



Connected

Remote technology in mental health services

Summary

Finding alternatives to in-person contact within mental health services was hastened globally by the Covid-19 pandemic. For many people across the world, it went from being non-existent to becoming a lifeline within weeks or even days.

The Mental Health Policy Research Unit has been leading a programme of research about the use of technology (such as video and phone calls, text messages and email) in the delivery of mental health services. This is sometimes known as ‘tele-mental health’ care.

The Unit’s research demonstrates that the use of remote care has the potential to offer people new and effective options for mental health support, alongside (rather than replacing) face-to-face service delivery:

- It enables people who might miss out on face-to-face services to access support
- It breaks down geographical boundaries in service provision and increases access to specialist services with large catchment areas, which can increase choice and diversity

- It can support involvement from family and others
- It can enhance continuity of care when someone is in hospital
- It may facilitate access to care for people who do not wish to be seen at mental health service premises or have a worker visit their home.

But making routine use of technology in practice, and for the long-term, requires some significant shifts in the way services work to ensure that the benefits are distributed equitably and that no one is disadvantaged by the use of technology.

Remote technology can be effective in mental health support for some people more than others. This may include people who cannot travel to face-to-face appointments because of work or caring commitments, disabilities or a need to access specialist services far from their home. For some, it may not be possible to use remote technology at all.

There are some major concerns about the safety, equity and efficacy of remote technology being used in mental health services. It may be impossible for some people to find a safe, private space at home. Some people may not have a reliable or secure internet connection, or lack the right kind of device. There are particular challenges to using remote technology for people with visual or hearing impairments. Staff may also face challenges in accessing good connections and privacy to make calls, in the context of busy, open-plan offices. And for some activities, such as physical health support or medication management, remote care may not be effective at all.

The adoption of remote technology cannot simply be allowed to proliferate without decisions being made about how it is funded, managed and regulated. Remote technology should not limit people's choices about how they access mental health support, and nor should people miss out because they do not have the right equipment or home environment.

We recommend:

1. Mental health services should offer remote mental health options as alternatives to face-to-face support wherever possible and clinically advisable, as a means to increasing access to care and choice for service users.
2. People should always be offered the option of a face-to-face appointment. Wherever possible, staff should use the mode of communication and platform that the service user prefers.
3. Decisions about the use of technology and remote working should be made in partnership between service users and staff.
4. Mental health service commissioners and providers must address digital poverty and exclusion in the use of remote technology.
5. Mental health workers must be given access to good connections, clear policies and guidance, and training and ongoing support to use technology appropriately, safely and effectively.
6. Mental health service providers should create safeguards to ensure that people are able to engage safely with services from a remote connection and not put at greater risk as a result.
7. The use of technology in mental health services must be funded adequately to ensure that it is of high quality, up-to-date and a valid alternative to face-to-face provision.

Introduction

The NIHR Mental Health Policy Research Unit (MHPRU) at University College London and King's College London was established in 2017. Its aim is to help the Department of Health and Social Care and others involved in making nationwide plans for mental health services to make decisions based on good evidence. It makes expert views and evidence available to policymakers in a timely way and carries out research that is directly useful for policy. The MHPRU is managed by academics at UCL and KCL in partnership with the University of Greenwich. Centre for Mental Health and The Mental Elf work alongside the Unit to ensure its work is accessible and relevant to policymakers, practitioners and the public. The MHPRU's Lived Experience Working Group contributes to its work.

The MHPRU has been leading a programme of research about remote care (or 'telementalhealth'): the use of technology (such as video and phone calls, text messages and email) in the delivery of mental health services. This policy briefing summarises the key findings of that research and explores its implications for mental health policy and practice in England, across the UK, and internationally.

The studies

So far, six studies have been produced from this programme of work, of which four have been published. The six studies are :

- Schlief, M. *et al.* (2022) *What works for whom with telemental health? A rapid realist review*
- Barnett, P. *et al.* (2021) *Implementation of Telemental Health Services Before COVID-19: Rapid Umbrella Review of Systematic Reviews*
- Appleton, R. *et al.* (2021) *Implementation, Adoption, and Perceptions of Telemental Health During the COVID-19 Pandemic: Systematic Review*
- Vera, N. *et al.* (2021) *Service user experiences and views regarding telemental health during the COVID-19 pandemic: A co-produced framework analysis*
- Appleton, R. *et al.* (preprint) *TMH Implementation strategies for telementalhealth: systematic review*
- Clark, A. *et al.* (2022) *Are remote mental healthcare interventions cost-effective? A systematic review of economic evaluations of remote mental healthcare.*

Findings

The studies show that the use of video and phone technology has the potential to offer people new and effective options for mental health support alongside face-to-face service delivery. But implementing these in practice, and for the long term, requires some significant shifts in the way services work to ensure that the benefits are distributed equitably and no one is disadvantaged by the use of technology.

The adoption of remote working was hastened globally by the Covid-19 pandemic. For many people across the world, it went from being non-existent to becoming a lifeline within weeks or even days. This sudden shift has enabled researchers to gauge the usefulness of technology in mental health services at scale for the first time, and to assess what this means for the longer term.

Quality and efficacy

The studies explored whether technology could give people using services as good an experience as face-to-face delivery, and what outcomes it produced. They found that, on the whole, clinical outcomes and experiences were comparable – at least in the short term, with less certainty about longer term benefits. For some groups, for example disabled people, autistic people and people with severe anxiety, the use of technology improved the accessibility of mental health support. In other instances, remote technology was found to be inappropriate – for example in carrying out initial assessments, in treating trauma or in managing medication. And while many service users accepted remote contact during lockdowns or periods of restriction, levels of acceptance tended to fall once these were lifted.

“Having counselling over the phone is very liberating and it’s very freeing. I really, really enjoyed it.” (Quoted in Vera *et al.*)

The research explored whether different types of technology worked especially well or poorly in particular circumstances. They found that people’s personal preferences were a major factor: while many liked the human connection of a video call, especially for initial meetings and more prolonged assessments, others preferred the greater privacy or anonymity of a phone call or text-based communication. Vera and colleagues (2021) found a distinction between ‘functional’ contacts, such as to make appointments or order repeat prescriptions, and ‘relational’ activity, where the ability to read body language or social cues is more important:

“Phone appointments are okay with the care co-ordinator, but not so brilliant with the psychiatrist, [...] because there’s more to talk about with the psychiatrist, it’s better to either see them in person or see them by video.” (Quoted in Vera *et al.*)

Online support groups were found to create social connections people might otherwise not have, but those without video connections struggled to build supportive relationships between participants.

The research also explored the wider implications of using technology for mental health workers and services. They found that it could reduce travel time and costs and may consequently reduce services’ environmental impact. It could also improve people’s work/life balance if it enables working from home, and their access to online training, but brings with it a risk of very concentrated work with limited time for reflection.

Concerns and challenges

The studies unearthed significant concerns, however. While video-conferencing could produce good clinical outcomes and patient experiences for those with the resources to use it, this is not the case for many of the most disadvantaged and marginalised groups of people, as they do not have access to the necessary hardware or internet connection. Concerns were also raised about people's safety and privacy: for example, for people experiencing domestic violence or coercive control who can't speak freely, for people in multiple occupancy homes with no private spaces, and for people in families where there is a particular stigma towards mental illness. And both service users and providers found that it was more difficult to build rapport remotely and provide more holistic support (for example when supporting people with their physical health). Having therapy at home could be intrusive for some, while for others poor internet connections meant sessions were persistently interrupted.

Rushed implementation of remote working during the pandemic meant it was sometimes adopted without protocols or plans for the safety, quality or equity of services. Training, guidance and safeguards may either have been missing or produced in a hurry. Some people were moved to remote provision without the right devices or knowledge of how to use them. (In other cases, staff provided people with helpful information and training to use devices so that they could continue remotely.)

This is a major concern in the light of Barnett and colleagues' assertion that "telemental health [remote or digital support] is potentially an effective, feasible, and acceptable tool for providing mental health treatment, at least when interventions are relatively well-designed and well-planned, as has been the case in research studies". In other words, in real world conditions, the benefits may be reduced and the risks may be magnified.

For some people, the use of technology meant support stopped suddenly if they found themselves without an internet connection or quiet space – for example, when in hospital or a crisis house. Others described feeling unable to keep up with remote services when they were very unwell, risking a loss of support at the time it was most needed.

Where and when technology is useful

A key theme in the studies is the need for technology to be incorporated into services alongside face-to-face provision as an additional option, not necessarily as a replacement. Rather than favouring one over the other on all occasions, they find that different types of technology can be beneficial for some purposes but not others, and a blended model would enable remote working to be included within services as part of a mixed approach. For example, blending face-to-face appointments with email or messaging contact in between may help to make interactions with mental health professionals closer to the ways people communicate in other aspects of their lives, and allow for briefer but more frequent interactions, which may suit some people.

The studies sought evidence about which groups of people in which circumstances might benefit from video or phone technology. Overall, they found that people's individual circumstances and preferences were key; it is not possible to identify specific groups of people for whom it is always or never appropriate to use remote technology. But there are examples of situations where it can be particularly useful: such as for people who cannot travel to appointments, or have work or caring commitments that make it difficult; for accessing specialist expertise that isn't available locally; and for getting family members together across large distances, especially when someone is in hospital.

Implementation issues

Schlieff and colleagues (2022) explored what conditions need to be in place for the safe and effective use of technology in mental health care. They identified four core conditions that need to be met:

1. For people to be well-connected, with access to an appropriate device, internet or phone connection, and the know-how to use them
2. For services to be flexible and to personalise the types of support available remotely and in person, making collaborative decisions about how and whether to incorporate remote technology in care
3. For safety, privacy and confidentiality to be maintained, with plans for how to respond if these are at risk
4. For therapeutic quality and relationships to be maintained while working remotely.

The study by Appleton and colleagues (2022) explored what steps are needed for remote technology to be implemented successfully and equitably for the longer term. They conclude that it requires a ‘multi-component implementation strategy’ including a mixture of initial training for staff members, ongoing support through technical assistance, and offering people a choice of platforms.

Implications for policy

The studies are clear that the adoption of remote care brings with it some significant policy choices. The Covid-19 pandemic has accelerated learning about the potential to use technology to deliver services in ways that may be more flexible and improve access for some. However, remote care cannot simply be allowed to proliferate in mental health services without decisions being made about how it is funded, managed and regulated.

As Appleton and colleagues (2021) observed:

“The successful delivery in a pandemic of telemental health [remote care] should not necessarily be seen as confirmation that people are happy with this mode of delivery long-term, as some of the identified problems may become more serious over time, and reports of being satisfied may have reflected awareness that at the time of the study, it was difficult to offer care by any other means. The longevity of these changes will ultimately turn not only on information technology, safety, and quality, but also on whether policy changes will support the reimbursements and regulatory adjustments implemented during the current crisis.”

The use of phone and video technology in mental health services also brings significant risks of exacerbating inequities and inequalities. People facing digital exclusion or digital poverty may be unable to access remote care altogether. And as Schlieff and colleagues observe, digital poverty is still poverty. It is deeply rooted in systemic economic inequality and exclusion. Simply providing someone with a device and internet access may assist someone to get access to mental health support, but it will not, in itself, address those bigger issues.

The lived experience commentary to the same study (Machin, Rowan Olive and Shah, 2022, in Schlieff *et al.*, 2022) also notes that, without safeguards, the use of technology in mental health care might end up reinforcing inequality and injustice. Decisions about how mental

health services are delivered are inherently political, infused with power imbalances and unequal relationships. Technology has already been used by mental health services for oppressive purposes, for example in sharing health data with external agencies to support the imposition of restrictive practices such as Serenity Integrated Monitoring (SIM – STOPSIM, 2021). And the use of technology may mask harmful experiences people are going through when their needs are being assessed and when choices are made (by professionals) about the support they are offered:

“Within mental health, service users are often expected to bare our souls to get our choices respected. With telemental health, this is dangerous. If the criteria for accessing a face-to-face service are harm-based, we might be forced to put ourselves at risk to get what we need. Where someone is being abused by their partner, they may need face-to-face services, but not explain why at a first assessment. We must be taken at our word without explaining ourselves to clinicians who have not yet earned our trust.” (Machin, Rowan Olive and Shah, 2022, in Schlieff *et al.*, 2022)

The authors also note that choices are not genuine when people do not have the resources to exercise a choice:

“If you have to wait six months for a face-to-face appointment, but you can have telemental health next week – that is not a meaningful choice. If you cannot afford to connect to the internet, you do not have a meaningful choice. The option of telemental health must not become an excuse to allow face-to-face services to become harder to access.” (Machin, Rowan Olive and Shah 2022, in Schlieff *et al.*, 2022).

It is therefore essential that the use of remote care is accompanied by policies, both nationally and locally, designed to ensure its safety, maximise its usefulness, minimise the risks and address inequalities.

Recommendations

1. Mental health services should offer remote technology options as alternatives to face-to-face support wherever possible and clinically advisable, as a means to increasing access to care and choice for service users.
2. People should always be offered the option of a face-to-face appointment. Wherever possible, staff should use the mode of communication and platform that the service user prefers.
3. Decisions about the use of technology and remote working should be made in partnership between service users and staff. Mental health professionals should not assume whether an individual is or is not willing or able to use technology in any given context.
4. Mental health service commissioners and providers must address digital poverty and exclusion in the use of remote technology. No one should be denied access to care and support for lack of a device, a stable internet connection and a safe and private space at home.
5. Mental health workers must be given access to good connections, clear policies and guidance, and training and ongoing support to use technology appropriately, safely and effectively. They should know how to use different types of technology for different purposes, and when not to use it at all.
6. Mental health service providers should create safeguards to ensure that people are able to engage safely with services from a remote connection and not put at greater risk as a result. Staff wellbeing should also be safeguarded to prevent excessive workloads and burnout from long hours of continuous work.
7. The use of technology in mental health services must be funded adequately to ensure that it is of high quality, up-to-date and a valid alternative to face-to-face provision. This may include investing in equipment for both workers and service users to help them to maintain contact.

References

- Appleton, R. *et al.* (2021) *Implementation, Adoption, and Perceptions of Telemental Health During the COVID-19 Pandemic: Systematic Review*. Available from: <https://dx.doi.org/10.2196/2F31746> [Accessed 7 December 2022]
- Appleton, R. *et al.* (preprint) *TMH Implementation strategies for telementalhealth: systematic review*. Available from: <https://doi.org/10.1101/2022.04.29.22274367> [Accessed 7 December 2022]
- Barnett, P. *et al.* (2021) *Implementation of Telemental Health Services Before COVID-19: Rapid Umbrella Review of Systematic Reviews*. Available from: <https://doi.org/10.2196/26492> [Accessed 7 December 2022]
- Schlieff, M. *et al.* (2022) *What works for whom with telemental health? A rapid realist review*. Available from: <https://doi.org/10.2196/38239> [Accessed 7 December 2022]
- The #StopSim Coalition (2021) 'Concerns Regarding Privacy And Data Protection Within The High Intensity Network (HIN) And Serenity Integrated Mentoring (SIM)'. Available from: <https://tinyurl.com/mrymjatb> [Accessed: 18 March 2022]
- Vera, N. *et al.* (2021) *Service user experiences and views regarding telemental health during the COVID-19 pandemic: A co-produced framework analysis*. Available from: <https://doi.org/10.1371/journal.pone.0257270> [Accessed 7 December 2022]
- Clark, A., *et al.* (2022) *Are remote mental healthcare interventions cost-effective? A systematic review of economic evaluations of remote mental healthcare*. Available from: <https://www.medrxiv.org/content/10.1101/2022.12.01.22282817v1> [Accessed 7 December 2022]

Connected

Published December 2022

Image: www.istockphoto.com/portfolio/Artistan

Centre for Mental Health is an independent charity and relies on donations to carry out further life-changing research. Support our work here: www.centreformentalhealth.org.uk

© Centre for Mental Health, 2022

Recipients (journals excepted) are free to copy or use the material from this paper, provided that the source is appropriately acknowledged.



BRIEFING

Centre for
Mental Health

Connected

Remote technology in mental health services

Summary

Finding alternatives to in-person contact within mental health services was hastened globally by the Covid-19 pandemic. For many people across the world, it went from being non-existent to becoming a lifeline within weeks or even days.

The Mental Health Policy Research Unit has been leading a programme of research about the use of technology (such as video and phone calls, text messages and email) in the delivery of mental health services. This is sometimes known as 'tele-mental health' care.

The Unit's research demonstrates that the use of remote care has the potential to offer people new and effective options for mental health support, alongside (rather than replacing) face-to-face service delivery.

- It enables people who might miss out on face-to-face services to access support
- It breaks down geographical boundaries in service provision and increases access to specialist services with large catchment areas, which can increase choice and diversity

- It can support involvement from family and others
- It can enhance continuity of care when someone is in hospital.
- It may facilitate access to care for people who do not wish to be seen at mental health service premises or have a worse visit their home.

But making routine use of technology in practice, and for the long-term, requires some significant shifts in the way services work to ensure that the benefits are distributed equitably and that no-one is disadvantaged by the use of technology.

Remote technology can be effective in mental health support for some people more than others. This may include people who cannot travel to face-to-face appointments because of work or caring commitments, disabilities or a need to access specialist services far from their home. For some, it may not be possible to use remote technology at all.

Centre for
Mental Health



Centre for Mental Health
Room AG.22, 11-13 Cavendish Square
London W1G 0AN

www.centreformentalhealth.org.uk

Follow us on social media: @CentreforMH

Charity registration no. 1091156. A company limited by guarantee registered in England and Wales no. 4373019.