



Staying Connected

Decision Making Tools,
Learning and Case Studies

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Remote Working work stream

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The Quality Centre is how we work with staff, patients, and carers, alongside colleagues at Kings College London and Kings Health Partners, to drive improvement, innovation and value-based commissioning in mental health care. All our work is underpinned by the principles of collaboration, inclusion, shared learning and the use of data intelligence to achieve our vision of optimising health outcomes for the populations we serve, whilst bringing together our learning for wider benefit.





A consultation should be, wherever possible, remote (either by telephone or video call). This decision, however, should be clinically informed.

We know that there are many advantages and disadvantages associated with remote clinical working. Generally, seeing someone on video is more informative than just speaking to them on the phone. Relying *only* on telephone calls might mean we miss visual cues and so should be avoided if possible, unless phone calls alone are suitable for the type of intervention your team offers. Again generally, there can be information you can pick up only when you are with someone in person that you might miss with video, although we know some people feel more comfortable talking on video from home, rather than in one of our team bases wearing a mask. **Individual preferences and needs can change** over time, so what's right to use can change. Most importantly, **there are no hard and fast rules** and you need to **use clinical judgement about what is best for your patient, and when.**

Please read the **Staying Connected guidance** to help thinking and get more information about remote working.

What do we do now?

- Continue to offer remote consultations where possible (refer to decision tool)
- Offer service users the choice where possible (including those on waiting lists)
- Caseloads to be assessed to ensure individuals service users' care plan documents how often they should be seen remotely, how often face to face and in what circumstances
- For individual service users and caseloads, document in care plan using supervision and/ or zoning review meetings what these mean for an individual
- Ensure consistency across services and teams by using the new Staying Connected dashboard (<https://app.powerbi.com/groups/me/apps/c40f6878-253a-425e-b7c5-d3f6a61c1f0f/reports/14647fbd-69c7-4df9-83db-829d393d6fbe/ReportSectionab4f2ee10d738513a0ed?ctid=a1cfe44a-682e-4a95-8e72-d03b9b5887aa>)
- Use appendix 1 for further advice around Psychological Interventions using remote access

Clinical Consultations Decision Tool

Choosing between Remote, In Person and Blended Consultations

Summary

- Choosing remote vs in person contact requires a risk/benefit analysis.
- Maintaining contact is the priority. **Dropping contact for non clinical reasons is not acceptable.**
- Each option has different risks/benefits and contributes to the clinical picture in unique ways. One approach does not work for all situations, people and tasks and so clinical judgment is required.

To aid in making team decisions, we have prepared a tool to guide decision making.

All disciplines and staff should:

- In discussion with their MDTs
- **And** for each clinical task/ intervention (individual and group)
- In zoning, referrals meeting and supervision

Use this tool as an asset to help consider carefully what option is most appropriate.

Further considerations.

In addition to the considerations built into the tool, we ask you to also consider:

Learning and Teaching Needs

SLAM is a trust that is very much invested in teaching new generations of mental health professionals, as well as the CPD of our workforce.

Students **will not** be able to learn the full range of clinical skills from remote consultations only. Within the risk/benefit analysis, please consider the learning needs of each student and professional.

Disability and Accessibility Needs

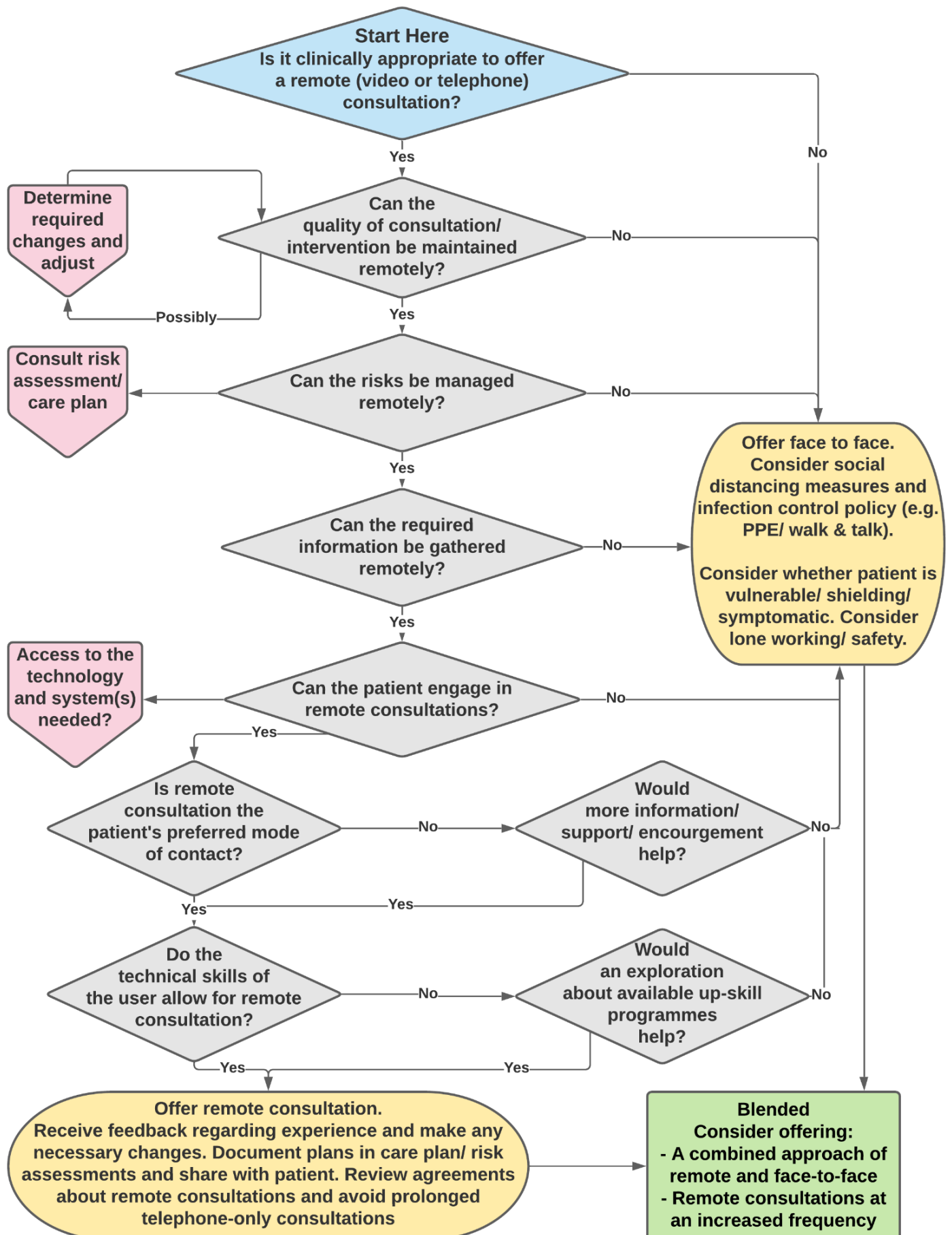
Consider the impact of disabilities, especially in the context of covid19. These include but are not limited to hearing and visual needs, as well as (for example) possible autism related needs.

This must be assessed for. Accessibility assessments are found on the Core Info Section of ePJS

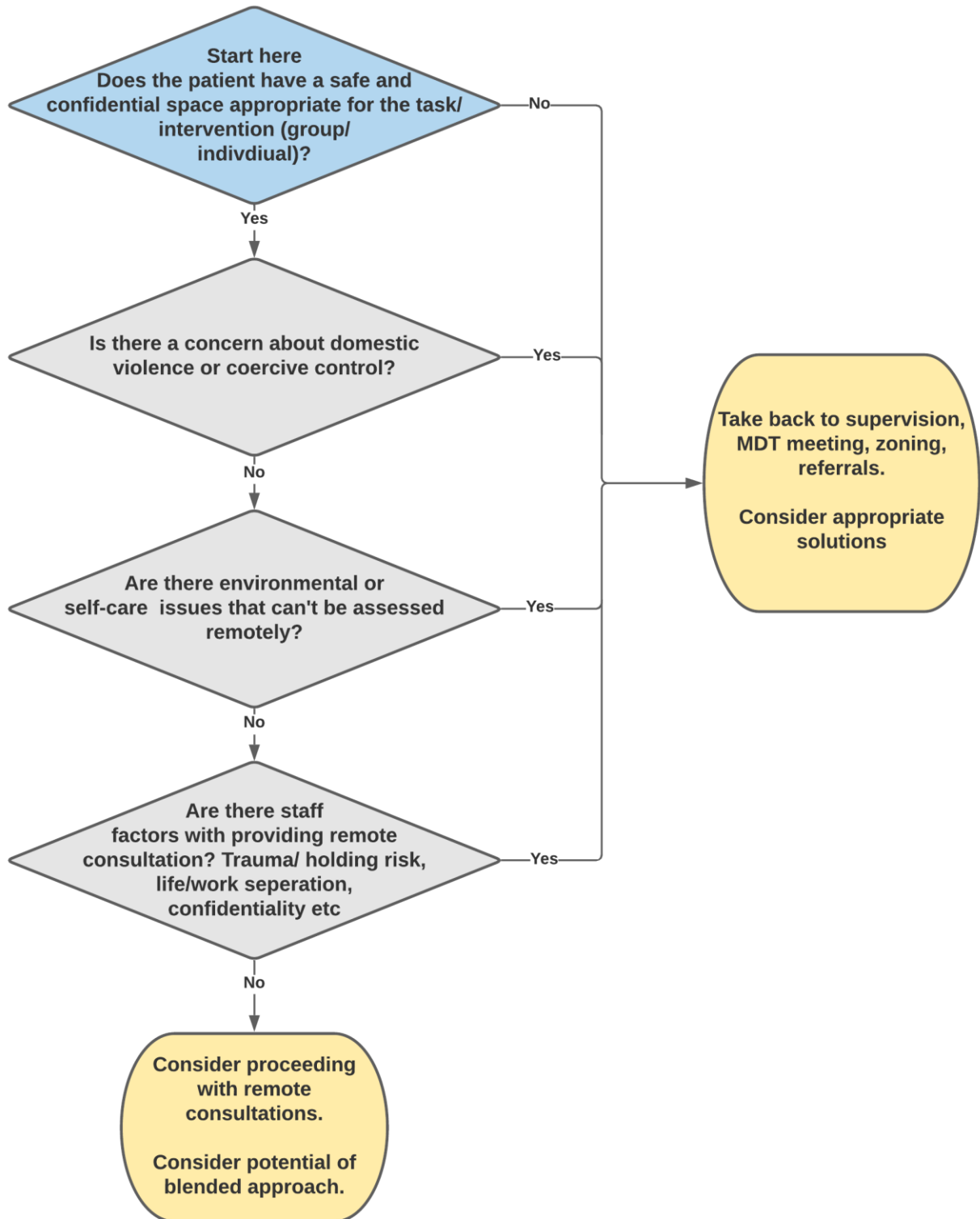
Staff Wellbeing

There may be important reasons for which staff may not feel able to work from home. Staff may not feel able to discuss these reasons in detail. Please see the return to workplace decision tool.

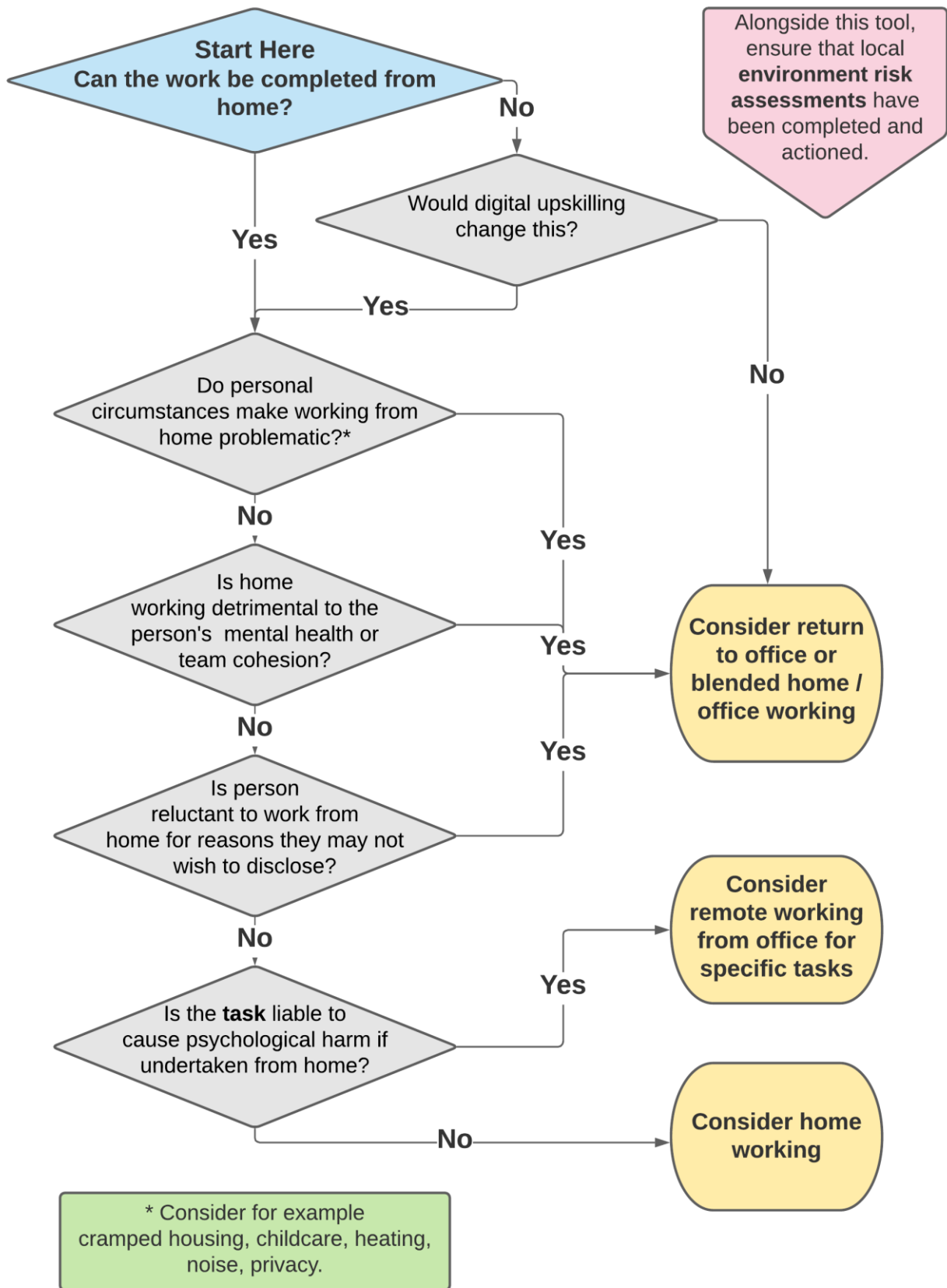
Decision Tool: Remote / In Person / Blended Consultations



Decision Tool: Risk Assessment for Remote Consultations



Decision Tool: Return to Office / Remote Working



Learning from projects across the Trust

A number of local and organisation surveys have been completed to better understand staff, service users and carers views and experience of remote working

From a **trust wide survey**, where over 500 people (staff, carers and service users) responded, the results showed that people have had variable experiences of working virtually, with associated advantages and disadvantages. The analysis also identified five key contributors to successful virtual working which generated ideas of change, namely: access to equipment/ hardware, technological support, guidance for virtual working, choice in contact type and having the adequate environment.

From the **Psychological Interventions Clinic for outpatients with Psychosis (PICuP)**, service users are likely relatively well compared to other psychosis services within SLAM.

Only 76% of service users have access to the internet. Of these, less than 60% have access to the gold standard (a large screen device with fast enough internet for video and access to a private space) for accessing remote therapy. 1/3 of PICuP's service users do not have a private space for therapy.

To provide effective therapy service users need a choice:

- To do remote therapy:
 - To be provided with, and trained in, the use of technology that will enable the gold standard for remote therapy.
 - OR
 - To have access to safe private space with the technology to do therapy over video link.
- To be offered Face to Face. In a way that is safe for the service user and staff member.

The **Sun Project** is offered to people who struggle to safely manage their emotions. Members universally feel isolated, unable to cope are often live situations where they are not safe, the idea of not running the group was not an option.

Attendance on the Saturday morning group was the least attended so it was temporarily stopped. The week before the official lockdown members of the Sun Project were prepared for working online. For members who could not master the IT they were called into the group by phone so they could be heard but not seen.

Positives	Difficulties
Continuing to feel connected and supported when world is crazy and lack of support from other services	Poor connection/ wifi problems
Not having to travel both better for anxiety and cost	Confusing to get online
Able to join from anywhere	Prefer face to face so you can pick up on emotional cues
When there are difficulties between members it feels safer online	Hate seeing face on camera – it is distracting
Being able to turn the camera off	Socialising in the tea break is missed
Able to search/access information to help members quicker	
Easier to talk online	
Don't have the hurdle of getting dressed and out by 10 am for Friday group	

Case studies and examples

On the subsequent pages, case studies have been provided which will provide some information on how services have adjusted their ways of working to meet the demands of their clients. The case studies have been provided from:

- PicUp service
- Community Psychosis services (psychology)
- IPTT
- CAMHS Community borough service
- Adult Community service
- National Adult ADHD and ASD Psychology Service
- ADHD Transforming care in Autism
- MHL D social connection group
- MHL D initial assessment
- Older Adults
- Carer peer support group (Southwark)
- Recovery College
- Staff Support



PICuP Team

Methods used: phone, video, face to face, in vivo exposure sessions, home visits.

Details changed for confidentiality.

Amanda was being treated for PTSD before the covid-19 pandemic. The pandemic meant that sessions had to move to phone. Following the death of a friend from covid-19, Amanda disengaged altogether for several weeks, with command hallucinations (voices) telling her not to engage. Contact was continued via family members.

Re-engagement was possible by phone, Amanda said that she did not want video contact. Amanda then said that the voices were interfering over the phone and she requested face to face therapy. Both Amanda and the therapist felt that face to face sessions were more productive, even with masks. Amanda felt that eye contact was important to help manage the voices. In these sessions, with Amanda feeling safer, the therapist introduced video work for when face to face was not possible. This enabled therapy to continue even when Amanda went to abroad to see a sick relative. Video work also enabled something akin to eye contact, and the therapist could see when Amanda was distracted or dissociating. Finally, exposure therapy (to the site of the index trauma) included work done via Google Street View and this moved to in person work at the site of the trauma.

No one delivery method was perfect for this therapy, flexibility was key in providing a good therapy experience that included the essential treatment components.

Community psychosis services (psychology)

Methods used: Walk and talk

The lockdown disrupted many regular clinical appointments, including the meetings Alfonso was having with his psychologist. Despite multiple admissions to hospital in the past, he had never before received this kind of help. Progress was initially slow but by March they had just started to touch on the painful loss of a family member. The psychologist believed this issue was key to resolving several other difficulties he faced. Rather than miss the opportunity to talk about it, his psychologist arranged to see him outdoors during lockdown. She cycled from her home to his, they met at the front door, and walked to a nearby park maintaining 2m distance. Walking and talking proved itself to be a useful way to continue a conversation about bereavement, in the context of the loss of other kinds of support at this time. He expressed his appreciation of the extra effort that was made to sustain a relationship that could so easily have been lost, restoring some of his faith in services.

IPTT

Methods used: video and video call with no camera

Couple therapy

Couple initially seen face to face, referred client (PS) is trans (prefers pronoun 'they') and has a diagnosis of EUPD, attends with husband for couple therapy. Goal of therapy – to reduce conflict in relationship. Initially PS said they preferred to see people face to face, although husband (who spends more time online generally) was comfortable with online work. However, after a couple of online sessions, PS reviewed this and said it worked well – they did not have the stress of travelling to the clinic. The therapist and clients also noted that PS was able to speak more openly about their vulnerability than in face to face sessions, and the couple generally appeared more relaxed in their own environment, and more able to speak freely.

Family therapy

Mother (with diagnosis of EUPD, A&L client) and 14year old daughter seen virtually with care coordinator from A&L and family therapist from IPTT, for help with conflict in mother-daughter relationship. Goals – to improve communication, reduce conflict and facilitate daughter in speaking about difficult experiences in the past. Mother said her daughter would never have come to a physical clinic, and although daughter remained off camera for sessions, she spoke and engaged well. They made good progress in their relationship after just 3 sessions. Therapist needed to be more active in these online sessions, to engage mother and daughter, and at times needed to check that daughter still present. As not able to see daughter's non-verbal responses, had to rely on mother for information about this.

CAMHS (community borough services)

Methods used: video and face to face

Johnny, a young person with Autism and ADHD, is 14 years old. He takes medication and has reviews with us in the clinic regularly. He is often brought by his mother to the clinic – who has a lot of really useful information about how he has been doing in school. During lockdown, a few issues came up – access to medication, face to face consultations, physical health checks and anxiety around his schooling.

We used Teams, which was by now widely available in the Trust, to establish a connection with Johnny and his mother individually. It meant we could see them in different 'windows', and we were able to have a private conversation with Johnny's mother with his permission. He was much more engaged with the conversation and he described more clearly the effects of medication on him. We were able to agree a regime that suited his timetable at home. I was pleased to hear how differently he was able to engage with us around his difficulties as well as things he was doing well at.

His mother was worried about access to medication as they struggled to get hold of their GP, we were able to reach an agreement around providing longer prescriptions to minimise potential breaks in medication (2 months instead of 1).

Finally, we were able to get some agreement around how to get physical health checks (mainly blood pressure, weight and height measurements) from equipment he had at home. We offered an in-person appointment when our clinical placement put in place sufficient measures (PPE for staff and patients, a room set up which was big enough to socially distance). This offer was especially helpful when his behaviour escalated and it was possible for us to discuss with his parent's possible solutions and make an agreement.

Adult community services

Methods used: video, telephone and face to face

HTT – a mix across the boroughs, some team reduced face to face, some have continued but at home visits, and many a mixed with alternate days.

Many teams have reverted to a task oriented way of planning, where people meet in the morning and decide what contacts and 25% staff on site and staff remotely are taking more of a role in administrative tasks e.g. KPIs and telephone calls.

Generally, PRTs 50% people are seen face to face, primarily in the office and home visits for people who are most vulnerable or concerned to go out.

Approach depending on the clinical need, staff involved and intervention. One person may attend for a face to face meeting for their intervention e.g. depot medication, and stay for less than 30 minutes, have a follow up on the telephone by his care coordinator to follow up on their progress and consultant arranged a CPA with a video call to include the person's team members and support network in their care plan review. Patients can attend the team base and meet with a member of their care team, e.g. care coordinator and consultant, and then bring other people "into the room".

MHLD social connection group

Methods used: video and telephone

Mindapples is a group that regularly met on Monday afternoons at the Maudsley hospital meeting room. The group consists of Estia staff and people with learning disabilities who had lived experiences of mental illness and living in the local community. In these meetings, we shared life events and experiences, learnt things as well as socialise.

After the lockdown, we reshaped these meetings to run on a virtual platform using zoom. This enabled people who couldn't come the group before to join but it was and remain a problem for those who do not have an appropriate device or internet access.

Prior to Lockdown, there were 6 people attending the hearing voices group for people with learning disabilities. During lockdown we started meeting on MS Teams; however 3 people were digitally excluded and could no longer attend the group and we offered 1:1 contact by phone instead. The other 3 people could all access the group as they resided in supported living homes; however the online format meant they needed additional staff support whereas they would normally be able to access the group unsupported. The remaining 3 people were thankful that the group still met online, but found it harder to engage and missed meeting in person. We would also normally use objects and art materials as communication aids within the group, which was not possible online.

Older Adults

Methods used: telephone and face to face

An 82 year old man was referred to the older adult CMHT by St Thomas's liaison team after admission following a fall and found to be lithium toxic. He was also treated for heart failure. He has a history of bipolar affective disorder and had been stable on lithium for many years. His lithium was stopped due to the toxicity and the CMHT were asked to review him.

An assessment was conducted over the telephone as the service user had no mobile phone and no internet. He reported that his mood was stable since coming home, but that he would like to restart his lithium as to maintain his stability longer term. As he is hard of hearing he stated that talking on the telephone was very difficult and requested a home visit (he agreed to social distancing and IPC measures).

On seeing the service user at home, it was evident they needed more support. He had been taking his medication incorrectly, likely contributing to his recent toxicity and worsening heart failure. His legs were very oedematous from the heart failure and were impeding his mobility and increasing his falls risk.

As a result of the assessment an urgent referral to social services was made and we liaised with his GP and hospital at home team about his physical condition.

Whilst there have been cases where virtual consultations have been possible, this case highlights that in particular telephone only consultations not well known to services, can miss many of the issues, especially for isolated individuals.

Carer peer support group (Southwark)

Methods used: video

Remote work stream

28/10/2020

From April, we have run an online carers peer support group for family & carers of Southwark inpatients. As social distancing measures saw our face to face group suspended, plus with increasing stresses and pressures carers encountered due to covid-19, the group aimed to be a regular point of contact where carers could connect and offload.

The group is co-facilitated by a carer employed by the Involvement Register & the carer lead for Southwark inpatients. Having this carer lived experience at the centre of the group's production helps create a space where carers are confident to share their experiences. We start with a group agreement, then have check in and check out sections at the start and end respectively. Otherwise the majority of each session is led by the carers themselves, as they bring the subjects and themes that we discuss each week.

Recovery College

Methods used: video

The Recovery College stopped all face to face teaching just before the official lockdown and staff began working from home on coproduction of Covid-19 relevant course materials. We recognised that there would be a shift in the needs of the students currently enrolled and there would likely be a mental health impact of the pandemic where education could play a support role. The Mental Health First Aid England programmes have been delivered for the first time and at no cost to students using MHFA's online portal during the pandemic alongside a range of new wellbeing topics.

The first online webinars were sent 'live' on 21st April. 872 individuals have participated across the live online sessions with a further 93 registering for access to the 'Webinar Rewinds' library of recordings within one week of that being made available on Sept 13th. 218 online sessions have been taught over 22 weeks, with morning and afternoon weekday sessions. 20,573 individual registrations for online sessions (av. 94.37 registered participants per session). Students have signed up for an average of 24.38 sessions each. Further research is required to determine the participation numbers for each session by looking at the webinar recording data to compare to the enrolment data. We believe that some of the students are registering and watching the sessions in their own time when they receive the recording

Staff Support – Mindfulness for All (M4ALL)

Methods used: video

At the beginning of the pandemic a group of mindfulness teachers from SLAM and KCH came together to consider what they might offer as support for staff during the pandemic. They decided to offer daily mindfulness practices via Microsoft Teams

which staff might access before starting work at 8.30am, or might view as recordings at a later date. The aim of these sessions has been to give viewers the opportunity to follow guided mindfulness practices in real time and to hear mindfulness teachers discuss how mindfulness and other self-care approaches could help them cope with the challenge of working through Covid 19. Sessions have covered different themes such as understanding the landscape of emotions, coping with health worries, living with uncertainty, and finding compassion for self and others. Many mindfulness practices are available online, but M4ALL aims to be current and topical so that the discussion has freshness: this particularly spoke to people at the beginning of the pandemic.

Some viewers have valued being able to have a half hour of settling before work, while others have enjoyed watching the recordings. Those who have already had some experience of meditation have remarked that the sessions have helped them get back into practice and deepened their understanding. People who have not previously experienced meditation have perhaps valued the stress management/relaxation element of the programme.

Appendix 1: Psychological interventions using remote access

Aim:

To continue to offer 1-1 psychological assessment and therapies using appropriate technological means available.

Psychology & Psychotherapy (P&P) offer during the Covid-19 crisis

- Support at a time of high anxiety, particularly when unwell and / or self-isolating / shielding
- Containment of anxiety and frustration during a time of national crisis, 'lockdown' and reduced access to the community
- Support for dealing with loss or bereavement
- Support for separation from family at this time, when they may be ill/vulnerable
- On-going assessment and intervention as far as possible while largely working remotely
- Support for progress towards mental health recovery

A. Routine 1:1 psychological therapy / intervention sessions

1. The default option during the crisis is contact by telephone or video call. Before offering this, consider whether any developmental, emotional or financial factors for the service user might affect their ability to engage with and make use of sessions provided. For example,
 - How important is it to be able to see each other's reactions? How important will be to be able to communicate sensitive information, e.g. in trauma work? Is the session likely to cause anxiety or distress?
 - Are there any barriers to full participation, e.g. equipment, data allowance, skills/abilities? The BACP does not recommend working with younger children (under 10s) via video.
 - Are there any specific issues such as domestic abuse, disabilities or cognitive impairment or where an intermediary or interpreter is required?
2. Psychological therapists should seek to limit any disadvantages these factors may create in access to services. There will be times when the risk of not delivering therapy, or delivering sub-optimal therapy, outweighs the risks of having face to face sessions. When face to face sessions are needed, it can be made safer using social distance and/or PPE.
3. It is helpful to begin with a pre-therapy telephone conversation that acknowledges the current restrictions, offers an opportunity to think about whether a telephone or video call is preferable and considers how the person might access a video link, e.g. computer, laptop or smartphone. Discuss the person's privacy and help them to consider which room they would like to be in for remote appointments. For example, are there other people around and/or can they be overheard. If others are around at home, agree on what you will do if they are disturbed. Also, should video technology fail during the session, agree what you will do, e.g.

- attempt to reconnect or continue by telephone. For people with social or communication difficulties, it may be helpful to summarise what is agreed as a written pre-therapy contract about the set-up of future phone or video calls.
4. Service users should be made aware by phone or in writing by the therapist of the time of the first appointment in advance. Therapists may need to warn people that if using a phone, the number may appear as a withheld number (use 141 to withhold caller ID on a landline).
 5. It is the therapist's responsibility to ensure that if they are working from home, that their communications with service users and colleagues remain confidential at all times. Remind the service user that neither party should use the record function without consent of the other (see SLaM Multimedia policy).
 6. If using video, the background should be free from confidential information and distractions. Beware of the glare from bright objects in your background or that of the service user. Try to orientate yourself so you do not have a window behind you, otherwise the other person will only see a silhouette in the camera. Make sure your own face is adequately lit and consider using a headset/earbuds to maximise the sound quality of your voice. This will enhance what is known as 'telepresence' which is associated with a strong therapeutic relationship. If necessary, MS Teams offers the option of using a virtual, i.e. anonymous, backdrop.
 7. In ward settings, liaison with ward staff is needed to receive a pre-session handover, agree a procedure for summoning assistance, and facilitate patient access to a device.
 8. In community settings, establish where the service user is at the start of your session in case you need to support them by summoning help, e.g. if they share an intention to self-harm and then terminate the call.
 9. When starting video therapy for the first time, spend the first few minutes ensuring the other person is comfortable with the link, and that everything is working.
 10. During the session, attend to the therapeutic relationship and consider with the person and in supervision how the online delivery of sessions is impacting on this. For example, sessions might be shorter, and therapists should reflect in supervision about whether this is having an impact on effectiveness. Video working might offer a more mutual and transparent process, affecting the balance of power in the therapeutic relationship which will need discussion.
 11. Before and during the session, consider whether you might e-mail or use screen-sharing options to share resources and information. This is particularly important to consider if you are a therapist who tends to draw out ideas during a face-to-face session.
 12. Apps can add value to the work of psychological therapists provided they are safe and secure, allow confidentiality to be maintained and data protected. A range of apps meeting these standards is available from the NHS Apps library.
 13. Social media use has increased significantly during the pandemic. Mental health benefits include providing a sense of belonging, decreasing loneliness, and increasing social connectedness. However, social media use can also increase feelings of inadequacy through social comparison, anxiety

associated with fear of missing out, and negatively affect personal relationships as well as pose risks of spending too much time online, promote physical inactivity, and have adverse impacts for sleep and productivity.

Psychological therapists should consider how their clients use social media and advise accordingly on healthy and safe use.

14. If there are any risk or vulnerability concerns, the therapist should document these and liaise with multi-disciplinary colleagues, as appropriate. Service users should be asked if they have appropriate crisis information e.g. how to contact out of hours services. Where domestic abuse is known or suspected, it is helpful to agree a code-word for use when the patient is unable to talk.
15. ePJS notes should be written by the therapist after the session, noting the method by which the session was conducted.
16. It is important to maintain regular supervision, particularly if this is a new way of working. You may need to set up more regular and longer supervision to deal with the added aspect of remote working and its challenges.
17. Working alone can feel isolating. Be sure to schedule breaks, especially after working with distress. Ensure you have time for lunch, social interaction, and short periods of rest. Use virtual means to remain in contact with team members and for support.

B. New assessments

1. New assessments can be done using telephone or video calls, however with some service users it may prove difficult without an initial face to face meeting. For example, if the person has some learning difficulties, is an older person or is prone to paranoid thoughts, which might affect practical engagement or the therapeutic relationship. None of these factors should be a reason to exclude someone from the opportunity for having their session remotely, but the relative risks and benefits will need to be considered carefully. Reasonable adjustments should be made to enable all to engage in this as far as possible, recognising that it will not be possible for all.
2. Some forms of assessment, such as cognitive or neuropsychological assessment, are particularly difficult to conduct remotely. Careful consideration on a case-by-case basis must be given as to whether it is necessary to proceed in order to address urgent need e.g. to investigate a suspected deteriorating condition, risk to self or others, or placement breakdown. Some telephone screening tools are available, e.g. the Telephone Interview of Cognitive State. Published studies indicate that remote administration of some neuropsychological tests can produce reliable and valid results, though the evidence is limited (see Division of Neuropsychology, April 2020).

C. Group or family sessions

1. It is possible to conduct groups and family sessions remotely using video calls, but it can be more challenging to manage, particularly when participants present with risk issues or lack privacy. However, an advantage is that family

members who are not based locally can be included. Consider how participants and their environments may impact on each other in your planning for the session. It is generally easier to move an established group/family therapy onto a virtual platform than to start a new group using this medium.

2. If for safety reasons it is important for you to be able to see all participants, i.e. their reactions to the therapist and other participants during the group, this will affect the size of the group when using MS Teams, or require you to use a different platform (see Information Governance bullet guide, April 2020).
3. Depending on the platform, when setting up group sessions the email addresses of participants may become visible to each other. Service users can be advised to set up a new and dedicated email address for the purpose of the group.
4. At the beginning of each session it is likely to be important to agree ground rules, taking into account the same factors related to privacy and confidentiality as for individual sessions. In addition, it may be necessary for the therapists to agree a secondary method for contacting individual group or family members if someone unexpectedly terminates the call before the end of the session.
5. The therapist may need to conduct the session in a more active way than usual, making explicit who might talk next and setting parameters for who can talk for how long. In Teams try introducing the 'raise your hand' facility to support turn taking. You may also need to ask more questions in lieu of being able to 'feel' what is going on in the room.
6. For family sessions, there may be times when it works best for family members to each have their own device so that everyone can see everyone else's faces. A reflecting team can join and sit with microphone and camera muted while the family talk with the lead therapist. Then, the reflecting team can talk while the family are muted and listening.

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May 2020

Remote work stream

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