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# Understanding and Accommodating Patient and Staff Choice When Implementing Video Consultations in Mental Health Services

Jon Painter, PhD, James Turner, PhD, Paula M. Procter, MSc

During the COVID-19 pandemic, some mental healthcare in the United Kingdom has moved online, with more likely to follow. The current evidence base for video consultations is modest; hence, this study seeks to aid decision-makers by reporting on one large National Health Service mental health trust's video-consultation pilot project. Patients' choices/preferences were gathered via online forms; and staff's views, through a focus group. The typical patient was female, 26 years old, living in a deprived locality. Consultations typically lasted 37 minutes, saving patients 0–30 minutes of travel and £0–£3.00. Satisfaction was high, and the software was intuitive. Audio quality varied, but patients felt able to disclose “as if in person,” were willing to use video consultation again, and found them more preferable than home visits and clinic attendance. Staff could foresee benefits but were concerned for their therapeutic relationships and were avoidant without familiarization, training, clinical coaching, and managerial reassurances especially regarding high-risk patients/situations. They argued video consultation would not suit all patients and should be used according to individual need. We found COVID-19 is necessitating staff to adopt video consultation and that patients are satisfied. However, unless staff's concerns are resolved, enabling them to use their full repertoire of interpersonal skills, therapeutic relationships will trump efficiency and video consultations may not remain their treatment modality of choice.

**KEY WORDS:** Mental health, Online, Psychiatry, Telehealth, Video consultations

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Telehealth is an umbrella term that encapsulates the delivery of healthcare interventions via a range of mediums from traditional phone calls to video calls.<sup>1</sup> The current COVID-19 pandemic has dramatically increased its use,<sup>2</sup> and although telehealth purports to reduce costs while improving access to services,<sup>3,4</sup> setup costs can be significant. As a result, many healthcare providers are spending significant amounts of money on implementation with only a relatively modest evidence base<sup>5</sup> upon which to base their decisions.

Mental health services have been using these technologies for some time to deliver clinical interventions.<sup>4,6,7</sup> However, although there have been positive reports,<sup>5,8,9</sup> reservations have also been expressed about its suitability for this patient group.<sup>6</sup> These concerns include a potential detrimental impact on the development of therapeutic relationships<sup>10</sup> as well as staff's inexperience of delivering telehealth interventions and even the technology itself.<sup>11</sup>

There seems, therefore, to be some dissonance between the empirical evidence and the perception of those required to use these technologies. This position has been described by some as ambiguous.<sup>5</sup> However, from the telehealth literature published in 2020, it is clear that COVID-19 has dramatically changed staff and patients' perceptions (and use) of online clinical consultations.<sup>12</sup>

For staff, never has the old adage “needs must” been more relevant. Many have had little choice, but to overcome their reservations as the alternative would be to withdraw their support completely. However, for patients, the choice is starkly different in that they are not bound by a duty of care. Instead, they can elect to disengage from services or may be forced to do so for practical reasons.

As the impacts and restrictions of COVID-19 wax and wane, mental health services are forecast to face a significantly increased demand that they will struggle to meet.<sup>13</sup> It is then crucial that any efficiencies gained from the “COVID-enforced” use of telehealth are maintained, consolidated, and developed,<sup>2</sup> rather than services incrementally regressing to more traditional delivery styles.

Whereas staff's behaviors can be managed to some extent, patients are immune to such influences. Also, reductions in quality, which may be tolerated in the short term, cannot be justified as a new norm. Thus, it is important to understand

which patients are perceived to be most suited to telehealth and which are most likely to find it acceptable. In this way, staff will know which patients can be supported by current technologies and which ones will require the technology to advance before their needs will be adequately met.

Commissioning new technologies in the National Health Service requires significant time, effort, and finance. The current evidence base upon which to base such decisions is somewhat embryonic,<sup>4,12</sup> as the majority of evaluative literature is purely anecdotal and/or qualitative.<sup>10</sup> Therefore, the aim of this paper is to present the early findings of a pre-COVID-19 study that quantified the experiences and preferences of a small group of patients and staff in a large (National Health Service) mental health and disability trust, in order to assist decision-makers in other mental health services with their current investment dilemmas.

## METHOD

### Participants

In preparation for a wider rollout, staff from four community mental health services in a large National Health Service mental health and disability trust in the North East of England were asked to trial a newly commissioned video-conferencing platform. The teams included a Children and Young People's Service team, an Improving Access to Psychological Therapies team, a Community Mental Health team for working aged adults, and a Care Home Liaison team for older adults. These teams were selected on the basis of the diverse range of patients they collectively worked with and their well-established links with the trust's informatics department. However, the 12 staff who participated were entirely self-selecting, and they were able to choose which patients to offer video calls to. Of the 68 patients these staff deemed potentially suitable, 21 accepted. Ultimately, 13 patients received a total of 19 calls.

### Procedure

Staff volunteers were given 1:1 in-vivo training on the new software by a member of the informatics team, who also provided ongoing support if required. Importantly, other than periodic emails to reiterate the offer of support, staff were not performance managed any differently from usual and there were no expectations placed on them as to when, with whom, or how often they should use the technology.

The configurable, secure, cloud-based video-call application allows patients to join a virtual waiting room without software downloads or log-ins. In addition to basic call features, the solution supports group consultations, transferring callers between virtual waiting rooms, screen sharing, pinning and spotlighting speakers, and multiple screen layouts.

After each consultation, patients were automatically presented with a bespoke set of feedback questions (see

Table 1). These were developed in light of the aims of the project and a review of the available literature. To minimize the burden of completion, their format was primarily a combination of Likert scales<sup>14</sup> and multiple-choice questions. Responses, call details, and basic patient demographics were collated by the trust's informatics department from multiple sources before being securely transferred to the researchers for analysis using SPSS version 24 (IBM Inc, Armonk, NY, USA). All relevant data governance procedures were adhered to throughout.

After a period of 3 months, the 12 staff were invited to discuss their pre-conceptions and early experiences during a 90-minute, semi-structured focus group (eight attended). The semi-structured interview schedule included opening questions and prompts to elicit perceived/encountered benefits, unhelpful aspects, obstacles, observations of the actual software solution, impacts on their therapeutic relationships, and preferences for training and support. Staff were also asked about the types of patient they would and would not offer a video consultation to.

Following transcription, thematic analysis was conducted using Braun and Clarke's<sup>15</sup> six-phase approach. Once fully familiar with the transcript, pertinent comments were highlighted (coded) and copied into a separate Microsoft Excel table. Subsequent coded extracts were placed under an existing column (node) if possible or used to start a new one. This process continued until all salient points had been extracted from the transcript and allocated to a node. Columns (nodes) were then reviewed for coherence, and coded extracts were transferred as necessary. Finally, the optimized nodes were reviewed and combined to create a more parsimonious set of themes outlined below.

In this regard, the project was a mixed-method, naturalistic service evaluation and was approved as such by the trust's research office (SER-19-019-NTW). It was also granted ethical approval by Sheffield Hallam University (ER15924620), which was commissioned by the trust to undertake an independent evaluation of both this trial and its subsequent, wider rollout.

## RESULTS

All 13 patients who received video consultations were from the Children and Young People's Service (n = 7) or Improving Access to Psychological Therapies (n = 6) team. Overall, eight were female, their mean (SD) age was 26 (14.8) years, and all identified as White British. Of the 12 callers with identifiable postcodes, seven resided in the top 20% most deprived areas of England. From the 47 patients who declined video consultations, 29 offered a rationale. Fifteen simply said they preferred in-person contact, eight had no suitable device, and the remaining seven were uninterested/unsure about the technology.

**Table 1.** Coding and Frequencies of Patient Responses Plus Median Ratings

Patient Survey Question/ Statement		Response Options	Response Coding	Frequency	Median Rating
I was satisfied with the overall experience of today's video call.		Strongly disagree	-2	0	2.00
		Disagree	-1	0	
		Unsure/NA	0	0	
		Agree	1	1	
		Strongly agree	2	7	
I would be willing to receive future mental healthcare via a video call.		Strongly disagree	-2	0	2.00
		Disagree	-1	0	
		Unsure/NA	0	1	
		Agree	1	1	
		Strongly agree	2	6	
The technology was easy to use.		Strongly disagree	-2	0	1.50
		Disagree	-1	0	
		Unsure/NA	0	0	
		Agree	1	4	
		Strongly agree	2	4	
The sound quality was good.		Strongly disagree	-2	0	1.00
		Disagree	-1	0	
		Unsure/NA	0	1	
		Agree	1	5	
		Strongly agree	2	2	
The picture quality was good.		Strongly disagree	-2	0	1.00
		Disagree	-1	0	
		Unsure/NA	0	1	
		Agree	1	4	
		Strongly agree	2	3	
I felt able to share information the same as is if the clinician was in the room with me.		Strongly disagree	-2	0	1.50
		Disagree	-1	0	
		Unsure/NA	0	2	
		Agree	1	2	
		Strongly agree	2	4	
Based on your recent experience, how would you rank these options for your future contacts?	Video calls	First choice	3	3	2.00
		Second choice	2	4	
		Third choice	1	1	
	Clinic attendance	First choice	3	4	1.00
		Second choice	2	3	
		Third choice	1	1	
	Home visits	First choice	3	2	1.00
		Second choice	2	1	
		Third choice	1	5	

Abbreviation: N/A, not applicable.

The 19 video calls that did take place lasted an average of 37 minutes (SD, 13 minutes). Only one call ended prematurely because of technical problems; however, a further four calls encountered some degree of audio difficulty.

**Patient Feedback**

For 12 of the calls, patients provided information about the time and financial savings compared with attending clinic appointments (typically by private transport). Seven calls

reportedly saved 0–30 minutes, and three saved 31–60 minutes. Financially, eight of these journeys would have cost £0–£3.00 and two saved £3.01–6.00. The remaining two calls achieved no savings. Eight of the callers also answered the seven choice/satisfaction questions on the feedback screen (see Table 1). Responses were universally positive (median ratings, all ≥ 1.0 on scales ranging from -2 to +2), and video consultations proved more popular than both outpatient appointments and home visits.

**Staff Feedback**

Eight staff (representing all teams involved in the pilot) discussed their pre-conceptions, early experiences, and preferences in the focus group. From this, a number of themes emerged, which are discussed in the following sections.

*Cultural Shift*

The magnitude of the cultural shift that video consultations represented for patients was stressed throughout the discussion: "It's just the culture of it, is not it? It's just that people just do not like it." In particular, staff believed older patients would be very reluctant: "We are dealing with people who have cognitive impairment, ...who are certainly not technically savvy...we will not even do telephone treatment."

For the staff themselves, there was a recognition that they lagged behind in the use of this type of technology and that, initially, even telephone triage had been "a big culture shift and I think this is another one." One participant felt that "a culture in the trust where we were familiar with [video calling] and used it, it would have helped to take off with the online [patient] consultations." One suggestion was to encourage staff to use video calls for non-patient activities first (such as supervision and team meetings) "to create that culture that might allow it to filter down." In this way, staff's first patient video consultations would be less anxiety provoking.

*Patient Suitability*

Staff were concerned about practicalities for some patients: "I cannot hear what people are saying, cannot hear on the headphones...and so if any of them [patients] are deaf..." They worried that many of their patients "do not even have laptops, let alone Wi-Fi and things" like sufficient data allowances.

They were also keen to "identify the key groups that it would be beneficial for" as they felt video consultations would never be suitable for some patients, for example, those with paranoia or even just a "suspicion of technology as a whole." They did, however, feel online treatment might actually be better for some, for example, those with caring responsibilities: "A lady with very severe post-natal depression; she'd canceled her appointment. So [staff] just rang her and said; can I Skype you? And she did, and that put the clinician at ease because she saw the patient, plus the patient gave her a tour of her house and showed her the new baby on the screen" and explain that she had canceled "because the boiler's broke down, and she was waiting on the central heating [engineer]."

*Risk*

As well as the example above where video consultation had formed part of an individual patient's risk assessment, a more general risk-related observation was that "you are less often in people's houses and therefore you are at less physical risk."

Interestingly however, staff felt conflicted about video consultations with patients known to be volatile because they also felt the need to see high-risk patients face-to-face to be sufficiently confident in their assessments: "I want to see the environment that they are living in...because a huge part of our risk assessment is people's home environment." In essence, there was a concern that "it's just another piece of clinical judgment for us to get wrong or be held accountable for."

*Therapeutic Relationships*

Therapeutic relationships were universally seen as the basis for effective care/treatment. Concerns were expressed that video consultations might make it harder to establish a rapport: "I think you get something face-to-face that you are not going to get on a screen." More specifically, staff were concerned about missing non-verbal cues when relationships were in their infancy: "You are looking at someone's body language, and you might not be able to get that on a screen." That said, staff were prepared "to try it, to kind of see" because "some staff...use it fine with certain patients and they have used it for all their sessions." As alluded to earlier, being able to choose which patients to video call was again seen as imperative: "I think maybe...it's about knowing relationships...your sort of patients and what you would use it for...maybe once that relationship is developed and you have built that trust."

Some staff envisaged gradually replacing in-person contacts with video calls (to reduce dependency on services), but others were concerned that this could be "hard for the patient to accept...because they want to just come back to see you" and feared it could lead to feelings of abandonment and damaged therapeutic relationships. Instead, they preferred to use video calls from the outset arguing that, "if that's all you have ever had, then why would you [expect anything] different?"

*Preference to Retain Some Face-to-Face Contacts*

Overall, staff felt strongly that they should retain the option to see patients face-to-face according to their clinical judgment. In addition to the arguments outlined above, the software's functionality was deemed insufficient by some therapists "because often we'll give a patient a copy of that [handout or formulation diagram] in the room, or we'll take a photo of it." "You want the choice to be able to present documents...what you are drawing on your boards and your pictorial things...to present them at the same time so the patient sees them and you are able to talk through." There were other very practical concerns such as the need to monitor physical health: "We pick up on a lot of stuff that we'll refer to the GP; they might have, you know, oedema in their legs or things like that." and "We cannot check people's medication." Finally, the essence of nursing was alluded to, that is, "with older persons...the tactile approach sometimes works enormously



with engagement...A gentle hand on somebody's arm...you just could not get that on a screen.”

### *Training, Technical, and Administrative Support*

Initial and ongoing face-to-face training were highly valued: “IT have been really supportive of, you know, spending a lot of time, you know, with individual training for staff, especially in the early stages where ‘if you mention the word online training people go grr!’ and...they are still helpful now. You can still ring up...and they'll find the space to give them training.” Support and encouragement from a more confident clinical colleague were also seen as necessary to overcome clinical (rather than purely technical) issues/anxieties.

Dedicated “admin was quite key” to ensuring appointments were scheduled promptly and that patients received clear instructions regarding accessing online appointments because “if someone is picking it up that is not familiar with it, then it might end up being missed or it might not be done properly.” Administrators were also needed to accommodate short-notice, ad hoc calls because “clinicians'...diaries are so compact, they have to plan, sort of in advance...it's having that slick support there and then when you need it.”

For some, regardless of the support on offer, implementation had unhelpfully coincided with the introduction of voice recognition dictation software: “...this thing that came around about using headsets and you would talk to the headset and the laptop would type it for you. It was an incredibly frustrating process because the words it would come out with were, it was just a nightmare.” In general, staff preferred one change at a time.

### *Time and Financial Savings*

Savings for individual staff were anticipated, “If you are doing it over Skype then you do not need that joint visit or travel,” as were organizational savings (hiring consulting rooms). Patient savings were also envisaged, for example, a university student who, rather than “taking the time out to come to the appointment here, it was easier for her just to book a room in the library and Skype from there.” Participants therefore felt “did not attend” rates would also improve as they “might not be able to do the full therapy session but at least they can check out, like, the risk, say for example.”

It was posited that briefer, more frequent consultations might shorten overall treatment durations, for example, by improving motivation with homework tasks as staff could “check in to see how they are getting on with that, ...it might not be like a full hour, it might just be 15 to 20 minutes just to kind of see how they are getting on with that experiment, and that encourages them to keep doing it.” Additionally, some staff felt video consultations had helped them to structure their sessions better as there was less “social chit chat...if it's just psychological when you go into the sessions, you

know, it's a bit like when I do the Skype supervisions...although you cover the same things,” it takes less time. Another participant felt having the clock on-screen made it easier to keep to time and say, for example, “I'm very sorry, we are going to have to leave this 'til next time, because I've got another call scheduled.” There was, however, some concern that the conversations with staff may be “the only social interaction that person gets, and if we formalize our interactions with patients all of the time, particularly just thinking about the older person, though not exclusively...,” they lose out.

## **DISCUSSION**

The introduction of video consultations into routine mental healthcare is fraught with a wide range of complexities, as encapsulated by Greenhalgh et al<sup>16</sup> in their non-adoption/abandonment framework. The findings from this pilot are of course tentative and will be reviewed against those obtained from the full rollout. However, despite the modest scale of the project to date, it has yielded results that have already been helpful to the trust in understanding the slow uptake of video consultations by staff. In light of COVID-19 and the relative scantness of the existing evidence base surrounding video consultations in psychiatric services, it is hoped they are also of interest to other mental healthcare providers.

The age range of patients who chose video consultations over face-to-face contact was skewed towards youth, but this was almost certainly exacerbated by the team type. There was a higher proportion of females, fitting with the notion that video consultations may be preferable for those with caring responsibilities. Additionally, a significant number of callers resided in areas of high deprivation. This was contrary to staff's predictions; many of whom feared a lack of suitable smart device, data allowance, and/or Wi-Fi would preclude the less well-off. Overall patient satisfaction was high, and almost all were willing to receive further video calls, finding the software easy to use. The least satisfactory aspect was the audio quality, but patients still felt able to share information as if face-to-face, making video consultations more popular than home visits and clinic attendance.

Numerous variables have been shown to affect employees' uptake of technology, and our findings certainly chimed with several well-accepted explanatory models.<sup>16,17</sup> Although staff could logically foresee benefits, the prospect of video consultations represented a significant and anxiety-provoking cultural shift that required a variety of technical, administrative, clinical, and managerial support to overcome. Tangible suggestions included “in vivo” software training; a familiarization period using non-patient video calls; coaching from a confident clinical user; and managerial reassurance that their learning curve would be recognized and supported (especially with high-risk patients and/or situations<sup>18</sup>).

Regardless of these support strategies, staff were keen to retain the choice to see patients face-to-face according to clinical need. They stressed that, for some patients and situations, video calls would never be the right choice, typically citing an unjustifiable threat to their therapeutic relationships. In many ways, the following comment sums up the pre-pandemic focus group's dilemma: "I can certainly see the benefits, maybe if I worked with a different client group...," that is, staff's heads would say yes but their hearts would say no. This perhaps explains the project's faltering first steps as Carradice and Round<sup>19</sup> argue that practice change in mental health services requires both hearts and minds to be won.

CONCLUSION

COVID-19 has reportedly been the catalyst for some previously inconceivable practice changes.<sup>12</sup> It will inevitably mean these focus group participants have overcome their anxieties<sup>17</sup> to become regular video callers, and early findings suggest their patients will be satisfied. However, unless staff's initial concerns have been fully resolved, as and when the cost-benefit balance<sup>17</sup> returns to its pre-pandemic position, so will they.<sup>20,21</sup> This study suggests mental health staff value therapeutic relationships over efficiency and that, unless they feel able to use their full repertoire of interpersonal skills, video consultations are unlikely to become/remain their treatment modality of choice.

References

1. Hau Y, Kim J, Hur J, Chang M. How about actively using telemedicine during the COVID-19 pandemic? *Journal of Medical Systems*. 2020;44: 108. <https://dx.doi.org/10.1007%2Fs10916-020-01580-z>
2. Zhou X, Snoswell C, Harding L, et al. The role of telehealth in reducing the mental health burden of COVID19. *Telemedicine and e-Health*. 2020;26(4): 377–379. <https://doi.org/10.1089/tmj.2020.0068>
3. Shore JH. Telepsychiatry: videoconferencing in the delivery of psychiatric care. *The American Journal of Psychiatry*. 2013;170(3): 256–262. <https://doi.org/10.1176/appi.ajp.2012.12081064>
4. Spencer T, Noyes E, Biederman J. Telemedicine in the management of ADHD: literature review of telemedicine in ADHD. *Journal of Attention Disorders*. 2020;24(1): 3–9. <https://doi.org/10.1177%2F1087054719859081>
5. Armfeld N, Bradfords M, Bradford N. The clinical use of skype—for which patients, with which problems and in which settings? A snapshot review of the literature. *International Journal of Medical Informatics*. 2020;84: 737–742. <https://doi.org/10.1016/j.ijmedinf.2015.06.006>
6. Basit S, Mathews N, Kunik M. Telemedicine interventions for medication adherence in mental illness: a systematic review. *General Hospital Psychiatry*. 2020;62: 28–36. <https://doi.org/10.1016/j.genhosppsych.2019.11.004>

7. Costanzo MC, Arcidiacono C, Rodolico A, Panebianco M, Aguglia E, Signorelli MS. Diagnostic and interventional implications of telemedicine in Alzheimer's disease and mild cognitive impairment: a literature review. *International Journal of Geriatric Psychiatry*. 2020;35: 12–28. <https://doi.org/10.1002/gps.5219>
8. Kruse CS, Lee K, Watson JB, Lobo LG, Stoppelmoor AG, Oyibo SE. Measures of effectiveness, efficiency, and quality of telemedicine in the management of alcohol abuse, addiction, and rehabilitation: systematic review. *Journal of Medical Internet Research*. 2020;22(1): e13252. <https://doi.org/10.2196/13252>
9. Lichstein K, Scoggin F, Thomas J, DiNapoli E, Dillon H, McFadden A. Telehealth cognitive behavior therapy for co-occurring insomnia and depression symptoms in older adults. *Journal of Clinical Psychology*. 2013; 69(10): 1056–1065. <https://doi.org/10.1002/jclp.22030>
10. Torous J, Wykes T. Opportunities from the coronavirus disease 2019 pandemic for transforming psychiatric care with telehealth. *Journal of American Medical Association of Psychiatry (Online)*. 2020;77: 1205–1206. <https://doi.org/10.1001/jamapsychiatry.2020.1640>
11. Hilty D, Chan S, Torous J, Luo J, Boland R. A framework for competencies for the use of mobile technologies in psychiatry and medicine: scoping review. *JMIR MHealth and Uhealth*. 2020;8(2): e12229. <https://doi.org/10.2196/12229>
12. Bloem BR, Dorsey ER, Okun MS. The coronavirus disease 2019 crisis as catalyst for telemedicine for chronic neurological disorders. *JAMA Neurology*. 2020;77: 927–928. <https://doi.org/10.1001/jamaneurol.2020.1452>
13. Serafini G, Parmigiani B, Amerio A, Aguglia A, Sher L, Amore M. The psychological impact of COVID-19 on the mental health in the general population. *QJM: An International Journal of Medicine*. 2020;113: 531–537. [doi:https://doi.org/10.1093/qjmed/hcaa201](https://doi.org/10.1093/qjmed/hcaa201).
14. Likert R. A technique for the measurement of attitudes. *Archives of Psychology*. 1932;140: 1–55. <https://dx.doi.org/10.4135/9781412961288.n454>
15. Braun V, Clarke V. Using thematic analysis in psychology. *Qualitative Research in Psychology*. 2006;3(2): 77–101. <https://doi.org/10.1191/1478088706qp063oa>
16. Greenhalgh T, Wherton J, Papoutsi C, et al. Beyond adoption: a new framework for theorizing and evaluating nonadoption, abandonment, and challenges to the scale-up, spread, and sustainability of health and care technologies. *Journal of Medical Internet Research*. 2017;19(11): e367. [doi:10.2196/jmir.8775](https://doi.org/10.2196/jmir.8775).
17. Venkatesh V, Bala H. Technology acceptance model 3 and a research agenda on interventions. *Decision Sciences*. 2008;39: 273–315. <https://doi.org/10.1111/j.1540-5915.2008.00192.x>
18. Luxton DD, O'Brien K, Pruitt LD, Johnson K, Kramer G. *Suicide risk management during clinical telepractice*. *The International Journal of Psychiatry in Medicine*. 2014;48(1): 19–31. <https://doi.org/10.2190%2FPM.48.1.c>
19. Carradice A, Round D. The reality of practice development for nurses working in an inpatient service for people with severe and enduring mental health problems. *Journal of Psychiatric and Mental Health Nursing*. 2004;11(6): 731–737. <https://doi.org/10.1111/j.1365-2850.2004.00773.x>
20. Lewin KC. *Field Theory in Social Science*. New York, NY: Harper & Row; 1951. <https://doi.org/10.1177%2F000271625127600135>
21. Standing C, Standing S, McDermott M, Gururajan R, Kiani Mavi R. *The paradoxes of telehealth: a review of the literature 2000-2015*. *Systems Research and Behavioural Science*. 2016;35: 90–101. <https://doi.org/10.1002/sres.2442>