164	-0.7523	1.01107	-0.7458	0.83247	-0.5761	0.79708	-0.4032	0.84341
F2FVirtual	221	-0.6833	1.06803	-0.7189	0.86537	-0.6153	0.83080	-0.4257	0.83240

A MANOVA was conducted to see whether delivery method had an impact on change scores across the different domains. There was no significant difference in the change scores for wellbeing, $F(1)=0.411$, $p=0.52$, $eta_2=0.001$, problems, $F(1)=0.094$, $p=0.759$, $eta_2=0.0$, functioning, $F(1)=0.217$, $p=0.759$, $eta_2=0.001$, or risk, $F(1)=0.069$, $p=0.922$, $eta_2=0.0$.

We can conclude from the results described that delivery method of psychological treatment when comparing face to face treatment, to face to face to virtual treatment, had no statistically significant effect on service users change scores. The mean change score in both groups represent an improvement in clinical outcomes observed by the CORE-OM for service users, providing evidence that transitioning to virtual delivery of psychological treatment did not appear to have a negative impact on service users treatment outcomes.

7.2.2 Qualitative data

7.2.2.1 Impact on service user outcomes and therapeutic relationship

Service users articulated differing views on whether virtual therapy had helped or hindered their mental health. Some reported benefits and appreciated the continued support (as highlighted under Reach section as a reason for acceptance).

"Yes, I would say so [it has helped]. I mean, it's been okay, because obviously, we had to, sort of, go with what was available. But I would still like the one to one. I can't say it didn't help because I still have that contact. It did help to have that contact once a week" (SU03)

"Yeah, the things are moving on through the therapy. And, yeah, I've reached some deep understanding and things. It's been very positive. (SU15)

"I think it has made a difference. Maybe because the therapy is not stopped. And for me I've become more comfortable with talking about the trauma here and working on it. Whereas compared to face-to-face I struggled. For me, that is a positive. That has been an extreme benefit of that." (SU28)

Service users also highlighted that having the option of virtual therapy facilitated contact with professionals, reducing feelings of isolation and loneliness:

"Some people don't get out that much, they're not actually seeing anybody else as well. So they can become quite isolated. So, I think that the virtual is still a way of having someone - of letting someone else into your home, and you still have an actual contact with someone else." (SU04)

"Yes, massively reaching out to like-minded people with the peer group, this has been a very positive experience. You don't feel so alone, you have people that can understand some things you're describing

that maybe other people with mental health issues, they don't quite understand. Having that group platform is really good. You know, it's a positive experience." (SU17)

However, service users also expressed that, in some cases, virtual therapy had impeded recovery:

"No, face-to-face is far better. That human contact. Especially for somebody like me that human contact is something that I hate with a vengeance. And not just hate it, human contact is something that I've got a try and slowly, slowly, slowly back into the world if you like. So to lose that now, especially with the lockdown….. Losing going once a month to see the Therapist is maybe one of the only times I've went out to actually meet somebody." (SU11)

"It was really a lot worse. I was able to hide more emotions. And I believe that sometimes your body language can speak for much more than what verbally comes out." (SU16)

In addition, service users highlighted how virtual therapy had exacerbated condition and/or caused additional stress for them:

"…having to panic about 'am I going to get onto the internet? Am I going to get onto the internet today? Am I going to be able to do this? Am I going to be able to do that? That was always a bit of a build up for me and obviously when I couldn't get on the computer. I remember once at 20-odd minutes, that was most of my session gone. So - whereas, if I'd gone to the hospital and walked there or drove there, I wouldn't have had those issues of being worked up and worried." (SU03)

"I'm not a fan of the videoing. I found it really quite frustrating and difficult. Yeah, I feel like it's just kind of another level of stress on top of already having therapy. I hadn't met the therapist beforehand or have met her once in person, I found that difficult." (SU06)

Both service users and clinicians spoke extensively about how the change in delivery impacted the therapeutic relationship. Responses articulated a number of key observations:

Trust: For those service users who moved to virtual consultations mid-way through therapy some report that the therapist relationship is maintained, the trust built during face-to-face therapy helping facilitate the switch. From the interview responses, it is not clear if the process of building trust differs for new patients (i.e. assessment and therapy all delivered through virtual). There was an acknowledgement in some service user interviews that building a new relationship is perceived to be harder when online; however this was also noted by individuals who had be in receipt of face-to-face therapy. Clinicians and service users spoke about the negative impact of not being able read others' body language, micro expressions or engage in direct eye contact.

Place and emotional memories: Some service users reported how being in their own home promoted a sense of safety, enabling them to feel more comfortable and leading to honest and open conversations. Conversely, a number of service users also reflected on the difficulties of reliving trauma in a home environment and this subsequently infiltrating what had previously been seen as a safe space. A number of service users identified how receiving therapy in what was perceived to be a contained space, outside of their home, often helped separate the trauma from day-to-day life and this had now been removed with the introduction of virtual therapy.

Boundaries: A frequently articulated point was in regard to how virtual consultations removed opportunities to prepare for, and subsequently reflect on, therapy. For example, service users spoke about how the process of travelling to and from face-to-face sessions became an important part of therapy and, without this structured time, it has become trickier to engage in this work outside of the virtual session. Often service users would describe their experience of ending a session and then immediately going back to work or doing

a household task. Clinicians were aware of this behaviour and described strategies offered to service users to facilitate the space to reflect (e.g. sitting in the garden, going for a walk).

Clinicians view of how virtual therapy and impacted on outcomes were overall cautious, mindful that at time of the interviews there were few data available to make any firm conclusions. Some clinicians felt they had observed positive changes For example,

> *"I feel really positive about it. I think it's a really good way of working actually. With some clients, I wish I could be them face to face that it would be really useful for them to have that sense of human contact but I don't feel that so strongly that I want to change what we're doing. Because I think it's working for all of them. And, in fact, I think they've all at various times said, you know, how they trust the relationship and how, how it helped them. So from what they say, virtual therapy seems to work. And my sense is that it works."* (Clinician 018)

> *"Some of the outcomes haven't been great. But that's not to say that's because of the switch to life size that it maybe. But some of the outcomes have been reasonably positive. And certainly I know qualitatively people have said to me that it's been helpful to have the consistency and to continue therapy in some capacity."* (Clinician 019)

While others articulated how they felt positive outcomes were harder to achieve through virtual delivery:

> *"I don't think that the outcomes have been to my satisfaction. And I feel like I'm walking with an arm tied behind my back. And I feel like I'm doing my best, limping along. And I feel like I'm, I'm not literally doing a lot of apologising, but I feel like I am for the kind of interactions being inadequate."*(Clinician05)

Feedback also illustrated how understanding the impact on service users is complex and may change over course of therapy.

> *"In terms of kind of symptom relief, and kind of making changes. Yeah, I suppose I do feel like it has been as effective. But I guess in terms of, sometimes if you have people in a session face to face, you bring stuff in or you draw stuff out, especially being CBT being the modality that I work from, you know, you draw it out, and you'd have it there. I find that that side of it's more complicated for me to show that. That's been improving as times gone on, and I've become more familiar with life sized scree sharing function."* (Clinician 007)

> *"Initially my feeling was actually this is okay. And this is just the same as usual. And it's good that this technology is here and that we can carry on doing the work that we that we usually do. And I think that was informed by the messages that we were getting from patients who sort of claim that they were quite happy with it. But over time thinking about it, I actually find that it's hard to maintain sort of focus and attention when you're just looking at a screen. And it's hard that the patients, that they don't get to come away to go somewhere to come to their appointment and sort out that space and find the sort of process or they might have spoken about what they might want to work on."* (Clinician 009)

It was also raised by clinicians that diagnosis may influence effectiveness of virtual consultations

> *"I think if you if someone's already very avoidant, then online therapy can really feed into that. It's harder to challenge someone, and maybe try and get them out of their comfort zone when online. That's what I found. I don't know why. I don't think it's as effective in the highly anxious clients."* (Clinician 013)

"I know that our liaison teams at the beginning of lockdown. We're seeing a lot of people with personality disorder, who were not finding online interventions suitable. They wanted to be seen in person." (WI02)

In summary, the feedback gathered through interviews did not provide a consistent picture as to the usefulness and effectiveness of virtual therapy. Both clinician and service users reflected how personal circumstances such as individual differences in diagnosis, stage of therapy, home environment and willingness to engage were important factors to consider. Often individual responses reflected the conflicting thoughts on usefulness.

"It's difficult in some ways. In some ways, it's been pluses and minuses. Because I found generally that it's quite convenient just to be able to do it, you know, from home. But the problems have been around for sort of during lockdown because I've got children. And when they were around, it was a bit awkward." (SU15)

7.2.2.2 Process of attending therapy

Processes associated with attending face-to-face sessions (i.e. travelling to and from appointments and leaving safety of home), were often highlighted as important aspects of therapy. A number of service users spoke about how the process of attending face-to-face therapy facilitated an opportunity to challenge themselves. The act of travelling to sessions was often spoken about as an added element of therapy and removal of this was frequently viewed as a negative impact of the virtual offer. The quotes below articulate this viewpoint:

"We didn't have to make that much of an effort to have my session and I still got out of it what I needed to therapy-wise. I just don't feel like you put yourself - you're not putting yourself out that much. But you're not testing yourself or challenging yourself enough. Having the virtual sessions is okay. But there's nothing to it, you just sit and wait for someone to call you up. And you just press a button and you're online and that's it. Whereas for me, it was a big deal for me to actually be able to get up the morning, get myself ready, and then actually challenge myself to leave the house." (SU04)

"I know that kind of that would normally be a positive thing that you wouldn't have to travel to get there. But for me, honestly, I think kind of hospital appointments and therapy appointments are normally the only time I get out the house. I really struggle physically to get out the house." (SU06)

"Well, for me personally, because it was part of my therapy to get out of the house to go to see him. On the screen, it isn't the same. It's not as personal." (SU11)
"For myself, you know, remaining in a virtual setting, it suits me. It helps me, you know, engage in those sessions knowing that I don't have to leave the house. On the flip side of that, that could also be seen as a negativity whereas you know if you have the chance to go face to face, if you have the chance to get out and meet people that is part of the healing process." (SU17)

"That's the one of the downsides is that you don't actually get put into that position to actually force yourself to put yourself in a position, to actually confront going out and dealing with things." (SU23)

Some service users spoke about how there being no distinction between home and the therapy setting led to a lack of mental and physical preparation for the therapy session.

"But I think what it does is it makes you not as prepared in a mental way, but physically, so for example, you can get quite blaze about it: Oh, it's going to start in quarter of an hour, I think I've got another five minutes, I won't, I won't start getting ready till then. Whereas if you are travelling somewhere,

you've always had to plan in advance to get there on time. You know, you normally go use the bathroom before you go into an appointment, you know, all that sort of thing." (SU21)

7.2.2.3 Management of risk

How management of risk changed with the switch to virtual delivery was reflected upon in both service user and clinician interviews. One strategy to manage risk articulated by both groups was a cautionary approach to eliciting or expressing strong emotions.

> *"However, I think I'm probably a little more considered and cautious in some of my therapies, the risk taking, in terms of what I like to do with clients."* (Clinician 001)

> *" Part of the work that we do is that you make sure you're very mindful of not going near or not eliciting high levels of emotional arousal or distress, unless you stand a good chance of then being able to contain and work through that."* (WI05)

And to introduce additional checks on service users who leave a session early:

> *"When somebody clicks off from a group and you don't see them for the rest of the day, there is sometimes more of an uncertainty about if they're going to be left for the rest of the day. So we find that I suppose we find ourselves checking up a bit more and being a little bit more available outside of the group, which we wouldn't normally do at all."* (Clinician 021)

Service users spoke about how the change to virtual delivery removed the additional support they could access on a KMPT site if they became distressed during therapy and consequently affecting perceptions of safety. For example:

> *"I would feel safer face to face, then having it at home and having no one here. And then suddenly, that session finishes you're left with nobody watching you straight away. But again, that might be because of the high suicide risk."* (SU08)

> *"There was one occasion with myself, where I was getting so irate and upset, it was touching a nerve-I just disconnected. So I was able to just log off and do what I want to do. Where, when you're face to face if I was to walk out of the room, usually someone would come after me and say come back in. Obviously they did encourage me to stay on video and I got a couple of text messages saying to come back on to group, but there was no sort of support."* (SU09)

In the interviews with clinicians and wider informants different views emerged regards managing risk and the experience of supporting service users who become distressed during a virtual therapy session. Few interviewees had first-hand experience of dealing with severely distressed individuals but were conscious to have plans in place in the event of this happening.

> *"So I guess, you know, if you've got a patient sitting in front of you, and they're talking about when they leave the building, they're going to follow through the suicide plan, then you would make efforts to keep them in the building. And we would refer them to the crisis team. You would be doing things on site with patients, should they be present. I think it raises clinicians anxiety about how they manage risk, they haven't got the patient in front of them, and whether they can as effectively assess risk if they haven't gotten in front of them. What actually transpired in my service anyways, that it doesn't seem to be particularly problematic."* (Clinician 003)

"We spoke about that fairly early on and it was decided that if things do get too much, you want to leave or walk away, you can do-either leave the call completely, or turn the camera audio off, and volume down and just walk away. And it was decided that if you were to do that one of the moderators would either call during the break or after the session, depending on when you walked away. And there would be the conversation there." (SU19)

7.2.2.4 Impact on referrals, caseloads and work.

When interviewing clinicians there were conflicting views on how caseloads had changed, potentially reflecting differences according to service or geographical area. Some clinicians reported that at the time of the interview (September/October, 2020) their caseload remained consistent with levels experienced face-to-face, while mindful that this would likely change as the pandemic goes on.

"It's busy, we've got people waiting, but I don't think it's obscenely busy. You know, maybe it's still to come. But right now, we're kind of working as we would have done face to face. We've got the same caseloads, and similar length waiting list." (Clinician 013)

"So my caseload stayed the same. So when February March came around, it was certainly getting towards capacity. But then COVID came along, and meant that our role shifted slightly towards offering the supporting to our colleagues in the wider community team with checking phone calls, before then returning back to my case job, which was gradually building." (Clinician 019)

This view was contrasted with some clinicians who reported that virtual delivery had resulted in larger caseloads

"So there was an increase, definitely, we had a lot of very anxious clients and referrals being made. And that during that first bit was certainly happening because the GPs weren't seeing clients so that was definitely an increase in what we have to do. That's probably settled a bit more now but clients increasingly anxious. So there's certainly more of that going through." (Clinician 015)

"Actually, I am seeing a larger caseload because I don't have the restraints of rooms, which used to be a major problem. And I can fit people in where before I couldn't make it. So I say I'm seeing probably about 20% more patients at the moment the way I used to." (Clinician 017)

While views regards the impact on caseload differed, one strong theme that emerged from across the clinician interviews was the detrimental impact of working for long periods on a computer screen. The quotes below typify response regards online working.

"I really, really struggle with being online and on computer all day. I mean, if you think about the way I previously have worked and would have worked for years, is that I would spend something like four to five hours a day with a patient, and then the other two hours on the computer. And now I'm spending like, what, six, seven hours on the computer. And I'm finding on a personal level, like looking so in the two dimensional screen all day, just really, really awful, really, really tiring. And very, very draining." (Clinician 005)

"The thing that I can say is that for the clinicians, for me the level of physical tiredness, physical exhaustion with this, and focusing on a computer all day is unbearable now." (Clinician 020)

"Also being online- we really are online literally all the time and it has an ongoing impact. And the kind of wear and tear of it on patients and staff quite significant." (Clinician 016)

Interviewees also frequently spoke how this way of working conflicted with what they enjoyed about their roles.

"I don't find it particularly enjoyable just looking at a screen. One of the reasons I wanted to be a psychologist because I didn't want to sort of just be staring at a screen. I wanted to be sort of with people and interacting with people." (Clinician 009)

Some clinicians also reflected that while caseloads may not have increased, the amount of preparation work required for each session had intensified. However, this was not a universal finding with some interviewee articulating no discernible change.

"Yeah, definitely, I do feel like it takes more time than it did. You just feel like you've got to prepare for sessions more in terms of sending things to people." (Clinician 009)

*"When it's Lifesize, you need to then talk through that it's going to be on video and check that's okay, you have to do some preparation about what that means and privacy, and just the technicality of it as well. So there's quite a bit more to do before you actually meet with somebody on Lifesize.***"** (Clinician 021)

"I think it's pretty much the same much into having prepared notes beforehand, and review of the last sessions picking up where we left off from where we're going to go some sort of agenda lined up in my CBT head. I don't think that's changed particularly." (Clinician 014)

7.2.3 Group-based therapy

Interviews with service users attending group therapy generated a number of important findings specific to this setting and relevant to the effectiveness of virtual therapy. First, a frequently highlighted negative impact was how virtual delivery hindered the development of close relationships between those in the group. Interviewees reported finding it harder to build trust across an online platform and attributed this to missing opportunities between therapy sessions to have 'informal' contact (i.e. socialising before and after the meeting, eating lunch together) to build connections and relationships.

"When we were face to face, I used to get a bus, did two hours of therapy then we would pop into a cafe and have a drink after. Even though it wasn't therapy in the cafe, we were there still just chatting away, which was quite nice as that sort of downtime." (SU09)

"10-15 minutes before group therapy you come and talk in the waiting room, and then after the group therapy you will wander downstairs and smoke a cigarette There's general chitchat outside, you wish each other luck for the weekend, give each other hug. There's that interaction there without the facilitator. And I think that builds additional bonds. And, you know, you can't do that online. Because when the facilitator says' "well that's time's up, guys, see you next week" when they decide to hit that end button you've all disconnected." (SU14)

"I don't think that there is enough opportunity for people to get to know each other, because what you are essentially doing is asking people to share very personal stuff to them-what happens behind closed doors-with people who might still appear to be strangers." (SU19)

"We can't build that feeling of trust and safety with each other and connection. Because there is no forums do that, or not, in an easy way. Whereas in person that happened really quickly, actually, within a couple of weeks, I felt like a really trusted and felt close to people in the group." (SU27)

Clinicians also commented on the importance of interacting outside of the formal therapy session, reflecting on the role these interactions play in providing a space for disagreements within the group to be resolved or emotional responses to diffuse. Without this opportunity, it was felt there was a risk that a key benefit of the Therapeutic Community programme could be lost. Clinicians working in this service recognised this early on and adaptations to delivery were introduced.

> *"… you have lunch around a table with maybe the very same people you've just been arguing with. And therapists to. And you can talk about either something completely unrelated, or you can talk about what happened in a more relaxed way. And so what we've noticed is that patients really were struggling with this and not able to work, not able to have a process. And so that was why we expanded our programme to try and offer more of what they would add in. So we moved from just three days a week, three groups a week to expanding it."* (Clinician- number nor included to prevent identification)

Overall clinicians reinforced the difficulties of delivering group sessions virtually expressed by service users:

> *"Our clients fundamentally they don't trust anyone in the world-they often don't trust themselves in the world. So part of our therapy is about being together and having some sort of reparative experience of being with others, in a very sort of physical, practical way. That begins to sort of challenge that story that everybody's out there to harm me, or everybody's out there to take advantage of me. It's just the being together. So I don't think that trust, develops as easily online."* (Clinician- number nor included to prevent identification)

Service users and clinicians also highlighted how reading social cues was harder and consequently could affect the quality of the session:

> *"If you're sat in the same room as everyone you can take cues from their body language. Or you can, when you have the conversation someone face to face, you know, you look like in the group dynamic, you look at someone when they're taking their time to talk, and then you move your head look at someone else that you know. Whereas online, there's none of that-you're all looking at the screen."* (SU14)

> *"I find it hard to read silence properly, like because I just shut down and internalise and go into my negative sort of thought patterns. And I think that can be hard. Because you're not in the same room as somebody is, it is very different."* (SU18)

> *"I think you've got to be able to articulate, be quite articulate to be on the group session, because there is a lot of things you need to be aware of around you at the time of doing the group. Because you've got to be able to pick up on other people's reactions. You know, you haven't got your facilitator who's able to give you the facial reactions and things like that, not quite so easily. And I wouldn't put people off doing it. But I would say there are some people who would be able to deal with it and others who wouldn't."* (SU21)

> *"I think group session via video gives the opportunity for lots of misunderstanding to happen. And misunderstanding of communication, and people misconstrue things, when, when actually in face to face session, you can see like, things can be clarified, quicker."* (Clinician 002)

Ensuring all group members were provided sufficient time to speak in the group sessions was another challenge reported by both service users and clinicians.

"And I think it can be in terms of doing therapy groups on video, I think that presents a little bit more complexity in terms of turn taking in the group. That's a little bit harder than face to face." (Clinician 003)

"You would have maybe about 10 of us on group, sometimes more, sometimes less, but not everyone would get a chance to speak. Which, when you're in the room, you can pick up on people's body language." (SU09)

Interruption to the flow of conversation due to either internet connection issues or inability to read social cues adds complexity to the group sessions. As two service users succulently articulate:

"I think the online format introduces all of these ways that create extra layers to encourage the sort of paranoia that happens for most of the people with my diagnosis anyway. I think the same is true of silence, when there's a silence there's an extra layer on it because people can't feel each other's body language." (SU27)

"The group ones, it takes a little getting used to. And until you really gauge who you're talking to, the amounts of people that you're talking to, it can be very difficult to open up to relax, you're very aware of over talking or not talking enough. You're worrying about whether or not to chime in with your opinion.." (SU17)

Reflecting on how impact of group therapy was affected by the change in delivery, the overall feeling from both service users and clinicians was it was harder to achieve the same impact through virtual sessions. This view is illustrated by the two service user quotes below:

"At the beginning of starting out on online with lifesize, it was almost like, rewinding back to before that point. And, because there's always an element of frustration when it comes to group therapy, because sometimes you can feel like you almost didn't get to the nitty gritty. You spent so long making sure that everyone's had their fair chance to explain their week or whatever, that you wouldn't normally have to do in a group face to face. Don't get me wrong having the virtual group is definitely by far better than having no group at all. But it definitely does bring like a whole new set of challenges." (SU14)

"I'd say pretty negative overall. Yeah, there's been a thing about kind of picking up the general mood of the group as well-everyone feels like it's not equivalent to therapy. It's felt like a sort of holding place sort of exercise. A way to keep us in touch, but it hasn't felt therapeutic." (SU27)

Clinicians referred to how delivery of group therapy presented additional challenges compared to individual sessions, although they felt it was too early in the process to determine any consequences on effectiveness.

"And I think where it's probably been more difficult from face to face to online has been to group. I think the group's it's been very different." (Clinician 008)

"Group work was probably the most challenging. Particularly with the those in personality disorder community, because so many issues for them about engagement and anxiety. So that was very challenging." (Clinician 015)

7.2.4 Summary

Responses on the role of virtual consultations in supporting treatment and recovery were mixed, with few consistent patterns emerging from the data in terms of effectiveness. Experiences shared were often unique to the individual, influenced by diagnosis, personal circumstances and type of therapy (i.e. group vs. individual).

Focusing on the challenges associated with virtual delivery of consultations, the main themes emerging from the service user interviews were:
- Increased anxiety due to worry about accessing and engaging in online session
- A feeling that therapy is 'impersonal'. A lack of personal connection and the sense they were 'speaking to the computer' as opposed to an individual or therapist.
- Service users in group therapy had specific concerns about being given adequate chance to speak and felt turn-taking was more difficult online.
- There was a sense that virtual delivery of therapy prevented some individuals from exploring topics – reluctance to open up and speak about emotional memories when not in the same room as the therapist.
- Alongside a reluctance to fully open-up, feedback articulated concerns about accessing immediate support post-session if this is needed from wider team (e.g., duty worker) who would be normally be available onsite when therapy delivered face-to-face.
- Although recognition that for individuals with agoraphobia virtual therapy may be seen as a convenient alternative, service users and clinicians were also cognisant that leaving the house and travelling to a face-to-face appointment was itself an important part of therapy.

Service users also articulated how the virtual offer had been of benefit to them:
- Provided a mechanism of having contact with someone, especially those at risk of loneliness and social isolation.
- Group therapy offered an opportunity to engage with others who have similar diagnosis
- Helped to provide a routine and structure to life- some normality in a time of uncertainty.
- Ensured continual engagement with the recovery process. Some service users felt it was still an opportunity to move forward and make progress

Findings from analysis of CORE-OM data suggested that comparing face-to-face treatment to virtual consultation, there was no statistically significant effect on service users change scores. The mean change score in both groups represented an improvement in clinical outcomes as defined by CORE-OM scores, suggesting that transitioning to virtual delivery of psychological treatment did not appear to have a negative impact on service users' treatment outcomes.

7.3 Adoption

Under the RE-AIM framework adoption explores organisational reach for the new way of working and is captured by establishing any factors that enabled or hindered adoption of virtual consultations. Three common themes emerged for what interviewees felt helped adoption and development of virtual consultations.

First, knowledge of online platforms and confidence in using IT was viewed as an enabling factor for adopting the approach. Clinicians reflected on their own competencies had eased the process of moving across to virtual consultations.

> *"Well, I think personal experience is a good thing. And I think it confidence is also a good thing as well."* (Clinician 001)

Second, access to opportunities for peer-learning and additional training was viewed as crucial for successful adoption within teams and services.

> *"I think that having the experience of it can be very influential for others. So I was one of the first in the team to deliver video. So we were able to talk to colleagues who was going to be doing that, but who haven't done it at that point, about our experience of it and are kind of welcome surprise that it seemed to work as well as it did. I think having your own lived experience is very influential."* (Clinician 003)

Finally, to alleviate anxiety about use and subsequently promote adoption, interviewees articulated the importance of preparation for both themselves and the service user. For example, being clear from the start about what will happen in the session and having an agreed plan if they were to become distressed or need to leave the session unexpectedly.

> *"One of the key things for me would be to encourage them to prepare, so not just prepare themselves in terms of thinking in advance about what their space will look like, how they will set up that space, so that they feel comfortable and safe in it, but also preparing their clients to think about those things."* (Clinician 004)

> *"The setup, the process of how you set up and guide people into the online experience is really important. And talking very clearly with the patient about what those parameters are. So I would say, start your group or your individual sessions with the absolute understanding that they must be on camera that they must have a private space that they can't be on the phone, I would say that if they need to leave the session, they need to tell someone because you know as in right there at the moment, you need to be understanding."* (Clinician 016)

7.4   Implementation

The implementation domain of the RE-AIM framework focuses mainly on the clinician perspective regards contextual factors that facilitated or hindered the rollout of virtual consultations; however some important considerations were raised from the service user interviews about the role of support for transitioning to virtual delivery hence we felt important to highlight.

7.4.1 Service users

Service users spoke about how clinicians had provided support to ease the transition. This included discussing the different options available to them for continuation of therapy and providing step-by-step guidance to using Lifesize.

> *"Yeah, they sent like a link, and instructions on what would happen. And because we got sent that in advance of the session, I was able to explore the programme. So I knew what it would look like, what I needed to do, which I think is helpful. She did ask me that, even though she knew obviously I live by myself, but I think you know, she was just checking because obviously, you know, my circumstances might have changed. We talked about the Wi Fi connection, and if it doesn't connect in the first five minutes she would ring me and vice versa. If I can't get through to her then I have a number in the email that I can contact if there's like an issue."* (SU05)

> *"Yeah, my therapist explained what it was going to be. And she, I think when we went on she phoned me. We were on the phone while I was setting up to talk me through it."* (SU15)

Some service users articulated how they felt there was an absence of adequate support with the transition:

> *"No, I didn't have any help or advice. I'm quite lucky that I'm tech literate. Otherwise, I would have struggled."* (SU07)

> *"They sent an email saying how to do it. But I still had to speak to the members of the group, because I couldn't get on. So it's really talking to others that I managed to get one in the end."* (SU13)

> *"Well they couldn't because they couldn't come out and actually show me how to do it. The whole idea was that there was no actual contact. So there's not much they could do. So I had to get on with it from this side."* (SU24)

While others noted that it was relatively easy and no additional support was required.

> *"From my perspective, everything was okay. Quite autonomous. And you tell me, just to do something, and I'll kind of master or figure out how to do it on my own. So from my perspective, I think that, you know, the help offered was good."* (SU19)

7.4.2 Clinicians
Four common topics on implementation emerged from the interviews with clinicians – thoughts on early stages of changing to virtual delivery, training and support offered to staff, impact on workload and how therapeutic techniques were adapted.

7.4.2.1 Initial transition from face-to-face to virtual delivery

Clinicians described how initially contact with service users was maintained by telephone. These calls was not necessarily focused on providing therapy but to check-up and assess how service users were coping, alongside providing updates on service delivery.

> *"Some patients in the initial stages, it was more of a process of checking in with them, rather than trying to deliver therapy. As time went on, we realised we needed to carry on delivering therapy."* (Clinician 003)

Interviewees remarked upon the pace of change. Some feedback highlighted how the rollout of Lifesize happened quite quickly, while others remarked this took longer than expected. This difference, in part, might be explained by the need of those accessing the specific service.

> *"Happened pretty, pretty immediately, quite responsive and did the best that anyone could do to fit our needs. However I think because we work with very high risk patients of suicidality or self harm that was taken into account, and that the urgency was there for us set up our Lifesize."* (Clinician 016)

> *"We were prioritised as a service because ours was like complex clients and our numbers quite big. Otherwise, there would have been quite an impact on other services if our members didn't have a service. So we got a lot of support actually in life size, coming online, very quickly."* (Clinician 021)

> *"So it didn't happen as quickly as I expected. At first, everything moved to telephone calls initially, which was fine, assuming that I could get through to somebody on the phone, and they had signal, that sort of thing. But it obviously meant that for lots of people, they definitely missed out on a good few weeks of therapy, and what I would call, you know, good therapeutic contact."* (Clinician 004)

Interviewees reflected on how they would have liked to be more involved in the initial decision to use Lifesize.

> *"....not enough engagement with real world practical reality of being on the front line of running a service, running a therapy provision."* (Clinician xx)

> *"And rather than seeking the clinicians wisdom from the shop floor, which we were keen to provide, there was no sort of discussion of that."* (Clinician xx)

And articulated how the development of SOPs was viewed as fragmented with a lack of consistency across services for how virtual consultations were rolled out and implemented in to routine practice:

> *"At a local level we put together our own guidance around accessing videos sessions. I'm not aware that there's anything that was standardised Trust level around."* (Clinician 003)

> *"I think it's a complete lack of standardisation. I think that was probably the problem of sort of structure and guidance and instructions. It was almost like this is Lifesize, away we go. That's what I look at is the having clear instructions on how to make this work if you like that will be standardised across the board. So everybody knew how it operates."* (Clinician 014)

> *"And as a result, you have across KMPT, a whole range of different practices. So some people who only recently began this in the same service in different localities, but some people only recently begun to start video consultations, six months down the line."* (Clinician 001)

When asked to explain the variation in approaches interviewees highlighted a couple of factors. First, there was a sense that while waiting for Trust-wide guidance, services and/or teams took the initiative to develop practices locally.

> *"I think the trust were quite slow in offering guidance. It felt for quite a long time that we were all muddling through. And there wasn't much in the way of guidance around what we should be doing with patients. What do we do with a patient who is only coming to the service for therapy, but has declined audio and video, what do we do in that circumstance? There wasn't guidance around that we were kind of making decisions about what seemed most sensible. And there wasn't policy around it."* (Clinician 003)

Second, when SOPs were developed, clinicians felt it was important to adapt the guidance to fit clinical population and therapeutic approach.

> *"Then having flexibility in how it can be operationalized after that, I think is important as well."*(Clinician 014)

Across the interviews there was little consensus regards the experience of changing to virtual delivery, with some clinicians finding the transition easier than others.

> *"So I have found it really, really, really challenging. And the main challenge was convincing people to do it in the first place, and then getting them set up, I've had a lot of trouble with equipment."* (Clinician 005)

> *"I didn't want to do this work at all, and that I would rather go on leave without pay until it's ended. I don't like it at all."* (Clinician 006)

> *"Lifesize just wouldn't work for me. So I would be on the phone to IT every day, like for an hour and a bit with them going through it all and trying to connect here and I think there was an awful, a lot of awful lot of teething problems which actually caused me so much stress."* (Clinician 012)

> *"I'm really pleased that it's working out as well as it seems to be. And it isn't something that I would have imagined would have been as successful as it seems to be. I much prefer it to audio but I think that more is lost from the connection and the relationship with audio. I haven't experienced many technical issues with it. So that hasn't been problematic."* (Clinician 003)

> *"I think I've been quite pleasantly surprised as an over overarching sort of comment. I think it's worked relatively well."* (Clinician 014)

> *"I think I probably fumbled a bit around what I needed to say at the beginning about the protocol...stressing that they needed to create a space where they felt it was confidential, and all of that sort of stuff, but I think that was just getting used to it. And in terms of actual clinical work- maybe it was strange on the screen initially, but my sense is that it's been a good a good experience rather than the opposite."*(Clinician 018)

7.4.2.1 Training and support

Overall, the support provided by the IT team at KMPT was viewed favourably:

> *"We had there was a particular member of the IT team who spent time with us. I think we were fortunate because I think that we identified that we wanted to use Lifesize very quickly. So we got access to him quickly. And, you know had an individual meeting with him and talking through it or so yeah. And he was responsive to answering questions."* (Clinician 003)

> *"And our IT service is really good. So I've been able to phone them up whenever there's been a major issue I've needed help with. And they always sort it out quite quickly."* (Clinician 004)
> *"So I certainly had the phone call conversation with one of the main guys there [IT support] who was incredibly helpful."* (Clinician 015)

For further guidance and support, many clinicians report taking the initiative to engage in independent training to improve knowledge on how to adapt therapeutic techniques for delivery in virtual consultations. In the most part, professional bodies and networks external to KMPT delivered this training.

"I took on my responsibility for finding out what I need to find out in order to do this [deliver virtual consultations]. So via my professional bodies, I've got three professional bodies. So those professional bodies-some of them were quite good in terms of providing training, a lot of independent bodies the and the association. A lot of other things we're doing seminars and lots of in a whole range of, of different trainings where you can pull out stuff that's really, really useful." (Clinician 001)

"A lot of us have sought out our own training for specific types of therapy, which need to be delivered over video. So I have done a couple of trainings over the video platform. I've been able to access quite a lot of research and virtual webinars, but again, it's through separate avenues. So my accreditation body and stuff, rather than KMPT, but I think maybe in terms of the NHS I think it would have been helpful if they'd have been able to provide something in-house for their therapist around that." (Clinician 004)

"And also professional bodies, they did put out a lot of videos about what it's like working online and things to account for, and I spend a lot of time watching to help me feel confident." (Clinician 005)

Feedback also illustrated the areas where clinicians felt more support from within KMPT would have been beneficial- for example, opportunities to share knowledge and experiences with people in a similar role and additional training in how to use Lifesize and deliver therapy online.

"I would have liked to have been put in touch with more senior colleagues working on the same level to share the stresses and the indecision. The choices that you're having to make on your own-causes anxiety, I would appreciate it." (Clinician 016)

"Because we had to adapt ourselves very quickly as an institution to video sessions and telephone sessions and be more flexible, which is fine. But as I said to before, I think we need more training, we need more." (Clinician 002)

"There wasn't anything that was sort of suggested or sent down from higher than the service leads. I think lots of therapists are struggling with that they sort of haven't had training around how you do virtual sort of consultation or therapy or assessments. I know that for me, it wasn't in any of the training that I've done, it wasn't mentioned or spoken about. We've sort of having been having to adapt just and get used to it. As we've, as we've been going along, really." (Clinician 009)

"What would have been helpful would have been to have had some training, even if it was only a couple of hours or an hour of how to actually implement it, how to get it all up and running." (Clinician 012)

"In terms of actual IT support and technical support, which was the bit I was most apprehensive about, I didn't feel there was much of that at all. It was more just keep encouraging us to just kind of give it a go and then kind of persuading clients to give it a go. Maybe a demo, like a little training on how to use it. Maybe we could have all been , just send out a link and given very brief instructions of how to actually get on to we use and get on to life size and then actually just watch someone run for a few things as a demonstration." (Clinician 013)

"Again, the Lifesize-how best to make it work. Again it can be useful to know, more proper way of making it work if you like rather and just trying to work it out yourself. I'm sure there's a lot more than I know about that would be useful." (Clinician 014)

7.4.2.2 Impact on volume and type of work

Clinicians also highlighted that implementation of virtual consultations had resulted in supplementary tasks and challenges. This is also discussed in the Effectiveness section **7.2.2.4 Impact on referrals, caseloads and work.** Looking at this topic in relation to the Implementation dimension, clinicians spoke about the additional time required for assessments to ensure those about to enter the service knew what to expect from virtual consultations and how it may differ from face-to-face.

> *"Because the new ones [service users], it did require a lot of legwork, because normally you're quite protected by admin staff [who] send out letters, inviting people. Now, because we have to kind of encourage people to use the platform right from the beginning we had a lot of difficulty with that, because a lot of people were resistant that didn't want to hear about the online world. A wall of resistance to begin. So the assessments took longer online and it wasn't enough, it didn't feel that it was enough to just do it the traditional way, which was sent out the letter. Now what I've said to the admin staff, I've got a vacancy, could you please invite that person the next one on the waiting list for an assessment that didn't feel enough anymore, it felt like we decided as a staff that we needed to speak to them about what it will involve."* (Clinician 020)

> *"I suppose it's not what we were trained to do to be so tech savvy. So it's an additional burden. You can't measure it in time. It's stressful. Yeah. That's a big stress."* (Clinician 011)

7.4.2.3 Adaptation of therapy to virtual delivery

Interviews explored how therapeutic modalities and techniques had been adapted for use in virtual consultations. Challenges with specific aspects of therapeutic modalities were raised as potential barriers for implementation. A frequently referenced issue related to practicalities of producing and sharing worksheets used in CBT.

> *"If I'm doing CBT, or cognitive analytic therapy, then obviously, I'll be using tools in a therapy. You would easy be able to photocopy something for a client, so [now] you don't have that sort of fluidity in- a client comes in, and you can give them you can give them kind of information and resources and you know, photocopy things."* (WI04)

> *"Face to face, yes, I feel more confident to bring like a worksheet and work the client to know, review the homework. I think it's such a difficulty to send materials to clients, because we need to do that via admin."* (Clinician 002)

Other concerns focused on the process associated with delivering a specific type of therapy. For example:

> *"I think that MBT-mentalization based therapy-I don't think that works particularly well, personally, because, again, you lose so much in the body. And it's quite difficult to try and mentalize when you're doing that over a 2d screen that might have technical glitches, you know, delays in facial expressions or whatever. That's not ideal. It's not impossible, but it's not ideal."* (Clinician 004)

Alongside this feedback, there was recognition that some modalities- ones referred to as using 'structured' approaches (i.e. CBT, ACT) - might be more adaptable and appropriate to deliver through virtual consultations.

> *"It's interesting. I think video maybe lends itself better to structured approach, like CBT. You can share materials on the screen. Just thinking about psychodynamic where there isn't, I don't know, maybe there's something about managing things like silence. That maybe is a little bit more complex than it is face to face. You're limited in the cues that you have on video, or you perhaps you lose some of the*

subtleties. And so I would, I think it probably lends itself that maybe there are less disadvantage with more structured focused approaches to therapy." (Clinician 003)

"In terms of sort of more structured therapies like CBT and ACT. I think my experience is that it can work virtually. And we've now got an email address sort of systems, where we can email patients, sort of the materials that they'll need for the session sort of in advance and sort of, if they need to send us some outcome measure sort of scores, we can they can do it in that way. So that that helps. I think some of my colleagues who are CBT therapists, they quite like you, and they think it's working quite well." (Clinician 009)

Overall, a positive approach to adapting therapeutic techniques and ways of working was demonstrated throughout the interviews. Clinicians acknowledged the challenges and developed pragmatic solutions to ensure continuation of support.

"And I think in the mentalizing group, we try to bring some of the technology issues into the process of therapy. And thinking about the effects of being online on our states of mind, because mentalizing is all about understanding what's on your mind and what's in other people's minds. And so that becomes part of the process. It's just another thing for us to kind of explore a bit." (Clinician 010)

"I'm aware that if they were to physically come to appointment, they would have then had the journey home. Whereas now they're still sort of sitting in a bedroom or in their lounge and, and they've just been talking about something really traumatic. So I've had to adjust and spend a lot more of my time really grounding people and really making sure that they feel okay, because they are in their own home." (Clinician 013)

7.4.3 Summary

Regards the acceptability of virtual consultations, responses from clinicians were mixed. Continuing some form of therapy service was unanimously welcomed by clinicians but the depth of engagement by service users, richness of their experience and quality of interactions with the therapist were queried. Some clinicians expressed how over time how their scepticism had reduced; however all clinicians spoke of the desire of a return to face-to-face therapy in the long-term. Some spoke about the potential of a blended approach, with virtual options included for specific types of therapy and diagnoses.

There was a sense from some clinicians that certain approaches *may* be better suited to online delivery- for example, CBT or ACT; however it was also noted that additional work was required before these sessions to send the necessary handouts and worksheets. Differences in acceptability was also noted according to modality, with group therapy viewed as more challenging to deliver online.

Clinicians sought out additional professional training on the delivery of virtual consultations from external organisations and would welcome a KMPT-wide training offer to further develop these skills.

Clinicians frequently spoke about the impact on workload. Overall, an increase in work was noted although this was not necessarily aligned to caseload but attributed to the additional demands of delivering therapy online. Clinicians felt they were often '*holding a lot more material'* and working harder to make connections and build trust with service users. As one interviewee articulated: *"you are working a lot more actively to try and offer some containment from across a screen."* Coupled with these concerns was a general sense of fatigue due to increased screen time.

7.5   Maintenance

This aspect of the RE-AIM framework seeks to identify opinions from services users and clinicians about the future delivery of virtual consultations. It also explores components that need to be in place to ensure sustainable model of delivery.

7.5.1 Future delivery of virtual consultations

When considering the merits of continuing with virtual consultations there was an acknowledgement throughout both clinician and service user interviews that virtual delivery of therapy could improve accessibility to, and inclusivity of, mental health services.

> *"So certainly for those clients where health reasons, I don't know, travel, whatever it may be, if there was a real limitation that would prevent them, not just a choice, that would really prevent them from accessing therapy, and having that level of therapy would be better than none, then I'd be certainly willing to do that."* (Clinician 004).

> *""I would like to be able to offer whatever the client wants that makes clinical sense. I wouldn't rush straight back into face to face because I think could be something it's really awkward. For instance, if we just do face to face we miss out on some very agoraphobic clients because the service doesn't do outreach or hasn't done until this pandemic had to come into the office, which I think was really unfair, at least to certain people who just couldn't, couldn't access centre from where they lived. For those sort of people particularly being a bit more creative with how we can deliver."* (Clinician 014)

> *"I can look at it now and be like, actually this software would be an equality builder. It would be a recommended pathway for some people. Yeah, personally, I'm seeing so many benefits to people with like social phobia, physically disabled, elderly. People with Agrophobia, that could be so essential to helping them to taking steps to actually take a step outside."* (SU28)

There was some indication that virtual delivery could be continued as part of a 'blended' approach or as a mechanism to extend hours and access to mental health services. As described by a key informants and clinician:

> *"I think actually there are a lot of really positive things that came out of COVID. Extending the hours to support patients in the community is one of them. But we don't need to go all out seven days a week. So it's about adjusting what we did pre COVID and picking up the learning of what we did during the knockdown."* (WI01)

> *"I'm starting to think about, are there ways that we can be less binary...is it possible to do a blended version a bit like University. But being a little bit more adaptable, being more flexible, creative with the way that we're responding? So is it possible that we keep the groups online that perhaps we have an agreement that once every month or something we have individual, which we wouldn't normally do we have individual meetings, one to one, you can do that and face mask, to give them some sense of connection. So to be honest, what I'd say partly is, I think, perhaps what the future holds, and we need to start thinking about is not trying to be so binary about it. i don't think you can cut out the relationship experience of real relating completely. I don't I don't feel that it's particularly safe."* (Clinician 016)

However, the predominant feeling from both clinicians and service users was that although virtual consultations had some merits and successful adaptations introduced, the overarching preference was to return to face-to-face delivery of therapy.

"I think we quite coped quite well. We adapted quite well. We've got to use the technology well. Majority of our patients have gone on to online therapy. Some have not been able to and been deferred. I think that people are starting to show the strain more now, I think that that we people need to have personal contacts need to be in more often. I think if we could go back, we would want to I think if we could go to see patients face to face and colleagues face to face more regularly, we would be very happy to do that." (Clinician 010)

"There is not a single colleague of mine who's happy with what's happening." (Clinician 020)

Furthermore, the desire for a return to face-to-face delivery was unanimous for service users attending group-based therapy. Reluctance to retain virtual groups highlighted the additional burden service users felt:

"I think to be honest maybe if it was for issues were less severe, I can see that that might work. So I think for the group I'm in, it felt really high risk for everybody. All of the extra elements add just the level of extra layer kind of stress into as we meet three days a week." (SU27)

"So, don't get me wrong having the virtual group is definitely by far better than having no group at all. But it definitely does bring like a whole new set of challenges." (SU14)

Moreover, how not gathering 'in person' affected the group dynamics and consequently the quality of the therapy sessions:

"Having experienced group face to face and group online, group face to face I don't think you ever achieve 100% of that online. I just don't think it's possible. But, if you've got a group of people that are all there to try and improve their own mental health, deal with difficult things... all it takes is one member of the group to ruin it for everyone. Because a face-to-face if you saw someone's overpowering in the group you can confront them. Yeah, that's not something you can do online." (SU14)

"I'd say pretty negative overall. Yeah, there's been a thing about kind of picking up the general mood of the group as well-everyone feels like it's not equivalent to therapy. It's felt like a sort of holding place sort of exercise. A way to keep us in touch, but it hasn't felt therapeutic. Because there's a lot of things about being online that make everybody feel less able to engage." (SU27)

"Oh, it's really difficult. I think I'm not the only one, everybody in the group feels the same. You do the best you can but definitely not the same experience." (SU25)

Although there were differing opinions as to the usefulness and effectiveness of virtual consultations and whether delivery should continue post-pandemic, one clear message that came through from both clinician and service user interviews was the importance of choice. Whichever method of delivery is chosen, this needs to reflect the needs of the service user and the consequence of a collaborative process between themselves and the clinician.

"I think it's important that people have a choice. I think that should be that should always be an option. Yeah, just choice, I think choice." (SU26)

"And what we can't do is change the way that we deliver our clinical services, just as a result of pandemic. We have to do work, such as the evaluation and the research that you're doing. And other pieces of work to understand that it's not an either or, that actually, we need to be able to offer choice to staff as well as patients. And ultimately, the bottom line is, it will always come back to delivering safe services, and the individual risk that poses to our patients." (WI01)

7.5.2 What changes would improve future delivery?

When asked about how virtual delivery could be improved a number of ideas were offered with the most frequent focusing on the three topics discussed below.

The sharing and use of documents either before or within the session was something service users felt could be improved

> *"I think that the functionality of it is good for what we need it for. I think one other feature could be beneficial to it….depending on how you implemented it, but potentially a chat function while you're within the group. Be that to upload a document to show or if you wanted to just send a message directly to one of the moderators to kind of say, this is getting a bit too much for me."* (SU19)

> *"I mean, having it there - sort of, possibly to hand if you had before the session, would be good. Because you can go through - because that's what we used to do, prior to the pandemic. So I would be given some information, and we would work through it together. What I would need to do, whereas at the moment, because I'm unable to see it until the end of the session, it's difficult to, sort of, visualise what's in that document. Even though it's been explained it's still difficult to sort of visualise what that person is talking about until you've actually been able to view it after." (SU03)*

The use of documents in virtual consultations was a challenge also recognised by clinicians. Short-term solutions were often found to enable sharing with service users; however there was a desire to implement longer-term solutions if virtual delivery was to become routine.

> *"….just simple things like integrated measures and so on, you know, we're all trying to work between sort of paper based thing measures and excel things and you know, it's a mess."* (Clinician 001)

Some service users also referenced how use of the waiting room generated additional anxiety and expressed desire for this aspect to change.

> *"No, that's the main things for me. My biggest fear. Yeah, that I now have to go into a waiting room. And so by the time you know I get the appointment, I've got the sweats. It just worries me that somebody else by accident can click and get into my space. I don't know how badly that would affect me."* (SU11)

Finally, the process for starting and ending sessions was seen as an aspect that would benefit from some reflection on how to change going forward should virtual consultations be maintained long-term.

> *"When you go to a group[in person] you're usually in a waiting room….you might see one of the people that you're familiar with, you might have a little bit of a chat. And then the facilitator takes you through, within a few minutes, you've just got, you know, hello, how are you and all that sort of thing. So you've got all that, which is beneficial. On a video call, you don't have any of that- extremely unnatural. So you don't have that. But I think the facilitator could allow you to have a bit more of a chat and be a bit more relaxed about that bit before we actually start. So perhaps leave only about four or five minutes."* (SU21)

8. Summary

The evaluation, underpinned by the RE-AIM framework, investigated the impact and implementation of virtual consultations in KMPT. Key findings from the evaluation are summarised below under each of the main evaluation questions.

8.1   What impact are virtual consultations having on KMPT service user outcomes and quality of care?

As highlighted, feedback from service users was mixed regards impact on mental health outcomes. Most were pleased that therapy and continued in some form and appreciated maintaining contact with their therapist. Some service users reflected that virtual delivery enabled easier access and facilitated open conversations, while others felt that delivery via a computer disconnected them from the process and disliked how non-verbal communication was harder to read. Service users attending group therapy report additional complexities associated with facilitating multiple individuals and ensuring everyone in a group had sufficient time to talk. The lack of opportunities to build relationships outside the group therapy sessions was viewed as a major drawback of virtual delivery and one acknowledged by both services users and clinicians. Analysis of the CORE-OM data suggests no significant difference in outcomes between individuals receiving face-to-face compared to those who received virtual consultations.

Overall clinicians felt it was too soon to comment on how the change to virtual delivery impacted on service user outcomes. They felt the quality of care remained high and was optimal under what the circumstances allowed. As clinicians became more confident with delivery online, therapeutic techniques were adapted and additional aspects introduced (e.g. art therapy).

8.2   What has been the impact on the therapeutic relationship?

Trust: For those service users who moved to virtual consultations mid-way through therapy some report that the therapist relationship is maintained, the trust built during face-to-face therapy helping facilitate the switch. From the interview responses, it is not clear if the process of building trust differs for new patients (i.e. assessment and therapy all delivered through virtual). There was an acknowledgement in some service user interviews that building a new relationship is perceived to be harder when online; however this was also noted by individuals who had be in receipt of face-to-face therapy. Clinicians and service users spoke about the negative impact of not being able read others' body language, micro expressions or engage in direct eye contact.

Place and emotional memories: Some service users reported how being in their own home promoted a sense of safety, enabling them to feel more comfortable and leading to honest and open conversations. Conversely, a number of service users also reflected on the difficulties of reliving trauma in a home environment and this subsequently infiltrating what had previously been seen as a safe space. A number of service users identified how receiving therapy in what was perceived to be a contained space, outside of their home, often helped separate the trauma from day-to-day life and this had now been removed with the introduction of virtual therapy.

Boundaries: A frequently articulated point was in regard to how virtual consultations removed opportunities to prepare for, and subsequently reflect on, therapy. For example, service users spoke about how the process of travelling to and from face-to-face sessions became an important part of therapy and, without this structured time, it has become trickier to engage in this work outside of the virtual session. Often service

users would describe their experience of ending a session and then immediately going back to work or doing a household task. Clinicians were aware of this behaviour and described strategies offered to service users to facilitate the space to reflect (e.g. sitting in the garden, going for a walk).

8.3   Is the KMPT virtual consultation offer acceptable, feasible and appropriate for service users?

Views on acceptability of virtual consultations differed across service users and between those who access individual vs. group-based therapy. Some service users who accessed individual therapy felt that it was an acceptable option and would consider continuing with this form, while others felt that virtual consultations was a temporary solution and desired to return to face-to-face as soon as it is offered. No interviewees who attended group therapy wanted to continue with virtual consultations once face-to-face was an option. Some clinicians and service users felt the virtual offer might not be appropriate for individuals with diagnoses of personality disorders or paranoia. Overall, the main theme emerging from discussions on the acceptability and appropriateness of virtual consultations was the importance of service users choosing their own care pathway. Offering the option to participate in either virtual or face-to-face (or a combination/blended approach) may benefit certain populations and increase access to mental health services. In summary, virtual consultations work best when everyone has access to the right equipment, have the skills and capability to use the technology and have a safe and appropriate space to engage in a meaningful therapeutic relationship.

8.4   Do clinicians delivering virtual consultations as acceptable, feasible and appropriate?

As highlighted, responses from clinicians reflected a range of opinions with no consensus on acceptability of virtual consultations. Views were influenced by levels of confidence in using IT and technology, therapeutic modality and whether delivering individual vs. group therapy. Clinicians reported needing more time to both prepare for virtual consultations and afterwards to reflect and process the session. A clearer picture emerged regards future delivery, with the majority of clinicians expressing a desire to return to face-to-face consultations, with the option of virtual delivery if feasible for those who request.

9. Recommendations

Based on feedback from both service user and clinician the following recommendations are made:

- Reflecting the predominant view from service users and clinicians, a return to face-to-face therapy, when government guidelines permit, is the preferred option. There should also be provision for virtual delivery to accommodate service users who express a preference for this method. Decisions on access to virtual consultations should be clinically informed, assessed for risk and involve the service user in the discussion.

- The choice to engage with virtual consultations should also extend to clinicians. Individual preferences should be considered and delivery adapted if required (i.e. where possible could delivery of virtual consultations be within KMPT premises to allow clinicians to run sessions away of the home).

- Explore with clinicians and service how a 'blended' approach may be implemented- who should this be targeted at and how can resources be best used to support recovery. Virtual consultations have the potential to widen service offered- for example, access virtual support post-discharge

- Until face-to-face delivery is able to return, introduce additional opportunities for individuals in group therapy to talk/interact outside of the formal session.

- Provide a universal training offer to build knowledge, understanding and confidence in clinicians in delivery of virtual therapy. To ensure the training package reflects the needs of both clinicians and service users, representatives from both groups should be involved to decide content.

- Consider investment in provision of one-to-one in-person support for services users to assess technical readiness and support with technical issues at start of virtual consultations.

- Provide opportunities for KMPT staff in similar roles/responsibilities to come together to share experiences, concerns and learning.

- Develop best practice for sharing documents in virtual consultations and provide appropriate IT support/programmes/platforms to do this.

10. References

American Psychological Association (APA). (2013). Guidelines for the practice of telepsychology. *Retrieved from https://www.apa.org/practice/guidelines/telepsychology*

Catarino, A., Bateup, S. Tablan, V., Innes, K, Freer,S. et al. (2018). Demographic and clinical predictors of response to internet enabled cognitive-behavioural therapy for depression and anxiety. *BJPsych Open, 4(5), 411-418.*

Connolly, S., Miller, C., Lindsay, J. A. and Bauer, M. S. (2019). A systematic review of providers' attitudes toward telemental health via videoconferencing, *Clinical Psychology: Science and Practice.*

Egede, L. E., Acierno, R., Knapp, R. G., Walker, R. J., Payne, E. H., and Frueh, B. B. (2016). *Psychotherapy in older veterans via telemedicine: Effetct on quality of life, satisfaction, treatment credibility, and service delivery perception.* The Journal of Clinical Psychiatry, 77(12), 1704-1711.

Egede, L. E., Acierno, R., Knapp, R.G., Lejuez, C., Hernandez-Tajeda, M., Payne, E. H., and Frueh, B. C. (2015). Psychotherapy for depression in older veterans via telemedicine: A randomised, open label, non-inferiority trial. *The Lancet Psychiatry, 2(8), 693-701.*

Foley, T. and Woollard, J. (2019). Digital Future of Mental Healthcare and its Workforce: a report on a mental health stakeholder engagement to inform the Topol Review*, Health Education England.* https://topol.hee.nhs.uk/wp-content/uploads/HEE-Topol -Review-Mental-health-paper.pdf.

Glasgow RE, Vogt TM, Boles SM. Evaluating the public health impact of health promotion interventions: the RE-AIM framework. Am J Public Health 1999; 89: 1322–

Miu, A. S., Vo, H. T., Palka, J. M., Glowaki, C. R. and, Robinson, R. J. (2020). Teletherapy with serious mental illness populations during COVID-19: telehealth conversion and engagement. *Counselling Psychology Quarterly https://doi.org/10.1080/09515070.2020.1791800*

O'Cathain, A. Murphy, E., Nicholl, J. (2010) Three techniques for integrating data in mixed methods studies. *BMJ*. 341:doi:10.1136/bmj.c4587.

Osenbach, J., O'Brien, K., Mishkind, M. and Smolenski, D. (2013). Synchronous telehealth technologies in psychotherapy for depression: a meta-analysis*, Depress Anxiety 30: 1058–1067.*

Pierce, B. S., Perrin, P. B. and McDonald, S. D. (2019). Demographic, organizational, and clinical practice predictors of U.S. psychologists' use of telepsychology. *Professional Psychology: Research and Practice, 51*(2*), 184–193.* https://doi.org/10.1037/pro0000267.

Poletti, B., Tagini, S., Brugnera, A., Parolin, L. Pievani, L., Ferrucci, R., Compare, A. and Silani, V. (2020). Telepsychotherapy: a leaflet for psychotherapists in the age of COVID-19. A review of the evidence, *Counselling Psychology Quarterly:* https://doi.org/10.1080/09515070.2020.1769557

Ritchie, J. and Spencer, L. (1994). Qualitative data analysis for applied policy research. In A. Bryman and R. G. Burgess [eds.] 'Analysing qualitative data', (pp.173-194). London: Routledge.

Strauss, A. L., and Corbin, J. (1990). *Basics in qualitative research*. Sage: London.

Topol E. (2019). *The Topol review*: preparing the healthcare workforce to deliver the digital future. https://topol.hee.nhs.uk/.

Van Daele, T., Karekla, M., Kassianos, A.P., Compare, A., and Haddouk, L. (2020). Recommendations for policy and practice of telepsychotherapy and e-mental health in Europe and beyond. *Journal of psychotherapy integration, 30(2), 160-173.* http://dx.doi.org/10.1037/int0000218

Vindegaard, N. and Eriksen Benros, M. (2020). Covid-19 pandemic and mental health consequences: Systematic review of the current evidence. Brain, Behavior, and Immunity.

Zerwas, S. C., Watson, H. J., Hofmeier, D. M., Levine, M. D., Harmer, R. M., Crosby, R. D., Bulik, C. M. (2016). CBT4BN: A randomized controlled trial on online chat and face to face group therapy for Bulimia Nervosa. Psychotherapy and Psychosomatics, 86(1), 47-53.

11. Appendices

11.1 Service user information sheet

NHS
Kent and Medway
NHS and Social Care Partnership Trus

CHSS
University of **Kent**
Centre for Health Services Studies

Video and Telephone Psychological Therapy Services in NHS Mental Health Provision:
An Evaluation to Understand What Works, For Whom and in What Circumstances

Telephone/Video Interviews

An invitation
You are invited to take part in our research project about the Video or Telephone Psychological Therapy Services that are being provided by Adult Community Mental Health Teams within KMPT.
We are inviting everyone who has been offered the Video or Telephone services to give their thoughts and opinions in an informal interview – whether they accepted the offer or declined it.

About us
We are a team of researchers made up of staff from KMPT and staff from the Centre for Health Services Studies (or CHSS for short) at the University of Kent. We're working together to evaluate the use of Video and Telephone Psychological Therapy Services within KMPT.

Why is this research being carried out?
Traditional face-to face psychological therapy sessions were urgently replaced by Video and Telephone services within KMPT so that staff could continue to offer mental health support during the Covid-19 pandemic. There was no time for evaluation beforehand. We now need to know what is, or is not, working well.

What are you asking me to do?
You are being asked to take part in a telephone call with a researcher. The call should last no longer than 40 minutes. You will be asked questions about your opinions and experience of Video and Telephone Psychological Therapy Services.
We will ask your permission to record the call on a Dictaphone so that we can type up the conversation afterwards. The sound recording will then be deleted.

Do I have to take part?
No. It is up to you whether you wish to take part.
Your decision will not change the support you receive from KMPT, or anywhere else. If you do decide to take part, you can change your mind at any point without giving a reason.
It is important to understand what the research is about and what taking part in the research involves, so please ask as many questions as you need. It may be helpful to discuss taking part with someone you trust, for example: friends, family or another health professional.

Are there advantages or disadvantages to taking part?

There are no direct advantages. The information you give us will help shape any future of use of Video and Telephone Psychological Therapy Services and may help those seeking support in the future.

There are no obvious disadvantages to taking part in the interview. However, it is not uncommon to experience strong feelings when thinking about personal experiences. **Support for your mental health is available from Single Point of Access on 0300 222 0123 or your usual care team** - if there are issues which you would like to discuss.

Will I learn the results of the research?
You will be asked if you would like to know the results of the research when giving consent to take part. If you say yes, you will be sent a summary of results once the research is complete.

Has the research been approved by an Ethics Body?
Yes. The research has been approved by the School of Social Policy, Sociology and Social Research Ethics Board within the University of Kent.

Complaints
If you have a concern about any aspect of this project, you can ask to speak with the researcher (details above) who will do their best to answer your questions. If you remain unhappy and wish to complain formally, you can do this through the University of Kent Complaints Procedure for Research Participants:
https://www.kent.ac.uk/socsci/faculty/research-ethics/new%20ethics%20website/complaints.html

---

Who do I contact if I have more questions about the research?
If you have further questions about the research, please contact Dr Rasa Mikelyte at R.Mikelyte@kent.ac.uk

---

Data and Confidentiality
All research staff must comply with the requirements of the GDPR with regard to the collection, storage, processing and disclosure of personal information and will uphold the regulations core principles. People taking part in the project will only provide information that is needed to meet the research questions.
The legal basis for collecting and processing the sensitive personal data is the explicit consent you will be asked to provide. We would like to reassure that we will protect your identity. We will store your interview answers under a unique code, instead of your name, so that no one except the researchers will know it was you that has said what you have said.
Interview data will be stored on a password protected network at either KMPT or the University of Kent. Any data shared between the two will be sent via secure email.
Please be aware that we may need to breach confidentiality if we have serious concerns about anybody's safety. In this event, we will discuss with you the best thing to do.
For more information on how the University of Kent uses your personal information please look at Centre for Health Services Studies (CHSS) research privacy notice. https://www.kent.ac.uk/chss/contact/privacy.html

Thank you for reading the information and considering taking part

11.2   Service user consent form

Video and Telephone Psychological Therapy Services in NHS Mental Health Provision:
An Evaluation to understand What Works, For Whom and in What Circumstances

Telephone/Video Interview
CONSENT FORM

Please read the statements below and **initial each box** if you agree.

Initial

I confirm that I have read and understood the Participant Information Sheet (Version[..], [Date]) for the above study.	
I have had enough time to weigh up the information and have had any questions answered satisfactorily.	
I know that taking part is voluntary and that if I do take part, I am free to withdraw at any time (without giving a reason).	
I understand that I will receive the same level of support from KMPT whether I take part or not.	
I understand researchers will make sure that no one else can tell which interview answers are mine when reporting and sharing the research results.	
I understand that the interviews will be audio-recorded and later transcribed.	
I agree to the storage of my anonymous interview transcript, and the separate storage of my contact details, on a password-encrypted computer network at the University of Kent for 5 years.	
I agree to take part in the above research project.	

PLEASE TURN OVER…

Yes　　**No**

I would like to be sent a summary of results once the study has finished.　☐　☐

_____　_____　_____
(Participant Name)　　　　(Signature)　　　　　　(Date)

_____　_____　_____
(Researcher Name)　　　　(Signature)　　　　　　(Date)

Participant ID_____

NHS
Kent and Medway
NHS and Social Care Partnership Trust

CHSS
University of **Kent**
Centre for Health Services Studies

Video and Telephone Psychological Therapy Services in NHS Mental Health Provision:
An Evaluation to Understand What Works, For Whom and in What Circumstances

Telephone/Video Interviews

An invitation

You are invited to take part in our research project about the Video and Telephone Psychological Therapy Services provided by Younger Adult Community Mental Health Teams in KMPT.

We are inviting everyone who has facilitated a video session to give their thoughts and opinions around its use in an informal interview.

About us

We are a team of researchers made up of staff from KMPT and staff from the Centre for Health Services Studies (or CHSS for short), at the University of Kent. We're working together to evaluate the use of Video and Telephone Psychological Therapy Services within KMPT.

Why is this research being carried out?

Video and Telephone Psychological Therapy Services were urgently introduced by KMPT so that staff could continue to offer mental health support during the Covid-19 pandemic. There was no time for evaluation beforehand.

We now need to know what is, or is not, working well.

What are you asking me to do?

You are being asked to take part in a telephone call with a researcher. The call should last no longer than 50 minutes. You will be asked questions about your experience and thoughts of Video and Telephone Psychological Therapy Services.

We will ask your permission to record the call on a Dictaphone so that we can type up the conversation afterwards. The sound recording will then be deleted.

Do I have to take part?

No. It is up to you whether you wish to take part.

If you do decide to take part, you can change your mind at any point without giving a reason. This will not affect your statutory rights.

It is important to understand what the research is about and what taking part in the research involves, so please ask as many questions as you need.

Are there advantages or disadvantages to taking part?

There are no direct advantages. The information you give us will help shape any future use of Video and Telephone Services and may help those seeking support in the future.

There are no obvious disadvantages to taking part in the interview.

Will I learn the results of the research?

You will be asked if you would like to know the results of the research when giving consent to take part. If you say yes, you will be sent a summary of results once the research is complete.

Has the research been approved by an Ethics Body?

Yes. The research has been approved by the School of Social Policy, Sociology and Social Research Ethics Board within the University of Kent.

Complaints

If you have a concern about any aspect of this project, you can ask to speak with the researcher (details above) who will do their best to answer your questions. If you remain unhappy and wish to complain formally, you can do this through the University of Kent Complaints Procedure for Research Participants:

https://www.kent.ac.uk/socsci/faculty/research-ethics/new%20ethics%20website/complaints.html

---

Who do I contact if I have more questions about the research?

If you have further questions about the research, please contact Dr Rasa Mikelyte at

R.Mikelyte@kent.ac.uk

Data and Confidentiality

All research staff must comply with the requirements of the GDPR with regard to the collection, storage, processing and disclosure of personal information and will uphold the regulations core principles. People taking part in the project will only provide information that is needed to meet the research questions.

The legal basis for collecting and processing the sensitive personal data is the explicit consent you will be asked to provide. We would like to reassure that we will protect your identity. We will store your interview answers under a unique code, instead of your name, so that no one except the researchers will know it was you that has said what you have said.

Interview data will be stored on a password protected network at either KMPT or the University of Kent. Any data shared between the two will be sent via secure email.

For more information on how the University of Kent uses your personal information please look at Centre for Health Services Studies (CHSS) research privacy notice. https://www.kent.ac.uk/chss/contact/privacy.html

NHS
Kent and Medway
NHS and Social Care Partnership Trust

CHSS
University of **kent**
Centre for Health Services Studies

Video and Telephone Psychological Therapy Services in NHS Mental
Health Provision:
An Evaluation to Understand What Works, For Whom and in What Circumstances

Telephone/Video Interviews

An invitation

You are invited to take part in an informal interview about the Live Video Psychological Therapy Services provided by Adult Community Mental Health Teams in KMPT.

We are inviting a selection of people that hold an interest in these video sessions, but are not directly involved in their use.

About us

We are a team of researchers made up of staff from KMPT and staff from the Centre for Health Services Studies (or CHSS for short), at the University of Kent. We're working together to evaluate the use of Video and Telephone Psychological Therapy Services within KMPT.

Why is this research being carried out?

Video and Telephone Psychological Therapy Services were urgently introduced by KMPT so that staff could continue to offer mental health support during the Covid-19 pandemic. There was no time for evaluation beforehand.

We now need to know what is, or is not, working well.

What are you asking me to do?

You are being asked to take part in a telephone call with a researcher. The call should last no longer than 50 minutes. You will be asked questions about your thoughts around Video and Telephone Psychological Therapy Services. The interview will cover the topics of reach, effectiveness, adoption, implementation and maintenance.

We will ask your permission to record the call on a Dictaphone so that we can type up the conversation afterwards. The sound recording will then be deleted.

Do I have to take part?

No. It is up to you whether you wish to take part.

If you do decide to take part, you can change your mind at any point without giving a reason. This will not affect your statutory rights.

It is important to understand what the research is about and what taking part in the research involves, so please ask as many questions as you need.

Are there advantages or disadvantages to taking part?

There are no direct advantages. The information you give us will help shape any future of use of Video and Telephone Psychological Therapy Services and may help those seeking support in the future.

There are no obvious disadvantages to taking part in the interview.

Will I learn the results of the research?

You will be asked if you would like to know the results of the research when giving consent to take part. If you say yes, you will be sent a summary of results once the research is complete.

Has the research been approved by an Ethics Body?

Yes. The research has been approved by the School of Social Policy, Sociology and Social Research Ethics Board within the University of Kent.

Complaints

If you have a concern about any aspect of this project, you can ask to speak with the researcher (details above) who will do their best to answer your questions. If you remain unhappy and wish to complain formally, you can do this through the University of Kent Complaints Procedure for Research Participants:

https://www.kent.ac.uk/socsci/faculty/research-ethics/new%20ethics%20website/complaints.html

---

Who do I contact if I have more questions about the research?

If you have further questions about the research, please contact Dr Rasa Mikelyte at

R.Mikelyte@kent.ac.uk

Data and Confidentiality

All research staff must comply with the requirements of the GDPR with regard to the collection, storage, processing and disclosure of personal information and will uphold the regulations core principles. People taking part in the project will only provide information that is needed to meet the research questions.

The legal basis for collecting and processing the sensitive personal data is the explicit consent you will be asked to provide. We would like to reassure that we will protect your identity. We will store your interview answers under a unique code, instead of your name, so that no one except the researchers will know it was you that has said what you have said.

Interview data will be stored on a password protected network at either KMPT or the University of Kent. Any data shared between the two will be sent via secure email.

For more information on how the University of Kent uses your personal information please look at Centre for Health Services Studies (CHSS) research privacy notice.

https://www.kent.ac.uk/chss/contact/privacy.html

11.5   Clinical staff and wider stakeholder consent form

Video and Telephone Psychological Therapy Services in NHS Mental Health Provision:
An Evaluation to understand What Works, For Whom and in What Circumstances

Telephone/Video Interview
CONSENT FORM

Please read the statements below and **initial each box** if you agree.

Initial

I confirm that I have read and understood the Participant Information Sheet (Version[..], [Date]) for the above study.	
I have had enough time to weigh up the information and have had any questions answered satisfactorily.	
I know that taking part is voluntary and that if I do take part, I am free to withdraw at any time (without giving a reason).	
I understand that taking part will not affect my statutory rights.	
I understand researchers will make sure that no one else can tell which interview answers are mine when reporting and sharing the research results.	
I understand that the interviews will be audio-recorded and later transcribed.	
I agree to the storage of my anonymous interview transcript, and the separate storage of my contact details, on a password-encrypted computer network at the University of Kent for 5 years.	
I agree to take part in the above research project.	

PLEASE TURN OVER…

	Yes	No
I would like to be sent a summary of results once the study has finished.	☐	☐

_____   _____   _____
(Participant Name)   (Signature)   (Date)

_____   _____   _____
(Researcher Name)   (Signature)   (Date)

11.6 Service user interview topic guide

Service Users

Confirm consent form has been correctly completed by participant and researcher.

➢ Thank you for taking part.

➢ The interview should last no longer than 40 minutes.

➢ My name is […], I'm a [job title] at the University of Kent.

➢ This study will be used to make recommendation as to how Community Mental services, provided by KMPT, can be improved, so the results will be a part of publications and presentations.

➢ Please don't answer anything that you don't want to answer. Remember that you are free to withdraw at any point, without giving a reason.

➢ There are no right or wrong answers. We are interested in finding out your thoughts, feelings and experiences.

➢ Whilst I have a set of questions, I want you to feel free to direct the conversation to other areas if you feel they are relevant

➢ Our conversation is confidential and your interview answers will be anonymised.

➢ Do I still have your permission to record us? It is for analysis purposes, only.

Description/Question	Approx. time (mins)
Introduction • **How long have you been accessing the community mental health team (include pre COVID-19 when face-to-face)?** Probe: ○ Check if started therapy prior to COVID-19 or after and video consultations are only therapy they have received. ○ Define access to services – could be 'multiple occasions over a number of years or a singular long/short event. • **What community mental health team do you currently receive support from? Prompt with options.** Probe: ○ Individual or group? ○ Workshops?	5
Implementation **Were you provided with information to help with the move to therapy sessions by video?** Probe: ○ Did you use it? How frequently? ○ Did you find it useful? ○ If not provided would something like this have been helpful? 'What to 'expect leaflet'	10

Were you provided with information and/or support to help you access your video therapies?
     Probe:
        o Was the information and support provided in a clear and easy to understand format?
 	
Have you had any problems with accessing and participating in therapy sessions by video?
     Probe:
        o Technical issues?
        o Privacy in the home?
        o Digital privacy?
        o Structure of session?
 	
Are you satisfied with the amount of support you receive through therapy sessions by video?
     Probe:
        o What other support would you have liked/would you like?
        o Could anything have been done differently?
        o Length of consultations satisfactory?	

Reach
How did you find accessing therapy sessions by video?
     Probe:
        o Was there anything that made access easier or more difficult?
        o Is there anything that could make access easier for others in the future?
 	
What were your concerns about accessing? Did you consider not participating/accessing service? If so, why?
	5

Efficacy/Effectiveness
How has the move to therapy sessions by video affected the quality of care you receive from KMPT service?
     Probe:
        o What do you like and dislike about the new way services are being delivered?
        o How has it affected the way you relate to and interact with your psychologist therapist?
        o Do you feel connected to therapist?
        o Do you feel safe or have safe place to have conversation
 	
Can you describe what a 'good' video therapy session would include?
 	
How has the move to therapy sessions by video affected your mental health?
     Probe:
        o How has it helped your recovery and management?
        o Does this differ compared to face-to-face consultations?
        o Has it hindered recovery/management? If so, can you tell me how?
 	
Has the move to therapy sessions by video had any unintended negative or positive impacts on your life?
	10

Maintenance	5

How do you feel therapy sessions by video could be improved?

How do you feel about therapy sessions by video continuing long-term?
        Probe:
                o   If offered chance to continue, would you?

What do you feel has worked well that could be used in a future service?

11.7   Clinical staff interview topic guide

Interview Guide – KMPT Clinical Staff

Confirm consent form has been correctly completed by participant and researcher.

➢ Thank you for taking part.

➢ The interview should last no longer than 50 minutes

➢ My name is […], I'm a [job title] at the University of Kent.

➢ This study will be used to make recommendation as to how virtual consultations can be improved, so the results will be a part of publications and presentations.

➢ Please don't answer anything that you don't want to answer. Remember that you are free to withdraw at any point, without giving a reason.

➢ There are no right or wrong answers. We are interested in finding out your thoughts, feelings and experiences.

➢ Whilst I have a set of questions, I want you to feel free to direct the conversation to other areas if you feel they are relevant

➢ Our conversation is confidential and your interview answers will be anonymised.

➢ Do I still have your permission to record us? It is for analysis purposes, only.

Description/questions	Approx. time (mins)

General Background
Would you tell me a bit about your job and what you do?
    Probe:
      ○ Role?
      ○ What service?
      ○ Length of time?
      ○ Day to day responsibilities and activities?
      ○ How has your role changed since C-19 pandemic?
	5

Implementation
 	
How has the move to video consultations affected the therapeutic relationship?
    Probe
      ○ Time taken to establish trust
      ○ Learning/adopting new therapeutic techniques
 	
What factors do you consider important to encourage acceptance of virtual consultations with other clinicians (i.e., would minimise resistance/disruption and/or maximise its acceptability and feasibility)?
    Probe:
      ○ Time to set-up/prepare
      ○ Increase/decrease in staff work burden
      ○ Workflow changes
	10

o Work/team role changes o Patient factors o Costs **What have been the challenges/difficulties switching to virtual consultations?** **What resources/support has been helpful to you?** **Do you feel you know enough about using video platforms (e.g. operating, safety, etc)?** Probe: o Have you had training? o Who provided the training? o Are there any areas you would like to have more knowledge in (and if so, what are these)? **How does it compare to practice before C-19?** **What recommendations do you have for services within KMPT who have not yet transferred to virtual consultations?**	
Reach **Have you noticed any patterns/trends with patients who have not engaged with virtual consultations?** Probe: o Demography o Diagnosis o Living situation (i.e. alone, with family, shared, stable/temporary) **Have you found any common reasons for people withdrawing from the service or declining the opportunity to access virtual consultations?** **What factors do you think are important to assure acceptance of virtual consultations for patients (i.e., how to maximise its acceptability and reach)?** **Have you taken on less/as much/more new referrals since the pandemic? Why?** **What mechanisms are in place to help service users access video consultations?**	5
Efficacy/Effectiveness **What are the core components of virtual consultations that contribute to its effectiveness?** **Have you noted any changes to the way that service user psychological /MH needs are now being met (e.g. more/less timely)?** **What impact do virtual consultations have on service users?** - impact on mental health / symptoms / wellbeing - impact compared to F2F delivery **Do you spend more/less time on video delivery overall, if we include both preparation and the virtual sessions (e.g. finding a consulting room which may no longer be relevant)?**	5

Adoption **What kinds of internal changes were necessary to accommodate the intervention?** Probe: o Changes in scope of practice? o Changes in formal policies? o Changes in information systems or electronic records systems? o Other? **Was there any resistance to implementing virtual consultations? If so, what concerns were highlighted?** **Has virtual delivery impacted on working together in your team? If so, in what way?**	5
Maintenance **Do you think virtual consultations will continue?** Probe: o Do you think will virtual consultations will be adopted as the new standard by your service? Why or why not? o What part(s) will you no longer continue and why? o What modifications will you make? Why?	10

11.8 Wider stakeholders interview topic guide

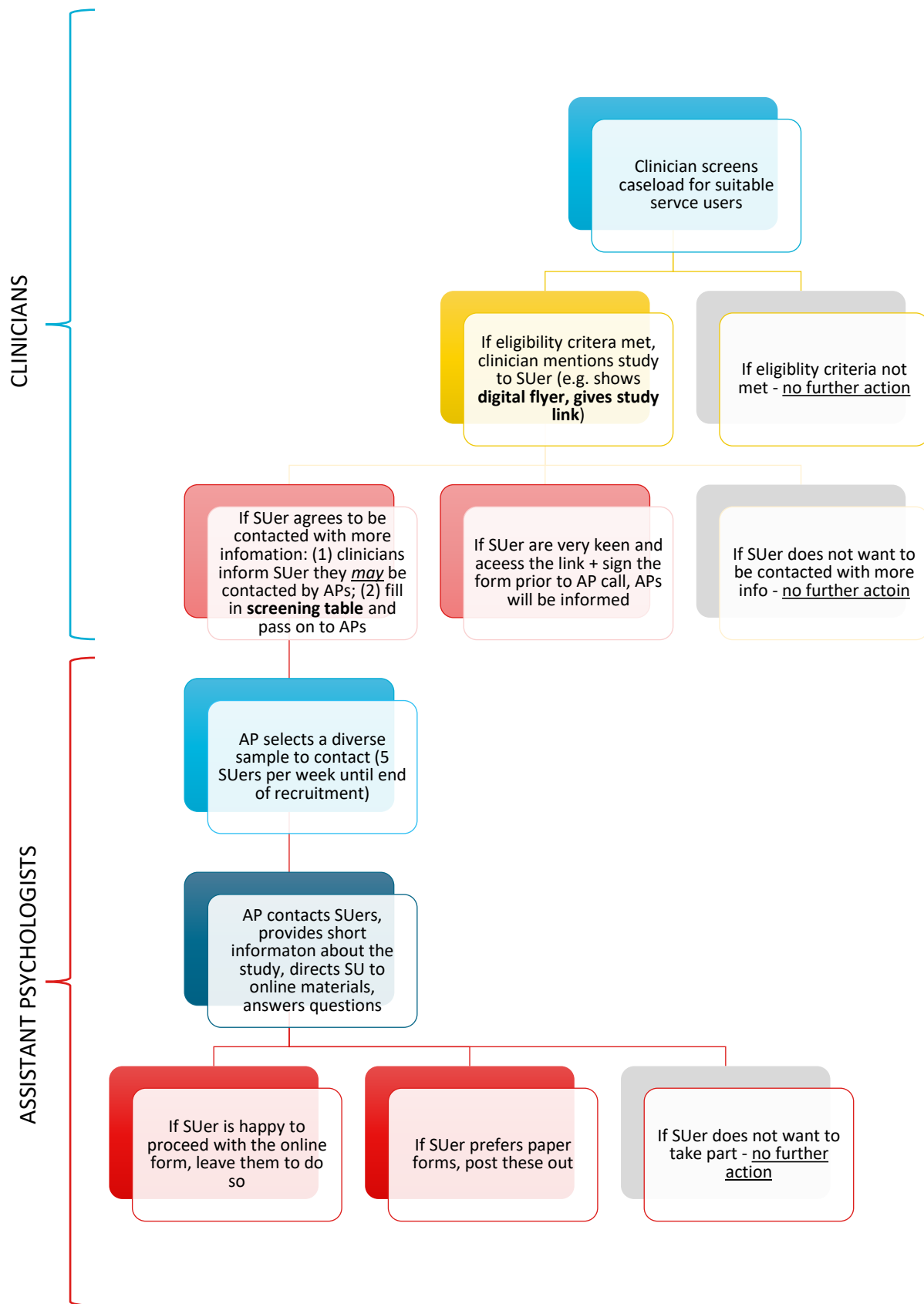<div align="center">

Interview Guide – Wider Stakeholders

Confirm consent form has been correctly completed by participant and researcher.

</div>

- ➢ Thank you for taking part.

- ➢ The interview should last no longer than 50 minutes

- ➢ My name is […], I'm a [job title] at the University of Kent.

- ➢ This study will be used to make recommendation as to how virtual consultations can be improved, so the results will be a part of publications and presentations.

- ➢ Please don't answer anything that you don't want to answer. Remember that you are free to withdraw at any point, without giving a reason.

- ➢ There are no right or wrong answers. We are interested in finding out your thoughts, feelings and experiences.

- ➢ Whilst I have a set of questions, I want you to feel free to direct the conversation to other areas if you feel they are relevant

- ➢ Our conversation is confidential and your interview answers will be anonymised.

- ➢ Do I still have your permission to record us? It is for analysis purposes, only.

Description/questions	Approx. time (mins)
General Background **Would you tell me a bit about your job and what you do?** 　　Probe: 　　　　o　Role? 　　　　o　Day to day responsibilities and activities?	5
Implementation **What are your general experiences of managing virtual delivery of psychological therapies? What has been easy and what has been challenging?** **Has virtual delivery turned out to be what you expected it to be? If yes/no please tell me why.** **Has virtual delivery had any effect on the way staff work together?** **Has the implementation of virtual delivery had an impact upon your current workforce? If so, what? (e.g. staff morale, workload management)** **Do you feel there are any differences in the resources needed for virtual delivery?**	20

What have been the challenges/difficulties switching to virtual consultations?	
Reach **What factors do you think are important to assure acceptance of virtual consultations for patients (i.e., how to maximise its acceptability and reach)?** **What mechanisms need to be in place to help service users access video consultations?**	5
Efficacy/Effectiveness **What are your views on how virtual delivery has impacted on patients receiving care?**	5
Adoption **What kinds of internal changes were necessary to accommodate the intervention?** Probe: o Changes in scope of practice? o Changes in formal policies? o Changes in information systems or electronic records systems? o Other? **Was there any resistance to implementing virtual consultations? If so, what concerns were highlighted?** **Has virtual delivery impacted on working together in your team? If so, in what way?**	5
Maintenance **Do you think virtual consultations will continue?** Probe: o Do you think will virtual consultations will be adopted as the new standard by your service? Why or why not? o What part(s) will you no longer continue and why? o What modifications will you make? Why?	10

11.9   Recruitment Pathway

CLINICIANS

Clinician screens caseload for suitable servce users

If eligibility critera met, clinician mentions study to SUer (e.g. shows **digital flyer, gives study link**)

If eligiblity criteria not met - no further action

If SUer agrees to be contacted with more infomation: (1) clinicians inform SUer they _may_ be contacted by APs; (2) fill in **screening table** and pass on to APs

If SUer are very keen and aceess the link + sign the form prior to AP call, APs will be informed

If SUer does not want to be contacted with more info - no further actoin

ASSISTANT PSYCHOLOGISTS

AP selects a diverse sample to contact (5 SUers per week until end of recruitment)

AP contacts SUers, provides short informaton about the study, directs SU to online materials, answers questions

If SUer is happy to proceed with the online form, leave them to do so

If SUer prefers paper forms, post these out

If SUer does not want to take part - no further action

11.10 Introductory Flyer

Have you been offered virtual psychological therapy consultations?

Have your say! Tell us about your experiences.

Whether you took up or declined the offer of virtual consultations, we would like to interview you. The interviews are part of a project aiming to evaluate the implementation of virtual therapy consultations and asses impact on service user outcomes in NHS mental health services

For further information, please go to: tiny.cc/chss20

11.11 Interview Coding Framework

Reach (R)		
1.	*Comparison to Face-to-face and Telephone Consultations*	Heavily coded this one; each time respondent contrasts virtual delivery with other forms
	a. Telephone consultations	A small number of participants experienced or delivered therapy by phone. Specific references to phone format go here.
	b. Group therapy	Separating group therapy comparisons (ie F2F group vs V group) will aid report
2.	*Service User Characteristics enabling/hindering take-up*	For SUers this involves mention on how their condition/symptoms/living arrangements/age influence ability to take up or participate in virtual sessions
3.	*Factors encouraging & hindering acceptance of virtual consultations among service users*	Some crossover with R2 but involves factors outside of SU characteristics (if hard to judge – double code with R2). Group therapy aspects may go here, too
4.	*Reasons for withdrawal (after initial take-up)*	Includes not taking up virtual offer, drop outs during session (intentional and non-intentional) and withdrawing from therapy after first attempting virtual delivery
Effectiveness/Efficacy (E)		
1.	*Referral numbers – meeting organisational targets*	Any mention of referral numbers as well as other organisational targets (e.g. KPIs), and their change since the pandemic
2.	*Patient outcomes (health/symptoms/wellbeing/)*	Both outcomes in general and compared to F2F delivery. Use a broad sense of 'outcome' including wellbeing and sessions 'making a difference'
3.	*Ability to deal with adverse events virtually*	Includes serious incidents, suicidality, distress, anger, psychological 'holding'
4.	*Workload*	For clinician and WI interviews only
5.	*Teamwork*	For clinician and WI interviews only
6.	*Perceived usefulness / effectiveness*	Will cross over with E2, but is wider than patient impact and includes clinical effectiveness
7.	*Experience of use (Lifesize/Attend Anywhere)*	Specifically looks at platforms; technical issues/glitches go here
Adoption (A)		
1.	*Accommodation of virtual consulting within policies and procedures*	For clinician and WI interviews only
2.	*Recommendations to other services/service users*	This is <u>not</u> about how to improve VC delivery, but specifically talking about replication in other services (eg CMHTOPs) and what SUers would say to other SUers who are not sure if to take up VC offer
Implementation (I)		
1.	*Experience of switching over to virtual consultations*	Oriented more to clinicians, but from SU interviews would involve those who went from F2F to virtual delivery, time that the switchover took, etc.
2.	*KMPT resources and support to switch over*	For clinician and WI interviews only
3.	*Support for service users to take up virtual consultations*	Both IT support and how clinicians provided reassurance, set boundaries, explained choices and so on (may overlap with TR)
4.	*Strategies clinicians use online (relationships/set-up/preparedness)*	This is not about beginning per se like I2&I3. This is about how skills and strategies used differ online (e.g. when unable to use light bar for EMDR online)
5.	*Contextual factors encouraging & hindering acceptance of virtual consultations among clinicians*	Could include aspects like IT familiarity, clinician own living arrangements/privacy, resources, therapeutic modality appropriateness to online delivery, group vs individual delivery.
Maintenance (M)		
1.	*What should be maintained / not changed?*	Which aspects should not be lost even if improvements/changes are made
2.	*Existing/intended changes*	What changes are underway *(e.g. introducing Attend Anywhere)*
3.	*Desired/needed changes and additional resources needed (not currently intended)*	Recommendations that are not yet implemented
4.	*Resistance to virtual consultations*	Reasons for dislike (this is not about context, but rather about beliefs). Context hindering take up is captured in I5, R2 and R3
5.	*Intention to continue using virtual consultations beyond the pandemic*	Whether SUer/clinician intends to use/deliver VCs long term, including after pandemic.
Therapeutic Relationship (TR)		
1.	*Trust*	Can be broadened out to quality of the relationship overall
2.	*Transference / countertransference*	
3.	*Sense of safety*	EG feeling safe enough and contained enough to share difficult memories
4.	*Sense of privacy*	Includes digital privacy, privacy in own home, clinician set up / confidentiality
5.	*Place and emotional memories*	Whether sharing difficult emotions/memories in own space makes a difference
6.	*Flow/structure of sessions*	Turn taking, feeling heard, etc
7.	*Time (length/number of sessions)*	Does V delivery make a difference to preferred length or number of sessions?
8.	*Boundaries*	Includes not only boundaries during session (e.g. drinking wine), but also boundaries between session and everyday life (e.g. space to reflect; travel)