Digital Technology for Mental Health

Survey of Mental Health Professionals in Cumbria
March 2016

1. Introduction

The [Cumbria Rural Health Forum](#)[1] has developed the [Cumbria Strategy for Digital Technologies in Health and Social Care](#)[2]. The [scope for our work on digital technologies](#) includes telemedicine, telehealth, telecare and assistive technologies, e-health products and services that are commercially available[3]. From October 2015 to March 2016 we conducted a number of digital implementation workshops with the aim of proposing specific ways in which digital technologies should be implemented within a pathway, place or around a particular group of individuals. We also conducted a survey of Mental Health professionals (19th January – 22nd February 2016); the results of this are reported here. Our aim was to gauge usage of digital technology within the profession and also to understand professional acceptability of the use of digital technology to support people with mental illness. The exercise was approved as a Clinical Audit by the Cumbria Partnership NHS FT (reference: MHCM03$C1516:S6. Using digital technology to support patients with mental illness in Cumbria. ML Mental Health Services).

2. Background

In Cumbria, mental health service provision faces particular challenges:

- Cumbria has a relatively small population dispersed over a large geographical area; mountainous terrain central to the county makes travel difficult and some populations isolated.
- Community nurses and social workers often use large amounts of time travelling to meet patients' needs. In addition, some people struggle to attend clinic appointments in the towns where clinics are held, given poor public transport links. Some people with severe mental illness struggle to leave their homes.
- Cumbria has problems in recruiting and retaining clinicians, particularly consultant psychiatrists, and particularly to more remote and isolated parts of the county on the western side. This impacts adversely on people seeking help from mental health services.
- Across the county there are currently long waiting lists and waiting times to be seen by clinicians. This is especially the case with mental health act assessments, as professionals from around the county coordinate to meet.

Poor patient access (due to waiting times and geography) can impact on morbidity and functioning, as people's health is more likely to deteriorate, therefore:

- Reducing waiting times for patients will improve quality through reducing distressing waits.
- Reducing clinician travel time will reduce fatigue, which will have overall and longer-term benefits on quality patient care.

It is in this respect that digital interventions are seen to have the potential to impact positively on patient care in rural communities.

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[1] See www.ruralhealthlink.co.uk

[2] See http://www.ruralhealthlink.co.uk/about-us/cumbria-strategy-for-digital-technologies-in-health-and-social-care/

[3] See http://www.ruralhealthlink.co.uk/assets/uploads/reports/Briefing_paper_Digital_technologies.pdf for a fuller discussion

3. Use of digital technologies in mental health: how has it been used?

To illustrate some of the ways that technology has been used we have included some examples below (some implementations are in different fields but could be relevant in Mental Health; these are given for illustrative purposes only):
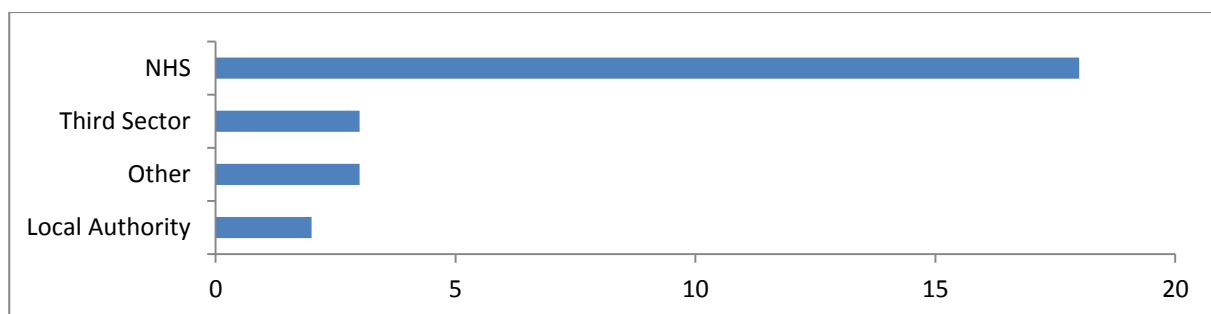
- There are an increasing number of mental health apps, available either free of charge or at low cost, for use by a patient or carer, see http://myhealthapps.net/. Apps can be easily downloaded onto any smartphone, tablet or PC device, either from an app library or from one of the device app stores (Apple or Android).
- Information services, forums, and social networks may also have a role and are many and various. Examples include http://www.thetrevorproject.org/ around crisis intervention and suicide prevention; https://www.breakthrough.com/ for online therapy and https://www.bigwhitewall.com/ is a well-known online mental health forum.
- Video links have been used for scheduled and unscheduled consultations (or other non in person contact such as phone, email, SMS). This can be with or without a nurse, carer or GP in attendance and can be to the patient's home or perhaps a local clinic. Examples within Cumbria are the telestroke service[4] and early pilots in fetal telemedicine[5] and orthopaedic post-operative care[6]. Outside of Cumbria, Airedale Hospital Trust[7] is a national leader in teleconsultation support and has a major programme. Some GP practices are successfully using Skype and there are many informal uses of phone and email.

4. The survey

The 'Digital technology for Mental Health' survey was constructed using Bristol online surveys; the survey link was distributed to mental health professionals via contacts at the Cumbria Partnership NHS FT and the Cumbria Rural Health Forum. Questions were mostly tick box style but with space to comment should the respondent have wished to explain their response.

Twenty-six people responded; over half were female (15). Respondents worked in range of occupations (including psychiatrist 5, nurse 4, manager 4, and therapist 3 – others 10) and most worked in the NHS:

Table 1 – Employment sector of respondents

NB- Others: 1 carer, 1 retired and 1 University.

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[4] See http://www.ruralhealthlink.co.uk/activities/list/telestroke
[5] See http://www.ruralhealthlink.co.uk/activities/list/fetal-telemedicine-improving-prenatal-diagnosis-and-management-in-cumbria
[6] See http://www.ruralhealthlink.co.uk/activities/list/telemedicine-remote-consultations
[7] See http://www.airedale-trust.nhs.uk/services/telemedicine/

5. Summary of findings

Results are summarised here and detailed findings are tabulated in the appendix.

5.1 Use of digital technology

Respondents were asked about their personal and work access to, and use of, digital devices (i.e. smartphones, PC/Laptops, Tablets); responses indicated the respondents were capable users of digital technology.

All respondents had access to at least one device and only one respondent did not have access to a smartphone. Further, all respondents used digital technology to communicate:

- All sent emails
- All but three sent SMS messages
- All but five used Apps
- All but twelve participated in video-conferencing.

5.1.1 Smart phone, access and usage

Most respondents had access to a personal smart phone (23) and to a work smart phone (18); those with personal access regularly used their smart phone for work purposes (15). Only one respondent did not have access to either a personal or work smartphone.

The majority of those with access to a smartphone sent SMS messages (21) and emails (19). Most respondents used Apps on their personal smartphone (19) but less than half of those with access used Apps on their work phone (8). Very few respondents participated in video-conferencing using a smartphone, only five used their personal phone and only three used their work phone for this purpose.

5.1.2 Personal computer and/or laptop, access and usage

All respondents had access to a personal computer/laptop; twenty-five having access to their own and twenty-four having access at work. Twelve respondents regularly used their own PC for work purposes.

All respondents sent emails and half (13) used a personal computer and/or laptop to participate in video-conferencing (9 using their own PC/laptop and 7 their work one). Fewer people used Apps on a PC/laptop (11 on their own and 8 on a work one).

5.1.3 Tablet, access and usage

Whilst fifteen respondents reported having access to a personal tablet, only one respondent reported having access at work; this respondent sent emails, used Apps and participated in video conferencing using the work tablet. Of those with access to their own tablet most sent emails and used Apps (both 14) and seven used their tablet to video-conference; five reported using their tablet regularly for work purposes.

5.2 Attitudes towards using digital technologies to support people with mental illness

5.2.1   Video-conferencing

Most respondents agreed with the proposition that supporting patients with mental illness via video-conferencing was a good idea (12 agreed and 3 agreed strongly), but the majority view was that video-conferencing was a good idea but only appropriate in certain circumstances (10 agreed and 9 agreed strongly). Only eight respondents believed that using video-conferencing to support patients in crisis was a really good idea; twelve respondents disagreed with this proposition.

Those explaining their responses appeared to take up one of three positions on this matter: enthusiasm, caution or scepticism. Both cautious and sceptical respondents emphasised the importance of face-to-face contact in working with people with mental illness; they highlighted the value of being able to pick up on subtle behaviours/clues which might be missed by video link. So whilst many respondents were open to the idea of delivering support via video conferencing they also viewed this as totally inappropriate for high risk patients, for example those in crisis or in extreme distress. However, one respondent believed video-conferencing to be the next best thing where face-to-face was impossible, and another remarked that in a crisis situation it would be better than waiting.

Notwithstanding, many emphasised that video-conferencing to support patients would be a good idea in certain circumstances and for certain patients; one respondent asserted that 'in most cases it will be fine'. Persons suitable for video-conferencing were those identified as being stable or with mild to moderate mental health problems; patients where relationships with staff have become established through previous face-to-face contact; patients with access to, and confidence in, digital technology. Unsuitable clients were identified as those in crisis or in extreme distress, those afraid of technology, and those without access to it. One respondent was concerned about confidentiality and questioned the evidence base for supporting people in this manner. Whilst one person questioned whether patients would be accepting of this method of communication another asserted that patients are more accepting of technology than are staff. One respondent believed video-conferencing might work better if the patient was supported by an intermediary, at a drop-in centre or mental health voluntary organisation.

In addition, respondents who were positive about the role of video-conferencing emphasised potential benefits, such as savings in cost and time from reduced travel which would then allow more contact time with patients. Video-conferencing might also facilitate access to support, especially for those living in isolated areas or those afraid to leave their home. One respondent proposed that supervision could be done by video link and others suggested using it for MDTs and out of area meetings. Later in the survey we specifically asked respondents about whether they would welcome the opportunity to access specialist advice through video-conferencing, twenty respondents agreed that they would; only two disagreed.

This range of opinion on video-conferencing can be illustrated by responses to the proposition 'I have concerns about using video-conferencing to support patients'; in this instance seven respondents agreed, seven disagreed and twelve neither agreed nor disagreed. With regards to concerns, one respondent highlighted a lack of Trust guidance on the use of video technology, especially in relation to security and confidentiality. Another believed it to be a 'cheap opt out'. Others commented upon the way such a change might be managed asserting it should be 'well-co-ordinated and managed', 'handled carefully', considerate of patients and staff and supported with training.

5.2.2   Secure messaging

Seventeen respondents agreed that using secure messaging to support patients with mental illness was a good idea (5 agreed strongly), and twenty agreed that this would only be appropriate in certain circumstances (10 agreed strongly). In explaining their answers four respondents highlighted security and pointed to confidentiality and the protection of patient information. Four indicated that only limited use of secure messaging would be acceptable to them, such as appointment confirmations or reminders, for example:

> *… they would need to be of a limited content, appointment requests and confirmations with follow-up voice contact and visual contact. Time scales need to be defined to allow for realistic response/replies.* (Female, 65 years or older, Other, NHS)

Five respondents referred to a client's ability to use and/or access technology, suggesting that such communications are only appropriate for those with both. Six respondents believed such communications may be problematic; two had concerns about 'boundaries' and three referred to the importance of face to face contact in picking up visual clues, for example:

> *… it could potentially be fraught with problems- would need careful management. Many things are picked up in an interaction with a client that cannot be picked up via secure messages- tone, body language. Lack of punctuation and spelling can create issues around misunderstanding. If people are involved in messaging and don't reply - are they in danger, have they just terminated the message etc.* (Female, 45-54 years old, Manager, Third Sector)

Two respondents felt secure messaging to be inappropriate with patients at risk or in crisis. However, when asked specifically about secure messaging with patients in crisis thirteen agreed this was a good idea (3 strongly) and only seven disagreed. For three respondents, use would be acceptable under certain conditions, i.e. where relationships have been established and for follow up after a face to face meeting. Three others mentioned the upside of a speedier response.

In spite of the above, seventeen respondents reported having concerns about the use of secure messaging with patients with mental illness. Only three explained their responses, two of whom were concerned about security and confidentiality.

Twenty respondents agreed that they would welcome the opportunity to access advice from specialist colleagues via secure messaging, few elaborated upon this but speed and access was mentioned and one queried how such communications could be personal.

5.2.3   Apps

When asked whether using Apps to support people with mental illness was a good idea twenty respondents agreed (8 strongly), and seventeen respondents agreed that they were happy to recommend Apps to patients (5 strongly). Few respondents explained their response but those with positive explanations referred to previous experience and to the benefits for patients. Some mentioned that Apps would only be suitable for people with the ability to use and access to technology. One respondent disagreed that Apps were a good idea:

> *Most APPS lose their impact within six months of use and are very expensive to develop.* (Male, 45-54 years old, Other, University Education)

Five respondents neither agreed nor disagreed that the use of Apps was a good idea and eight neither agreed nor disagreed to being happy to recommend Apps to clients. Again, few commented, but two people referred to their limited knowledge of Apps.

When asked whether given the right level of guidance respondents would be happy to prescribe Apps, twenty respondents agreed (9 strongly). Lastly, respondents were asked how far they agreed with the statement 'I have concerns about using Apps to support patients'; five agreed and fourteen disagreed; comments referred once more to conditions of use, for example:

> *Agree - I would have concern about apps being used to support patients unless this was their choice. In my experience, for most patients they are a useful addition to personal support from a mental health professional, but do not and could not currently take the place of that support.* (Female, 45-54 years old, Other, Third Sector)

> *Disagree - I don't have concerns if APPS have approval- there are some very unprofessional ones so direction and guidance would be needed. Also this cannot be seen as a replacement for contact but must be as an addition to.* (Female, 45-54 years old, Manager, Third Sector)

5.3 Ideas about ways digital technology might be used to support patients with mental illness

We were interested to hear respondent's ideas about ways that digital technology might be used to support patients with mental illness; four respondents shared ideas, these are set out on the next page.

Idea	Barriers	Risk factors
Audio Recorded Interviews: 'A technique being used by art psychotherapists to enable clients to review their art work and therapy stages as a personalised reflection tool and record of treatment' **Beneficiaries**: Patients and Clinicians	• Patient choice and technical support	• 'Confidential experience of therapy could be made public through patient choice and have an impact on the patient that is unanticipated'
Therapeutic Activity App: 'Questions would determine which self-help therapeutic activities would be appropriate for the individual then on each visit to the app activities would be suggested, e.g., therapeutic writing prompts' **Beneficiaries:** Patients, carers, and clinicians		
Video/facetime etc: 'Psychiatric assessments - for any purpose can be completed using video links' **Beneficiaries**: Patients, carers and clinicians	• Equipment and support to use it • Refusal by staff to grasp the technology	• Equipment failure
Technology aided CBT: 'Use of interactive programs to deliver structured psychological therapy as an adjunct to guided self-help' **Beneficiaries**: Patients	• Access to programs	• Failure to note a patient with a deteriorating condition

6. Conclusions

This report details results from a survey of mental health professionals on their use of digital technology and their attitudes to using digital technology with people with mental illness. The aim of the survey was aligned to the aims of the digital workshops facilitated by the Cumbria Rural Health Forum, to propose specific ways in which digital technologies could be implemented within a pathway, place or around a particular group of individuals, in this instance people with mental illness.

As we have seen, respondents to the survey were engaged with digital communications technology and used devices in a range of ways. But we also saw that respondents appeared to take up one of three positions with regards to using digital technology to support patients. Many respondents were simply cautious about using technology in this way and appeared more able to imagine where it could not work than where it could: "it's a good idea but"; as such they were open to the idea but yet to be convinced. Some respondents were highly sceptical about using technology to support patients, this group appeared concerned about security and patient confidentiality, made clear that such an approach was not appropriate for patients at risk or in crisis and were strongly in favour of face to face consultations. Then there were those who were enthusiastic about using technology; such respondents referred to the benefits that might come from telemedicine, such as improved access to services and financial savings; some stressed that digital access was better than no access at all.

The response rate was low and so further investigations should be made before making assertions based on this data. NHS services are generally under pressure, which are magnified by the particular geographical challenges facing both professionals and patients in Cumbria; these challenges impact upon patient access to services and on their recovery from mental ill health. It is in relation to access that digital technology has the potential to impact most. Undoubtedly, using digital technology to support people with mental illness will not be appropriate for all. Using technology to support those for whom it is appropriate should free up resources that can then be focused on those less able to access care.

Appendix – Data

1. Access to digital technology and usage

1.1 Smart phone, access and usage
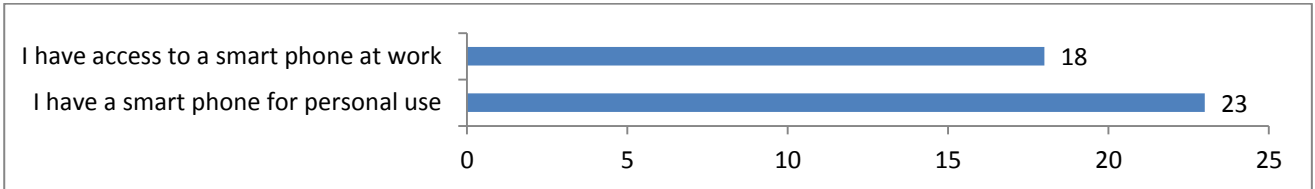
Table 1 – Access to a Smartphone
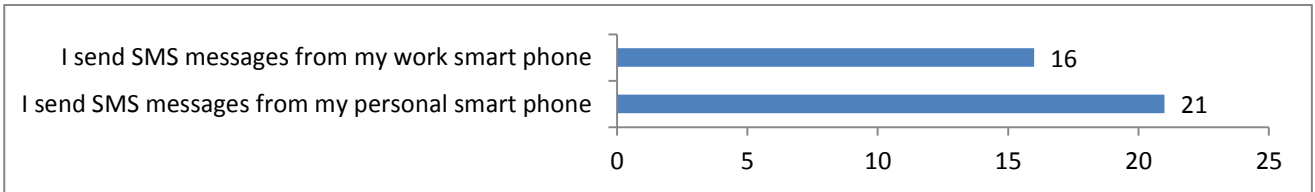

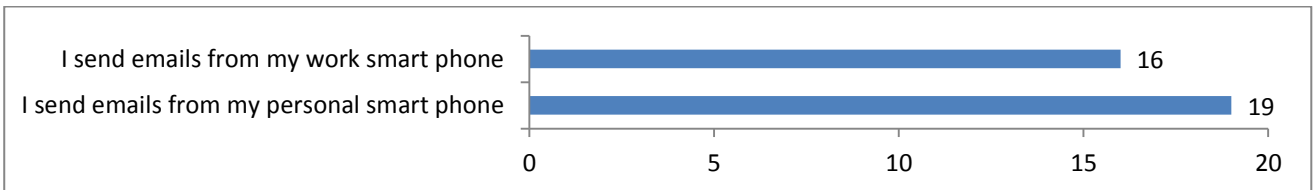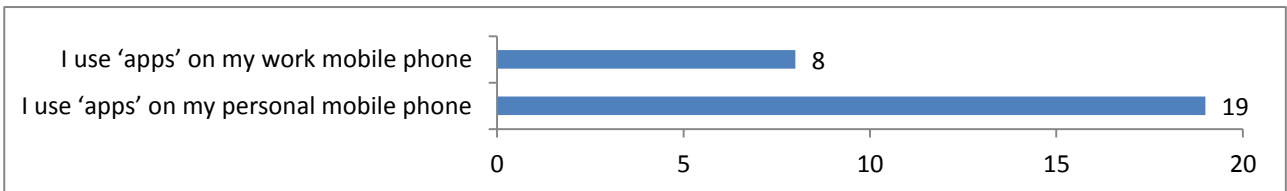**Table 2 – SMS messaging on Smartphone**

Table 3 – Emailing on Smartphone

Table 4 – Apps on Smartphone

1.2. Personal computer and/or laptop, access and usage
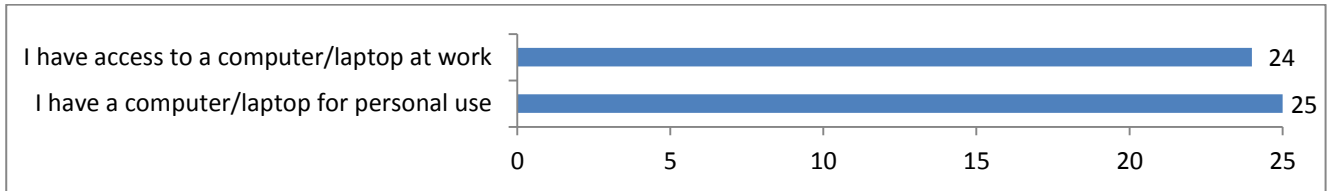
Table 5 – Access to a PC/Laptop

	Value
I have access to a computer/laptop at work	24
I have a computer/laptop for personal use	25

Table 6 – Video-conferencing on PC/Laptop

	Value
I particpate in video conferencing using my work PC	7
I particpate in video conferencing using my personal PC	9

Table 7 – Apps on PC/Laptop

	Value
I use 'apps' on my work PC	8
I use 'apps' on my personal PC	11
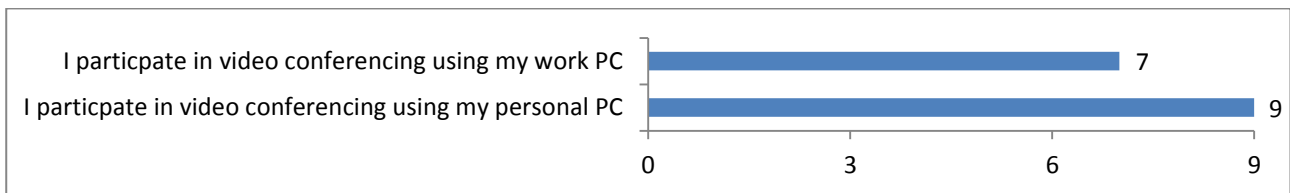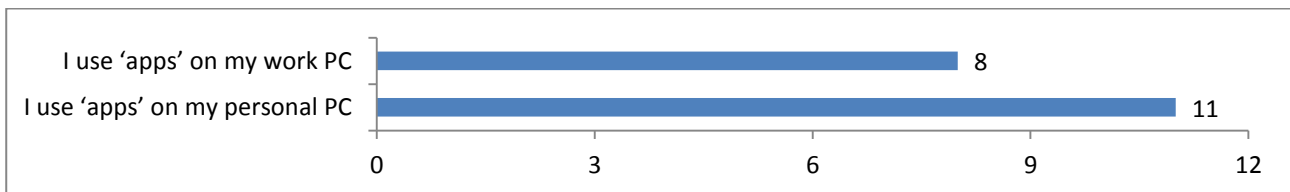
1.3. Tablet, access and usage

Table 8 – Access to Tablet

	Value
I have access to a tablet at work	1
I have a tablet (e.g. i-pad) for personal use	15

Table 9 – Usage of personal tablet

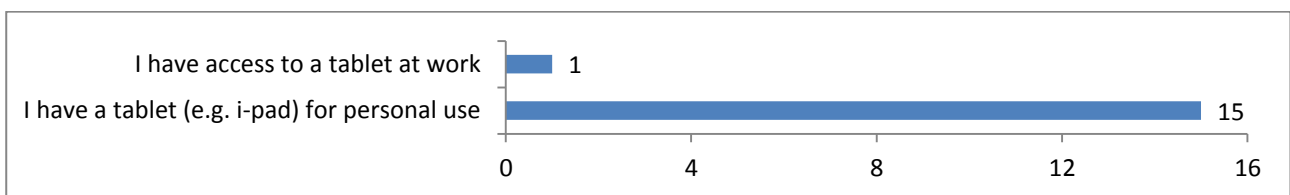|	Value
I video-conference using my personal tablet	7
I use 'apps' on my personal tablet	14
I send emails from my personal tablet	14

2   Attitudes to using digital technology to support people with mental illness

6.1 Video-conferencing

Respondents were asked to indicate how far they agreed with a range of statements relating to the use of video-conferencing.

Table 8 - Using video-conferencing to support patients with mental illness is a really good idea
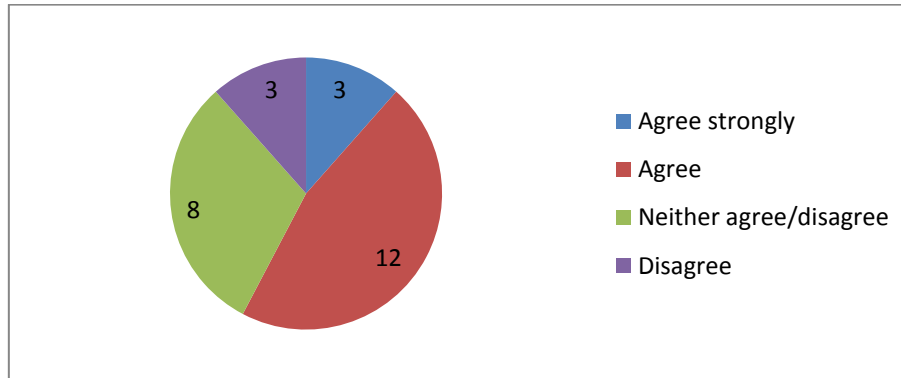
Agree strongly:

> *I have seen it work very well in remote healthcare settings* (Male, age missing, Psychiatrist, NHS)

> *We use video communication in our everyday lives, people are used to it, and it is efficient as reduces travel time* (Female, 55-64 years old, Psychiatrist, NHS)

> *Able to spend more time in contact with people rather than driving to and from appointments* (Male, 45-54 years old, Nurse, NHS)

Agree:

> *But only if they have access to the equipment. Face to face contact essential therefore video conferencing next best thing.* (Female, 55-64 years old, Manager, Local Authority)

> *Saves time, travel and money. Some patients are so anxious to go out and to be able to consult a Psychiatrist from home would help them.* (Female, 45-54 years old, Psychiatrist, NHS)

> *For certain clients it is totally appropriate as an option but is not for all* (Male, 35-44 years old, Manager, NHS)

> *It would cut down on travel time for reviews out of area and also when the weather is bad and some places are inaccessible due to the rurality of the area. Supervision could be done via video link to cut down on travel. Meetings cut be attended via video link to free up more patient time. We had video conferencing facilities in [place name] but the main part was stolen during a burglary and was never replaced which is frustrating as it was being used.* (Female, 45-54 years old, Nurse, NHS)

> *It's smart, quick, easy, more efficient; just need to think through the governance issues and risks.* (Male, 35-44 years old, Psychiatrist, NHS)

Enable MDT meetings for services in other counties. (Female, 35-44 years old, Other, NHS)

Access to specialist care or someone to listen to could be crucial for an isolated patient. (Male, 45-54 years old, Head of Academic Dept. University Education)

Neither agree/disagree:

It depends on the needs of the patient. Some people feel comfortable using digital technology, others much less. I have concerns about whether video-conferencing is as powerful as personal contact for people experiencing mental illness and social isolation. (Female, 45-54 years old, Other, Third Sector)

Not tried it. (Female, 25-34 years old, Nurse, NHS)

I think it can be useful. (Female, 45-54 years old, Nurse, NHS)

I've disagreed but I think it may have its merits with mild to moderate illnesses but not for many people with more serious issues. (Female, 45-54 years old, Manager, Third Sector)

I think it is difficult to take in the subtle behaviours and environmental factors when someone is not in the room with you in extreme situations of distress. (Female, 65 years or older, other, NHS)

I'm not sure how many patients would want to use it. (Female, 55-64 years old, Other, NHS)

Disagree

Confidentiality and evidence base. (Male, 25-34 years old, Manager, NHS)

I personally find video conferencing very difficult; I believe I am not alone with that. (Gender missing, 35-44 years old, Other, Local Authority)

Table 9 - Using video-conferencing to support patients with mental illness is a really good idea, but will only be appropriate in certain circumstances
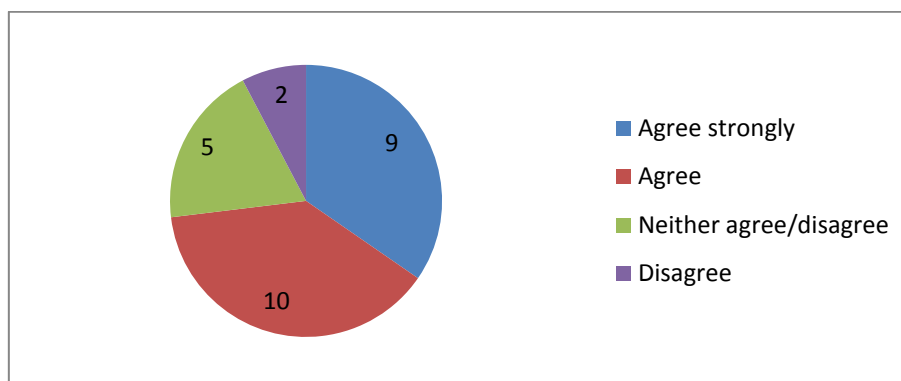
Agree strongly

Best to use when patient is more stable and can provide informed consent to that form of conversation. (Female, 45-54 years old, Psychiatrist, NHS)

For certain clients it is totally appropriate as an option but is not for all. (Male, 35-44 years old, Manager, NHS)

The technology has to be used sensitively, for example if someone has paranoid delusions about electronic appliances then using video conferencing is inappropriate and insensitive. (Male, 45-54 years old, Nurse, NHS)

Clients who are very ill- will fare better with face to face consultations. Sometimes using technology could add to stresses of contact. (Female, 45-54 years old, Manager, Third Sector)

Agree

There are times when it is more important, therapeutic to be in the presence of the patient. (Female, 45-54 years old, Nurse, NHS)

Probably, just need to be careful in cases where risk is high. (Male, 35-44 years old, Psychiatrist, NHS)

Not as a one to one with patient. (Female, 35-44 years old, Other, NHS)

When face to face is not possible or when travel is prohibitive. (Male, 45-54 years old, Other, University Education)

It depends so much on the needs and wishes of the individual patient. (Female, 45-54 years old, Other, Third Sector)

Mental health is a fluctuating condition and it depends on the condition of the patient. Low level issues may be ok such as support delivered via IAPT, but not severe ones. (Male, 45-54 years old, Other, Third Sector)

If this arrangement is based on previous contact and a professional relationship is established. (Female, 65 years or older, Other, NHS)

It will only work I think with patients who are fairly keen on the idea and if they see an added benefit from using video conferencing. (Female, 55-64 years old, Other, NHS)

Neither agree/disagree

I think risk assessment can be done better if it is face to face otherwise it may just be a tick box. 'Gut instinct' works better face to face. (Female, 45-54 years old, Psychiatrist, NHS)

Mostly it will be fine - there may be very occasional times when direct contact is necessary - but I can't think when they are. (Female, 55-64 years old, Psychiatrist, NHS)

Disagree/disagree strongly: no comments.

Table 10 - Using video-conferencing to support patients in crisis is a really good idea
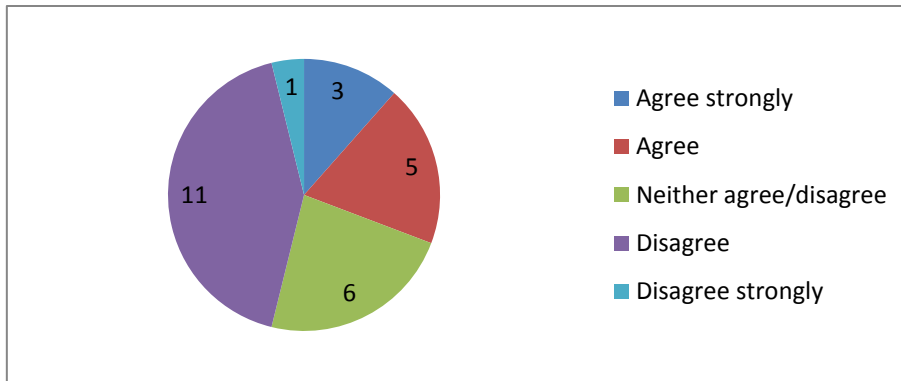
Agree strongly

> *I agree that video conferencing in crisis situations may be more use than having a patient in crisis wait for the clinician to drive for 90 minutes for a face to face meeting.* (Male, 45-54 years old, Nurse, NHS)

Agree

> *It could prove more accessible for patients as would cut down on travel time. It is a massive shift in practice and would need to be managed sensitively, but could provide a more timely interaction with patients.* (Female, 45-54 years old, Nurse, NHS)

> *Probably, just need to be careful in cases where risk is high.* (Male, 35-44 years old, Psychiatrist, NHS)

Neither agree/disagree

> *Maybe, if the person engages, it seems to rely on that engagement.* (Male, 45-54 years old, Other, Third Sector)

> *Videoconferencing can be very impersonal and patient in crisis in my opinion will still need to have a practitioner present physically to provide support during that process. I would feel uncomfortable to conduct for instance a mental health act assessment through this method as I cannot assess body language and the whole environment accurately.* (Female, 45-54 years old, Psychiatrist, NHS)

> *Clients in crisis need face to face support in majority of cases. Although video conferencing may work if it was managed by a provider- e.g. a local voluntary group such as Mind groups. Currently they quite often support clients in crisis, often accompanying them to A&E etc. - maybe if certain Places of Safety or Crisis Support Centres were developed and placed in well-known local groups they could facilitate a video conference call with someone in crisis.* (Female, 45-54 years old, Manager, Third Sector)

Disagree

> *I'm not convinced that video conferencing can take the place of personal contact for patients in crisis, given the complexity of their needs.* (Female, 45-54 years old, Other, Third Sector)

I think there is an unconscious boundary taken down when a visual link is made and the crisis situation may be best managed by a 'thinking' talking exchange until a direct face to face contact could be made, if required or seen as necessary. (Female, 65 years or older, Other, NHS)

I don't feel it would work as well as face-to-face contact for someone in crisis. (Female, 55-64 years old, Other, NHS)

Probably one of the areas where it may be less appropriate. (Male, 35-44 years old, Manager, NHS)

People in crisis need face to face assessment. (Female, 45-54 years old, Psychiatrist, NHS)

I think the personal touch is needed then. (Gender missing, 35-44 years old, Other, Local Authority)

Disagree strongly – no comments.

Table 11 - I have concerns about using video-conferencing to support patients
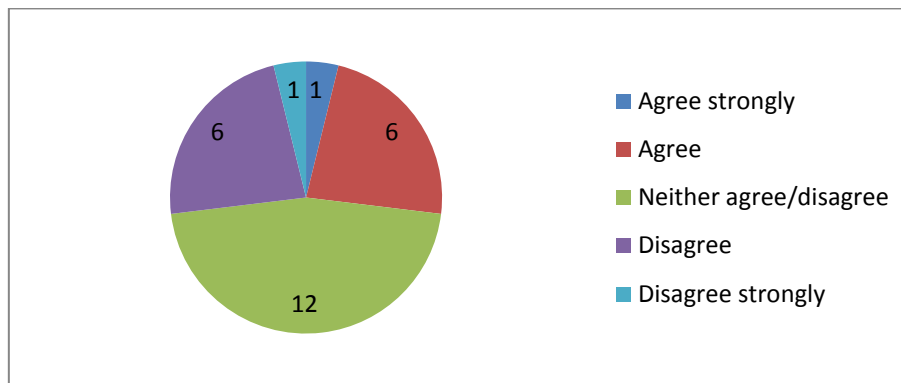
Agree strongly

> *There is no clear guidance from the Trust overtly published regarding the use of video conferencing especially around the confidentiality/security aspects.* (Male, 45-54 years old, Nurse, NHS)

Agree

> *It needs to be handled carefully as with any change and the views of the patient and staff considered. People need to see the positives rather than something being taken away.* (Female, 45-54 years old, Nurse, NHS)

> *It's more impersonal in my opinion.* (Gender missing, 35-44 years old, Other, Local Authority)

> *Could be a cheap opt out instead of frontline services where proper investment is needed.* (Male, 45-54 years old, Other, Third Sector)

> *It could be beneficial for some but would need to be very well coordinated and managed and must not be the only resource as when technology fails there must be a viable support network in place.* (Female, 45-54 years old, Manager, Third Sector)

Neither agree/disagree

> *Difficult to say as it depends on the circumstances. Could feel helpless if patient has serious problems.* (Male, 45-54 years old, Other, University Education)

Practitioners need some training in conducting consultations this way. It is not simply a case of doing everything that you would do in a live consultation. (Male, age missing, Psychiatrist, NHS)

It could work really well with some patients, but I wouldn't want it to replace the option of seeing patients face-to-face. (Female, 45-54 years old, Other, Third Sector)

I think this could be helpful in some physical health situations but wary of this being the only option. (Female, 65 years or older, Other, NHS)

Disagree

It is innovative and saves money for the NHS. We have to fit in with the times we are living in. Internet, social media, skype and viber is the future. Young adults would love it. The elderly people may hate it. (Female, 45-54 years old, Psychiatrist, NHS)

Stable patients can be well supported by videoconferencing. (Female, 45-54 years old, Psychiatrist, NHS)

Disagree strongly

I find patients accept technology better than staff do. (Female, 55-64 years old, Psychiatrist, NHS)

Table 12 - I would welcome the opportunity to access specialist advice through video-conferencing
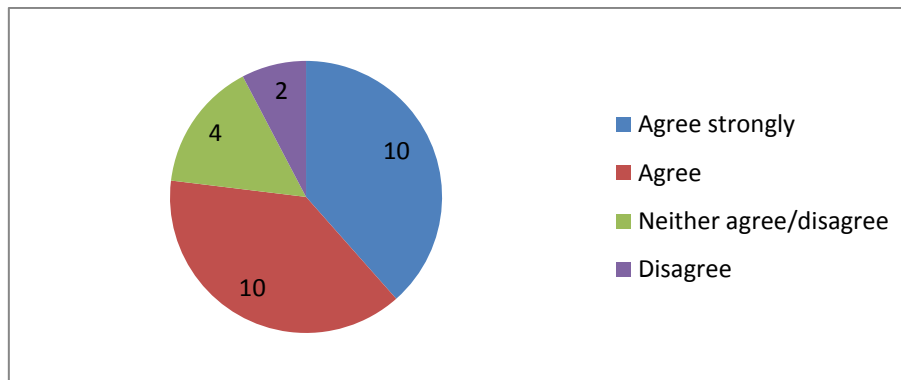
Agree strongly

As someone working with clients and supporting them in crisis this would be useful for us to be able to sit with a client and access specialist advice. (Female, 45-54 years old, Manager, Third Sector)

Saves on travel and waiting. (Female, 55-64 years old, Psychiatrist, NHS)

Agree

Access to Consultants or for extra clinical supervision. (Female, 45-54 years old, Nurse, NHS)

I think it would reduce the waiting times. It can be done from anywhere including home. Allows scope for flexible working from home. (Female, 45-54 years old, Psychiatrist, NHS)

Can save time and money and if equipment available will be almost as good as face to face. (Female, 55-64 years old, Manager, Local Authority)

It would be a useful way of accessing specialist advice. (Female, 45-54 years old, Other, Third Sector)

I already use telephone consultation for clinical supervision and this could be improved with further technical support but still is based on establishing a trusted professional contact face to face. (Female, 65 years or older, Other, NHS)
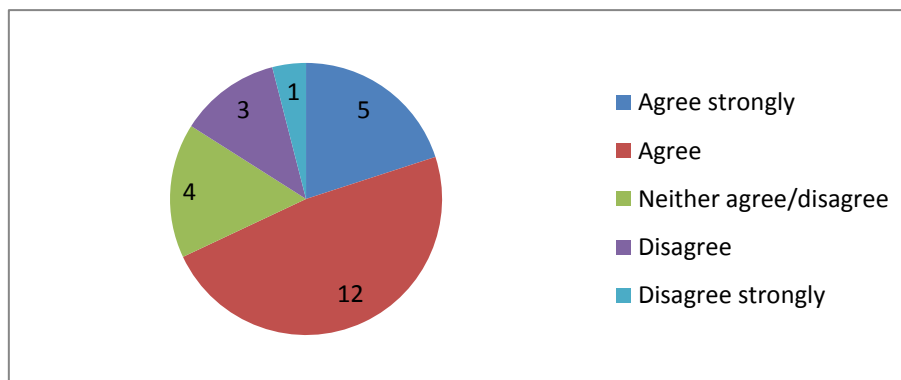
Neither agree/disagree

I would have to see what the specialist advice was. (Male, 45-54 years old, Other, Third Sector)

Disagree/disagree strongly – no comments.

6.2 Secure messaging

Table 13 - Using secure messaging to support patients with mental illness is a really good idea

Agree strongly

Protection of patient information. (Female, 45-54 years old, Nurse, NHS)

Good idea but professionals would require assurances from their employer around security and confidentiality. (Male, 45-54 years old, Nurse, NHS)

Agree

Will depend on the patient, may not give enough support and cannot see person's state of mind etc. by text. (Female, 55-64 years old, Manager, Local Authority)

However, they would need to be of a limited content, appointment requests and confirmations with follow-up voice contact and visual contact. Time scales need to be defined to allow for realistic response/replies. (Female, 65 years or older, Other, NHS)

Many patients probably already use messaging so I would think the barriers to uptake would be fewer as compared with video conferencing. (Female, 55-64 years old, Other, NHS)

Neither agree/disagree

Can be really helpful if it's one of the patient's preferred ways of communicating. However for some people digital technology is a barrier rather than an aid to communication. Many patients do not currently have access to digital technologies, other than via public spaces such as libraries. (Female, 45-54 years old, Other, Third Sector)

Depends what it is about? (Gender missing, 35-44 years old, Other, Local Authority)

OK for some, not OK for others. (Male, 65 years or older, Other, Other)

*NOT AUTOMATED MESSAGING!* (Male, 45-54 years old, Other, Third Sector)

Disagree

I would have concerns about boundaries of such messaging. (Female, 45-54 years old, Psychiatrist, NHS)

Again - it could potentially be fraught with problems- would need careful management. Many things are picked up in an interaction with a client that cannot be picked up via secure messages-tone, body language, lack of punctuation and spelling can create issues around misunderstanding. If people are involved in messaging and don't reply - are they in danger, have they just terminated the message etc. (Female, 45-54 years old, Manager, Third Sector)

Disagree strongly – no comments.

Table 14 - Using secure messaging to support patients with mental illness is a really good idea, but will only be appropriate in certain circumstances
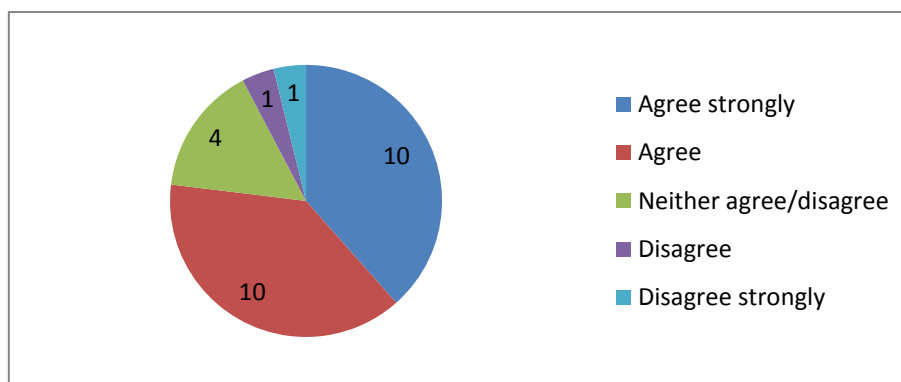
Agree strongly

Some patients will not cope with texts at times of crisis. (Female, 55-64 years old, Manager, Local Authority)

Security of the system will be paramount. (Male, 45-54 years old, Other, University Education)

Common sense dictates that this type of communication would not be appropriate for certain individuals. (Male, 45-54 years old, Nurse, NHS)

Agree

> *Need to take account of the reciprocal impact of conversation and how many mental health situations occur from underlying mistrust in not being 'heard.'* (Female, 65 years or older, Other, NHS)

> *Probably, just need to be careful in cases where risk is high.* (Male, 35-44 years old, Psychiatrist, NHS)

> *Only with patients who are happy to engage with messaging.* (Female, 55-64 years old, Other, NHS)

> *To protect patient information.* (Female, 45-54 years old, Nurse, NHS)

> *For functional things like confirmation and reminders of appointments but not therapeutic help.* (Male, 45-54 years old, Other, Third Sector)

Neither agree/disagree

> *Depends what it is about?* (Gender missing, 35-44 years old, Other, Local Authority)

Disagree/disagree strongly – no comments.

Table 15 - Using secure messaging to support patients in crisis is a really good idea
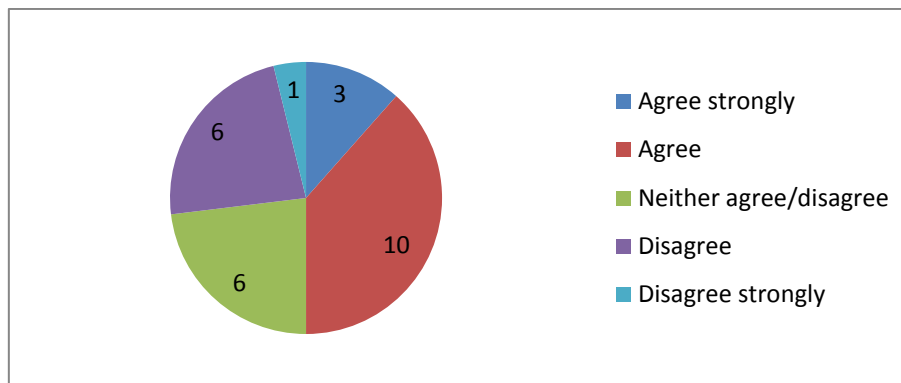
Agree strongly – no comments

Agree

> *Initial assessments for patients in crisis should always be face to face. Follow up contact can be done by messaging.* (Female, 45-54 years old, Psychiatrist, NHS)

> *Because I imagine there could be a quick response.* (Female, 55-64 years old, Other, NHS)

> *Could provide extra support and enable support information to be shared with the patient instantly.* (Female, 45-54 years old, Nurse, NHS)

Neither agree/disagree

As previously suggested there needs to be a history of connection with the correspondents to maintain best effect from this exchange. (Female, 65 years or older, Other, NHS)

Some situations it may be appropriate but not all. (Male, 35-44 years old, Manager, NHS)
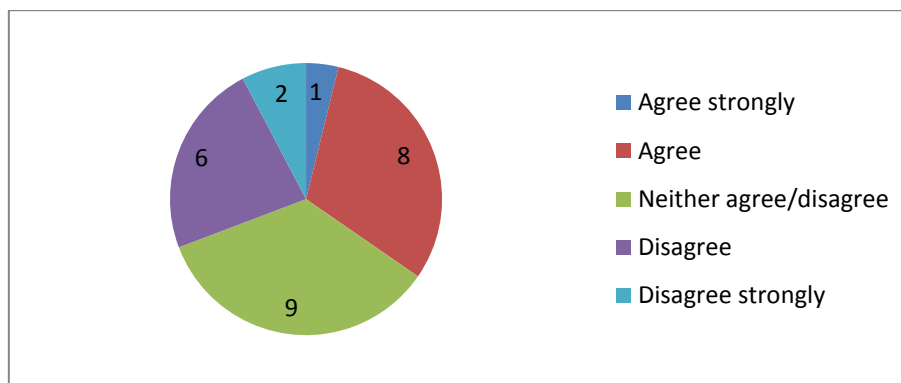
Disagree

Some patients will not cope with texts at times of crisis. (Female, 55-64 years old, Manager, Local Authority)

Too impersonal. (Gender missing, 35-44 years old, Other, Local Authority)

Disagree strongly – no comments

Table 16 - I have concerns about using secure messaging to support patients

Agree strongly

What if the messaging is accessed by someone else present when the message comes in? (Male, 45-54 years old, Other, Third Sector)
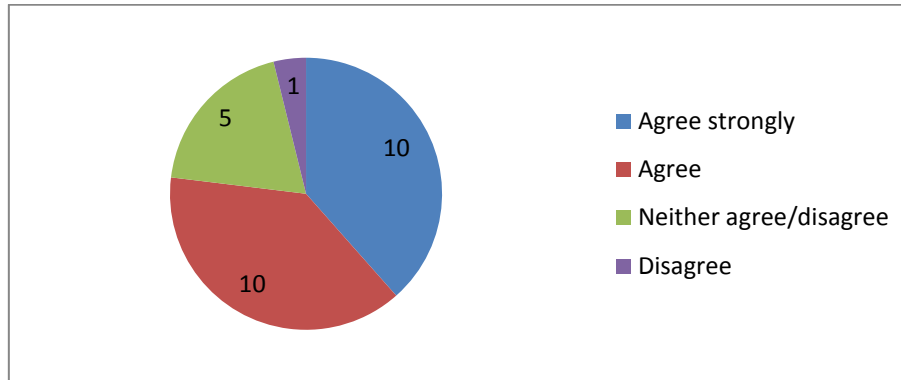
Agree

To ensure patient confidentiality. Some people share their Facebook log in details so others can access their account. (Female, 45-54 years old, Nurse, NHS)

Neither agree/disagree

I have concerns if it becomes the prescribed way of 'seeing' patients, and if patients are not given choice. (Female, 45-54 years old, Other, Third Sector)

Disagree/disagree strongly – no comments

Table 17 - I would welcome the opportunity to access advice from specialist colleagues through secure messaging

Agree strongly

> *Potentially quick, immediate access to support. This is especially true for patients living in rural areas.* (Male, 45-54 years old, Other, University Education)

Agree

> *Cuts down on postage and risk of items being lost on route.* (Female, 45-54 years old, Nurse, NHS)
>
> *I have received medical advice from specialist for myself with regards to physical health and I thought it was good.* (Female, 45-54 years old, Psychiatrist, NHS)
>
> *Useful means of gathering additional info/support* (Female, 45-54 years old, Other, Third Sector)
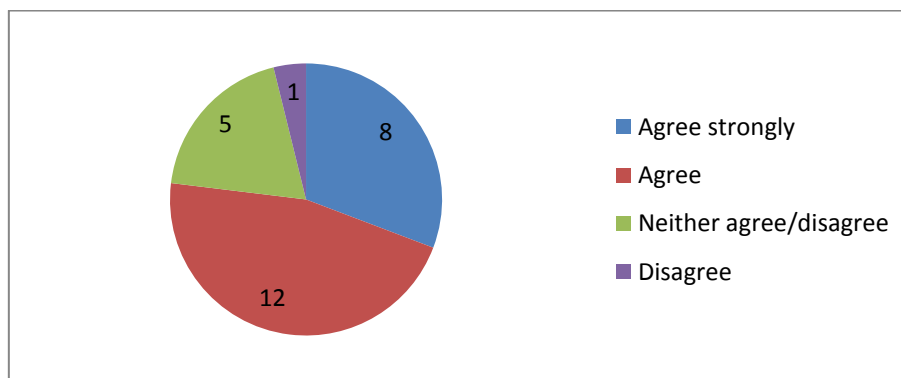
Neither agree/disagree

> *How can a messaging service be personal?* (Male, 45-54 years old, Other, Third Sector)
>
> *I don't think I would need this.* (Female, 55-64 years old, Other, NHS)

Disagree/disagree strongly – no comments

6.3 Apps

Table 18 - 'Apps' to support people with mental illness are a good idea

Agree strongly

Some fantastic award winning apps out there already being used. (Female, 45-54 years old, Nurse, NHS)

This offers some responsibility to client- this is a positive step- its accessible if developed well, can be done anytime and can be shared or kept private. (Female, 45-54 years old, Manager, Third Sector)

Agree

Previous experience of clients describing benefits of panic/anxiety apps as helpful when in social situations. (Female, 65 years or older, Other, NHS)

Neither agree/disagree

Depends what they are. (Gender missing, 35-44 years old, Other, Local Authority)

Agree - for people who are comfortable using digital technology and have personal access to it. However this is not the situation for many of the people I work with. (Female, 45-54 years old, Other, Third Sector)
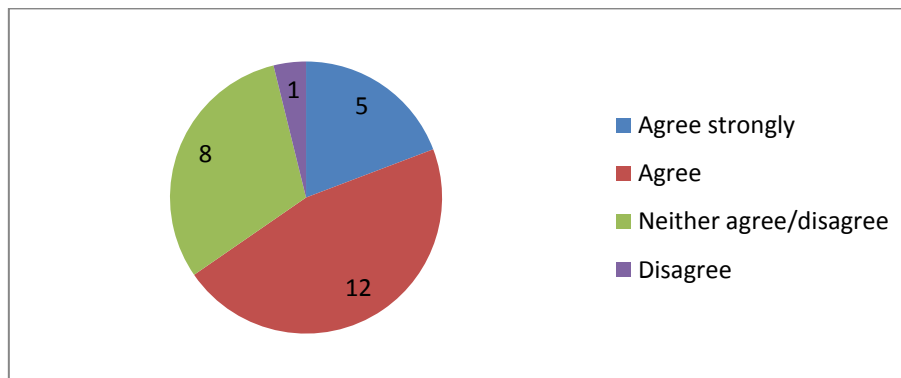
I am not familiar with apps that are available for mental health. (Male, age missing, Psychiatrist, NHS)

Disagree

Most APPS lose their impact within six months of use and are very expensive to develop. (Male, 45-54 years old, Other, University Education)

Disagree strongly – no comments

Table 19 - I am happy to recommend mental health support Apps to my patients

Agree strongly

> *Already do this.* (Female, 45-54 years old, Nurse, NHS)

> *This would depend on the patient but particularly in cases of mild to moderate issues or those with long term problems who have a degree of self-responsibility and a focus on recovery.* (Female, 45-54 years old, Manager, Third Sector)

Agree – no comments

Neither agree/disagree

> *I don't think I would need this.* (Female, 55-64 years old, Other, Therapeutic Writing Practitioner, NHS)

> *I do not know of any. However, if I was aware of some good ones, I would not hesitate to recommend their use.* (Male, age missing, Psychiatrist, NHS)

Disagree/disagree strongly – no comments

Table 20 - Given the right level of guidance I would be happy to prescribe mental health support Apps to patients
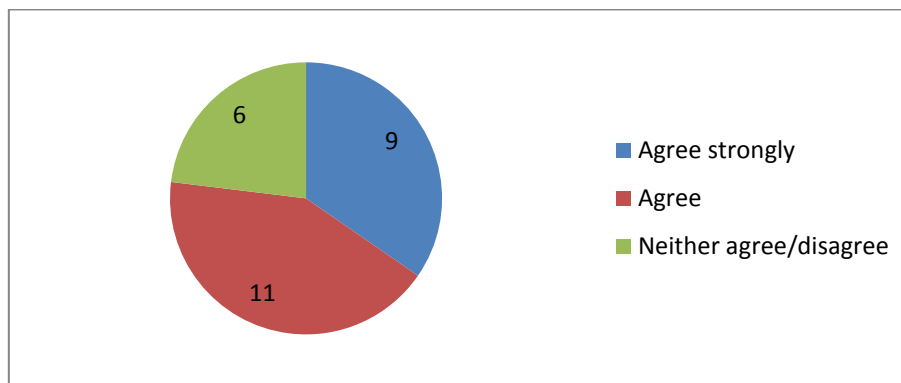
Agree strongly

> *They are already freely available to people. It would be useful to help patients by suggesting helpful and appropriate apps they may wish to look at.* (Female, 45-54 years old, Nurse, NHS)

> *I direct patients to use the internet already.* (Female, 55-64 years old, Psychiatrist, NHS)

Agree

> *Depends on the patients' needs.* (Male, 45-54 years old, Head of Academic Dept. University Education)
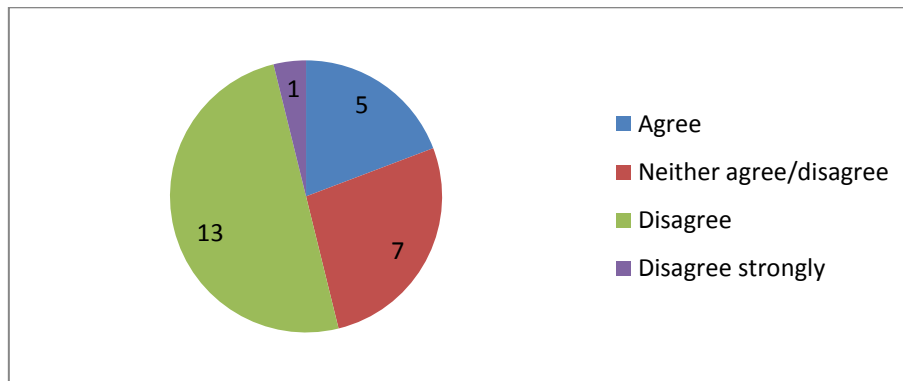
> *Agree - where it was right for the patient and they felt comfortable with that option.* (Female, 45-54 years old, Other, Third Sector)

Neither agree/disagree

This would not be appropriate for my role. (Female, 55-64 years old, Other, Therapeutic Writing Practitioner, NHS)

Disagree/disagree strongly – no comments

Table 21 - I have concerns about using Apps to support patients

Agree strongly – no comments

Agree

Agree - I would have concern about apps being used to support patients unless this was their choice. In my experience, for most patients they are a useful addition to personal support from a mental health professional, but do not and could not currently take the place of that support. (Female, 45-54 years old, Other, Third Sector)

Neither agree/disagree – no comments

Disagree

*Already out there and available. (*Female, 45-54 years old, Nurse, NHS)

As long as they are quality controlled. (Male, 35-44 years old, Psychiatrist, NHS)

I don't have concerns if APPS have approval- there are some very unprofessional ones so direction and guidance would be needed. Also this cannot be seen as a replacement for contact but must be as an addition to. (Female, 45-54 years old, Manager, Third Sector)

Disagree strongly – no comments