Supporting Technology Enabled Delivery of Psychological Therapies and Interventions

Purpose: Technology enabled treatments, such as video delivery of therapy or intervention packages that use digital platforms, are increasingly employed to expand access to psychological therapies and interventions and provide an alternative to traditional face to face delivery in the COVID-19 context. The first section of this paper summarises the efficacy literature and the second section outlines principles for good practice in technology enabled care. This document can be used to inform services as part of the changing delivery of psychological interventions and therapies and will be reflected in the revised Matrix document**.**

Scope: This paper refers to traditional psychological therapy or interventions provided by staff using a device (phone/computer) or through computerised packages completed by the person with the support of staff. It includes supported (non-clinician) and clinician-guided use of computerised packages. It also covers approaches blending the two formats. This guidance focuses on interventions that involve contact with a practitioner, or support from a member of staff and is intended to relate to services provided in Scottish healthcare settings. The summaries included will apply to many settings but do not replace tailored information designed for specific situations.

Development: This guidance was created by a short life working group (SLWG) formed as part of the ongoing review of the NES/SG (2015) *The Matrix: A guide for delivering evidence Based Psychological Therapies in Scotland.* The Group reviewed information collated from rapid reviews of the efficacy and clinical guidance literature conducted by the Scottish Health Technologies Group and the Knowledge Network on behalf of the NES Psychology Directorate. The SLWG consisted of an advisory group of representatives from different clinical settings and professional backgrounds (see appendix 1 for contributors). Technical subgroups from within the SLWG extracted the information presented below and these were edited by the advisory group.

Summary points: Technology can be used in various ways to support and deliver psychological therapies and interventions:

- The literature to date suggests that therapy delivered using video or telephone appears to generate the same benefits, and be as acceptable to people, as face-to-face treatment for patients with anxiety and depression. However, the evidence we found was not high quality and there were gaps in the literature, such as few cost-effectiveness studies and few studies incorporating safety outcomes.
- There is satisfactory evidence that computerised psychological interventions guided by a clinician are effective, and emerging evidence that they are cost-effective, although drop-out rates can be an issue. Where clinician-guided interventions are unavailable, packages supported by administrators are likely to have some benefits over pure self-help but are less efficacious than packages supported by staff who are trained in supporting delivery.
- Best practice in technology enabled care involves clear processes within the organisation to outline information governance requirements, overcome barriers that affect staff, such as access to equipment, and provision of appropriate training and guidance materials. There should also be guidance for people using the service, based on the principles of informed choice, and with considerations of issues of accessibility and digital poverty.

Part 1: Outcomes for technology enabled mental health interventions

1. Efficacy:

Overview of the efficacy literature:

The NES psychology directorate requested 4 rapid reviews conducted on this topic and have worked with a short life working group to produce this summary. This review had been scheduled as part of The Matrix (2015) updates but became particularly relevant in 2020.

There are two reviews, produced by the Scottish Health Technology Group (SHTG), which focus on technology enabled treatment delivered by, or guided by, clinicians working with adults with depression and anxiety disorders. This literature is described in more detail in sections 1.1 and 1.2 The Knowledge Network conducted a further review comparing clinician guided delivery of computerised packages with non-clinician guided delivery, as administration staff prompt the use of these packages in some Scottish services. This is described in section 1.3.

Much of the literature examines cognitive behaviour therapy and interventions based on CBT for people with mild/moderate anxiety disorders (including PTSD) and depression. There is some mixed, but emerging, evidence for other conditions, therapies and clinical specialties. A fourth rapid review conducted by the Knowledge Network in October 2020[1] included: eating disorders (12 studies), alcohol problems (14 studies), paediatric illness (17 studies), bereavement care (7 studies), long term conditions (IBS 45, headaches 31, HIV prevention 46, cancer 7, and Acceptance and Commitment Therapy (25 studies). Some information on this review is included in section 3.3 and a full review of these areas will be conducted as part of the update of the NES Matrix evidence tables for each condition.

Summary of specialist and enhanced psychological practice delivered via telephone or video:

- The literature to date suggests that psychological therapy and interventions delivered using video or telephone appear to generate the same benefits, and be as acceptable to people, as face-to-face treatment for patients with anxiety and depression. However, the evidence was not high quality and there were gaps in the literature, for example little known about impact on therapeutic alliance or safety, and no cost-effectiveness studies.

Summary of psychological practice involving computerised psychological interventions:
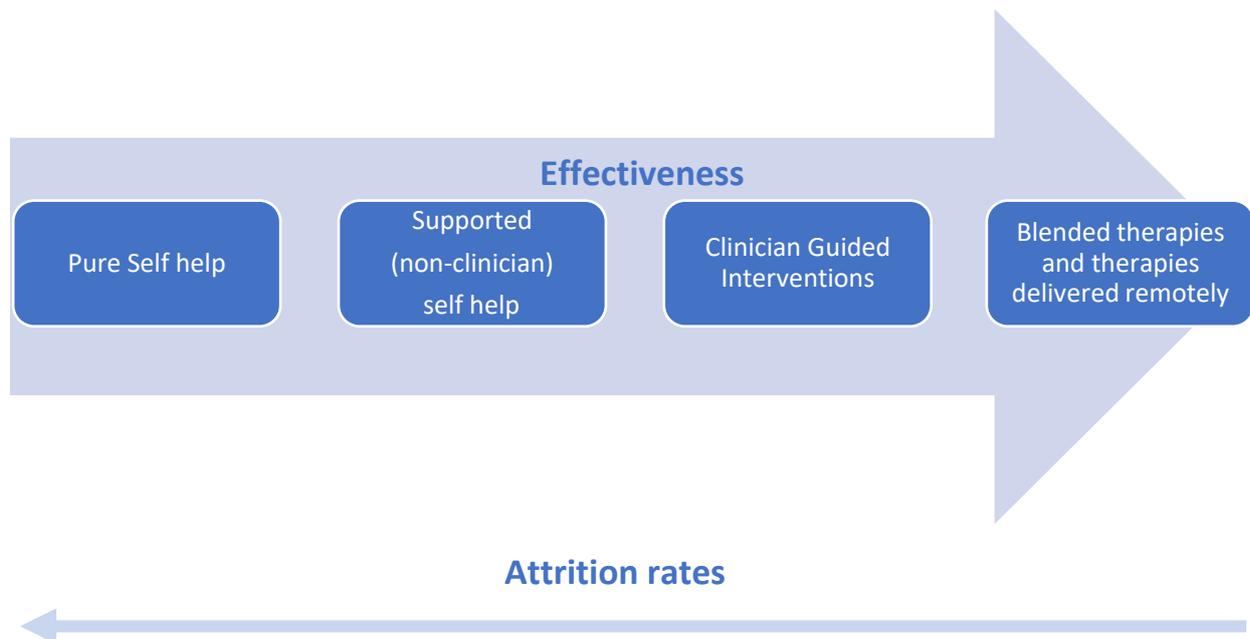
- Computerised psychological intervention packages can be supported by a wide range of staff in NHS and partnership settings.
- There is reasonable evidence that psychological interventions delivered via computerised packages and supported by a trained clinician are effective for common mental health problems when compared to self-help controls, waiting list controls or usual care (typically skilled or enhanced psychological practice).
- There is also some indication that computerised packages can offer benefits when used as an adjunct to traditional therapies (specialist psychological practice).
- Relatively few studies compare computerised interventions with active controls or traditional face-to-face delivery. The limited evidence available suggests they might have similar effects, but further research is needed before we are able to draw conclusions.

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[1] Remote Delivery of Psychological Therapies, Knowledge Network, October 2020.

- Support from administrators (informed practice) has some benefit to pure self-help, including reducing attrition, but is less effective than clinician guided support.
- Dropout rates are statistically higher for computerised packages than face-to-face therapy. Telephone reminders and feedback from clinicians can reduce drop-out rates.
- The relationship between efficacy, attrition and the ways that computerised interventions can be delivered is summarised in Figure 1 below.

Figure 1. Relationship between types of delivery with efficacy and attrition.

Effectiveness

| Pure Self help | Supported (non-clinician) self help | Clinician Guided Interventions | Blended therapies and therapies delivered remotely |

Attrition rates

The sections below describe more detail on areas that have significance for many managers and staff involved in the delivery of psychological therapies and interventions, with links to refer to the source information for particular areas of relevance.

1.1 Clinical effectiveness of remote (video/telephone) therapy compared with face-to-face therapy

Summary adapted from rapid review of the secondary literature conducted by the SHTG (2021)[2]

Five systematic reviews, two of which incorporated meta-analyses, explored the clinical effectiveness evidence for remote digital delivery of psychotherapies. Cognitive behaviour therapy (CBT) was the main modality reported in the literature. There was overlap across systematic reviews in the studies that were included. The literature to date suggests that psychological therapy interventions delivered using video or telephone appear to generate similar clinical outcomes as face-to-face therapy. The small number of primary studies, and the heterogeneity across

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[2] http://www.healthcareimprovementscotland.org/our_work/technologies_and_medicines/topics_assessed/assessment_01-21.aspx

participants groups and outcome measures used, limits confidence in the evidence and further studies are required. The results for each condition are presented below.

Depression
Most of the controlled studies reported no statistically significant differences in effectiveness at reducing depressive symptoms between the delivery methods whether using videoconferencing therapy (1 systematic review with 14 randomised controlled trials, four quasi-experimental studies and 15 uncontrolled studies) or telephone-administered CBT (1 high quality systematic review with meta-analysis of 6 trials). There was a small and non-significant beneficial effect of telephone-administered CBT over face-to-face therapy or other active controls in this review.

Anxiety
A systematic review including six comparative studies in patients with a range of diagnoses found no statistically significant differences in anxiety measures between videoconferencing therapy and face-to-face therapy.

Post-traumatic stress disorder (PTSD)
One high quality meta-analysis found that, when compared with face-to-face therapy, videoconference therapy did not result in statistically significantly different PTSD outcomes post-treatment but led to inferior outcomes at 3-6 months follow-up. A systematic review discussed patient safety and noted that a cautious approach should be taken when conducting exposure tasks via tele-therapy in the PTSD population due to the potential effects of high levels of emotional arousal.

1.2 Clinical effectiveness of clinician guided computerised packages

There is reasonable evidence that psychological interventions delivered via computerised packages and supported by a trained clinician are effective for common mental health problems when compared to self-help controls, waiting list controls or usual care. This means that guided computerised packages can provide an effective alternative to these controls[3].

However, the literature is less clear when directly comparing guided computerised packages with face-to-face therapy for people with mild to moderate depression. A review by the SHTG (2021)[4] indicates that there are only a small number of randomised controlled trials (around 10) involving this comparison and these trials have issues that affect the quality of studies and the generalisability of the results (e.g. non-clinical samples, small sizes, heterogenous groups, differing measurements of outcome).

The trials indicate that, in the short term, guided computerised CBT packages can be similarly effective to face-to-face CBT in improving symptoms of anxiety and depression. However, larger non-inferiority trials (specifically testing that the novel approach is not substantially worse than the control treatment) in clinical populations are required to provide more certainty around this, as are trials examining longer-term recovery and safety issues.

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[3] https://www.hqontario.ca/Evidence-to-Improve-Care/Health-Technology-Assessment/Reviews-And-Recommendations/Internet-Delivered-Cognitive-Behavioural-Therapy-for-Major-Depression-and-Anxiety-Disorder
[4] http://www.healthcareimprovementscotland.org/our_work/technologies_and_medicines/topics_assessed/assessment_02-21.aspx

1.3 Clinical effectiveness of computerised packages supported by non-clinicians

Summary adapted from a rapid review of the literature by the Knowledge Network (December 2020).

This evidence search looked for studies comparing the use of non-clinical support with completely unsupported use of computerised CBT or internet-based therapies. Computerised CBT packages commonly used in Scotland were additionally searched by name (e.g. Silvercloud and Beating the Blues).

None of the studies of the named programmes directly compared administratively-supported (non-clinician) with unsupported implementations, however a few (mainly qualitative) studies involving the named programmes highlighted perceived benefits of support. A number of studies looked at the effect of support in other programmes, including 7 randomised controlled trials (RCTs), one meta-analysis, and one 'realist literature synthesis'.

The trials found that telephone reminders were generally associated with higher adherence and in 4 studies also improved effectiveness. The meta-analysis of computerised psychological treatments for depression compared unsupported with administratively-supported interventions. Data showed an effect size of d=.58 for administrative-supported studies, and d=.36 for studies that included no support (and d=.78 for therapist-supported studies). However, analysis of subgroups showed that the effect of support was only statistically significantly different between studies with no support vs therapist support.

A 'realist literature synthesis' of design and delivery features to improve the use of computerised CBT for children and adolescents with anxiety (Radomski et al 2019), found that adjunct support seemed to improve program use even when input or support was minimal (e.g. in-person, classroom-based program administration with no treatment advice given) or when it was provided by a non-expert (e.g. teacher).

These studies indicate that supported use of computerised CBT packages involving telephone reminders can reduce attrition and potentially increase effectiveness of interventions over unsupported use but that effect sizes are lower than where packages are supported by feedback from clinicians.

2. Cost effectiveness

There is emerging cost-effectiveness evidence for computerised packages guided by clinicians.

A Canadian Health Technology Assessment (2019) included a systematic review indicating that guided computerised CBT likely offers good value for money for the short-term management of mild to moderate major depression or anxiety disorders when compared with usual care. It is unclear whether these results can be extended to comparisons against face-to-face CBT as few studies used individual or group-based CBT as the comparator intervention.

Other studies explore the cost-effectiveness of computerised CBT with face-to-face CBT using simulation or predictive models. These models indicate that computerised CBT is may have as good as or better clinical outcomes and be less costly than face-to-face CBT when used as one-time intervention to treat a single episode of depression and anxiety. They also indicate that these interventions can provide similar outcomes and be less costly when used as part of a stepped care

model with recurrent episodes. Variations in the information included and the design of these models means that, despite the promising findings reported above, there remains a moderate level of uncertainty with respect to the cost-effectiveness of guided computerised CBT compared with face-to-face CBT and more UK based research is required.

No systematic reviews of economic evidence on therapy delivered via telephone or video were identified.

3.   Acceptability of remote mental health interventions:

Acceptability in studies of non-face-to-face or computerised therapy can be assessed indirectly using a range of measures including take-up rates, adherence or completion rates, or can be directly assessed using questionnaires, focus groups or qualitative interviews to measure satisfaction rates and explore experiences and preferences. The results below are taken from the STHG rapid reviews.

3.1 Take up rates, adherence and completion rates

In trials, participants allocated to face-to-face CBT are more likely to complete all sessions when compared with those allocated to computerised CBT. There are no statistically significant differences in the rates of acceptability (drop out risk) between telephone-administered CBT and individual or group therapy for depression (network meta-analysis). The rate of completed sessions of telephone-administered therapy for depression was 73% (range 37% to 86%).

Evidence from two primary studies conducted in military veteran populations showed that although the retention rate between face-to-face and video therapy for treating PTSD may not be significantly different, patients undergoing video therapy drop out earlier in the programme compared to face-to-face.

Guided computerised packages have statistically significant higher drop-out rates than face-to-face individual or group CBT (network meta-analysis of 155 depression studies). The authors suggest that the reduced personal contact may make it easier for participants to disengage.

A meta-analysis analysed data on adherence to face-to-face CBT (14 studies) and guided computerised CBT (12 studies) in depression trials, however, a major limitation of the analysis was that none of the trials directly compared the two modes of CBT delivery. In the trials face-to-face CBT ranged in length from 12 to 28 sessions and computerised CBT ranged from 5 to 10 sessions. Three measures of adherence were analysed; proportion of sessions completed, proportion of participants competing all sessions and proportion of participants completing 80% or more of the allocated sessions. The level of heterogeneity was high for all comparisons. The proportion of sessions completed were similar for both computerised and face-to-face CBT (81% and 84% respectively), however, people undertaking computerised CBT were statistically less likely to complete either 100% of sessions (65% compared to 85%) or 80% of allocated sessions (68% compared to 85%).

3.2 Satisfaction and experiences

The literature suggests experiences of computerised CBT and face-to-face CBT vary widely according to expectations and circumstances of participants. The impact of their specific anxiety or depression symptoms on factors such as their motivation and concentration and their ability to travel may influence preferences. Where computerised CBT is preferred, this may be associated with the flexibility, convenience and accessibility offered, whilst the personalised and collaborative relationship in face-to-face interventions may be more important to others.

Therapy delivered via telephone or video: a systematic review found no statistically significant differences in satisfaction when comparing video therapy and face-to-face therapy for treatment of depression in randomised controlled trials. There was a correlation between patient satisfaction and treatment effect, suggesting that patients using video to access therapy received a treatment benefit.

3.3 Acceptability across wider settings

Summary taken from Knowledge Network review (October 2020)

A separate rapid review of meta analyses and systematic reviews focusing on acceptability literature across a wider range of mental health conditions was conducted. Across substance misuse, general wellbeing and child services as well as anxiety and depression settings, both guided and unguided (self-help) computerised psychological interventions were generally found to be moderately to-highly satisfactory by participants who engaged with them. Higher satisfaction was linked to therapist guidance, interventions that were structured, inclusion of specific examples, and the opportunity to make peer connections. Similar findings were demonstrated in child and adolescent samples with the additional finding that parents enjoyed the anonymous nature of computerised packages. This review indicated that issues with acceptability were associated with difficulty level of certain modules and the time demand required.

3.4 Acceptability - provider attitudes

Acceptability is also a consideration from the provider perspective. One systematic review showed that overall, providers' attitudes to using video conferencing for therapy were largely positive, with providers describing it as an important and acceptable mode of treatment delivery.

4 The therapeutic relationship

The evidence on the impact of mode of delivery on the therapeutic alliance has mixed findings and no firm conclusions can be drawn from this literature at present. The SHTG rapid review of the literature found evidence that therapeutic alliance developed in patients with anxiety disorders, depression, or PTSD undergoing videoconferencing therapy was sometimes equivalent, sometimes more developed and sometimes less developed than face-to-face therapy.

Conclusion: There is evidence that therapies delivered by phone or video and computerised packages can have comparable outcomes to face-to-face therapy, when the same content is delivered and supported by a suitably trained clinician. This form of delivery is an acceptable, and sometimes preferable, way to access therapy.

Part 2: Best practice when offering technology enabled care

Scope of Guidance: This guidance is intended to be used in relation to traditional face-to-face therapies and interventions delivered through telephone, video or with guided use of computerised packages. This is a paper that reflects the current context, recognising that some work will be undertaken from home, and should be updated in late 2021. Additionally, at this point, this guidance is concerned with the delivery of 1:1 therapy with further consideration required of group approaches.

Technical issues: Delivery of psychological therapies and psychological interventions using telephone video or computerised packages should be agreed by local governance arrangements.

The use of telephone, video and computerised packages to provide psychological therapies and psychological interventions was already under consideration but the requirements created by the COVID-19 pandemic has significantly expedited this process. The evidence suggests that using these means to deliver psychological therapies and interventions can be equally effective although there needs to be careful planning to balance the need for genuine, informed choice for people using the services and consideration of staff/workforce needs.

This guidance is a summary of a [Knowledge Network literature search conducted in May 2020](#) and a paper produced by the [Heads of Psychology Services in 2020](#) reflecting the Scottish context**.**

In order to support the safe and effective delivery of psychological therapies and psychological interventions using a telephone, video or computerised delivery approach the following should be considered:

1. **Organisational barriers**

- **Senior leadership buy-in:** To support the ongoing effective use of remote and digitally enabled psychological services there should be strong clinical leadership on both technical and adaptive capacities in line with best practice in implementation methodologies.
- **Communication:** There should be clear communication and engagement with both staff and people who use services. Staff will require engagement with planning for delivery and development of the policies and process to support the safe delivery of remote or digital services. People using services will require clear communication to support informed decision making on options for accessing services. All communication should also be reviewed to consider those who have additional communication needs, including but not restricted to those with autism/neurodiversity, learning disabilities or communication impairment. All communication should be trauma-informed.
- **Information governance:** Local requirements must be met. Safeguard personal and confidential information as in any other consultation and assure GDPR compliance for data storage and processing (refers to NHSX advice at https://www.nhsx.nhs.uk/information-governance/guidance/covid-19-ig-advice/). When using personal ICT equipment clinicians should check that their internet access is secure (e.g. use a virtual private network/avoid public wifi) and GDPR compliant. Refer to the National Cyber Security Centre's guidelines for

secure use of videoconferencing - https://www.ncsc.gov.uk/guidance/video-conferencing-services-using-them-securely. This guidance provides a good overview of all the issues: https://www.informationgovernance.scot.nhs.uk/covid-19-information-governance-advice/

- **Clinical governance:** Services should provide clear clinical governance structures to support safety for people using the services and the workforce delivering it. This includes access to adequate frequency and quality of clinical supervision. There are no changes in the requirement for clinical supervision (please see supervision section) regardless of method of delivery. For those accessing clinical supervision remotely, there must be similar robust systems of ensuring access to a trained supervisor, working within an agreed contract and using a range of supervisory methods to support adequate skills development and ensure safe practice. Recordings are an essential part of this process. Supervision should include a restorative element.

- **Technology:** Staff/workforce require access to adequate equipment (including hardware and enough connectivity to broadband/wi-fi).

- **Environment:** Access to an adequate and safe environment, this means delivery from an office or home environment requires consideration of issues of confidentiality that meet the same requirements as face-to-face delivery. Privacy is a pre-requisite if delivering therapies or interventions at home. For those delivering Psychological Therapies and Interventions at home, there should be consideration of wellbeing (see below).

- **Training:** Staff will require sufficient training
  - Training, education and support is required in the use of the technology including updates when required.
  - Training and education required on changes in general clinical practice including safety planning, etiquette and expectations of managing the digital/remote delivery.
  - Training and education required on the specific adaptations to delivering therapies and interventions online e.g. sharing visual formulations.

2. Clinical considerations

- Informed choice – The challenges and opportunities of remote or digitally delivered therapies should be discussed with individuals. This should be reviewed regularly and opportunities created to elicit feedback or address any concerns or fears.
- Clinicians should regularly monitor progress using routine monitoring to identify any risk of deterioration in presentation.
- It is essential to plan collaboratively for any instances of loss of connection during a session. A phone number or alternative number in the first instance and agreed plans for emergency responding with safe supportive families/friends/carers or other professional or emergency plan.
- Record keeping should maintain standards required of traditional delivery.
- Planning for sharing and receiving of therapy information is required. This might include cognitive diaries or other homework tasks.
- The literature is supportive of the use of remote/technology enabled delivery of trauma focused therapy, with reasonable adjustments and safety planning for both service user and therapist.
- Similar to traditional service delivery, planning for grounding or relaxing activities immediately following sessions should be routine.

- This BPS Guidance and the checklist in Appendix 2 provides additional information: https://www.bps.org.uk/sites/www.bps.org.uk/files/Policy/Policy%20-%20Files/Effective%20therapy%20via%20video%20-%20top%20tips.pdf

3. Accessibility

- Platforms selected should be accessible to those using the service and technologically supported for those who are delivering the service.
- Consideration and adaptations should be made to reflect the service users access to technology, both in term of technology and connectivity. Digital poverty including lack of internet access or lack of resources to fund data or telephone credit is a reality and proactive planning is required to ensure barriers to services are overcome. This recent review of Digital Inclusion in Scotland provides additional context http://www.healthcareimprovementscotland.org/evidence/rapid_response/rapid_response_03-20.aspx.
- Digital delivery should not be ruled out on the grounds of age, disability, language or type of difficulty. Where digital/remote delivery is the only option due to local restrictions or geographical barriers, reasonable adjustments should be made to enable all to engage as far as possible and where this is not possible alternative arrangements should be made.
- Although these considerations should not rule out digital or remote delivery, services and clinicians should take into consideration factors that are specific. This might include concerns for privacy for children and young people or confidence/skills gaps in some groups that have traditionally been more digitally excluded such as older adults.
- Availability of private space for the session needs to be planned for. Consideration must be made of how to mitigate any difficulties with association with stressful content of therapy or interventions.
- Accessing services remotely requires a degree of technical skills and confidence that cannot be universally assumed. Services should ensure these are not barriers to access, through providing support and early engagement via a more accessible format (i.e. phone) or providing 'test and practice' sessions, prior to first session.
- For those with learning disability, autism or any communication impairment clinicians and services must identify alternative or augmentative means of communication. This means additional preparation must be required including working with families/carers to understand the best means of communication

4. Safety

The emotional and physical safety of staff and people using services remains paramount.

4.1 Service users

- Staff should verify that the person attending is who is expected, where the person is and who is around them.
- People accessing services should be informed of the risks involved with remote or digital delivery including protecting their privacy/confidentiality and information security.

- Offer sufficient information to ensure person attending can make an informed choice about how to access therapy or interventions. This includes risks to privacy, impact of potential distractions and potential distress in discussing emotive subjects in own space. The information for service users in Appendix 3 can provide some prompts.
- There should be age and capacity appropriate discussions about who should and should not be present at the consultations. Considerations about domestic abuse and coercive control need to be included in collaborative decision making. Anyone else present should remain in view.
- Risk assessment should be completed as would be routinely. Be mindful of the availability of additional cues and reduced access to other key information (including non-verbal communication) depending on the media being used.
- If risk cannot be managed remotely, adapt practice and offer alternative service delivery.
- Managing identified risk should be proactively and collaboratively planned for including
  - Planning for unexpected loss of signal/unplanned disengagement. What is the back-up communication and what will be the next step if this is not available?
  - Use of a code word agreed to highlight risk including loss of privacy /unplanned arrival of someone or other potential risk.

4.2 Staff

- Management protocols should be updated to ensure they reflect the needs of staff delivering services remotely or digitally.
- Staff working with traumatic material in their home environment is recognised as a significant risk. The BPS (2020) recommends a step by step "5Rs" approach for organisations whose employees are at risk of vicarious trauma while working from home - Recognise, Review, Respond, Refresh, Respect; employers should carry out a full review before deciding whether a professional should work with trauma while homeworking; a role risk assessment to understand the challenges and identify particularly harmful elements is necessary when allocating work . If home working including trauma work is being considered, both informal mechanisms for support and formal supervisory arrangements must be in place.
- Work and private devices should be kept separate as far as possible.
- Discussion should take place about recording of sessions. Some therapists might prefer to ask that service user recording should not routinely take place. However, for some therapeutic approaches such as prolonged exposure, recording of clinical sessions can be an integral part of the therapy processes. There should be clarification that ownership and responsibility for recordings on their own device is the person using the services responsibility. Recording of sessions for the purpose of supervision and clinical governance of therapist is recommended. This requires informed consent and secure procedures in line with local information governance agreements.
- Staff should turn off listening devices such Alexa or Siri.

5   Safeguarding and risk

All child and adult protection responsibilities remain in place. People using the service should be routinely involved in the responsibilities to share concerns about risk.

6 Etiquette

Good practice guidance for technology or remote delivery includes

- An initial contact to test connection and practice use of platform may improvement engagement.
- To allow for non-verbal communication, slow the rate of speech to compensate for slower connections. Use clear language. For eye contact, focus gaze on the camera rather than the person, plain, dark or uncluttered backgrounds with light directly on your face may help.
- Particularly for new people to your service, it may take longer to complete introductions and signpost what is happening next.
- Regular summarising to ensure mutual understanding.

7 Considerations for specific groups

This was considered in detail in a document drawing together consensus of expert opinion across Scotland in 2020.

Appendix 1: Contributors

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This document may be available in other formats or languages. Please contact psychology@nes.scot.nhs.uk with any queries regarding to this paper.

Appendix 2: Remote Delivery Checklist

Topic	Detail	Completed (tick)
Confidentiality	Check that you are speaking to the right person. Ask if they are in a place where they can talk safely, who is around and agree a safe way to end quickly if the session needs to. State where you are and how you will maintain confidentiality.	
Informed choice	Discuss the challenges and opportunities of remote or digitally delivered therapies Review regularly and elicit feedback.	
Consent	Request consent to engage in the assessment and/or intervention through remote means.	
Connection issues	It is essential to plan collaboratively for any instances of loss of connection during a session. A phone number or alternative number in the first instance and agreed plans for emergency responding with safe supportive families/friends/carers or other professional or emergency plan.	
Communication style	Slow down and use more reflections and clarifications. Aim to look at the camera to reflect eye contact. Pay attention to non-verbal cues.	
Grounding	Similar to traditional service delivery, planning for grounding or relaxing activities immediately following sessions should be routine	
Sharing documents	Discuss how you will share therapy information, including, outcome measures, cognitive diaries or other homework tasks. Check the person has materials required to hand.	
Record Keeping	Record keeping should maintain standards required of traditional delivery.	
Recording	Discuss if recording is required by either party. State that consent to record should be clearly requested and agreed with written confirmation.	

Appendix 3: Guidance for Service Users

Guidance for video consultations

Preparing for Your Session

Do: Take some time to prepare before your first session.

Do: Test your microphone.

Do: Pick a quiet place to video call, where you will have some privacy.

Communication

Do: Try to be aware of your microphone settings - if it is muted no one will hear you.

Don't: Hold the device in your hand – put it down on a firm surface if possible.

Behaviours

Do: Be prompt. You will probably need 10 minutes before your appointment to get ready.

Do: Treat others with the same respect as you would if you were face to face.

Don't: be afraid to ask for things to be repeated or to ask questions.