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Frontline experiences of delivering remote mental health supports during the COVID-19 pandemic in Scotland: innovations, insights and lessons learned from mental health workers

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ABSTRACT

COVID-19 restrictions drove rapid adaptations to service delivery and new ways of working within Scotland's mental health sector. This study explores mental health workers' (MHWs') experiences of delivering their services remotely. Twenty participants, who had worked in mental health professions in the National Health Service (NHS) in Scotland throughout the COVID-19 pandemic, took part in online semi-structured interviews. Data was transcribed then analysed using an inductive thematic analysis. Two major themes are reported: (1) '*Improved Flexibility for both MHWs and Service Users*' and (2) '*Teletherapies Challenge Therapeutic Boundaries*'. In relation to (1) virtual platforms were seen as vital in maintaining patient care throughout the COVID-19 pandemic and a valuable resource for service users (SUs) who had previously struggled with mobility or social anxieties when accessing face-to-face services. Some MHWs' also noted benefits for their productivity and comfort. Regarding (2) MHWs highlighted that whilst conducting teletherapies from home, work-life boundaries became blurred and, in some instances, typically comforting spaces became associated with the traumatic content discussed by SUs. These stressors seemed to be compounded by MHWs' isolation, as they were less able to draw upon their colleagues for support. Further, confidentiality could not be assured, as MHWs and SUs alike had to accommodate their family members. These findings highlight important insights from MHWs in adapting to rapid changes in mental health working practices, particularly in relation to the challenges of delivering quality, safe and equitable services and the increased use of teletherapies. Such insights are vital in informing service developments and supporting future pandemic preparedness across a range of healthcare contexts and countries seeking to adopt hybrid models of mental health service delivery.

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Introduction

The COVID-19 pandemic has changed mental health care delivery. Whilst the public experienced worsening mental health during this time (Chen et al., 2020; Efstathiou et al., 2022; Murphy et al., 2021), face-to-face services were reduced to minimise the transmission of the virus (The World Health Organization, 2020) and teletherapies (consultations via video or phone call) were adopted to maintain vital contact with service users (SUs). Near Me, the only video-consultation platform approved for use by NHS Scotland, was rapidly deployed across hospital, community and GP care settings (Wherton & Greenhalgh, 2021). The platform remains in use today, alongside face-to-face services (The Scottish Government, 2021) and facilitates approximately 20,000 sessions per week in Scotland (Digital Health & Care Scotland, 2021), with Psychiatric and Psychological services constituting 37% of consultations (Wherton & Greenhalgh, 2021).

Several positives of teletherapies have been highlighted for SUs, such as the removal of logistical barriers to accessing therapy (travel, taking time off work, local provider shortages; Gajarawala & Pelkowski, 2021), increased scheduling flexibility (Frayn et al., 2021; Liberati et al., 2021) including childcare (Dockery & Bawa, 2020), and increased comfort for SUs with mobility issues (Seritan et al., 2019). In the COVID-19 pandemic context, remote therapeutic environments lowered infection risks, maintained service provision to SUs with their pre-existing, trusted clinicians (Liberati et al., 2021), and prompted service redesign (Wherton & Greenhalgh, 2021). Further, SUs' engaging in therapy from their home environments, provided MHWs with insights to inform treatment (Mitchell, 2020; Uscher-Pines et al., 2020) and increased SUs' comfort during difficult conversations (Maier et al., 2021). Moreover, meta-analyses have found that psychological outcomes do not significantly differ between treatment settings (Giovanetti et al., 2022; Lin et al., 2021a; Thomas et al., 2021) and, in combination, in-person and telehealth consultations (Hellstern, 2022).

Despite these benefits, we must question teletherapy's equity and safety, and MHWs' competency when conducting therapies remotely (McCord et al., 2022). Similar to SUs, MHWs have valued not commuting to work, schedule flexibility, and increased opportunity for family time and self-care (Buckman et al., 2021; Guinart et al., 2021; Steidtmann et al., 2021). However, negative psychological effects have been felt: including increased anxiety, fatigue, professional self-doubt and feeling less connected to SUs (Aafjes-van Doorn et al., 2021; Békés & Aafjes-van Doorn, 2020; Hoel et al., 2021; Lin et al., 2021b; Shklarski et al., 2021). Indeed, UK-based MHWs felt unable to accurately assess SUs' wellbeing without seeing essential non-verbal cues, or assure data security and confidentiality (Johnson et al., 2021), concerns shared by rural populations of SUs, alongside technological difficulties and worries that the therapeutic relationship might suffer (Riblet et al., 2021). Working from home has also caused people to feel disconnected from their colleagues and less supported by their workplace (Oakman et al., 2020; Steidtmann et al., 2021).

Virtual therapies may also be less suitable for certain clinical populations (Smith et al., 2022). For example: SUs with eating disorders whose physical health cannot be appropriately monitored (Graell et al., 2020); SUs whose social avoidance may be aggravated (Markowitz et al., 2021); and those with low levels of psychosocial functioning (Huscsava et al., 2021), communication impairments or paranoid delusions (Liberati et al., 2021).

Concerns have also been reported surrounding SUs' management of emotions whilst physically distanced from clinicians (Thompson-de Benoit & Kramer, 2021), especially for those with post-traumatic stress experiencing dissociation or flashbacks (Kaltenbach et al., 2021; Turgoose et al., 2018). Further, whilst providers can readily share materials through email, encrypted message or shared screen (Morland et al., 2020; Wells et al., 2020), neuropsychological and cognitive assessments are particularly restricted by virtual delivery, as they rely on the manipulation of physical materials, standardised interpersonal tasks, and clinical observation in physical environments (American Psychological Association, 2020).

In Scotland, telehealth models are being expanded as part of the government's recovery plan: to ensure service continuity as rates of suicidal thoughts, anxiety and depressive symptoms remain high (The Scottish Government, 2021, 2022a). The following offers an in-depth analysis of MHWs' experiences of delivering teletherapies in the context of COVID-19 restrictions in Scotland, which included working from home. We sought to explore the benefits experienced since teletherapies' implementation and to uncover any challenges faced in their delivery which should be addressed moving forwards. Such insights are vital in informing service developments and supporting future pandemic preparedness.

Methods

Design

This qualitative study was cross-sectional and used retrospective, purposive sampling to capture the experiences of MHWs within the context of COVID-19 in Scotland.A semi-structured interview design with an inductive thematic approach to analysis was utilised, to facilitate unanticipated findings by learning from participants' and their experiences (Braun & Clarke, 2013).

Procedure

The study was advertised through internal communications, specific to one NHS health board in the West of Scotland. Advertisements included a link to a brief *Qualtrics* survey which detailed the study aims and requirements, and collected participants' occupational (Table 1) and demographic information (Table 2), contact details and informed consent. Interviews were conducted until the principles of data saturation were met (Hennink & Kaiser, 2021). A total of 20 MHWs participated. They were required to have at least 3 months working experience during the COVID-19 pandemic, to ensure they were able to reflect on their experiences fully.

One-to-one, semi-structured interviews were conducted from February to April 2021 via *Zoom* (version 5.3.0), to maintain physical distancing. The research team designed the topic guide collaboratively for the purpose of this study: it explored the impact of the pandemic on MHWs' roles and how they, and their organisations coped with these changes. Questions were based upon current literature and asked in a non-directive manner, to elicit responses that revealed participants' personal interpretations of their experiences. Following their interviews, participants were sent debrief sheets which

Table 1. Participant occupational characteristics.

Participant	Gender	Occupation
Alice	F	Clinical Psychologist
Alison	F	Clinical Psychologist
Alastair	M	Clinical Psychologist
Catriona	F	Assistant Occupational Therapist
Daisy	F	Primary Mental Health Nurse Liaison
Ellen	F	Clinical Psychologist
Emma	F	Nurse Manager
Erin	F	Senior Charge Nurse
Katie	F	Occupational Therapist
Lisa	F	Applied Psychology
Megan	F	Clinical Psychologist
Rebecca	F	Mental Health Worker
Ryan	M	Clinical Psychologist
Patricia	F	Clinical Psychologist
Pearl	F	Occupational Therapist
Penny	F	Clinical Psychologist
Peter	M	Clinical Psychologist
Pia	F	Community Psychiatric Nurse
Scott	M	Clinical Psychologist
Thomas	M	Community Mental Health Nurse

Table 2. Participant demographic information.

	N = 20			
	n	Range	*M*	*SD*
Gender				
Female	15			
Male	5			
Age		27–60	40.9	8.75
Years of experience in mental health		1.25–30	13.63	10.05
Years of experience in current position		0.5–35	6.74	7.96

provided the researchers' contact information and appropriate supportive organisations, if needed. A £15 e-voucher was also sent to thank them for their time. All interviews were audio-recorded and transcribed in full verbatim.

Analysis

An inductive thematic analysis in accordance with the guidance of Braun and Clarke (2006), was conducted. Data familiarisation was achieved through multiple close readings before meaningful extracts (relative to the research aims) were identified and coded to depict each MHWs' key experiences of delivering teletherapies during COVID-19. The coding of individual transcripts was first completed by two researchers (BG and NC). These codes were then reviewed, refined, and developed collaboratively, by the research team. Codes were grouped according to similarity to develop themes that accurately captured each participants' perspective. The researchers returned to the interview transcripts several times during the analytical process to ensure that these themes were fully grounded in the data. Individual codes were then compared across the whole participant sample in QSR International's NVivo 12 Pro (QSR International Pty Ltd, 2018) and closely related codes were grouped, until no further groupings could be identified, to create a total of 20 'nodes'. Those most

prominent, fully-grounded and representative of the sample were cross-checked by the research team before being assembled to generate two main themes that captured participants' experiences, as suggested by Braun et al. (2019), Nowell et al. (2017), and O'Brien et al. (2014).

The research team ensured data quality and validity through sharing their perspectives at each stage, allowing for a consensus to be met on themes' definitions, interpretations, and significance in relation to current literature and practice. The team also kept reflective logs to enhance their self-awareness throughout this process and attended regular meetings, to address assumptions that could impose upon data interpretations (as advised by Braun & Clarke, 2020; Jootun et al., 2009; Ortlipp, 2008). Audit trails evidenced decision making throughout. This approach adhered to Levitt et al.'s (2018) Journal Article Reporting Standards for Qualitative Research, to ensure credibility. Ethical approval was granted by the University of Ethics Committee (reference: UEC20/81).

Results

Participants

Two major themes emphasised the benefits and challenges associated with teletherapies that were experienced by the MHWs interviewed: (1) Improved flexibility for both MHWs and SUs, and (2) Teletherapies challenge therapeutic boundaries. Thematic maps (Figures 1 and 2) show the relationships between the points raised within each theme.

Improved flexibility for both MHWs and service users

Several benefits were highlighted by MHWs from their experiences: teletherapy as a treatment option was found to (1) demonstrate the NHS's adaptability, (2) be a vital method of contact when face-to-face options are disrupted, (3) improve access to therapy for SUs with impaired mobility, and (4) allow socially anxious or avoidant SUs to feel more in control.

Remote working practices for MHWs were thought a 'challenge' (Alastair) for the NHS to implement, prior to COVID-19 and the rapid changes to service models largely employing virtual platforms was likened by one MHW to 'a bomb [going] off underneath us' (Scott). However, with time, most of the MHWs came to support the use of virtual communications, stating how it was a 'life-line' (Catriona) for SUs during COVID-19 lockdowns. MHWs felt that this adaptation displayed how 'flexible' (Pia) and 'resourceful' (Pearl) the mental health sector could be and noted the benefits of teletherapy for their productivity: where in-person therapy 'would be an afternoon, gone, for one meeting', teletherapy was typically 'an hour and [MHWs] can get on with other stuff' (Scott). Equally, working from home seemed to benefit MHWs' rest: 'I'm getting about an hour extra [sleep] … now I don't have to get up and drive 20 miles to get to my work' (Scott). Lisa, too, found that without travel, work had 'been a lot less exhausting' and that working from home was a relief whilst pregnant: 'I can sit however I want, in a way that's actually comfortable for me'.

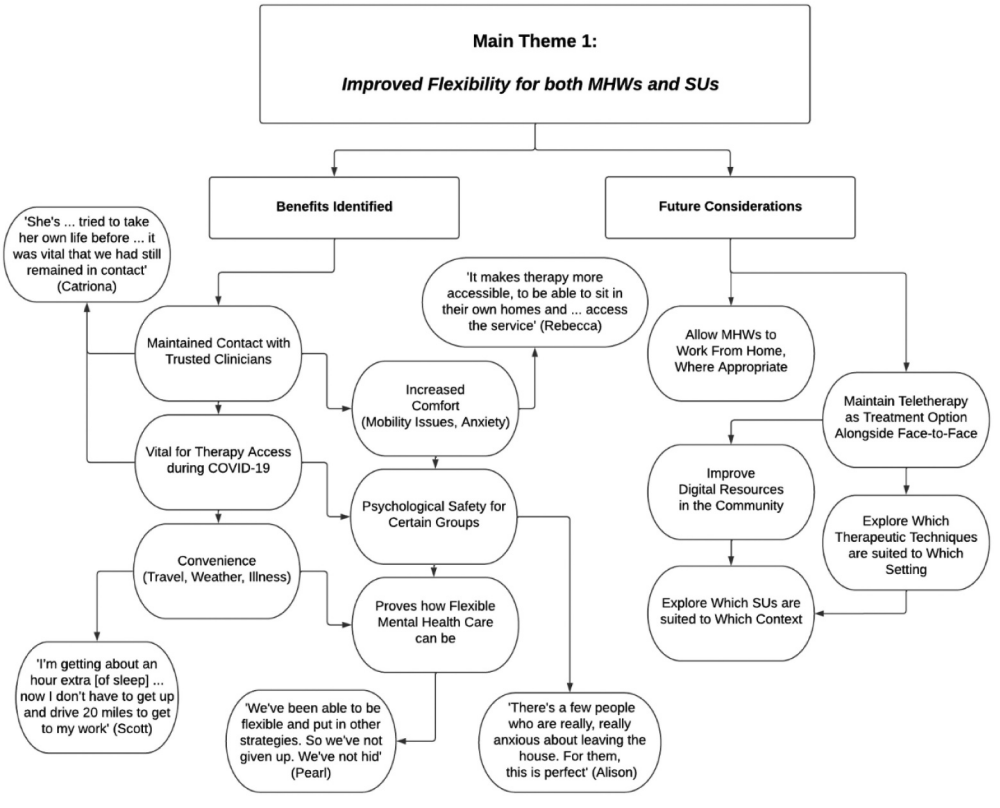

Figure 1. Schematic diagram of theme 1.

The ability to meet their SUs remotely was also thought to provide practical benefits, that could extend beyond COVID-19, by ensuring the continuation of therapeutic sessions despite unforeseen disruptions:

> Normally, we would just end up having to cancel . . . [now, if] somebody can't get out of the house to meet us somewhere, we could change and go onto Near Me, so I think it will be with our service as an added, um, positive method of contact. (Catriona)

MHWs expressed hope that, post-pandemic, their services would continue teletherapies as contact options alongside face-to-face, as they allow the consideration of convenience and comfort. Ellen found that teletherapies had also 'opened up' access for client groups who struggled with physical accessibility:

> I do have a patient who's very severely physically disabled, and he's been saying you know "I wish I knew you did video calls before . . . I've had to get in a car and it's really painful". (Ellen)

Moreover, MHWs believed virtual therapeutic spaces to have protective qualities for SUs with social anxiety or avoidance, as they have 'more control' (Emma) and are 'able to leave when they want to' (Pia), compared to in 'the outdoor world where it feels really scary' (Katie):

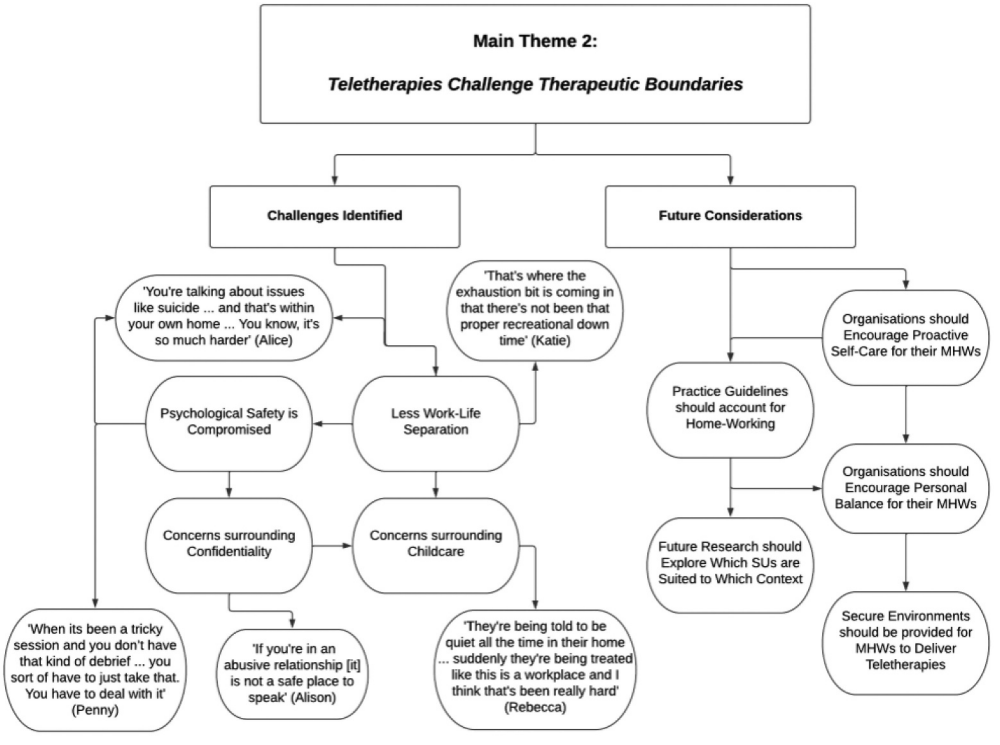

Figure 2. Schematic diagram of theme 2.

> There're a few people who are really, really anxious about leaving the house. For them, this is perfect. Finally, the NHS is flexible enough to offer them a remote therapy. (Alison)

Patricia echoed this sentiment and noted how recounting complex traumas could feel 'quite shameful' for SUs in face-to-face sessions: teletherapy was thought to ease this process, as 'over the phone people can't see your face' (Patricia).

In summary, MHWs felt that teletherapy promoted a more accommodating and comfortable therapeutic environment for groups who struggle with physical access and social anxieties. It was also advocated for future use, as it has proved a vital additional support resource for when face-to-face sessions were impacted by unforeseen circumstances.

Teletherapies challenge therapeutic boundaries

Most MHWs interviewed had spent the majority of 2020 delivering teletherapies from home, to minimise the risk of COVID-19 transmission. Here, we discuss the challenges reported by MHWs within this context relating to the maintenance of professional, work-life boundaries.

The main difficulty reported was MHWs' inability to separate themselves from work within their homes. Having round-the-clock access to work equipment often led to 'exhaustion', as there was a propensity to keep 'a wee [small] breast of what's going on' (Katie) and 'guilt trip' (Penny) themselves into working:

> The potential for me to do more [work], it's one of the things about working from home and- that I became obsessed with it. (Peter)

MHWs' felt that they 'never really had a proper day off' (Alison) as work spread into their personal time. This was especially troubling for those handling upsetting calls who, were unable to draw support from their colleagues and had 'nobody to check in with' (Penny) whilst at home:

> I felt quite isolated . . . there was a lot of emotional support [in the office] . . . Someone to put the kettle on and ask you if you're alright . . . there's a lot of things lost because of not being physically in the same building. (Ellen)

Without peer debriefs, MHWs had to 'deal with' (Penny) their emotions alone and could no longer 'go home and leave it [work] behind' (Rebecca). Alice described remote working as 'an invasion of your space . . . especially in crisis situations', as the traumatic experiences recounted by SUs became associated with MHWs' private spaces:

> I have rooms right now where I don't do any work . . . just so that I'm not- you're not contaminating that space. (Alice)You'd spoken about something quite traumatic [within the home] . . . and then [later], you were going to rest there . . . I found that really hard. (Katie)

MHWs homes were no longer seen as a place of respite, as teletherapies were conducted in spaces usually reserved for relaxing. Further, working around family members meant that many MHWs were lacking a confidential therapeutic space, deemed 'impossible' (Alison; Lisa; Rebecca), for those with children:

> I don't want them to be hearing me talking to people who are suicidal or who are self-harming . . . it's the impact on them and . . . the ability to do your work. (Ellen)

The blurring of boundaries between therapeutic and home settings prompted MHWs to question SUs' safety, as they could have been calling from hostile or manipulative environments:

> We're not really able to assess if they are at risk of people around them . . . or if somebody's . . . hinting them along [influencing the conversation]. (Thomas)

Rebecca echoed this sentiment, noting instances of compromised confidentiality, where she had 'realised that there are other people there'. Due to the complexities of individuals' backgrounds, she stated how these experiences felt 'unnerving' and 'unsafe'. The culmination of these stressors was found to affect MHWs' mental wellbeing; Ryan shared that working remotely felt 'heavier . . . emotionally' compared to in-person consultations.

In summary, MHWs felt a lack of distinction between their therapeutic-working and personal environments when delivering teletherapies from home and this presented challenges for them personally in terms of their own mental wellbeing.

Discussion

This paper contributes to the growing body of research on the adoption of teletherapies in mental health services by being the first paper to explore MHWs' experiences, specific to the context of COVID-19 pandemic in Scotland. We were concerned with understanding (1) what MHWs felt the benefits of teletherapy to be, and (2) what challenges accompanied

teletherapies' delivery, in order to understand and address them. Teletherapy was seen to vitally maintain service provision, improve services' flexibility, and enhance comfort for SUs with impaired mobility or social anxiety. However, when conducting teletherapies from home, MHWs struggled to separate therapeutic and personal environments, and were concerned for the safety of SUs in similar situations. As digital therapeutic models are expanded in Scotland (The Scottish Government, 2021) our findings may help to shape developments which support their sustainability and MHWs' and SUs' wellbeing.

The main benefit reported was how teletherapies increased services' flexibility which MHWs thought to improve comfort and access for SUs with impaired mobility. Similar findings are scarce; however, high satisfaction levels have previously been reported by patients with movement disorders for teletherapies' convenience (100%) and comfort (95%; Seritan et al., 2019). MHWs also felt that SUs with social anxieties could engage and remove themselves from virtual social scenarios more easily. The wider literature supports that teletherapy may help SUs with anxiety disorders to feel less scrutinised and more in control (Simpson et al., 2020; Thomas et al., 2021). For these groups, remote therapeutic settings were thought to have positively transformed their experiences. SUs can now prioritise their comfort by choosing their preferred consultation method.

The participating MHWs highlighted how providing teletherapies from home presented challenged confidential practice and work-life balance, as has been found in existing literature (Bar et al., 2021; Drum & Littleton, 2014; Simpson et al., 2020). Working additional hours and experiencing distressing work content within their homes implicated MHWs' wellbeing by placing them at risk of exhaustion and vicarious trauma. Vicarious trauma has been formally recognised by the The British Psychological Society (2020a, 2020b) as a threat to MHWs wellbeing in the context of home-working and COVID-19. Indeed, 15% of 339 MHWs surveyed by Aafjes-van Doorn et al. (2020) experienced high levels during this time and, similar to the findings of Békés et al. (2021), was associated with increased distress and fatigue, and decreased self-perceived competence, empathic responsiveness and therapeutic relationship quality.

Professional boundaries exist in psychological practice to ensure ethically sound client-practitioner relationships and to maintain the wellbeing for both (Borys, 1994). Considering our findings, and the reported deterioration of MHWs' psychological wellbeing during COVID-19 (Aafjes-van Doorn et al., 2020; Pappa et al., 2021), new practice guidelines should be created in the interest of public health for training relating to remote work, professional boundaries and teletherapeutic techniques (Stoll et al., 2020). Secure environments should also be provided to engage in teletherapies away from home, to protect wellbeing and confidentiality. Given the challenges of maintaining work life balance for MHWs working from home and how this can lead to exhaustion and vicarious trauma (Holmes et al., 2021), organisations should encourage proactive self-care. Further, staff wellbeing should be of prime concern to the enhancement of service delivery, as this has been associated with increased professional progress and stress reduction (Cogan et al., 2022; Gillen et al., 2022; Rupert & Dorociak, 2019; Zahniser et al., 2017). Setting up supportive debriefing and supervision mechanisms when working in online and remote settings is a key strategy to support MHWs, thereby creating a more psychologically safe working environment (Morton et al., 2022; O'Sullivan et al., 2022).

The need for a trauma informed approach to telehealth and digital mental health interventions is a priority in developing safe and quality working practices.

To sustain and expand its benefits, we must question teletherapy's viability from a population health perspective; SUs unable to access or communicate via technology may face care-exclusion (Bunyi et al., 2021; Kaihlanen et al., 2022; Leblanc et al., 2020; Tobitt & Percival, 2019). In Scotland, only 58% of those aged 75 or above use the internet, 21% of people in social housing have no access (The Scottish Government, 2022b) and 44% of care homes had partial or no coverage in 2020 (Care Inspectorate, 2020); groups already vulnerable to poor mental health, social exclusion and homelessness (N. A. Cogan et al., 2021; Leonhardt et al., 2022; O'Connor et al., 2021). Technology-enabling measures (ensuring adequate community internet access, devices and information, increasing mental health literacy) should be prioritised to help lessen the digital divide and address health inequities (Choi et al., 2021). Developing and measuring the extent to which digital therapeutics are experienced by SUs and practitioners as psychologically safe is also an important area for future research (Morton et al., 2022).

Important transferable insights have emerged from the current research. It is recommended that future work utilise multi-method approaches that incorporate the perspectives of SUs (as a point of comparison) and recruit from a broader sample of mental health professions (given the current study had a high proportion of psychological practitioner). Longitudinal research would help explore not only some of the challenges but the potential benefits of teletherapies and the infrastructure that is needed to support the best mental health digital practices. This would ensure that remote working practices, digital mental health innovations and standards for safe and quality digital mental health practices are well developed (Brown et al., 2022), role-specific and account for diverse professional and SU groups' needs.

Conclusion

Overall, teletherapy models were experienced as a vital and flexible alternative to face-to-face consultations during COVID-19. However, the blurring of work-life boundaries presented novel challenges for best practice and MHWs' wellbeing when working from home. Further research is needed to reveal teletherapy's scalability and efficacy with diverse SU groups, its effects on client-practitioner relationships, the long-term impacts of home working on practitioner wellbeing, and which patient groups and assessments are best suited to which therapeutic setting. It is envisaged that the insights and lessons learned from the perspectives of MHWs will promote a more accommodating, hybrid approach to mental health care, digital mental health interventions and inclusive and safe practices moving forward.

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