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Patient and provider perspectives of the implementation of remote consultations for community-dwelling people with mental health conditions: A systematic mixed studies review

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ABSTRACT

Remote, or tele-, consultations became a necessary form of mental healthcare provision during the COVID-19 pandemic. As the prevalence of mental health problems rises, they may have a role in future mental health services. We aimed to review the literature on patient and provider perspectives on factors influencing the implementation of remote consultations for community-dwelling people with mental health conditions. We searched five electronic databases (PubMed, EMBASE, Web of Science, CINAHL, and PsycINFO) for empirical research up to July 13th, 2022. Only studies of synchronous, interactive remote consultations conducted via video, phone, or live-messaging between patients and providers were included. Two reviewers independently assessed the quality of included studies using the Mixed Methods Appraisal Tool. We integrated qualitative and quantitative data from 39 studies into a single mixed-methods synthesis. We mapped reported factors to the domains of the Consolidated Framework for Implementation Research (CFIR). Acceptability was generally high among participants, despite concerns about the quality of care and the perceived impeded therapeutic relationship. A prominent facilitator was the increased accessibility and convenience of remote consultations, while lack of appropriate infrastructure and low patient comfort and competence were among the most prevalent barriers. This review highlights the importance of patient preferences and provider buy-in to the future of remote consultations.

1. Introduction

Use of telemental health, the provision of mental healthcare at a distance (Clarke and Yarborough, 2013), has grown slowly over the past two decades (Muir et al., 2020), until a rapid adoption of remote care during the COVID-19 pandemic allowed for the continuation of essential mental health services for community-dwelling patients. Telemental health is a broad term encompassing modalities such as email, online group therapy, video consultations, tele-monitoring, and SMS messaging (Alhajri et al., 2021). In particular, phone and video consultations became widespread during the pandemic (Car et al., 2020), where organisations and providers rapidly moved to provide an alternative to in-person care for people largely confined to their homes and neighbourhoods. Hence, the focus of this review are these remote consultations between mental health providers and community-dwelling patients.

Systematic reviews and meta-analyses have demonstrated that tele-mental health services are comparable to in-person care in terms of clinical effectiveness (Bashshur et al., 2016; Batastini et al., 2021), including for patients with depression (Guaiana et al., 2020),
pandemic was limited (Sheridan Rains et al., 2021). Reasons for its slow uptake included technical difficulties, reimbursement and licensure issues, provider reluctance, and privacy concerns (Chen et al., 2020; Cowan et al., 2019; Douglas et al., 2017). Many of these studies were conducted in large, academic hospitals in outpatient settings. During the pandemic, the transformation to remote care occurred across the entire mental health care landscape, from small primary care practices (Frank et al., 2021), to individual psychotherapists (Cantone et al., 2021), and large community mental health authorities (Kopec et al., 2020). This widespread move to remote care shed light on some novel, and previously-documented, challenges of telemental health implementation across a variety of settings.

For community-dwelling patients with mental health conditions, the adoption of telemental health was appreciated, allowing for the continuity of care (Madigan et al., 2021; Nicholas et al., 2021; Sugarman et al., 2021), and has potential to alleviate disparities in mental health provision beyond the pandemic (Bunnell et al., 2020; Husain et al., 2021; Qian et al., 2021). Moreover, recent literature has indicated an increase in mental health problems arising from the pandemic, which will place an increased pressure on already overburdened mental health services (Moreno et al., 2020). This increase in demand, coupled with patient and clinician expressions of interest in its future use (Gentry et al., 2021), has pointed to a need to explore the potential use of remote consultations for patients in the community.

Hence, to ensure the safe and sustained use of remote consultations, a systematic exploration of factors affecting its adoption has been identified as imperative (Stein et al., 2022). While previous reviews have attempted to examine telemental health implementation factors (Cowan et al., 2019), the rapid and increased use of remote consultations raises new questions about the sustainability of such services. Moreover, less is known about the implementation of mental health care provision when remote care is necessary, or in some cases, mandatory. Identifying the barriers and facilitators to sustained and satisfactory implementation is essential, in order to direct resources and infrastructure to improve the use of remote consultations and their outcomes (Alhajri et al., 2021). Moreover, to gain a comprehensive and relevant understanding of these factors, the perspectives of both mental health providers and patients were explored.

The primary objective of this review was to identify patients' and providers' perspectives of the factors influencing the implementation of remote consultations for patients with mental health conditions in the community. The secondary objectives was to map these factors to the domains of the Consolidated Framework for Implementation Research (CFIR).

2. Materials and methods

2.1. Design

A mixed methods systematic review was conducted following the Joanna Briggs Institute (JBI) approach to mixed methods systematic reviews (Stern et al., 2020) and the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) 2020 guidelines (See Supplementary material) (Page et al., 2021). A protocol was registered on the PROSPERO register of systematic reviews (Registration number: CRD42021273422) and published online (Galvin et al., 2021). Changes to the protocol are summarised in the Supplementary material.

The Consolidated Framework for Implementation Research (CFIR) (Damschroder et al., 2009) was chosen to classify the identified factors. This is a comprehensive framework comprising of constructs within five domains that are considered to be important determinants of implementing research into practice (Damschroder et al., 2009). This framework was chosen as it allows for the categorization of various implementation factors across diverse settings and enables the comparison of findings across studies and reviews (Damschroder et al., 2009). Previous telehealth reviews have demonstrated the utility of the CFIR to structure findings and inform recommendations for the implementation of such modalities (Dovigi et al., 2020), however a theoretically-informed understanding of the factors affecting the implementation of remote consultations for community-dwelling people with mental health conditions is missing.

2.2. Search strategy and selection criteria

A systematic literature search was undertaken of the following electronic databases: PubMed, EMBASE, Web of Science, CINAHL and PsycINFO. The search was comprised of terms relating to the main concepts of “mental health,” “telemental health,” “implementation” and “community setting”, and was guided by search strategies from reviews of telemental implementation (Barnett et al., 2021; Dovigi et al., 2020). Relevant MeSH terms and keywords were used and the search syntax was adapted to suit each database. An information specialist librarian was consulted to develop the final search strategy. The search was limited to articles published in English. We also searched references of all included studies alongside forward citation searching.

Studies were searched from January 2016 to July 2022. This time period was chosen to include relevant studies published prior to the pandemic. Due to this unique period of rapid implementation, it is considered valuable to draw on both experiences during the pandemic and the body of research conducted pre-pandemic (Barnett et al., 2021). In addition to including studies conducted during the pandemic when remote consultation were considered necessary, the inclusion of studies in a recent time period prior to this helped to understand the findings that are unique to the pandemic. Whilst research on telemental health extends beyond this time period, a scoping search prior to the review revealed that there is considerably less research on the implementation of remote patient-provider consultations; those that mirror the form of remote care that was swiftly adopted during the pandemic. The full search strategies for all databases can be found in the Supplementary material.

Remote consultations were defined as live, synchronous, individual consultations between a patient and a health care provider using phone, video, or live messaging modalities. We defined “providers” as individual health care professionals who provide mental health care to patients via remote consultations. To be eligible for inclusion, studies had to meet the following criteria: a) original research using quantitative and/or qualitative methods, b) include patients with mental health conditions, patients under the care of a mental health provider, or mental healthcare providers who work with patients with mental health conditions, c) published in English, d) published in a peer-reviewed journal, e) include data relating to the implementation of remote consultations, f) be conducted in community, primary care, or outpatient settings, g) include the perspectives of healthcare providers, patients, and/or caregivers/parents.

Articles with a primary focus on group, families, or couples consultations were excluded as the unique concerns and complexities relating to these were outside the scope of this review (Wrape and McGinn, 2019). While it was plausible that providers in some studies conducted group therapies as part of their practice, data was extracted relating to individual consultations where possible. We included studies that examined the perspectives of caregivers and/or parents, as these consultations involve the care of the individual patient only. Studies only exploring anticipated or hypothetical views were excluded. Grey literature, including commentaries and conference abstracts, were excluded,
due to the lack of peer-review within these studies.

2.3. Data screening and extraction

Titles and abstracts of studies identified through the search strategy were imported into a reference manager (EndNote X9) and duplicate records were removed. The first author (EG) and a second author (JH) independently reviewed the titles and abstracts for eligibility. Remaining articles were screened independently by two authors (EG & JH) by reading the full texts, with any discrepancies resolved through discussion. A standardised data extraction spreadsheet was created in Microsoft Excel and piloted on three studies. Extracted data included study title, author(s), publication year, country, study design, methods, instruments, dates of data collection, setting, consultation type, and sample characteristics. Data relating to implementation were extracted from the results sections of all studies, including reported barriers and facilitators. Data extraction was conducted by one author (EG) and was cross-checked by a second author (JH), to ensure data accuracy.

2.4. Data synthesis

In line with the JBI convergent integrated approach (Stern et al., 2020), after data extraction, quantitative data was “qualitised”, or transformed to textual descriptions, to allow for integration with the qualitative studies. The findings of both quantitative and qualitative were considered sufficiently similar to warrant an integrated method of synthesis (Sandelowski, 2000). Thematic synthesis, following the guidance of Thomas and Harden (2008) was conducted by the first author (EG) and involved three steps. Firstly, the extracted data, qualitative and transformed quantitative, from the results sections of the studies were coded line-by-line. Secondly, the codes were organised into descriptive themes, and finally, analytical themes were developed. The final themes were discussed and refined by the review team. The final thematic synthesis was presented narratively. The extracted data, qualitative and transformed quantitative, were then coded to the constructs and domains of the CFIR by the first author (EG), and presented in a tabular format.

2.5. Quality appraisal

The Mixed Methods Appraisal Tool (MMAT) was used to critically appraise all included studies (Hong et al., 2018). MMAT is a validated tool for appraisal of all study designs. Two reviewers (EG & JH) independently appraised all of the studies. Any disagreements were resolved.

Fig. 1. PRISMA flow diagram showing the selection of studies for a systematic review and meta-analysis, 2020 (Adapted from Page et al. (2021)).
by consensus. An assessment of confidence in the cumulative findings using the GRADE or ConQual approach was not conducted as per current recommendations for mixed methods systematic reviews using the integrated approach (Stern et al., 2020). Instead, themes were checked by re-reading the studies to ensure that they accurately represented the findings.

3. Results

3.1. Identification of selected studies

Up to July 13th 2022, we identified a total of 5962 articles from five electronic databases. After duplicates were removed, 4076 articles remained. Following title and abstract screening, 82 articles were screened for full-text eligibility. Of these articles, 31 full-text articles fulfilled the eligibility criteria. Backward and forward citation tracking was conducted on these articles and seven additional articles were identified. One additional study was identified during supplementary searches at the data synthesis stage. In total, 39 studies were included in the final systematic review (See Fig. 1).

3.2. Description of included studies

The 39 studies identified were published between 2019 and 2022, with 30 (77%) of the studies conducted during the COVID-19 pandemic. Twenty-two studies employed qualitative methods, 16 studies used qualitative methods, and one study used a mixed-methods design. Studies were primarily conducted in the USA (n = 22) and in hospital outpatient settings (n = 22). Remote consultation modality included video (n = 18), phone (n = 1), and both phone and video (n = 20). Patient/caregiver perspectives were explored in 15 studies and provider perspectives were explored in 16 studies, with eight studies exploring both perspectives. Detailed study characteristics can be found in the Supplementary material.

3.3. Quality appraisal

The full quality appraisal results using the MMAT can be seen in the Supplementary material. All studies scored “yes” to the two screening questions indicating that the MMAT was appropriate to assess them. Fifteen of the sixteen qualitative studies scored “yes” on the five methodological criteria, with one study scoring “yes” on four out of the five criteria. The mixed-methods study scored “yes” on four of the five criteria. All of the 22 quantitative studies were quantitative descriptive studies. One study scored 1/5, eight studies scored 2/5, seven scored 3/5, five scored 4/5, and one scored 5/5 on the methodological criteria. The most common reasons for low or moderate methodological quality in these studies included uncertainty about whether the samples were representative, low response rates, and lack of information about the validity and reliability of survey instruments.

3.4. Thematic synthesis

The thematic synthesis identified seven themes relating to patient and provider perspectives on the factors that influence the implementation of remote consultations for patients with mental health conditions in the community. These themes are 1) acceptability, 2) quality of care, 3) the therapeutic relationship, 4) accessibility, 5) patient comfort and competence, 6) provider workload and wellbeing, and 7) regulations and reimbursement (See Panel 1).

3.4.1. Acceptability

Across studies, participants reported satisfaction with remote consultations, with some patients and providers reporting that remote consultations were on par with in-person consultations. For studies conducted during the pandemic, there was a sense of appreciation for the continuity of care during this time (Schow et al., 2022), and it was suggested by providers in one study that patient acceptability may stem from this appreciation rather than satisfaction with virtual care itself (Uscher-Pines et al., 2020). Some providers acknowledged their reluctance when remote consultations were initially implemented, but quickly realised the benefits of remote care resulting in a more positive attitude.

During the pandemic, patients expressed gratitude to providers that continued to provide uninterrupted care at this time (Costa et al., 2021). Despite this appreciation of remote consultations, many providers were of the opinion that in-person care was still necessary and that remote consultations cannot replace in-person care (Olwill et al., 2021). In fact, during the pandemic, providers in one study reported that they could still see patients face-to-face if they were concerned for their wellbeing (Ashcroft et al., 2021). Many providers and patients expressed a preference for in-person care (Lockard et al., 2022), acknowledging that remote consultations were not suitable for every patient. Patients and providers across studies endorsed using remote consultations after the pandemic (Frye et al., 2022a), with a hybrid model of remote and in-person care being commonly suggested (Benudis et al., 2022).

3.4.2. Quality of care

Relating to perceptions of quality of care, many providers reported on the limits remote consultations place on their ability to effectively provide care to patients. While some providers reported that they were as effective as delivering care remotely as in-person, many reported that they perceived the quality of care in remote consultations to be inferior to that of in-person care, a view mirrored by patients (Kaigwa et al., 2022). Many providers reported that it was more difficult to assess patients, and their symptoms, remotely, with limited access to non-verbal and visual information on rapport building and the perceived inferior quality of connection.

Despite this appreciation of remote consultations, many providers were quick to realise the benefits of remote care resulting in a more positive attitude. Providers also reported that it was more difficult to do therapeutic or
behavioural work with patients, in some cases because providers did not have access to resources they would use in in-person consultations, such as whiteboards to draw out diagrams with patients. For example, some providers reported that eye movement desensitisation and reprocessing (EMDR) therapy was challenging to conduct remotely (Freske and Malczyk, 2021), with one provider stating that they attempted to teach their patient how to perform this therapy on themselves (Schow et al., 2022). Some providers reported that they would have liked to have received training and education on how to effectively deliver care remotely (Schriger et al., 2022), while others felt confident in their abilities and did not feel there was a need for training (Budhwani et al., 2021). In contrast, phone consultations were acknowledged as an effective and efficient method for some appointments such as medication visits (Budhwani et al., 2021; Wyler et al., 2021) and brief follow-up calls (Christensen et al., 2021).

3.4.3. The therapeutic relationship

An important facet of mental health care is the therapeutic relationship between provider and patient. Providers and patients shared their perceptions on the impact of remote consultations on the therapeutic relationship in multiple studies. Whilst negative views pertaining to the therapeutic relationship were more prevalent, some participants rated the working alliance in remote consultations as similar to that of in-person consultations (Doran and Lawson, 2021; Frye et al., 2022b), with half of providers in another study reporting that they were able to build rapport (Romanchych et al., 2022). Prominently, having less access to non-verbal or visual cues in both phone and video visits was reported as negatively impacting the quality of the interaction (Maher et al., 2022), with both patients and providers reporting the video was more engaging than phone for this reason. Providers reported that it was difficult to build rapport with patients (AlRasheed et al., 2022), particularly with new patients. Participants emphasised the perceived necessity of conducting an initial in-person consultation to build this rapport (Gullslett et al., 2021; Shang et al., 2021) and having an existing relationship (Moeller et al., 2022).

The perceived impersonal nature of remote consultations was cited as a barrier to virtual care for some respondents, which meant that some patients felt less likely to talk about sensitive issues. However, in one study the impersonal nature of remote consultations was cited as a potential benefit, making it easier to talk about certain topics (Frayn et al., 2021). In relation to disclosure, it was noted by one provider that young people may be less likely to talk freely at home (AlRasheed et al., 2022). The anonymity of a phone consultation, over video, was cited as a reason for increased disclosures (Lipschitz et al., 2022).

Finally, the therapeutic relationship was also perceived to be impacted by some patients being more distracted and having difficulty focusing in the virtual interactions. Patients reported being more distracted by interruptions such as notifications on screen and distractions in their home environment (Maher et al., 2022). Children, in particular, were reported as being more distracted and more difficult to engage (Gullslett et al., 2021; Severe et al., 2020; Wyler et al., 2021). Technical issues were also a source of interruption to the therapeutic process (Christensen et al., 2021), with providers noting that the fear of technical problems prevented them from pursuing sensitive topics with patients (Lipschitz et al., 2022). For example, one provider expressed concern that the internet connection would drop in the middle of a vulnerable conservation and they would have to ask a patient to repeat a part of a trauma monologue (Gullslett et al., 2021).

3.4.4. Accessibility

Overwhelmingly, the main facilitator to remote consultations was the increased access to care experienced by patients. This improved access to care was specifically reported as a facilitating factor for patients living far away or those living with mobility issues or long-term conditions. These improvements in accessibility were reported as making it easier to attend appointments. The time-saving benefits of remote consultations were also reported as facilitating factors, primarily in relation to reducing time spent travelling to appointments (Goetter et al., 2022; Moo et al., 2020; Schubert et al., 2019). In addition, patients also reported that remote consultations improved their access to care by removing some of the logistical barriers, including requiring less time off work (Aronowitz et al., 2021), reducing expenses (Das et al., 2020), removing childcare barriers (Lockard et al., 2022), and reducing waiting times (Tuijt et al., 2021). In the context of the COVID-19 pandemic, patients also remarked that remote consultations reduced their likelihood of contracting COVID-19 (Severe et al., 2020). Patients highlighted convenience and flexibility as facilitating factors to their participation in remote consultations, and acknowledged that they were more likely to attend appointments (Frayn et al., 2021; Guinart et al., 2020).

Furthermore, participants reported that remote consultation removed the psychological barriers of stigma (Al-Mahrouqi et al., 2022; Ashcroft et al., 2021) and anxiety (Frayn et al., 2021; Gullslett et al., 2021) that they associated with attending in-person consultations. A provider in one study elaborated that patients find it “less stigmatizing... they don’t have to worry about running into anyone” (Ashcroft et al., 2021). Other providers noted that the move to remote consultations during the pandemic increased the engagement of some patients who previously lacked motivation to attend in-person consultations. From the patient perspective, the reduction of logistical barriers removed some of the stress relating to attending in-person appointments (Frayn et al., 2021), such as rushing in traffic or trying to find parking, making attending remote appointments a more relaxing experience (Seritan et al., 2019). For example, caregivers of patients with dementia reported that they experienced less negative dementia symptoms compared to attending in-person sessions (Gately et al., 2022).

While remote consultations increased access to care for many patients, the presence of barriers to remote consultations was widespread across studies of provider and patient perspectives. Namely, lack of reliable internet or phone connection and lack of technology were the most commonly-reported barriers to accessing and partaking in remote consultations for patients with mental health conditions (Hunsinger et al., 2021). Some patients preferred phone consultations because of their reliability over unstable video calls (Kaigwa et al., 2022). These barriers were particularly prevalent among patients of low socio-economic status who lacked access to software, hardware, and sufficient internet data to successfully participate in remote consultations.

3.4.5. Patient comfort and competence

The fifth theme is patients’ comfort and competence with using remote consultations. Many patients reported finding remote consultations easy to use (Lima et al., 2022) and appreciated the option of choosing between virtual modalities. However, for others, lack of comfort with technology was reported as influencing patients’ decisions to partake or continue with remote consultations. This initial nervousness and apprehension diminished among some patients with use (Christensen et al., 2021). When technical issues persisted, patients with low digital literacy experienced frustration and feelings of incompetence. Some patients, namely older patients, reported relying on others for assistance when these issues occurred. In contrast, providers reported that younger patients, such as adolescents, were comfortable with technology, and were able to exert control over what they chose to display on the consultation. Finally, it was reported by some participants that patients were more relaxed in their own environments and therefore more forthcoming (Guinart et al., 2020; Uscher-Pines et al., 2020), and felt self-empowered participating from their home (Al-Mahrouqi et al., 2022).

Aside from concerns about competence, some participants reported patients’ concerns about privacy, particularly difficulties finding a quiet, private space to conduct the consultation. This is particularly relevant to mental health consultations, where patients reported not feeling as comfortable talking at home compared to at a clinic (Uscher-Pines et al., 2020).
2020). Providers recognised that patients were worried about being 
overheard (Uscher-Pines et al., 2020) and recognised the stigma of
attending a remote mental health appointment compared to a remote
general medical appointment (Budhwani et al., 2021). This issue of
difficulty finding privacy was exacerbated during the pandemic, where
multiple members of the same family or household were at home at the
same time (Budhwani et al., 2021). Furthermore, providers expressed
concern about the potential of an abusive or controlling partner being
in the room during a remote consultation (Gullslett et al., 2021). Patients
reported using phone, over video, in an attempt to heighten their pri-

cacy (Benudis et al., 2022).

3.4.6. Provider workload and wellbeing

The sixth theme is that of the workload and wellbeing changes
involved with the adoption of remote consultations, and the associated
move to remote working during the pandemic. During the pandemic in
particular, many providers reported increases in workload associated
with the transition to remote consultations. Specifically, some providers
reported an increase in the amount of administrative tasks and engaging
in extra work to help patients troubleshoot problems and prepare for
appointments. Feelings of exhaustion were also reported, specifically
from spending an increased amount of time in front of a screen, referred
to as “Zoom fatigue” (Buckman et al., 2021; Romanchych et al., 2022).
Some providers also reported difficulties managing their time and
needing to incorporate more breaks into their working day. On a more
positive note, many providers reported that there were less patient
cancellations and less “no-shows” and that patients were more likely to
be on time (Lipschitz et al., 2022).

Providers also discussed their experiences of working remotely
during the pandemic. Providers endorsed the benefits of working from
home such as not having to book rooms (Buckman et al., 2021), having
more flexibility in their day, and saving time travelling to the office. The
downsides of working from home included missing colleagues and
collegial support (Benudis et al., 2022), invasion of privacy, (Lipschitz
et al., 2022), and not having an adequate space to conduct consultations
from (Schow et al., 2022).

3.4.7. Regulations and reimbursement

The final theme relates to the regulatory factors considered impor-
tant to the future of remote consultations. Many providers, particularly
those working in the USA, expressed gratitude at the relaxation of
practice restrictions on telemental health at the start of the pandemic
(Aronowitz et al., 2021). These regulations were recognised as a barrier
to the pre-pandemic adoption of telemental health. Looking forward to
the future of remote consultations after the pandemic, many providers
expressed hope that these restrictions would remain lifted so they could
continue to practice outside of their jurisdiction (Freske and Malczyn,
2021). However, there was a sense of confusion and apprehension
among providers that these regulations may return when in-person care
resumed following the pandemic (Freske and Malczyn, 2021). Providers
expressed concern that re-instating restrictions could impact patient
care, and considered this to be a step backwards (Schow et al., 2022).
Similarly, providers and patients expressed concern that insurance
companies would not continue to reimburse for remote consultations or
may begin to bill at different rates. Patients in one study were particu-
larly concerned about the high cost of remote consultations within the
private health sector (Al-Mahrouqi et al., 2022). The lack of clarity
surrounding these issues led to a sense of uncertainty about the future of
remote consultations (Aronowitz et al., 2021).

3.5. Consolidated framework for implementation research

Patients’ and providers’ perspectives on implementation factors
aligned closely with four of the five domains of the CFIR, including
intervention characteristics (e.g. increased accessibility), the inner
setting (e.g. lack of necessary resources), the outer setting (e.g. patient
competence), and characteristics of individuals (e.g. provider beliefs
about effectiveness) (See Table 1 for examples). Only one study reported
factors relating to the process domain (Budhwani et al., 2021).

Barriers and facilitators pertaining to the intervention characteristics
domain of the CFIR were among the most commonly reported, particu-
larly relating to the relative advantage construct whereby comparisons
between remote and in-person consultations were frequently made. In
addition, factors relating to the patient needs and resources construct were
the most prevalent in the outer setting domain, emphasising the impor-
tance of patients’ needs and preferences to the implementation of
remote consultations. In the inner setting domain, reported barriers
mainly pertained to the available resources sub-construct of the readiness
for implementation construct, highlighting the lack of necessary re-
sources, such as adequate internet bandwidth, within organisations.
Finally, within the characteristics of individuals domain, participants
frequently reported barriers and facilitators relating to the knowledge
and beliefs about the intervention construct, emphasising the importance
of provider acceptability to the implementation of remote consultations.
Factors pertaining to the process construct of the CFIR were not as
frequently reported, reflecting the lack of planning and evaluation of
services during the pandemic. The presence of the CFIR constructs across
studies can be seen in the Supplementary material.

4. Discussion

4.1. Key findings

This synthesis identified seven themes relating to patients’ and
providers’ perspectives on the factors that influence the implementation
of remote consultations for community-dwelling people with mental
health conditions. Despite high acceptability among participants, a
number of barriers and challenges were reported, namely concerns
about the quality of care and the perceived impact of remote consulta-
tions on the therapeutic relationship. The increased accessibility and
convenience of remote consultations were among its primary facilita-
tors, removing logistical and psychological barriers to help-seeking and
allowing for continuation of care during the COVID-19 pandemic. Other
challenges included technical difficulties, lack of available guidance and
training for providers, and increases to providers’ workload.

Providers and patients endorsed a “hybrid” model of mental health
care going forward, taking into account the suitability of the patient,
consultation type, and patient preferences. However, providers
expressed confusion and concern about the uncertain regulatory envi-
ronment that may limit the use of telemental health beyond the
pandemic. Another potential systemic barrier to remote consultation
adoption and use is the lack of appropriate infrastructure such as un-
reliable phone and internet connections. These barriers, combined with
patients’ limited access to technology and low digital literacy, highlight
a risk of digital exclusion that may disproportionately affect patients of
low socio-economic status.

The reported barriers and facilitators were mapped to the domains of
the CFIR, and related to patient-, provider-, and system-level factors.
Across various contexts and patients, increased access to care was
identified as a prominent facilitator within the CFIR construct relative
advantage, highlighting its importance to the future of remote consul-
tations. In addition, provider knowledge and beliefs about the intervention
were as a facilitator to the implementation of remote consultations,
highlighting the importance of provider buy-in. Finally, the prevalence
of the CFIR construct patient needs and resources emphasised the
importance of considering patients’ preferences and circumstances to
the implementation of remote consultations.

4.2. Comparison with previous literature

The swift and somewhat-haphazard adoption of remote consulta-
tions during the COVID-19 pandemic created unique issues and
Table 1
Barriers and facilitators mapped to the domains of the CFIR.

| CFIR domain/construct | Barrier | Facilitator | Finding |
|-----------------------|---------|-------------|---------|
| **1. Intervention characteristics** |         |             |         |
| Relative advantage | B       |             | More challenging to build a therapeutic relationship |
|                     | B       |             | Increased challenges physically examining patients and taking vitals |
|                     | B       |             | More difficult to assess suicidal risk |
|                     | B       |             | Increase in provider workload and burnout |
|                     | B       |             | Increased challenges assessing and diagnosing patients |
|                     | B       |             | Less access to non-verbal and visual cues than in-person visits |
| Evidence strength and quality | B       |             | Lack of training on effectiveness of remote care |
| Trialability         | F       |             | Experience with pilot helped providers feel prepared for implementation |
| Adaptability         | F       |             | Being able to adjust the duration of the consultation to increase engagement |
| Complexity           | B       |             | Additional effort required to prepare patients |
| Design quality and packaging | F       |             | Remote consultations were uncomplicated |
| Cost                 | B       |             | Technical issues with platforms |
|                      | B       |             | Poor sound and audio quality |
|                      | B       |             | Technology was easy to use |
|                      | B       |             | Technology worked as expected |
|                      | F       |             | Satisfaction with sound and audio quality |
| **2. Outer Setting** |         |             |         |
| Patient needs and resources | B       |             | Patients lacked hardware and software |
| External policy and incentives | B       |             | Concerns about insurance coverage |
|                      | B       |             | Concerns about restrictions remaining lifted beyond the pandemic |
|                      | B       |             | Lack of standards and guidelines for conducting remote care |
|                      | F       |             | Providers appreciated having billing codes |
|                      | F       |             | Providers grateful for lifting of practice restrictions |
|                      | F       |             | Providers appreciated use of non-HIPAA approved platforms |
| **3. Inner setting** |         |             |         |
| Leadership engagement (readiness for implementation) | F       |             | Support from employers was helpful |
| Available resources (readiness for implementation) | B       |             | Lack of therapeutic resources available to providers |
|                      | B       |             | Lack of high speed internet/bandwidth problems within organisation |
| Access to knowledge and information (readiness for implementation) | F       |             | Adequate access to internet and equipment |
|                      | F       |             | Too busy to learn how to deliver remote care well |
| Compatibility (implementation climate) | B       |             | Increased administrative burden |
|                      | B       |             | Increase in scheduling challenges |
|                      | B       |             | Lack of automised documentation system |
|                      | B       |             | Taking longer to prepare patients for remote consultations |
| Relative priority (implementation climate) | F       |             | Remote consultations fitted with workflow |
| Networks & communication | F       |             | Belief that hospital will return to in-person care to recoup facility fee |
| Culture              | F       |             | Provider interest in continuing with remote consultations, even after return to in-person care |
| **4. Characteristics of individuals** |         |             |         |
| Self-efficacy        | B       |             | Reduced confidence in conducting assessments |
| Knowledge and beliefs | B       |             | Beliefs that remote care is not as effective as in-person care |
|                      | B       |             | Belief that remote care is not suitable for some patients |
|                      | B       |             | Belief that virtual care cannot replace in-person care |
|                      | B       |             | Belief that there are increased risk and safety issues |
|                      | F       |             | Belief that video has advantages over phone in relation to building a therapeutic relationship |
|                      | F       |             | Belief that remote care can meet patients’ needs |

(continued on next page)
are key concepts in psychiatry and psychotherapy (Trachsel and Sedlak, 2022). Their modality of care could foster their agency and autonomy, which of remote care may not have been available to patients pre-pandemic. The finding of the perceived impaired therapeutic relationship contrasts with some studies of effectiveness of telemental health (Hubley et al., 2016), while other reviews have recognised this as a potential limitation of telemental health (Connolly et al., 2020; Siegel et al., 2021). Perceptions of this impedited therapeutic relationship warrants further research as it has many ethical implications if not addressed (Frittgen and Haltauferheide, 2022).

4.3. Implications for practice and policy

The perceived utility of remote consultations to improve access to care appears to be a prominent facilitator to the continuation of remote consultations, as reported in other reviews (Barnett et al., 2021). As patients with mental health conditions may have comorbid long-term conditions (Puyat et al., 2017), the accessibility benefit is particularly important. In addition, provider buy-in to telemental health implementation has been reported as an important facilitator in previous reviews (Connolly et al., 2020). As suggested in a previous review (Connolly et al., 2020), providers may be willing to overcome the associated issues if they believe remote care benefits, such as increased accessibility and flexibility, outweigh the barriers. However, for some patients these benefits may not be enough to justify continuing with remote consultations. One such group of patients are those with low competence or comfort with remote consultations. Finally, organisational and system factors, such as concerns about the temporary relaxation of regulations during the pandemic have been documented in the recent telemental health literature (Chen et al., 2020).

4.4. Implications for research

A common narrative across the included studies was a sense of an appreciation of continuity of care during the pandemic, with patients happy to receive any care at all during this time, possibly reflecting short-term and immediate perspectives of remote consultations. Further research in this area could benefit from exploring acceptability in the long-term, when patients have a choice between both modalities, to investigate if these views change over time. The misalignment between high acceptability and perceptions of inferior quality points to a perceived trade-off between the continuation of care and the quality of care that was evident in the studies; patients and providers were willing to sacrifice some of the effectiveness associated with in-person consultations to continue with care in exceptional circumstances. An important question to consider now is will patients and providers be willing to make this trade-off beyond the pandemic? Considering the effectiveness of telemental health is well-established (Batastini et al., 2021), a more promising avenue of research could be the development of a conceptual model of provider acceptance to help further understand the factors that influence provider acceptability of telemental health, including the role of perceived effectiveness as a potential determinant of provider acceptability.

A limitation of the included quantitative studies is that many of them did not report using a validated instrument when measuring patient and provider perspectives. This points to a need to develop a validated survey to explore perspectives of telemental health services. Another gap in the research is the lack of studies that explored cost as a factor in relation to remote consultation implementation. Whilst participants mentioned cost savings in terms of reduced travel, there is a need for evidence on the cost-effectiveness of remote consultations if they are to be used beyond the pandemic. A further area of potential future research is the implementation of telemental health for child and adolescent populations. Conducting research with these populations, and their caregivers, may reveal unique challenges and advantages that have yet to be fully explored. Relatedly, while beyond the scope of this review, research into remote consultations for families and couples may elucidate some of the challenges relating to privacy, trust, and the therapeutic relationship, when multiple individuals are involved.

4.5. Strengths and limitations

This review has many strengths. We conducted a broad, comprehensive search and followed the current best-practice guidance on conducting a mixed methods review (Stern et al., 2020). A strength of this review is the inclusion of patient perspectives, which is considered an essential perspective to understanding mental health care delivery during the pandemic (Ashcroft et al., 2021). Another strength is the use of an implementation framework which aided with the interpretation of findings and allows for comparison with future studies and reviews.
Panel 2
Practical recommendations for the implementation and use of remote consultation for people with mental health conditions in the community.

| Recommendations for organisations |
|----------------------------------|
| Provide continuous training and skills sessions to providers, including training to improve self-efficacy with diagnosing and assessing patients. |
| Provide supports for staff who are burdened or struggling. |
| Obtain regular feedback from providers and patients to improve remote consultations. |
| Provide adequate administrative support and staff, particularly during initial stages of implementation. |
| Provide the necessary software and hardware for staff working remotely. |
| Offer adaptations to patients with hearing or visual impairments. |
| Provide a quiet, private room in GP, local health centre or pharmacy for those living in crowded homes etc. |
| Follow up with those who have refused online care and find out the reason for refusal e.g. low digital literacy, no internet connection. |
| Provide FAQs to patients and staff on common technical problems. |
| Conduct a separate session for preparing patients for remote consultations. |
| Make increased efforts to communicate delayed appointments to patients. |
| Advocate for continued insurance coverage for remote consultations. |
| Develop an automated documentation system whereby paper and electronic notes can be integrated and accessed remotely by all staff involved in a patient’s care. |

| Recommendations for patients |
|------------------------------|
| Adopt a hybrid model of care where possible, taking into account the type of consultation and patients' preferences. |
| Share positive experiences with colleagues to improve buy-in. |
| Schedule breaks and take regular breaks from the screen. |
| Encourage patients to include their full body on screen, and emphasise the importance of this to the patient. |
| Conduct special follow-up with older patients or those experiencing difficulties with remote consultations. |
| Make use of online resources such as online whiteboards for therapeutic work. |
| Offer choice of consultation format to patient and engage patient in decision-making. |
| Utilise phone consultations for certain visits when efficiency is required e.g. medication management visits. |
| Utilise virtual (inspection) physical examination (ViPE) when a physical examination is required. |
| For patients at risk of suicidal thoughts, schedule future appointments to which the patient can look forward. |
| Explain to the patients how the pathway of recovery will be addressed on remote consultations. |
| Test the technology with a colleague before conducting the initial consultation with a patient, to reduce fears and increase efficacy. |
| Be open with the patient about your insecurities with technology, if not confident, to create balance in the relationship. |

| Recommendations for providers |
|------------------------------|
| Develop an automated documentation system whereby paper and electronic notes can be integrated and accessed remotely by all staff involved in a patient’s care. |
| Advocate for continued insurance coverage for remote consultations. |
| Provide supports for staff who are burdened or struggling. |
| Obtain regular feedback from providers and patients to improve remote consultations. |
| Provide adequate administrative support and staff, particularly during initial stages of implementation. |
| Provide the necessary software and hardware for staff working remotely. |
| Offer adaptations to patients with hearing or visual impairments. |
| Provide a quiet, private room in GP, local health centre or pharmacy for those living in crowded homes etc. |
| Follow up with those who have refused online care and find out the reason for refusal e.g. low digital literacy, no internet connection. |
| Provide FAQs to patients and staff on common technical problems. |
| Conduct a separate session for preparing patients for remote consultations. |
| Make increased efforts to communicate delayed appointments to patients. |
| Advocate for continued insurance coverage for remote consultations. |
| Develop an automated documentation system whereby paper and electronic notes can be integrated and accessed remotely by all staff involved in a patient’s care. |

Nevertheless the review has limitations. While an exhaustive search was conducted, it is possible that some studies were missed, considering that the citation tracking revealed a number of additional studies. One possible reason for this is the heterogeneity of terms used to describe remote mental health care and telemedicine, which differ depending on the context in which they are applied (Sood et al., 2007). We acknowledge that by focusing the review on synchronous “remote consultations”, we may limit the generalisability of the findings to the broader area of telemental health, such as asynchronous modalities. Another possible limitation is the exclusion of grey literature. During the pandemic, many brief reports and commentaries were quickly published outlining how organisations adopted remote consultations and it is possible that we may have missed some important perspectives.

As we limited the search to the studies in the English, it is possible that we missed relevant studies, which could be a reason why only three studies were conducted in low- or middle-income countries. This may limit the applicability of findings to these countries and future research of telemental health implementation in low-resource contexts is warranted. In addition, the prominence of studies conducted in hospital outpatient settings may limit the applicability of the findings to smaller organisations. Finally, considering the majority of studies were published during the pandemic, this review is limited in its ability to draw comparisons between pre- and post-pandemic contexts.

5. Conclusion

This review aimed to identify patients’ and providers’ perspectives on the factors that influence the implementation of remote consultations for community-dwelling patients with mental health conditions. While many studies have explored the adoption of telemental services during the pandemic, this review draws together research across various mental health settings and services to provide an overarching view of some of the key considerations to the future of remote consultations. Our findings indicate that the views, preferences, and needs of patients and providers are important factors to the implementation of remote consultations. The review highlights several gaps in the research that need to be addressed, including understanding long-term acceptability and cost-effectiveness, and solutions to lessen digital barriers to access. Potential implications of the findings include taking into account the individual needs and preferences of patients when delivering remote mental health consultations.

Ethical approval and consent to participate

Ethical approval was not required.

Consent for publication

Not applicable.

Availability of data and materials

Not applicable.

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Appendix A. Supplementary data
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