



Adapting to the COVID-19 Pandemic: A Psychological Crisis Support Call Service Within a Community Mental Health Team

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Abstract

To mitigate potential mental health crises within a Community Mental Health Team (CMHT) the psychology department implemented a short-term, rapid access, crisis telephone support service for clients during the COVID-19 pandemic. We aimed to evaluate the feasibility and acceptability. Data was collected on who the service was offered to and whom engaged. Demographic information, referral and crisis support call information was collected from the service's electronic database. Forty-four participants were referred to the service. Seventy seven percent of participants engaged in one or more telephone sessions. Participants rated the service as highly useful, with simply 'talking to someone' seen as the most important aspect of the calls. A number of age differences were noted regarding the content that was discussed in sessions. The psychological crisis telephone support service was feasible and acceptable to service users during the COVID-19 pandemic.

Keywords COVID-19 · Coronavirus · Mental health · Anxiety · Depression · Therapy

Introduction

Background

The World Health Organisation (IASC, 2020) suggested that COVID-19 would impact the mental health of the general population, and anticipated a significant increase in negative

mental health outcomes for those with pre-existing mental health problems.

On the 16th March 2020 the Prime Minister of the United Kingdom announced that all non-essential travel and contact was to be avoided (Prime Minister's Office, 2020), and subsequently, the directors of therapies within our NHS trust instructed all therapists to begin preparing clients for online and telephone sessions. In line with these policies, all non-essential Community Mental Health Team (CMHT) appointments transitioned to online or telephone consultations.

An increase in isolation and restriction of access to community services and voluntary sector organisations, in conjunction with financial losses or unemployment, is known to magnify negative emotions and symptoms (Van Bortel et al., 2016). During the COVID-19 pandemic, individuals with pre-existing diagnoses of severe mental illnesses faced restrictions to their ability to receive support, leading to increased risks of relapses (Ho et al., 2020).

Locally there were concerns regarding a perceived increase in distress amongst isolated community-based clients, and risks to service user wellbeing, alongside the request for the early discharge of all "medically fit" psychiatric inpatients into community care to create additional capacity in Acute services (NHS England, 2020). Staff had to manage this increased client distress, whilst at the same time navigating new remote forms of care delivery.

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The Psychological Professions Network (PPN) branch of the NHS released guidance for psychological care during COVID-19 (PPN, 2020), recommending a biopsychosocial approach. It recognised the importance of maintaining the delivery of psychological interventions by transitioning to remote methods of care during the pandemic.

Cognitive behavioural therapy (CBT) and mindfulness-based cognitive therapy (MBCT) have well-demonstrated effectiveness in managing mood and preventing relapse, according to NICE guidance (NICE, 2011a) and early recommendations in COVID-19 research (Ho et al., 2020). Although there have been numerous studies exploring the effectiveness of online therapies (Donker et al., 2013; Rochlen et al., 2004), and recent recommendations regarding online and telephone therapy in the context of a pandemic (Altena et al., 2020; Inchausti et al., 2020; Murphy et al., 2020), there is limited research which explores the efficacy and viability of rapid access, brief remote therapy in a CMHT context.

Reports on the psychological impact of infectious disease outbreaks on healthcare workers have indicated that stress and inadequate support for staff were linked with adverse psychological outcomes (Tam et al., 2004). Practical support and clear instructions on managing different client presentations were identified as protective factors in moderating the effects of staff stress (Tam et al., 2004). An early U.K.-based study investigating the mental health impact of the pandemic noted that those lower socio-economic group, and those with pre-existing mental health conditions were significantly more likely to experience suicidality and thoughts of self-harm (O'Connor et al., 2020). The study recommended that tailored and accessible remote mental health services be provided to specifically support these vulnerable groups. Kopelovich et al. (2020) outlines a clear and directive “all hands on deck” approach to support community mental health care delivery during the COVID-19 pandemic. They emphasise that therapists should provide short-term cognitive-behavioural telephone support for clients to prevent additional strain on the wider team. Similarly, Inchausti et al. (2020) outlined a series of important recommendations on delivering remote therapy for an existing mental health service case load. This included normalising reactions of distress to a pandemic, and focusing on distress-management alongside challenging previously maladaptive beliefs where appropriate (Inchausti et al., 2020).

To mitigate potential mental health crises, and alleviate staff stress, the CMHT psychology department designed a short-term telephone intervention for clients, in line with historical recommendations from telemental health research (Godleski et al., 2012) available at the time. The service was set up with an ‘open-door’ policy for referring, such that staff were able to refer service users without prior

discussion. This was intended to reduce barriers to referrals and to increase speed of responsiveness.

Aims

The main of this audit was to review the crisis support calls (CSCs) conducted by the psychology department in response to the increase in distress in clients during the COVID-19 pandemic. Specifically, we examined.

1. The feasibility of conducting CSCs during the height of the pandemic, by examining uptake of the intervention;
2. The acceptability of conducting CSCs across the population served by the CMHT, by examining service user feedback;
3. The accessibility of this service by exploring whether demographic characteristics impacted on engagement;
4. What type of interventions were employed.

Materials and Methods

Service Context

This audit was conducted within a secondary care Community Mental Health Team (CMHT) Psychology service in an inner-city London borough with high levels of socio-economic disadvantage (Office for National Statistics (ONS), 2015). CMHTs are teams, based in the community, that provide assessments and evidence-based interventions for adults (18 years and over), with probable or diagnosed moderate to severe mental health difficulties. Once referred, individuals are assessed, and then offered a package of intervention, in accordance with the Community Mental Health Framework model (NHS England, 2019) and the National Institute for Health and Clinical Excellence (NICE) recommendations (NICE, 2011b). The interventions on offer for service users in this team routinely included psychiatric evaluation, pharmaceutical interventions, occupational therapy, social care interventions, psychological therapies and employment support.

The Intervention

Any team member of the CMHT could refer a service user, by writing their name in designated timeslots in a CSC diary and letting the allocated therapist know who had been booked. The majority of initial sessions were completed within 1 week of referral.

The intervention was the offer of up to two sessions on the telephone. To ensure parity of care, detailed guidelines were written for the sessions which included agenda setting, focussing on the here and now, and initially exploring

what had led to change in current levels of distress. A list of brief intervention techniques (and instructions on how to deliver these techniques) was available to the therapists to use as appropriate which included self-soothing techniques, recapping of techniques someone has found helpful previously, mindfulness, controlled breathing, behavioural activation [i.e. encouraging individuals to purposefully schedule and engage in enjoyable and meaningful activities, in order to decrease avoidance and isolation, and improve mood (Lewinsohn, 1975)], maintaining a routine, reconnecting to others (remotely), limiting time watching/reading news, focussing on what they can control, worry time and problem solving. A list of online and remote community resources was also available so that the therapist could ‘signpost’ (i.e. directing someone to an alternative organisation or resource) service users to these resources as appropriate. The sessions were delivered by clinical and counselling psychologists, trainee clinical and counselling psychologists, an arts psychotherapist and a group analyst, all of whom were previously trained in the abovementioned techniques, or were supported to deliver the techniques using the guidelines and supervision.

At the end of the call participants were asked for their feedback on the ‘usefulness’ of the session on a sliding scale of 1–5, where 1 represented ‘not very useful’ and 5 represented ‘very useful.’ They were then asked what the most useful aspect of each session was.

Design and Procedure

This was a retrospective cohort study using data from all service users referred to the CSC service between April and July 2020.

Inclusion and Exclusion Criteria

Any service user who was under the care of the CMHT was able to access this service.

Data Extraction

From the local clinical notes system data was extracted on:

- Demographic information (age, ethnicity, gender, diagnosis):
- Reason for referral
- CSC information:
 - o total sessions attended (out of the two offered);
 - o engagement in session (whether they attended);
 - o content of session;
 - o outcome of session.

- Participant feedback:
 - o Usefulness rating;
 - o Most useful content.

Care Co-ordinator Feedback

CMHT care co-ordinators asked to fill in a feedback form with the following questions:

1. What they thought had been helpful for the service user about the service;
2. What they thought had been helpful for their work with the service user;
3. What would improve this service.

Compliance with Ethical Standards

As this was an evaluation of a service improvement NHS ethical approval was not required, and service user consent was not required. This audit was registered and overseen by the local quality improvement and audit department of the NHS trust. All data were obtained and stored according to National Health Service (NHS) data protection policies.

Statistical Analyses

Statistical analyses were conducted using SPSS version 26 for Mac OSX. Chi-square (χ^2) tests were performed to explore the relationships between categorical variables (such as demographic characteristics and referral information) and the CSC data. Mann–Whitney tests were also performed on analyses that included both categorical and continuous variables, as parametric assumptions were not met. A $p < 0.05$ level was used as the cut off point for significance.

To meet the Chi-square assumptions of expected frequencies, a number of variables were collapsed into a fewer number of categories (Field, 2009). Ethnicity was collapsed into five categories using the guidelines from the ONS (2011) and diagnosis was collapsed using the ICD-11 classification of mental disorders (World Health Organization, 2018). For the chi-square analyses, age was divided into two groups: ‘adults below age 47’ and ‘adults aged 47+’ using the median split of 47 (DeCoster et al., 2011).

Results

Participants

Forty-four referrals were made to the CSC service during the abovementioned time period. This is in comparison to 35 referrals to standard psychological therapies in the CMHT

throughout this time period. Although 10 participants either did not attend or declined to engage in the calls, no participant data was excluded from the final analysis.

Participant ages ranged from 23 to 78 years ($M = 46.500$, $SD = 11.679$), with the median age being 47. Demographic characteristics of all the participants involved in this study can be found in Table 1.

Engagement

Of the 44 referrals made to the support call service, 34 (77.3%) participants engaged in one or more sessions. Of those who attended the first session, 58.8% ($n = 20$) chose to engage in a second session. See Fig. 1 for the consort diagram detailing engagement.

Usefulness

Of those that completed the 5-point scale for session usefulness ($n = 27$), the average usefulness rating of both initial and follow-up sessions was 4.519 out of 5 ($SD = 0.528$). A Mann–Whitney test showed that there was no statistically significant difference in the ratings of the usefulness of the sessions between those that attended one or two sessions, $U = 68.500$, $p = 0.671$.

Table 1 Demographic characteristics of participants involved in the study ($N = 44$)

Demographic characteristic	N	%
Gender		
Male	14	31.8
Female	30	68.2
Ethnicity		
White or Other White	13	29.5
Mixed or Multiple Ethnic Groups	13	29.5
Asian or Asian British	5	11.4
Black, African, Caribbean or Black British	8	18.2
Other Ethnic Group	5	11.4
Diagnosis		
Mental and behavioural disorders due to use of psychoactive substances	1	2.3
Schizophrenia, schizotypal and delusional disorders	6	13.6
Mood [affective] disorders	11	25.0
Neurotic, stress-related and somatoform disorders	12	27.3
Disorders of personality and behaviour in adult persons	13	29.5
Unspecified mental disorders	1	2.3
Referral reason		
Crisis management	4	9.1
Anxiety management	12	27.3
Anxiety around COVID-19	12	27.3
Low mood management	16	36.4

Of the participants that completed the feedback form for their initial sessions ($n = 23$), the session components that participants reported as the most useful, were ‘Talking to Someone’ (56.5%, $n = 13$), followed by encouragement of engaging in a weekly routine or trying to practice Behavioural Activation (17.4%, $n = 4$) (See Table 2).

Of the participants that gave feedback for their follow-up sessions ($n = 13$), the session components that participants reported as the most useful, were ‘Talking to Someone’ (61.5%, $n = 8$), followed by mindfulness (15.4%, $n = 2$) (See Table 2).

Some participants gave qualitative feedback:

What [I] found particularly helpful was information about worry time. [I also liked the] information about implementing pleasure and achievement activities and reaffirming social distancing as a problem-solving strategy to prevent the spread of the Covid-19 virus.

...being able to talk to someone was very helpful...

[I]t was very useful to be reminded of some skills [I] used in the past.

[I liked being given] websites for sleep difficulties and the headspace app.

Accessibility

A series of Chi-square analyses showed no significant association between gender ($X^2(2, N = 44) = 0.177$, $p = 0.915$), ethnicity ($X^2(8, N = 44) = 7.270$, $p = 0.508$), or diagnosis ($X^2(10, N = 44) = 12.080$, $p = 0.280$), and number of sessions (either 0, 1 or 2 sessions) that a client engaged with. Similarly, a Chi-square test showed that age was not a significant predictor of the number of sessions attended ($X^2(2, N = 44) = 3.087$, $p = 0.214$).

Content

Responses to the most useful content were classified into 6 categories of session components (see ‘the Intervention’ section for further description of each category).

1. Routine or BA
2. Talking to someone
3. Drawing on previously learned techniques
4. Cognitive coping strategies
5. Engaging with social support
6. Mindfulness

The most commonly utilised techniques across both initial and follow-up sessions were ‘routine management or behavioural activation’ ($n = 32$), ‘signposting to resources within session’ (i.e. directing someone to an alternative

Fig. 1 Consort diagram of participant engagement (N=44)

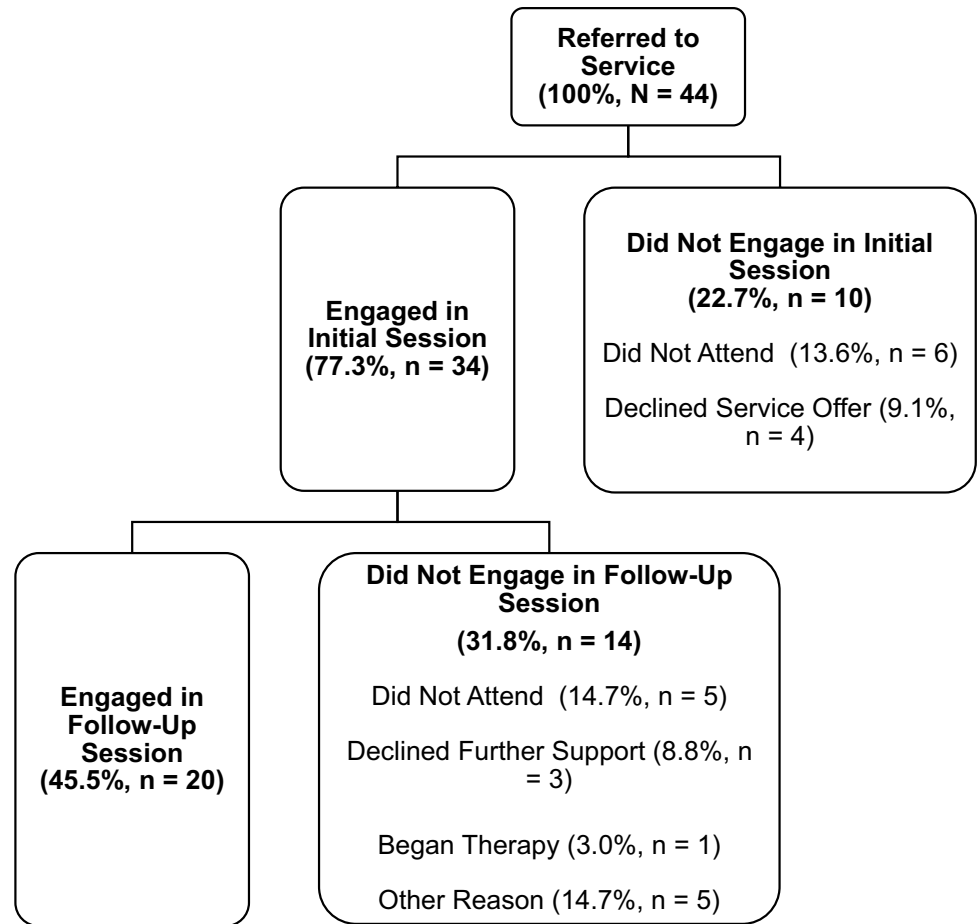


Table 2 Content rated as useful during sessions

Content rated useful	Initial session (N=23)		Follow-up session (N=13)	
	Frequency	%	Frequency	%
Routine or BA	4	17.4	1	7.7
Talking to someone	13	56.5	8	61.5
Drawing on previously learned techniques	1	4.3	1	7.7
Cognitive coping strategies	2	8.7	1	7.7
Engaging with social supports	1	4.3	0	0
Mindfulness	2	8.7	2	15.4

organisation or resource; n=25) and ‘mindfulness, breathing and relaxation exercises’ (n=25) (See Table 3).

There were no statistically significant associations between gender, ethnicity or diagnosis and any of the techniques or discussion topics incorporated into sessions.

There were differences in the content of the sessions when examining age. Sessions with adults aged 47+ were statistically significantly more likely than adults below age 47 to include a discussion on how to improve engagement with social support ($X^2(1, N = 34) = 3.927, p = 0.048$).

They were also statistically significantly more likely than adults below age 47 to be encouraged to draw on previously learned techniques ($X^2(1, N = 34) = 4.047, p = 0.044$).

Adults below age 47 were statistically significantly more likely to have suicidal ideation discussed in their session when compared to adults over 47 ($X^2(1, N = 34) = 4.047, p = 0.044$). Further description of the demographic details of those who discussed experiencing suicidal ideation is outlined in Table 4.

Table 3 Frequency of techniques or discussion topics utilised across both sessions (N = 34)

Content	Number of times this content used
Cognitive coping skills (e.g. worry management, problem solving)	20
Routine management or behavioural activation	32
Encouraging engagement with social supports	20
Exercise	18
Sleep hygiene	15
Signposting to resources within session	25
Discussion of suicidal ideation	8
Mindfulness, breathing and relaxation exercises	25
Self-harm management	4
Drawing on previously learned techniques (from prior therapy)	8
Discussion of drug and alcohol management	2

Table 4 Demographic characteristics of people who discussed experiencing suicidal ideation (N = 8)

Demographic characteristic	N	%
Gender		
Male	3	37.5
Female	5	62.5
Ethnicity		
White or Other White	4	50.0
Mixed or Multiple Ethnic Groups	1	12.5
Asian or Asian British	1	12.5
Black, African, Caribbean or Black British	0	0.0
Other Ethnic Group	2	25.0
Diagnosis		
Schizophrenia, schizotypal and delusional disorders	1	12.5
Mood [affective] disorders	2	25.0
Neurotic, stress-related and somatoform disorders	4	50.0
Disorders of personality and behaviour in adult persons	1	12.5

Outcomes

The most common outcomes for sessions were ‘encouraging clients to practice techniques’ (n = 31) and ‘signposting to further material’ (n = 25) (See Table 5). It should be noted that, although these were CSCs, none of the clients required referral to the local crisis services.

There were no statistically significant associations between gender, ethnicity or diagnosis and any of the session outcomes. However, adults below age 47 were statistically significantly more likely than adults aged 47+ to be placed on the waiting list for psychological therapies, ($X^2(1, N = 34) = 4.970, p = 0.026$).

Table 5 Frequency of outcomes following session (N = 34)

Outcome	Number of clients assigned outcome
Signposting to further material	25
Encouraging clients to practice techniques	31
Placed on waiting list for psychology (or already on waiting list)	20
Referral to local crisis service	0
Referral to home treatment team	0
Referral to A&E	0
Discussed as ‘Case of Concern’ with MDT	0
Discussion with care-coordinator	11

Care Co-ordinator Feedback

Five care co-ordinators gave feedback on the service. Responses included comments that care coordinators thought the service processes were helpful, particularly due to the quick response time of the service, and due to having another professional involved to provide an additional perspective and support. They thought it helped service users make sense of their anxiety and uncertainty, as well as provided individuals with strategies they could utilise. In terms of what care coordinators would recommend to improve this service, the main feedback was that it should be extended beyond the pandemic.

Discussion

The high referral rate, and feedback from care co-ordinators is a positive indicator of the appeal of the service to staff in the CMHT. The high engagement rate with the service (77.3%) indicates service users’ willingness to engage in a

newly-created service, and highlights the feasibility of this service.

Overall participants' feedback was that the service was useful, indicating that they found the service helpful and acceptable. That there was no significant difference in the usefulness rating between those that attended one or two may indicate that, even just receiving one session of support is useful for clients at this time. Alongside this, the engagement rate and feedback indicated that telephone sessions were acceptable to service users in a CMHT context. This adds weight to the developing evidence base on the successes of remote based therapies (Godleski et al., 2012; Moreno et al., 2020).

There did not appear to be any significant indicators that the service offer or engagement with the service was biased towards any demographic groups. This suggests that the service was potentially equally accessible to all CMHT service users. Although the small-n nature of the study may make it difficult to draw definitive conclusions, this result does bring into focus the importance of considering equity of access, and potential biases when setting up innovative services. Research has found that service users from black and minority ethnic groups (BAME), specifically those with a diagnosis of psychosis, are less likely to be referred for CBT (Das-Munshi et al., 2018). For the CMHT staff, there was no need for a specific referral form to be completed, or for a prior agreement to a referral. This might have led to a more equally accessible service, by reducing some of the barriers that are noted in the literature.

In line with recommendations and existing guidelines (Ho et al., 2020; NICE, 2011a), it was no surprise that routine management/behavioural activation and mindfulness were popular components of the sessions. Facilitated self-help utilising these techniques has already been shown to reduce depression and anxiety symptoms (Falbe-Hansen et al., 2009) and is considered standard practice (NICE, 2011a). Recent literature exploring the adaptations of mental health support during the Covid 19 pandemic also recommend these cognitive-behaviour techniques (Inchausti et al., 2020; Kopelovich et al., 2020; Thomas et al., 2020).

Research has highlighted the impact of loneliness and social isolation during the COVID-19 pandemic (Banerjee & Rai, 2020). It was, therefore, understandable that services users rated the most useful aspect of the CSCs simply talking to someone. This is also reflective of many studies that suggest that the most useful aspect of therapy is not the therapeutic model or orientation, but rather, the therapeutic relationship (Hubble et al., 1999). This is an encouraging result as it indicates that simply incorporating a service that provides someone to talk to could mitigate feelings of loneliness, and is highly valued by service-users.

Social isolation is a public health issue for older adults in normal circumstances, and social relationships (or

lack thereof) are a known risk factor for illness and death (Umberson & Karas Montez, 2010). A recent narrative review highlighted the importance of remote interventions targeting isolation and worry with older adults populations (Gorenko et al., 2020). The inclusion of discussions on social engagement with adults aged 47+ aligns with recent publications on the necessity of recognising social isolation as a public health challenge during the COVID-19 pandemic (Smith et al., 2020) and is specifically relevant to an older population.

The higher rates of discussion around suicidal ideation with adults below age 47, may have been indicative of the awareness of a shift in the suicide rate. This was reflected in the recent publication by the ONS (2020) stating that the suicide rate for men in England was the highest recorded in the last two decades (particularly ages 45–49) and for young people, particularly women under 25. The data on suicide rates during and after the initial phase of the pandemic are emerging. Early evidence in Japan saw a 7.7% rise in suicides in August 2020 (John et al., 2020). A U.K.-based study of over 50,000 adults in the first month of lockdown, found that 18% of participants experienced thoughts of suicide or self-harm (Iob et al., 2020). Another study, which took place in the U.K. from March 2020 until May 2020, found that participants aged 30–59 were more likely to experience suicidal ideation than those older than 60 (O'Connor et al., 2020). Alongside this, as they noticed a trend in increasing rates of suicidality across their study, they stressed that the economic fallout of the pandemic could potentially lead to further increased risk in vulnerable populations. This could indicate that the CSCs could be a useful intervention to continue not just throughout the pandemic but also in the aftermath.

Given that three quarters of mental health difficulties start before age 24 (Kessler et al., 2005) older clients may have been known to services for some time, and possibly more likely to have engaged with psychological services prior to engaging with the CSC service. This might explain why adults aged 47+ were more likely to be encouraged to utilise previously learned techniques. The fact that adults below age 47 were significantly more likely to be placed on the waiting list for psychological therapies may have been due to many factors. One possible suggestion might be that they had previously received a course of psychological therapy, or that they faced barriers to engagement with psychological services, such as believing that it is 'normal' to be depressed or anxious as one ages, or believing that psychological therapy may not be effective (Wuthrich & Frei, 2015).

Preventative mental health support and health promotion activities are linked with lower proportions of preventable hospital admissions (Chen et al., 2018). Alongside the rapid access of the CSCs service, mental health support and promotion activities were prominent features of the

intervention and might have contributed to the fact that no clients required a referral to emergency or crisis services after receiving a CSC.

Conclusion

Summary and Clinical Implications

Psychological services have arguably been rather slow to use alternative forms of service delivery, such as telephone calls, to provide psychological support and treatment. There is also a continued widespread challenge to offer timely access to psychological support, with service users often having to wait for long periods of time for psychological therapy. The Covid 19 pandemic offered an opportunity to pilot a new more rapidly accessible (within a week of referral) brief telephone support service for CMHT service users whose mental health was negatively impacted by the lockdown measure and who were not able to access face to face support from mental health services.

This audit has provided evidence that rapid access to brief structured telephone support is a viable and useful addition to the normal service offer. The telephone service was popular with CMHT staff who valued the speed of access and reduced barriers to psychological support for their clients. Results from the audit also demonstrated good uptake of the telephone service and provide valuable information on which components of the telephone sessions was most helpful. In general, this study provides further evidence that telephone contact is a viable method of supporting a vulnerable client group. There is sufficient reason to seriously consider extending this model of telephone working, perhaps with a focus on clients presenting with more acute and immediate distress or who have limited access to social support.

Whilst the service was popular and well used it did put significant additional strain on psychology resources. Further consideration needs to be given to how such a service might be delivered in a sustainable and productive way. One obvious consideration is whether with support and training, all members of the CMHT, would be able to provide psychologically informed telephone support calls. They may also prove useful as a short-term intervention for those on the waiting list.

Limitations and Future Developments

This audit was based on a limited number of participants who engaged over the space of 4 months. It may be difficult to determine if this particular snapshot is representative of what engagement and outcomes would be like if the service was offered over a longer time period to individuals within the CMHT. Readers should be wary to

draw absolute conclusions from this quasi-experimental study, as the small participant number may mean that some results are over-estimated. These small numbers also made detecting intergroup differences difficult, and conclusions regarding the acceptability of the intervention across different groups should be highly tentative. It would be useful to trial the service after the pandemic to explore the acceptability, uptake and perceived usefulness of the intervention in normal NHS delivery.

As well as this, since the feedback was collected by the therapists themselves, it is arguable that bias was a factor in the high ratings of the usefulness of the program. After an intervention, clients may be vulnerable to overvaluing the intervention and/or expressing satisfaction in an effort to please the therapist. In future, feedback should be collected through an anonymous online link or by a separate member of staff.

Unfortunately, risk history data was not readily available from the documentation in the clinical case record system at the time therefore no further conclusions on risk history and suicidal ideation were able to be drawn. Due to the high-pressured nature of the early stages of the pandemic, it was not feasible to request detailed histories of risk from staff members.

This particular study did not collect information regarding language preferences. With a telephonic intervention, especially in a culturally and linguistically diverse borough, linguistic accessibility is particularly important, and further study should investigate the impact of language preferences on accessibility of this type of service.

Finally, as this service was developed quickly as a response to urgent need, the CMHT was not yet set up to offer videoconferencing options. Therefore, future studies should examine the usefulness of videoconferencing in addition to telephone support.

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Data Availability The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

Declarations

Conflict of interest The author(s) declared no potential conflicts of interest with respect to the service evaluation, authorship, and/or publication of this article.

Ethical Approval The author(s) declared that this audit was registered and overseen by the local quality improvement and audit department of

the NHS trust. All data were obtained and stored according to National Health Service (NHS) data protection policies.

Patient Consent As this was an evaluation of a service improvement NHS ethical approval was not required, and service user consent was not necessary.

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