The Cognitive Behaviour Therapist (2013), vol. 6, e17, page 1 of 14
doi:10.1017/S1754470X13000226

ORIGINAL RESEARCH

A qualitative study of clinicians' experiences and attitudes towards telephone triage mental health assessments

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Received 1 June 2013; Accepted 4 December 2013

Abstract. This qualitative study investigated clinicians' experiences and attitudes towards conducting mental health assessments over the telephone in an IAPT service. Nine participants completed a semi-structured questionnaire and data were evaluated using a Thematic Analysis model. Participants were largely apprehensive about telephone working, but many reported positive experiences. Telephone assessments were felt to be structured, focused and comprehensive, and therapeutic rapport was able to be established. However, concerns persisted around whether risk assessments could be adequately conducted over the telephone. Reports of spontaneous feedback from patients during telephone triage suggested that there was appreciation for this method of assessment and that it increased access to the service. Further research is needed to better understand what, for clinicians, contributes to acceptable assessment of complex and subjective situations, such as risk and feeling states, over the telephone.

Key words: Anxiety, depression, practitioner survey, primary care, subjective assessment, therapeutic alliance.

Introduction

The Improving Access to Psychological Therapies (IAPT) programme is a UK initiative with the aim of increasing access to National Institute for Clinical Excellence (NICE) recommended psychological therapies for common mental health difficulties. Increased numbers of therapists have been trained to provide cognitive behavioural therapy (CBT); often the treatment of choice for anxiety disorders and depression (NICE, 2011). A core tenet of IAPT is the stepped care model of delivery. This refers to offering patients with mild-moderate symptoms of depression and anxiety low-intensity (LI) CBT treatments first, such as guided self-help, which is considered to be less intrusive. High-intensity CBT is subsequently offered only if LI treatment is deemed unsuccessful (Bower & Gilbody, 2005). LI interventions are said to reduce the amount of patient–therapist contact required, which increases accessibility

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through shorter waitlists as well as reducing costs for the NHS (Mead *et al*. 2005; Grayer *et al.* 2008; Hammond *et al.* 2012).

As part of the IAPT stepped care model, telephone delivery of LI interventions has been greatly encouraged in order to increase the number of patients accessing treatment in a timely manner. It is argued that telephone working can potentially reduce non-attendance rates for those who find it difficult to keep face-to-face appointments, due to their symptoms such as low mood and lack of energy (Toon, 2002; Richards & Whyte, 2008). It is suggested that telephone appointments are cost-effective for patients too, removing the need to organize childcare or take time off work, hence improving access for many (Toon, 2002).

There is emerging evidence that patients accept treatment delivered by alternative communication means. Indeed, Werner (2004) conducted a study of 1204 potential patients to explore their willingness to use telepsychiatry and concluded that 'potential users are able to accept the "virtual presence" of the healthcare provider as a legitimate way of providing care' (p. 290). It is suggested that patients often report positive experiences of telephone working (Bee *et al*. 2008), and that this treatment-delivery method leads to improved outcomes. A recent study across several IAPT sites in the East England region demonstrated that over-the-telephone and face-to-face LI appointments showed equivalent effectiveness for symptoms of depression, anxiety, work and social functioning in all but the most severely affected patients (Hammond *et al*. 2012). Lovell *et al.* (2006) compared treatment outcomes for CBT delivered face-to-face and over the telephone with patients diagnosed with obsessive compulsive disorder. Again, patients were found to be similarly satisfied with both delivery models, no differences in treatment outcomes between groups were indicated, and the authors concluded that working over the telephone is economically effective. Similarly, Simon *et al.* (2004) found that providing structured CBT telephone calls for patients beginning antidepressants led to significantly lower mean depression scores at follow-up. These patients were also significantly more likely to describe themselves as 'much improved' and 'very satisfied' with their treatment. The authors concluded that telephone working allowed for more flexible scheduling, as well as circumventing stigma.

Studies exploring patients' experiences of telephone working cite perceived benefits including: its ability to overcome geographical barriers to access for those living in rural areas, it being easier to relax in the comfort of their own home, reduced pressure to organize childcare, less distraction over the telephone, and increased anonymity enhancing patients' honesty about their difficulties (Kevin, 2002; Bee *et al.* 2010). Notably, Bee *et al.* (2010) found that although patients were initially apprehensive about telephone treatment, this resolved once sessions began, and patients highly rated the warmth and openness of their therapist. These common factors are suggested to be crucial in building a good therapeutic relationship (Wright *et al.* 2005).

Despite the evidence that patients are often satisfied with alternative communication means, it is argued that such methods are underutilized in primary mental healthcare due to resistance from professionals, with patients being less ambivalent (May *et al.* 2000; McLaren, 2005). Concerns raised by clinicians include that it makes patients anxious, it makes professionals anxious, important non-verbal cues may be missed and a therapeutic relationship cannot be established using alternative communication means (May *et al*. 2000). Similarly, Wagnild *et al.* (2006) discovered that most clinicians were dissatisfied with the use of telepsychiatry for geographically hard-to-reach patients, despite the fact that it has the potential to greatly increase access for those individuals. As well as feeling that it is more difficult to establish

rapport, clinicians reported that their ability to assess risk may be impaired, as 'feeling states' do not come across, they are unable to smell alcohol or body odour, and patients may alter their behaviour in front of a camera.

In spite of the suggested advantages of telephone working in primary-care mental health services, and its widespread adoption in IAPT services, most studies to date are not directly related to assessment in primary-care psychology over the telephone. Southwark Psychological Therapies Service (SPTS), the provider of IAPT services in the London borough of Southwark, piloted the use of telephone triage assessments in a graded fashion to a subset of referrals. Due to a lack of up-to-date literature surrounding clinicians' attitudes towards telephone working, and the suggestion that patients may be less resistant to this model, the researchers investigated clinicians' attitudes towards and experience of telephone assessments as part of the pilot.

Methodology

A qualitative methodology was used in order to gather rich data that could reflect participants' subjective experiences. Themes from participants' responses were identified and analysed following thematic analysis.

Aim

The aim of the investigation was to explore clinicians' experiences and attitudes towards telephone assessments.

Participants

Thirteen clinicians conducted telephone assessments during the SPTS pilot trial. Nine of those were subsequently recruited for the investigation into attitudes towards and experiences of telephone assessments. Four were psychological wellbeing practitioners and five were high-intensity therapists. All had routinely carried out face-to-face assessments prior to the trial. The number of telephone assessments conducted by each participant during the trial ranged from five to 20.

The researchers

The research team consisted of a counselling psychologist and two psychological wellbeing practitioners within SPTS primary-care IAPT service.

Procedure

A semi-structured questionnaire formulated to elicit participants' attitudes towards, and their experience of, conducting telephone triage was devised by the research team. This tool was used to enable the researchers to focus participants towards areas of interest, while allowing participants to expand on their answers and provide richness of data. It was a pragmatic choice that increased the chance of a reasonable response rate from staff in a busy service.

The questionnaire consisted of 17 items. Several items guided participants to topics previously identified as clinicians' concerns, including the ability to assess risk and build a therapeutic relationship. Examples include 'Please describe whether in your experience, you felt it was possible to establish a rapport with the client over the telephone' and 'What kind of feedback have you received from patients about their experience of telephone assessments, if any?' The trial, and use of the questionnaire, was approved as an audit study by the Mood and Personality Clinical Academic Group Executive from South London Mental Health Trust. All clinicians who conducted telephone assessments were contacted by email, provided with background to the study, and given the opportunity to anonymously volunteer to complete the questionnaire. The only demographic requested was job title. The questionnaire was not piloted.

Analysis

Thematic analysis was chosen as a flexible research tool that provides a rich account of qualitative data (Braun & Clarke, 2006). The researchers took a realist theoretical perspective and were interested in the experiences and reality of individual participants. The aim was to reflect the reality of participants' experience of telephone assessments and provide a rich thematic description of the entire dataset for this under-researched area. Themes were identified using an inductive, data-driven (or 'bottom-up') approach, as described by Braun & Clarke (2006). Nonetheless, the researchers remained aware of the potential influence of their position as clinicians within the service, with subjective opinions about triage assessments.

The analytical procedure involved three stages.

Stage 1

Each researcher independently read the completed questionnaire of each participant, made notes on initial thoughts or observations, identified and labelled themes for each section of text, and considered the themes in relation to one another.

Stage 2

The researchers met as a group to discuss each participant's questionnaire and the themes identified, and share their understanding of the themes in the context of the participant's broader experience. Themes were examined for commonalties and differences, and some were further consolidated. Themes that were not well supported by the data were eliminated. Inter-rater reliability in this process was very high. Only one significant change was made to a theme. Minor changes related to choosing the exact words used to label themes, as opposed to changing meanings. During this process the researchers agreed which excerpts of text characterized each theme.

Stage 3

Themes were integrated into a master document that reflected the experience of the group as a whole. A selection of quotes was included, enabling readers to assess consistency between the data and researcher interpretations.

Table 1. *Summary of main themes*

1. Worried anticipation *vs.* actual experience	4. Positive rapport
2. Timely efficiency	5. Patient perspectives
3. The 'riskiness' of risk	6. Environmental impact

Findings

Analysis of the data from the questionnaires revealed six main themes. These are presented in Table 1.

Each theme identified is presented with supporting quotes from participants' responses. In order to retain anonymity participants were allocated a number, given after each quote.

Worried anticipation vs. actual experience

The researchers noticed a general level of apprehension and negative predictions in participants' reports, prior to conducting telephone triage assessments. Concerns centred on the lack of visual cues, difficulties building a therapeutic alliance, devaluing the participants' skills, and worries that patients may feel inhibited:

> Apprehensive! I was unsure how I would get sufficient information and that I would miss the visual cues that I find helpful during assessment (participant 3).

> Reluctant, as I felt it was a 'call centre approach' that would make it difficult to build a therapeutic relationship with someone. Thought patients may find it difficult to open up to someone they cannot see (participant 2).

> It felt like I'd be going backwards in terms of skills developed from conducting face-to-face assessments (participant 4).

Others were approaching telephone assessment with a mixture of apprehension, excitement and curiosity:

> Apprehensive but eager to do one! (participant 5).

> Open minded … I was curious how it would work after having done face-to-face assessments (participant 1).

> Keen to see how it might work (participant 9).

Participants' actual experience of conducting telephone assessments was often quite different to their expectations prior to doing them. Participants reported generally positive experiences of telephone assessments:

> Really good [overall experience] (participant 7).

> Overall it has been a positive experience … Once I knew the patients liked it, I was happy to continue with it after the pilot trial ended (participant 2).

Less frequently, mixed or more negative reactions to their experience were also reported:

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> I personally prefer face-to-face assessments, but am happy to offer telephone appointments when people have requested them. I find that I have to really focus during telephone appointments and miss the interaction you get when someone is in the room with you (participant 3).

> I've found them incredibly draining, due to the increased level of attention required to pick up on verbal signals from the patient and to filter the information (participant 4).

Timely efficiency

Overall, participants conveyed a strong sense that telephone triage assessments saved time when compared to face-to-face assessments:

> Most of the calls were between 40–50 minutes in total, so was on average at least half an hour less than most face-to-face assessments (participant 1).

The main moderating factor reported by participants was the complexity of the assessment, which is a factor that could also be expected to impact on the length of face-to-face assessments:

> Triage takes less time to carry out in comparison to my face-to-face assessments … although this is dependent on complexity and co-morbidity of course (participant 2).

Saving time led to several participants feeling that they were providing a more efficient service for all:

> Really good – it feels much more efficient use of time 9for both me and client) (participant 7).

> For one client, it was really quick – only 45 minutes to get to the main issues, make a referral for the vocational service and discuss low-intensity options with him. It really speeded things up for him and me! (participant 6).

The process of carrying out shorter telephone assessments appeared to help referrals to more suitable services take place more quickly, compared to face-to-face assessments.

> Advantages: getting a quick overview of the likely main problem so can send them to the right place more quickly, especially when the referral letter has very little information or is ambiguous (participant 9).

> Good when people aren't suitable and can signpost (participant 7).

Overall participants felt that telephone-based assessments lent themselves to being focused and structured and although participants reported initial worries about their ability to gather sufficient and appropriate information over the telephone, many were clear that they still felt able to undertake a thorough assessment. Several participants reported the sense that patients found it easier to be focused during telephone-based assessments, and that this may also contribute to the assessments being shorter in duration:

> patients were a little more 'to the point' when on the phone, hence it taking less time overall (participant 2).

> Clients don't get so 'waylaid' (participant 5).

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Others agreed that telephone assessments were conducive to improved focus for the participant as well:

> I also find it easier to be very focused over the phone (participant 6).

The structure of the triage assessment form was often cited as making a positive contribution to the shortening of assessment time and the ability to gather comprehensive information:

> In fact, I liked having structure. It probably helped keep the assessment shorter (participant 2).

> Yes I think because of the structured nature of the assessment schedule, I felt I covered all areas. Where I felt I needed more information, the schedule is flexible enough to allow this (participant 1).

Many participants were also clear that they still felt able to undertake a thorough assessment and were able to make appropriate treatment decisions:

> Yes certainly – felt able to gather what I needed (participant 7).

> I have never felt that decisions had been rushed [and] have not seen any evidence of an inappropriate treatment plan based on a triage assessment (participant 8).

Another participant tracked the progress of their triage assessments and pointed to their success as evidence that the assessments had been comprehensive and accurate. Moreover, this participant had been initially concerned about the possibility of missing cues over the phone and so felt reassured that this had not been the case:

> Only one of the 14 onward referrals I made following telephone assessment was rejected. Some stayed within our service but were allocated to a different colleague; some were referred to a different service. Months later, it was clear from correspondence I received that 13/14 had been accurately diagnosed and sent to an appropriate team. This assured me that I was not missing important information or cues when on the phone (participant 2).

However, this was not universal and one participant felt that their telephone assessments were less thorough, albeit sufficient:

> Less so than face to face, but I feel that it has been sufficient. I have sometimes found that I have needed to ask a couple of additional questions to determine whether someone really does have symptoms of social phobia or health anxiety … I have found that the referrals are more likely to be accepted when you have sufficient knowledge to support them (participant 3).

Moreover, despite feeling they had conducted comprehensive assessments over the telephone, some participants remained concerned about the lack of visual clues:

> Can't see the person's face or body language which can be a very useful tool in therapy (participant 1).

> Maybe helpful body language cues not taken into account (participant 5).

Interestingly, however, one participant noted that they felt using the telephone actually helped to keep them more focused as there were fewer sensory distractions:

> less body language interfering with my cognitive processing (participant 7).

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The 'riskiness' of risk

One of the major concerns participants quoted prior to conducting telephone triage was their ability to effectively assess risk:

> Slightly apprehensive about risk issues coming up (participant 7).

In contrast, their actual experience of assessing risk was largely positive, although they reported that the clients they assessed did not present with significant risk:

> I did not feel [risk assessment] was any more difficult on the phone; however I did not have any very risky patients during triage (participant 2).

> I did not have any situations where somebody was immediately risky … I did make one safety plan with a client and it seemed to me that he felt supported in doing that by phone. I can only base my judgement on his voice and tone at the time (participant 1).

One participant indicated that they felt the telephone could bring a level of containment to managing a risky situation:

> I think I would feel more contained managing a risky situation over the telephone (participant 1).

There was a general sense that participants were surprised that their experience of assessing risk had so far been fine. One respondent appeared to be weighing up the advantages and disadvantages:

> Actually [my experience of assessing risk] felt OK – just harder to assess degree of helplessness as felt by client. Nice to have colleagues in the room to discuss risk plan afterwards. Not sure how client felt – almost easier to be a bit more business-like and create a plan (participant 7).

Despite reporting positive experiences of assessing risk over the telephone, apprehension about conducting risk assessments in the future persisted for some:

> I personally feel less comfortable doing risk assessments over the phone than face to face. I have been able to ask the [risk assessment] questions and everyone has responded well to them. I am nervous that if I had to assess someone who had an intention to hurt themselves, they would just hang up the phone and I would feel less able to assist than if they were with me (participant 3).

> I have done one telephone triage where risk issues had to be explored quite extensively. It was fine to do over the phone, although it may have been harder if the client, for example, was currently very risky or unwilling to use the crisis services (participant 6).

Positive rapport

Prior to conducting triage, there appeared to be a universal apprehension around the ability to create a rapport over the phone with a client. For example:

> I felt it was a 'call centre approach' that would make it difficult to build a therapeutic relationship with someone (participant 2).

However, after conducting triage assessments, participants on the whole reported that they were indeed able to establish a rapport:

> I was pleasantly surprised that [rapport] hasn't been a problem (participant 3).

Although some noted it felt more difficult or different:

> Yes this was fine … It was a little harder, but fine overall (participant 6).

> I have often been able to establish a rapport of some sort, but it does feel different to face to face. It does depend on the person on the other end of the phone as well (participant 4).

There were also contrasting views about whether clients would tend to disclose more or less information over the telephone:

> Yes [clients do disclose risk information] – to varying degrees. Will inevitably not have some info disclosed by some people but it's whether overall this is worth the risk (participant 9).

> I am not sure how the patient would feel [about disclosing risk]. I suspect for some it may be easier to talk about over the telephone with someone then in person (participant 1).

One participant reported initial apprehension around whether clients would feel they could open up (as noted above); however, their fears appeared to be allayed as a result of client feedback:

> All clients gave me positive feedback when I asked how the call went for them. Although a couple said they had initially been apprehensive to have a phone assessment, they said they were surprised they felt comfortable during the call (participant 2).

Patient perspectives

Although patient feedback regarding their experience of the telephone assessment was not routinely sought as part of the trial, approximately half of the participants reported either spontaneous patient feedback, or said they had proactively elicited patient feedback at the end of the call. This anecdotal feedback was largely positive:

> People were usually happy to be assessed over phone (participant 7).

> Only one [patient gave feedback] I can remember which was positive (participant 9).

As noted in the previous section, one participant received regular positive feedback about telephone assessments, including from patients who were initially uncertain about them. Patients also fed back reasons why telephone assessments were more convenient than coming in for face-to-face appointments. Such feedback included not having to take time off work or feeling too anxious to leave the house, thereby indicating how telephone assessments can remove barriers to access:

> One client mentioned that it was convenient as he did not have to take time off work to attend an assessment (participant 3).

> For another [patient], she was adamant she couldn't get time off work for a face-to-face assessment but we were able to do a triage at 5pm – I don't think she would have come in for an assessment face to face (participant 6).

> Others said they find it hard to leave the house because they are so anxious, therefore the call was more suitable (participant 2).

Some patients reported that quick access to support was most important to them, therefore they did not mind if it was carried out over the telephone:

> some said they were desperate for support and so they did not care how it was done (participant 2).

In contrast there was some feedback to indicate that patients were not universally happy with having an assessment over the telephone.

> Another mentioned that they were disappointed that they were originally offered a telephone assessment as they felt it was 'too impersonal' (participant 3).

Environmental impact

The environmental conditions of triage were viewed as something that could either complicate or ease the assessment process. For example, participants recognized they had less control over the environment of the patient, and felt this could have implications for confidentiality and disclosure:

> A few occasions where patients asked to call back or cancelled because they were shopping/walking kids to school/at work/at an airport waiting for a flight (participant 1).

There was also a sense that some patients did not view telephone appointments as legitimate appointments:

> [One disadvantage was] trying to get hold of people to commit to a time to do the triage undisturbed. It seems not seen as important by them (participant 9).

Nevertheless, participants also reported that the triage environment could ease the assessment process. They valued being able to stay seated at their desks, and having the support of colleagues nearby when wishing to discuss risk issues:

> Less trouble around room booking (participant 1).

> Nice to have colleagues in the room to discuss risk plan afterwards (participant 7).

As previously noted, the triage environment was also valued by patients who felt unable to leave the house or found it difficult to get time off from work.

Discussion

The study found that prior to conducting telephone assessments, participants shared apprehension around their ability to assess risk, build rapport and conduct comprehensive assessments. This corresponds with findings from previous studies investigating clinicians' attitudes towards the use of telepsychiatry for mental health appointments (McLaren, 2005; Wagnild *et al.* 2006). However, consistent with the findings of Bee *et al*. (2010), participants' actual experience of conducting telephone assessments was often quite different to their expectations prior to doing them. They reported generally positive experiences, sometimes even surprising themselves. Advantages cited included that telephone assessments were shorter in duration, saving time for themselves and the patients and bringing a sense of improved efficiency. In support of the efficiency hypothesis (Short *et al*. 1976), several participants felt that it was

https://doi.org/10.1017/S1754470X13000226 Published online by Cambridge University Press

easier for both parties to be focused over the telephone, and that having less sensory cues as a distraction was helpful in optimizing efficiency and reducing time used.

This experience contradicted participants' initial worries that a lack of sensory cues would be unhelpful. Indeed, most reported that they had felt able to conduct comprehensive assessments that effectively assessed risk factors, despite being unable to see the patient. Furthermore, most described feeling able to establish rapport over the telephone, akin with the findings of Bee *et al*. (2010). Although largely positive experiences were reported, not all participants were completely satisfied with their experience of telephone triage. Some felt it was an adequate medium for conducting assessments, while preferring the traditional face-to-face model, and some reported assessing patients with complex difficulties, meaning that no time was saved by using the telephone.

Although data was not directly gathered from patients about their own experience of being assessed over the telephone, some clinicians provided anecdotal evidence that suggested most patients were happy with it. Several had cited the benefits of being seen quickly and not having to travel for the appointment or take time off work, which supports earlier findings from Toon (2002). One patient made clear that she would not have been able to take time off work and would therefore not have accessed the service if a face-to-face appointment was offered. This reiterates how access to psychological therapies can be improved by providing alternative mediums to carry out appointments (Toon, 2002; Wagnild *et al*. 2006). Another patient stated that they felt comfortable during the call; challenging that particular participant's prediction that patients would not find it easy to 'open up'. Notably, one participant made a point of acknowledging to the patient that doing a telephone assessment was experientially 'a bit different', even though no patients had voiced concerns. This suggests that participants may make assumptions that patients will find telephone appointments awkward, and may inadvertently pass these beliefs to patients.

Interestingly, despite the positive experiences described by participants, there was some evidence of persistent apprehension regarding telephone working. The advantages of triage that participants identified were the result of actual experiences. Significantly, however, future predictions about telephone triage remained negative for some. This is consistent with previous findings which suggest that despite the benefits of telephone working, resistance on behalf of clinicians tends to persist, and it is this factor which has slowed the uptake of telephone working in mental health services (May *et al*. 2000; McLaren, 2005). A novel finding from the current study appears to be that this resistance is often unmoved regardless of positive experiences. Although tentative, there was evidence that those participants who approached telephone triage with open-minded curiosity were more likely to elicit feedback from patients, and those who did seek patient feedback were more satisfied with telephone working. Asking for feedback is a feature of collaborative working, which may have enhanced rapport between patient and clinician, and in turn improved the triage experience for both parties. Those with more negative attitudes who did not routinely seek feedback were prevented from gathering evidence that could challenge their beliefs about triage.

There were practical considerations that presented a variety of influences over participants' views about telephone working. Not having to leave one's desk and having colleagues in the room for support were seen as an advantages, whereas patients not always recognizing a telephone appointment as a valid appointment, and therefore not being available or in a confidential setting during the call, were disadvantages.

There are a number of limitations to this study. First, it was small in scale with few participants, and therefore presents only a snapshot of clinicians' experience of telephone assessments. Second, semi-structured questionnaires were pragmatically chosen as a method of data collection that would demand little time from participants, and therefore most likely result in a higher response rate within a busy primary-care IAPT service. In retrospect, the data created by the semi-structured questionnaire may have been less suited to the chosen methodology, due to the questionnaires eliciting less rich data than is usual for thematic analysis. As interviews were not conducted, participants could not be asked to elaborate on descriptions of their experiences, and although three researchers were involved in interpretation to reduce individual bias, it was necessary at times to make inferences regarding the meaning of responses. An alternative method such as content analysis could have been used; however, it was felt that this would not have captured the textural experiences of participants. Third, patient experiences were not systematically investigated within this study. A number of participants reported anecdotal positive patient feedback; however, it could be that patients are less likely to volunteer negative feedback to their clinician. Subsequent research that directly investigates patients' experiences of telephone triage assessments, and the influence this in turn may have on clinicians' experiences, is warranted.

What this brief study does indicate is that telephone assessments can be efficient, thorough and acceptable to patients. Nonetheless, clinicians can remain resistant to this approach, and their concerns tend to focus on whether the type and amount of information available to them is sufficient to make a clinical judgement, in particular with regard to risk. This raises questions with regard to clinician training and whether the skills required for telephone working are different than those for face-to-face working. In the first instance, there appears to be a need for further research to better understand what elements (e.g. level of training and experience) are required for the assessment of complex and subjective situations such as risk and feeling states over the telephone to be feasible and acceptable for clinicians. This research appears even more important given the increasing use of telephone contact in routine work with patients within IAPT. Moreover, previous research into patients' experiences of telephone working has focused on treatment, not specifically mental health assessments over the telephone; therefore this should be the basis of future research.

Summary of main points

- Based on analysis of semi-structured interviews, previous to conducting mental health assessments over the telephone clinicians were largely apprehensive.
- After conducting telephone assessments, clinicians reported them to be structured, focused and comprehensive, and they felt able to establish therapeutic rapport.
- Concerns persisted that it would be more difficult to manage risk situations over the telephone.
- Spontaneous feedback from patients suggested that they often appreciated this method of assessment and that it increased access to services.
- Further research is needed to better understand what contributes to making a good assessment of complex and subjective situations such as risk and feeling states over the telephone.

Declaration of Interest

None.

Follow-up reading

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Learning objectives

(1) Gain a better understanding of clinicians' attitudes towards telephone mental health assessments.
(2) Clinicians to consider and reflect on their own attitudes towards telephone working. More specifically to begin to consider what makes clinicians resistant to assessing mental health difficulties over the telephone.
(3) To see the advantages of conducting assessments over the telephone as experienced by clinicians.