Video Consultations in the Mental Health Services

An exploration of adult outpatients' and mental health professionals' experiences with video consultations between the clinic and the patient's home

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PhD Thesis

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List of Scientific Papers

This thesis is based on the following three papers:

Paper 1

Patients' acceptance of video consultations in the mental health services: A systematic review and synthesis of qualitative research.

Anne Marie Moeller, Lone Fisker Christensen, Jens Peter Hansen, & Pernille Tanggaard Andersen.

Digital Health, 8. (2022). https://doi.org/10.1177/20552076221075148

Paper 2

Patients' Experiences of Home-Based Psychotherapy via Videoconference: A Qualitative Study.

Anne Marie Moeller, Jens Peter Hansen, & Pernille Tanggaard Andersen.

Archives of Psychiatric Nursing, 39, 91-96. (2022). https://doi.org/10.1016/j.apnu.2022.03.004

Paper 3

Factors that determine mental health professionals' decision to support home-based video consultations: A qualitative study.

Anne Marie Moeller, Jens Peter Hansen, & Pernille Tanggaard Andersen

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English Summary

Introduction: The current PhD study focuses on patients' and mental health professionals' experiences with using home-based video consultations from a psychiatric hospital. Video consultations has the potential to increase access to health care services, but this way of communicating may also have limitations affecting the treatment quality. Providers of these services are, therefore, trying to find the most meaningful ways to use these consultations. Studies have already established that the clinical effect of using video consultations is similar to in-person consultations for a number of mental health diagnoses. However, many mental health professionals have been reluctant to make use of video consultations due to assumptions that the medium will lower the treatment quality. Given that the mental health professionals are gatekeepers to the implementation, it is important to understand their concerns and that of their patients by exploring their experiences with its use in usual practice.

Research question: The overall research question of the thesis is: "how do adult outpatients and mental health professionals experience using video consultations in psychiatric hospitals?" The thesis is based on three scientific papers with the following aims:

- Paper I: to explore patients' perceptions of factors influencing their acceptability of video consultations.
- Paper II: to explore adult outpatients' experiences with home-based psychotherapy via videoconferencing in a Danish psychiatric hospital.
- Paper III: to investigate what constitutes a professional video consultation with regard to its framework and content from the perspectives of mental health professionals and explore what is of importance for the establishment and realization of video consultations to make it accepted among the professionals.

Methods: The current PhD study used different qualitative research methods. In the first paper, a systematic review and synthesis of qualitative research was performed. The synthesis was based on a meta-summary and then a taxonomic analysis. The second paper was based on individual interviews with adult outpatients (n: 7) from a Danish psychiatric hospital who had used at least one video consultation with their therapist. Systematic text condensation was used to analyze data. The third paper was a grounded theory study that were based on field observations and individual interviews with managers and facilitators (n: 7) and different mental health professionals (n: 11). It used theoretical sampling, constant comparisons, and open, axial, and selective coding, to develop a substantive grounded theory.

Findings:

In paper 1, a model was developed with five factors influencing patients' acceptance of video consultations that precede and interact with each other. Patients thought video consultations were acceptable when 1) they experienced barriers and inconvenience to accessing the location of services, 2) they had already established a trustful relationship with their therapist, 3) technical interferences were minor and problems were resolved quickly, 4) patients expected a less personal meeting, and 5) the degree of the patients' issues were less complex.

In paper 2, the findings indicate that patients found videoconferencing-based psychotherapeutic sessions for preventive relapse useful, and they believed that it was possible to maintain a good therapeutic relationship via videoconferencing when they knew their therapist in advance. However, experiences with more in-dept psychotherapy was more inconclusive as some felt alienated and preferred other ways to communicate. In general, the patients found videoconferencing-based psychotherapy to be less personal but worth considering when travel hassles outweigh the need for meeting in person.

In paper 3, it was found that mental health professionals believed a professional video consultation was one that was not inferior to an in-person consultation but offered something else, such as more and easier access, accommodating patients' needs and wishes. At the same time, it should not interfere with the treatment quality, e.g., by hampering communication and therapeutic tasks. The expected treatment quality was based on an individual assessment of the patient and varied from mental health professional to mental health professional. The implementation process and support which the organization provided affected the mental health professionals' attitudes as well as their experiences and hence how they assessed the quality of the service.

Conclusion: Using video consultations between mental health professionals and their patients while the patient is at home is an acceptable practice when barriers to access exist. From both patients' and mental health professionals' perspective, video consultations should not be used if it would hamper the treatment, such as negatively impacting the therapeutic relationship, or be impossible to complete due to technical disruptions. Finally, acceptance of video consultations is also based on individual attitudes and personal preferences.

Dansk Resumé

Introduktion: Denne ph.d.-afhandling handler om psykiatriske patienter og deres behandleres oplevelser med at bruge hjemmebaserede videokonsultationer. Videokonsultationer kan øge adgangen til sundhedsvæsenet, men denne form for kommunikation kan også have en begrænsende effekt på behandlingskvaliteten. Derfor er udbyderne af videokonsultationer nu i gang med at undersøge hvordan disse konsultationer bruges på den mest acceptable måde. Andre studier har allerede fundet at den kliniske effekt ved at bruge videokonsultationer i psykiatrien er den samme som ved konsultationer med fysisk fremmøde blandt patienter med mange forskellige psykiatriske diagnoser. Mange behandlere har alligevel været tilbageholdende med at implementere videokonsultationer på grund af antagelser om at det vil nedsætte behandlingskvaliteten. Eftersom behandlerne er gatekeepere for brugen, er det vigtigt at forstå deres bekymringer ved at studere deres oplevelser med at bruge dem i almindelig praksis.

Forskningsspørgsmål: Det overordnede forskningsspørgsmål er: ”hvordan oplever voksne ambulante patienter og behandlere brugen af videokonsultationer i tilknytning til psykiatriske sygehuse?”. Afhandlingen er baseret på tre videnskabelige artikler med følgende formål:

- Artikel 1: at udforske patienters opfattelse af faktorer som påvirker hvorvidt de godtager videokonsultationer.
- Artikel 2: at udforske voksne ambulante patienters oplevelser med hjemmebaseret psykoterapi via videokonference tilknyttet et dansk psykiatrisk hospital.
- Artikel 3: at undersøge hvad der konstituerer en professionel videokonsultation med hensyn til rammerne og indholdet fra behandlere i psykiatriens perspektiv, og udforske hvad der er vigtigt for etableringen og gennemførelsen af videokonsultationer for at gøre det acceptabelt blandt behandlerne.

Metode: Dette ph.d.-studie har brugt forskellige kvalitative forskningsmetoder. Den første artikel er et systematisk review med en syntese af kvalitativ forskning. Syntesen er baseret på et meta-sammendrag og en taksonomisk analyse. Den anden artikel er baseret på individuelle interviews med voksne ambulante patienter (n: 7) fra et dansk psykiatrisk hospital som havde brugt mindst én videokonsultation med deres behandler. Til at analysere data blev der brugt systematisk tekst kondensering. Den tredje artikel var et grounded theory studie som var baseret på feltobservationer og individuelle interviews med ledere og facilitatorer (n: 7) og forskellige behandlere (n: 11). Der blev brugt teoretisk sampling, foretaget sammenligninger og data blev kodet åbent, aksialt og selektivt for at udvikle en selvstændig teori.

Fund:

I den første artikel blev en model udviklet med fem faktorer der påvirker patienters accept af videokonsultationer. Faktorerne går både forud for hinanden og interagerer med hinanden. Patienterne syntes videokonsultationerne var acceptable når 1) de oplevede adgangsbarrierer og besvær med at møde op på klinikken, 2) de allerede havde etableret et tillidsfuldt forhold med deres behandler, 3) tekniske problemer var begrænsede og problemer blev løst hurtigt, 4) patienter forventede et mindre personligt møde, og 5) patientens symptomer var mindre komplekse.

I artikel 2 blev det fundet at patienter syntes at videokonferencebaserede psykoterapeutiske sessioner til forebyggende tilbagefald var brugbare, og de mente at det var muligt at bevare en god terapeutisk relation via videokonference når de kendte deres behandler først. Patienternes oplevelser med dybdepsykoterapi var ikke lige så positive da nogle følte sig fremmedgjorte og foretrak andre måder at kommunikere på. Generelt følte patienterne at videokonferencebaseret psykoterapi var mindre personligt, men værd at overveje når transportbesvær opvejede behovet for at mødes fysisk.

I artikel 3 blev det fundet at behandlerne mente at en professionel videokonsultation var en der ikke var underlegen en konsultation med fysisk fremmøde, men var en der kunne tilbyde noget andet, såsom mere og nemmere adgang, hvor patienternes behov og ønsker ligeledes blev imødekommet. Videokonsultationerne må ikke forstyrre behandlingskvaliteten ved for eksempel at vanskeliggøre kommunikation og terapeutiske opgaver. Den forventede behandlingskvalitet var baseret på en individuel vurdering af patienten, og varierede fra behandler til behandler. Implementeringsprocessen og den støtte organisationen tilbød påvirkede behandlernes indstillinger til og erfaringer med at bruge det, og dermed hvordan de vurderede kvaliteten.

Konklusion: Brugen af videokonsultationer mellem psykiatriske behandlere og deres patienter, hvor patienten er i sit eget hjem, er en acceptabel praksis når der eksisterer adgangsbarrierer. Både patienter og behandlere mener at det ikke skal bruges hvis det vanskeliggør behandling, såsom at påvirke den terapeutiske relation negativt, eller når det er umuligt at gennemføre på grund af tekniske problemer. Hvordan videokonsultationer opleves afhænger derudover af behandlernes og patienternes individuelle holdninger og personlige præferencer.

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Introduction

Purpose of the Present PhD Study

This PhD study develops knowledge about adult outpatients' and mental health professionals' experiences with using video consultations within the framework of psychiatric hospital services. The thesis' point of departure was that video consultations were introduced as a new service into usual practice at the public Danish psychiatric hospital in the Region of Southern Denmark in 2015 (Region Syddanmark, 2015). It was the first time that it was implemented in large scale at a Danish psychiatric hospital (Folker, Helverskov, Nielsen, Jørgensen, & Larsen, 2018). Evidence in 2015 suggested that equal clinical outcomes when using videoconferencing in the delivery of psychiatric assessments and psychotherapy for multiple disorders could be achieved (Backhaus et al., 2012; Chakrabarti, 2015), but little was known about how patients and mental health providers experienced using video consultations. This PhD study was, therefore, initiated with the question: "what are the users' experiences with video consultations at a Danish psychiatric hospital?". This PhD thesis comprises of a review of adult outpatients' experiences with video consultations from a variety of settings and empirical research conducted at the public Danish psychiatric hospital located in the Region of Southern Denmark. The research design is based on different qualitative methods: synthesis of qualitative research (Sandelowski & Barroso, 2007), systematic text condensation (Malterud, 2012), and grounded theory (Strauss & Corbin, 2015). The empirical foundation of the thesis is based on qualitative interviews with patients and mental health professionals and observations of implementation practices.

In the following, I will unfold the challenges of access to mental health services, explain how video consultations could help alleviate these issues, and finally present a literature review of the current knowledge of using video consultations with patients at psychiatric hospitals.

Disease Burden of Mental Illness

Mental health is an integral part of an individual's capacity to lead a fulfilling life, which include the ability to form and create relationships and be able to study, work, and pursue leisure interests. Mental illness involves significant disturbances in thinking, emotional regulation, or behavior and will lead to diminished functioning at the individual level and economic losses both for the individual and society (World Health Organization, 2013). Globally, 1 in every 8 people live with a mental illness (World Health Organization, 2022a), and the onset of mental illnesses most often occur at a young age (Kessler et al., 2005). For that reason, it is among the top ten leading causes of disease burden worldwide with a prevalence of 970.1 million cases in 2019. That year it contributed to 125.3 million years lived with disability which corresponded to 14.6 % of years lived with disability (GBD 2019 Mental Disorders Collaborators, 2022). Mental disorders do not only impair health in its own right,

but it also contributes to other health outcomes such as suicide (Too et al., 2019). In continuation hereof, people with a mental disorder can expect to live 10 years shorter than the general population on average (Walker, McGee, & Druss, 2015), and among serious mental ill patients it is 15-20 years shorter (Wahlbeck, Westman, Nordentoft, Gissler, & Laursen, 2011). In a recent study it is found that citizens in Denmark with a mental illness are more likely to die if they are affected by a somatic disorder compared to others (Behandlingsrådet, 2023). To reduce the burden of disease, coordinated delivery of effective prevention and treatment programs are needed. Treatment regimens exists, including psychotherapeutic interventions and medications, which can be effective in improving symptoms, functional outcomes, and quality of life (Sundhedsstyrelsen, 2014, 2018, 2019a, 2019b, 2021). However, globally there is a shortage of these services, and unmet needs for mental health treatment are pervasive (Thornicroft et al., 2017; World Health Organization, 2021). Moreover, during the COVID-19 pandemic, the lack of sufficient access to services increased due to disruptions of mental health services and a rise in both anxiety and depressive disorders (World Health Organization, 2022b).

Access to Mental Health Services

Access to healthcare services can be defined as a concept representing the degree of "fit" between the clients and the system, and it summarizes a set of more specific areas: availability, accessibility, accommodation, affordability, and acceptability (Penchansky & Thomas, 1981). Unmet needs for mental health treatment worldwide are caused by all the specific areas such as lack of sufficient service offers and challenges for people receiving these services (Clement et al., 2015; World Health Organization, 2021). Insufficient availability is, among other things, caused by a lack of funding and health care personnel (World Health Organization, 2021). Estimates from 2019 show that countries globally spend around 2.1 % of governmental total health spendings on mental health, and among high income countries exclusively it is around 3.8 % (World Health Organization, 2021). Compared with the disease burden of 14.6 % (GBD 2019 Mental Disorders Collaborators, 2022), the health spendings does not correspond with the burden of disease mental disorders represent. In continuation of this, there is a shortage of mental health professionals worldwide. Even though it is most profound in low-income countries, unmet needs of mental health professionals are, however, also seen in high income countries (World Health Organization, 2021). On top of this, psychiatry has been a less popular specialty during the last decades, and in USA it has resulted in a predominant number of psychiatrists that are nearing the end of their carriers and a proportional amount not entering the field (Butryn, Bryant, Marchionni, & Sholevar, 2017). Furthermore, high rates of psychiatrists and psychiatric trainees in various countries around the world experience burnout symptoms and low job satisfaction (Bykov et al., 2022; Jovanovic et al., 2016; Yao et al., 2021). This could increase the shortage even further in the future.

In addition, individuals in need of mental health care experience barriers to accessing the existing services. Some of these include difficulties paying for the services in countries with no universal health care coverage (Samuel & Kamenetsky, 2022), long distances to the clinics (Packness et al., 2017), stigmatization (Patel & Saxena, 2019), and language and cultural barriers (DeSa, Gebremeskel, Omonaiye, & Yaya, 2022). Fear of stigmatization, such as holding stigmatizing views about oneself in regard to having a mental illness or stigmatizing views about seeking or receiving treatment for mental illness, have a negative impact on help-seeking behavior (Clement et al., 2015; DeSa et al., 2022). Studies of barriers to care-seeking show that about 21-23 % of participants across studies report shame or embarrassment, negative social judgement, and employment-related discrimination as barriers (Clement et al., 2015). Besides stigma, language barriers can exist among some groups, e.g., among refugees. This may lessen the effects of talking therapies and hamper understanding of how to enter mental health services (DeSa et al., 2022).

In conclusion, mental disorders are a major cause of the overall disease burden. While effective interventions exist to reduce this burden, citizens in need experience several barriers to accessing these. Future challenges mental health care services are facing include the limited number of available mental health professionals and difficulties reaching all citizens in need.

Access to Mental Health Services in Denmark

It has been estimated that every 10 Dane has a mental illness, and every third person living in Denmark will receive a psychiatric diagnosis during their life course (Bedre Psykiatri, 2022). Similar to the global burden of disease, the prevalence of mental illness in Denmark constitutes 14.5 % of all causes of disability or death in 2019 (Institute for Health Metrics and Evaluation, 2019). The annual healthcare cost of any mental disorder in Denmark has been estimated to be 1.63 billion Euros including psychiatric services, somatic services, primary health care, and subsidized prescriptions, however, the annual income loss for any mental disorder was more than three times as high which underpins the importance of efficient health care services (M. K. Christensen et al., 2022).

In the Danish Healthcare Act, chapter 1, § 2., it is stated that there need to be easy and equal access to healthcare services (Indenrigs- og Sundhedsministeriet, 2022). The mental healthcare services in Denmark are tax-financed and right-based and, therefore, universally available without direct individual payment for the patient with few exceptions (Nordentoft, Krantz, & Hageman, 2022). Affordability is, thus, not a major access barrier. However, the Danish Health Authority have described several challenges that the Danish mental health services face today, including a lack of treatment offers, lack of coherence between services, and considerable challenges with recruitment and maintaining employees (Sundhedsstyrelsen, 2022). These limitations may cause bottlenecks on the existing services and produce longer waiting lists, ultimately leaving patients without treatment.

Mental health services seem to have politically been given a lower priority than the somatic hospitals (Sundhedsstyrelsen, 2022). The Danish Council on Ethics made a comparison of selected illnesses and found that the spendings on cancer patients are three times higher than that of long-term mental ill patients even though it is not evident that there are similar differences in these groups' treatment needs. The Danish Council on Ethics proclaim that there are no apparent ethical relevant reasons for this discriminatory practice (Det Etiske Råd, 2018).

A specific challenge at Danish psychiatric hospitals is, besides lack of psychiatrists, that patients in outpatient care have high no-show rates and late cancellations (Moesgaard & Aagaard, 2016). It is challenging for mental health providers to rearrange their time with short notice leading to ineffective use of their time. Moreover, it has been observed that the distance from the patient's home to the psychiatric service is negatively related to the number of visits to outpatient psychiatrists even though psychiatric services in Denmark are free at delivery. This correlation is strongest among people in lower income groups (Packness et al., 2017). Therefore, delivery of effective prevention and treatment programs with established efficacy needs to be expanded to reach all of the population.

Video consultations in the Mental Health Services

Various initiatives could alleviate these access barriers. One of them is to use digital solutions and health technologies that can increase the patients' accessibility and assist mental health care services making working procedures and treatment more efficient (Feusner et al., 2022; Shore, 2015). These technologies have been suggested as one of several solutions to the mental health professional shortage (Butryn et al., 2017; OECD, 2021). In Denmark, the Danish Health Authority have recommended that for an efficient use of resources, digital solutions should be disseminated, and used systematically and evidence based to a larger degree than it already is. This is both to increase the accessibility and the patient experienced quality of mental health services (Sundhedsstyrelsen, 2022). In Denmark, the vast majority (97 %) have access to internet in their own home, owns a computer, and are frequent users and trustful of digital solutions offered by the public sector (Tassy & Nielsen, 2020). This means that the technology on the users' side is ready, and the digital transformation is thus dependent on the healthcare organizations' adaptability.

An obvious technology to use is video consultations. When using a video consultation, regular practice, such as psychoeducation, psychotherapy, social support, medication management and assessment, is moved to a videoconference. Video consultations have several benefits on supporting mental health services, such as improving access and convenience to care among patients by reducing travel obstacles, time, and costs (Bleyel et al., 2020; Borges, 2019), provide specialty services to underserved locations (Bleyel et al., 2020; Borges, 2019), improve continuity of care and follow-up (Shore, 2020), reduce the need for patients taking time off from work due to the saved time (Borges,

2019; Shore, 2020), provide services to disabled that cannot leave their home (Amirsadre, Burns, Pizzuti, & Arfken, 2017), eases inclusion of relatives (Borges, 2019), and it can reduce the barrier of stigmatization for treatment-seeking since it is possible to get treatment without leaving home (Bird, Chow, Meir, & Freeman, 2019; Shore, 2020).

Moreover, according to OECD Mental Health System Performance Framework, a high-performing mental health system must be person-centered, focusing on the individual who is experiencing mental ill-health. This means that "the individual-centered care should ensure the individual feels they have ownership of their own care; be respectful and inclusive of the individual, career (where relevant), and family; ensure care and treatment is tailored to individual needs and preferences; be culturally, age and gender appropriate; empower the individual to realize his or her own potential and contribute to society" (OECD, 2021). Telemedicine, including video consultations, has been proposed to make healthcare services more person-centered, since it gives patients more options on how to receive treatment (Shore, 2015). It may also displace the power relations between the patient and provider in a direction where the patient has more control over the situation and clinical setting, and using videoconferencing requires more active collaborative interactions both for technical and clinical parts (Shore, 2015). This is also the argument that are used in the Mental Health Services in the Region of Southern Denmark's developmental plan from 2018-2021, where it appears that the organization wants to be leading in the use and development of telepsychiatry, including video consultations, and digital tools that will support the patient and streamline treatment courses with take-off in the individual's demands and needs (Psykiatrien i Region Syddanmark, 2018c).

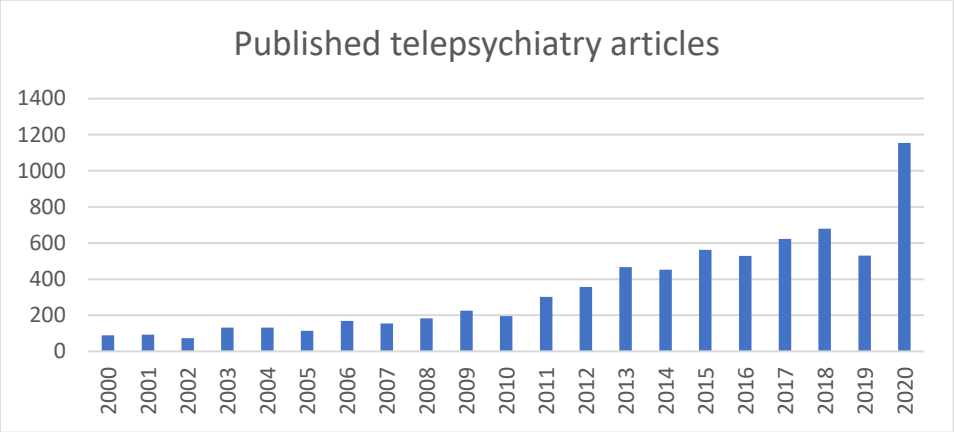
In conclusion, using video consultations in the mental health services, has the potential to increase accessibility and it could give patients more options of how to receive their treatment which would strengthen person-centered care.

Evolution

The use of video consultations in psychiatry has a long history. Back in 1959 the University of Nebraska began using two-way closed-circuit microwave television for medical treatment and education largely in psychiatry. Shortly after, it was expanded to two psychiatric hospitals nearby providing consultations, education, training, and research. This proved to be an effective way of allocating personnel time due to a scarcity of psychiatrists (Wittson & Benschoter, 1972). During the 1960s and the early 1970s some other video consultation systems were launched. However, all of them were shut down for various reasons. Lack of funding was the most important cause (Brown, 1998). Nevertheless, in the 1990s cost of videoconferencing and telecommunications were reduced, and the quality of both sound and picture improved. Then the use of video consultations sharply increased, and many more studies of its availability have been published (Brown, 1998). From an

examination of published articles in scientific journals found in the literature review that are part of the present PhD study, it is evident that the amount of research conducted in the field has increased markedly through the last two decades. In Figure 1 the number of individual hits that appeared when using the search strand and strategy from the review (see the search strand in the Method section on page 23). The search strand covers digital mental health technologies broadly, not only video consultations, and are referred to as telepsychiatry.

Figure 1. Published telepsychiatry articles the last 20 years



Note: Number of individual hits arising from the search strand used in paper 1

Adoption

From the 1990s and 2000s, use of video consultations in mental health services were mostly adopted in highly developed countries with large rural and sparsely populated or impassable areas, such as rural USA (Brown, 1998), Canada (J. Simpson, Doze, Urness, Hailey, & Jacobs, 2001), Australia (Hawker, Kavanagh, Yellowlees, & Kalucy, 1998), New Zealand (Al-Qirim, 2006), the island of Jersey (Harley, McLaren, Blackwood, Tierney, & Everett, 2002), Canary Islands (De Las Cuevas, Artiles, De La Fuente, & Serrano, 2003), the Inishmore Island (Mannion, Fahy, Duffy, Broderick, & Gethins, 1998), Shetland Islands (S. G. Simpson, Deans, & Brebner, 2001), the Highlands of Scotland (Freir et al., 1999), northern Finland (Mielonen, Ohinmaa, Moring, & Isohanni, 1998), and northern Norway (Hanssen, Wangberg, & Gammon, 2007). Since then, there has been a slow increase of video consultation services to cover more citizens. In USA, the number of video consultations did rise from 2012-2017, but the overall adoption was still low (Creedon et al., 2020). In 2017 only 29.2 % of mental health facilities in USA offered video consultation services, however, those located in states with a high proportion of rural areas had more often adopted the service than those in other states (Spivak et al., 2020). Higher adoption in rural areas underpins that distance to services makes the modality perceived more useful and acceptable. It also seems that using video consultations to increase mental health care coverage had not reached its full potential.

On March 11, 2020, the COVID-19 pandemic was declared by the World Health Organization (World Health Organization, 2020). A policy brief from the United Nations followed that recommended to scale up access to remote support for any mental health need (United Nations, 2020). During the COVID-19 crisis many health care systems have been adopting telehealth care services, including video consultations, to overcome social distance policies and to slow down the transmission of the virus (Greenhalgh, Wherton, Shaw, & Morrison, 2020). In Denmark, 10-20 % of contacts were virtual before the COVID-19 lockdown experienced in March 2020 which include video and telephone calls. During the lockdown it drastically changed to cover up to 75 % of all consultations with patients (Hansen, van Sas, Flojstrup, Brabrand, & Hvolby, 2021). Due to the slow pre-COVID-19 adoption of telehealth there is now a discussion of to what degree the rapid and extensive telehealth adoption during COVID-19 is going to be sustained (Wind, Rijkeboer, Andersson, & Riper, 2020).

Current Knowledge

During the last decades, research about video consultations in the mental health services have been conducted. The continuing part will go through the most salient research that this PhD study builds upon.

Clinical Outcomes

When offering video consultations, it is important to know the effectiveness compared to usual practice. The research that focuses on clinical outcomes have, in general, found similar effects on symptoms when using a video consultation compared with an in-person consultation among a variety of mental health patients (Hubley, Lynch, Schneck, Thomas, & Shore, 2016; Norwood, Moghaddam, Malins, & Sabin-Farrell, 2018).

Different psychological interventions given through videoconferencing have proven to be as effective as when given in person (Norwood et al., 2018). A meta-analysis of randomized controlled studies found that clinical outcomes of psychotherapy delivered via videoconference are noninferior to psychotherapy delivered in person. The included studies covered patients with depression, anxiety disorders, PTSD, and bulimia nervosa (Norwood et al., 2018). Example of studies that have been conducted with patients with PTSD where prolonged exposure therapy and eye movement desensitization and reprocessing therapy given via videoconferencing in the patients home were compared with the same delivered in person, and similar effects were found in regard to symptoms of PTSD and depression, and are considered to be safe and effective even for severe or complex cases (Acierno et al., 2017; Bongaerts, Voorendonk, van Minnen, & de Jongh, 2021). Of other anxiety disorders, there have been positive findings for patients with OCD receiving exposure and response prevention via videoconferencing. Clinically and statistically significant reductions were observed on symptoms of OCD, depression, anxiety and stress, and improved quality of life with improvements

maintained 12 months after. It also appeared to be advantageous that therapists could readily interact with patients in the specific settings that most triggered the patients' obsessional thoughts, images, or urges, e.g., at home (Feusner et al., 2022). In randomized controlled studies, where in-person based cognitive behavioral therapy for either a variety of anxiety disorders or panic disorder with agoraphobia were compared with videoconference-based cognitive behavioral therapy, similar reductions were found in symptoms of anxiety and stress (Bouchard et al., 2004; Stubbings, Rees, Roberts, & Kane, 2013). Among patients with a depression, problem solving therapy and cognitive behavioral therapy received over a videoconference in the patients' home have also yielded similar reductions in symptoms of depression as compared with the same received in person (Choi, Hegel, et al., 2014; Stubbings et al., 2013).

Randomized studies of psychiatric treatment, such as psychotropic medication assessment, psychoeducation, and brief supportive counselling or cognitive behavioral therapy, given via videoconference in the patient's home, have also found similar treatment effects as when given in person among a variety of patient groups (De Las Cuevas, Arredondo, Cabrera, Sulzenbacher, & Meise, 2006; O'Reilly et al., 2007; Ruskin et al., 2004). Furthermore, several studies have also proven that psychiatric assessments, symptom assessments, and diagnosing via a videoconference can yield similar precision as in person (Lexcen, Hawk, Herrick, & Blank, 2006; Rees & Haythornthwaite, 2007).

Satisfaction and Acceptance

Video consultations are supposed to increase person-centered care (Shore, 2015) which include catering to the individual's preferences (OECD, 2021). It is therefore important to know what the patients' satisfaction and acceptance of the services are. Mental health professionals are the gatekeepers (Cowan, McKean, Gentry, & Hilty, 2019), and their opinions are similarly important. In studies with patients using videoconference for mental health issues, patients' responses to quantitative self-report questionnaires most often reveal high satisfaction that are comparable with in-person services (Hubley et al., 2016; Yuen et al., 2015). In a study from USA, rural patients' satisfaction with psychiatric teleconsultations was higher than that of their suburban counterparts, though both were overall high (Hilty, Nesbitt, Kuenneth, Cruz, & Hales, 2007). In another study from USA of older adults with a depression receiving problem-solving therapy in their own home, it appeared that those who received the therapy via a videoconference compared to those who received it in person were more satisfied (Choi, Hegel, et al., 2014). The patients specifically highlighted the convenience, such as not having to go anywhere, and not having to prepare or clean oneself or the house before a session (Choi, Wilson, Sirrianni, Marinucci, & Hegel, 2014). Mental health professionals' satisfaction is typically not as high as that of the patients, probably due to that they are

comparing it with usual in-person sessions (L. F. Christensen, Gildberg, et al., 2020a; Hubley et al., 2016). However, the majority of both patients and mental health professionals have been satisfied with video consultation services during the COVID-19 social distancing policies (Li et al., 2022).

Qualitative studies suggest that video consultations increase satisfaction among patients and providers because they are convenient (Dunstan & Tooth, 2012; Frayn, Fojtu, & Juarascio, 2021; Gordon, Wang, & Tune, 2015; Hensel, Yang, Vigod, & Desveaux, 2020; Sheikh et al., 2023; Tarp & Nielsen, 2017; Ye et al., 2012). Patients highlight as a benefit that it is possible to save transport cost and time, so they easier would be able to attend other appointments and job obligations (Ashwick, Turgoose, & Murphy, 2019; Frank et al., 2017; S. G. Simpson, Guerrini, & Rochford, 2015; Tarp & Nielsen, 2017). They can also rest immediately after a session (Tarp & Nielsen, 2017). Moreover, it is possible to keep the same therapist in case the therapist or the client moves away (S. G. Simpson et al., 2006; S. G. Simpson et al., 2015), it is possible to continue a treatment course in case of social restrictions (Leukhardt, Heider, Reboly, Franzen, & Eichenberg, 2021), and it is possible to find a therapist with same cultural background that speaks the same language and has a similar ethnic background even when the therapist lives far away (Cipolletta, Frassoni, & Faccio, 2020; Ye et al., 2012). Some therapists believe that video consultations are better than phone consultations (Zentner, Gaine, Ethridge, Surood, & Abba-Aji, 2022), and some patients similarly state that they prefer video to a telephone call (Frank et al., 2017; Tarp & Nielsen, 2017). Some psychiatrists have mentioned that they think phone consultations are just as effective as video consultations for follow-up assessments (Sheikh et al., 2023). Some patients mentions that they want to meet in person as well (Cipolletta et al., 2020). Many patients prefer meeting their mental health provider in person (Bleyel et al., 2020), but when counterbalancing this disadvantage with the benefits of meeting over a video, then video consultations can be acceptable (Ashwick et al., 2019). Both therapists and patients mention that using video consultation was troublesome in the beginning but got easier over time (Bakke, Mitchell, Wonderlich, & Erickson, 2001; Dunstan & Tooth, 2012; López, Shealy, & Rheingold, 2014; Oakes, Battersby, Pols, & Cromarty, 2008; Rayner et al., 2016; Simms, Gibson, & O'Donnell, 2011; S. G. Simpson, 2001; S. G. Simpson et al., 2006; S. G. Simpson et al., 2015; Stubbings, Rees, & Roberts, 2020).

Therapeutic Relationship

What is essential to the psychotherapeutic course is the patient's own responsible involvement in the change process (Bugental, 1963). Edward S. Bordin [1913-1992], posited that it is the strength of the working alliance that will be the strongest factor for changes achieved in psychotherapy. He defined the working alliance as an agreement on goals, an assignment of task or a series of tasks, and the development of a bond (Bordin, 1979). Based on this concept, the Working Alliance Inventory

questionnaire was developed (Horvath & Greenberg, 1989). While using this questionnaire, the working alliance has proven to be one of the most important aspects of clinical improvement in psychotherapy (Horvath, Del Re, Fluckiger, & Symonds, 2011).

A review of the alliance in psychotherapy given over videoconference concludes that patients rated bond and presence at least equally as strong in video sessions as in-person sessions across a range of diagnostic groups (S. G. Simpson & Reid, 2014). Therapists also rated high levels of therapeutic alliance; however, it was typically not as high as that of their clients (Lopez, Schwenk, Schneck, Griffin, & Mishkind, 2019). A recent meta-analysis of randomized controlled studies has, though, shown that the working alliance of psychotherapy delivered via videoconference was inferior to that of psychotherapy delivered in person, but the working alliance was still rated very strong. The included studies covered patients with depression, anxiety disorders, PTSD, and bulimia nervosa (Norwood et al., 2018).

Communication via a videoconference affects the way the therapeutic relationship plays out. Studies of video consultations used for mental health issues, suggest that there might be benefits, such as a slower interaction through turn-taking, there will be more attention to social cues, and the power balance might be more equal (S. G. Simpson & Reid, 2014). However, many patients and mental health professionals find that video sessions are less personal and inferior to being in person (Ashwick et al., 2019; Frank et al., 2017; Frayn et al., 2021; Leukhardt et al., 2021; May et al., 2001; Simms et al., 2011; S. G. Simpson et al., 2006; Tarp & Nielsen, 2017; Wagnild, Leenknecht, & Zauher, 2006; Ye et al., 2012). Therefore, both therapists and patients recommend building a relationship in person before using video consultations (L. F. Christensen, Moller, Hansen, Nielsen, & Gildberg, 2020; Frank et al., 2017; Gordon et al., 2015; Hensel et al., 2020; Simms et al., 2011; Tarp & Nielsen, 2017). Some mention that when rapport is developed there are no preferences for either video or in-person encounters (Frank et al., 2017; S. G. Simpson et al., 2015; Tarp & Nielsen, 2017). When patients do not meet with their therapists in person first, it seems to take more time to develop an alliance over video (Gordon et al., 2015). Therapists mention that it might help to talk about uncertainty with webcams, talk about the shared environments, and use humor about the online communication to strengthen the relationship over video (Cipolletta et al., 2020; Dausch, Miklowitz, Nagamoto, Adler, & Shore, 2009).

A frequent issue discussed in regard to meeting over a videoconference and how this affects the relationship between the patient and the therapist relates to intimacy and how this might affect the patient's confidence in disclosing private thoughts and feelings. Some therapists and some patients find that communicating using video feels less intimate (Simms et al., 2011; Tarp & Nielsen, 2017; Wagnild et al., 2006) and less intensive (Dunstan & Tooth, 2012; Frank et al., 2017; Tarp & Nielsen,

2017) and that video can make some feel isolated and alienated depending on their situation (Sheikh et al., 2023; S. G. Simpson, 2001). However, other patients find the video consultations less intimidating and intrusive (Bakke et al., 2001; Rayner et al., 2016; S. G. Simpson et al., 2006; S. G. Simpson et al., 2001). Some patients and some therapists also find that being home allows for more intimacy (Gordon et al., 2015; Rayner et al., 2016).

An important part of a good therapeutic relationship is that the patient feels that they can share their intimate thoughts and feelings. Some therapists and patients find that it may be easier to disclose feelings and negative transference over video (Gordon et al., 2015; S. G. Simpson, 2001; S. G. Simpson et al., 2006). It has also been observed that patients can display a full range of affect (Himle et al., 2006; Oakes et al., 2008). A therapist has also observed that for some patients with anxiety, video consultation seems to reduce concerns about showing distress to the therapist (Himle et al., 2006). This could be due to the fact that the physical distance between therapist and patient made several patients feel less embarrassed (S. G. Simpson et al., 2006; S. G. Simpson et al., 2001) and more relaxed (Rayner et al., 2016; S. G. Simpson et al., 2006; Tarp & Nielsen, 2017) especially among anxious and avoidant people (Himle et al., 2006; Simms et al., 2011; Stubbings et al., 2020; Tarp & Nielsen, 2017). However, some therapists find that it is difficult to make anxious people settle (May et al., 2001; May et al., 2000) and some patients feel that video was noisy, confusing, and uncomfortable (Tarp & Nielsen, 2017). Finally, some patients finds that the conversation was less deep and that it was easier to lie over video (Tarp & Nielsen, 2017).

The Technology's Impact on the Encounter

Technical Disruptions

In studies of patients' and mental health professionals' experiences with video consultations, technical disruptions are very often reported (Ashwick et al., 2019; Cipolletta et al., 2020; Hensel et al., 2020; Sheikh et al., 2023). Reported disruptions includes issues such as delays (Dunstan & Tooth, 2012; May et al., 2001), poor picture quality or that the picture froze (Dausch et al., 2009; Dunstan & Tooth, 2012; Hensel et al., 2020; May et al., 2001; S. G. Simpson, 2001), problems with sound (Bakke et al., 2001; S. G. Simpson et al., 2001; Wagnild et al., 2006; Ye et al., 2012), and errors in file exchange (Cipolletta et al., 2020). Both therapist and patients felt that disruptions made the conversation feel artificial and during disruptions it was hard to identify facial expressions and non-verbal cues (Bakke et al., 2001; May et al., 2001; S. G. Simpson, 2001). Patients will handle these technical difficulties differently. Some studies indicate that technical interruptions will affect the therapeutic relationship depending on the quality of the alliance already established between therapist and patient (L. F. Christensen, Wilson, Hansen, Nielsen, & Gildberg, 2021; S. G. Simpson et al., 2015; Tarp & Nielsen, 2017). In a study of women receiving psychotherapy during their postpartum

period it was found that most of the technical difficulties were expected and normalized, and only when the problems were persistent and unresolved had a negative impact on the treatment course (Hensel et al., 2020).

Technical disruptions cause different types of interruptions. Total interruptions create misalignments that therapists have to try to repair, and temporary interruptions cause breaks in conversation flow (Cipolletta et al., 2020). Interruptions require meta-communication and attention towards solving instrumental problems. Interference may cause loss of verbal and non-verbal communication and, hence, it increases risk of misunderstandings, e.g., silence can be misunderstood as a technical interference and false overlap caused by asynchronous communication could make therapist and patient continue separate talks (Cipolletta et al., 2020). Several therapists find it important to talk about the communication explicitly to adjust for technological demands (Cipolletta et al., 2020; Dausch et al., 2009; May et al., 2000), such as where the camera should be pointing, how the sound is, and how to restart from a technical interference, so that misunderstandings can be avoided.

Limitations of the Videoconference

Even when no technical problems occur, communication via video are different than in person. The meeting takes place where therapist and patient are located at two different settings and only share the technology to create the feeling of presence. Having a conversation over video causes non-verbal communication to be attenuated (Dausch et al., 2009; Dunstan & Tooth, 2012; Frank et al., 2017; Himle et al., 2006; May et al., 2001; S. G. Simpson, 2001; Tarp & Nielsen, 2017; Turner, 2006; Wagnild et al., 2006). Therapists explain that it is not possible to see if patients have anxious feet (Dunstan & Tooth, 2012), to read tics, tremors and facial expressions well (Frank et al., 2017; S. G. Simpson, 2001; Wagnild et al., 2006), or to smell the patient (Wagnild et al., 2006). Moreover, the video encounter does not allow for physical touch. The lack of physical touch makes some therapists feel disconnected with their patients and uncomfortable about not being able to touch their patients for comfort (Gordon et al., 2015; May et al., 2001). Moreover, some therapeutical exercises, such as “bold moves”, can be difficult to do via a videoconference at a distance, because the patient could feel that it is difficult to do the tasks on their own. However, experience has shown to increase the patient’s confidence in doing tasks on their own (Borges, 2019).

Some patients also feel a lack of physical presence (S. G. Simpson et al., 2006). The therapists use these non-verbal cues to assess the patients’ state of mind and then adjust their own behavior and treatment strategy in accordance. This performance will help the patients feel understood and hence improve rapport. Therapists explain that to make these assessments over video they must rely more on verbal reports (Dausch et al., 2009; Himle et al., 2006). It might therefore help to explicitly address non-verbal cues both at the patient site and the therapist site. A frequently mentioned topic in the

literature regards eye contact. It is not possible to create real eye contact, and some worry how that may affect the perception of empathy and the creating of a bond. However, proponents of video consultations mention that a greater and more direct amount of eye contact occur in a telemedicine consultation (Yellowlees, Richard Chan, & Burke Parish, 2015). Given that it is not real eye contact, it is possible to look at the other person for a longer period of time without being intimidating. To avoid that the screen view reduces non-verbal cues, several authors recommend using a camera that can change direction and zoom in and out (Dausch et al., 2009; May et al., 2001; Simms et al., 2011; Turner, 2006) so a full picture of the participants and their environment is visible for the other part. Alternatively, it is recommended to move the camera around in the room manually to show the environment. This may also help take away paranoid thoughts and secure the feeling of having a private conversation (Simms et al., 2011). Psychiatrists further explain that if the videoconferencing is used in a dynamic way, they can gain additional insight into the patient's home environment (Sheikh et al., 2023).

Empowerment and Control

A typical clinician-patient interaction is asymmetrical in power distribution, and it has been suggested that the use of videoconferencing might equalize some of this (Jerome & Zaylor, 2000; Yellowlees et al., 2015). However, it could potentially also have the opposite effect. In regard to communication factors, it has been shown that the way the device is presenting a person will affect the interaction which have an impact on power dynamics. In a videoconference, as already noted, perceptual information is limited and differences in camera placement can alter observers' representation of other people in ways that color the strategic social decisions they make (Thomas & Pemstein, 2015). In addition, it is important to notice that when the communication is mediated, it affects the presentation of self and the control in that regard. It is easier to disguise things, e.g., with the help of lightning and camera placement, than in an in-person encounter. On the other side, your presentation to the other is dependent on their device and the internet connection which you may not have control over. They can turn down the volume, place you on a big screen or small screen, and distortions may occur.

In general, the evidence points towards patients feeling more in control over video sessions since they are in the comfort of their own familiar space, combined with that they can interrupt and leave whenever (Ashwick et al., 2019; Kocsis & Yellowlees, 2018; S. G. Simpson et al., 2006; S. G. Simpson et al., 2015). Having a choice between video and in person can produce a stronger sense of capability and make clients take responsibility for their treatment (Tarp & Nielsen, 2017). In some emergency settings, video consultations can provide a direct way of communication between the patient and the psychiatrist, which leads to more transparency for the patient, and that the patient are

more likely to be heard and have a direct impact on their treatment (Trondsen, Tjora, Broom, & Scambler, 2018). Videoconferencing can also increase engagement in treatment (S. G. Simpson et al., 2006) and in this way video consultations increase patient empowerment. However, the relational dominance of the interaction over video consultation, that is who initiate topics and control the conversation, has been found to be similar to the relational dominance seen in therapeutic sessions in person and appear to be a result of therapeutic orientation and personal therapist style (Cipolletta et al., 2020).

Privacy

Privacy means that you have control over who gets what information about you. When it comes to therapy sessions held over a videoconference, it is important to secure a sufficient level of data protection. Evidence suggests that clients, in general, feel that their anonymity and privacy are secured, and confidentiality is protected (Bakke et al., 2001; S. G. Simpson, 2001; S. G. Simpson et al., 2015). Some patients also find it more discrete, appreciate that they will not meet their therapist outside of sessions, and that it is a comfortable way to talk about private issues (S. G. Simpson et al., 2015; Tarp & Nielsen, 2017; Ye et al., 2012; Yellowlees et al., 2015). Other patients fear that they are being recorded (Simms et al., 2011; S. G. Simpson, 2001) and some feel that video is less private and worry if someone would be listening at the door (S. G. Simpson et al., 2006). Therapists have also found that it is not always apparent whether the video setting at the patient's place is private (Cipolletta et al., 2020; Frank et al., 2017; Sheikh et al., 2023; Wagnild et al., 2006).

Type of Client

It may be that some clients are more likely to benefit from a video consultation than others. It has been suggested that it could depend on the patient's attachment style, where some might feel more secure sharing intimate content when there is a distance between them and the therapist. It might also be used therapeutically with dependent people who can practice comfort levels at a distance (S. G. Simpson & Reid, 2014). Some therapists have found that video consultations are very suitable for emotionally stable patients, who easily "bounce back" and for those that are resistant to changes (Simms et al., 2011). Video is also beneficial for patients concerned with social stigma (Cipolletta et al., 2020) and for those who desire to have a choice (Tarp & Nielsen, 2017). It may also have a positive impact on the treatment course that the patient shares ethnic background with the therapist (Cipolletta et al., 2020; Ye et al., 2012). Video consultation is also a good idea when the patient lives far away from specialist treatment (Frank et al., 2017), when psychiatrists are needed only for medication management (Dausch et al., 2009; Sheikh et al., 2023), and when the patient is in a transition period (Frank et al., 2017). Some patients find video consultations most suitable for less important sessions (Tarp & Nielsen, 2017).

Patients that are perceived by therapists to be less suitable for video consultations are talkative patients, upset patients, patients who need coaxing or are very distressed (May et al., 2001), emotionally unstable, impulsive patients or who have poor coping skills, patients with cognitive impairments (Simms et al., 2011), and suicidal or patients in crisis since it is not possible to physically intervene (Sheikh et al., 2023; Wagnild et al., 2006).

Implementation Factors Regarding Video Consultations

Several factors need to be in place for the establishment of a successful implementation of video consultations. Both the unmet need for services, and organizational and practical factors plays a role. In a review of Australian telehealth models (Bradford, Caffery, & Smith, 2016), they found six factors that influenced success and sustainability which is depicted in Table 1.

Table 1. Factors influencing success and sustainability of telehealth services

Category	Definition
Vision	Having a clear, realistic goal defining the purpose of the service.
Ownership	Clinicians and managers had to be 'on board' and supportive of the initiatives.
Adoptability	Recognizing the requirements to adapt the service model in response to the needs of patients, clinicians, and health services, often going through several iterations before establishing a suitable model.
Economics	The service must offer value that are transparent, in terms of cost or time savings, with comparable clinical benefits to in-person services.
Efficiency	Efficient development of procedures and processes. Successful and sustainable services did not always have high activity levels but needed to be efficient with processes.
Equipment	Considerations for the infrastructure. Equipment did not have to be expensive but needed to have processes in place to manage technical issues.

Note: Adapted from "Telehealth services in rural and remote Australia: a systematic review of models of care and factors influencing success and sustainability," by N. K. Bradford, L. J. Caffery and A. C. Smith, 2016, *Rural and Remote Health, 16:*3808.

In another systematic review, barriers to adopting telemedicine worldwide were evaluated. It revealed that the most cited organizational barriers were cost, reimbursement, legal liability, privacy confidentiality, security of data, and effectiveness. The most cited patient barriers were age, level of education, eHealth or computer literacy, bandwidth, and unawareness, and the most cited provider barriers were technically challenged staff and resistance to change (Scott Kruse et al., 2018).

Implementation of video consultations into mental health services are among other things dependent on mental health professionals' opinions about the new service as they function as gatekeepers (Cowan et al., 2019). Evidence suggest that they typically hold divergent opinions about video consultations. Some psychiatrists believe that they need to see the patient in person to make a reliable assessment, and other highlight that they believe that there is a great therapeutic effect when patients

have to leave their home (Magal, Negev, & Kaphzan, 2021; Sheikh et al., 2023). Other believe that their ability to assess and treat patients via videoconference has equally high quality as when conducted in person (Magal et al., 2021). In general, it is found that after participating and gaining user experience, mental health professionals' attitudes become increasingly more positive (Magal et al., 2021).

The Research Gap

The research that has been carried out has typically been in areas where excessive travel distances, geography, and climate have motivated the use of telepsychiatry. Little is known about the meaningful use of telepsychiatry in areas with a well-developed infrastructure and with relatively easy geographical access to health care services which Denmark represents. Furthermore, there is little research on mental health professionals' attitudes and decision making in regard to offering a video consultation when it is entirely up to each professional to decide when and how to use it and how it potentially should be blended with consultations held in person introduced into routine practice. Moreover, there is limited knowledge of how social influence from leadership and contextual factors impact providers' attitudes (Connolly, Miller, Lindsay, & Bauer, 2020). In addition, little is known about how to individually adapt use of video consultations to accommodate the individual needs and resources and to study patients' acceptance and experiences to identify advantages and drawbacks of the services when it has been implemented into routine practice (L. F. Christensen, Moller, et al., 2020). This is particularly relevant, given that technology is developing rapidly, and during the last 20 years, videoconferencing technology has both improved in quality and become mainstream among users. This makes ongoing research about its applicability and participants attitudes relevant to study.

Research Question

The present PhD study focusses on patients' and mental health professionals' experiences with using video consultations during an implementation phase of video consultations into routine practice at a psychiatric hospital among adult outpatients in Denmark. To make health care more person-centered and to inform clinical decision-making, it is important to investigate patients' experiences and factors that will influence their acceptance with services ongoing. Given that the mental health professionals are gatekeepers into these services, it is similarly important to understand what their experiences are and what will influence their decision on how and when to use it. They can provide important insights into what might be core issues needing attention for the implementation process as video consultations become everyday practice.

The **overall research question** of the present thesis is:

> How do adult outpatients and mental health professionals experience using video consultations in psychiatric hospitals?

The users of video consultations are adult psychiatric outpatients and their mental health providers. At the psychiatric hospital in the Region of Southern Denmark, adults are defined as citizens aged 20 years and older. The mental health professionals include psychiatrists, psychiatric nurses, psychologists, and other health professionals who provide psychotherapy and/or mental health support. Video consultations are defined broadly as all meetings via a videoconference between a patient and a mental health professional.

Methods

Overview of the Study Design

The present PhD study uses qualitative methods to explore the study phenomena. For that reason, specific aims for the articles that are part of the present PhD study have been developed and reshaped while collecting and analyzing data from the field (Dixon-Woods et al., 2006; Strauss & Corbin, 2015). The present PhD study was initiated with a review of the literature regarding video consultations in the mental health services as well as participation in video consultation implementation activities at the psychiatric hospital in the Region of Southern Denmark. Both activities influenced the direction of data collection of the other which is further elaborated in the following sections. The review resulted in a systematic review and qualitative synthesis, and the empirical data resulted in two papers where one focused on the patients' experiences and the other focused on the mental health professionals' experiences. An overview of the three papers is presented in Table 2.

Table 2. Overview of aim, study design, data sources, and analysis of papers 1-3

	Paper 1	**Paper 2**	**Paper 3**
Aim	To explore patients' perceptions of factors influencing their acceptability of video consultations	To explore adult outpatients' experiences with home-based psychotherapy via videoconferencing in a Danish psychiatric hospital	To investigate what constitutes a professional video consultation with regard to its framework and content from the perspectives of mental health professionals and explore what is of importance for the establishment and realization of video consultations to make it accepted among the professionals
Design	Systematic review and qualitative synthesis	Qualitative interview study	Grounded theory
Data	11 qualitative articles	7 patient interviews	>45 hours of field work, formal interviews with 7 managers and 11 mental health professionals
Analysis	Meta-summary and a taxonomic analysis	Systematic text condensation	Strauss's and Corbin's grounded theory analysis

In the following, I will initially go through the methods of the review. Thereafter, I will present the setting of where the empirical studies took part. Then I will go through data collection procedures, and finally data analysis of the two empirical studies.

Systematic Review and Synthesis of Qualitative Research (Paper 1)

Synthesizing Qualitative Research

Systematic reviews are important for the evidence-based policy and practice movement, which aims to bring research closer to decision-making (Dixon-Woods et al., 2006). Traditionally, 'rationalist' models of systematic reviews have been promoted, but after being criticized for being unhelpful and inappropriate for answering complex questions and fail to acknowledge individual variability or the influence of context, methods for reviewing qualitative research in a systematic way have been developed (Dixon-Woods et al., 2006). Synthesis of qualitative research can provide a range and depth of meanings, experiences, and perspectives of participants across health-care contexts. It can accumulate data across contexts and generate new theories or conceptual models, identify research gaps, inform the development of primary studies, and provide evidence for the development, implementation, and evaluation of health interventions (Tong, Flemming, McInnes, Oliver, & Craig, 2012). When synthesizing qualitative research there are several methodologies available with common features and key differences (Barnett-Page & Thomas, 2009). The first paper in the present PhD study is based on a meta-summary (Sandelowski & Barroso, 2007), and then a taxonomic analysis inspired by an interpretive synthesis of qualitative research. The purpose of an interpretive synthesis of qualitative research is to develop concepts with a development and specification of a theory that integrates these concepts. It incorporates the concepts identified in the primary studies, as well as concepts that were not found in the original studies, but which help to characterize the data as a whole, into a more general theoretical structure (Dixon-Woods et al., 2006).

Initially Sandelowski and Barosso's (2007) method for synthesizing qualitative research guided the process. It highlights five steps that need to be accomplished. First, it must be based on a systematic and thorough literature search of reports of completed qualitative studies about the topic. Second, the reports must be analyzed systematically, and typology and quality of the reports must be identified (Sandelowski & Barroso, 2007). The typology refers to what we understand as qualitative research which can vary from researcher to researcher (Dixon-Woods et al., 2006). In the present study I followed Sandelowski and Barosso's definition, that include thematic surveys, thematic/conceptual descriptions, and interpretive explanations and excludes topical surveys and studies with no explicit analysis of data (Sandelowski & Barroso, 2003). Systematic appraisals are used to reduce the possibility of bias when conducting systematic reviews, even though, it can be difficult to assess the quality across a variety of qualitative study designs. Third, the findings must be extracted carefully using analytical and interpretative emphasis. Fourth, the findings must be integrated in a systematic and appropriately eclectic way of using qualitative methods, and fifth, the researcher must use reflexive accounting practices to optimize the validity of study procedures and outcomes (Sandelowski & Barroso, 2007).

The research question when doing an interpretive synthesis of qualitative research has been recommended to take an iterative approach (Dixon-Woods et al., 2006). This means that the research question has been adjusted continuously according to search results and findings. While reviewing the literature, I found that published review articles had focused on effectiveness and survey measured satisfaction with video consultation services and none had focused on the qualitative aspects of an experience. Consequently, a search strategy was developed for a systematic literature review dealing with the more qualitative aspects of experiences. In the beginning, it focused on the therapeutic relationship that many mental health professionals that I met while collecting data for the empirical studies had conveyed worries about. However, later it changed focus to 'experiences' more broadly, due to that there were nearly no qualitative research about the therapeutic relationship published. At the beginning of the PhD study, the mental health professionals at the psychiatric hospital were not provided with any guidelines on how to choose which of their patients should be offered a video consultation. They were also concerned about what the patients might think about it. Therefore, the aim of the study became: "to explore patients' perceptions of factors influencing their acceptability of video consultations." It is based on patients who have had experience with using a video consultation for psychotherapy or psychiatric assessments which is what is offered at the outpatient services at the psychiatric hospital.

Data Collection

A systematic literature search was conducted in PsycINFO, PubMed, Scopus, Web of Science, CINAHL, Embase, Sociological Abstracts and Academic Search Premiere to get a thorough search in a variety of scientific databases covering psychological, medical, nursing, and social aspects. The search strategy included dividing the topic into two areas. One was focusing on video consultations and the other treatment of mental health patients. Keywords/headings/subject terms were identified in the respective databases and a list of words that would be searched free text restricted to abstracts in all the databases were made. A full search matrix displaying specific words that were used in the search can be found in Table 3.

Table 3. Search Matrix

No.	Heading or subject term or keyword	Free text in abstract and title
	Focus 1	
1	Teleconsultation (Embase) (Scopus)	
2	Telecommunication in psychiatry (ASP) Telecommunication in psychotherapy (ASP)	
3	Teleconferencing (ASP) (Cinahl) (PsycInfo) Teleconference (Embase)	Teleconf*
4	Telemedicine (ASP) (Cinahl) (Embase) (PsycInfo) (PubMed)	Telemedicine
5		Telemental
6	Telepsychiatry (Cinahl) (embase) (PsycInfo)	Telepsych*
7	Teletherapy (Embase)	Teletherapy
8	Videoconferencing (ASP) (Cinahl) (Embase) (PsycInfo) (PubMed) Video conferencing	Videoconf* OR "video conf*"
9		"Video counseling" OR "video counselling" "Video counsel*"
10	Webcams (ASP)	"Web camera" OR webcam*
	Focus 2	
1	Behavior therapy (ASP) (Cinahl) (Embase) (PsycInfo) (PubMed) Cognitive behavior therapy (PsycInfo) Cognitive behavioral therapy (PubMed)	"Behavior therapy" OR "behaviour therapy" "Behavi* therapy"
2	Cognitive therapy (ASP) (Cinahl) (Embase) (PsycInfo) (Scopus)	"Cognitive therapy"
3	Psychoanalysis (ASP) (Cinahl) (Embase) (PsycInfo) (PubMed) (Scopus) (Soc Ab)	Psychoanaly*
4	Psychoeducation (ASP) (Cinahl) (Embase) (PsycInfo)	Psychoeducation
5	Psychotherapy (ASP) (Cinahl) (PsycInfo) (PubMed) (Scopus) (Soc Ab)	Psychotherap*
6	Counseling psychologists (ASP) Counseling psychology (ASP) (PsycInfo)	"Counseling psycholog*" OR "counselling psycholog*" "Counsel* psycholog*"
7	Mental health counseling (ASP) Mental health counselors (ASP)	"Mental health counseling" OR "mental health counselling" "Mental health counsel*"
8	Mental health consultation (ASP)	"Mental health consultation"
9	Psychological consultation (ASP)	"Psychological consultation"
10	Psychiatric consultation (ASP) Psychiatrc day treatment (ASP) Psychiatric treatment (ASP) (Embase) Mental illness treatment (ASP) Mental health care (Embase) Psychiatric home care (Cinahl)	Psychiatric
11	Psychiatry (ASP) (Cinahl) (Embase) (PsycInfo) (PubMed) (Soc Ab) Community psychiatry (PsycInfo) (PubMed) Social psychiatry (Embase) (PsycInfo) Mental Health Services (Soc Ab)	Psychiatry

Words categorized under the same focus area were combined with "OR" and after that the two focus areas were combined with "AND." Then the search would be restricted to peer-reviewed original research, in English, German, or a Scandinavian language, published between 1st of January 2000 and the final search was conducted 1st of November 2021. Reasons for having that cut-off point was that a review of doctor-patient communication in telemedicine with literature from before the cut-off point January 2000 had already been conducted (Miller, 2001), that mainstream use of video calls among the general population increased from the beginning of the century, and that the technologies used for videoconferencing have been rapidly changing and improving with time.

Two researchers conducted the search. Then titles and abstracts were screened to see if they included individual psychotherapy or psychiatric assessments via videoconference with adult outpatients (aged ≥18). These articles went on to full-text screening. Eligibility of these articles were again assessed by two researchers, and disagreement were resolved by discussion. Inclusion were that it had to be mental health patients and qualitative research as defined by Sandelowski and Barroso's typology of qualitative findings (Sandelowski & Barroso, 2003).

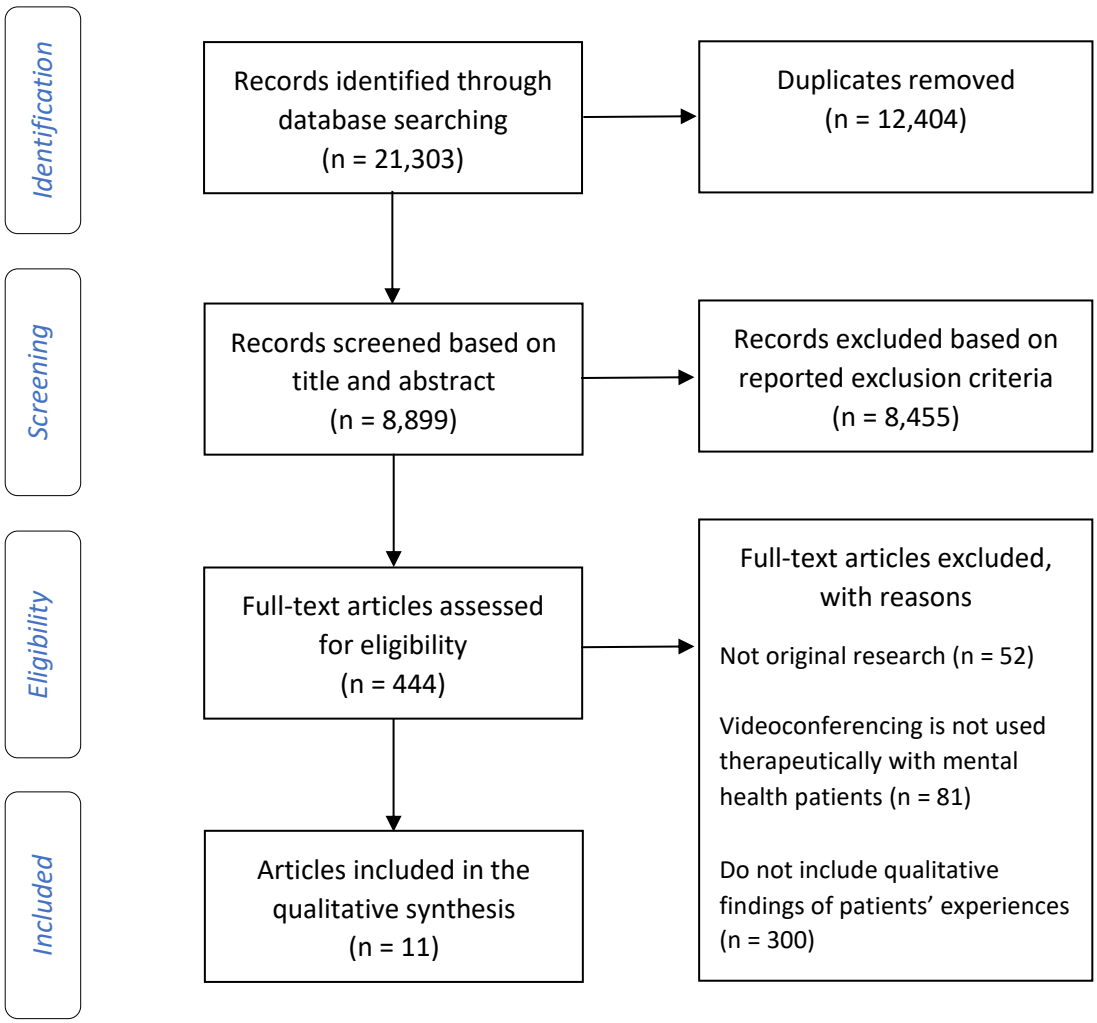
Out of 8,899 identified unique records in the search process, most were excluded leaving only 11 articles to be included in the qualitative synthesis. The selection flow is depicted in Figure 2.

Analysis of Data

The included articles were critically assessed using the Critical Appraisal Skills Programme's qualitative checklist (CASP Critical Appraisal Skills Programme, 2018). It consists of 10 questions to make sense of qualitative research, and it is divided in three sections: 1) Are the results of the study valid? 2) What are the results? And 3) Will the results help locally? Each question had a number of prompts to help understand why the question was important. Questions should be answered with a "yes", "no", or "can't tell". This appraisal helped assess the quality of the articles which were then categorized as either having high, medium, or low quality. The assessment can be seen in Table 4.

10 of the articles were rated with high quality. To avoid drawing unreliable conclusions, only the studies with high quality were used in the initial analysis. Two of them were, though, added after the final search where the first draft of the model was developed. The last article was rated with low quality, and it was added in the end to see if it supported or disputed the already existing themes.

Figure 2. Selection flow chart



Note. From "Patients' acceptance of video consultations in the mental health services: A systematic review and synthesis of qualitative research," by A. M. Moeller, L. F. Christensen, J. P. Hansen and P. T. Andersen, 2022, *Digital Health, 8*

First, a meta-summary was conducted, beginning with extracting all text labeled as "results" or "findings" as data to be analyzed. One of the articles included a quantitative part, and this part was not included. The texts were separated into meaning units and edited into independent texts. The meaning units were grouped into descriptive categories and put together into themes. A taxonomic analysis was used to synthesize the findings. The interpretive synthesis started by identifying all possible conceptual relations between the themes, and then testing the relationships by re-reading the articles. Eventually they were developed into an explanatory and logic model.

Table 4. Quality assessment of the included articles guided by the CASP qualitative checklist

	Checklist item[a]	1	2	3	4	5	6	7	8	9	10	Quality rating
	Report											
1	Ashwick et al., 2019	Y	Y	Y	Y	Y	-	Y	Y	Y	H	High
2	Christensen et al., 2020	Y	Y	Y	Y	Y	-	Y	Y	Y	H	High
3	Frank et al., 2017	Y	Y	Y	Y	Y	-	?	Y	Y	H	High
4	Frayn et al., 2021	Y	Y	?	Y	?	-	Y	Y	Y	H	High
5	Hensel et al., 2020	Y	Y	Y	Y	Y	-	Y	Y	Y	H	High
6	Leukhardt et al., 2021	Y	Y	Y	Y	Y	Y	Y	Y	Y	H	High
7	May et al., 2000	Y	Y	Y	Y	Y	-	-	Y	Y	H	High
8	Simpson et al., 2015	Y	Y	Y	Y	Y	-	Y	Y	Y	H	High
9	Tarp & Nielsen, 2017	Y	Y	Y	Y	Y	-	Y	Y	Y	H	High
10	Trondsen et al., 2018	Y	Y	Y	Y	Y	-	Y	Y	Y	H	High
11	Ye et al., 2012	Y	Y	Y	Y	?	-	Y	-	-	L	Low

Note: [a]CASP criteria for qualitative reports: 1. Was there a clear statement of the aims of the research? 2. Is a qualitative methodology appropriate? 3. Was the research design appropriate to address the aims of the research? 4. Was the recruitment strategy appropriate to the aims of the research? 5. Was the data collected in a way that addressed the research issue? 6. Has the relationship between researcher and participants been adequately considered? 7. Have ethical issues been taken into consideration? 8. Was the data analysis sufficiently rigorous? 9. Is there a clear statement of findings? (Yes: Y, No: -, Unclear: ?) 10. How valuable is the research? (H: Highly, L: Little). The assessment is only based on the qualitative part of a report.

From "Patients' acceptance of video consultations in the mental health services: A systematic review and synthesis of qualitative research," by A. M. Moeller, L. F. Christensen, J. P. Hansen and P. T. Andersen, 2022, *Digital Health, 8*

Description of the Setting (Paper 2-3)

Mental Health Services in Denmark

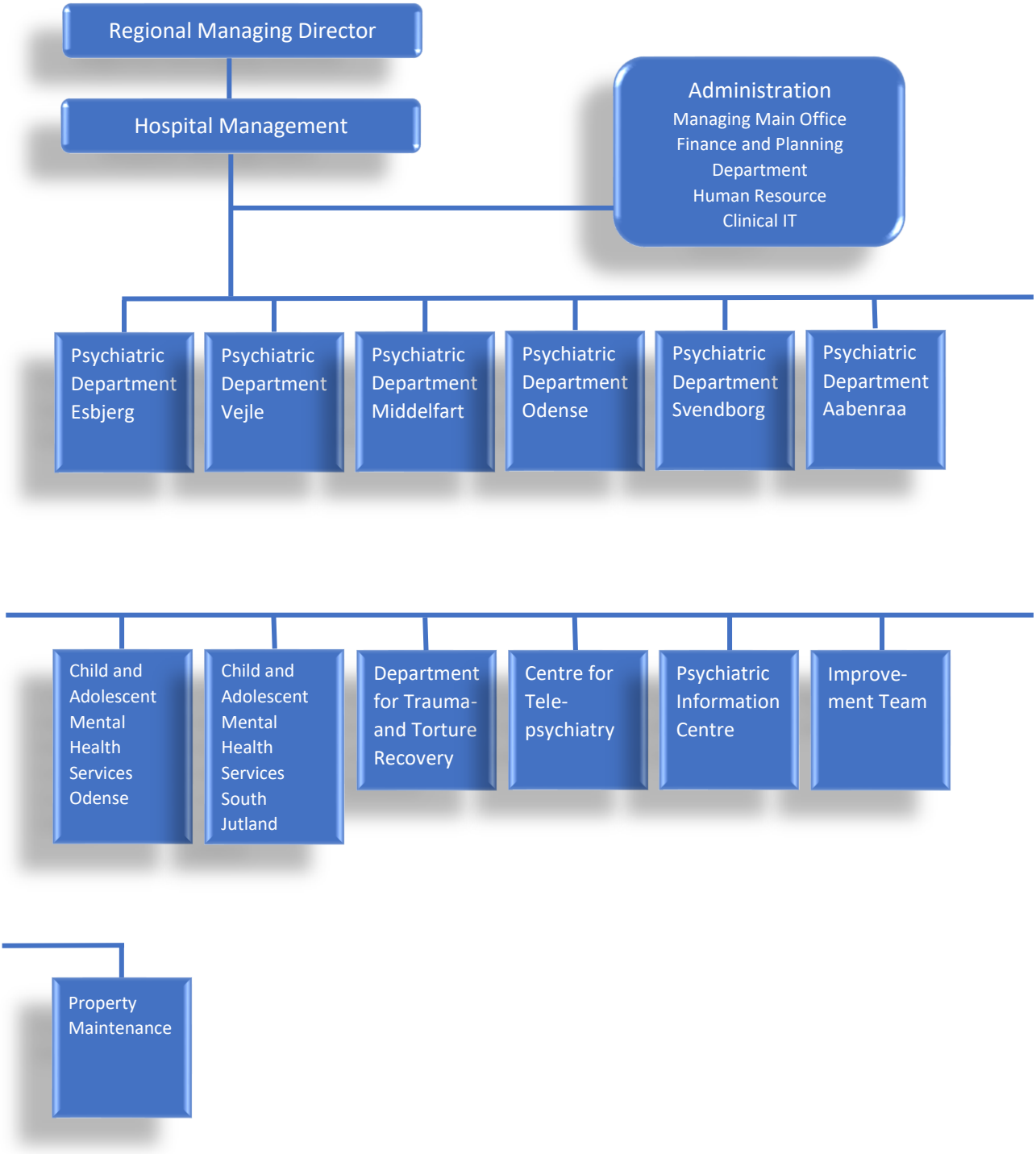
The Danish healthcare sector is based on values such as free of charge, equal and easy access for all; equality in regard to treatment offer and care; solidarity; free choice, and social justice. The healthcare sector is well-developed and collaborates with social services with similar values (Lindhardt, 2017). The healthcare sector is divided into a primary care sector and a secondary care sector. The primary sector includes general practitioners, practicing medical specialists, and psychologists. The secondary sector includes hospitals, both outpatient functions, such as community psychiatry, and inpatient wards. The organization is based on a step-care-model, so that all can get treatment that corresponds to their needs (Lindhardt, 2017). Denmark is divided into five regions and 98 municipalities. Each region is responsible for the healthcare sector, and the municipalities are responsible for the social sector, such as social psychiatry. This means that psychiatric hospitals are owned, managed, and financed by regions, which are governed by democratically elected councils. To access outpatient care at the psychiatric hospitals, the patient needs a referral from an allied health care professional such as a general practitioner (Lindhardt, 2017).

Management tools at the psychiatric hospitals have been guided by New Public Management principles. That is, it has been governed by optimization based on economic principles; a performance-based management. The healthcare sector is measured on number of patient contacts and compliance with budgets, and every year they have to increase output with 2.5 %. There has been a political wish to further increase how many patients that receive treatment, and how many consultations are given in a year. They also wish to secure a consistency in treatment everywhere in the country and secure that more patients receive treatment as early as possible (Lindhardt, 2017).

The Mental Health Services in the Region of Southern Denmark

The Region of Southern Denmark covers an area of 12,191 km^2 and has 1,223,000 citizens (Region Syddanmark, 2020). The public psychiatric hospital in the region is politically anchored in the Psychiatry and Social Committee placed under the Regional Council (Psykiatrien i Region Syddanmark, 2022). In 2018, it was organized with a board of directors working in the hospital management, an administration, and 13 departments, which can be seen in the organizational chart in Figure 3 (Psykiatrien i Region Syddanmark, 2018a). The hospital management consist of three people, a managing director, a medical director, and a nursing director (Psykiatrien i Region Syddanmark, 2022). Clinics are distributed across the region, and in 2018 it included 13 local outpatient clinics, 3 child and adolescent clinics, 6 inpatient clinics, 1 forensic clinic and 3 specialized clinics in trauma- and torture recovery. Moreover, there is a Psychiatric Information Centre that among other things provides guidance for patients and their relatives as well as professionals working with mental vulnerable citizens, and there is a Centre for Telepsychiatry that develops, do research on, and implement digital solutions in the organization and provides internet psychiatry (Psykiatrien i Region Syddanmark, 2018b). See Figure 4.

Figure 3. Organizational chart over the Mental Health Services in the Region of Southern Denmark



Note: Adapted from: "Organisationsdiagram," Psykiatrien i Region Syddanmark, 2018

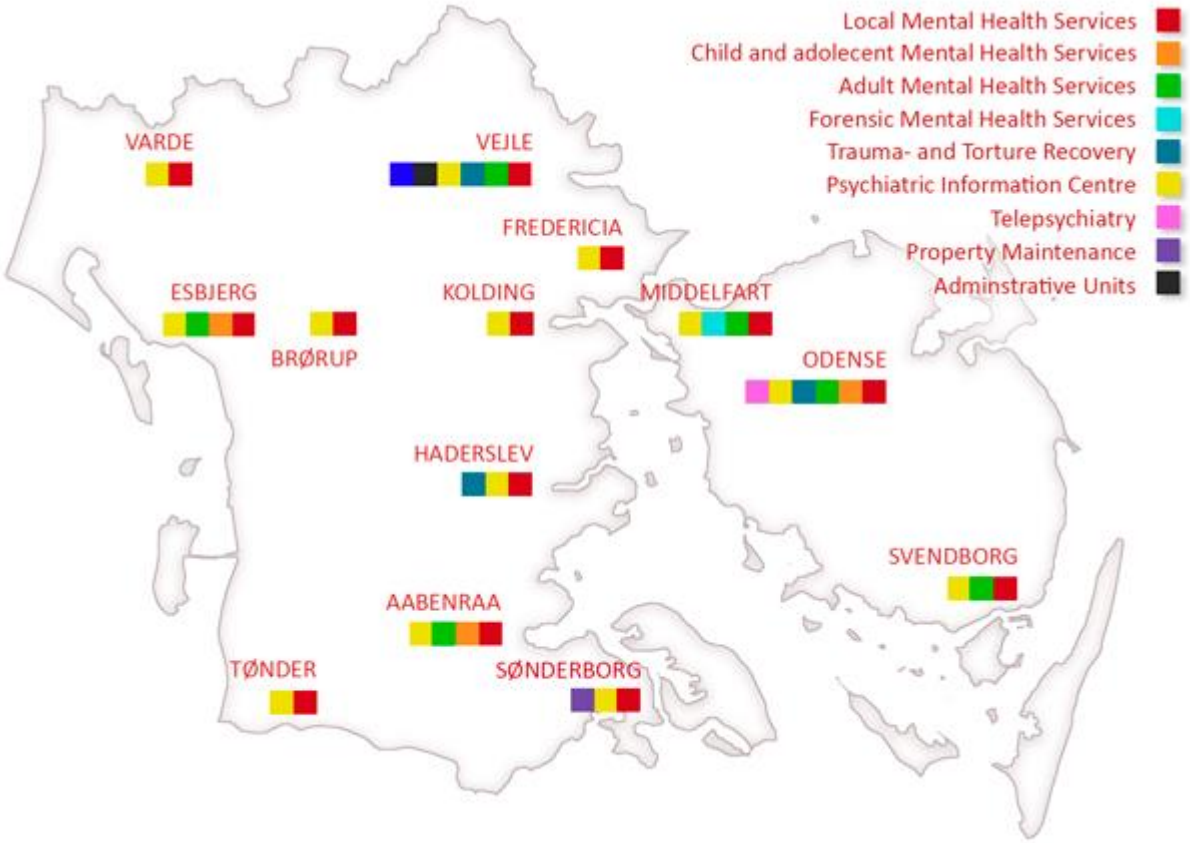
The organization had 2,883 employees and treated 43,500 different citizens in 2021 (Psykiatrien i Region Syddanmark, 2022). Among adult patients (20≤ years) 4,450 patients were hospitalized and 29,575 patients received ambulant care in 2021 (Sundhedsdatastyrelsen, 2022). See Table 5.

Table 5. Adult patients treated at the psychiatric hospital in the Region of Southern Denmark

	2018	2019	2020	2021
Hospitalized patients	4,951	4,953	4,742	4,450
Hospitalizations	8,679	8,893	8,709	8,593
Patients with ambulant contact	31,021	30,955	29,329	29,575
Ambulant contact	205,518	199,912	169,042	170,226

Note: Adapted from "Key figures for the hospital system and practice area," Sundhedsdatastyrelsen, 2022

Figure 4. Distribution of clinics in the Mental Health Services in the Region of Southern Denmark



Note: Adapted from: "Psykiatrisygehuset," Psykiatrien i Region Syddanmark, 2018

Video Consultations at the Psychiatric Hospital

Decision-makers at the psychiatric hospital in the Region of Southern Denmark, decided to include telepsychiatry in their mental health service strategy to improve accessibility and to strengthen the coherence in the patients' treatment courses. Therefore, the Centre for Telepsychiatry was established in 2013 to facilitate the development and implementation of tele-psychiatric solutions across the organization (Psykiatrien i Region Syddanmark, 2020b). In 2018, the Centre for Telepsychiatry consisted of an implementation team, a clinical team of psychologists offering therapy online, a research team conducting various research on digital tools used to enhance treatment for patients, a general secretariat supporting research in the whole psychiatric hospital, and an administration. In the implementation team, two consultants were chosen to be project coordinators regarding home-based outpatient care through videoconferencing together with a student assistant. These consultants functioned, among other things, as a supporting unit where they offered introductory courses about how video consultations can be used, offered support with installation of the system and equipment needed, arranged workshops for mental health professionals where they could exchange their video consultation experiences, they advised department managers of implementation strategies, and more. The center is a department at the same level as the other clinical departments as can be seen in Figure 5. For that reason, they did not have any power over working procedures in the other departments. Implementation strategies were developed individually with each department management. Follow-up on implementation processes were the responsibility of the department managers. Making sure that video consultations technically could be implemented was the responsibility of the Centre for Telepsychiatry.

From 2015, mental health professionals were officially given the opportunity to consult their patients via videoconference while their patients were at home as a substitute or supplement to in-person consultations. Any kind of consultation, including psychiatric assessment, psychoeducation, medication management, psychosocial support, and psychotherapy could be given via a video consultation (Healthcare Denmark, 2018). From 2015-2018, it was required that the mental health professionals had an individual license to the video software that were used, and this license was paid by the department where the mental health professional worked. It meant that in practice, only some mental health professionals had a real option of using it at that time.

Hospital managers wanted to be pioneers regarding telepsychiatry in Denmark and advocated strongly for its use. They placed video consultations on an equal footing with in-person consultations regarding legislative demands and better regarding reimbursement. Still they, nor the department managers, imposed any specific demands on the mental health professionals about using video consultations. It was each mental health professional's decision to decide if they wanted to offer it to

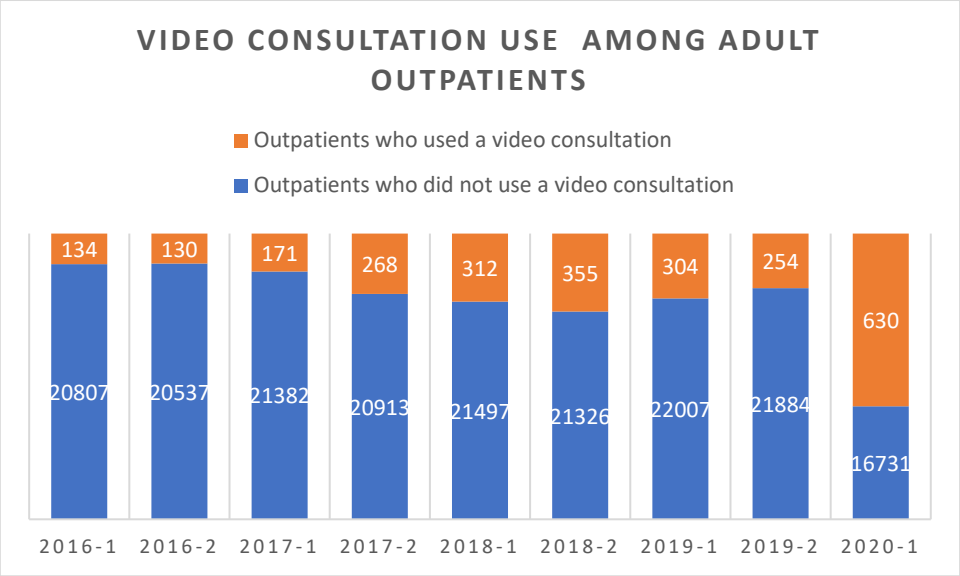
a patient. They did not have any guidance at the time, such as screening tools, they could use. They had to assess by themselves if they found it meaningful to offer. The general working procedures when offering a video consultation to a patient was that if the patient accepted, the mental health professional had to request a patient license from the designated administrator of licenses at that department or in that team. This license included a username and a password that the mental health professional had to send via a safe mail to the patient together with information about how the patient should install the program and perform troubleshooting. The patients had to use their own personal devices compatible with videoconferencing. If they experienced any technical difficulties, they would have to talk with their therapist or doctor about it. Some teams had designated a superuser among the mental health professionals who would help all patients with the installation of the video consultation program. In the beginning it was recommended only to use it on computers and tablets and not on smartphones. Later around 2018 it became possible to have video consultations via a smartphone. The video consultations were most often scheduled, and it was only the mental health professionals who were able to call the patient via the video program.

In 2016, department managers at one clinical department decided to buy licenses for all the clinicians. During the spring, implementation facilitators arrived at the department and gave a presentation with an introduction of its use to the different teams. At another date they would come back to the same teams and install the program on the clinicians' computers. They would also give a presentation of how to use the program and give suggestions for working procedures. In December 2016, nearly no clinicians at that department had used it yet. At another department, the department managers decided to implement it based on team managers demands. At this department, some teams had inquired for a video consultation solution for quite some time before they finally could get it in late 2017 or the beginning of 2018. One team already had licenses from late 2015 and had received an introduction to video consultations at that time. When I meet the team in the beginning of 2017 none of them had used it. They also did not have the program or webcams installed on their computers, and they did not know that they had a license. These are the two departments from where my empirical data are collected.

Adoption Rates Among Patients and Professionals

In Figure 5, the percentage of adult (20 ≤ years) outpatients who tried at least one video consultation is presented. Video consultations at the psychiatric hospital were first registered as such in 2016 which is why data does not cover 2015.

Figure 5. Percentage of adult outpatients who tried a video consultation



Note: Data covers adult (20≤ years) outpatients from the hospital, excluding patients from the Centre for Telepsychiatry (the Internet Psychiatry). Internal data from The Mental Health Services in the Region of Southern Denmark, 2020.

As can be seen in Figure 6, less than one percent of the patients had used at least one video consultation in 2016, and the number increased very slowly up to about 1½ percentage in the second half of 2019 and increased to more than three percent in 2020 due to the COVID-19 pandemic. In the four years' span from 2016 up until 2020, less than 2 percent of patients had tried a video consultation.

In Table 6 the number of adult (20 ≤ years) outpatients who have tried at least one video consultation during a period of 22 months is distributed on their diagnosis and the number of registered video consultations for those groups are presented. What can be seen from Table 6 is that video consultations have been registered used with patients with various diagnoses, especially patients with mood or anxiety disorders. The average number of video consultations used per patient in the 22-month span is 2.8 times.

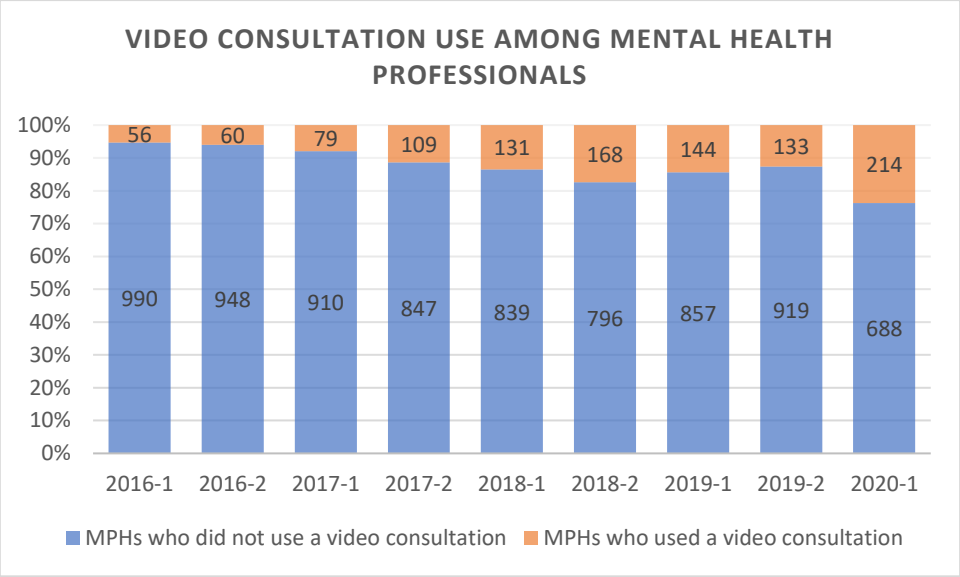
Table 6. Number of ambulant patients who used a video consultation based on diagnoses

ICD-10[a]	Ambulant patients who tried at least one video consultation	Number of registered video consultations	Average number of video consultations
F0 Organic, including symptomatic, mental disorders	10	23	2.3
F1 Mental and behavioral disorders due to psychoactive substance use	7	26	3.7
F2 Schizophrenia, schizotypal, and delusional disorders	127	508	4.0
F3 Mood [affective] disorders	338	755	2.2
F4 Neurotic, stress-related, and somatoform disorders	436	1035	2.3
F5 Behavioral syndromes associated with physiological disturbances and physical factors	22	278	12.6
F6 Disorders of adult personality and behavior	49	229	4.7
F7 Mental retardation	2	2	1.0
F8 Disorders of psychological development	5	11	2.2
F9 Behavioral and emotional disorders with onset usually occurring in childhood and adolescence	93	211	2.3
Total	1,089	3,078	2.8

Note: [a]The International Statistical Classification of Diseases and Related Health Problems 10th edition. Data cover adult outpatient departments, including the Centre for Telepsychiatry (the Internet Psychiatry), in the period 01.01.2017 – 31.10.2018. Internal data from The Mental Health Services in the Region of Southern Denmark, 2018.

In Figure 6, the percentages of mental health professionals working in the adult outpatient services that have tried at least one video consultation are displayed. As can be seen in Figure 7, in the first half of 2016, around 6 percent of the mental health professionals that were working in the adult outpatient services had tried at least one video consultation. That number increased to around 13.5 percent 2 years after. Then there was a slight decline in 2019, and an increase in 2020 due to COVID-19.

Figure 6. Percentage of mental health professionals treating adult outpatients who tried a video consultation



Note: The graph covers mental health professionals working in the adult outpatient services. Internal data from The Mental Health Services in the Region of Southern Denmark, 2020.

What can be concluded about the video consultation adoption rates is that the four years covering 2016 until 2020 is characterized by a slow adoption rate with less than 2 % of patients having tried it and less than 14 % of mental health professionals having tried it.

Research Design (Paper 2-3)

The empirical studies conducted at the psychiatric hospital used qualitative approaches to explore the adult outpatients and mental health professionals' experiences with using home-based video consultations. Qualitative research is used to study experiences, attitudes, and behavior, as it has the advantage of being open to explore phenomena from the perspective of the participants themselves by letting them explain how, why or what they have been thinking, feeling, and experiencing (Tenny, Brannan, & Brannan, 2022). One study focused on the adult outpatients' experiences and was analyzed via systematic text condensation. The other study focused on the mental health professionals' experiences and was based on a grounded theory approach. Grounded theory is a good methodology to use when explaining how and why an event occurs or how and why people might behave in certain ways (Tenny et al., 2022). Grounded theory uses theoretical sampling which means that collection of data is based on questions that arise when previous data have been analyzed (Strauss & Corbin, 2015). That is, data is analyzed directly after it has been collected and will guide which other data should be collected.

In the following, I will start with a presentation of how data was collected, and then present how data was analyzed. The data collection is presented in a chronological sequence so that the theoretical

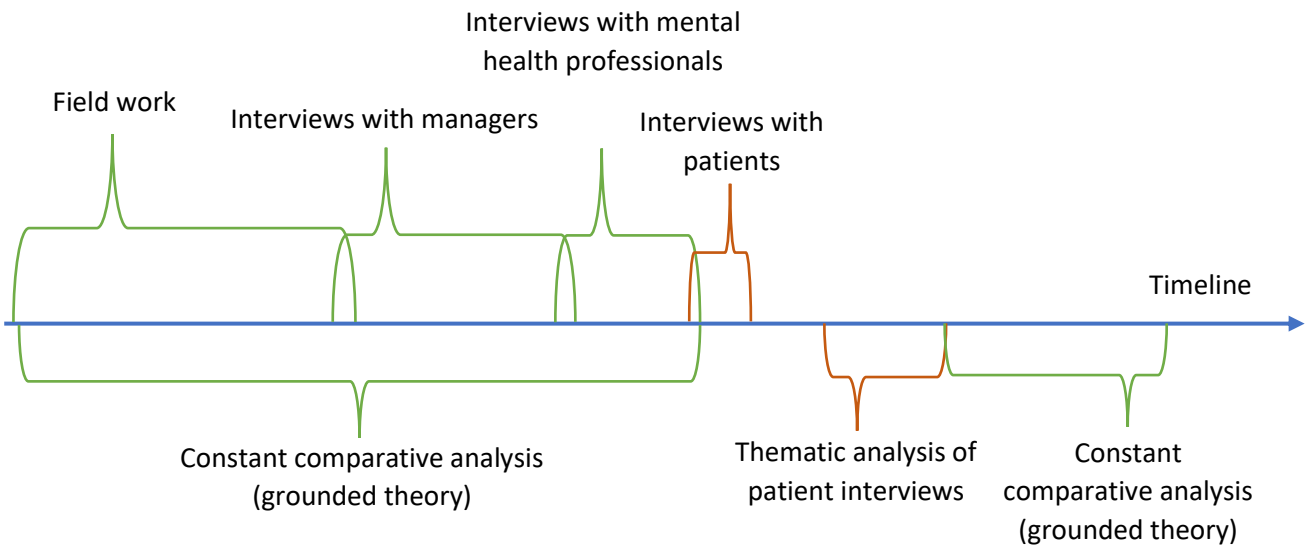
sampling can be followed. However, even though the interviews with patients were done as the final step of data collection, they were analyzed before the final analysis of the interviews with the mental health professionals which is why they are presented in this PhD thesis as paper 2.

Data Collection (Paper 2-3)

Timeline over Data Collection

In the beginning of 2016, field work was carried out in two departments at the public psychiatric hospital in the Region of Southern Denmark to get into the field and find areas to explore further. In 2017 managers at different levels at the two departments and at the Centre for Telepsychiatry were interviewed to get an understanding of the background of why video consultations were to be implemented, what their engagement in that process was, and what their expectations or success criteria were. Even though video consultations had been an option since 2015, only few mental health professionals had used it, and, for that reason, interviews with mental health professionals and outpatients who had tried to use a video consultation was conducted in the second half of 2018. An overview of the timeline of data collection and analysis can be seen in Figure 7.

Figure 7. Timeline over data collection and data analysis



Field Work – Getting into the Field (Paper 3)

Field work consists of participant observations in a naturalistic setting by observing and taking part in common and uncommon activities, where there is a systematic collection of information with explicit recording and analyzing of data (DeWalt & DeWalt, 2011). According to James Spradley [1933-1982] (1980), there are different types of participation based on the degree of involvement. *Passive participation* means that the researcher is present but does not participate in the activities or interact with other people to any great extent. *Moderate participation* requires some involvement in activities while still balancing the insider and outsider perspectives. *Active participation* happens when the researcher seeks to do what other people are doing to learn the cultural rules for behavior.

Complete participation happens when the researcher is studying a situation in where they are already an ordinary participant (Spradley, 1980).

During a period of 18 months covering 2016 and 2017, I did various types of participant observations at two departments at the psychiatric hospital. The purpose of the field work was to explore what was going on at the clinics in regard to letting the mental health professionals use video consultations with their patients. It gave me an insight into how the mental health professionals were introduced to video consultations and their initial reactions towards it. It also gave me some insight into how the departments were run, what challenges they were facing, and how to approach people. The observations and analysis thereof were used to raise new questions or narrow down questions. I spend more than 45 hours on participant observation activities.

It is social situations that are observed, and they consist of places, actors, and activities (Spradley, 1980). The social situations chosen for this study was based on activities that focused on implementation of video consultations at the psychiatric hospital. Actors were both the consultants that were facilitating the implementation of video consultations and the mental health professionals that were going to use it.

I participated in status and program meetings about implementation of home-based video consultations held by the implementation team facilitators. Typically, three implementation consultants would participate and sometimes invited other participants with interest or special knowledge about video consultations would participate. At the meetings, participants discussed what activities they had been doing, how their efforts were going, and difficulties they were facing. My participating role was mainly to ask follow-up questions so that I got a better understanding of their experiences of the implementation process. I took notes during the meetings. I also participated in a workshop the implementation consultants held for mental health professionals where they could exchange experiences about video consultations. Mental health professionals with experience at all departments were invited. It was held in a meeting room at a clinic in the center of the region. Few participated, and only three of them had some experience with using video consultations. I was a passive participant, and I took notes and afterwards made an account of what was discussed.

Together with the implementation consultants, I participated as an observing participant in team introduction meetings held at meeting rooms at one of the departments either arranged by the implementation consultants or the department managers. Here, a team would get a presentation about why they should use video consultations. At days arranged after these initial introduction meetings, I would also participate as an active participant in technical start-ups where I helped install the video program, webcam, and headset on the mental health professionals' computers at their offices. The

mental health professionals would be present, and we would have informal conversations about their interest in using video consultations with their patients. At these technical start-ups, the implementation consultants would give a presentation in a meeting room where they talked about how to use the video program and give some good advice on working procedures. It was optional for the mental health professionals to participate in these meetings, and it varied how many showed up. After these meetings and start-ups, I would write an account of the essential incidents that had happened or was said about video consultations.

At the other department at the psychiatric hospital, I had contacted a team that had licenses for over a year, but they had not used them. I found out that they did not have the programs installed. Together with their team manager, we agreed that I could introduce them to video consultations. The team consisted of six psychiatric nurses, but only four participated in the formal meetings I held about video consultations. There was a psychiatrist connected with the team who were a proponent of video consultation, had already tried to use a video consultation, and would give video consultation support to the psychiatric nurses when I was not there. I held a technical start-up at their place similar to that in the other department, and I arranged a meeting in their meeting room, where we could discuss their concerns. Before this meeting, I had prepared various questions that were focusing on what they would do in different situations. The situations were potential scenarios that could happen when they would introduce video consultations to a patient or something that could happen while talking with a patient via a video consultation. I also arranged a meeting where we could try to call each other via the video consultation. I had to re-arrange it two times due to technical problems with the video consultation program. In that process, I both talked with supporters from the IT-department and the implementation consultants and learned that several mental health professionals did not know who to contact when they encountered technical problems while using a video consultation, and that the implementation consultant, for that reason, did not receive all information about technical problems with the video consultation program.

While I was participating at this department, I offered my assistance with solving technical problems around the video consultation program for the mental health professionals. Since they were responsible for supporting their patients, in some few instances I also helped their patients with getting the video consultation program working on their devises. It gave me an insight into what technical problems they encountered. I also engaged in informal conversations about what they thought about using a video consultation. After these meetings, start-ups, and technical assistance, I would write an account of the essential incidents that had happened or was said about video consultations.

I also participated in a work group that were developing clinical guidelines about telepsychiatric home-based treatments. I contributed to the work with a literature review of the existing evidence on the area. At the meetings, I only listened and wrote down a summary of what was discussed. Participants included mental health professionals with some experience in using video consultations, the implementation consultants, researcher with knowledge of ethics in psychiatry, researchers with knowledge about video consultations, designated department manager, and administrative staff such as a registration consultant.

Based on the written accounts or summaries, I regularly reflected about what was essential and discussed this with other researchers, especially my main supervisor. Then I noted down initial concepts. Based on constant comparisons used in grounded theory (Strauss & Corbin, 2015), these concepts would be compared and adjusted as more data were gathered.

Spradley (1980) are explaining things to be aware of, when doing participant observation contrary to ordinary participation. There is a *dual purpose*, that is the purpose of participating in the social activity, and then observing the situation at the same time. It requires an *explicit awareness* towards information that normally are considered insignificant and unwanted, which includes using *wide-angle lens*. When doing participation observation, there will be an alternating between having an *insider and outsider experience* and having both simultaneously. Having an insider experience stem from being inside the situation. Having an outsider experience comes from viewing the situation from an outside perspective, viewing participants and activities as objects (Spradley, 1980). Moreover, it is recommended that the participant observer has to be aware of and record their own reactions and feelings to the situations that they are studying (Spradley, 1980). While interacting with mental health professionals and patients, I have always presented myself as a researcher. I have always felt like a researcher, and even though I sometimes supported the implementation consultants, I never felt like a consultant, and I did not share their concerns about the implementation process since I had no responsibility in that regard. Instead, I always tried to keep an outsider perspective, looking at the consultants as participants rather than colleagues while doing the participant observations. The mental health professionals did also consider me an outsider as I am not a mental health professional, and I did not work at their department.

Interviews with Managers – Understanding the Rationale for Video Consultations (Paper 3)

Several questions emerged during the field research. The most important questions were: “why did the mental health professionals have to use video consultations with their patients?” and “who are responsible for what activities?”. I decided to interview managers at different levels to let them answer these questions. I started with a hospital manager, then a department manager, two managers from the Centre for Telepsychiatry, and finally three team managers from the two departments. I invited

them via an e-mail and our internal booking system, and they all consented. I did semi-structured interviews with them at their offices or at a meeting room at the hospital using an interview guide. The guide was developed based on the questions that arose during participant observations and were adjusted to the different managers. An example of an interview guide is presented in Box 1, which is the one used with the department manager. The interviews lasted from 30-60 minutes. The interviews were recorded and transcribed.

Box 1. Interview guide used with a department manager

Introduction and consent

How long time have you been working as a department manager and what is your main task?
Why do you want to implement video consultations?
What is the purpose?
What are your considerations about the success criteria?
In regard to the implementation process, is there an implementation strategy prepared for what you want to accomplish with the implementation of video consultations?
How do you work with the implementation of video consultations?
When do you asses that the implementation has succeeded so far?
What is your role as a department manager in implementing video consultations?
Which role does the team managers have in this process?
How have you communicated about video consultations to team managers and the mental health professionals?
The number of video consultations held are different at each department. Why do you think that is?
What do you think the Centre for Telepsychiatry's role is in the implementation process?
Who do you think are opinion makers in regard to getting the departments started on using video consultations?
What do you think need to be done to get the mental health professionals to use video consultations with their patients?
What is the biggest challenge that you face in regard to getting the video consultations implemented?
What would make it easier for you to implement video consultations in your department?
A lot of things are being implemented at the hospital. How important are video consultations in comparisons to other initiatives?
What is the time frame?

Closing

Is there someone that you think it would be important that I interviewed?
Is there anything else you think would be important to add?

Interviews with Mental Health Professionals – Decisions to Support Video Consultations (Paper 3)

At the time of field observation, very few mental health professionals had used video consultations. They had no guide to support their decision on when to use it and to whom they should offer it. The interviews with the managers revealed that there was no specific reason to use video consultations other than it could increase patient quality not further defined. For that reason, I found it interesting

to know why the mental health professionals would think that video consultations could be used. To find out what determined their decision to support home-based video consultations, mental health professionals who already had done at least one video consultations with a patient were invited to participate in individual interviews. To explore variations and similarities across mental health professionals, several types of mental health professionals were approached. They had various occupational backgrounds and were working with patients with different diagnoses.

When the team managers were interviewed, they were asked to identify mental health professionals in their team that they knew had tried to use a video consultation with a patient. Other team managers were also contacted at the two departments to identify mental health professionals who had used video consultations. These mental health professionals, together with professionals identified by the implementation consultants and professionals I had supported during the field observations were contacted and asked to participate in in-depth interviews. They were interviewed at their offices, and it lasted around 1 hour.

I developed a semi-structured interview guide based on questions that evolved during the field observations, discussions with implementation consultants, and from the literature I had been reading. Topics included: 1) What do you think about video consultations? 2) How was it introduced to you? 3) How do you choose to whom you offer video consultations? And 4) How did you experience communicating with the patient via video and how did that affect the therapeutic relationship? The full interview guide can be seen in Box 2. When I met with the interviewees, I would bring the interview guide together with a notepad and a pencil which I would lay on the table. I would start giving the formal description of the purpose, their rights as participants, and ask them to sign a consent form. Then I asked if I could record the interview, and all approved of it. During an interview, I would typically only in the end look at the interview guide to check that we had covered all topics. After the interview, I would note down initial concepts and use them to direct specific focus in the coming interviews.

Eventually, 15 clinicians were invited to participate in individual interviews. 11 responded to the request and consented. The participant characteristics can be seen in Table 7. In the final interview, no new substantial concepts emerged, and no more mental health professionals were contacted.

Box 2. Interview guide used with mental health professionals

Introduction and consent

What is your profession and professional experience?

Introduction to video

How were you introduced to video conversations?

What did you think about it at that time?

What do you think about IT in general? And in the Mental Health Service?

How many patients did you have video conversations with?

How did you select the patients that you offered a video conversation?

Did anybody say, “no thanks?” Did they say why?

Experiences with video conversations

What type of consultations did you have over video?

How did they go?

How do you think they differ from conversations in person?

What kind of things do you normally focus on when you create a good contact or relationship with the patient?

Is that a challenge over video?

Is it possible to read emotions over video?

What do you think about the general quality of the treatment when the treatment is over video?

Future perspectives

How do you think video consultations could be used? Are there particular patients that you think would be better suited to video conversations than others?

What benefits do you see regarding using video?

What are the downsides?

The technology

How was the program Cisco Jabber to use? How does it function?

What did you do when something did not work? Did you contact the IT department? Did you contact Telepsychiatric Centre?

Is there something about the technology that you miss?

Closing

Is there anything else you think would be important to add?

Table 7. Participant characteristics of mental health professionals		
Gender		
	Female	9
	Male	2
Occupation		
	Psychiatric nurse	5
	Psychiatrist	2
	Psychologist	1
	Psychotherapist	1
	Occupational therapist	1
	Medical social worker	1
Number of patients seen via a videoconference		
	Mean	≈ 3
	Range	1 - 6

Patients' diagnoses of those seen via videoconference
• **Anxiety disorders including obsessive-compulsive disorder** • **Depression** • **Bipolar disorder** • **Schizophrenia** • **Eating disorders** • **Asperger's disorder** • **Personality disorders**
Services given via videoconference
• **Medication adjustment** • **Psychoeducation** • **Cognitive therapy** • **Follow-up sessions** • **Preventive conversations** • **Social support**
How video consultations are used
• **In a combination between video and physical presence** • **Start-up courses or final courses** • **The whole treatment course**
What video consultations are used for
• **Replaces consultations with physical attendance** • **Adds additional consultations** • **Used instead of a cancellation**

Note: From "Factors that determine mental health professionals' decision to support home-based video consultations: A qualitative study," by A. M. Moeller, J. P. Hansen and P. T. Andersen, 2022, *Frontiers in Psychiatry, 13,* 984026.

Interviews with Patients – Patients' Perspectives (Paper 2)

To inform person-centered care, it is important to explore what are the patients' perspectives on video consultations. The aim of the second paper was to explore adult outpatients' experiences with home-based psychotherapy via videoconferencing in a Danish psychiatric hospital.

All the mental health professionals who participated in interviews were asked if they had any current patient or patients they could ask if they wanted to elaborate on their experiences with video consultation to a researcher. Many of the mental health professionals had only used video consultations with few patients of whom several was discharged. Some of the patients that were asked by their mental health professional declined. Eventually only six patients identified by two psychiatric nurses were found. Then department managers at other departments at the psychiatric hospital than the initially two were contacted and asked for help to identify more mental health professionals that had patients they had used a video consultation with. This resulted in getting three more patients from one more psychiatric nurse.

Two of the three psychiatric nurses worked at two different local mental health services where they provided support and therapy to patients with various diagnoses. The other psychiatric nurse worked in a specialized team focusing on preventing relapse among pregnant women. They were all female. They have a graduate degree in mental health nursing and further education in cognitive therapy. They can provide both mental health support and psychotherapy to their patients.

I initially contacted the patients via a text message before scheduling a call. Then I called them to explain what the interview was going to be about, how it would be carried through, and ask if they still wanted to participate. Initially they all consented, however, two had to withdraw before the actual interview due to non-mental health issues and labor. Finally, interviews were scheduled and conducted with seven patients.

Interviews were conducted via the same videoconference that they had used for having a video consultation with their therapists. In that way, I tried to make the experience partially similar to a video consultation potentially enhancing the participants' memory about the video contact, and to give me, the interviewer, a feeling of the interaction as well. Moreover, it was practical in the sense that the participants lived far away from the clinics, and it was, therefore, easier for them to participate. Two of the participants were, though, interviewed over the phone. One felt uncomfortable using the videoconference which also was a theme in that interview. The other had simply deleted the program after the treatment course had ended.

Since the participants were interviewed via a videoconference or phone, it was not possible to obtain written consent. Due to that there were no written consents, the desire to protect patients' anonymity,

and to comply with in-house regulations, the interviews were not audio recorded. Instead, data were collected via notes taken during the interviews where quotes, as many as possible, were included. To validate the points taken down, before I changed a subject, I would sum up in my own words how I understood what the main point of what the participant had just explained and let them correct it. This functioned as a reflective exercise for the patients as well, making it easier for them to highlight what was most important for them. When the interview ended, a full detailed written account of the interview based on the notes and quotes was completed. In these accounts, data were reordered and grouped into aspects that speak to a given issue. Writing down notes during the interview may have affected the interaction. Not being recorded may also have affected the interaction.

All interviews were initiated with a presentation of the purpose, data collection, and their rights as participants, followed by an explicit question of whether they consented. During the interviews, I used a semi-structured interview guide which can be found in Box 3. It was developed based on questions that arose from the field work as well as from the literature review. It sought to answer questions about how and why video consultations were used, how participants felt about communicating via video, and how the personal contact was experienced. The questions in the guide were not followed exactly as presented, they were used for inspiration and to make sure that all the interviews covered the same basic topics. The interviews lasted on average 30 minutes.

Seven patients participated. They all had experience with the use of videoconferencing prior to using it with their therapist. Four of them used video consultations for preventive relapse sessions which are sessions that follow a previous treatment course. The four patients had previously been diagnosed with a depression, and one of them with co-morbid borderline personality disorder. They were all considered to be at risk of relapse due to a pregnancy. The last three participants used video consultations for psychotherapeutic sessions. They had anxiety disorders. Participant characteristics can be seen in Table 8.

Box 3. Interview guide used with patients

Introduction and consent

What is your general experience with the Mental Health Services?

How many times did you use video conversations?

Why did you choose to use video conversations?

Did you meet in person before the first conversation?

What do you believe is your therapist's role in offering video?

How did you find talking over video?

Do you experience differences in the way you converse when over video? What differences?

What are your thoughts about the personal contact over video?

How important is the personal contact?

What advantages did you experience?

Is there something that you do not think works over video?

Are there particular conversations that do not work over video?

How did you experience the videoconference app/the technical aspects?

Is there anything you think could be different?

Is there anything you would like to add?

Is there anything that you find important that I did not ask about?

Thank you for your participation!

Note: From "Patients' Experiences of Home-Based Psychotherapy via Videoconference: A Qualitative Study," by A. M. Moeller, J. P. Hansen and P. T. Andersen, 2022, *Archives of Psychiatric Nursing, 39,* 91-96.

Table 8. Participant characteristics of patients		
Gender	Women	6
	Men	1
Age group	20's	2
	30's	3
	50's	2
Diagnosis	Previous depression	3
	Previous depression and borderline personality disorder	1
	Anxiety disorder	2
	Post-traumatic stress disorder	1
Type of treatment received over video	Preventive relapse	4
	Psychotherapy	3
Number of video sessions	All sessions/all sessions except the first	2
	5 last sessions	3
	2-3 last sessions	1
	2-3 sessions, alternating with in-person sessions	1
Device used for video sessions	Tablet/iPad	3
	PC	3
	Smartphone/iPhone	1

Paper 2-3: Analysis of Data

Systematic Text Condensation (Paper 2)

In the second paper of the present PhD study, the aim was to explore adult outpatients' experiences with home-based psychotherapy via videoconferencing in a Danish psychiatric hospital, and a qualitative analysis based on a reflexive methodology was chosen. The take-off was in the interpretative sciences which explores meanings of social phenomena as experienced by individuals themselves in their natural context (Malterud, 2001). Key values shared in interpretative sciences are subjectivity, interpretation, context, and reflexivity. This also means that credible stories are no more or less true or valid than other available, and for that reason research should be assessed on its relevance (Malterud, 2016). There are no superior interpretative approaches, different ways of approaching the same subject result will lead to an increased understanding of complex phenomena. The purpose is to supplement and contest other's statements (Malterud, 2001).

The qualitative analysis used in paper 2 was based on a systematic text condensation. It is descriptive in its approach, presenting the experiences as expressed by the participants. The method was developed by Kirsti Malterud [1949-] who were inspired by Amedeo Giorgi's [1931-] psychological phenomenological analysis. Systematic text condensation is, though, only a systematic thematic cross-case analysis (Malterud, 2012). Due to the type of interviews and that the interviews were not recorded, a simple thematic analysis strategy was chosen. The systematic text condensation consists of 4 steps of analysis:

1. Total impression – from chaos to themes
2. Identifying and sorting meaning units – from themes to codes
3. Condensation – from code to meaning
4. Synthesizing – from condensation to description and concepts

When all the interviews were conducted, I read all of the written accounts in their entirety to get a general impression of the whole and to establish preliminary themes. Then meaning units from each account were identified, classified, and sorted into the preliminary themes. With systematic text condensation, only parts of the whole interview are meaning units (Malterud, 2012), and these have to some degree been established when the full accounts were written. My two supervisors then reviewed the accounts, meaning units, and preliminary themes, and we engaged in a discussion about the themes. When coding, the meaning units are decontextualized for cross-case synthesis where the themes are guiding. The meaning units were then further sorted into subgroups and content were reduced into a condensate which is an artificial quotation maintaining original terminology used by the participants (Malterud, 2012). In this process, the themes, or code groups, were elaborated on and labels were adjusted in accordance with the evolving understanding. Based on the condensates and quotations under each code group, descriptions and then category headings of each code group about the participants experiences with video consultations were developed grounded in the empirical data. At the end, all of the accounts we re-read to validate that the synthesis still reflected the original context. My two supervisors reviewed and gave feedback on the evolving drafts of the analysis.

Grounded Theory (Paper 3)

To explore the mental health professionals' experiences with video consultations, a grounded theory approach was chosen. It is a flexible and well-known methodology, that is appropriate to use when little is known about a phenomenon and the aim is to produce an explanatory theory that uncovers processes (Chun Tie, Birks, & Francis, 2019). Grounded theory was originally developed by the sociologist Barney Glaser [1930-2022] and Anselm Strass [1916-1996] in the 1960s (Glaser & Strauss, 1967). The methodology is characterized by having an inductive approach to research where the purpose is to construct theory grounded in data. Concepts are derived from data collected during the research process, and research analysis and data collection are interrelated. Any type of written, observed, or recorded data can be used as data (Strauss & Corbin, 2015). Data are analyzed based on *constant comparisons*. This means that each manageable piece of data is compared for similarities and differences. Furthermore, grounded theory makes use of theoretical sampling, where the constant analysis is leading the further collection of data (Strauss & Corbin, 2015).

Grounded theory procedures can be used to uncover the beliefs and meanings that underlie action in a culturally sensitive way, and therefore this methodology was chosen (Strauss & Corbin, 2015). We

decided to use the approach by Anselm Strauss and Juliet Corbin [1942-] due to their epistemological assumptions about how findings are constructed by inter-subjective understandings of the phenomenon being studied (Howard-Payne, 2015a). It encourages the researcher to be personally engaged with the research to get a better understanding of the world as the participants perceive it (Howard-Payne, 2015a). Strauss was inspired by *pragmatism* and *symbolic interactionism* by John Dewey [1859-1952] and George Herbert Mead [1863-1931] who, among other things, state that knowledge is created through action and interaction (Strauss & Corbin, 2015). George Herbert Mead laid the foundation of symbolic interactionism (Blumer, 1969). He is known for his triadic nature of the meaning of a gesture: it signifies what the person to whom it is directed is to do; it signifies what the person who is making the gesture plans to do; and it signifies the joint action that is to rise by the articulation of the acts of both. When the gesture has the same meaning for both parties, they understand each other. Engaging in symbolic interaction requires that the parties take each other's role. You have to be able to imagine a possible response or action, and you have to be able to understand the other part's intensions (Mead, 2015). According to Herbert Blumer [1900-1987], symbolic interactionism rests on three simple premises. The first premise is that *human beings act towards things on the basis of the meanings that the things have for them*. The second premise is that *the meaning of such things is derived from, or arises out of, the social interaction that one has with one's fellows*. The third premise is that *these meanings are handled in, and modified through, an interpretative process used by the person in dealing with the things he encounters*. Meaning arises in the process of interaction between people. The meaning of a thing for a person grows out of the ways in which other persons act toward the person with regard to the thing. Meanings are social products that the individual interprets by selecting, checking, suspending, regrouping, and transforming the meanings in the light of the situation the individual is in and the direction of one's action (Blumer, 1969). Assumptions about the inevitability of contingencies, the significance of process, and the complexity of phenomena, have influenced the methodology to locate action in context, to look at action and interaction over time, and to examine actions and interaction in routine as well as problematic situations in order to obtain a better understanding of how these are related (Strauss & Corbin, 2015). When using Strauss' method, coding is used to identify concepts, similarities and conceptual reoccurrence in data, and has three coding stages: open coding (developing categories of information), axial coding (similar concepts are collected), and then selective coding (building a storyline that connects the categories) (Chun Tie et al., 2019). Sampling of data continues until a category is considered to be sufficiently developed. To construct theory, the context and process must be studied, among other things by coding conditions, action-interaction, and consequences around a category (Strauss & Corbin, 2015).

During the field work, each of the accounts and summaries I did, would be analyzed via open coding, which would end with one or more concepts that would describe the incidents and a temporary category. See Box 4 for an example. The field notes would then be analyzed via axial coding, where incidents would be compared back and forth with previously incidents to refine the categories.

Box 4. Example of a field note, memo, and related category

"Together with an implementation consultant, I approached different teams in a department to help install the video program and video equipment on the clinicians' computers in their offices. In one office, a clinician, who was mainly working with patients with a schizophrenic disorder, stated that we were allowed to install the program on her computer, but she had no intention of using it due to the type of patients she had. She pointed toward the smoke detector in the ceiling, a dark grey round box with a small red flashing light, and said that some of her patients thought they were being recorded through that, and she, therefore, thought that it would be of no good for her patients to talk through a screen."

Memo: The clinician is skeptical about using video consultations. She worries about what is right for her patients and whether video consultation could do harm. I consider it professional to be skeptical about trying out new things in order to protect her patients. I also wonder how the clinicians are supposed to choose their patients. It appears that managers still need to communicate what the purpose with video consultations is, since it is not clear for this clinician.

Temporary category: Professional skepticism. Concept: Withholding video consultation option.

Note: From "Factors that determine mental health professionals' decision to support home-based video consultations: A qualitative study," by A. M. Moeller, J. P. Hansen and P. T. Andersen, 2022, *Frontiers in Psychiatry, 13,* 984026.

Concepts and categories were continuously discussed between me and my main supervisor which led to a preliminary analysis. Two categories were defined during the fieldwork period. The first category was 'professional attitudes' which uncovered various degrees of both skeptical and pragmatic attitudes towards video consultations, and the other category was 'assessed treatment quality' which uncovered various degrees of suitability of patients, impact on the therapeutic relationship, and safety.

The interviews with managers were analyzed via open coding. The concepts that emerged, were used to understand how video consultations had been implemented and inspired questions for the mental health professionals' interviews.

After all interviews with the mental health professionals were collected and transcribed, data from each interview were analyzed via open, axial, and selective coding to refine established categories. To get into the data, I found it particular helpful to use the 'flip-flop technique' (Strauss & Corbin, 2015), where concepts are turned upside down, to really get an idea of what stands out. Of other analyzing strategies were asking sensitizing and theoretical questions of data and making constant comparisons where data are compared to see if they belong to the same concept (Glaser & Strauss, 1967).

Reflexivity and Position

Reflexivity is a mayor strategy for quality control in qualitative research. It is a process of continual internal dialogue and critical self-evaluation of the researcher's position and recognition of how this position may influence the research process and outcome. Positions of the researcher may impact the research in three different ways: a) access to the field, b) the way the relationship between researcher and participants are shaped, and c) analysis and interpretation of data. This means acknowledging that the way the researcher constructs the world, uses language, poses questions, etc., shape the interaction, the findings, and conclusions of the study (Berger, 2013). Throughout the research process I have tried to be reflective and transparent about my position, preconceptions, and how this might have affected the data that I have been collecting and analyzing. This section will elaborate on this.

My position as a researcher is characterized by my education and training in science of public health. This has sparked my motivation for studying accessibility, patient experienced quality, and organizational factors when implementing new health care services. My background in science of public health has also influenced my understanding of how much environments, social determinants, and culture shape human activities. In the present study, I have been interested in both patients' and clinical staffs' opinions and attitudes regarding the video encounter and to understand their experiences on that basis. I have been looking for what has influenced the interaction as well as interpreted their narratives based in the given context. That is why I found it important to do participant observation and interview managers about the implementation process and what they thought of video consultations to better understand the context the mental health professionals were situated in.

Simultaneously, I acknowledge that the narratives from interviews are co-constructed and negotiated between the participant and me (Malterud, 2016). Therefore, in all the interviews I did, I used member checking, where I summed up what I understood as their main points, and made the participants validate or correct this. During the interviews, participants typically became more reflective about the topics, and sometimes wanted to refine their statements. In this way it becomes clear that the narratives were co-constructed.

By virtue of my education, I am familiar with how healthcare services work and are organized in Denmark. I have been working as a research assistant at a psychiatric hospital prior to starting my PhD study. Here I gained specific knowledge of how psychiatric hospitals are run and partly became aware of the workplace culture. However, I am not a mental health professional, neither a mental health patient. To understand their situation and experiences, I therefore had an outsider perspective. Being an outsider poses the question of whether I really understood the experiences that I had not had. Videoconferencing is, however, used for many different encounters, and I have experience with using it professionally in my work and private, though not for therapy. On the other hand, it ensured that the participants were the experts. I might also have approached the study from a fresh and different viewpoint, e.g., by asking naively about things related to their working procedures and their approach to IT support. Due to being an outsider, questions for the individual interviews were developed later in the process, where I might have gone from outsider to some degree of insider due to my participation in introductions to video consultations. During my PhD study, I was an employee at the Centre for Telepsychiatry which is a clinical department in the Mental Health Services. Through that I had the opportunity to work close with the implementation consultants of video consultations which gave me current knowledge of the status of the implementation process of video consultations and made it possible for me to access workshops, participate in introductions, and help the mental health professionals with technical challenges. I also had a workplace email and video license that established me as an employee in the organization. This gave me an insider position which made it easy for me to access other employees and, through them, patients. However, the hospital is a large organization with around 2,600 employees, and since I am not a mental health professional, and I did not work at their department, I kept a certain level of being an outsider to the mental health professionals.

In continuation of this, when I analyzed data, I retracted to being an outsider again due to not having shared the experience of a video consultation first handed. As Dwyer and Buckle argue, you do not have to be a member of the group being studied to adequately represent their experiences, but have the ability to "be open, authentic, honest, deeply interested in the experience of one's research participants, and committed to accurately and adequately representing their experience." There will

always be differences and similarities, even between people with the same experiences (Dwyer & Buckle, 2009).

During the interviews with both mental health professionals and patients, I presented myself as a researcher, but I also highlighted my connection with the implementation team, to ensure them that their participation and answers would have a direct impact on practice. I also tried to encourage them to think about something about the practice or the technology that they thought could improve. This was both on my research agenda, but I also wanted them to feel free to 'complain' or give negative feedback, without seeming unthankful, so that the video consultation experience could be investigated from different perspectives. My connection with the implementation team, could on the other side have let them to hold back negative remarks to protect my feelings. Among the mental health professionals, during the field work, I experienced that most teams had a culture where it was allowed to raise concerns and be critical about processes, and in my interviews, they also did raise concerns and frustrations, so I believe that was not the case. Among the patients, it was less obvious how my employment at the hospital affected them. They were interviewed via a videoconference, to underpin what service they were assessing, and this might have created a distance between them and I, that could make it easier for them to be critical. Of the patients that participated, some had good experiences and others had bad experiences and it, therefore, seemed that they could be open about their overall experience. It is possible that some nuances were lost due to the more impersonal nature of meeting on a video compared to a meeting in person.

All of the mental health professionals were aware of the importance of research, since they are schooled in evidence-based practices, and they had a personal and professional interest in the topic, given that they would be working with this moving forward. Several of them mentioned explicitly that they were interested in the results. This most likely encouraged them to be genuine and open. Further, they also had, except perhaps the psychiatrists, knowledge about the qualitative research interview, and due to knowing how the interview would go about, they seemed on ease and calm with it. It was also very apparent that they had a therapeutic background. Many of the therapists engaged in reflective meetings where they would supervise each other on different dilemmas they had encountered. They appeared to be very reflective of the interview questions, sometimes rephrasing the questions and answering to additional questions they would raise themselves. They would further give alternative explanations, saying: "It might be due to this, or it might be due to that," and they typically said: "This is my current opinion, and it might change over time."

Finally, I am a woman; the participants were mostly women. It is possible that this made some women voluntarily share more information with me due to shared genders (Padfield & Procter, 2016).

Ethical Considerations

Formal Approval and Data Storage

The Regional Committee of Health Research Ethics for Southern Denmark was queried for ethical approval. According to § 14, subsection 1, in Act on Research Ethics Review of Health Research Projects, approval is not needed since the study is based on interviews and observations and does not include any intervention or human biological material (response on query was emailed 22 Feb 2016; the decision is filed under S-20162000-29).

Hospital and department managers were informed about the study, and team managers and local research coordinators approved that the study could take place in their department or team before the beginning of data collection.

An approval of data storage was first granted from the Danish Data Protection Agency through the Region of Southern Denmark (granted 11 July 2016 under umbrella report 2008-58-0035 "Sundhedsvidenskabelig forskning i Region Syddanmark"). Data processing was later moved to the University of Southern Denmark, and approval of data storage was then granted from the university's Legal Services, SDU Research & Innovation Organisation (granted 17 March 2021, notification no. 11.334).

Practicing Ethics

Ethical dilemmas have been considered throughout the research process. Based on these considerations, my supervisors and I have carefully decided how to obtain honest informed consents meanwhile protecting confidentiality and anonymity to avoid any consequences from participation.

During the field work, I always presented myself as a researcher and not a facilitator. My general impression was that the mental health professionals did not act differently towards me as towards the facilitators at meetings and workshops. When conducting the interviews with the mental health professionals, I got access via their team managers. It both validated my inquiry that their team manager had approved that I contacted them, but it could potentially make them feel obligated to participate. However, some mental health professionals did not respond on the request to participate, so I believe that was not the case. Participating mental health professionals in the interviews were informed in writings of the purpose of the study in their invitation to participate and orally before the interviews. They were assured anonymity, voluntary participation, and the right to withdraw their consent. They all gave written informed consent before the interviews began (consent form used with the mental health professionals can be found in Appendix A).

When conducting interviews with patients, I got access to them via their therapist. The therapists asked their patients if they wanted to participate and highlighted the voluntariness. Some patients said

no, and I did not get any personal information about them. Others consented, and I got permission to contact them via phone. There I explained the purpose of the research and how the interviews were going to be held. If they still wanted to participate, we scheduled a date. Before the interviews started, I covered the purpose of the research, how data were going to be collected and used, and the patients' rights as participants. I then asked if they had any questions, and then I specifically asked if they wanted to participate (consent form used with patients can be found in Appendix B). It was not possible to get written consents since they were interviewed via video or phone. Therefore, no personally identifiable data were stored.

Findings

The overall aim of this PhD study was to explore adult outpatients' and mental health professionals' experiences with the use of video consultations at psychiatric hospitals. To investigate this, three studies were carried out. In this chapter, I will present a summary of the findings from each study and then a synthesis of the findings exploring how the findings underpin and extend each other.

Paper 1: Systematic Review and Synthesis of Qualitative Research

It is important for clinical decision-makers to understand what influences patients' acceptability of the services provided so that the services can be adapted and used most efficiently. Therefore, the aim of the first paper was to review published qualitative research and explore adult outpatients' perceptions of factors influencing their acceptability of video consultations used for individual psychotherapy or psychiatric assessments (Moeller, Christensen, Hansen, & Andersen, 2022).

Description of the Included Studies

11 studies were included, and ten of them were rated with high quality. They used qualitative interviews as their method. Most were analyzed using thematic analysis or qualitative content analyses. Study samples were drawn from varying western countries, with sample sizes between 1 and 27 and a total number of 138 participants. Interventions varied. They focused on patients with different diagnoses, where video consultations were used supplementary or during the whole intervention, and where the patient were at home or at a clinic. Moreover, different treatments were used, most often a type of cognitive behavioral therapy. A full overview of the study characteristics is given in Appendix C.

Underlying Conceptual Relations

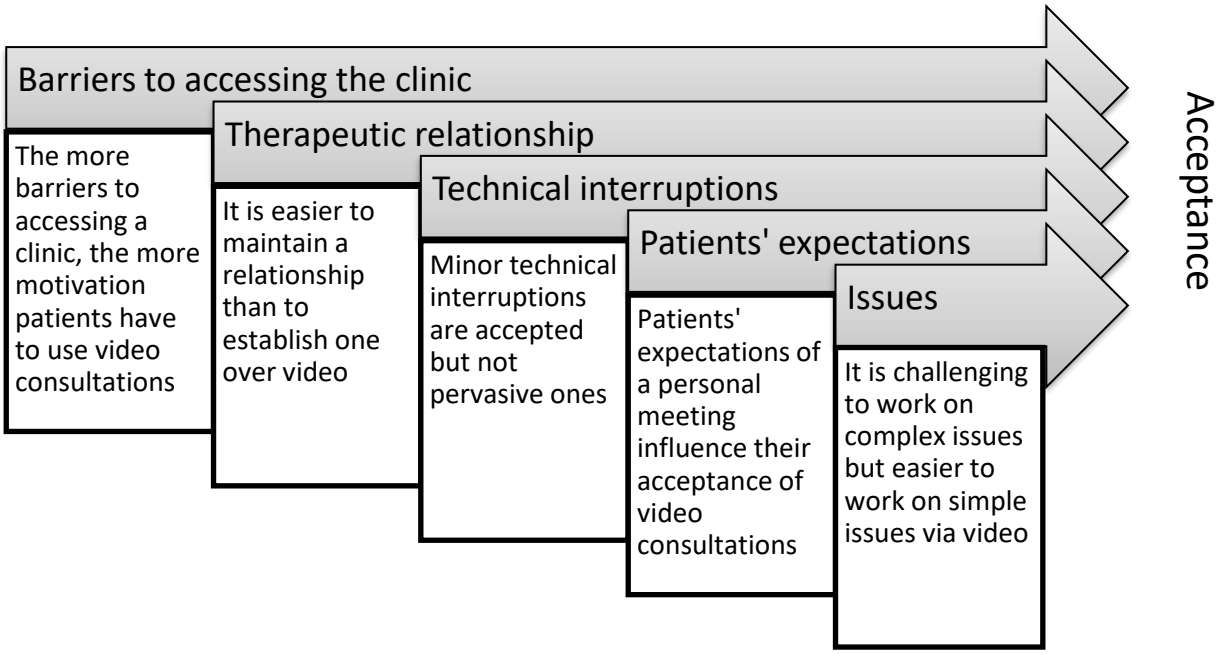
Five themes about patients' acceptance emerged from analyzing the included studies. The first theme precedes the next regarding acceptance, et cetera, and they interact with each other. The first theme and most profound factor was about barriers to accessing the clinic. Very long distance to specialized clinics and COVID-19 restrictions could prohibit physical attendance, and in these situations, video consultations would often be considered acceptable (Frayn et al., 2021; Leukhardt et al., 2021; S. G. Simpson et al., 2015). Barriers were also related to individual perceived inconvenience attending the clinic, where trade-off between perceived drawbacks regarding transportation and perceived gained value from in-person therapy would impact patients' motivation to use video consultation (Ashwick et al., 2019; Hensel et al., 2020; Tarp & Nielsen, 2017). That is, the more barriers to accessing the clinic the patients experienced the more likely they were to accept a video consultation. The second factor concerned the relationship between the patient and the therapist. In general, patients considered it easier to establish a relationship with the therapist in person, and, therefore, they were more likely to accept a video consultation when they already knew their therapist (Ashwick et al., 2019; L. F.

Christensen et al., 2021; Frank et al., 2017). However, patients would still accept a video consultation with a new therapist if the barriers to attending physically were sufficiently serious (S. G. Simpson et al., 2015). Regarding psychiatric assessments, the importance of establishing a relationship with a psychiatrist in person seemed less evident. The patients were typically already supported in person by other health care personnel, such as mental health nurses, and this may have alleviated the need for in-person contact with the psychiatrist (May et al., 2000; Trondsen et al., 2018). The third factor relates to technical interruptions caused by the videoconference equipment. Interruptions frequently occurred. The pervasiveness and how quickly they were resolved were related to patients' acceptance (Hensel et al., 2020; Tarp & Nielsen, 2017). Technical interruptions could have a negative impact on the therapeutic relationship (L. F. Christensen et al., 2021), and how well technical interruptions were tolerated sometimes depended on the therapeutic relationship already established (S. G. Simpson et al., 2015). This underpins the benefit knowing the therapist beforehand had. The fourth factor relates to what expectations patients have to the consultation. In general, patients felt that the video sessions were less personal. To some, this was considered a benefit, because this made them feel that it was safe to be open toward the therapist, but to the majority, it had the opposite effect, and they preferred in-person sessions (Frayn et al., 2021). Some patients were indifferent, since they believed that they could attain what they wanted from the session even when it was less personal (L. F. Christensen et al., 2021). Consequently, patients have different preferences regarding how personal the sessions should be which affected their acceptance of video consultations. The final factor related to patients' issues that needed to be dealt with during the specific session. Some patients expressed that it is more suitable to use videoconference when treating less complex and deep issues (Tarp & Nielsen, 2017). The complexity of the patients' symptoms may also have an impact on the patients' ability to work constructively and to create a trusting relationship with their therapist via a videoconference and hence make it more or less acceptable for them (L. F. Christensen et al., 2021). Anxiety symptoms could be managed easier when the patient was at home which could make it easier for the patient to attend, engage, and be open in regard to content and emotions (Ashwick et al., 2019; Hensel et al., 2020; Leukhardt et al., 2021). The issues that need to be addressed in the session might, therefore, be less difficult or complex to talk about. Video consultations therefore seemed more acceptable when the issues that needed to be dealt with were less complex. The underlying conceptual relations among the themes are depicted in Figure 8.

The five factors do both precede each other and interact with each other. Patients' willingness to accept 1) establishing a therapeutic relationship via video, 2) technical interruptions, 3) a less personal session, and 4) handling complex issues over video, are correlated with the perceived barriers they experience to accessing the clinic. The extent of technical interruptions during a video consultation

affects the ability to create a therapeutic relationship, and both patients' expectations of how personal they want the session to be and what type of issues that need to be handled affected the requirements for how strong the therapeutic relationship needed to be. Finally, patients' expectations to how personal the session ought to be were, to some extent, related to the issues that needed to be addressed.

Figure 8. Factors influencing patients' acceptance of video consultations



Note. From "Patients' acceptance of video consultations in the mental health services: A systematic review and synthesis of qualitative research," by A. M. Moeller, L. F. Christensen, J. P. Hansen and P. T. Andersen, 2022, *Digital Health, 8*

Paper 2: Patients' Experiences with Video Consultations

Satisfaction with video consultations may be related to context and individual circumstances. The second paper is therefore an empirical study that explore adult outpatients' experiences with home-based psychotherapy via videoconferencing in a Danish mental health hospital via qualitative interviews. The interviews are analyzed using systematic text-condensation (Moeller, Hansen, & Andersen, 2022b).

Cross-Case Themes

From the systematic text-condensation four themes emerged that captured both benefits and drawbacks patients had experienced during their treatment course with video sessions. The first theme was **'easier everyday life.'** The participants who used video consultations for preventive relapse sessions were all pleased with it and found that it was possible to have meaningful conversations while obtaining the benefits of staying home. They all had small children, and, therefore, saving time eased their everyday life.

The second theme was **'strained meetings.'** Among the participants who used video consultations for psychotherapy, some felt uncomfortable and nervous being on a camera for therapy and preferred a telephone conversation. It affected their ability to speak freely. Another participant felt comfortable and confident using videoconference and had suggested using it for therapy herself. However, the video sessions were scheduled more inconveniently than the in-person sessions which let the participant to choose in-person sessions prospectively.

The third theme was **'diverse sense of presence.'** Some participants believed that the video sessions were less intimate and formal, and this made them feel as if the sessions were less significant. Ultimately, they preferred in-person sessions if all other things were the same. Other participants did not find that the contact with their therapist changed when meeting over a videoconference. In general, they believed the video format aided the communication compared with a telephone call.

The final theme was **'attention to symptoms.'** All the participants expressed that they were involved in the decision-making of whether to use a video or an in-person consultation. Yet, some few mentioned that they found the therapists would have to be attentive to their symptoms, since they believed that under certain circumstances, they would agree even though it would not be in their own interest. One explained how tempting it would be to stay home when she was low on energy but had previously experienced a positive therapeutic impact when leaving the home. The other feared that she would feel rejected if the therapist suggested to 'lessen' their contact unless they had established a strong trustful relationship beforehand.

Paper 3: Mental Health Professionals' Decision to Support Home-Based Video Consultations

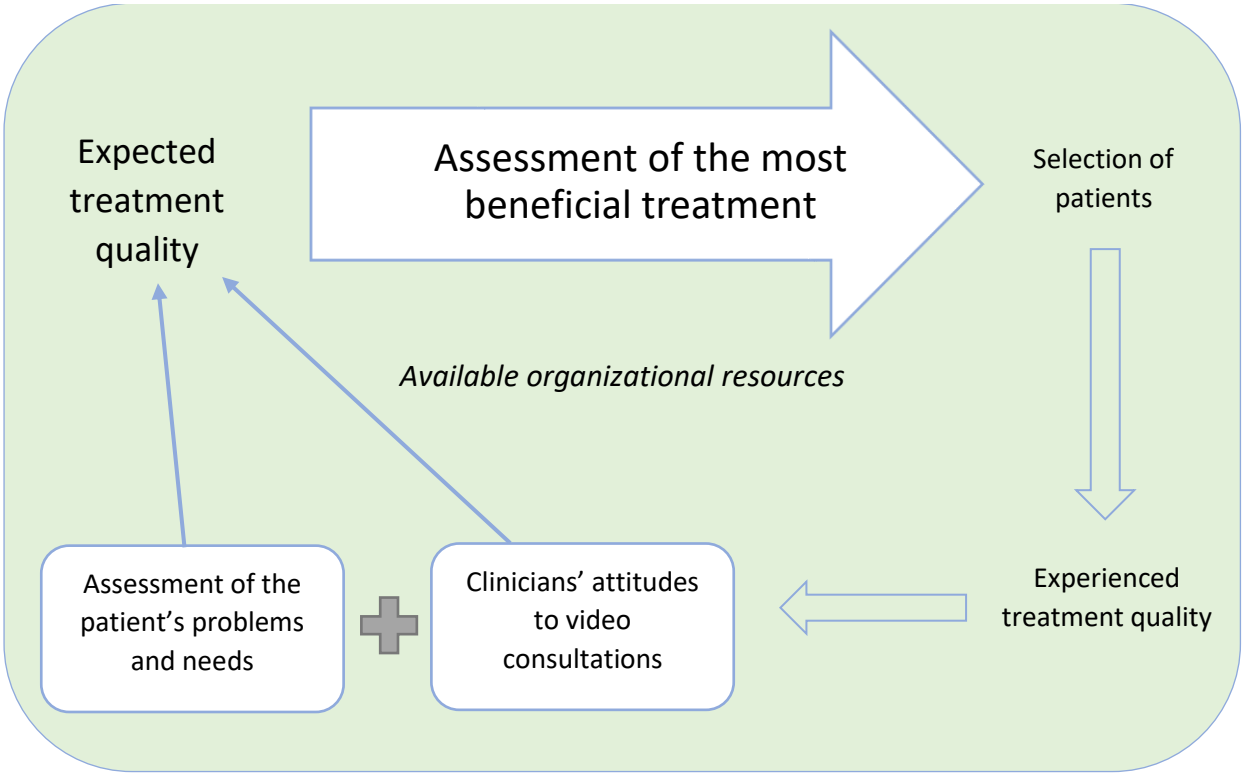
Mental health professionals are gatekeepers when it comes to offering a video consultation to patients. Their perspectives are therefore important to understand if video consultations are to be part of mental health services. The third paper is a grounded theory study that aimed to investigate what constitutes a professional video consultation regarding its framework and content from the perspectives of mental health professionals and explore what is of importance for the establishment and completion of video consultations to make it accepted among the professionals. It is based on field work and qualitative interviews with mental health professionals at a Danish psychiatric hospital (Moeller, Hansen, & Andersen, 2022a).

Grounded Theory Categories

The core category that derived from the analysis was **'assessment of the most beneficial treatment.'** It was established based on the five categories: **'expected treatment quality,' 'assessment of the patient's problems and needs,' 'clinicians' attitudes to video consultations,' available organizational resources,'** and **'experienced treatment quality.'** The clinicians would assess what would be the most beneficial treatment for the patients and based on that select the patients they

wanted to offer a video consultation to. Their assessment was grounded in how they expected the treatment quality to be when using a video consultation which was influenced by their assessment of the patient's problems and needs as well as their own attitude toward video consultations. They balanced perceived barriers with perceived advantages, and when the total quality was expected to be better than without it, they offered it. For those who selected patients and tried it out, their newly gained experience would support or dispute and hence change their beliefs and assessment of the expected treatment quality. The quality of the treatment was affected by what the video consultation could offer, and this was restricted by the available organizational resources. Figure 9 displays the connections between the categories.

Figure 9. Mental health professionals' patient screening process



Note: From "Factors that determine mental health professionals' decision to support home-based video consultations: A qualitative study," by A. M. Moeller, J. P. Hansen and P. T. Andersen, 2022, *Frontiers in Psychiatry, 13,* 984026.

The clinicians generally considered that the video consultation could improve the treatment quality when the patients increased their access to services, and it would deteriorate when it prevented or hampered significant treatment components. When the clinicians considered using a video consultation, they would take the patient's ability to access the clinic as the starting point. Then they would consider the patient's mental condition and social competencies to assess how using a video consultation would affect the treatment. Furthermore, the patients' interest in using a video

consultation was also a strong motivator for offering it. Assessments of factors, such as the importance of exposure related to going to the clinic, varied between clinicians and were dependent on their attitudes. Some were very skeptical and eventually refused to offer it to any of their patients, and others were slightly skeptical and managed to offer it to some of their patients. Finally, some clinicians took a pragmatic stance, and offered it to several patients that they though could benefit from it somehow. Their attitudes were affected by their workload and ability to solve IT issues. High workload resulted in a diminished mental capacity to acquaint themselves with something new and would lead to clinicians having negative attitudes towards new additional tasks. Moreover, their IT skills would determine how difficult it was to establish, use, and solve issues regarding video consultations. Of those who offered video consultations to their patients, they all had positive experiences when using it with patients as long as they did not encounter substantial technical issues.

Synthesis of Findings

The overall aim with the current PhD study was to explore adult outpatients' and mental health professionals' experiences with the use of video consultations at psychiatric hospitals. Overall, what led both mental health professionals and patients in my studies to accept a video consultation was their assessment and assumption of the patient first of all having difficulties accessing the clinic, and then second, their assessment and assumption of various other factors that could impact the treatment when using a video consultation (Moeller, Christensen, et al., 2022; Moeller, Hansen, et al., 2022a, 2022b). This can be illustrated by counterbalancing the perceived difficulties to accessing the clinic with the expected quality of treatment when using a video consultation. Patients' and mental health professionals' assessment of the perceived quality of treatment may, however, differ. This raises the questions of 1) who holds the decision-making power in terms of whether a video consultation is established? And 2) how is patients' and mental health professionals' assessments of the treatment quality weighted against each other?

Decision-Making Power when Initiating Video Consultations

The current PhD study took part in an organization where the mental health professionals had the initial decision-making power over video consultations. They were in a power position in terms of whether they would offer a video consultation to a patient or not. The patients then had a choice to accept it or reject it. A few patients who had been offered a video consultation rejected it, but most accepted it. This was probably due to that the mental health professionals only offered it to patients with obvious difficulties accessing the clinic (Moeller, Hansen, et al., 2022a). However, the patients could ask their therapist or doctor if it was possible to meet via a videoconference, but the mental health professionals, like the patients, could reject it. Patients were often unaware that it was an established offer, and therefore, it mostly relied on whether the mental health professional would

introduce it or not. Some patients did, though, ask if a videoconference was possible, such as Facetime or Skype. It is uncertain whether the patients that were not offered a video consultation would have benefited from it, but many of the mental health professionals had their first video consultation as a result of a patient wanting to use a videoconference (Moeller, Hansen, et al., 2022a). It therefore seems evident that the mental health professionals did not always know whether a video consultation would be beneficial from the patients' perspectives.

In data from the empirical part of this PhD study, no instances of mental health professionals who directly rejected a video consultation to a patient were found. From the field observations, some mental health professionals appeared in distress over having a patient who demanded it, since they felt that they had to offer it. When I raised the question of how to ensure safety via a videoconference, none of the mental health professionals had any concerns, since they believed it was similar to a telephone conversation where they already had established working procedures in that regard. So, even if they could reject it, they may not feel that their concerns would justify not offering it to the patient when the patient wanted it. Instead, mental health professionals who were skeptical about using video consultations would not inform the patients about the option. Mental health professionals who were proponents of the offer would both inform their patients about it and have leaflets about the video consultation option available in their offices. This means that access to the video consultation solution differed among patients.

Patients who participated in the current PhD study, explained that they felt confident in being able to reject the video consultation offer if they were not interested. Some few did consider whether they would always be able to do so (Moeller, Hansen, et al., 2022b). This highlights that both patients and mental health professionals believe that the responsibility for the decision to use video consultation should be shared between them.

Diversity in the Quality Assessment Between Patients and Mental Health Professionals

The way mental health professionals and patients interact does change when a video consultation is used. They have to rely more on verbal communication which gives the patients more responsibility for the communication than when they meet in person. This change has the potential to move the power dynamic in the relationship more toward the patient than when in person. Mental health professionals would, among other things, try to assess if they believe their patient would be able to take more responsibility for the interaction before offering a video consultation, such as not offering it to patients who are very taciturn (Moeller, Hansen, et al., 2022a). One factor that could possibly affect the treatment and therapy when using video consultations is the therapeutic relationship. Mental health professionals had been concerned about the therapeutic relationship, and they all believed, as most patients, that it was important to have established a relationship in person before using a video

consultation (Moeller, Christensen, et al., 2022; Moeller, Hansen, et al., 2022a, 2022b). Some patients did not find this to be important (Moeller, Christensen, et al., 2022), which might relate to their various expectations of how a therapeutic session should be both in terms of intimacy and content (Moeller, Christensen, et al., 2022; Moeller, Hansen, et al., 2022b). The discrepancy between mental health professionals' and patients' concerns and experiences with the therapeutic relation may be affected by their different roles during consultations. The mental health professionals have a professional understanding of the therapeutic relationship. They know that the collaboration between the mental health professional and patient is paramount for the treatment quality. Their professional concerns for the therapeutic relationship centered around whether they would be able to understand the patient well enough and convey enough empathy via a videoconference (Moeller, Hansen, et al., 2022a). Due to their professional role, they have a greater responsibility for establishing a therapeutic relationship than that of their patients. They have the knowledge and the experience, which builds on their professional identity and understanding of 'good quality treatment'. The patients have a private understanding of the therapeutic relationship which means they will experience the relationship based on their personal attachment style, personality traits and relational experiences. Some patients will for that reason explain that the services are similar and are not affected by the change in modality, and other patients find it uncomfortable (Moeller, Hansen, et al., 2022b). If a patient and the patient's therapist disagreed, in practice, as already mentioned, the patient's assessment would be weighted highest; when a patient wanted it, it was implemented, when a patient did not want it, it did not happen.

In conclusion, the mental health professionals exerted decision power by withholding information about the video consultation option from their patients if they did not want to use it. If the patient demanded a videoconference, however, their wishes were always accommodated.

Discussion

The present PhD study explored adult outpatients' and mental health professionals' experiences with video consultations at psychiatric hospitals. The key findings indicate that patients and mental health professionals counterbalance benefits and drawbacks between the video and the in-person option. The primary benefit of video consultations is that it increases accessibility, but the value of that depends on subjective attitudes and convenience. From the patients' perspective, examples of drawbacks include that some will feel alienated and nervous, the consultation might feel less personal, some might feel rejected by the offer, and it may maintain a certain level of isolation. From the mental health professionals' perspective, examples of drawbacks include uncertainties about whether they will be able to assess the patient and intervene correctly and uncertainties about whether the technology will work. The empirical part of the study took place in a Danish public psychiatric hospital, and at this hospital, the main barriers among the mental health professionals who had some experience using the video consultation were related to implementation issues regarding technical problems and unclear working procedures.

In the following part, I will discuss how video consultations contribute to increasing access to mental health services in Denmark, how mental health professionals and patients find video consultations acceptable, how they experience the interaction via video, and expand upon some implementation difficulties that arose in the setting where the empirical part of the PhD study took place. Finally, I will discuss the limitations of the selected methods used in this PhD study.

Access to Care

Access to services has been defined as a general concept that summarizes availability, accessibility, accommodation, affordability, and acceptability (Penchansky & Thomas, 1981). Findings from the present PhD study has found that using video consultations at psychiatric hospitals, including in Denmark, has increased accessibility since distance between the clinics and the patients' location has been eliminated; it has increased affordability to some, since they save time and money on transporting themselves to the clinic; and it is perceived to be an acceptable mode of receiving treatment among patients and mental health professionals under various circumstances, especially when it increases accessibility (Moeller, Christensen, et al., 2022; Moeller, Hansen, et al., 2022a, 2022b). Moreover, it is possible that the use of video consultations has freed some time for the mental health professionals so that they can see more patients which would increase the availability of services.

Before the time of COVID-19, video consultations have mostly been used with patients living in remote and rural areas in countries such as USA (Creedon et al., 2020) and Australia (Wilson, Moretto, Langbecker, & Snoswell, 2020). The empirical part of the present PhD study took part in

Denmark where distances to services due to geography and infrastructure typically are rather short. Still, participating patients found it convenient and highlighted that they saved time and energy on transport (Moeller, Hansen, et al., 2022b). The mental health professionals also experienced that video consultations had increased accessibility for the patients. For example, they had observed that transportation infrastructure where the patient lived and whether the patient owned a car or were dependent on public transportation could affect patients access options, and video consultations could in these cases prevent cancellations (Moeller, Hansen, et al., 2022a). Moreover, video consultations could bridge the additional distance to the clinic for patients who were referred to regional specialist services, video consultations could enable the continuation of a treatment course when the patient moved to a different city, and video consultations could ease access for the patients who struggled mentally with accessing the clinic (Moeller, Hansen, et al., 2022a, 2022b).

In a Danish context, offering video consultations to mental health patients will increase access especially for those who have difficulties transporting themselves to a clinic. It may, therefore, lessen the inequality in access to healthcare experienced by these groups which conform to the Danish Healthcare Act's statement that there need to be easy and equal access to healthcare services (Indenrigs- og Sundhedsministeriet, 2022). However, using telecommunication technologies requires both ownership of the right equipment and knowledge of how to use it. These are unevenly distributed, making it harder to reach people with low socioeconomic status, socially marginalized people, ethnic minority groups, and the elderly; hence it may reinforce the inequality in health that is already seen among these groups (Ghaneirad, Groba, Bleich, & Szycik, 2021; Litchfield, Shukla, & Greenfield, 2021; Scott Kruse et al., 2018). In a study from Germany during the COVID-19 hygiene protection measures, nearly a fifth of mental health patients did not have the right equipment to access video consultations (Ghaneirad et al., 2021). Ownership and compatibility will, therefore, restrict its use. This played a minor role in the empirical part of the present PhD study; however, it was mentioned by one of the mental health professionals that she had patients who were not offered a video consultation due to that the patients had a low income and did not have the resources to buy a computer or tablet that would be required for a home-based video consultation. At the beginning of the PhD study period, it was not possible to use smartphones for video consultations at the psychiatric hospital, but later in the process, around 2018, the videoconferencing system became compatible with smartphones. Most Danes (90 % in 2021) own a smartphone (Tassy & Berg, 2022), and for that reason the obstacle of ownership was handled, and more people were able to use it. Beside ownership of compatible devices, stable internet connection is also a prerequisite. Mental health professionals in the present PhD study who served small islands did mention that the internet coverage on the islands sometimes were poor, and other mental health professionals mentioned that some of their

patients who used smartphones could have connection problems that they thought was related to access to sufficient internet services (Moeller, Hansen, et al., 2022a). Digital competencies were only mentioned by some mental health professionals who believed it might play a role and that it most likely was associated with age (Moeller, Hansen, et al., 2022a). That is, older patients would find it more difficult to use. They may also have more deep-rooted attitudes about the level of intimacy that can be established in a video consultation than younger generations.

Mental health professionals and patients experienced that video consultations increased access to mental health services in Denmark, but some patients might not benefit from video consultations due to lack of ownership, sufficient internet coverage, digital literacy, and trust in therapy via video.

Acceptance of Video Consultations

A dimension of access is acceptance. Acceptability is a broader concept that encompasses patient and provider attitudes toward the service, and it is expected to influence utilization and patients' satisfaction with the services (Penchansky & Thomas, 1981). For that reason, investigating acceptability of healthcare interventions is recommended (Sekhon, Cartwright, & Francis, 2017). To fully understand what acceptability means, Sekhon et al. (2017), have proposed a conceptual definition of acceptability of healthcare interventions: '*a multi-faceted construct that reflects the extent to which people delivering or receiving a healthcare intervention consider it to be appropriate, based on anticipated or experienced cognitive and emotional responses to the intervention*.' They highlight several constructs that affects acceptability, such as how participants feel about it, the perceived effort to participate, how it fits with the participant's value systems, participants understanding of the intervention, and perceived benefits versus costs (Sekhon et al., 2017). Findings from the present PhD study indicate that acceptance of a video consultation is from the patients' perspectives related to difficulties accessing the clinic, a preestablished therapeutic relationship, limited technical issues, expectations of video consultations being suitable for therapy, and the issues that needs to be discussed in the particular session (Moeller, Christensen, et al., 2022). These factors are mostly based on the patients' subjective experiences. A pre-implementation study of patients who did not yet have any experience with mental health specialist video consultations, found, similar to our study, that the patients were positive about the fact that it would ease access, they worried about not being able to see their therapist in person, and whether they could deal with technical challenges (Bleyel et al., 2020). A scoping review of studies about patients' experiences with video or audio consultations during the early stages of the COVID-19, found, similar to our study, that most patients preferred therapy in person and that the video or audio consultations felt less personal, but they appreciated the increased accessibility and convenience (van Kessel, de Pont, Gasteiger, & Goedeke, 2022). A theme related to the COVID-19 situation found in the review was that the patients were

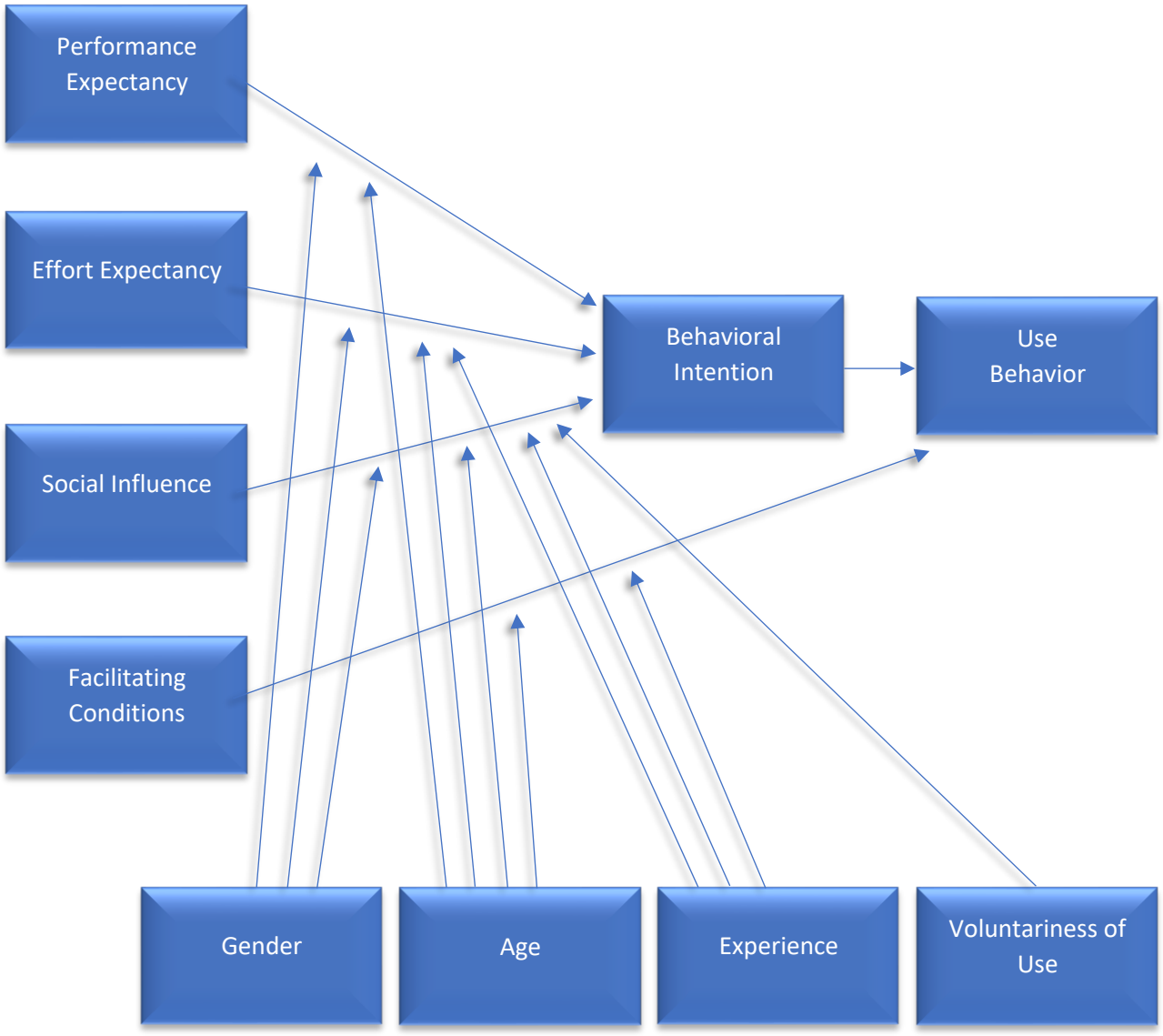
grateful for the opportunity to continue their care that the online modality provided (van Kessel et al., 2022). An interesting finding about acceptability was that patients who have it available but never use it still believe that it served to increase their overall satisfaction with the services they received (Hensel et al., 2020; Tarp & Nielsen, 2017). When it functions as a backup solution, it can reduce stress among patients and the need for a late cancellation which may explain the increased satisfaction (Ashwick et al., 2019; Moeller, Hansen, et al., 2022a; S. G. Simpson et al., 2006). This is important for decision makers to be aware of, since it might be a success having video consultations available regardless of the number of registered video consultations if success is patient experienced quality of the treatment. A success criterion could then be that all the scheduled video sessions are happening and are not disrupted by technical issues. Another success criterion could be that all the patients referred to outpatient services are aware that video consultations are an option after their first or second session.

Findings from the present PhD study indicate that the mental health professionals' acceptance is based on whether they believe using a video consultation would lead to a more beneficious treatment compared with usual treatment (Moeller, Hansen, et al., 2022a). Their assessment of how video consultations could improve the treatment is similar to patients' perspectives of increased access. Factors they considered could hamper the treatment is also to a large degree similar to that of patients': the therapeutic relationship, technical issues, and issues that needs to be addressed in the session (Moeller, Hansen, et al., 2022a). To increase acceptability among the mental health professionals, the mental health professionals' interaction competences, e.g., by education and experience, must be strengthened and technical issues should be solved before introducing it into the clinic. In a Canadian study, telemental health training among mental health professionals have been linked to whether the professionals find it useful (Simms et al., 2011). During the COVID-19 restrictions, many mental health professionals were encouraged to use video consultations. Studies from UK during this time have found that the mental health professionals, similar to our study, worry whether they are able to accurately assess their patients' wellbeing via video and consider it to be best suitable for patients with less complex needs, but also highlight the flexibility, how it increases access for patients during social restrictions, but also serve to ease access for patients struggling with social anxiety or physical disabilities that impede usual transportation, and finally that it could be used instead of a cancellation (Griffith et al., 2022; Johnson et al., 2021). Unlike our study, many of the mental health professionals in the UK have felt unable to assure data security and confidentiality (Johnson et al., 2021). In Denmark, citizens in general have high trust in digital technologies (Tassy & Nielsen, 2020), and concerns about data security did not appear as a theme. Another point is that the mental health professionals in UK during the social restrictions were asked to work from home,

and many did not have a fully private location to have these sessions at home (Johnson et al., 2021). Working from home had also made it difficult for them to set working boundaries and to receive sufficient social support from colleagues (Griffith et al., 2022). In the present PhD study, the mental health professionals worked from their usual offices and were able to receive support, including technical support, from their colleagues which must be considered a strength from their perspectives.

Fred D. Davis developed a theory that basically describe that the users perceived usefulness and perceived ease of use of a any technology would determine acceptability that would lead to system use (Davis, 1989). Based on this, a more sophisticated theory was later developed and referred to as the Unified Theory of Acceptance and Use of Technology (UTAUT) displayed in Figure 10.

Figure 10. The Unified Theory of Acceptance and Use of Technology



Note. Adopted from "User Acceptance of Information Technology: Toward a Unified View," by V. Venkatesh, M. G. Morris, G. B. Davis, and F. D. Davis, 2003, *MIS Quarterly, 27(3):* 425-478.

It includes four primary constructs that underlie individuals' acceptance of a technological innovation. The first construct, *performance expectancy*, is the strongest predictor of intention to use a technology. It is the degree to which an individual believes that an innovation will be useful and will have relative advantage over other systems (Venkatesh, Morris, Davis, & Davis, 2003). This resembles the core category 'the most beneficial treatment' in the grounded theory from paper 3. The mental health professionals' decision to use a video consultation did depend on whether they could see the relative advantage to their usual practice (Moeller, Hansen, et al., 2022a). Patients similarly found that to be true (Moeller, Christensen, et al., 2022; Moeller, Hansen, et al., 2022b). The second construct is *effort expectancy* which is the user's self-efficacy or perceived ease of use with the technology (Venkatesh et al., 2003). This was also an important factor when considering the mental health professionals. The mental health professionals that were ready to use a video consultation were either technology savvy or believed that they would be able to figure out the technical parts with support. The more the mental health professionals believed that the technological part easily would be handled, the more likely they were to initiate a video consultation (Moeller, Hansen, et al., 2022a). The patients that participated in this PhD study's empirical part did not encounter important technical difficulties since they were recruited if they already had used a video consultation.

The third construct is *social influence*. It refers to perceptions that important people want the individual to use the new technology and would view the individual positively for doing so (Venkatesh et al., 2003). The present PhD study took part at a psychiatric hospital where the mental health professionals have a high amount of autonomy during an individual patient encounter even though they have to follow clinical guidelines. It appeared as if their professional identities weighted more than any social influence. Colleagues working in the same team could have very different opinions of how to use a video consultation (Moeller, Hansen, et al., 2022a) which might indicate that social influence is not important for this setting. The difference regarding social influence, may be explained by different cultural practices between the organizations where the theory is developed and at psychiatric hospitals. UTAUT is developed and tested among various industries, such as telecom services and banking, and not from a hospital setting (Venkatesh et al., 2003). The hospital sector is characterized by being a professional bureaucracy where the core tasks are complex and unclear. Tasks are difficult to standardize and have to be solved through professional knowledge and estimated assessments from case to case. It is to a high degree the professional personnel that decide how the work is organized best (Kjær & Vikkelsø, 2018). In addition, when the treatment is based on conversations, the quality is very difficult to assess, since it is subjective. In these settings, social norms may play a different role, since it is not as strong a factor as deep-rooted professional identities. The fourth construct is *facilitating conditions*. It is defined as the perceived level of organizational

and technical infrastructure in place to support the technology (Venkatesh et al., 2003). This is also a category in the grounded theory in paper 3. In the grounded theory, it was evident that established working procedures and technical support both influenced whether it was possible to undertake a video consultation and whether the mental health professionals believed it was worthwhile to do so (Moeller, Hansen, et al., 2022a).

In a study of Canadian mental health providers attitudes towards video consultations using the UTAUT, *performance expectancy* was the only unique predictor of intention to use video consultations prior to COVID-19 (Zentner et al., 2022), and in another Canadian study, using the older version of the technology acceptance model, they similarly found that only perceived usefulness predicted intention to use videoconferencing for psychotherapy services (Monthuy-Blanc, Bouchard, Maiano, & Seguin, 2013). This might relate to the fact that *effort expectancy* and *facilitating conditions* may be subcategories of *performance expectancy*, which the grounded theory in the present PhD study indicate.

The four constructs in the UTAUT can be moderated to varying extends by user age, gender, experience with the technology, and the degree of voluntariness of adoption (Venkatesh et al., 2003). Age and gender did not appear as an evident factor in the present PhD study. This might be explained by the target group being adults that may be somewhat experienced with similar technologies already, and the majority of participants were women, and therefore, gender did not appear as a concept. In a study of satisfaction with videoconferencing among patients who had a depression, satisfaction was not related to either age or gender (L. F. Christensen, Gildberg, et al., 2020b). Since satisfaction is closely related to acceptance (Penchansky & Thomas, 1981), it is possible that age and gender does not have a big impact on whether patients find it acceptable. However, some studies with mental health professionals have found that those who had worked within the mental health field for a longer time were more likely to rate telemental health services useful and to use it (Gilmore & Ward-Ciesielski, 2019; Simms et al., 2011), so it might be different from the mental health professionals' perspective. From the present PhD study, it seems that experience with video consultations have an impact on acceptance as it could strengthen the mental health professionals' confidence in using it (Moeller, Hansen, et al., 2022a), or a patient might find out that it was not the right option for that person (Moeller, Hansen, et al., 2022b). In a study by L. F. Christensen, Gildberg, et al. (2020b), satisfaction with video consultations among patients who had a depression were positively related to the patients' number of sessions attended, which might indicate that they only continue using it if they are satisfied with the service.

Acceptability of a healthcare intervention can be assessed at different timepoints. In the present PhD study, acceptability was explored during the intervention delivery where participants had had some

exposure to the intervention and following completion of the intervention; some of the patients that were interviewed were discharged, others were still in a treatment course (Moeller, Hansen, et al., 2022b), and all of the mental health professionals that were interviewed were in their early phases of adopting video consultations into usual practice (Moeller, Hansen, et al., 2022a). Focusing on participants who had not yet any experience with video consultations would most likely have yielded other findings. Similarly, perceptions of acceptability may change with more experience. The included studies in the review, as well as the empirical studies, all focus on users who have had some experience. It is possible that their perceptions will change even more with more experience. During the COVID-19 many have used it to comply with social restrictions, and research that follow-up on this would be interesting.

Mental health professionals and patients find that video consultations are acceptable when they are perceived useful. From the patients' perspectives, this includes easier access to services while counterbalancing potential interfering therapeutical effects based on their expectations of how a consultation should be. From the mental health professionals' perspective, it includes accommodation of patients' needs and demands for easier access while not interfering with therapeutical tasks. This requires that the organization has provided sufficient resources to establish video consultations.

Video Consultation Interactions

Video consultations were considered to be acceptable by patients and mental health professionals when it did not interfere with therapeutical aspects of the treatment (Moeller, Christensen, et al., 2022; Moeller, Hansen, et al., 2022a, 2022b). The difference between a video consultation and an in-person consultation is that the individuals taking part do not share the same space, and their communication to one another are mediated by technological devices. The mental health professionals and most of the patients felt that the video consultations were more formal than in-person consultations (Moeller, Christensen, et al., 2022; Moeller, Hansen, et al., 2022a, 2022b), which might be related to that they would be sitting straight in front of the screen as opposed to sitting with a more natural body posture when in person. Some of the mental health professionals explained for example that they would use less small talk, and that the agenda that they have made were easier followed. There would be less 'irrelevant' talk, and the sessions would then be shorter (Moeller, Hansen, et al., 2022a). Formal and informal conversation was reflected in observations during the videoconferencing interviews with patients (Moeller, Hansen, et al., 2022b). Some patients would present themselves very formal, sit stationary in front of their device, having arranged an anonymous background. Others used it more dynamically, letting the pet out during our conversation and varied how 'present' they were. This created an informal environment that also felt more intimate. It is likely that the patients had received recommendations of how to participate in the video consultation, such as keeping it stationary and

not making too many movements during a session. The question is whether these recommendations are supporting a good therapeutical environment. Patients who were very accustomed to interactions via videoconferencing would use it more dynamically displaying more of their private life. Mental health professionals from the present PhD study described that in these cases, they were able to get a fuller picture of, for instance, the patients functional capacity. Patients and mental health professionals who participated in the current PhD study were early adopters and did not have a lot of experience with video consultations. Some professionals did, though, mention that they were able to improve their interactional skills with experience (Moeller, Hansen, et al., 2022a). To make the sessions more personal, the mental health professionals must find ways to interact, that matches their personal interaction style. However, more research about general optimal therapeutical interaction styles via videoconferences is still needed.

Since the communication is mediated by a videoconference, it may make the presentation of self slightly more controllable over a video than in person. For example, patients highlights that they do not have to shower before a session (Moeller, Hansen, et al., 2022b). It is easier for them to control how they appear over a videoconference. This could have a positive impact on the relationship, in the sense that the patient feels more presentable and for that reason believes that the therapist holds more positive feelings towards them. It will also create a more equal and respectful relationship. From the therapist's perspective it means that they are less sensitive to assessing the patient's capacity level (e.g., do the patient have the mental surplus to shower), which helps the mental health professionals to decide what would be a proper way to interact with the patient. This means that the patient is being given more power over the encounter. This makes some mental health professionals uncertain if all of the patients can handle this (Moeller, Hansen, et al., 2022a). It is important to notice that using video consultation should be a decision that are shared between the mental health professional and patient, and this decision should be discussed consecutive during a treatment course. Shared decision-making applies for all treatment elements (Psykiatrien i Region Syddanmark, 2020a), and in that sense, decisions regarding video consultations does not differ from usual practice. A psychiatrist mentioned that she did not worry whether the patient would feel pressured to use a video consultation, because the patient could choose to not answer when she called them. This perspective could inspire other mental health professionals. The current rate of adult outpatients in the Mental Health Services in the Region of Southern Denmark that are satisfied with the extent of involvement in decisions about their own treatment is 95 % (Psykiatrien i Region Syddanmark, 2020a). This agrees with the current PhD study's findings that the mental health professionals would accommodate the patients demands.

Implementation Difficulties

Mental health professionals' opinions about video consultations are important as they function as gatekeepers. For that reason, it is important to understand what their concerns are. In the present PhD study, mental health professionals raised concerns about the quality of treatment while using the service, but they may fear using video consultations due to other factors as well. Their concerns appeared to not only be related to meeting on a screen and the potential alienation and lack of ability to read the patient but did also center around aspects of technical skills. They worried about not feeling proficient in handling technical requests, and whether they would appear more unprofessional if technical disruptions would occur and whether that would make patients distrust their therapeutic abilities. The fear of the technical aspects was sparked by that video consultations was not just a new procedure, to many it was a new procedure with a lot of uncertainty. Working procedures were not always clear and they changed regularly. Technical support was organized and handled different than other technical issues, and available support were not always evident to the mental health professionals. For that reason, implementation facilitators did not always hear about the technical issues mental health professionals experienced, and, therefore, could not help them. The mental health professionals also had to support their patients with technical issues which not all of them were able to do. These factors impeded the implementation process. Research from Australia have found that efficient development of working procedures and processes are decisive factors for successful and sustainable implementation (Bradford et al., 2016). During COVID-19, and the rapid change of service provisions into video or audio sessions, mental health professionals from UK still felt that important technological, social, and procedural barriers existed (Johnson et al., 2021). It seems as if the resources put into implementing video consultation solutions does not always live up to the mental health professionals' expectations.

Another important factor is regarding legitimacy. Mental health professionals, managers, and patients have to be supportive of the initiative if it should be a success (Bradford et al., 2016). In the setting of present PhD study, video consultations were implemented top-down, since it was regional politicians who had prioritized it. At the same time, mental health professionals were to decide how to use it, making it a bottom-up implementation. Implementation facilitators were employed at a department in line with the other clinical departments, and, therefore, they did not have the power to make decisions in other departments. There were no clear decision lines, and different actors had different understandings of the other actors' responsibilities. The psychiatric hospital is a big complex organization where many things are constantly implemented. The infrastructure was not in place in terms of IT support, and many managers and mental health professionals were not fully committed to implementing video consultations. It therefore seemed as if video consultations were not a high priority in the organization.

Methodological Considerations

Strengths and Limitations of the Chosen Methodologies

The current PhD study used qualitative methods to collect and analyze data. Qualitative methods are used to understand social processes and human actions in different contexts (Strauss & Corbin, 2015). Qualitative research has the advantage of being open to explore anticipated and unanticipated issues and get nuanced and detailed understandings of the phenomena (Malterud, 2016).

In the first paper of the present PhD study, qualitative research was synthesized. Concepts about adult mental health outpatients' experiences with video consultations were developed based on concepts from the primary studies as well as deducted from the whole data to generate theoretical structures. It was therefore possible to develop a theory that went across contexts increasing transferability. However, context plays a role in the primary studies, and the findings represent the different researchers' interpretation of the patients' experiences in these contexts. The findings must therefore be interpreted as 3rd order observations, that is, findings in the primary studies are to some degree de-contextualized and assumed to be commensurable. The theoretical model that was developed captured the subjective experience that affects patient acceptability of the service, and I believe that the model is relevant for mental health professionals when they have dialogues with their patients about using video consultations.

In the second paper, experiences of video consultations among patients in a Danish setting were explored using systematic text condensation. It is a systematic thematic cross-case analysis which implies that data are decontextualized in a way where the individual context could get lost. For that reason, it is a benefit to have few participants to keep the overview. However, including few participants requires a very thoughtful purposive sample. Systematic text condensation is a pragmatic procedure that is simple, rigid, and accessible for novices. Although it does not leave space for creative interpretations, it is a detailed prescription of procedures which increase transparency of how data were handled (Malterud, 2012).

In the third paper, grounded theory was used. It is a strong and field-proven methodology used to examining topics and related behaviors from many different angles and to develop comprehensive explanations (Spradley, 1980). I have chosen to use Strauss and Corbin approach to grounded theory (Strauss & Corbin, 2015). Strauss and Corbin's approach is positioned in a pragmatic relativism, which means that 'facts' are restricted to the established consensus in a given context and at a period of history, and that there are multiple outlooks in regard to a certain phenomenon (Howard-Payne, 2015a, 2015b). The context and historical period must be taken into account in the creation, judgement, revision, and reformulation of theories (Strauss & Corbin, 2015). It means that the core category and related categories that I developed as part of the present PhD study is truth for this

setting at this time, and that there might be other truths about the phenomenon. It means that the theory does not have universal validity. Another aspect of developing a grounded theory is saturation. Collecting more data will eventually lead to the ability to refine categories even more (Strauss & Corbin, 2015).

Connection Between Studies

The first and the second paper deals with patients' experiences with video consultations, and it enables the comparison between patients' experiences across context with that of the patients in this setting. The third paper deals with mental health professionals' experiences with video consultations in the same context as the patients in the second paper. That is, all three papers deal with the same phenomenon from different perspectives. This may increase credibility of the findings (Tanggaard & Brinkmann, 2015). However, the studies were carried out simultaneously, and data from one study may have influenced the findings and conclusions of another.

Strengths and Limitations of the Chosen Methods

Review

The review was based on a systematic search with dual-author screening of abstracts, eligibility assessment, and quality appraisal to minimize biased selection of studies, and it was conducted in 8 scientific databases ensuring a thorough search. However, some relevant studies may have been missed due to publication bias or exclusion of grey literature. Non-publication of qualitative research seem to be related to the quality of the reporting of methodological information (Petticrew et al., 2008) and the exclusion may therefore not have had a huge impact on the findings. Researchers working with syntheses of qualitative research also disagree whether a systematic search is important, e.g., Margarete Sandelowski and Julie Barosso encourages a thorough systematic search including grey literature (Sandelowski & Barroso, 2007), others, such as Dixon-Woods et al., argues that for interpretive syntheses, where concepts are identified and developed into a theoretical structure, theoretical sampling of literature might better support the emerging synthesis (Dixon-Woods et al., 2006). In paper 1 of the current PhD study a systematic search was chosen, but additional to that, the final literature search on November 1, 2021, was conducted after the model was developed. Two additional papers were identified and included, and their findings supported the model indicating a level of saturation. However, not all of the factors were equally saturated and further research in the area could benefit the model.

In the included studies, there were a variety of settings, such as whether the patient was at home or at a clinic, whether video consultations were used consequently or not, and patients had different diagnoses. It was therefore possible to draw broad conclusions. However, there were no studies of patients with schizophrenia or bipolar disorder. Another aspect to mention is that only studies

including patients who were given an actual option to use video consultations were used in the analysis. I could have included pre-implementation studies, but that would be about the patients anticipated benefits and drawbacks, and their intention to use it may not represent actual use. Regardless, the findings represent to a large degree what leads patients to accept a video consultation. Three of the studies did, though, include patients who were given an option to use it but did not.

Fieldwork

While doing fieldwork, it is important to note that you as a participant asking questions, are also affecting the study object. That is, the field might change while you are there (DeWalt & DeWalt, 2011). During the study period, many working procedures were changed. I did the study while the field were in a transition period from not using video consultations to using it, and therefore, the findings must be used to understand such a period. It did provide an opportunity to look at how professionals handle the introduction of new technologies when it is introduced to them, and how they handle being able to decide themselves whether they wanted to use it or not.

Another important aspect is how the participants saw me and how that made them act (DeWalt & DeWalt, 2011). As an employee at the hospital, they might have treated me differently than if I only represented a researcher from the university. They might be more constructive as they might believe that I could change their practice, or they might be less open about critique if they thought it would have a negative impact on me. I tried to accommodate for the latter by asking if they wanted somethings to be improved. Regardless, my position did affect the findings in some way.

Interviews

Individual interviews were conducted with patients, mental health professionals, and managers. Interview with managers were conducted to get an understanding of the context of video consultation implementation. The managers are those who are responsible for implementing new policies, and sometimes they need to implement things that they might not agree on. Since they are responsible, they may not always want to let others know about their own opinions. This could have affected the interviews, where they might have been less critical. However, many of them did raise some concerns about the implementation process, and I found out that there were unclear expectations about who had which responsibilities.

The mental health professionals were interviewed at their offices which is a familiar environment for them, and it created a professional atmosphere. Patients were mostly interviewed via videoconference, the same that they used with their therapists. For that reason, they would also be in a familiar environment, though personal. Doing interviews via videoconferencing was a risk in terms of ensuring a safe environment where the participants would feel comfortable being open and sharing their thoughts. Most of the participants mentioned that video consultations felt less personal. On the

other side, they might have felt that the interview was more anonymous since we did not meet in person which, on the other side, could make them feel safer, hence make it easier to share their thoughts.

During interviews with both patients and mental health professionals, I would paraphrase their main points and ask if I understood it correctly. This member checking technique would increase credibility by ensuring that the participants agreed with my interpretation of what was said. It could be increased further if they would validate the final findings. The few mental health professionals that I asked if they wanted to validate the findings, did, though, decline, trusting my judgement. All interviews with the mental health professionals were recorded and transcribed, however, the interviews with the patients were not recorded. Data that were produced in the patient interviews were accounts of their statements which reduced rigor in the data collection. Audio-recorded transcripts and interview scripts written directly after an interview have, however, shown comparable levels of the detail captured (Rutakumwa et al., 2020), and given that the data were used for a thematic cross-case analysis, it may not have distorted the main findings. However, not having transcribed the interviews raises an ethical issue about the findings. The analysis is not directly based on the patients' statements, but my account of their statements. I did try to make the patients validate my accounts by reading them to them, but it did lower the accuracy in regard to letting the patients express themselves in their own words.

During analysis of both the patients' and the mental health professionals' interviews, my two supervisors audited and read my codes and interpretations to check for discrepancies, overstatements, and shortcomings which have increased credibility of findings (Tanggaard & Brinkmann, 2015).

Patients were recruited via their therapists, and they had to accept that I, a researcher, contacted them. It may, therefore, be that it only was the resource strong patients that participated. The included group could be divided into patients in preventive treatment courses and patients receiving psychotherapy, and they had anxiety or mood disorders. They all agreed to use it, they could still meet up at the clinic as an alternative. In this small sample it was possible to show variances, such as how personal it feels and how comfortable it feels (Malterud, 2001). However, it also left some questions open, such as, how does the level of current symptoms in the patient affect the way they look at video consultations? And how do we ensure that the negotiation of using video consultations leads to the optimal solution?

The mental health professionals were most often appointed by managers based on whether they had tried to use a video consultation. This means that the mental health professionals who participated in the interviews, had already accepted the use. Interviewing mental health professionals who were not willing to use it, would have contributed to a more nuanced understanding of the barriers the mental

health professionals experienced. Of the findings, the mental health professionals shared some assumptions about situations where they would not use a video consultation. They therefore did not have experience about this, and the findings must be interpreted as the mental health professionals' believes about video consultations, rather than actually consequences, such as concerns about using it with suicidal patients and patients with a substance use disorder. Moreover, the mental health professionals were early adopters which means that they might not have taken in the full impact of the treatment, how it affected their relationship with their patients, and they lacked experience in both handling the technical parts as well as finding effective interaction styles via the video screen. The findings may therefore be transferable to the implementation phases of video consultations.

The present PhD study only focused on video consultations with adult outpatients in a psychiatric setting. The findings may therefore not be transferred to child and adolescent psychiatry, gerontological psychiatry, social psychiatry, and inpatient stay. Another important factor is that adoption of telemedicine and development of new technological services happens fast, and there has been a change on many parameters since I started this PhD study. A significant change that happened was the COVID-19 pandemic with its social restrictions that forced many health care personals to change their practices to telemedicine, using a variety of video consultations, telephone contacts, and e-mails. Interviews and field work was conducted before this event which may question transferability. However, research indicate that the use of video consultations fell after the COVID-19 restrictions to nearly the same level as before (Hansen et al., 2021). Therefore, the findings of this study would still be useful and relevant when trying to understand video consultation experiences.

Conclusion

The overall aim of the thesis is to explore adult outpatients' and mental health professionals' experiences with the use of video consultations at psychiatric hospitals. Using video consultations between mental health professionals and their patients while the patient is at home is an acceptable practice when barriers to access exist. From both patients' and professionals' perspectives, video consultations should not be used if it would hamper the treatment, such as negatively impacting the therapeutic relationship, or be impossible to complete due to technical disruptions. Finally, from both patients' and mental health professionals' perspectives, the acceptance is also based on attitudes and personal preferences.

Implications for Practice, Policy, and Research

Perspectives for Practice and Policy

Based on the findings of the present PhD study, clinicians should feel confident in offering video consultations to those of their patients that are experiencing difficulties accessing the clinic. Both patients and mental health professionals find it meaningful to use for preventive relapse sessions, medication follow-up sessions, and follow-up of therapeutic tasks or schedules, since these are sessions with a clear and straightforward purpose that are easy to handle via a videoconference. It can also be used for social support and crisis management instead of a telephone conversation, since being able to see the other person can create trust and the ability to assess the other person more accurately. Moreover, it can be used therapeutical to practice exercises in context, e.g., exposure exercises where the patient want a therapist to assist. Using video consultations can also require less resources and it can therefore be used to increase the contact with patients by having shorter and more frequent sessions. Finally, it can be used as a back-up plan to in-person sessions, potentially lowering the rate of late cancellations.

The findings of the present PhD study did also elucidate some implementation challenges. It is important that the clinicians are on board with the use as they function as gatekeepers. First of all, it is important to create legitimacy of the use by including clinicians in the decision-making process of how to implement it. Moreover, it is important that the working procedures as well as support systems functions, do not change often, and are clear. It is important that responsibilities among clinicians, managers, and support systems are clear. To give the clinicians an idea about the usefulness of video consultations, the implementation would benefit from having educational programs targeting the clinicians consisting of evidence-based knowledge and arranged testing of working procedures and practicing technical skills in regard to the video program. Finally, there is a need for a process of continual feedback from departments, clinicians, and patients to increase awareness of where problems occur and what has been seen as effective.

Perspectives for Future Research

Based on the findings of the present PhD study, several further questions arose. First of all, it would be beneficial to investigate further the interactional skills that can be used to create a trusting therapeutic environment via a video consultation. Some performances might work better than others in terms of creating a personal and intimate session, so that the consultations are more like a consultation in person. Alternatively, video consultations could be used to create a different way of communicating with its own benefits over communication in person. It is not possible to create genuine eye contact, and it has therefore sometimes been recommended to look into the camera to give an illusion of eye contact. However, it is merely an illusion, and it is unclear what that means for the involved parties. Especially younger people have a better and more intuitive understanding of computer mediated communication and may consider the eye contact to be fake. An apparent benefit of not having direct eye contact is that it is possible to look at the other persons face for a long period of time without being intimidating. All in all, more research on strategies that can be used to strengthen the therapeutic communication during a video session is needed. Moreover, the clinicians concern about their attenuated ability to read their patients might also need to be further scrutinized. The fact that they cannot observe as much via a video screen as in person might lead them to ask and verbalize more of what they want to observe. They have to trust their patients in being able to communicate what is important for the clinicians to know. This might have a positive impact on the relationship and on the treatment rather than a negative one. Interactional skills and communication could both be tested in experimental studies, as well as investigated in observational studies.

It would also be beneficial to know the thoughts about video consultation among patients in ambulant mental health care in general and not just among those who used it. It could be conducted via a survey and follow-up interviews with a representable number of patients, investigating whether they want to use it or not, and in what circumstances. In that connection, the model of patients' acceptance of video consultations developed in paper 1 could be tested. The present PhD study did also raise questions about whether having established video consultations as back-up for patients would lead to a reduction in no-shows and late cancellations, how that would affect the therapeutic course, and whether the ease of access could lead to changed engagement in therapy for some patients. Moreover, would more people in the general population seek help if they knew they could use a video consultation? That is, does the video consultation offer reduce stigma of help-seeking?

Finally, since data were collected before COVID-19, a follow-up investigation of acceptance after COVID-19 could confirm or disprove the findings of the present PhD study and give insight in how a global crisis, or an abruption in normal practice, impacts acceptance.

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Appendices

Appendix A: Consent Form Used with Clinicians

Informeret samtykke vedrørende deltagelse i interview om videokonsultationer i psykiatrien

Titel: Oplevelser med videokonsultationer i psykiatrien

Formål: At undersøge behandleres oplevelser med at bruge videosamtale med patienter.

Metode: Der foretages interview med forskellige behandlere som har prøvet videosamtaler med patienter.

Erklæring fra interviewpersonen:

Jeg har fået skriftlig og mundtlig information, og jeg ved nok om formål og metode til at sige ja til at deltage.

Jeg ved, at det er frivilligt at deltage, og at jeg altid kan trække mit samtykke tilbage.

Jeg giver samtykke til at deltage i interviewet og at det bliver optaget, og har fået en kopi af dette samtykkeark med information om projektet.

Navn:_____

Dato:_____Underskrift:_____

Erklæring fra den, der afgiver information:

Jeg erklærer, at interviewpersonen har modtaget mundtlig og skriftlig information om studiet.

Efter min overbevisning er der givet tilstrækkeligt information til, at der kan træffes beslutning om deltagelse.

Navn: Anne Marie Møller, anne.marie.moller@rsyd.dk, tlf.: 40 38 34 72_____

Dato:_____ Underskrift:_____

Appendix B: Consent Form Used with Patients

Text and questions were read aloud, and then the consent was given verbally before the interview. The text and questions are presented below translated from Danish.

- **Purpose:** To explore the quality of video conversations, I will be talking with different users and make an overall analysis of how they experienced video conversations, what advantages they experienced, and whether they think something could be improved.
- **Data collection:** I write down the things you tell me, and this will be used for the analysis. I will not be recording you.
- **Rights as participant:** You participate anonymously. The only thing I know about you is your name, your phone number and that you have had at least one video conversation with your therapist. I will delete this information upon your participation. Your therapist will not be notified whether you participate or not. Participation does not affect your treatment course. Participation is voluntary, and you should only tell the things you want to tell. You are welcome to contact me afterwards if you have questions or would like to withdraw your statements.

Do you have any questions?
Would you like to participate?

Appendix C: Study Descriptions of the Included Articles

Authors, publication year, and country	Aim of study, study design, method, analysis, typology, and author discipline	Gender, age, diagnosis, and type of provider	Treatment type, sessions, met provider in person first, and videoconference program
Ashwick et al., 2019 England	**Aim of study**: To explore the acceptability of tele-therapy in a sample of UK veterans with PTSD **Design**: Intervention study **Method**: Qualitative interviews **Analysis**: Thematic analysis **Typology**: Thematic survey **Author discipline**: Psychology	**Gender**: 15 men, 1 woman **Age**: *Mean* 41 years (27-58 years) **Diagnosis**: Combat related post-traumatic stress disorder **Provider**: Psychologist	**Treatment type**: Cognitive behavioral therapy **Sessions**: 12 video sessions received from home **Met provider first**: yes **Videoconference program**: Skype for business
Christensen, et al., 2021 Denmark	**Aim of study**: To investigate older patients' and their providers' experiences with video consultations **Design**: Qualitative study **Method**: Semi-structured interviews **Analysis**: Thematic analysis **Typology**: Interpretive explanation **Author discipline**: Nursing	**Gender**: 5 men, 8 women **Age**: *Mean* 76 years **Diagnosis**: Depression **Provider**: Mental health nurses, psychiatrists, and psychologists	**Treatment type**: Treatment as usual **Sessions**: Optional. Patients had on average 6 sessions they received from home **Met provider first**: yes **Videoconference program**: Cisco Jabber
Frank et al., 2017 Germany	**Aim of study**: To report the first experiences with therapy over videoconference from a case **Design**: Case report **Method**: A structured interview based on open questions **Analysis**: Qualitative content analysis **Typology**: Thematic survey **Author discipline**: Social work	**Gender**: 1 man **Age**: 67 years **Diagnosis**: Chronic depression **Provider**: *not stated*	**Treatment type**: Cognitive behavioral analysis system **Sessions**: After 11 weeks of hospitalization the treatment was continued through 6 sessions of video consultations received from home with the same therapist **Met provider first**: yes **Videoconference program**: *not stated*
Frayn et al., 2021 USA	**Aim of study**: To qualitatively examine patient perceptions of teletherapy **Design**: Mid-program assessment of a randomized controlled study **Method**: Individual semi-structured interviews	**Gender**: 3 men, 7 women, 1 transgender man **Age**: *Mean* 42.8 years **Diagnoses**: Binge eating disorder, bulimia nervosa, or other specified	**Treatment type**: Cognitive behavioral therapy combined with various components of mindfulness and acceptance-based treatment **Sessions**: 16 video sessions received from home **Met provider first**: no

Authors, publication year, and country	Aim of study, study design, method, analysis, typology, and author discipline	Gender, age, diagnosis, and type of provider	Treatment type, sessions, met provider in person first, and videoconference program
	Analysis: Thematic analysis **Typology**: Thematic survey **Author discipline**: Psychology	feeding and eating disorder **Provider**: *not stated*	**Videoconference program**: *not stated*
Hensel et al., 2020 Canada	**Aim of study**: To explore the factors that influence engagement with videoconferencing for psychotherapy for postpartum depressive and anxiety symptoms **Design**: Intervention study **Method**: Semi-structured telephone interviews after a three months' intervention **Analysis**: Thematic analysis **Typology**: Thematic description **Author discipline**: Psychiatry	**Gender**: 12 women (of whom 2 did not use video) **Age**: *Mean* 34.5 years **Diagnosis**: Postpartum depression or anxiety **Provider**: Master's trained social workers	**Treatment type**: Psychotherapy based on cognitive behavioral and interpersonal therapy approaches **Sessions**: Weekly sessions if needed for three months. At each session video contact from home was optional. On average 50 % of sessions were via video **Met provider first**: optional **Videoconference program**: Vidyo (Ontario Telemedicine Network)
Leukhardt et al., 2021 Germany	**Aim of study**: To examine how the switch from traditional treatment to video-based treatment during the COVID-19 pandemic was experienced by patients and therapists regarding the therapeutic relationship and the therapeutic process **Design**: Grounded Theory study **Method**: Semi-structured telephone interviews **Analysis**: Grounded Theory methodology procedures based on Corbin and Strauss **Typology**: Thematic survey **Author discipline**: Psychology	**Gender**: 4 men, 5 women **Age**: *Mean* 42.5 years **Diagnoses**: Mood or affective disorders, anxiety disorders, or personality disorders **Provider**: Licensed psychotherapists or in psychotherapists in training	**Treatment type**: Psychoanalytic or depth psychology **Sessions**: Weekly or biweekly video sessions received from home **Met provider first**: yes **Videoconference program**: *not stated*
May et al., 2000 England	**Aim of study**: To establish the acceptability of psychiatric referral by simple videophone **Design**: Qualitative evaluation **Method**: Semi-structured informal interviews **Analysis**: Conventional model of discourse analysis	**Gender**: 22, *gender not stated* **Age**: *not stated* **Diagnoses**: Depression and/or anxiety disorders **Providers**: Psychiatrists	**Treatment type**: Diagnosis and management advice **Sessions**: Referrals from general practice where the patient was located during their psychiatric video consultation **Met provider first**: no

Authors, publication year, and country	Aim of study, study design, method, analysis, typology, and author discipline	Gender, age, diagnosis, and type of provider	Treatment type, sessions, met provider in person first, and videoconference program
	Typology: Conceptual description **Author discipline**: Sociology	supported by nurses in-person	**Videoconference program**: Simple videophone units - telephones with an additional LCD screen and fixed video camera joined by a high bandwidth (ISDN2) telephone line
Simpson et al., 2015 Australia	**Aim of study**: To explore perceptions of and reaction to video therapy as described by participants **Design**: Mixed-methods design **Method**: Semi-structured interviews conducted over videoconference **Analysis**: Content analysis **Typology**: Thematic survey **Author discipline**: Psychology	**Gender**: 3 men, 3 women **Age**: *Mean* 34 years (20-58 years) **Diagnoses**: Most had comorbid disorders; all had depression, 3 had social anxiety or social phobia **Providers**: Provisional master's level trainee psychologists	**Treatment type**: Cognitive behavioral therapy and schema therapy **Sessions**: Participants had between 5 and 20 video sessions from within the mental health services **Met provider first**: no **Videoconference program**: Client site had Cisco C20 endpoint with a 50" plasma display; therapist site had Lifesize Express 220 unit with 40" LCD display
Tarp & Nielsen, 2017 Denmark	**Aim of study**: To describe patient perspectives on optional videoconferencing-based treatment for alcohol dependency **Design**: Qualitative descriptive study **Method**: Semi-structured interviews **Analysis**: Qualitative content analysis **Typology**: Thematic description **Author discipline**: Anthropology	**Gender**: 27 mostly men (of whom 11 did not use video) **Age**: *Mean* 47 years **Diagnosis**: Alcohol dependency or alcohol problems **Providers**: *not stated*	**Treatment type**: Treatment as usual **Sessions**: At each session video contact was optional. There was a total of 60 video sessions among the 16 patients who used it. The patients received the video sessions in their homes **Met provider first**: yes **Videoconference program**: Cisco Telepresence videoconferencing client
Trondsen et al., 2018 Norway	**Aim of study**: To explore experiences of social interaction in which both patients, nurses, and psychiatrists are involved regarding video consultations in psychiatric emergencies	**Gender**: 1 man, 4 women **Age**: 18-51 years **Diagnoses**: Varied **Provider**: Psychiatrists supported by nurses in person	**Treatment type**: Psychiatric assessment in emergency consultations **Sessions**: Patients were at regional psychiatric centers where nurses assessed if the patients needed to talk with a psychiatrist. The patient had

Authors, publication year, and country	Aim of study, study design, method, analysis, typology, and author discipline	Gender, age, diagnosis, and type of provider	Treatment type, sessions, met provider in person first, and videoconference program
	Design: Qualitative exploratory design **Method**: Semi-structured interviews **Analysis**: Stepwise-deductive-inductive approach **Typology**: Interpretive explanation **Author discipline**: Sociology		one video consultation with the psychiatrist where the nurse was present without intervening **Met provider first**: no **Videoconference program**: *not stated*
Ye et al., 2012 USA	**Aim of study**: To examine the extent to which Korean patients accept a tele-psychiatric service **Design**: Questionnaire survey **Method**: Qualitative open-ended questions in survey **Analysis**: Thematic analysis **Typology**: Thematic survey **Author discipline**: Public Health and Communication	**Gender**: 5 men, 11 women **Age**: *Mean* 45.1 years **Diagnoses**: Depressive disorders, anxiety disorders, and adjustment disorders **Provider**: A psychiatrist with Korean background	**Treatment type**: Medication management and supportive psychotherapy **Sessions**: All received an initial diagnostic assessment via video. Each patient received up to three additional video sessions. Sessions were in Korean **Met provider first**: no **Videoconference program**: Tandberg Movi on laptop computers

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