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Recommended Citation

Kelshaw S, Boyd J, Gallagher I, Sara G. Consumer experience of mental health services during the COVID-19 pandemic: Evidence from an Australian mental health system. *Patient Experience Journal*. 2022; 9(1):72-81. doi: 10.35680/2372-0247.1658.

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Cover Page Footnote

We would like to acknowledge Joanne Sharpe and the members of the YES advisory committee for their work in implementing the YES questionnaire in NSW. This article is associated with the Quality & Clinical Excellence lens of The Beryl Institute Experience Framework (<https://www.theberylinstitute.org/ExperienceFramework>). You can access other resources related to this lens including additional PXJ articles here: http://bit.ly/PX_QualityClinExc

Consumer experience of mental health services during the COVID-19 pandemic: Evidence from an Australian mental health system

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Abstract

COVID-19 has increased the need for mental health care but disrupted its delivery. We examined impacts of the first year of the COVID-19 pandemic on consumer experience of NSW hospital and community mental health services, compared to their pre-COVID baseline. We also examined whether increased telehealth use was associated with changes in the quantity or experience of community mental health care. Data were 73,488 Your Experience of Service (YES) surveys from state mental health services in New South Wales (NSW), Australia, grouped into three periods: pre-COVID (January 2018 to March 2020), early-COVID (April to June 2020) and stable-COVID (July to December 2020). Experience scores were compared using mixed effects ordinal logistic regression. Supplementary questions on telehealth and community care (n=621) were examined by multinomial logistic regression. Experience scores improved significantly during the early-COVID period for community consumers and during the stable-COVID period for hospital consumers. Of community clients, 78% received some or all care by telehealth. Positive experience was more likely when most or all care was by telehealth and the amount of care increased. A reduced quantity of care, regardless of care modality, was the strongest predictor of worse experience. Increased service provision and telehealth support were well received over the first year of the pandemic. When contact hours are reduced due to COVID-19 risk mitigation strategies, it is vital to provide alternative methods of care such as telephone, or internet support, rather than just reducing face to face contact hours.

Keywords

Patient experience, consumer experience, mental health, public mental health system, COVID-19 pandemic, experience measurement, quality of care, quantity of care, telehealth

Introduction

The global COVID-19 pandemic has simultaneously increased the need for mental health services and disrupted their delivery. Understanding the experiences and views of service users is essential if mental health services are to adapt and respond to these challenges.

COVID-19 has had direct and indirect effects on mental health and wellbeing, with particular impacts for people with pre-existing mental health conditions.¹⁻² Experiences of illness, loss, social isolation due to public health control measures, and economic or employment losses may all worsen anxiety, depression and distress.³⁻⁴

Like all health services, mental health services have had to adapt quickly. Social distancing and infection control requirements have impacted hospital-based services in many ways including service closures and reconfigurations, reduced freedoms, limitations on social contact or visitors, disruptions to therapeutic contacts, changed access to legal and advocacy services, and the implementation of rapid

discharge processes.^{3,5} For many community-based mental health services, the pandemic has involved rapid re-orientation towards technology-enabled services, including telehealth for assessment and ongoing care.⁵⁻⁶ These changes have been implemented by a mental health workforce who may be stressed or underprepared,⁷ without the support of well-developed models of care or “telehealth best practices.”⁸

There is currently limited evidence about the impact of these changes on the quality, safety and experience of mental health care. While there are obvious risks to effective care, there are also potential opportunities for innovation and improvement.³ New models such as telehealth have been delivered effectively in other areas of health-care,⁹ and are seen as providing easier access and greater flexibility by some staff and service users.¹⁰⁻¹¹ However, they may be less suitable for some individuals or groups or for some stages of care such as new assessments.¹¹ There are also risks that what has been termed “digital exclusion”² may further amplify health inequalities in some disadvantaged groups.

This study examines consumer experience of specialist mental health care during the first 12 months of the COVID-19 pandemic in a large state-wide mental health system in New South Wales (NSW), Australia. During the pandemic, an established process of continuous measurement of consumer experience, the “Your Experience of Service” (YES) survey, was supplemented with additional questions specific to the experience of telehealth and of changes in care since COVID-19. Our aim was to examine:

- i. Whether the overall experience of NSW hospital and community mental health care changed during initial (first three months) or ongoing (subsequent 9 month) COVID-19 period compared to experience in the two years prior to COVID-19.
- ii. How increased use of Telehealth in NSW community mental health services changed the experience of care for NSW mental service users during the pandemic.

Methods

Service setting

NSW is Australia’s most populous state, with an estimated resident population of 8.1 million people in 2019. Most (94%) of the population lives in major cities or inner regional areas. More than one-third (35%) of the NSW population were born in a country other than Australia, and more than half have (54%) at least one parent born overseas. Australian health services are primarily government funded. Within a federated system of government, responsibilities for mental health care are shared between Commonwealth (national) and state or territory governments. The data in this study come from state government services, which account for around two thirds of total mental health service expenditure. State governments provide acute and emergency hospital care, acute community mental health care and long-term community mental health care for people with severe or enduring illness. These are mostly provided through geographically organised Local Health Districts. The data used in this study do not include private office-based primary or specialist care, clinical and support services provided by non-government organisations, or private hospital care.

Governance and approval

Your Experience of Service (YES) data is anonymous, and collected for the purpose of planning, managing and improving NSW Health services. Implementation of the NSW YES survey is overseen by a steering committee comprising NSW Ministry of Health, Local Health District and Consumer representation. Data were used with permission of the Data Custodian and the YES Steering Committee.

COVID-19 and mental health service impacts in NSW

The COVID-19 pandemic in NSW has had several phases. The ‘first wave’ of COVID-19 illness and restrictions occurred from mid-March to late April 2020. From 15 March, NSW Public Health Orders imposed progressive state-wide restrictions on household visiting, public social gatherings, live entertainment, religious services, weddings, funerals, festivals, and major events.¹² Home school was encouraged where possible. By late April 2020 case numbers had peaked and restrictions began to ease. Restrictions on intra-state travel, religious services, schooling and children’s sport eased from June 2020. However tertiary education, tourism and hospitality industries remained significantly disrupted due to closures of Australia’s national border, some restrictions on interstate travel, quarantine requirements and ongoing physical distancing requirements. Direct illness impacts of the first wave of COVID-19 in NSW were modest by international standards: by the end of the current study period on 31 December 2020, NSW had experienced 4,906 cases and 54 deaths.

The COVID-19 first wave had a substantial impact on NSW public health services. During the early COVID period (late March to June), activity was substantially reduced across the NSW health system.¹³ Compared to 2019, mental health emergency department presentations declined 13%, acute mental health admissions declined 12%, and new community mental health clients declined by 17%.¹³ The proportion of community mental health services delivered by telephone or video increased from a pre-COVID baseline of 20% to 48% in April 2020.¹³ Activity returned towards usual pre-COVID levels from June onwards, though with telehealth continuing to account for up to 30% of community contacts.

Therefore, for this study we defined three observation periods based on the month in which questionnaires were received: (1) Pre COVID baseline, from January 2018 to March 2020; (2) Early COVID from April – June 2020, and; (3) Stable COVID, from July 2020 to December 2020.

Since that time, there have been further outbreaks, including a localised outbreak in January 2021, and a larger Delta variant outbreak since July 2021 leading to a return to social restrictions and disrupted service delivery. Due to the time required to collect, receive, analyse and report the data, those periods are not covered by the current study but should be considered as part of a future longer-term analysis. Throughout the COVID-19 pandemic, all NSW public mental health services were provided with routine monthly reporting on consumer experience to allow for ongoing and monitoring.

The Your Experience of Service (YES) questionnaire

Experiences of mental health services in NSW are measured using the Your Experience of Service (YES)

questionnaire. The YES survey has been used since 2015 in Australian government mental health services.¹⁴ It is an anonymous questionnaire, with 26 questions organised in domains of Respect, Safety and Fairness, Individuality, Participation, Information and Support, and Making a Difference. All NSW government mental health services are required to offer the measure. Approximately 2,000 completed responses per month are received, and results are reported monthly to services and via an annual public report.¹⁵ Questionnaires are delivered in paper and electronically, and available in English and 35 community languages.

There were 73,488 responses to the YES survey over the study period (January 2018 to December 2020). Questionnaires were excluded if they had no valid service identifier (preventing attribution to hospital or community setting) or had less than half of the 22 questions validly completed (preventing calculation of an overall experience index) (Figure 1). There were 4,287 valid questionnaires included in the early-COVID period and 11,072 in the late COVID period. Up to three quarters of questionnaires were received from hospital-based services. The demographic mix of respondents was consistent with long term trends in NSW YES data (Table 1).¹⁵ There were similar numbers of returns from male and female

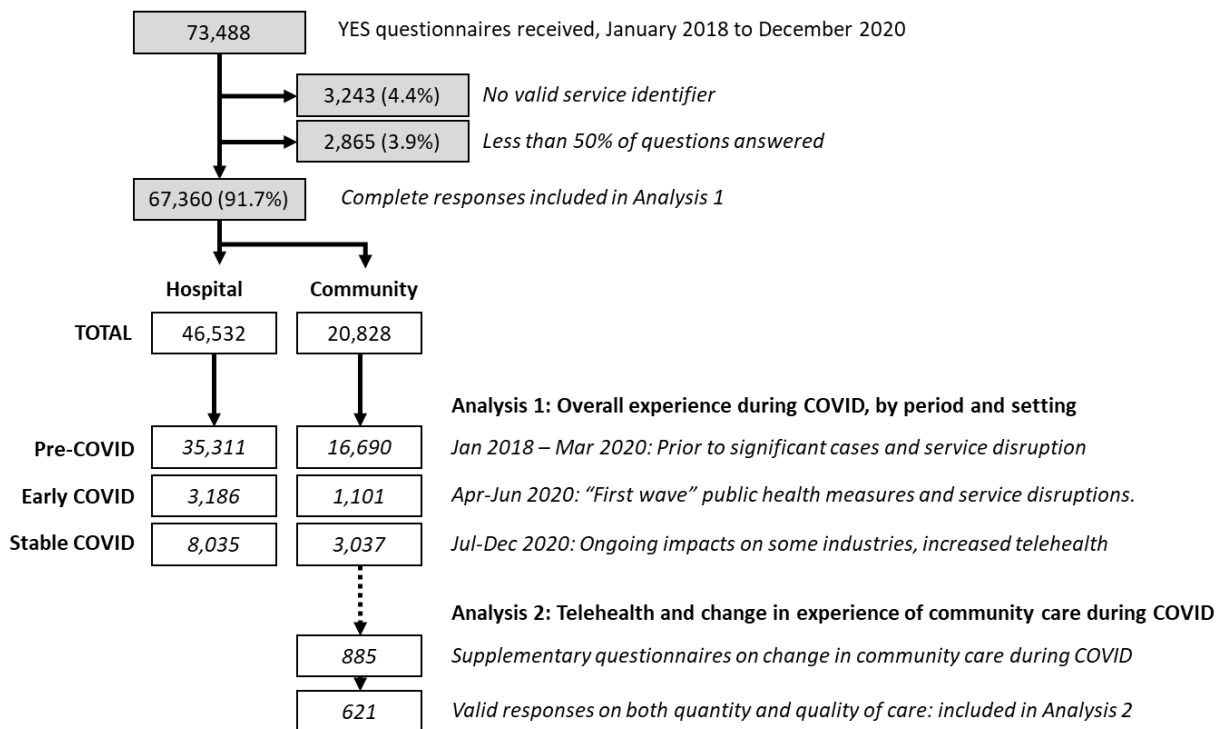
more than six months (46%) of care. There were only minor differences in demographic and care characteristics between pre-COVID and post-COVID returns, although an increase in the proportion of responses from patients with the involuntary status was observed for community during early COVID.

Change in overall experience during the first nine months of COVID

All statistical analyses were conducted in Stata v 15. Previous analyses show that YES scores are skewed towards positive experience.¹⁶ Therefore, scores were converted into an ordinal categorical variable (Stata command xtile) with nine levels for hospital records and eight levels for community records.

To address potential changes in service composition due to COVID-19, demographic variables that had previously been shown to affect the YES Index score were included as covariates in the model, specifically gender, age group, duration of care and involuntary care status (whether a person had received care against their will at any period in the preceding three months). Because YES surveys are anonymous, these covariates are self-reported by consumers who complete the survey and cannot be linked

Figure 1. Study Flow Diagram



consumers. Most hospital returns were from people receiving brief care (0-4 weeks), while most community returns are from people receiving 1-6 months (30%) or

Table 1. NSW Your Experience of Service (YES) returns by consumer characteristics, for time periods of pre-COVID (January 2018 to March 2020), early COVID (April-June 2020) and late COVID (July-December 2020)

	Hospital			Community		
	Pre-COVID	Early COVID	Late COVID	Pre-COVID	Early COVID	Late COVID
TOTAL	35,311	3,186	8,035	16,690	1,101	3,037
GENDER						
Female	16,011 (45%)	1,454 (46%)	3,693 (46%)	8,417 (50%)	576 (52%)	1,538 (51%)
Male	16,734 (47%)	1,478 (46%)	3,732 (46%)	7,519 (45%)	487 (44%)	1,349 (44%)
Other	339 (1%)	33 (1%)	94 (1%)	146 (1%)	11 (1%)	37 (1%)
Missing	2,227 (6%)	221 (7%)	516 (6%)	608 (4%)	27 (2%)	113 (4%)
AGE GROUP						
00 - 17	2,781 (8%)	247 (8%)	788 (10%)	2,072 (12%)	88 (8%)	361 (12%)
18 - 24	4,896 (14%)	414 (13%)	1,195 (15%)	1,679 (10%)	72 (7%)	281 (9%)
25 - 34	7,040 (20%)	607 (19%)	1,608 (20%)	2,493 (15%)	160 (15%)	403 (13%)
35 - 44	6,409 (18%)	594 (19%)	1,374 (17%)	2,563 (15%)	184 (17%)	489 (16%)
45 - 54	5,961 (17%)	576 (18%)	1,287 (16%)	2,719 (16%)	178 (16%)	490 (16%)
55 - 64	3,256 (9%)	271 (9%)	656 (8%)	1,845 (11%)	161 (15%)	370 (12%)
65 and over	2,339 (7%)	222 (7%)	577 (7%)	2,518 (15%)	226 (21%)	520 (17%)
Missing	2,629 (7%)	255 (8%)	550 (7%)	801 (5%)	32 (3%)	123 (4%)
DURATION OF CARE						
< 24 hours	2,058 (6%)	177 (6%)	452 (6%)	613 (4%)	25 (2%)	110 (4%)
1 day - 2 weeks	16,620 (47%)	1,568 (49%)	3,850 (48%)	1,108 (7%)	69 (6%)	250 (8%)
3 - 4 weeks	5,535 (16%)	498 (16%)	1,328 (17%)	1,409 (8%)	90 (8%)	219 (7%)
1 - 3 months	4,139 (12%)	361 (11%)	948 (12%)	2,643 (16%)	167 (15%)	507 (17%)
4 - 6 months	1,147 (3%)	97 (3%)	240 (3%)	1,954 (12%)	129 (12%)	396 (13%)
> 6 months	2,683 (8%)	185 (6%)	533 (7%)	7,953 (48%)	573 (52%)	1,399 (46%)
Missing	3,129 (9%)	300 (9%)	684 (9%)	1,010 (6%)	48 (4%)	156 (5%)
LEGAL STATUS						
Voluntary	14,192 (40%)	1,211 (38%)	3,191 (40%)	10,127 (61%)	690 (63%)	1,795 (59%)
Involuntary	12,186 (35%)	1,114 (35%)	2,828 (35%)	2,635 (16%)	204 (19%)	519 (17%)
Unsure	5,378 (15%)	515 (16%)	1,226 (15%)	2,705 (16%)	146 (13%)	546 (18%)
Missing	3,555 (10%)	346 (11%)	790 (10%)	1,223 (7%)	61 (6%)	177 (6%)

to administrative data. Missing or invalid answers are coded as a separate category and included in analyses. YES index scores were compared across the three time periods using a Mixed Effects Ordinal Logistic Regression (Stata command `meologit`). Community data were clustered by individual community mental health team, and Hospital data were clustered at both ward and hospital levels. Analyses were adjusted to reflect that these were survey data.

Impacts of telehealth and quantity of care on community care experience

NSW Health added supplementary questions to the YES during the stable COVID period (from July to December 2021). People using mental health services were asked to rate the following questions using a Likert scale:

(1) How has COVID-19 changed the amount of contact you had with the service? (no contact, a lot less contact, a little less contact, no change in contact, a little more contact, a lot more contact, N/A started with the service)

Table 2. NSW Your Experience of Service (YES) experience index scores for hospital and community settings for three time periods of pre-COVID (January 2018 to March 2020), early COVID (April-June 2020) and late COVID (July-December 2020). Average score (out of 100) and standard deviation, and percent with overall score in “Excellent or Very Good” range (Experience Index > 80/100)

	Pre-COVID	Early COVID	Late COVID	Overall
HOSPITAL				
Average score	84.4	84.4	84.9	84.5
StDev	16.1	16.0	15.9	16.0
Excellent or Very Good (%)	69.9	69.8	71.3	70.1
COMMUNITY				
Average score	87.4	89.0	88.6	87.7
StDev	16.0	15.0	15.2	15.9
Excellent or Very Good (%)	78.9	82.1	81.7	79.5

during COVID-19). (2) How much of your care with this service was by phone or online? (a lot worse, a little worse, no change, a little better, a lot better, N/A started with the service during COVID-19). (3) How has your experience of care with this service changed during COVID-19? (a lot worse, a little worse, no change, a little better, a lot better, N/A started with the service during COVID-19).

These questions were added to the electronic and paper forms of the YES. There were 885 supplementary questionnaires returned from community clients, including 621 with answers to both questions (i) and (iii). To examine possible impacts of telehealth and changes in the amount of care received, predictors of change in the quantity and experience of care were analysed using two separate multinomial logistic regressions. Each regression used a three-level outcome variable (reduced, unchanged, increased), and the unchanged category was used as the reference point. Sex, age group (under-18, 18-65, over 65), legal status (voluntary, involuntary) and proportion of care received by telehealth (none, little, some, most or all) were used as covariates. For analysis of change in experience, change in quantity of care (less care, no change, more care) was also included as a covariate.

Results

Change in overall experience during the first nine months of COVID

For hospital returns, unadjusted scores (average Experience Index and proportion scoring in the “Excellent or Very Good” range) were statistically consistent over all three time periods (Table 2). For community returns, there was a slight increase in unadjusted scores in the early and late COVID periods, compared to the pre-COVID period. After controlling for differences in self-reported gender, age, duration of care and involuntary care status (Table 3), only the community YES index scores for the early

COVID period were statistically different compared to the pre-COVID baseline (OR 1.16, 95% CI 1.01 – 1.34, $p < 0.05$).

The mixed effects ordinal logistic regression facilitated investigation of which demographic populations were positively or negatively impacted by the changes in care in the early and stable COVID periods. For those receiving hospital care, more positive experience was predicted by male gender (OR 1.31), shorter rather than longer care (particularly those admitted for two weeks or less) and voluntary admission for care (OR 1.31).

For community returns, people under 18 reported less positive experience (OR 0.77), as did those with shorter durations of care by mental health services. Patients who were in voluntary care reported more positive experience (OR 1.36) compared to involuntary patients.

Impacts of telehealth and quantity of care on community care experience

Most respondents (42%) said the amount of contact they had with community services remained unchanged during COVID-19, while 35% said it decreased and 25% said it had increased (Table 4). During this period, 17% of patients said that all or most of their care had been by telehealth, 60% said some or little of their care and 22% said none of their care. People reporting greater use of telehealth were more likely to report a stable or increased amount of care: when most or all care was by telehealth, 35% of people reported an increased amount of care and a further 35% reported no change in care compared to prior to COVID. By contrast when little or no care was by telehealth the quantity of care received was most often unchanged (47%) or reduced (35%).

Generally, community patients tended to be more positive (25%) about their experiences of care during COVID-19

Table 3. Mixed Effects Ordinal Logistic Regression of NSW YES Experience Index scores, comparing early and late COVID periods to pre-COVID after adjusting for differences in consumer and care characteristics. Analyses conducted separately for hospital and community settings. (* p < 0.05, ** p < 0.005, * p < 0.0005)**

	Hospital		Community	
	OR	95% CI	OR	95% CI
GENDER				
Female	1.00 (Ref)		1.00 (Ref)	
Male	1.31	(1.25-1.35)***	1.01	(0.94-1.07)
Other	1.29	(1.05-1.59)*	1.20	(0.91-1.56)
Missing	0.52	(0.43-0.63)***	0.61	(0.44-0.82)**
AGE GROUP				
00 - 17	0.88	(0.75-1.02)	0.77	(0.65-0.90)**
18 - 24	1.00 (Ref)		1.00 (Ref)	
25 - 34	1.06	(0.97-1.15)	0.89	(0.78-1.01)
35 - 44	1.03	(0.96-1.10)	0.84	(0.73-0.96)*
45 - 54	1.12	(1.03-1.21)**	0.83	(0.72-0.95)*
55 - 64	1.06	(0.99-1.13)	0.87	(0.71-1.05)
65 and over	1.11	(0.99-1.23)	0.89	(0.69-1.14)
Missing	1.04	(0.89-1.21)	0.83	(0.65-1.05)
DURATION OF CARE				
< 24 hours	1.43	(1.25-1.62)***	0.83	(0.66-1.03)
1 day - 2 weeks	1.26	(1.19-1.34)***	0.82	(0.72-0.94)**
3 - 4 weeks	1.11	(1.04-1.18)**	0.87	(0.77-0.97)*
1 - 3 months	1.00 (Ref)		1.00 (Ref)	
4 - 6 months	1.13	(1.03-1.23)*	1.03	(0.93-1.14)
> 6 months	1.16	(0.99-1.34)	0.97	(0.88-1.05)
Missing	1.07	(0.95-1.19)	0.81	(0.67-0.97)*
LEGAL STATUS				
Voluntary	1.31	(1.24-1.38)***	1.36	(1.21-1.52)***
Involuntary	1.00 (Ref)		1.00 (Ref)	
Unsure	1.05	(0.99-1.12)	0.98	(0.86-1.10)
Missing	1.18	(1.03-1.34)*	1.14	(0.95-1.36)
TIME PERIOD				
Pre COVID	1.00 (Ref)		1.00 (Ref)	
Early COVID	1.00	(0.92-1.07)	1.17	(1.01-1.34)*
Late COVID	1.07	(1.00-1.14)*	1.17	(0.98-1.38)

than less positive (17%) (Table 4). However, the majority still reported no change to the quality of the service (59%). The proportion of people reporting a more positive experience was highest in those receiving most or all care via telehealth (44% of this group) and those receiving more care than before COVID (56% of this group). Conversely, the group most likely to report a worse

experience of care were those reporting a reduced quantity of care during COVID (32% of this group). In multivariate analyses (Table 5), after controlling for gender, age group and legal status, the strongest predictor of receiving more care was receiving most or all care via telehealth (OR 2.50, 95% CI 1.29 – 4.84). However, receipt of any amount of telehealth also predicted a

Table 4: Responses from 621 people completing supplementary questions on change in their experience of NSW community mental health services during COVID-19. Cross-tabulation of proportion of care by telehealth, change in quantity and change in experience of care

Proportion of care by telehealth	People		Change in quantity of care (N, % of row)		
	N	Pct	Less	Unchanged	More
None	136	22%	33 (24%)	71 (52%)	32 (24%)
Little	188	30%	79 (42%)	80 (43%)	29 (15%)
Some	187	30%	75 (40%)	70 (37%)	42 (22%)
Most or all	105	17%	31 (30%)	37 (35%)	37 (35%)
Not answered	5	1%	1 (20%)	2 (40%)	2 (40%)
Total	621	100%	219 (35%)	260 (42%)	142 (23%)
Proportion of care by telehealth	People		Change in quality of care (N, % of row)		
	N	Pct	Worse	Unchanged	Better
None	136	22%	14 (10%)	100 (74%)	22 (16%)
Little	188	30%	37 (20%)	114 (61%)	37 (20%)
Some	187	30%	33 (18%)	108 (58%)	46 (25%)
Most or all	105	17%	18 (17%)	41 (39%)	46 (44%)
Not answered	5	1%	1 (20%)	2 (40%)	2 (40%)
Total	621	100%	103 (17%)	365 (59%)	153 (25%)
Change in quantity of care	People		Change in quality of care (N, % of row)		
	N	Pct	Worse	Unchanged	Better
Less	219	35%	71 (32%)	111 (51%)	37 (17%)
Unchanged	260	42%	20 (8%)	203 (78%)	37 (14%)
More	142	23%	12 (8%)	51 (36%)	79 (56%)
Total	621	100%	103 (17%)	365 (59%)	153 (25%)

reduced quantity of care, suggesting that telehealth had diverse impacts. There were also significant but diverging associations between change in the quantity of care and change in experience. There was an observable power effect in the odds ratios where less care had a larger relationship with worse experience (OR 6.61, 95% CI 2.76-11.64) than better experience (OR 1.99, 95% CI 1.17-3.39), while more care had a stronger relationship with better experience (OR 11.27, 95% CI 6.43-19.78) than worse experience (OR 2.76, 95% CI 1.21-6.30).

Discussion

Despite the substantial challenges and disruptions of the COVID-19 period, NSW mental health service users responding to a consumer experience survey reported slightly better experience of care during the COVID-19 period than in the pre-COVID baseline. Scores on a composite experience index increased significantly for community mental health services during the early COVID phase, which was characterised by significant

public health restrictions and service disruption. They increased significantly for inpatient service users during later stages of the pandemic.

These unexpected findings may reflect a number of factors. In the first few months of the COVID-19 pandemic, NSW community mental health services greatly increased the amount of care provided by telehealth. In a subset of consumers responding to supplementary questions, greater use of telehealth was associated with a greater quantity of care for some consumers, and an increased quantity of care was strongly associated with a more positive experience. This suggests that while individuals' experiences of telehealth were varied, where it enabled people to have more contact with services, they reported a more positive experience. This may reflect convenience, a greater sense of safety in avoiding health care settings at a time of infection risk,¹⁷ or greater importance of regular service contact in feeling less isolated at a time of COVID-19 social restrictions.¹⁸ However, telehealth approaches are not suitable for all

Table 5. Separate multinomial logistic regressions for (1) Predictors of change in quantity of care and (2) Predictors of change in experience of care in 621 community MH consumers. Reference category for both regressions is no change. Missing/invalid response groups in predictors are included in regression but not displayed

	N	Predictors of changed quantity of care				Predictors of changed experience			
		Less care		More care		Worse experience		Better experience	
		OR	95% CI	OR	95% CI	OR	95% CI	OR	95% CI
Gender									
Female	297	1.00	-	1.00	-	1.00	-	1.00	-
Male	251	1.18	(0.80 - 1.74)	0.92	(0.58 - 1.48)	0.97	(0.58 - 1.63)	0.84	(0.53 - 1.34)
Other	11	1.41	(0.33 - 5.97)	2.36	(0.49 - 11.25)	4.24	(0.87 - 20.58)	1.70	(0.30 - 9.78)
Age group									
Under 18	83	1.47	(0.86 - 2.49)	0.86	(0.42 - 1.75)	1.37	(0.71 - 2.65)	1.03	(0.54 - 2.00)
18-65	450	1.00	-	1.00	-	1.00	-	1.00	-
Over 65	35	1.08	(0.48 - 2.39)	1.19	(0.47 - 2.97)	0.43	(0.14 - 1.36)	0.26	(0.08 - 0.82)*
Involuntary care									
Voluntary	350	1.00	-	1.00	-	1.00	-	1.00	-
Involuntary	214	1.07	(0.72 - 1.60)	1.68	(1.05 - 2.67)*	0.86	(0.51 - 1.47)	1.44	(0.91 - 2.28)
Proportion of care by telehealth									
None	136	1.00	-	1.00	-	1.00	-	1.00	-
Little	188	2.14	(1.26 - 3.63)**	0.86	(0.45 - 1.62)	1.91	(0.93 - 3.91)	1.85	(0.96 - 3.56)
Some	187	2.47	(1.45 - 4.23)**	1.57	(0.86 - 2.86)	1.79	(0.87 - 3.68)	1.78	(0.93 - 3.40)
Most or all	105	1.93	(1.01 - 3.69)*	2.50	(1.29 - 4.84)*	3.17	(1.36 - 7.35)*	4.44	(2.18 - 9.06)***
Change in quantity of care									
Less care	219	-	-	-	-	6.61	(3.76 - 11.64)***	1.99	(1.17 - 3.39)*
Unchanged	260	-	-	-	-	1.00	-	1.00	-
More care	142	-	-	-	-	2.76	(1.21 - 6.30)*	11.27	(6.43 - 19.78)***

Note: * $p < 0.05$, ** $p < 0.005$, *** $p < 0.0005$

consumers or all stages of outpatient and community mental health care.¹⁹ We found divergent or polarised effects of telehealth, with some consumers reporting less care and less positive experience. People over 65 were less likely to report improved experience of community care during COVID-19. People under 18 years also reported a less positive experience of community mental health services early in COVID-19. Young people have experienced significant disruptions and distress during the pandemic,^{1,20} and issues such as physical distancing, lockdown, home schooling, social isolation and economic stresses have created increased risk for this already vulnerable group. To meet young people's needs for direct social connection mental health services may need a lower threshold for in-person consultations.²⁰

While on average, consumers reported a more positive experience, it is also important to consider the risks that some groups of people may be systemically excluded from digital care. This has been termed digital exclusion.³ Barriers may be present for people from non-English speaking backgrounds, those with poor internet connection or limited access to digital services,²¹ or those who find remote communication challenging.⁵ Therefore, the increasing reliance on telehealth may increase the inequality by providing additional barriers for already disadvantaged groups to access care.

The number of people accessing hospital mental health services decreased early in the COVID-19 pandemic. Many hospitals implemented programs to divert people from emergency departments and placed restrictions on

consumers being able to leave hospital units or have visitors. Overall, experience of hospital mental health services did not change significantly. Males, people with brief care and those voluntarily admitted had more positive experiences.

Consumer experience is dynamic, and many factors can impact whether a person has a more or less positive experience. When interpreting this data, it is important to consider how COVID-19 may have impacted people's expectations of services and the greater impact that services may have had on throughout the global pandemic. The context in which care is provided is important when attempting to understand any changes in experience. During a public health crisis, changes to service delivery, such as increased use of remote mental health care may be more acceptable.²² The YES questionnaire contains two free text questions. These are provided to services for local improvement activities but are not included in regular quantitative analysis. While the free text results were not analysed systematically, we observed that many consumers commented that they appreciated the additional pressures that services were under and did not blame the staff or service for any negative changes in experience. The responses to the free text questions should be included as part of any further analysis.

With the shift to telehealth in the community, certain groups of people may not have received support or may have been less likely to provide feedback on their experience. "Reported satisfaction with virtual consultations naturally omits the voice of those unable to participate, and so conclusions should be viewed with caution."²³

Some groups may be underrepresented, and a selection bias may be present for those who completed the COVID specific questions. In the early-COVID period, people aged less than 18 years, 18-24 years and those with brief contact (less than 24 hours) were underrepresented in community responses compared to pre-COVID. People over 65 years were underrepresented in the COVID specific responses. The supplementary COVID-19 specific questions have not been psychometrically validated and were better able to capture the impacts on people who had previous contact with services. Research in consumer/patient experience throughout COVID-19 has primarily focused on the provision of telehealth. Our findings support that experiences throughout COVID-19 were varied, but the amount of contact had a greater impact than the method. It would be valuable and informative to conduct further investigations as to the generalisability of these findings to other health systems, both nationally and internationally and other health settings, beyond mental health specific services. Although a range of experience measurement tools and collection methods are used across different service types,

the impacts of COVID-19 on overall service experience could be explored across different health scenarios.

Conclusion

Throughout COVID-19, mental health services have developed new flexible options for delivering care and people's experience of these changes has been varied. With the availability of telehealth, many people reported receiving more contact with services and more contact was associated with a more positive experience. When conducting further research or considering how this research can be used to inform service delivery, it is important to consider those people, who are at risk of increased health inequalities when care is provided virtually. With more flexible support options available, how care is provided needs to be determined on an individual basis and adjusted depending on the changing needs and preferences of the consumer.

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