



# **“You and Your Experience of Mental Health Services During COVID-19 Pandemic”**

**(1st August 2020-30th Sept 2020)**



**Share your story, shape our service**



<b>Section</b>	<b>Content</b>	<b>Page</b>
	Acknowledgements	4
	Table of Abbreviations	5
	Project Summary	6
1.0	Introduction	10
2.0	Project Outline	10
3.0	Methodology	11
4.0	Findings & Analysis	14
5.0	Conclusions	43

# ACKNOWLEDGEMENTS

The Public Health Agency and 10,000 More Voices Facilitators would like to express their heartfelt thanks to the many people who submitted a personal experience of Mental Health Services during the first phase of COVID-19 pandemic. We are aware that this may not have been easy; however the valuable contribution of so many has enabled this report to be as comprehensive and rich as it is. Many extracts from the stories and free text questions have been included throughout this report, some of which have been edited to ensure anonymity of respondents. We would also like to thank the Service User Consultants for their invaluable support in promoting and gathering stories. Without their energy and support it would have been impossible to have reached so many in such a short time.

**"During this time it was invaluable to have someone to talk to, who listens, understands and has compassion. I dread to think what may have happened without this support."**



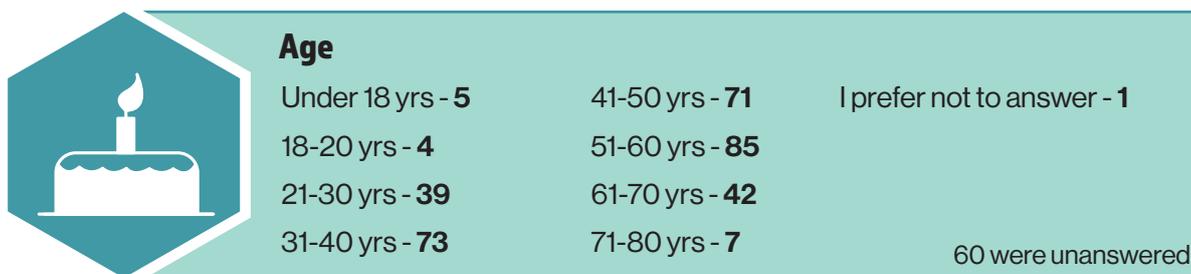
# TABLE OF ABBREVIATIONS

Within the stories shared by service users & carers abbreviations are common. The following table outlines the full title for each abbreviation.

<b>Abbreviation</b>	<b>Title</b>
ASD	Autism Spectrum Disorder
CBT	Cognitive Behavioural Therapy
CPN	Community Psychiatric Nurse
EDYS	Eating Disorders Young Person Service
IPT	Interpersonal Therapy
MH	Mental Health
SW	Social Work

# CONTEXT

Data collection commenced in 1st August 2020 and ended 30th September 2020. In total **387** stories were collected across the region.



# ANALYSIS OF SURVEYS

Key messages and areas of reflection highlighted in this report have been identified using a range of analysis tools, these provide rich insight and understanding into the experience of the people who engaged Mental Health Services during COVID-19 pandemic.



# RESULTS

Summary of the main findings in relation to the key concepts analysed through Sensemaker®.

**1 Approaches to Coping**  
60% of respondents focused upon activities they normally did.

**2 Seeking Help**  
78% of respondents stated that services were available to them during the pandemic.

**3 Partnership Working**  
74% of respondents felt listened to when engaging Mental Health Services.

**4 Changes**  
68% of respondents recognised the need for changes when engaging Mental Health Services, for example telephone consultations.

**5 Treatment by Telephone**  
301 respondents engaged through telephone consultation. 75% of respondents indicated this was a positive and supportive experience. 62% of respondents felt this was an effective method for engagement.

**6 Treatment by Video Conferencing**  
81 respondents engaged through video conferencing. 74% of respondents indicated this was a positive and supportive experience. 74% of respondents felt this was an effective method for engagement.

**7 Treatment by Online Service or app**  
79 respondents engaged through online services or apps. 81% of respondents indicated this was a positive and supportive experience. 68% of respondents felt this was an effective method for engagement.

**8 Contact through Face to Face Appointments**  
196 respondents engaged through face to face appointments. 83% of respondents indicated this was a positive and supportive experience. 88% of respondents felt this was an effective method for engagement.

# KEY MESSAGES

The following is a summary of the findings from the regional data. Each Trust can also review local Trust data to inform further service improvement.

- **Continuity of care:** It is important to stay connected with the practitioners and wider team known to the service user.
- **Sustaining Relationships:** The transition from face to face to a more blended approach to care is supported through an established relationship between the service user and their Mental Health Practitioner.
- **Occupational Therapy:** Provide a key role in the mental health and well being of service users during the pandemic.
- **Communication of changes:** Service users and carers require timely and concise information regarding changes to accessing services.
- **Choice in the methods of engagement:** The method of engaging Mental Health Services during the pandemic should be in line with the service users choice and may adopt a blended approach of methods.
- **Accessing Mental Health Services:** It is important the methods to engage mental health services are inclusive and accessible to all.
- **Partnership Working:** Regardless of the method of engaging Mental Health Services, service users should continue to work in partnership with the mental health practitioners, in particular, changes and decisions regarding their care.

# 1.0 INTRODUCTION

In March 2020 the Health & Social care system faced one of its greatest challenges as COVID-19 Pandemic took hold in Northern Ireland. As the nation moved into locked down services were challenged to work outside of current practices to support and engage with patient, clients, carers and families. Within Mental Health services across the region it was recognised the importance of embracing new methods and approaches to engage with Northern Ireland citizens who needed support & treatment for mental health presentations at this time. In May 2020 the Regional COVID-19 Assistant Director Sub-group connected with the 10,000 More Voices initiative as part of the Regional Reset and Service Recovery Plan for Adult Mental Health Services. The purpose of the project was to explore the lived experiences of people who engaged with Mental Health Service through the range of communication strategies adopted during COVID-19 pandemic.

The 10,000 More Voices Initiative has been commissioned and funded by the Health and Social Care Board (HSCB) and the Public Health Agency (PHA) to provide a person centred approach to improving and influencing experience of health and social care services. Embracing the principles of Co-Production, Patient Client Experience (PCE) is both a quality indicator and a driving force for service improvement. This initiative supports exploration of people's experience through analysis of their stories, identifying key elements of positive experiences and understanding what needs to be improved.

## 2.0 PROJECT OUTLINE

### 2.1 Aim

To explore the lived experience of engaging with Mental Health Services during first wave of COVID-19 Pandemic.

### 2.2 Objectives

1. To capture and learn from the narrative of people who engaged with Mental Health Services, providing a platform for them to share freely their experience.
2. To explore how people engaged differently with Mental Health Services and the effectiveness of the engagement.
3. To consider areas for reflection and improvement and to inform new ways of working for Mental Health services into the future.

### 2.3 Target Group

The project was open to all ages, including those with experience of Child and Adolescent Mental Health Services (CAMHS), to support anyone engaging with Mental Health services to share their story. Throughout the report anyone who has returned a survey will be referred to as a "respondent"; In the discussion and conclusion the phrase "service user" refers to anyone who has the lived experiences of mental health services.

# 3.0 METHODOLOGY



## 3.1 Survey Design

In line with Experience Based Co-Design (EBCD) 10,000 More Voices promotes the principals of Coproduction through engaging service users in the design of the survey at the start of each project; however in light of the restrictions during the COVID-19 pandemic it was not possible to undertake a design workshop. Therefore the design of the survey was based upon the tool adopted in “10,000 More Voices –Your Experience of Mental Health Services, 2018/2019”. Including questions which had been tested in previous projects the survey design was piloted. The pilot project was led by Trust Service User consultants with 51 responses across the region. These stories are included in the full database and analysis within this report. Following approval through the Regional COVID-19 Assistant Director Sub-group the project launched on 31st July 2020.

## 3.2 Engagement

Promotion of the project was primarily through infographics on social media platforms, led by PHA and promoted by HSCB and Trust Corporate Communications teams. There were also two promotional videos that featured an Assistant Director from the WHSCT & a Service User Consultant for SEHSCT encouraging people to engage with the project. Further engagement was led at local trust level by each Service User Consultant through established networks & forums. The survey was promoted in a range of formats to support wide engagement.

1. Online product supporting respondents to share their experience directly into the Sensemaker® database.
2. Printed easy read version, made available with stamped addressed envelopes.
3. Telephone consultation through 10,000 More Voices Regional Office.
4. Zoom workshops to engage with service users who speak with British Sign Language and Irish Sign Language (supported through the British Deaf Association)

## 3.3 Data collection

All data collection was anonymous with no personal identifiable detail recorded. All raw data from postal surveys, telephone consultations and video conferencing was collated and entered onto the Sensemaker® Analyst Online programme by 10,000 More Voices team. This online programme supports the analysis of narrative and identifies the key themes shared by respondents. Data was managed in line with Data Management Guidelines for 10,000 More Voices and 10,000 More Voice Governance Processes. For stories with content which was extremely negative or caused concern the information was managed internally by the relevant trusts. It is important to note 10,000 More Voices data is anonymous and therefore cannot be used to commence formal investigation; the purpose of escalating a story is to support analysis of the content in line with other processes (for example complaints or SAI's) and to ensure timely learning & intervention where necessary.

### 3.4 Survey Design

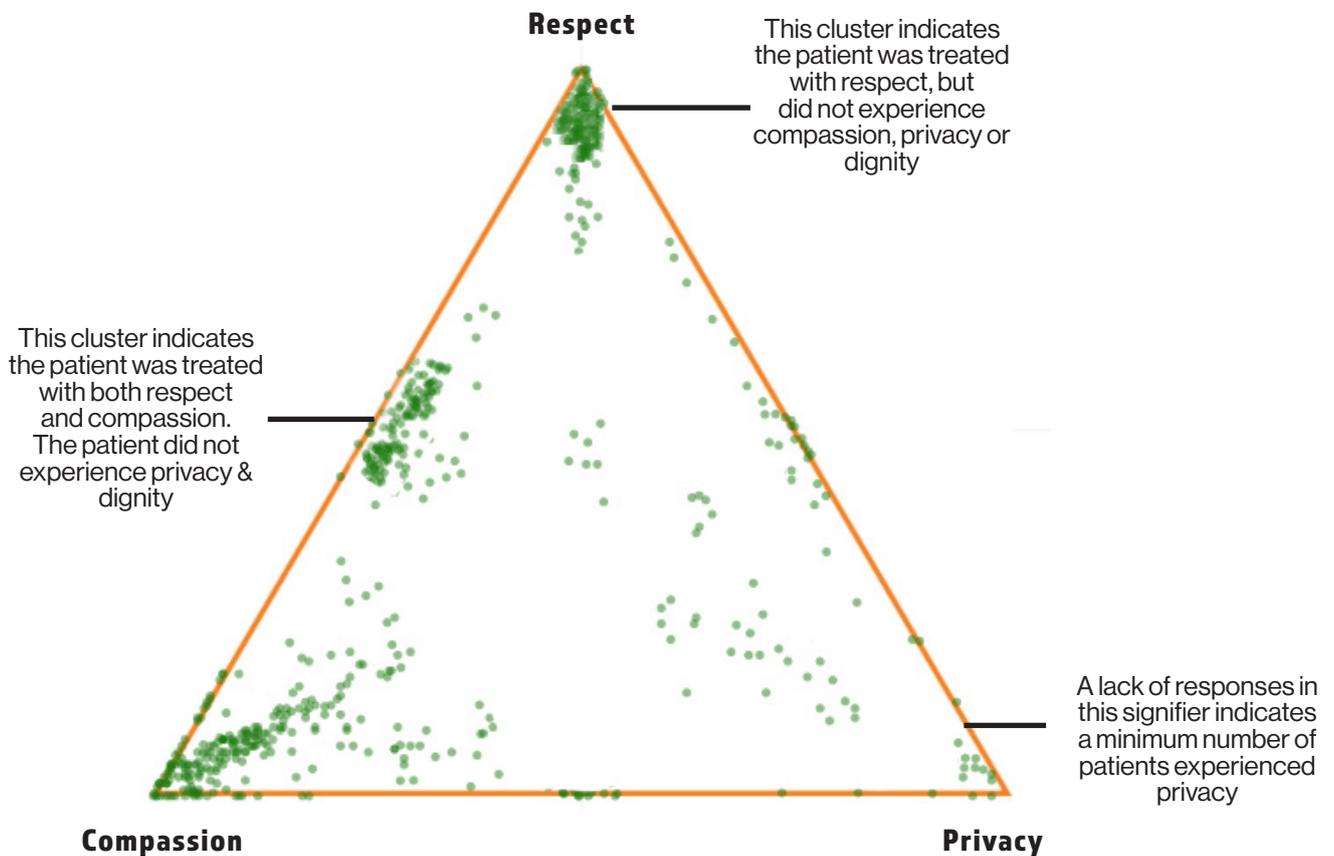
#### Using Sensemaker®: Understanding the responses.

The following outlines the concept of Sensemaker® with particular reference to the analysis tools known as Triads & Dyads. When completing the survey all respondents were asked to describe their most memorable experiences of engaging Mental Health Services during COVID-19 pandemic. The second section contained a number of statements to support the respondent to reflect deeper on their experience. These responses are recorded in Sensemaker® in the form of a Triad (triangles) or Dyad (linear sliding scale) and are included in Sections 4 of this report.

Triads illustrate pattern formation and clusters of response to each statement. In relation to triads the dot was plotted according to the relevant answers selected; if none of the responses applied the respondent could tick “this does not apply to me”. Each dot within the triad represents an individual experience of the resident, relative or staff, with each individual story accessed through the analysis software. A high concentration of dots in a specific area identifies an emerging pattern in relation to the answer. An example of responses to a triad is demonstrated in Figure 1.

**Figure 1. Example of a Triad**

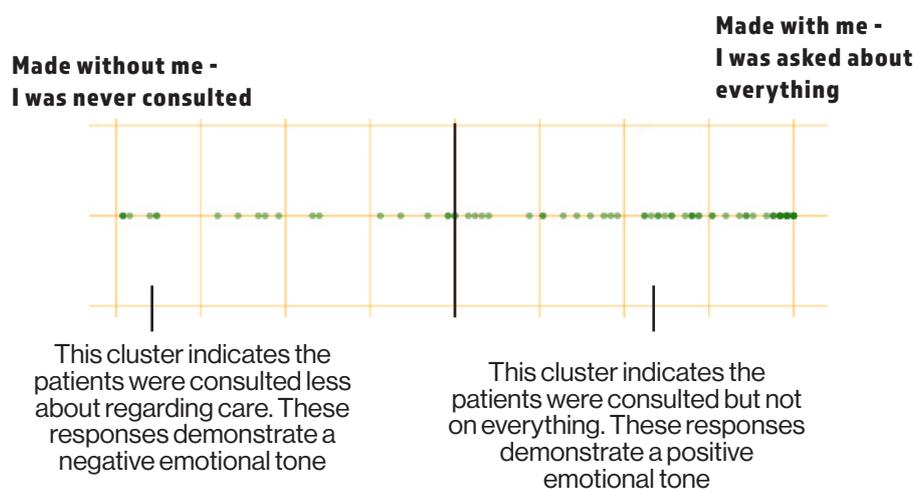
**Responses to statement: In my experience I was treated with...**



The same principles apply for dyads, which demonstrate two extreme responses to a statement/question, moving from negative emotional tone to a positive emotional tone. An example of a Dyad is illustrated in figure 2.

**Figure 2. Example of a Dyad**

**Responses to statement: Decisions regarding my care were...**



### 3.5 Limitations of the Study

- To integrate the learning from experiences during the first wave of COVID-19 Pandemic into the Reset and Service Recovery plan for Mental Health Services the timeframes for data collection was limited to 8 weeks.
- Delays in postal services impacted upon the timeliness of processing surveys, with many received up to 4 weeks after the survey was closed. The numbers included in this report are accurate at 1st November 2020.
- Survey design with Sensemaker® is an academic data collection tool requiring a level of understanding around concepts such as triads & dyads. To support engagement and understanding with as many service users as possible, the methodology was adapted to support easy read versions and still support data analysis through Sensemaker®. It is recognised that the easy read version did not meet the needs of all patients/clients, in particular within Learning Disabilities and further developments in this area is required for further studies.
- Sample selection for the study was opportunistic in a short rapid process of data collection. Although numbers are not statistically representative of over the vast numbers of people who engage with Mental Health Services it is recognised every story counts and learning can be identified in each experience.
- Due to low returns within ages under 20 it would be important to consider further studies exploring deeper the experience of children, young people and young adults.
- For the purpose of this study the target audience was focused upon the service user, however future studies should support the full support network, including relatives & carers.
- Competing demands within services, for example reduced staffing levels challenges teams to promote and support service users in the completion of the survey.

# 4.0 FINDINGS & ANALYSIS

## 4.1 Overview of Returns

From 31st July 2020 to end of October 2020 (accounting for postal surveys received after the project had closed on 30th September 2020) 388 experiences were shared through the 10,000 More Voices project. The first step of the survey was to build context around the experience through a small number of closed statements as outlined in the following figures. It is important to highlight the subsequent analysis focuses upon the data as a whole, however for each of the following questions briefing papers can be developed to dive deeper into the experiences in a particular context (for example by age group, trust, services etc.).

Figure 3 illustrates the returns according to trust. It is evident there was engagement across the region with WHSCT demonstrating the highest number of returns.

**Figure 3. Returns according Trust (n=388)**

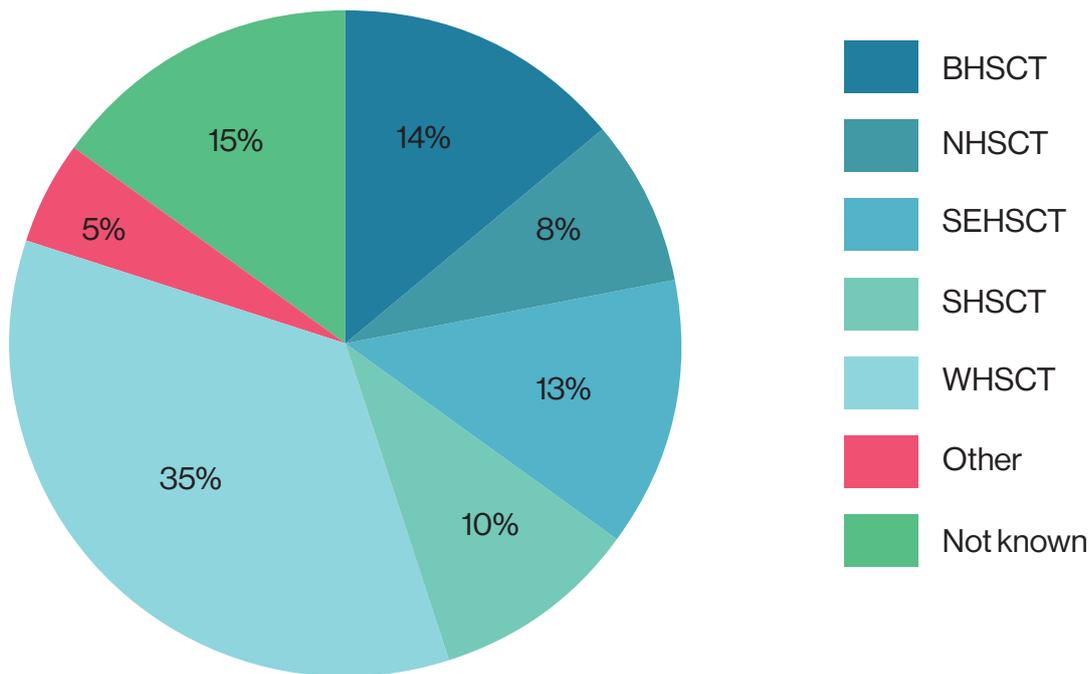


Figure 4 demonstrates the response to the question which asks “Which of the following statements describes you best?” exploring who completed the survey. The audience for the survey was the first hand experience of service users however a small number (n=17) of stories were shared from the perspective of the relative or carer under ‘Other’. This should be considered for future studies to capture the experience of the full network of support around someone engaging Mental Health Services.

**Figure 4. Who responded to the survey?**

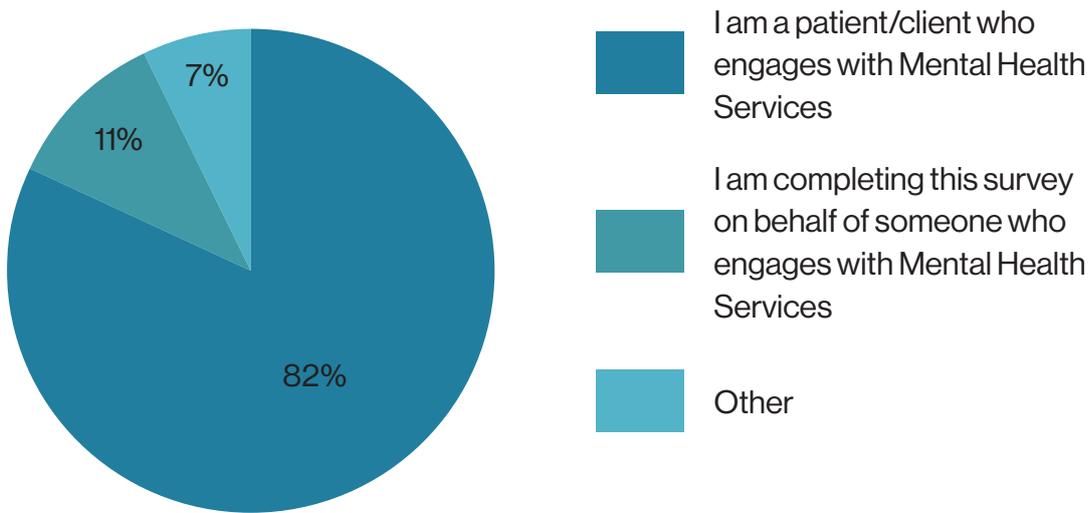


Figure 5 demonstrates the highest number of responses related to ages 31 years to 70 years. There was minimal engagement with age groups less than 20 years, highlighting a gap for future studies. Specific learning and analysis for this age group will be presented to Child and Adolescent Mental Health Services (CAMHS) recognising that every story is important and learning is available. There is also minimal response in the older years, 71-80years. It is also important to explore the experiences in this age group, which may inform future studies.

**Figure 5. The age groups represented by the respondents.**

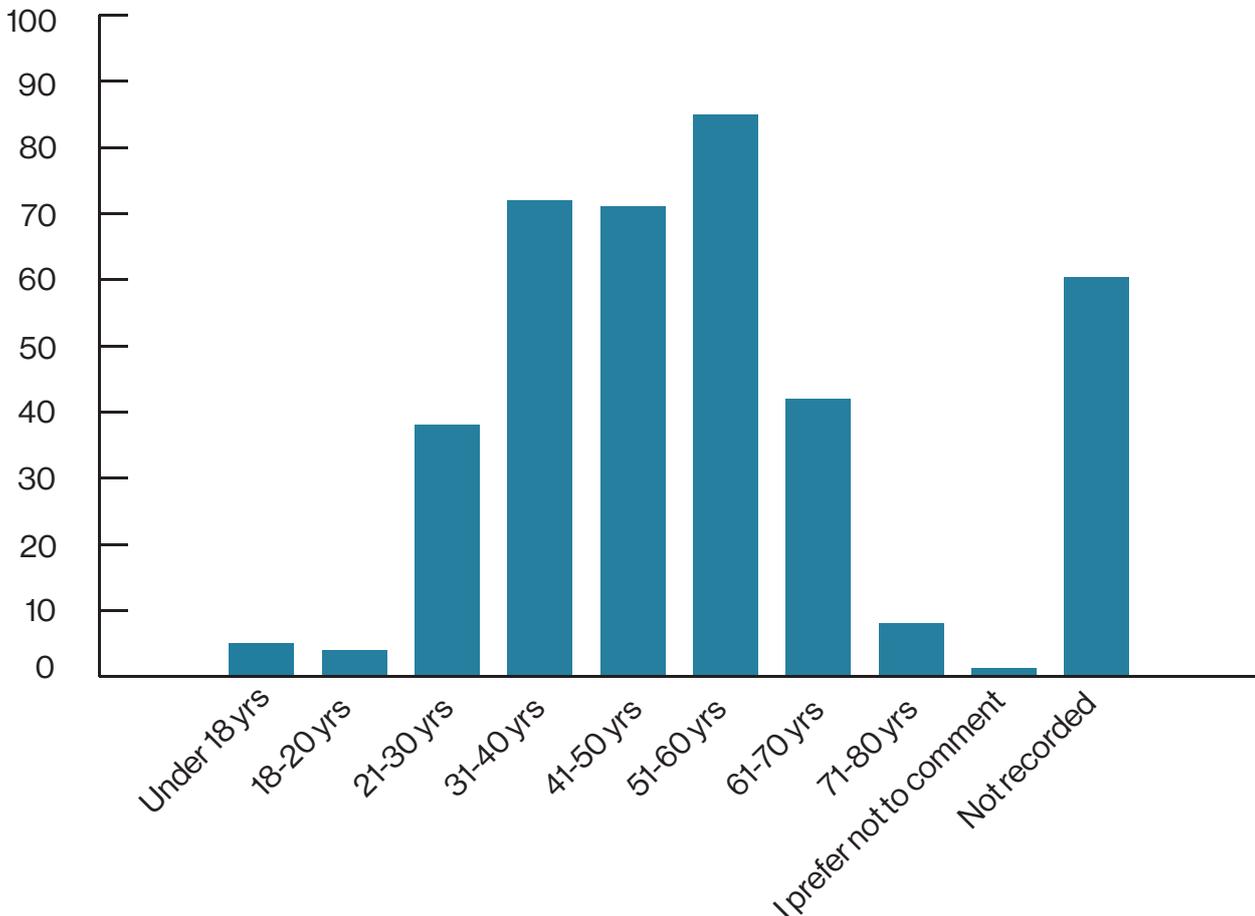
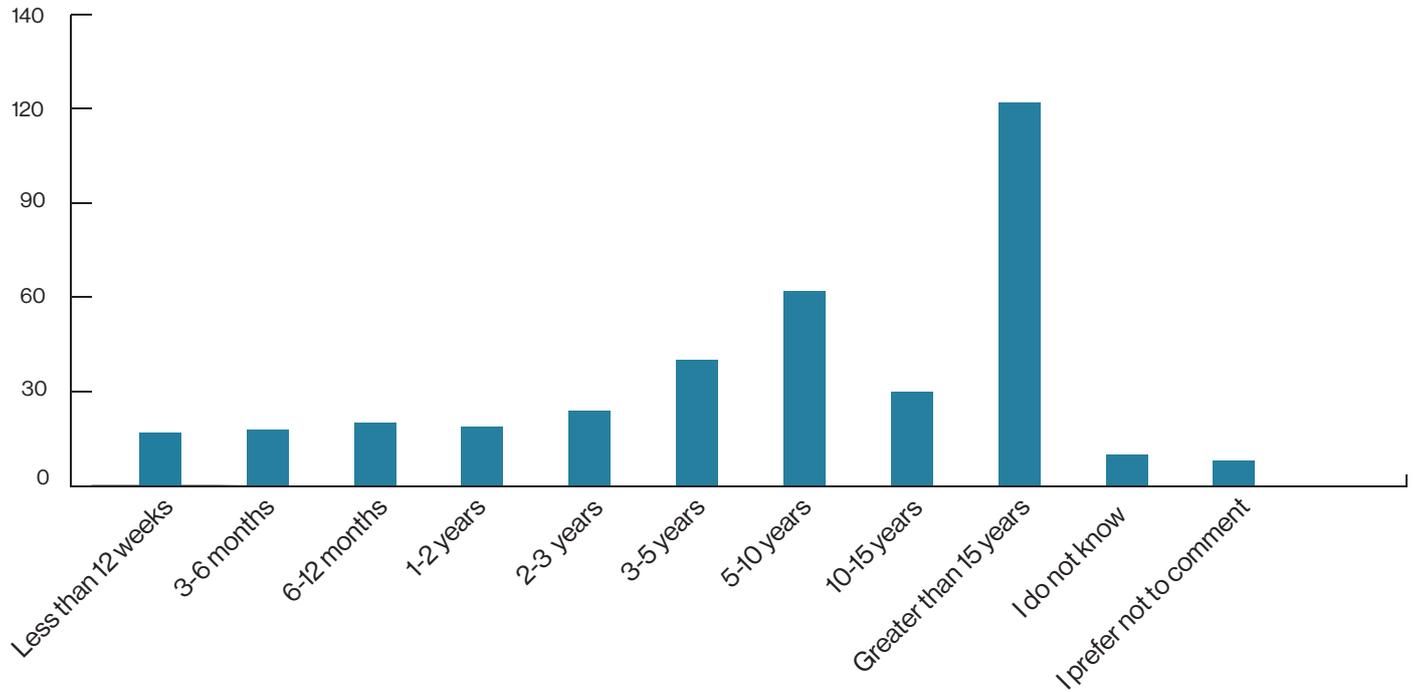


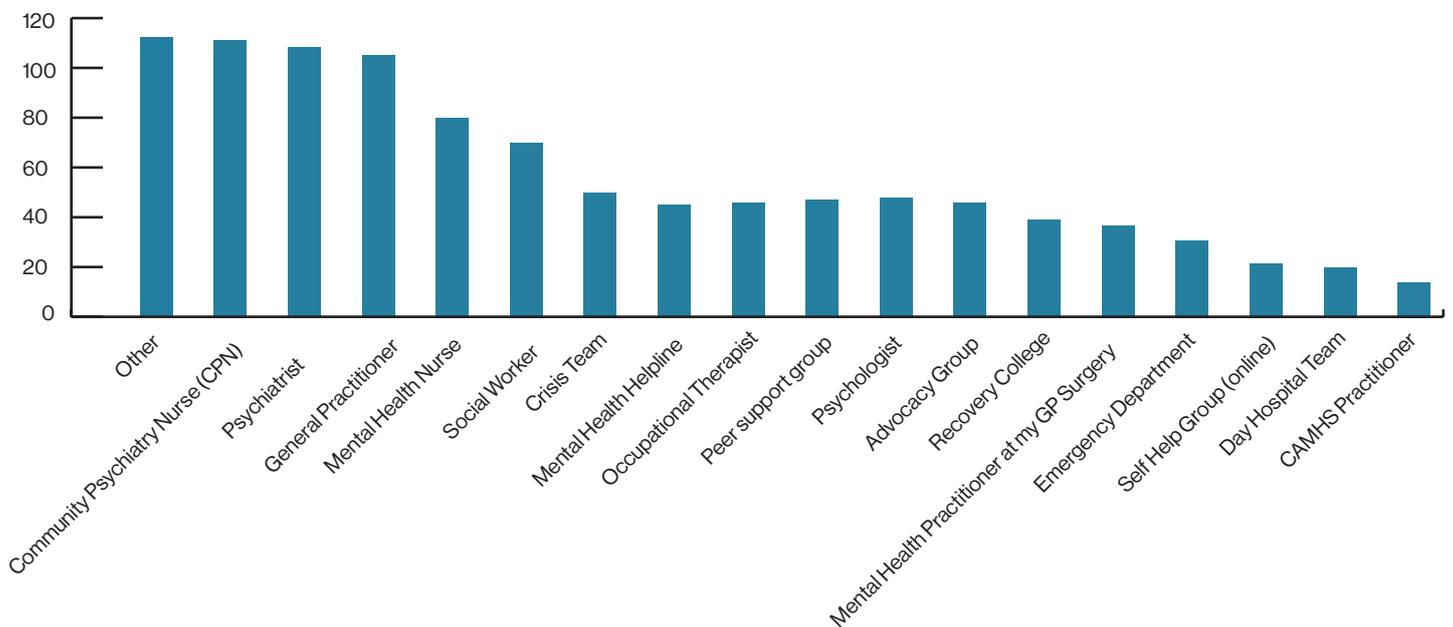
Figure 6 shows the length of time a respondent has engaged with the service. Within the database there are 30 surveys completed for service users who are new to mental health services (less than 6 months) during the first wave of the COVID-19 pandemic. Conversely the majority of responses were shared by service users who have been engaging with Mental Health Services for longer than 15 years and will have long term experience prior to the COVID-19 Pandemic.

**Figure 6. Responses to the question "How long have you engaged with Mental Health Services"**

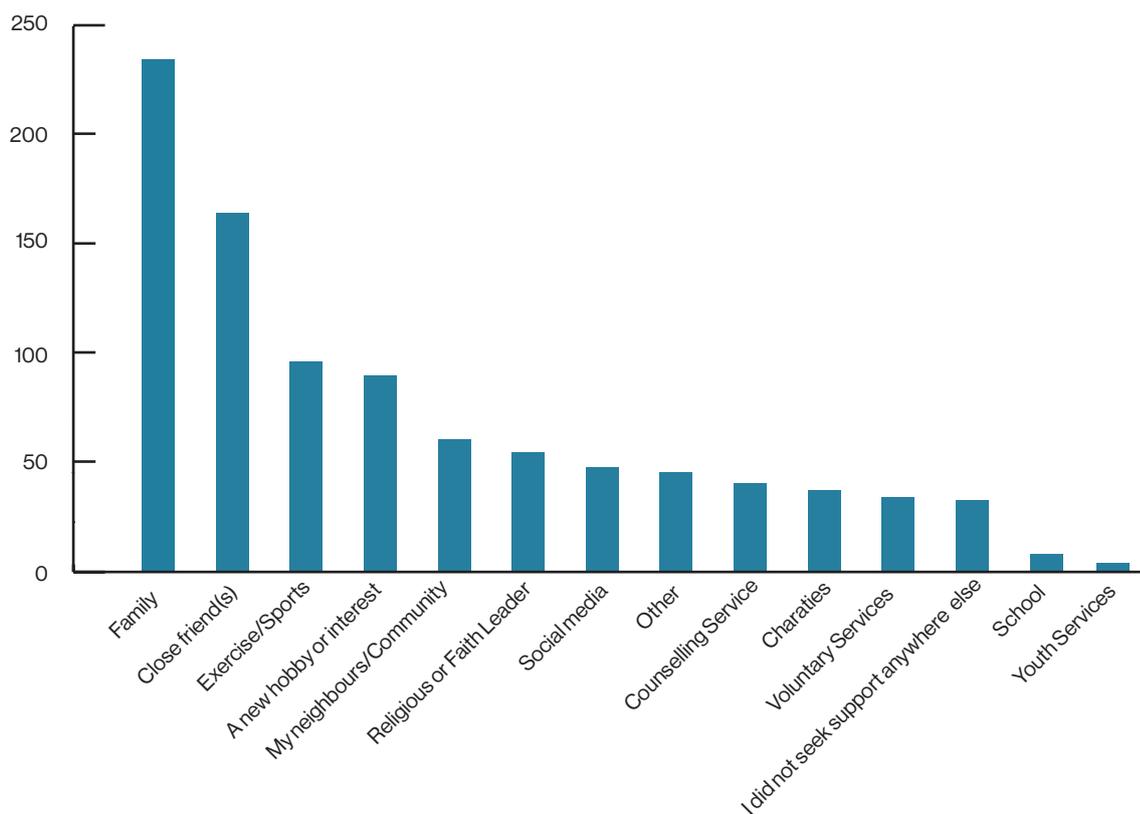


Within context there were also two questions exploring what services the respondent engaged with during the pandemic and other ways they sought support, as illustrated in figure 7 and figure 8. This demonstrates the wide range of services respondents have reflected upon in their returns.

**Figure 7. "What services did you engage to support your Mental Health during the COVID-19 Pandemic?"**



**Figure 8. "To support your mental health and wellbeing during COVID-19 who/where did you seek help?"**



With reference to Figure 7 the services engaged with the most by respondents during the COVID-19 pandemic were the Community Psychiatric Nurse (CPN), General Practitioner (GP), Psychiatrist, Mental Health Nurse and Other (examples given are day opportunities, acute hospital admission, support worker, charity groups, learning disability team, addiction services). Figure 8 shows the areas respondents sought support from the most, outside of Mental Health Services, was their personal network of friends and family. One respondent reported,

**"...Brought me closer to immediate family. Out of routine. Developed my own daily routine. Family relationships became close..."**

Also 90 respondents indicated they engaged in a new hobby or interest for support, providing examples of engaging with online studies, expressing themselves through art/music and engaging with the Recovery College Programmes. This is further examined in section 4.3.

**"... It was a strange timeout for me... suddenly there was time for me to consider new things that I never had time to do before like learning to knit.. It wasn't easy but staying distracted was key..."**

The following sections explore eight concepts formed as statements. The triads are based upon appreciative enquiry, exploring the strengths within the concept. However it is important to be cognisant of the respondents who did not identify with any of the signifiers. This is included in the analysis in Section 4.0 and the number summarised in the following table.

**Figure 8. "To support your mental health and wellbeing during COVID-19 who/where did you seek help?"**

Concept	Content		
		Completed the Question	Not part of their experience
Approach to Coping	Triad 1	328	60
Seeking Help	Triad 2	283	105
Partnership working	Triad 3	299	89
Changes	Triad 4	295	93
Treatment by Telephone	Dyad 1	301	87
	Dyad 2	301	87
Treatment by Video Conferencing	Dyad 3	81	307
	Dyad 4	81	307
Contact through Online Service/App	Dyad 5	79	309
	Dyad 6	79	309
Contact through Face to Face appointments	Dyad 7	196	192
	Dyad 8	196	192

## 4.2 Summary of Experiences

Step 2 explored the narrative of the respondent's experience. This narrative is integrated into the analysis of each triad/dyad to enrich the key messages shared by respondents. One of the key questions in Step 2 was also to consolidate their experience into 3 words. The following word cloud

(figure 9) illustrates the top 50 words shared and provides insight into the reflections and mixed emotions experiences at this time.

**Figure 9. Word Cloud illustrating the response to the statement "Summarise your experience in 3 words"**

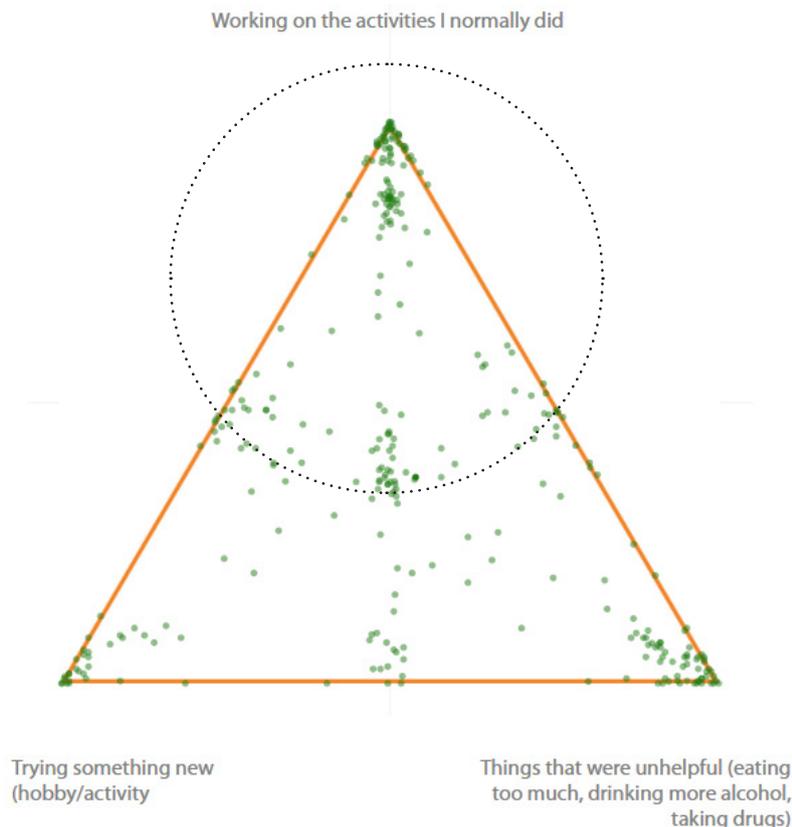


The following sections present an overview of the findings of the core concepts included in the survey, providing an understanding of the data as a collective.

### 4.3 Approaches to Coping

Figure 10 illustrates the responses to the statement “During COVID-19 pandemic I focused upon...” explored how the respondent coped at this time. The three signifiers were - proceeded with activities as normal, tried something new or turned to areas which were unhelpful (for example alcohol/drugs). 328 respondents completed this triad. The dominant signifier represented is “working on the activities I normally did” indicated in 60% (n=199) of the responses.

**Figure 10. Triad 1 (n=328) “During COVID-19 Pandemic I focused upon ....”**



This raises the importance of routine for the respondents to support mental health and wellbeing. In the narrative the reflections highlighted the role of the Occupational Therapist in supporting activities. Also there was a focus upon the importance of continuity in the person's care, in particular maintaining an established relationship with the mental health practitioner.

**“...My daily routine was thrown completely out the window and uncertainty surrounding my exams is still very much playing on my mind. However, I knew I could always have the support of EDYS and that really helped to know they were there...”**

**“...That every two weeks my clinical Nurse specialist from EDYS would ring me which helped bring some normality into my life. I did miss going up to see my Nurse but it was still good to talk to someone...”**

**“...I was able to continue my therapy with my psychologist, just in a new way over the phone. She was able to help me with worries that I didn't even realise surfaced because of COVID-19. I also took part in a weekly support group and board games with the wellness network. It was really beneficially to talk to other people who had difficulties with their mental health and to actually have some fun as well as the serious stuff...”**

**"...I really appreciated that my psychiatrist kept in touch regularly throughout lockdown and even brought me in to see him twice- I felt like I mattered and that people were still there and willing to help me..."**

**"... when my routine fell apart the occupational therapist supported my everyday life... He helped me understand how to engage in my normal activities, albeit in a different way..."**

In relation to the signifier "things that were unhelpful" 40% (n=131) responses reflected upon this element. In the narrative behind these responses there were concerns raised regarding access to services, lack of follow up and closing of services with no alternative services available, all of which may have impacted upon the person's approach to coping during COVID-19.

**"...It has been a nightmare to get talking to your GP or counsellor. AA meetings were non-existent. Anyone with drink problems had nowhere to turn to. You were left high and dry. If you couldn't use zoom it was good luck to you!..."**

**"I was sent to see someone for a MH [mental health] assessment... told me I needed more help in the MH service... then lockdown happened. I got some letter at the start with numbers if I needed them. At that time I did not know my own name. Don't know where letter is now. I went back to GP. He said he could contact them. Still no word from anybody. They say ask for help then nothing..."**

**"...Eventually I was contacted by a member of staff who was not my usual counsellor and who I had never met or had contact with before. She did not seem to be aware of my case or have any information about my lengthy engagement with the service so it seemed pointless to have any follow up phone calls..."**

**"...I had to engage with MH [mental health] because coping on a daily basis was getting harder, I began self-harming to try and make myself feel something, being secluded from friends and family was tough, I found myself drinking alcohol a lot more during my down time..."**

**"...At the start I did hit the drugs again. Then my ma phoned her [CPN] I went mad about that but glad she did it now. We all had a good talk and new meds. That helped - she said let's start again and we did from that day till now. Things have got better and I have not went back on the blow..."**

Referring to the signifier "Trying something new – hobby/activity" 38% responses highlighted this as an approach to coping during the pandemic. In the narrative a number of respondents reflected upon new activities organised through support of Mental Health Services at this time.

**"...The group that has helped me the most has been occupational therapy. I feel I have been aided by creative activities.... The occupational therapists have been very kind and caring and the music and art activities have been very beneficial... they have been terrific in the hospital. They have really helped me. Thank you to them..."**

**"...What I talked to the OT [occupational therapist] about was how to use the free time to keep occupied. Talked to community addicted (SP) services about keeping sober during times of boredom..."**

**"..Some has taken up new hobbies. We were doing jigsaws. They are up on the wall. Some go to music entertainment- everyone is different. I hope I have done well - I have completed peer advocacy level 3 and am now doing level 4..."**

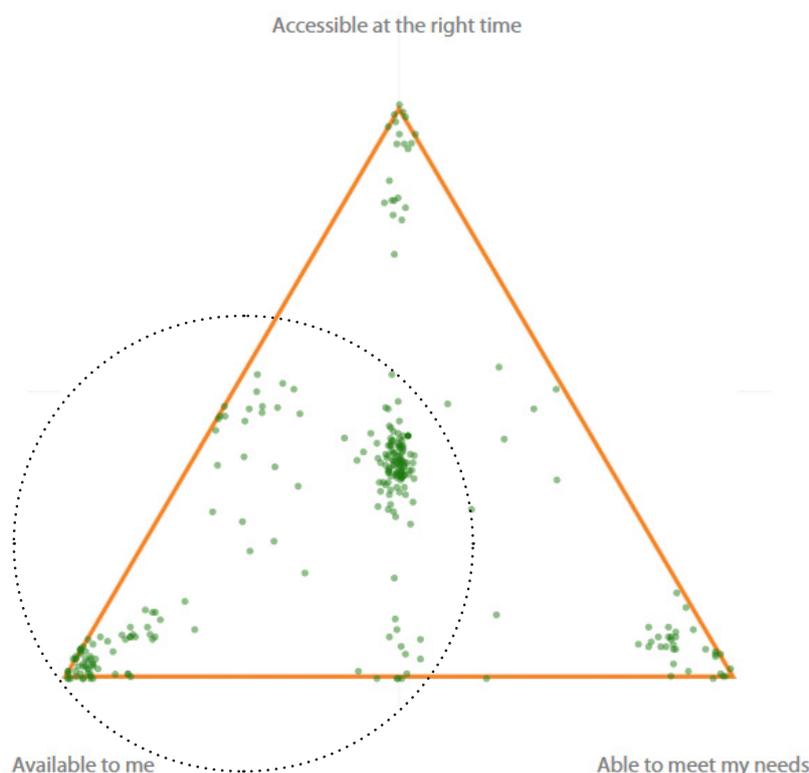
**“...For me COVID-19 took away my extra support that I did receive from the 'Support Group'. At times I felt alone, because the users that I meet at the support group, I have grown to trust them and they are part of my recovery, as these persons all understand what it is like to have addictions and mental health issues. Being alone I had to use the tools that I received at the beginning of my journey, reading up on information I received from 'Recovery College' -this did help me, I also have a brilliant friend who I trust and can talk about everything going on in my mental health and addiction...”**

The key messages in this triad are the importance of continuity in the relationship with the mental health practitioners, even if the mode of engagement has changed. Also availability of activities or new alternative activities to support the individual's mental health & wellbeing during the pandemic was highlighted as important, with occupational therapy identified as playing a vital role.

## 4.4. Seeking Help

Figure 11 illustrates the experiences of respondents when seeking help. The signifiers explored if the help was available, accessible and able to meet their needs. 73% of returns (n=283) completed this triad with 27% (n=105) of returns indicating the signifiers were not part of their experience.

**Figure 11. Triad 2 (n=283) in my experience when I needed help with my mental health & wellbeing service were...**



The dominant signifier was the services were available to the respondents as indicated by 78% (n=198) of responses. There is also a central cluster of 41% (n=116) demonstrating when the person sought help during COVID-19 the services were available, accessible and met their needs. This demonstrates that in these experiences the changes made ensured the services could be continued during the pandemic. This is evident in the narrative with respondents reflecting upon a positive experience of the services.

**“...I engaged with perinatal mental health services with the trust in the middle of lockdown with a 6 week old baby. As I have prior mental health history I was under the care of perinatal psychiatry during my pregnancy and when I needed their help at 6 week postpartum I was so overwhelmed by how rapidly my GP got my referral through to them and the support given to me as I was really struggling with anxiety being a first time mum in lockdown with a history of major depression. I am so grateful by how quickly and effectively I received support and I’m feeling so much better now...”**

**“....My brother has been known to MH services for 42 years and he has a number of CPN's. None better than his current CPN (name removed).They support my brother extremely well. He is accessible, compassionate and professional. The support they give me as a carer could not be better. He takes my calls and listens to me and acts on any concerns. He/she has done carers assessment, organised a grant but more than this, I and we as a family feel he/she is there for us all, the whole family. During COVID he made even more regular contact (contact is excellent anyway) to reassure us and care for my brother...”**

It is also important to reflect upon the 99 stories that did not identify with the signifiers – where, in the respondents' experience, the service was not available, not accessible and did not meet their needs. In the narrative stories reflected difficulties accessing appointments, problems accessing support through ED and lack of response when seeking help.

**“...I was to have an appointment with my psychiatrist just as lockdown came in. I was in a bad way and needed that appointment. My CPN said she could not do anything about my tablets until I seen the consultant. It was cancelled and I still have not seen him. My CPN would phone me but still cannot do anything. Everyone is on about looking after your mental health. I have a consultant and a nurse and still can't get help. This is wrong. I need help. Where is it today when I need it...?”**

**“...That I was removed from their services for not attending appointments as I was unwell and unable to get out of bed to attend which I explained. I also rang and cancelled these appointments -I just didn't not turn up. I was also sat in waiting all day for an appointment which never materialised or was rang through and when I complained it was as if it never happened...”**

**“...My mother attended ED after a suicide attempt. Within 4 hours they attempted to discharge her home. When I refused to take her home the mental health nurse arrived back with a colleague, who proceeded to tell my mother they can't help her due to her alcoholism and suggested that if she stopped drinking she would look better and her partner might take her back. A few weeks later an ambulance had to be called for my mother due to a mental breakdown and she was home within 3 hours with no more help...”**

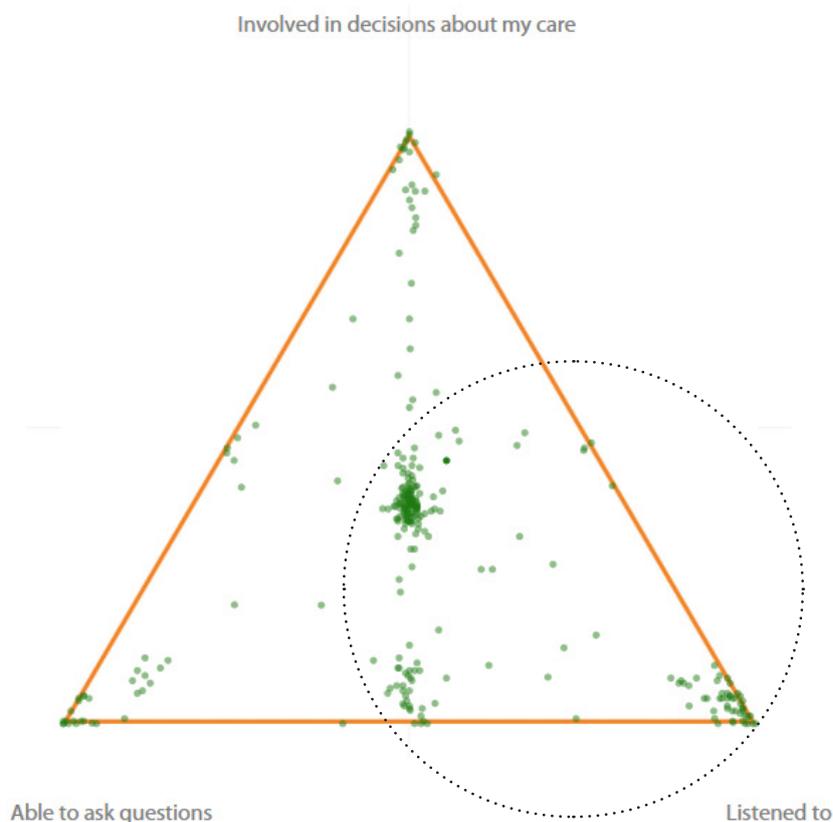
**“...No visits no calls no letters to tell me what is happening. My Da phoned the number we had but was told to ring another one...”**

The key messaging when seeking help was the importance of knowing how to seek help (communication regarding changes to telephone numbers/referral processes), support available for the patient and their relatives during crisis and referral to the correct service at the point of need.

## 4.5 Partnership Working

Figure 12 illustrates responses to statements in relation to partnership working - exploring if the respondent was able to ask questions, felt listened to and was involved in decisions about care during COVID-19 pandemic.

**Figure 12. Triad 3 (n=299) When I spoke with mental health services I was...**



The dominant signifier was the experience of being listened to, with 74% (n=221) respondents indicating this was part of their experience. Also there is a central cluster of 45% (n=135) stating all three signifiers were part of their experience, supporting the concept of partnership working. The narrative demonstrates that even in the toughest of times partnership working supported a positive outcome for respondents.

**"...Suffering with eating disorder, COVID-19 and isolation was challenging for me and definitely my family. Isolation has an impact on direct face to face appointments with my therapist and dietician- although this was the case I was well supported too with weekly telephone calls, discussing weight, diet and overall mental health. Have to admit not having the face to face service lead to my eating disorder symptoms increasing at times with no weight gain - as my illness continued I knew with no face to face appointments I wasn't answerable to no one. However I'm grateful to have (name removed). They listened, encouraged and reassured me they could be contacted at any time..."**

**"...During this time it was invaluable to have someone to talk to, who listens, understands and has compassion. I dread to think what may have happened without this support. It could even have meant suicide if I was alone, without anyone. The thing that did not go as well for me during this time was not seeing my therapist on a one-to-one basis. I really missed the human contact..."**

**“...I was struggling with my mental and physical health just prior to COVID-19 and lockdown. My GP was worried about me and put an urgent referral through to the mental health team. I got a letter from them saying that due to the pandemic I could not be offered any appointment which was devastating. However, they contacted my GP also and although, I don't know what was said, I am so thankful to him as I then got an appointment for the following week. That first meeting was somewhat traumatising as I had to go through everything, but in a way it was also a huge relief to talk to someone about my experiences. This person wasn't judging, just listening, taking notes and showing empathy. I am on a waiting list for therapy with a psychiatrist and have regular phone calls with a key worker which I find very helpful...”**

Considering the responses to the triad there is a challenge regarding involving services users in decision making. Less than 50% (n=145) responses indicated this was part of their experience. In the narrative of these stories respondents reflected upon decisions made in partnership with the service – For example choice regarding the method to engage during the pandemic and the adjustments made to support ongoing treatment or care.

**“...My psychiatrist was lifesaving to me at that time. They told me I can contact them as they know things are not good at times. She said to leave a message and they would get back to me and they did. They even agreed to a face to face appointment. It came at the right time for me. It got me through as they knew I cannot talk openly on the phone. So she is seeing me face to face at all my appointments...”**

**“...He [peer worker] has been very helpful. He phones me just like I had an appointment with him. We will go over the work set out from the last appointment. He is very open about himself and his journey but so professional in what he does... After talking with him I know things for me will be better. It will not be easy but I am up for it...”**

In the returns where this triad was not answered (n=89) there is evidence of negative experience whereby the respondent did not feel engaged and their needs were not met. The narrative also highlights frustrations in accessing support through delays with telephone consultations.

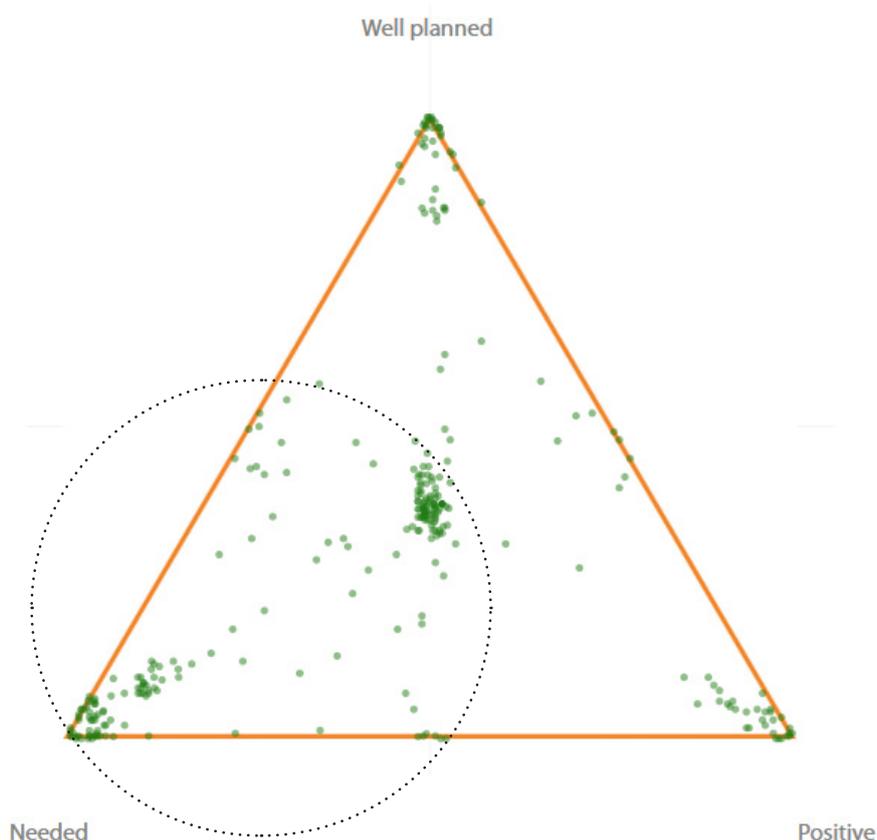
**“...I initially contacted my GP and found them too difficult to get hold of and when I managed to speak with them, I was met with a degree of condescension, disbelief as a previous appointment just before the pandemic was not recorded adequately and I was spoken down to. When I spoke to GP within the practice I was bullied and shouted at. She refused to listen or allow me to talk and continually spoke over me. I work within the Trust and can say the service I received was atrocious and I am only lucky I didn't have suicidal ideations as I honestly believe that I would not be alive now due to the doctor's failure to listen or provide me with help...”**

The key message reflects that the majority of respondents recognised that throughout the pandemic, elements of partnership working, in particular listening, were valued. The challenge is to explore how shared decision making can be integrated into care during the pressures of a pandemic. As illustrated in the positive experiences choice of how to engage services during the pandemic empowered the respondent and supported meaningful interactions.

## 4.6 Changes

Figure 13 illustrates respondents' opinion regarding the changes made as part of the pandemic – in particular exploring if services user's regarded the changes as positive, needed or well planned.

**Figure 13. Triad 4. (n=295) In my experience the practical changes to Mental Health Services during COVID-19 Pandemic were...**



The dominant signifier is recognition that the changes were needed in the Mental Health Service in a response to COVID-19. 68% (n=200) respondents included “needed” in their response, demonstrating an understanding of the pressures at the time. For respondents who indicated the changes were positive they reflected positive experience of virtual platforms and measures taken to ensure continuity in treatment.

**“...It was easier than having to leave the house to go for a face to face appointment... less social anxiety...”**

**“...My husband was attending a Psychologist for CBT Therapy, this continued by telephone which my husband found very useful and is still continuing. This helped me as well as a Carer knowing that my husband was being supported in this way...”**

**“...I have a neck brace that helps to support my head up for eating, the Speech Therapist spoke to the Occupational Therapist and they got me this...”**

**“...I know things have been bad but I got good support. He phoned me every week. I was able to talk to someone who understood me. I know and understand I can't see my worker yet. That will be great but I'm sure everyone knows the reason why we must wait...”**

Smaller numbers included the signifier “well planned” in their response presenting a challenge as to how services plan the changes and then subsequently communicate the changes to the service users. In the narrative good practices were shared in relation to information sharing, proactive approach by services to engage the service user and to support service users to adapt to the regulations around COVID-19 pandemic.

**“... For a short time I felt abandoned but then we received a letter outlining the ways the service would change and how to access it. It was reassuring to know it was being thought through, albeit a little adhoc at the beginning...”**

**“...Staff advised us about covid, they kept us indoors as much as possible and told me to wear gloves and masks and stay away 2 metres from each other. It went on for 16 weeks you were not allowed to touch each other or come into contact with others. It was hard at the start but we got used to it...”**

**“...I think they all do a great job. I can phone when things are not going good. I know I can't see my SW at this time. Everything was explained to me and I got a letter with phone numbers to call. Even not seeing her, she got work done to the flat for me. I could not get through all this without her help...”**

Returns where this triad was not answered illustrated frustrations due to lack of proactive engagement and lack of information regarding the changes which impacted upon the respondent's ability to manage their mental health.

**“...The fact that GP's closed without notice was very distressing for me. I had been due to collect repeat prescription and had no meds left. GPs closed their doors and didn't answer their phones. I was very stressed and anxious. My wife had to beg local pharmacist to give me some meds...”**

**“...During Covid19 I felt that it was a case of sink or swim. No health care professionals seem to want to go near anyone that was sick with either physical or mental health issues. I live on my own and have limited mobility and had it not been for carers or family I don't know what I would have done...”**

**“...The difficulty in this [telephone consultation] was the phone calls weren't appointment based, they could happen at any time, therefore I wasn't always able to take the phone call in private...”**

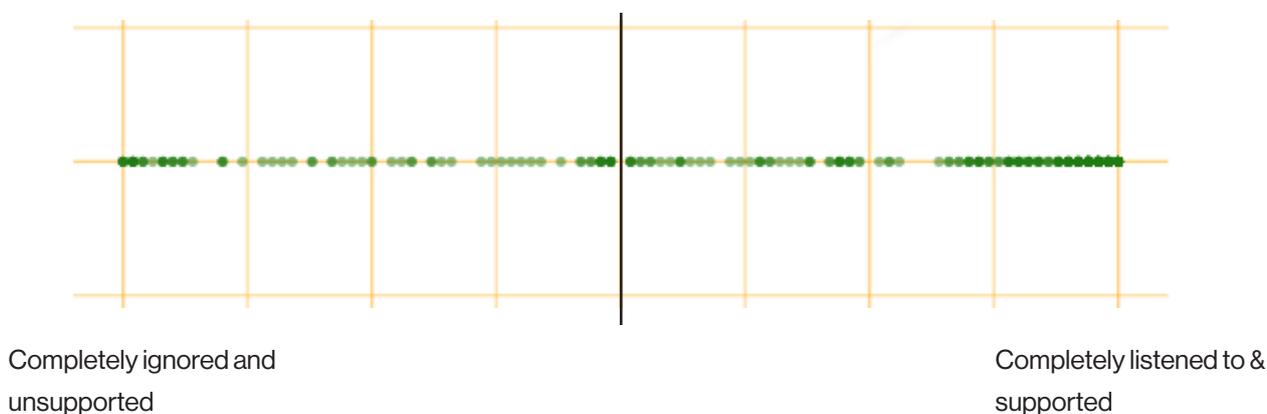
The key message is the majority of respondents understood the need for changes to how services engaged with service users, however the challenge is the communication of the changes to ensure service users are informed and remain empowered in their care or treatment. All changes to services need to be clearly and quickly communicated to service users and options set clearly, in particular when accessing help in a crisis.

The last sets of statements in the survey were presented as dyads and explored reflections on the various strategies adopted by Mental Health Services during COVID-19 pandemic. These are telephone consultations, video conferencing, online apps and face to face appointments.

### 4.7 Treatment by Telephone

Figure 14 explores if the respondents felt supported through telephone consultations. This was the most common method of consultation with 301 returns on this statement. 75% (n=226) of responses to the dyad were of a positive emotional tone indicating the experience was supportive and the respondent felt listened to.

**Figure 14. Dyad 1. (n=301) When talking to a member of Mental Health Services on the telephone during COVID-19 Pandemic I felt ...**

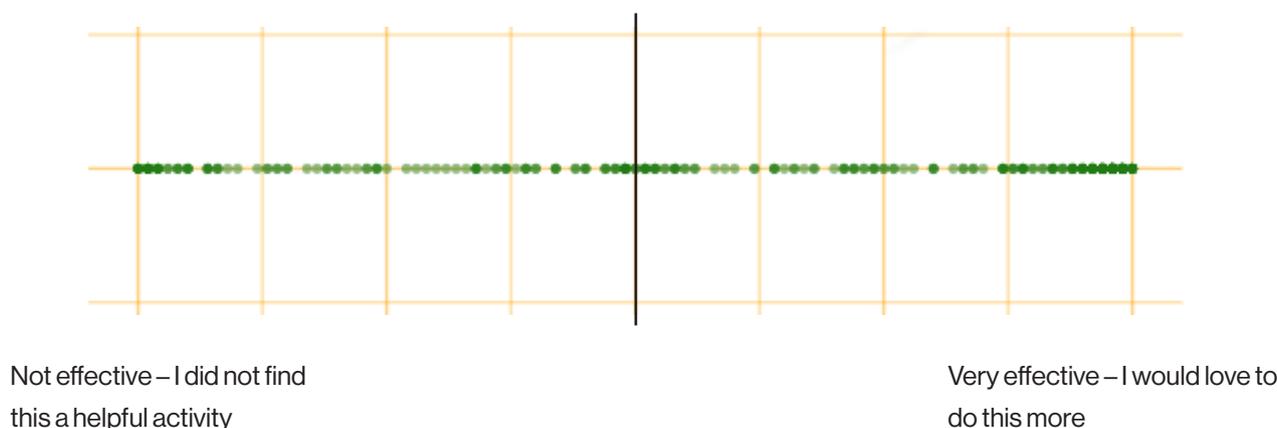


**“...In the beginning of the pandemic I immediately felt my mental health deteriorate... The fear of the unknown was terrifying, however knowing others were feeling the same was a support in a way. Not very long into the pandemic I received a letter for a telephone conversation with my Psychiatrist. Having this connection via phone call helped me continue to feel safe and connected with mental health services. Now having had two appointments via phone call I feel that my needs were met...The Psychiatrist listened, offered self-care advice and also helped by prescribing medication to aid an ongoing sleep problem, Improving my sleep has helped to keep me well and also self-care routine has allowed me a little time for me...”**

**“...the biggest change was not being able to see psychologist one to one face to face in her office. When I was told that appointments would become remote i.e. .telephone for one hour per week I was dubious about efficacy of service at a distance, but worked in my case because relationship was already well established i.e. in its third year. We were able to communicate because there was trust and pervious knowledge between us. The phone was a life line for me and still is during pandemic...”**

Figure 15 explores if contact by telephone was considered an effective method to engage with treatment through mental health services. 62% (n=187) of responses were of a positive emotional tone and reflected an effective experience which the respondent would be happy to do again.

**Figure 15. Dyad 2 (n=301) Contact by Telephone was...**



With reference to both figure 15 and 16 responses with a negative emotional tone illustrate aspects of the experience less effective and which should be considered areas for improvement. In the narrative it is evident telephone consultations are less effective or meaningful when the practitioner does not know the patient/client, time is not taken to engage with the patient/client and recognition that telephone consultations do not meet the needs of all patients/clients.

**“...The phone call was rushed and I felt that the girl only rung to complete a tick box exercise and put me on another list for CBT. Useless and disappointing...”**

**“... Eventually I was contacted by a member of staff who was not my usual counsellor and who I had never met or had contact with before. She did not seem to be aware of my case or have any information about my lengthy engagement with the service so it seemed pointless as have any follow up phone calls...”**

**“... As a member of the Deaf community I didn’t know where to turn when my mental health became a problem. My GP offered me telephone numbers (which were no good to someone who uses sign language) and I was unable to access the helplines though an interpreting service... I was lost... I still don’t know where to turn to get help...”**

**“...Lack of support - as soon as lockdown hit I got 1 phone call a week even when I told them I was actively suicidal they just told me it was normal and to try and distract myself with hobbies etc. This does not work for me and I ended up with 5 suicide attempts in 2 weeks and my partner was having to watch me practically 24/7.If it wasn’t for her I don’t know where I would be right now...”**

**“...I was unable to speak to an actual body. Everything was over the phone and I can’t relate to this medium. It is too brief and I don’t find the opening to say what I need to. Body language can’t be seen over the phone. Tears can’t be seen over the phone. Unwashed and unkempt bodies can’t be seen over the phone. The counselling I received was too brief. It opened a can of worms that I was then left with unable to close the lid on. This made me feel worse...”**

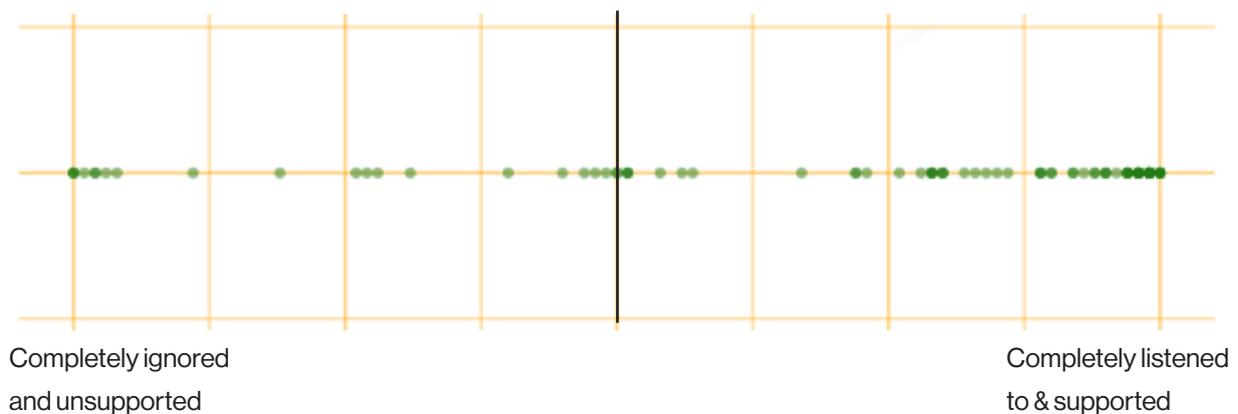
The key messaging for telephone consultations is that for the majority of respondents they were a positive alternative to face to face consultations – this is particularly true when there is an established patient/practitioner relationship; however it is important to note, telephone consultations should not be the only available method to communicate, consideration needs to be given to individuals needs and preferences. In particular consideration needs to be given to accessibility for the Deaf Community to helplines for example through Interpreter Now or text services. Service users need to be reassured that their individual needs and preferences for communication will be considered as part of their plan of care.

It is identified that staff had to learn and adapt core services quickly in very difficult circumstances. It is highlighted to support the service user during a call it is important the mental health practitioner does not rush the interaction, but has dedicated time to explore treatment & care.

## 4.8 Treatment by Video Conferencing

Figure 16 explores if respondents felt supported through video conferencing. Only 81 returns responded to this statement. 74% (n=60) of respondents answered with a positive emotional tone, reflecting they felt supported through the video conferencing. In the narrative there is limited commentary on the use of video conferencing. Services such as CAMHS and counselling were identified to have engaged through zoom calls and it is recognised this engagement was set up quickly and the respondents experienced good support.

**Figure 16. Dyad 3. (n=81) When talking to a member of mental health services on video conferencing I felt...**



**“...It is very hard to carry out CBT Therapy over zoom as it is very interactive and you need the use of a white board etc. to get the true experience you need face to face. I appreciate how difficult the circumstances are and why this wasn’t possible so I was grateful I was able to access counselling in this challenging time over zoom and my counsellor was so supportive...”**

For the respondents who had a more negative experience of video conferencing the narrative reflected upon limitations on trust systems and that video conferencing was not offered when appointments were being cancelled.

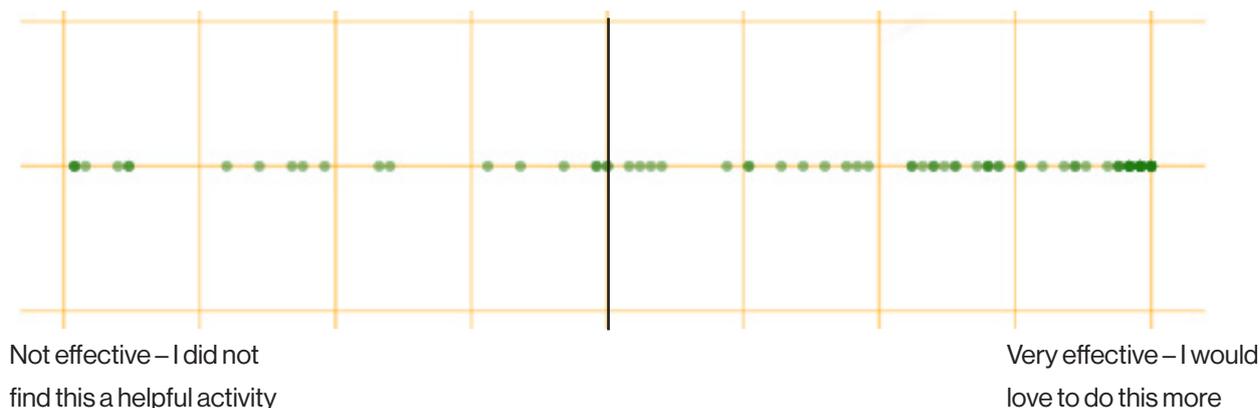
**“...Calls with (name removed) were good but using the Trust video call service was unreliable...”**

**“... I would have liked to talk to someone over video conferencing but I couldn’t access a computer and my internet is poor... I missed out on this because I simply couldn’t afford it...”**

**“...My intervention with IPT was halted; I had waited for a significant period of time to start this treatment... It was halted after 4 sessions. I appreciate the pandemic has caused difficulties... however I believe it is time these services were re-instated with the appropriate precautions for staff and patients or an alternative way to do things. My appointment with my psychiatrist was cancelled and never re-appointed. I believe that all these services should have been done virtually...”**

Figure 17 explores if treatment through Video Conferencing was considered effective. The majority of responses to this statement (74%/ n=60) identified it as an effective method and would be willing to engage in this manner as highlighted in the narrative. Due to the limited number of responses to video conferencing it would be important to explore further areas this method could be offered.

**Figure 17. Dyad 4. (n=81) Treatment by Video Conferencing was...**



**“... My husband and I have been attending family therapy. This has continued very successfully via a video platform. I have a disability and being able to use technology rather than travelling to appointments has greatly increased my accessibility to services. I am more able to participate in the sessions and take less time to recover from them.... I would actually prefer to continue via video and I do not think we lose anything through using technology rather than being in the room together. We have made great progress through the family therapy even though this has been a time of additional stress due to Covid and the complicated issues in relation to my son...”**

**“...The What’s App group and zoom meetings were unreal- they were helpful and essential. Access to mental health was very good our zoom meetings worked very well. To me it was a lifeline and only for it during lock down I never would have survives it. it worked very well even the efforts to get restarted after lock down were AMAZING...”**

**“...All of the meetings stopped so my support network was removed. The addiction team started daily Zoom recovery support meetings for alcoholics like me. My addiction Nurse continued to support me also by phone calls and by continuing to give my medications every week. This was enough to support me in recovery & I can't thank the staff enough...”**

It was also identified through the Sign Language workshops that video consultation supported someone to engage with their normal Mental Health Practitioner using a remote sign language interpreter. This was identified as a good method to support the Deaf community however did require working knowledge of the system and was exhausting due to the additional concentration required.

**“... I still spoke with my counsellor through zoom. There were a few issues at the start getting set up and understanding the system but as I had a regular booking with an interpreter for my appointments we were able to keep to our plan through zoom. The only thing was I was exhausted at the end – video consultations should not be any longer than an hour for anyone...”**

Again it is clear in the narrative that video conferencing is not a solution for all patients/clients and the importance of assessing the best possible method of communication for the individual, particularly when communication needs are more complex.

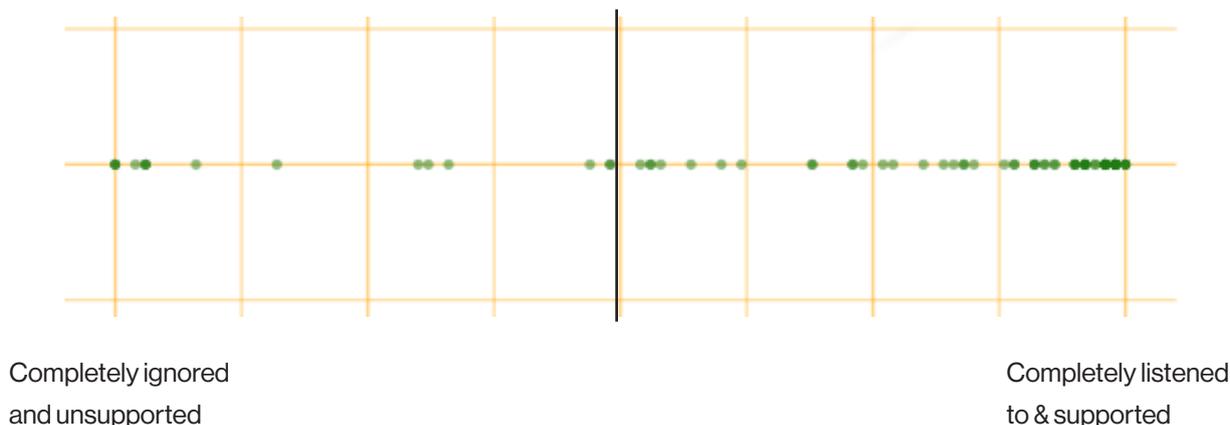
**“...I am the parent of a teenager who has ASD and mental health issues. During Covid face to face contact with psychiatrist and CAMHS therapist ceased. My son has significant communication issues and has found telephone contact very difficult. For a number of weeks he refused all contact and now struggles with the phone. He feels unable to do video calls. He has had one face to face contact with the therapist which was difficult due to change of venue, length of time since last face to face contact, and Covid arrangements such as temperature, Covid questions and masks. There is a lot of uncertainty as to when the next face to face appointment will be, or how often. These uncertainties and change of routine are very challenging due to his ASD.... This unusual situation has demanded a more creative response including use of technology, and understanding of his anxiety and communication difficulties...”**

The key message around video conferencing was that it was an effective method for engaging services, however reflecting on the low numbers there may be benefit in exploring opportunities for integrating video conferencing into a wider range of services. Further consideration should be given to the training needs of the service users. It is also clear for video conferencing there are limitations with a need for reliable equipment/network and ability to navigate and access the video conferencing platform. Again it is important to be mindful of the individuals needs with an understanding that video conferencing will not meet the needs of all patients and clients and a more blended approach with other methods would be beneficial.

### 4.9 Contact Through Online Services/App

Figure 18 explores if respondents felt supported through contact with online services or apps. There was a small number of returns on this statement (n=79) however for the greater proportion (81%/n=64) indicated this was a positive experience.

**Figure 18. Dyad 5. (n=79). When engaging with Mental Health Services through an online app or service I felt...**



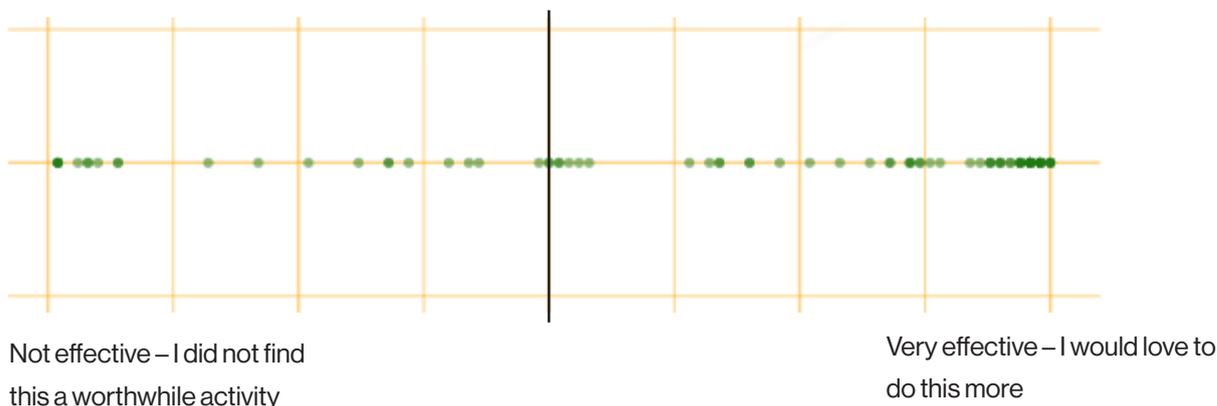
**“... I will always remember how supportive they [Mental Health Services] were even when they were virtually helping me...”**

**“...When eventually I was able to do a few courses online through a mental health charity I felt happier as I was able to communicate both verbally and non-verbally as we could see each other...”**

**“...A revised service was available via phone and online options this is understandable given risks of face to face review and possible extra distress of a young person having to attend a clinician who is wearing full PPE...”**

Figure 19 considers if engaging with online services or apps were effective. 68% (n=54) of responses indicated a positive experience when engaging with Online apps/services, however in the narrative a number of concerns were raised - for example anxieties regarding confidentiality & security and skills required to engage with the online products..

**Figure 19. Dyad 6 (n=79) Engaging with online service or app was...**



**“...Initially was nervous about using online app and security of this re. confidentiality etc. but my therapist reassured me of this...”**

**“..Services were accessible to me as I was able to use online app offered, but this would definitely not be the case for all service user..”**

**“...I looked forward to my contact with the services. Initially I felt anxious re. using the online app/video call option, as this was not face to face and I was concerned re. the security of these options. However I still would have chosen these options over no contact at all or reduced contact...”**

In the smaller numbers where the online apps were not considered effective a number limitations were raised. These were primarily frustrations in the use of the system, limited as an alternative to face to face and lack of accessibility of the resources. Through addressing these issues engagement through online apps/services may be more effective.

**“... as a sign language user it is disappointing to find the online services are not subtitled or translated into sign language. It is completely inaccessible to me but I know the blogs or the videos would help me with self-care, particularly at this time. The other apps around meditation or calming music will never be accessible to me but with some adjustments I do think some of the apps could be more accessible...”**

**“...was referred to a charity support group[name removed]... it has been a complete disaster, a very confusing timetable, being asked to attend and then told that there is nothing for us to do, signing up to online activities and not receiving links...”**

**“...Total lack of services, no support other than changing medication. On-line services which were of no help...”**

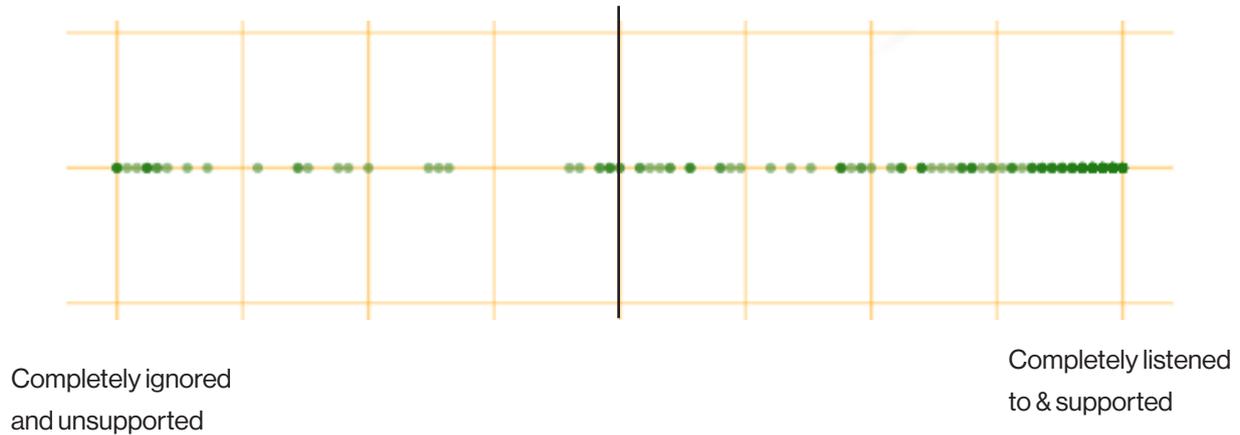
**“...My daughter is a patient with CAMHS, having waited nearly 9 months for an assessment and treatment was to begin at the start of the year. This intervention was postponed and eventually it has moved on-line with me only. I feel we have been abandoned by the CAMHS team, clearly children who have been referred, assessed and identified as having problems are likely to suffer more during the lockdown. I have been left with an online program to teach me to help my daughter when I already suffer from a serious mental health diagnosis myself. This has impacted my own health...”**

The key messaging is that online apps and services played a positive role in Mental Health Services during COVID-19 pandemic but as a method it is not available to all and for some does not provide an effective intervention in the absence of other interventions. Also as the numbers of responses in this area are low it should be explored where the apps could be further promoted to support wider engagement. As with previous communication methods it is important to be cognisant of the needs of the individuals when exploring the best methods to engage treatment. This may be supported best through a blend of the methods explored in this study.

## 4.10 Contact through Face to Face Appointments

Figure 20 explores if respondents felt supported when engaging with Mental Health Service wearing protective equipment during the COVID-19 Pandemic. 196 respondents completed this statement with 83% (n=163) of responses indicating a positive experience engaging Mental Health Services face to face.

**Figure 20. Dyad 7. (n=196) When engaging with a member of Mental Health Service wearing protective equipment during COVID-19 Pandemic (such as face masks) I felt...**



In the narrative there is limited commentary on PPE as a barrier to engaging face to face. It is recognised for some patients, for example children with ASD, that the facemasks may cause distress; however in the majority of the narrative respondents reflected upon the value of face to face sessions throughout this time, recognising the dedicated work of the practitioners.

**“...The service did their best to see me face to face. If support had've been over the phone it wouldn't have helped as much. Some of the professionals were warm and personable it was like just having a conversation and it helped me open up about what was happening in my head and they took the time to look at my strengths too not just my 'symptoms'. Others were cold and clinical, it felt like a tick box exercise - are you eating, sleeping, taking your tablets, thinking of harming yourself? I didn't want to talk to them about what was actually happening with me then...”**

**“...My psychiatrist was life-saving to me at that time. They told me I can contact them as they know things are not good at times .He said to leave a message and they would get back to me and they did. They even gave me a face to face appointment. It came at the right time for me. It got me through as I cannot talk openly on the phone. So he is seeing me face to face at all my appointments...”**

**“...The way that when I rang the Specialist team, my Psychologist rang me back within 10 minutes personally -He said he would clear his diary for that morning and that I was to come straight over to him when I was ready. He then spent considerable time with me. I will never forget how bad I was feeling, I couldn't cope and was having a meltdown. He literally saved my life...”**

In the narrative of responses which indicated they were not supported through face to face, reflections were based on the lack of face to face appointments and difficulty accessing support during a crisis (for example through Emergency Departments or GP practices)

**"...Everything shut down. I got no help or assistance other than A&E. I attempted suicide several times as all services shut with very little or no support as provided before COVID-19..."**

**"...couldn't get to see doctor or talk to them on the phone. Spoke to receptionists asked me was I suicidal - when I said 'not yet' she responded ring back when you are..."**

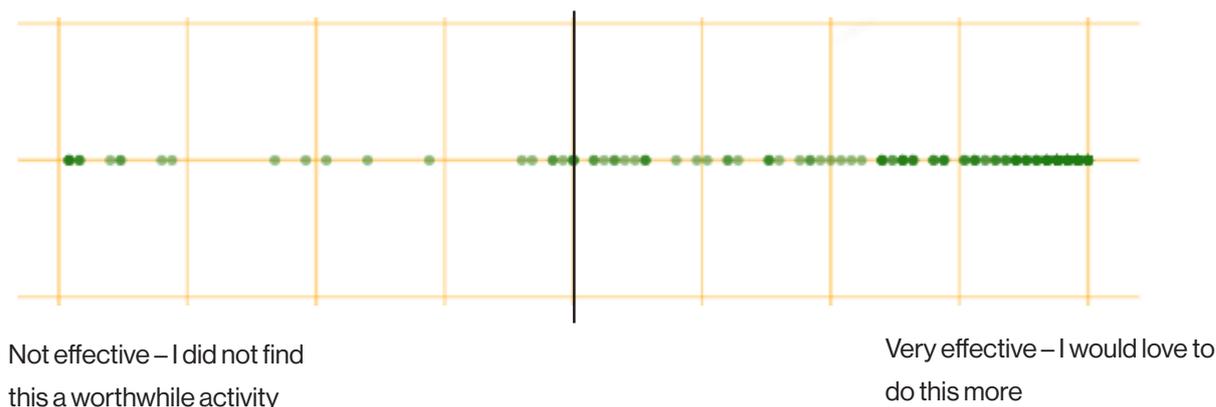
**"...in the Emergency Department I was let know that it was selfish to have mental health problems at this time and they had much more important things to deal with..."**

**"...Not interested ... made false statements about appointments and didn't keep them or follow up on anything I said. To say I was depressed was an understatement and I strongly felt no one cared and I was on my own..."**

In the narrative of responses which indicated they were not supported through face to face, reflections were based on the lack of face to face appointments and difficulty accessing support during a crisis (for example through Emergency Departments or GP practices)

Figure 21 explores if engaging through face to face sessions was effective and a method for further engagement; 88% (n=172) of responses indicated the positive engagement through face to face appointments.

**Figure 21. Dyad 8. (n=196) Engaging through face to face appointment was...**



**“...The phone calls with the mental health practitioner were significantly less useful than the face to face contacts which eventually were re-instated...”**

**“...Face to face is essential - can't reinforce this enough how much this helps him. Can express emotions better face to face...”**

In the responses with a more negative emotional tone the narrative was reflective of the difficulty accessing face to face services and on occasions the approach of the practitioner during the face to face session.

**“...My brother was seriously mentally ill during lockdown (he's not normally anything like this), suffering obsessive thoughts with suicidal intentions (with a plan to kill himself), and could not get in to see any mental health providers. He was told it would be several weeks before he would even get an assessment. We explained he couldn't wait weeks, and it wasn't related to drink or drugs. They said they couldn't help us...4 days later he nearly took his own life, by some miracle he survived”**

**“...Being asked the same questions (some irrelevant and shocking) each time the home treatment team visited was inappropriate to my circumstances and not relevant to my needs. I felt I wasn't being listened to and could not fully engage with or speak my mind...”**

The key messaging regarding face to face appointments is the recognition that it is highly valued by the respondents and the importance of maintaining the safety of the service user and the staff during face to face appointments. This is further discussed in the findings of the following section which explores two open questions around positive experiences and what needs to be improved.

### 4.11 Looking Forward

The final questions asked the respondents to reflect upon what went well in their experience of Mental Health Services during COVID-19 and the areas of improvement for improvement moving forward . Figure 22 demonstrates the top ten themes identified as positive in the respondents' experiences, with the most frequent comments relating to telephone consultations and a compassionate, supportive approach by staff. The restart of face to face services and input by support groups was also highlighted as a positive.

**Figure 22. Themes identified from Step 5a. What did we do well to support you and your mental health & wellbeing throughout the COVID-19 pandemic**

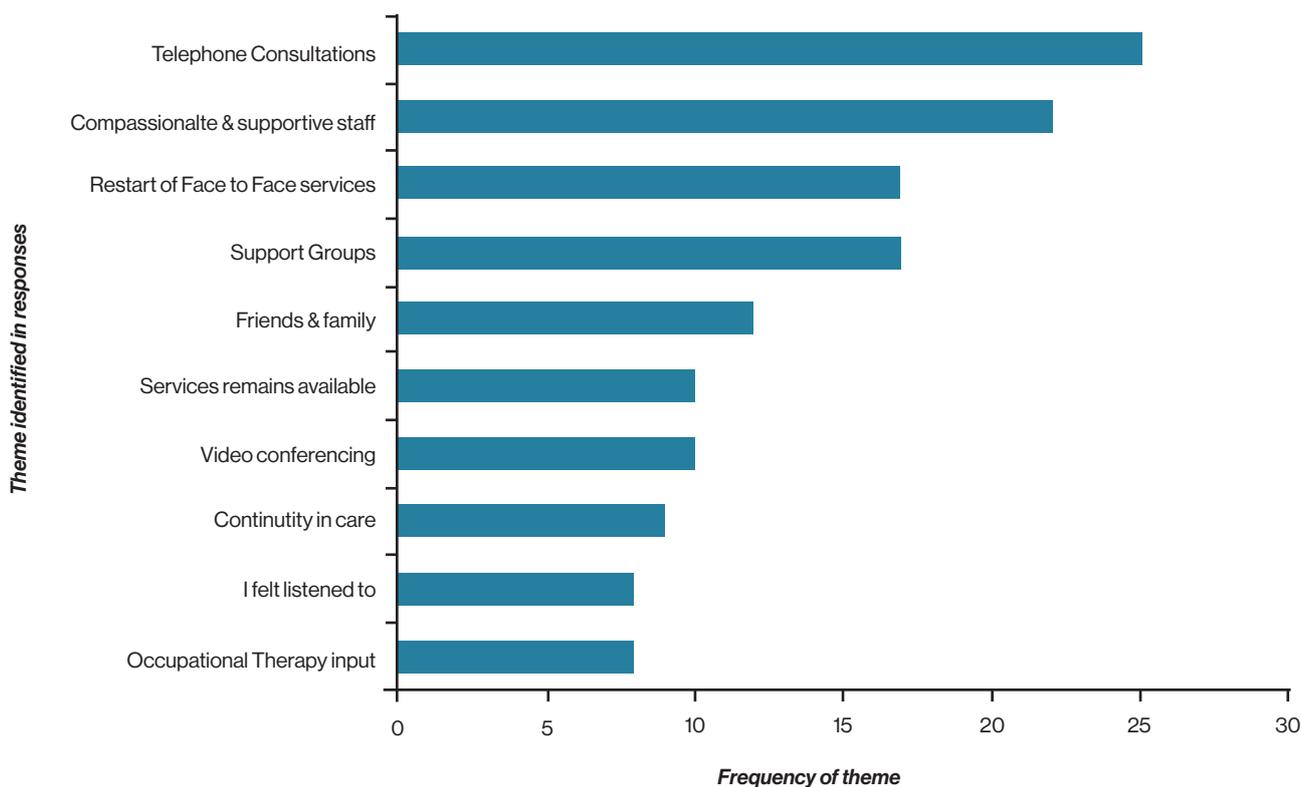
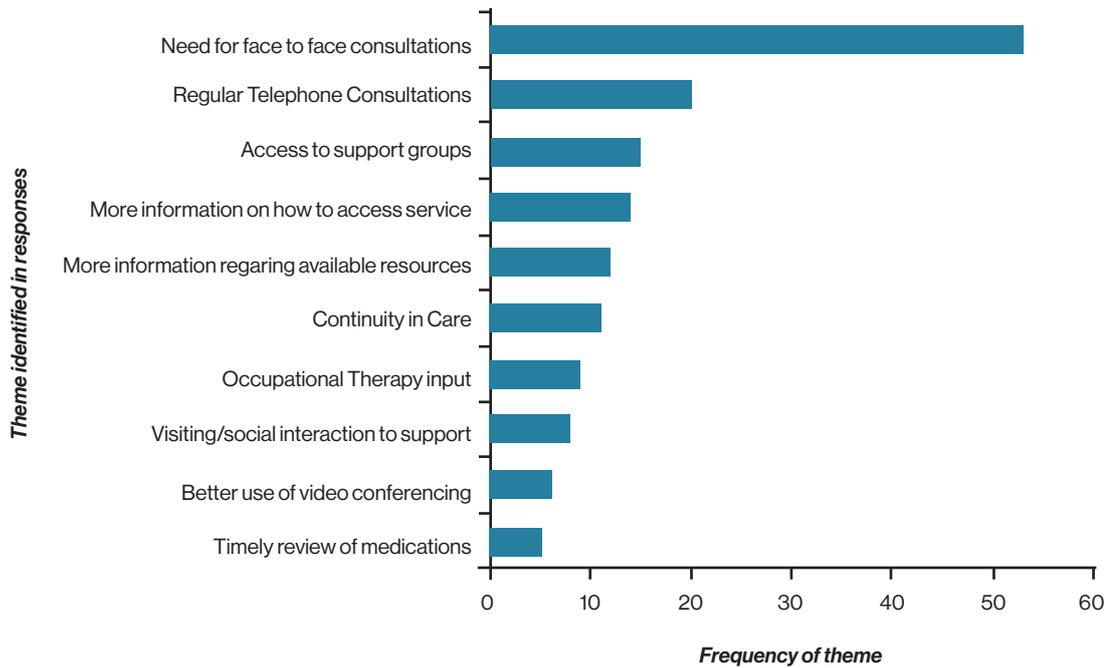


Figure 23 outlines the top ten themes identified in the final question –“What could we improve upon to support you and your mental health and wellbeing throughout COVID-19 pandemic. It is evident that face to face consultations are high on the list of priorities for the respondents alongside telephone consultations, increased access to support groups, more information on available resources/changes to services and continuity in care.

**Figure 23. Themes identified from Step 5b. What we could improve upon to support you and your mental health & wellbeing throughout the COVID-19 Pandemic**



The themes identified echo the key messaging found in the previous discussions (4.3-4.10). There is a clear emphasis on the importance of face to face consultations. Many respondents acknowledge the importance of the alternative methods, in particular regular telephone consultation, however they also reflect on the value of face to face meetings.

**“...Personally, I would like more face to face contact but I understand that the nature of Covid makes this extremely difficult...”**

**“...Facilitate more face to face communication for those who really need it and find remote communication too difficult. Recognise the needs of service users who need a carer to accompany them to appointments but where the carer usually waits in a waiting area...”**

**“...I appreciated the telephone calls but nothing compares with face to face but I do understand why this is essential...”**

**“...At present face to face meetings are beneficial even if restrictions are tightened up again, could screens be put up in centres to allow face to face to continue?...”**

The challenge identified in moving forward in mental health services is to balance effective engagement with the service user and keeping service users and staff safe during COVID-19 pandemic. As identified each method had limitations and challenges and to meet the needs of the individual it may be necessary to embed a blended approach to engaging during the COVID-19 Pandemic.

The following section presents the summary of key messages identified in the analysis and the next steps to support the voice of the service users & carers to be integrated into future plans for Mental Health Services.

# 5.0 CONCLUSIONS

## 5.1 Summary of Key Findings

The following statements frame the key messages shared by the respondents through this study and should be considered for further development at both local and regional levels. It is important to re-emphasise these are the collective messages informed by the responses to the survey; further deeper dives into the data in relation to context questions can give support messaging in a specific area of interest, for example specific services, professions, age etc..

- **Continuity of Care:** For service users who have been part of Mental Health Services prior to the pandemic, it is important to stay connected with the practitioners and wider team known to the service user and support continuity of their treatment and care.
- **Sustaining Relationship:** the importance of the relationship between the service user and their mental health practitioner is key to ensuring the transition from face to face to more blended approaches to care and treatment.
- **Occupational Therapy:** provide an important role in supporting the mental health and wellbeing of service users, in particular when activities/routines are interrupted by lockdown measures.
- **Communication of changes** is key to support service users and carers to understand how services have changed & adapted during the pandemic; Also clarity on how or where service users can access help during a crisis is essential, in particular timely assessment for new referrals.
- **Choice in the methods of engagement** – options in methods of engagement (telephone consultations, video conferencing and online apps) offer effective alternatives to face to face consultations in support of service users during the COVID-19 pandemic; however it is recognised there are limitations for each and they do not fully replace the value of a face to face interactions. It is important each method is explored according to the needs of the individual and a blended approach adopted to ensure safe meaningful engagement between the service user and Mental Health Services.
- **Accessing Mental Health Service** through alternative methods can present a barrier for individuals with more complex communication needs – for example telephone led services are inaccessible to Sign Language speakers. It is important that appropriate communication methods are developed to support accessibility for all service users requiring interaction with Mental Health Services across the region.
- **Partnership working** remains an important part of the service users experience during the COVID-19 pandemic. In particular listening is identified as an important skill for meaningful engagement. In relation to telephone consultations it was highlighted the importance of taking time to listen and not to rush the call. Involvement in decision making needs to be further embraced when engaging Mental Health services for example informed decisions around how to best engage with a service (i.e. telephone consultations, face or face) and how often.

## 5.2 Next Steps

Through integration of these key messages from the regional study into future service planning, the experiences of the service users and carers will shape and improve the delivery of care in Mental Health Services. The analysis and key messaging will be shared with strategic forums to influence plans for the rebuild of Mental Health Services and the long term commitment for the Mental Health Strategy for Northern Ireland which is currently in development.

In acknowledgement of the dedication of service users and carers who shared openly and honestly their experience of Mental Health Services during the COVID-19 Pandemic. This report will also be formatted into an interactive link to support communication of the findings with the public. Through embracing the words of service users & carers stakeholders in Mental Health Services can reflect upon the current experience and learn how to improve the delivery of treatment & care in partnership with their patient, clients and families.



**1000 More Voices Initiative is managed by-**  
**Regional Lead for Patient Client Experience (PCE): Mrs Linda Craig: [linda.craig3@hscni.net](mailto:linda.craig3@hscni.net)**  
**Assistant Director for AHP, PPI and PCE: Mrs Michelle Tennyson: [michelle.tennyson@hscni.net](mailto:michelle.tennyson@hscni.net)**



<http://1000morevoices.hscni.net>