UNIVERSITY *of York*

This is a repository copy of *Caregiving and receiving experiences in UK community mental health services during COVID-19 pandemic restrictions : A qualitative, co-produced study*.

White Rose Research Online URL for this paper:
https://eprints.whiterose.ac.uk/206580/

Version: Published Version

Article:

White Rose
university consortium
Universities of Leeds, Sheffield & York

ORIGINAL ARTICLE

WILEY

Caregiving and receiving experiences in UK community mental health services during COVID-19 pandemic restrictions: A qualitative, co-produced study

Jane McKeown[1] 🟢 | **Valentina Short**[2] | **Elizabeth Newbronner**[3] | **Ellie Wildbore**[4] 🟢 | **Carrie-Ann Black**[5]

[1]Sheffield Health and Social Care NHS FT/University of Sheffield, Sheffield, UK

[2]Tees Esk and Wear Valley NHS FT, Durham, UK

[3]University of York, York, UK

[4]Sheffield Health and Social Care NHS FT, Sheffield, UK

[5]South London and Maudsley NHS FT, London, UK

Correspondence
Jane McKeown, Sheffield Health and Social Care NHS FT/University of Sheffield, Sheffield, UK.
Email: j.mckeown@sheffield.ac.uk

Accessible Summary

What is known on the subject?

- At the outset of the COVID-19 pandemic, little was known about ways of delivering registered nurse practice within CMHTs under restrictions associated with a global pandemic.
- Emerging research focused on broad healthcare staff wellbeing during the pandemic. Qualitative research explored the overall response of COVID-19 on people with existing health needs or remote working more specifically.
- Over the past 2 years studies have emerged detailing experiences but no studies have used qualitative research to understand community mental health nurses and service users experience of services.

What the paper adds to existing knowledge?

- This co-produced qualitative study is the first to explore the changes to CMHT care from the experience of service users and nurses later in the COVID-19 pandemic.
- The study questions whether recovery-based approaches are possible in a hybrid way of working.
- The findings identify challenges for nurses' well-being and work–life boundaries when working from home.
- The study adds to historical professional narratives of mental health nursing.

What are the implications for practice:

- While hybrid approaches developed in response to COVID-19 restrictions may offer more choice these approaches need further co-produced evaluation on the impact of recovery-focused care and therapeutic relationships.
- Mental health nurses need to review how future hybrid working continues to impact nurses' mental health and emotional safety.
- Nurses and service users need to raise awareness within society and policy on the impact that COVID-19 had on people with existing mental health conditions.

Abstract

Introduction: Community Mental Health Team responses to COVID-19 included fundamental service delivery adaptations.

Aim/Question: Our co-produced study sought to understand which service delivery changes experienced by service users and registered nurses were helpful or unhelpful to caregiving and receiving.

Method: Qualitative semi-structured interviews were undertaken with 10 service users and 13 registered nurses from 3 NHS England sites. Co-produced throughout, people with lived experience of mental health services and nurses wishing to improve their research experience undertook interviews following training. Data were analysed thematically.

Findings: Care radically changed from in-person to large phone or video contact. This reportedly altered therapeutic relationship building and raised questions about whether recovery-focused care was possible. Hybrid working was viewed as helpful but raised challenges for nurse wellbeing.

Discussion: Changes to care delivery challenged the fundamentals of recovery-focused interventions and therapeutic relationships. Service users and nurses well-being consequently suffered. The impact of the pandemic on people with existing mental health conditions was poorly acknowledged in the media.

Implications for Practice: Recovery-focused interventions and relationship building need evaluating in the light of ongoing hybrid working. Teams need to consider the well-being of nurses engaged in complex service-user interactions from home.

KEYWORDS

care, Community Mental Health Team, co-production, COVID-19, lived-experience, qualitative

1 | INTRODUCTION AND BACKGROUND

In response to the COVID-19 pandemic, the UK Government instigated unparalleled changes to the NHS in order to manage the extreme demand for services concomitant with reduced service capacity (Stevens & Pritchard, 2020).

Community mental health services modifications included replacing face-to-face visits with phone and digital platforms for all but the most vulnerable and to reduce infection transmission, service users, where possible, were discharged from the hospital. This created increased complexity within community populations and increasing self-referrals coincided with a time of major staff shortages (NHS Providers, 2020; NHS Reset Campaign, 2020).

Early studies examining the pandemic impact on existing service users and services provide a picture of mental health services in 2020 and 2021. A number of survey studies were designed to understand the impact of COVID-19 on healthcare workers more generally. McGlinchey et al. (2021) report that staff redeployment impacted negatively on well-being and exhaustion, while a large survey by Gilleen et al. (2021) found that moderate to severe anxiety and depression arose from healthcare workers across a range of settings during COVID-19. These studies provide

valuable insights but did not isolate the specific experiences of mental health professionals.

As accounts emerged with a more specific focus on mental health professionals, a survey of 464 mental health staff (Eddy, 2021), found that 65% of respondents reported a loss of confidence in relating emotionally with service users, along with perceived reductions in morale, empathy and client-centred care. A survey of 156 mental health workers delivering older adult mental health care in the UK identified that while digital technologies enabled care continuation, they were a barrier for some (Bhome et al., 2021). Early in the pandemic a mixed-method survey of 2180 statutory and voluntary sector mental health multi-professional staff, reported that remote care was only a partially successful strategy due to limited availability of technology (Johnson et al., 2020). While these studies extended understanding within mental health services, they focused on multi-professional groups and relied on survey methods and experiences early in the pandemic. The first survey specifically reporting mental health nursing experiences during the pandemic (Foye et al., 2021) extracted data from the previous study by Johnson et al. (2020) and reported the belief that service users were not receiving adequate service. Additionally, service adaptations were reportedly made

too quickly for staff to adapt emotionally or practically (Foye et al., 2021) with nurses reporting problems with the availability of devices or internet connectivity, alongside increased workload and longer working hours.

Interviews with service users with pre-existing mental health conditions, accessing care through the pandemic reported concern about inadequate access to services (Gillard et al., 2021). These accounts focused on life for people with existing mental health services more generally, although did make some observations about care. With a specific focus on the delivery of remote mental healthcare, the qualitative study by Liberati et al. (2021) reported service users, carers and staff perceptions of the challenges that remotely delivered mental health care had on non-verbal cues in therapeutic interactions, safe space, and relational building (Liberati et al., 2021). The assessment and observation of deteriorating mental health and concern raised about the lack of training for technology use were additional challenges (Liberati et al., 2021).

At the time our study commenced the research already published provided: understanding of healthcare staff experiences during the COVID-19 pandemic more generally (Gilleen et al., 2021; McGlinchey et al., 2021) along with mental health staff perspectives more specifically (Bhome et al., 2021; Eddy, 2021; Johnson et al., 2020); mental health nurses across services in-patient and community services (Foye et al., 2021); mental health multi-professional staff, service users and carers perception of remote care across inpatient and Community Mental Health Teams (CMHT) (Liberati et al., 2021) and mental health service user experiences of how COVID-19 impacted on their lives as a whole (Gillard et al., 2021).

This study responds to the gap of existing research at the time, nationally and internationally in focusing very specifically on qualitative accounts of registered nurses and service users experience of CMHT care. Additionally, this study connects with the intention of the National Institute for Health Research that research is co-produced with service users (NIHR, 2015, 2021). The study was undertaken after the initial UK COVID-19 restrictions and so offers insights across the course of the pandemic rather than a focus on experiences early in the pandemic.

The study addressed two questions: what are working-age adult CMHT service users and registered nurses' experiences of receiving and giving care during the COVID-19 pandemic restrictions? and what has helped or hindered the provision of good care?

2 | METHODS

A co-produced qualitative methodology was used to explore 'helpful' and 'unhelpful' caregiving and receiving during the COVID-19 restrictions within working age CMHT across three National Health Service mental health Trusts in England. Semi-structured interviews were used to gather the experiences and perspectives of service users and nurses.

The study team comprised three registered mental health nurses, a service user research ambassador and an academic colleague. The study was co-designed and funded by service user interviewers to interview the service user participants, with the rationale that participants may speak more openly to peer interviewers (Harding et al., 2010). Three community-based nurses, interested in developing their research experience, were supported to undertake the nurse participant research interviews.

2.1 | Sample

A convenience sampling approach aimed to interview 15 service users and 15 registered nurses across the three NHS Trusts. This sample size of 30 was consistent with sample sizes for qualitative studies employing thematic analysis to elucidate specific beliefs (Marshall et al., 2013).

Participants with at least 6 months as a registered nurse or service user with the CMHT before and after the commencement of COVID-19 restrictions in March 2020 were included.

Nurses were excluded if they were not registered with the Nursing and Midwifery Council and if they did not assess and plan care. Service users were excluded if they were under 18 years or they lacked capacity to consent.

Informed consent was received and audio-recorded immediately prior to the research interview by the interviewer.

Challenges in recruiting in one of the three Trusts resulted in a final sample of 10 service users from two Trusts and 13 nurses across the three Trusts. Twenty-three people were recruited (service users n10; nurses n13). Sixteen respondents were female (service users n4; nurses n12). Service users had been receiving care on average for 6 years, ranging from 2 to 14 years. Nurses had been registered from 2 to 37 years and working in CMHTs from 1 to 21 years.

2.2 | Data collection

Semi-structured interviews lasting between 30 and 50 min were undertaken between 15 April 2021 to 13 July 2021. Previous COVID-19 research (Johnson et al., 2020; Pierce et al., 2020) informed the topic guide. This was adapted to improve the 'flow' and acceptability of the questions following a pilot and feedback from the team members with lived experience.

Interviews were conducted using 'Microsoft Teams' for staff and 'Attend Anywhere' for service users. This allowed for video interviewing but only audio was recorded via an external encrypted voice recorder. Three interviews were concluded via telephone due to connectivity issues.

Service user and nurse interviewers received written guidance and interview skills training in which 3 tailored training sessions were designed and delivered by the service user and academic members of the research team. The pilot interview feedback prompted a bespoke session designed and delivered by a trainer with lived experience of mental health issues. Training had an emphasis on recognizing and responding to distress in online

interviews. A risk protocol was developed to prompt action if safety concerns arose during an interview. A nurse research team member was available for support during all interviews. Service user interviews were supported by the service user ambassador and nurse.

2.3 | Ethical approval

Research and ethical approval was gained (ref. 20/EM/0266) from the Health Research Authority and Health and Care Research Wales Research Ethics Committee (HRA, 2022). Research governance was obtained from the participating organizations.

2.4 | Data analysis

Data were analysed using thematic analysis (Braun & Clarke, 2006). Audio recordings were transcribed and then examined, line-by-line. Initial codes were organized into categories analogous to the research question and generated from an independent review of a selection of transcripts by VS and refined by further analysis by JM. The core research team discussed these to agree on a set of deductive codes. The remaining transcripts were shared equally between VS and JM who used NVIVO to organize the data against the agreed themes.

2.5 | Findings

Findings are reported under each theme by service users and then nurse responses. Thoughts, feelings and experiences of helpful and unhelpful care amendments, including personal impact, are reported first. Perceived changes to support the needs of service users are reported next before finally participants offer advice for any future pandemic care amendments.

2.6 | Service user perceptions of helpful changes to care

The COVID-19 restrictions prompted changes to care and this often resulted in care being delivered more often over the telephone or video call. Phone calls were experienced as more regular and helpful than home visits by some and enabled easier, quicker contact with the care worker.

> there was always someone at the end of the phone and every other week I'd get a phone call. And then every week from the lady that normally comes to see me once a week, she was phoning me as well once a week. So it was really lonely but I knew that I could call somebody
>
> [01A4].

Some service users who felt especially anxious about leaving the house especially welcomed phone calls.

> I just don't like being around a lot of people. So, like being on buses and things like that, I get frightened, it triggers my anxiety. So, it's been a lot easier on the phone
>
> [01A5].

Signposting to other services and resources during phone calls was useful. Service users found emails and video meetings were also helpful for maintaining contact with their care workers.

Being reassured and speaking to staff who were responsive to care needs was perceived as important. Updates from staff on national developments regarding COVID-19 restrictions was valued, when watching the national news was too personally upsetting.

Some service users appreciated the flexibility and choice offered of either an appointment or a phone call:

> I could take up an appointment. Sometimes that did happen but also they used to call me and to look after me. Really, they have done a great job for me
>
> [03A13].

2.7 | Nurse perceptions of helpful changes to care

An early amendment to care for some teams involved organizing service users into groups by levels of risk and vulnerability, with weekly or more often contact maintained with the highest risk group as a priority:

> …red zone clients, people who were either relapsed in mental states, needed still to be seen face to face, …Amber zone clients was a case-by-case basis, but for the most part, because that was at risk of mental state relapse, …that we do still need to see them face to face every fortnight. …service users are in the green zone, doing well, concordant with their medication and treatment, …We had to move to phone-based sessions with them
>
> [02B6].

The use of telephone support was perceived by nurses to be helpful, enabling ongoing contact with the most vulnerable and high-risk service users. Nurses reported that the option to phone the team reassured service users that there was still a service.

Video meetings were helpful for both individual and group appointments, meaning some therapeutic groups could be maintained, enabling staff to see the service user, thus enhancing risk assessment and relationship building.

I think generally people have appreciated virtual meetings. Even though obviously, there are delays or people get kicked out and have to come back in, it means that actually we can speak to people without travelling and still get some idea of who we're looking at across the screen than in comparison to a phone call

[01B2].

Once socially distanced outdoor meetings were allowed face-to-face contact was reinstated for those service users who were assessed as more vulnerable. In addition, depot clinics were reinstated for some service users who usually had a home visit. Nurses preferred to see service users face-to face-where possible, as an aid to relationship building, risk assessment and therapeutic care.

Nurses found it helpful when managers increased communication with the team and acted as a conduit between the team and the Trust, finding this reduced team anxiety.

Having a management team in there and just, sort of like, buffer that, absorb as much of it as possible, and then pick up the things that we needed to be doing and the things that we weren't sure about, you know

[02B6].

Managers were experienced as being extremely helpful when they rapidly and proactively filled vacant posts and absences. Some Trusts set up wellbeing hubs, with space to talk to a psychologist or relax or get refreshments, nurses who had access to these found them helpful.

Third-sector organizations, which could help with social aspects of care, were reported as helpful in maintaining basic but crucial elements of care, for example, delivery of food bank goods to service users' houses.

…befriending stuff, people to go round and drop off some food supplies if people were struggling to get them because a lot of my caseload were having real difficulty getting basic food items. So these kinds of pop-up people were absolutely fantastic and they would phone the clients and just have a chat with them, drop round, and I did find them very good

[02B10].

2.8 | Service user perceptions of unhelpful changes to care

Just as some service users found phone calls helpful, others experienced this change as more unhelpful to their care. It was sometimes difficult to make phone contact with mental health workers,

particularly their named worker and crisis teams and unhelpful in a time when additional support was needed.

when you want to just, want to talk to the nurses, and you need some emotional support, and you're like, I can't get through. So, you wait hours, and nobody rings you. You can't get through and if you leave a message, they don't get it

[01A5].

When service users phoned their team, it could be to a person they had never spoken to before who did not know them. This was difficult as they felt their personal circumstances, mental health problems and treatments were not always understood. One service user experienced a whole change of team due to pandemic care changes which had distressing consequences.

Cause like I say, when I got sectioned, it was a bit…. put me on some different tablets and I reacted to them quite badly to be fair. So I have some really bad reactions, … And they were trying to, like I said, they were trying to, well they weren't re-diagnosing me but they were trying to diagnose me with something

[01A4].

Another service user underwent a change from oral medication to depot injection as usual checks for medication had ceased. Another had her medication stopped altogether as communication failed and interrupted the usual service:

I was on Mirtazapine and that got stopped because with my anxiety being so bad, I used to get my meds delivered and then they just stopped delivering them out of nowhere. And I'd called and they're, like, well, the prescription hasn't come through and I was, like, what do you mean…now I don't take any medication at all because it was such a fuss on, trying to get my medication that it was more stressful

[03A12].

Care was perceived as less reliable or responsive with too many changes happening all at once. Less contact with services was reported and that little or no help was offered when service changes were initially made:

And over the last few months now I haven't heard a word from anyone, like, at all, like, no check ins. Because I used to have weekly appointments with my CPN nurse and my support worker, but now, nothing. Absolutely nothing at all

[03A12].

2.9 | Nurse perceptions of unhelpful changes

Care amendments experienced as helpful were also reported as unhelpful for differing reasons. Nurses reported that replacing face-to-face appointments with phone calls was problematic in understanding service user circumstances and risks. Nurses felt that rapport building and accessing the whole picture presented by the service users in crisis was exceptionally difficult to manage via phone.

> That relationship just got cut off here where, you know, we just pick up a phone and said, oh how are you doing, how are things going, have you got your meds? …people don't open up more in what they're feeling over the phone
>
> [02B7].

The lack of connectedness when service users needed reassurance or comfort was reported. Service users who phoned frequently were perceived as accessing additional but unneeded help, in comparison to other more vulnerable people who did not phone due to their mental health or inability to say how they really felt.

Phone care was experienced as at odds with the recovery-focused care that staff were striving for, particularly as long-term work had largely ceased. Service users spoke with different staff at each contact, and those less at risk were left to call in if they needed help.

> That lack of face-to-face contact, I don't like doing lots of phone contact with people, I'd rather see them face-to-face, … And not everyone likes face-to-face contact, that's absolutely fine, but for people who do, you can build that rapport, you can do the reassuring, … person-centered care, you can do being a human person having that contact rather than it all just being on the phone
>
> [01B1].

Nurses reported the delivery of care by video contact had a negative impact on recovery which either faltered or stopped. Additionally, video was limited only to service users and nurses with digital access and skills.

Nurses felt uncertain about the personal impact of COVID-19 and were also overwhelmed by the volume of work and increased service user needs. This was compounded when colleagues who were either sick or leaving were not replaced. Shifting from individual caseloads to whole-team duty working was stressful and concern was raised about forgotten service users who had less immediate needs. Care was equated with risk aversion.

> …just literally firefighting and running out and doing 11 depots and then a crisis assessment and five phone calls is not how I want to work and it was awful
>
> [01B1].

Working from home reduced informal but vital colleague support and also raised challenges with the blurring of home and work boundaries. One nurse expressed difficulty in having video calls in their own home with a service user with a history of child sexual abuse. Immediate emotional support was not always available.

> And I was just in my home, and I couldn't really mitigate the fact that I had to take that phone call, and I tried moving from room to room. I thought I don't want to take this in the living room, so I tried to …I walked into my bedroom and thought no this is definitely not where I want to be hearing this conversation. …that was quite a dangerous thing for an individual's mental state to have to take on that information outside of a work environment and there was no-one I could turn to afterwards to debrief
>
> [02B6].

Criticism was directed at the government for its lack of understanding of mental health services. Reduced support for mental health service users in comparison to that received by acute trusts led to anger and stress among nurses.

> I think it's a pandemic that we've never had anything like it before and you don't know what's happening and you are kind of expected to go and support other people without an awful lot of support yourself. That's very difficult and that made me quite angry at times
>
> [01B5].

Team unity and attitude changed. Some nurses experienced increased divisions between disciplines but more unity between nurses who felt as if they had the hardest work changes. In response to feeling that teams were not coping, nurses reported teams were overwhelmed with increased anxiety, stress and low mood.

> I'd just lie on my bed and I'd be really tearful sometimes in the evening because I was like, I can't continue to cope like this. And I actually wanted to be off sick because I was like, I don't feel like I can provide a safe and effective service to my patients […] one of the worst experiences I've had of being a nurse
>
> [01B1].

2.10 | Service user feelings and changed support needs

Service users voiced gratitude for some staff or teams who they perceived as offering more than they needed to.

To be honest, if they weren't as good as they were, I would have deteriorated, without a doubt. But, because they gave me the phone calls as and when I needed them, were constantly there, it, kind of, kept me afloat. And they were fantastic, I mean, at one point I was having three calls a week for a number of weeks because I wasn't good

[01A1].

Conversely, others reported feeling isolated and lonely, finding uncertainty regarding pandemic restrictions difficult to tolerate. Care was also experienced as unreliable and unsafe with a personal sense of being disregarded and forgotten, leaving self-monitoring as the only option.

I do still need help, but because of the changes I've made in myself and the things I've done myself, like, I would really appreciate the help and the support and stuff like that, but I know right now, I probably couldn't, right now, live without it, but I don't need it as much, but that's because of the things that I've chose to improve on myself

[03A12].

Needs increased as other support and usual ways of coping diminished. At a time when tensions were building in families, family support, access to gyms, diet clubs or wider community also diminished. People felt that the support needed to self-manage was reduced at a time when there was increased anxiety, relapse, suicide risk and crisis.

I would like more support, yes, not less because you weren't able to go out and do your daily stuff like going to the gym or doing your walking or Slimming World, those kind of things. We were stuck in

[03A11].

2.11 | Nurse perception of impact on service users' support needs

Nurses reflected on how the impact of changes had overwhelmingly negative consequences for service users. Service users who had received regular visits, prior to COVID-19 restrictions, but who were not viewed as urgent or in crisis when cases were re-prioritized, were described as forgotten or falling through care gaps.

Her world got smaller and smaller and smaller, she didn't leave the house, she's now developed quite a lot of anxiety about going out, she used to get herself on the bus and go to town, shopped for clothes, and it's just like people like this lady are just a forgotten section of society. She doesn't complain, she doesn't go out and harass people, …she'd literally, if you left her alone, she'd just disappear

[01B1].

Services which had helped keep service users well, such as walking, art or therapy groups ceased or dramatically reduced. In some cases, this included vital support services supplying food from food banks to people. One service user lost their benefits as previous support for opening letters and addressing bills stopped. Nurses described an extreme decrease in quality of care and opportunities for very ill people to engage with services.

A perceived increased use of the Mental Health Act was reported, and across service user populations increased anxiety, depression, psychosis and alcohol use. This was accompanied by increased loneliness and isolation.

…a stretch that we had in between December 2020 and about, I would say, end of February/beginning of March 2021 where every week we had a Mental Health Act of one of our service users…By comparison if you rewound to 12 months previously, we were averaging a Mental Health Act every four weeks, so it went up fourfold…and there weren't enough hospital beds, half of our beds were closed down

[02B6].

Conversely, some nurses developed a greater awareness of the resilience of service users and also reported service users appreciating the impact on staff and asking if they could help staff in any way.

Their resilience to do what they need to do to make sure that they are well supported and supporting other people has absolutely astounded me and made me rethink about what we mean by when we talk about vulnerable people…Some of the strongest people I've worked with have mental illness, and it's been fantastic to learn that

[02B6].

2.12 | Advice for future pandemic restrictions

Service users reported they would like video and phone contact again:

If there was another lockdown, I think the one thing that needs to be improved on, is if you can't physically go and see your patient or whatever, try and call them

or Zoom, Facetime, anything like that because sometimes when people suffer so badly sometimes you are their only outlet and as much as it can be hard, it…but it's the job, do you know what I mean, like, they can't just fob it off

[03A12].

Nurses learned that it was possible to work more flexibly and still offer service users the care they need:

> we've proved the last 18 months that we can work from home, we don't always have to have face-to-face contact, so it's being a bit more flexible in what we can and can't do as opposed to this rigid you're in base and you're seeing patients face-to-face, it can just be a phone call
>
> [02B12].

However, nurses wanted to see better work planning, to allow for more personally restorative time for any hybrid working arrangements, for example, increased personal support and pacing of work:

> have a better understanding of a work and personal life boundary, and how, even though I am a frontline healthcare worker, and I have innate responsibility to my service users and public health in general, I'm still allowed to be a human being, and I still struggle and I'm not just the, sort of…a badge, or a profession, there's a human being behind that.
>
> [02B6].

Service users advised that teams need to adapt proactively to changing care needs and provide information about what support is available:

> It's the easy access to be able to get hold of them, like, they do just have a direct number for my team, I think there's a list, there's a directory list that's on a PDF which I found. I think they should bring that closer to the front of the, like, you know, the list of websites they have. But if you do find the PDF, it has all the direct numbers that you need for the teams you need
>
> [03A15].

Some nurses emphasized the need for more awareness of the negative impact of COVID-19 on people with serious mental health conditions, who were at higher risk than the general population and reflected that people with existing mental health needs were largely invisible in media accounts of COVID-19:

> I think initially people were understandably very focused on the acute services, general health and the like. Actually, one of the first deaths in our trust was on the ward I used to work on, and I think people

were really shocked about that. And I was like, but why? I know we're not intensive care, but, in fact, our patients are far more vulnerable to getting physical illness

[02B8].

Many nurses felt that much has been learned through successive periods of restrictions and that services were better placed to respond than when the pandemic began. However, a few nurses felt that some practice guidance would be helpful.

3 | DISCUSSION

Findings from service user and nurse participants in our study revealed that the COVID-19 pandemic restrictions and associated changes to CMHT services had many negative consequences for service user wellbeing. Some service users found it difficult to contact a practitioner with whom they had an existing relationship which is at odds with current national policy in improving access to mental health services (Department of Health, 2014). Consequently, some service users became lost to services or had treatments and diagnoses changed. Nurses reported an increased use of the Mental Health Act compared to previous years. These findings resonate with other research which reports risks to service users mental health and safety when access to care was compromised during the pandemic (MIND, 2020) and when services struggle to meet demand (Vize, 2017).

Remote working impacted on nurses' perceived ability to maintain therapeutic relationships with service users and accurately assess and respond to distress. This is concerning as therapeutic relationship building and maintenance is central to mental health nursing practice (Peplau, 1962; Royal College Nursing, 2010) with nurses being the profession in most frequent contact with service users (Felton et al., 2018). Weakened therapeutic relationships threaten the alliance in which interventions can be progressed (Bambling & King, 2011; Browne et al., 2014) and inhibit shared decision-making (Ahmed et al., 2021).

Nurses in this study report the distress many of them and their colleagues experienced during the pandemic working restrictions. Changes in the way that teams worked added to nurses feeling isolated, overworked, anxious and overwhelmed. Our findings align with other research reporting poor mental health and psychological difficulties in healthcare workers during the pandemic (Gilleen et al., 2021; McGlinchey et al., 2021). Concerns over work–life boundaries and personal psychological safety were highlighted by some nurses in response to remote working.

Some reports of poor management interventions and communication when levels of need were high contributed to stress among nurses. High workloads are cumulatively associated with reduced personal accomplishment, depersonalisation, emotional exhaustion and burnout (Helfrich et al., 2017; Maslach & Jackson, 1981) acting as barriers to care pathway implementation (Prytys et al., 2011).

Importantly, our findings highlight the detrimental impact that the COVID-19 restrictions had on people with existing mental health needs. At a time when service users often needed more support, less was generally available, reflecting the findings of Leeming et al. (2022). Mental health activist Rose (2002) considers the paradox of being grateful during COVID-19 for appointments with mental health professionals whom she had previously disregarded as working in flawed and unethical systems. The media emphasis of the pandemic on acute hospitals was recognized and experienced in a negative way by both service users and nurses. Some nurses perceived their specialist area of practice to have been undervalued and dismissed.

An unexpected consequence for some of the nurses delivering care within the COVID-19 restrictions was an increased respect for the resilience and self-management of service users. As a consequence, nurse assumptions about the vulnerability of some service users were challenged at a time when people with multiple morbidities were labelled by the UK Government as vulnerable.

The pandemic restrictions and associated changes to CMHT services introduced a wider range of methods for delivering and receiving care. Although these had negative consequences for some, others reported the greater range of methods was positive and offered more flexible contact arrangements. Some service users felt reassured by regular phone calls, for others, it helped with reducing travel costs and avoiding travel anxiety. To concur with Newbronner et al. (2022) and Liberati et al. (2021), different approaches could be used and tailored to meet service users preferred means of contact with services in the future.

3.1 | What the study adds to the existing research

At the time it was undertaken, this study was to our knowledge the first to undertake qualitative interviews with registered nurses specifically within CMHTs. Previous research had either gathered mental health nursing responses from broader survey studies (Foye et al., 2021) or had included nurses in a broader mental health worker participant group (Liberati et al., 2021).

Our findings hint at the perceived challenges nurses felt in being able to truly engage with recovery-focussed care through online meetings. This adds to the recommendation by Foye et al. (2021) for the need for more research on how therapeutic relationships are potentially affected by remote working.

Existing research reports the privacy challenges of receiving online care from a service user perspective (Johnson et al., 2020; Liberati et al., 2021). This study extends the discussion to nurses experiences and includes nurses' struggle to protect their home space and de-brief after difficult meetings.

This study contributes to historical accounts of mental health nurse and service user experiences of care during a global pandemic.

3.2 | Study strengths and limitations

Our study was strengthened by the degree of co-production which enabled a thoughtful research question and topic guide, co-designed and asked by people with their own lived experiences that would lead to the collection of meaningfully rich data.

We also acknowledge some limitations to the study. Our sample was smaller than intended and self-selecting and therefore participants may have had particular views about care receiving or giving during the pandemic. We mitigated this by ensuring that we reached data saturation and that interview questions were evenly balanced towards what was experienced as helpful as well as unhelpful. Furthermore, all study interviewers received training in how to ask topic questions that were not skewed towards eliciting unbalanced responses from participants. We also acknowledge that demographic data on ethnicity was not collected, however, service users and nurses from Black and Minority Ethnic groups were not excluded from the study.

4 | CONCLUSION AND IMPLICATIONS FOR MENTAL HEALTH NURSING PRACTICE

The ways that nurses adapted care during the pandemic to maintain relationships are reported and highlight the significance that mental health nurses place on face-to-face encounters in order to support rapport and recovery. However, new insights and learning for continued hybrid working for nurses and the impact of this on working in a recovery-focused way was hinted at and deserves further discussion within the profession.

Our findings call for more discussion and practical guidance within the nursing community as to how nurses may be supported to maintain their well-being particularly when working with clients with complex histories remotely from their own homes. The move to a broader range of ways of providing care, if properly evaluated, could offer a more personalized and responsive approach for service users. This would require a re-examination of the nature of therapeutic relationships in an increasingly digital world.

Nurse recognition for the unique challenges faced by existing mental health service users and heightened respect for their resilience was significant at a time when the national focus was on intensive care services. This offers insights into the unique role of mental health nurses and their specialist understanding and skills at a time when the needs of people with existing mental health needs and those supporting them appeared to receive little attention.

5 | RELEVANCE STATEMENT

The paper contributes to historical accounts of mental health nurses and service users experiences of care during a global pandemic. The challenges that the COVID-19 restrictions presented for nurse and

service user relationships and recovery are explored. Homeworking challenged how nurses maintained their professional duties whilst also protecting their own well-being. Nurse respect for service users' resilience was significant at a time when the national focus was on intensive care services.

AUTHOR CONTRIBUTIONS

ACKNOWLEDGEMENTS

DATA AVAILABILITY STATEMENT

Data available on request from the authors.

ORCID

Jane McKeown https://orcid.org/0000-0003-2920-4931
Ellie Wildbore https://orcid.org/0000-0002-6007-5843

REFERENCES

Ahmed, N., Barlow, S., Reynolds, L., Drey, N., Begum, F., Tuudah, E., & Simpson, A. (2021). Mental health professionals' perceived barriers and enablers to shared decision-making in risk assessment and risk management: A qualitative systematic review. *BMC Psychiatry*, *21*(1), 594. https://doi.org/10.1186/s12888-021-03304-0

Bambling, M., & King, R. (2011). Therapeutic alliance and clinical practice. *Psychotherapy in Australia*, *8*(1), 38–43.

Bhome, R., Huntley, J., Dalton-Locke, C., San Juan, N. V., Oram, S., Foye, U., & Livingston, G. (2021). Impact of the COVID-19 pandemic on older adults mental health services: A mixed methods study. *International Journal of Geriatric Psychiatry*, *36*(11), 1748–1758. https://doi.org/10.1002/gps.5596

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77–101.

Browne, G., Hurley, J., & Lakeman, R. (2014). Mental health nursing: What difference does it make? *Journal of Psychiatric and Mental Health Nursing*, *21*(6), 558–563. https://doi.org/10.1111/jpm.12162

Department of Health. (2014). *Achieving Better Access to Mental Health Services by 2020*. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/361648/mental-health-access.pdf

Eddy, C. M. (2021). The social impact of COVID-19 as perceived by the employees of a UK mental health service. *International Journal of Mental Health Nursing*, *30*(S1), 1366–1375. https://doi.org/10.1111/inm.12883

Felton, A., Repper, J., & Avis, M. (2018). Therapeutic relationships, risk, and mental health practice. *International Journal of Mental Health Nursing*, *27*(3), 1137–1148. https://doi.org/10.1111/inm.12430

Foye, U., Dalton-Locke, C., Harju-Seppänen, J., Lane, R., Beames, L., Vera San Juan, N., Johnson, S., & Simpson, A. (2021). How has COVID-19 affected mental health nurses and the delivery of mental health nursing care in the UK? Results of a mixed-methods study. *Journal of Psychiatric and Mental Health Nursing*, *28*(2), 126–137. https://doi.org/10.1111/jpm.12745

Gillard, S., Dare, C., Hardy, J., Nyikavaranda, P., Rowan Olive, R., Shah, P., Birken, M., Foye, U., Ocloo, J., Pearce, E., Stefanidou, T., Pitman, A., Simpson, A., Johnson, S., & Lloyd-Evans, B. (2021). Experiences of living with mental health problems during the COVID-19 pandemic in the UK: A coproduced, participatory qualitative interview study. *Social Psychiatry and Psychiatric Epidemiology*, *56*(8), 1447–1457. https://doi.org/10.1007/s00127-021-02051-7

Gilleen, J., Santaolalla, A., Valdearenas, L., Salice, C., & Fusté, M. (2021). Impact of the COVID-19 pandemic on the mental health and well-being of UK healthcare workers. *BJPsych Open*, *7*(3), e88. https://doi.org/10.1192/bjo.2021.42

Harding, R., Whitfield, G., & Stillwell, N. (2010). Service users as peer research interviewers: Why bother? In I. Greener, C. Holden, & M. Kilkey (Eds.), *Social policy review 22: Analysis and debate in social policy, 2010* (pp. 317–336). Bristol University Press. https://doi.org/10.2307/j.ctt9qgsrq.19

Helfrich, C. D., Simonetti, J. A., Clinton, W. L., Wood, G. B., Taylor, L., Schectman, G., Stark, R., Rubenstein, L. V., Fihn, S. D., & Nelson, K. M. (2017). The Association of Team-Specific Workload and Staffing with odds of burnout among VA primary care team members. *Journal of General Internal Medicine*, *32*(7), 760–766. https://doi.org/10.1007/s11606-017-4011-4

HRA. (2022). *Health Research Authority*. https://www.hra.nhs.uk/

Johnson, S., Dalton-Locke, C., Vera San Juan, N., Foye, U., Oram, S., Papamichail, A., Landau, S., Rowan Olive, R., Jeynes, T., Shah, P., Sheridan Rains, L., Lloyd-Evans, B., Carr, S., Killaspy, H., Gillard, S., & Simpson, A. (2020). Impact on mental health care and on mental health service users of the COVID-19 pandemic: A mixed methods survey of UK mental health care staff. *Social Psychiatry and Psychiatric Epidemiology*, *56*(1), 25–37. https://doi.org/10.1007/s00127-020-01927-4

Leeming, D., Lucock, M., Shibazaki, K., Pilkington, N., & Scott, B. (2022). The impact of the COVID-19 pandemic on those supported in the community with long-term mental health problems: A qualitative analysis of power, threat, meaning and survival. *Community Mental Health Journal*, *58*, 1297–1309. https://doi.org/10.1007/s10597-021-00932-4

Liberati, E., Richards, N., Parker, J., Willars, J., Scott, D., Boydell, N., Pinfold, V., Martin, G., Dixon-Woods, M., & Jones, P. (2021). Remote care for mental health: Qualitative study with service users, carers and staff during the COVID-19 pandemic. *BMJ Open*, *11*(4), e049210. https://doi.org/10.1136/bmjopen-2021-049210

Marshall, B., Cardon, P., Poddar, A., & Fontenot, R. (2013). Does sample size matter in qualitative research?: A review of qualitative interviews in is research. *Journal of Computer Information Systems*, *98*(1), 11–22. https://doi.org/10.1080/08874417.2013.11645667

Maslach, C., & Jackson, S. E. (1981). The measurement of experienced burnout. *Journal of Occupational Behaviour*, *2*(2), 99–113. https://doi.org/10.1002/job.4030020205

McGlinchey, E., Hitch, C., Butter, S., McCaughey, L., Berry, E., & Armour, C. (2021). Understanding the lived experiences of healthcare professionals during the COVID-19 pandemic: An interpretative phenomenological analysis. *European Journal of Psychotraumatology*, *12*(1), 1904700. https://doi.org/10.1080/20008198.2021.1904700

MIND. (2020). https://www.mind.org.uk/newscampaigns/news/mental-health-charity-mind-finds-that-nearlya-quarter-of-people-have-not-been-able-to-access-mental-health-services-in-the-last-two-weeks.

Newbronner, E., Spanakis, P., Wadman, R., Crosland, S., Heron, P., Johnston, G., Walker, L., Gilbody, S., & Peckham, E. (2022). Exploring access to mental health and primary Care Services for People with Severe Mental Illness during the COVID-19 restrictions. *Frontiers in Psychiatry*, *12*, 799885. https://doi.org/10.3389/fpsyt.2021.799885

NHS Providers. (2020). *Spotlight on…The Impact of COVID-19 on Mental Health Trusts in the NHS.* https://nhsproviders.org/media/689590/spotlight-on-mental-health.pdf

NHS Reset Campaign. (2020). *Mental health services and COVID-19: preparing for the rising tide.* https://www.nhsconfed.org/publications/mental-health-services-and-covid-19

NIHR. (2015). *Going the extra mile: Improving the nation's health and wellbeing through public involvement in research.* https://www.nihr.ac.uk/documents/about-us/our-contribution-to-research/how-we-involve-patients-carers-and-the-public/Going-the-Extra-Mile.pdf

NIHR. (2021). *Guidance on co-producing a research project.* https://www.learningforinvolvement.org.uk/wp-content/uploads/2021/04/NIHR-Guidance-on-co-producing-a-research-project-April-2021.pdf

Peplau, H. E. (1962). Interpersonal techniques: the crux of psychiatric nursing. *AJN the American Journal of Nursing*, *62*(6), 50–54.

Pierce, M., Hope, H., Ford, T., Hatch, S., Hotopf, M., John, A., Kontopantelis, E., Webb, R., Wessely, S., McManus, S., & Abel, K. M. (2020). Mental health before and during the COVID-19 pandemic: A longitudinal probability sample survey of the UK population. *The Lancet Psychiatry*, *7*(10), 883–892. https://doi.org/10.1016/S2215-0366(20)30308-4

Prytys, M., Garety, P. A., Jolley, S., Onwumere, J., & Craig, T. (2011). Implementing the NICE guideline for schizophrenia recommendations for psychological therapies: A qualitative analysis of the attitudes of CMHT staff. *Clinical Psychology & Psychotherapy*, *18*(1), 48–59. https://doi.org/10.1002/cpp.691

Rose, D. (2002). *The Paradox of COVID 19 and 'extreme vulnerability'.* https://www.nsun.org.uk/the-paradox-of-covid-19-and-extreme-vulnerability/

Royal College Nursing. (2010). *Principles of Nursing Practice.* https://www.rcn.org.uk/professional-development/principles-of-nursing-practice

Stevens, S., & Pritchard, A. (2020). *Important and urgent—Next steps on NHS response to COVID-19.* NHS England and NHS Improvement. https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/03/urgent-next-steps-on-nhs-response-to-covid-19-letter-simon-stevens.pdf

Vize, R. (2017). Pressures on the NHS are holding back progress on mental health. *The Guardian.* https://www.theguardian.com/healthcare-network/2017/sep/22/pressures-nhs-progress-mental-health