

Experiences of Mental Health Professionals with Control and Labor Demands during the Implementation of Teleconsultation at a University Care Center during the First Stage of the COVID-19 Lockdown

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ABSTRACT

Introduction: The implementation of teleconsultation during the first stage of the COVID-19 pandemic created work stress for mental health professionals, who were obliged to act in a timely manner without previously tested procedures. **Objective:** To describe the experiences of mental health professionals with control and work demands during the implementation of teleconsultation at a university health care center during the first phase of COVID-19. **Method:** This is a qualitative study with a phenomenological design. Twenty-eight focused interviews were conducted with the mental health team of a university health care center to explore the experiences of control and work demands associated with technological, organizational and human limitations. Results were analyzed using the meaning categorization technique: 1. Control/demand in the technological domain; 2. Control/demand in the organizational domain; and 3. Control/demand in the human domain. **Results:** Lack of structure, intermittent schedules, inclusion of technical assistance that conditioned their work, lack of control over meeting job demands, difficulty caring for high-risk patients, and no strategy for controlling a space that will guarantee confidentiality, constitute a high-stress scenario for professional performance. **Discussion and conclusion:** Lack of experience in the implementation of teleconsultation creates stress and distrust in the ability to establish therapeutic relationships. There is a need to construct teleconsultation care protocols for crisis care.

Key words: Mental health, teleconsultation, Covid-19, mental health professionals.

RESUMEN

Introducción: La implementación de la teleconsulta durante la primera etapa de la pandemia por COVID-19 creó una situación de estrés laboral al tener que actuar de manera oportuna y sin los procedimientos previamente probados. **Objetivo:** Describir las experiencias de profesionales de salud mental sobre el control y las demandas laborales durante la implementación de la teleconsulta en un centro de salud universitario en la primera fase de la pandemia SARS-CoV-2 (COVID-19). **Método:** Este es un estudio cualitativo con diseño fenomenológico. Se realizaron veintiocho entrevistas focalizadas con el equipo de salud mental de un centro de salud universitario para investigar las experiencias de control y demanda laboral relacionadas con limitaciones tecnológicas, organizativas y humanas. Los resultados fueron analizados mediante la técnica de categorización de significados: 1. Control/demanda en el dominio tecnológico; 2. Control/exigencia en el ámbito organizacional; y 3. Control/demanda en el ámbito humano. **Resultados:** La falta de estructura, horarios intermitentes, inclusión de asistencia técnica que condicionaba su trabajo, falta de control para resolver las demandas laborales, dificultad para la atención de pacientes de alto riesgo y ninguna estrategia para controlar un espacio que garantice la confidencialidad, representa un alto -Escenario de estrés para el desempeño profesional. **Discusión y conclusión:** La falta de preparación para implementar la teleconsulta, genera estrés y falta de confianza en el establecimiento de relaciones terapéuticas. Se destaca la necesidad de establecer protocolos de atención de teleconsultas para la atención de crisis.

Palabras clave: Salud mental, Teleconsulta, Covid-19, profesionales de la salud mental.

INTRODUCTION

The COVID-19 pandemic required addressing the health needs of the population (World Health Organization, 2020). because it also increased psychological distress and mental disorders (Dettmann et al., 2022; Hampshire et al., 2022; Bueno-Notivol et al., 2020; Yunitri et al., 2022). Lockdown also negatively impacted on the mental health (MH) of university students (Chang et al., 2021; Liyanage et al., 2022; Oliveira Carvalho et al., 2021; Reyes & Trujillo, 2021) raising the need for professional mental health care.

The implementation of lockdown as a protective measure led MH practitioners to use teleconsultation as a means of providing care for the population (Kane et al., 2022; Vázquez-García et al., 2021; Olwill et al., 2020; Siegel et al., 2021). This alternative has been endorsed as an essential tool during emergencies, although it underlines the need to reflect on the barriers inherent to teleconsultation (World Health Organization, s/f). The limitations of this form of intervention have been identified and grouped by scope, whether technological, organizational, human or financial (Saigí-Rubió et al., 2016).

At the onset of the COVID-19 pandemic, healthcare professionals reported complications during the implementation of teleconsultation, such as interacting with multiple tools and platforms immediately and without training in some cases, together with security and privacy issues (Kane et al., 2022; Olwill et al., 2020; Siegel et al., 2021). The environmental elements involved in changing the care and treatment management model was a limitation that raised concerns, as was the possibility of developing a physician-patient relationship and the absence of face-to-face social interaction (Kane et al., 2022; Olwill et al., 2020; Siegel et al., 2021). Likewise, the benefits of teleconsultation have been recognized in relation to outreach, schedules, and its impact on certain MH treatments (Kane et al., 2022; Olwill et al., 2020; Siegel et al., 2021).

The crisis triggered by the pandemic, together with the implementation of MH teleconsultation, created a work environment with elements that could cause fatigue and feelings of exhaustion. It is important to address this discomfort through qualitative methods that explore the experiences leading to burnout and the way this interferes with work performance. In this respect, the theoretical framework of demand and control allows us to delve into work life from the technological, organizational and human fields, enabling us to observe the way knowledge in the work field is intertwined with the pressure to perform one's job under emergency conditions. Studies have already revealed the impact of chronic exposure to occupational stress on the MH of health professionals (García-Arroyo & Osca Segovia, 2018; Hiver et al., 2022; Peckham, 2019). High levels of work fatigue associated with emotional exhaustion have

been found, particularly in psychiatrists (Peckham, 2019; Rotstein et al., 2019).

The implementation of teleconsultation under the emergency conditions involved in the first stage of the COVID-19 pandemic created a situation of job stress due to having to act in a timely manner without previously tested procedures. This article analyzes the experiences of MH professionals related to work control and demands during the implementation of teleconsultation at a university care center during the first COVID-19 lockdown.

METHOD

Study design

This study employs a qualitative methodology with a phenomenological design, with the aim of deepening the analysis of the experiences and meanings of the participants (Vargas-Huicochea, 2022).

Participants

The entire mental health team responsible for providing services at a university healthcare center participated in semi-structured interviews.

Procedure

Over the course of 45 days between November and December 2020, the research objectives were presented and clarified with participants to conduct the interviews via audio-recorded videoconferences. The audio recordings were subsequently transcribed, categorized, and analyzed.

Instruments

The data were collected from semi-structured interviews for which a focused interview guide was constructed (Kvale, 1996; Saavedra-Solano & Berenzon-Gorn, 2022), to learn about the experience of care staff during the implementation of teleconsultation in the domains of safety, effectiveness, efficiency, access, and timeliness (World Health Organization et al., 2018). The chosen interview technique enabled us to explore to the experiences of control and work demand in relation to the limitations in the technological, organizational and human domains of MH care providers during the implementation of teleconsultation.

Analysis

The meaning condensation technique (Kvale, 1996) was used to analyze the experiences of participants within

the context of the theoretical framework of demand and control (DC) (Karasek & Theorell, 1990) and barriers in teleconsultation (Karasek & Theorell, 1990; Saigí-Rubió et al., 2016). This approach yielded three saturated categories. The following categories were identified: DC in the technological domain, DC in the organizational domain, and DC in the human domain.

Ethical considerations

This study was evaluated and approved by the research and ethics committees of the university where the research was conducted (FM-DI/058/2020). Likewise, all guidelines were followed to guarantee the safety and confidentiality of participants.

RESULTS

The participants were psychiatrists ($n = 10$), psychologists ($n = 6$), social workers ($n = 5$), psychiatric resident physicians ($n = 3$), and medical interns ($n = 4$). All of them belong to the health team of the university MH service at the institution where the research was conducted, and agreed to participate by signing the informed consent form.

Seventy-five percent of the participants were women.

The following is a qualitative description of the data found. In each of the categories, DC are understood as the source of work stress.

Control is built on the autonomy of a worker to perform their work and contribute to their work group and organization, as well as the opportunity to develop new skills and learning that will allow them to do their job better. *Work demands* refers to the workload, working under pressure,

and level of concentration required. (Karasek & Theorell, 1990). In this model, social support reduces stress through social relationships and the instrumental support of colleagues and superiors. Conversely, a lack of social support increases stress (Johnson & Hall, 1988). There are therefore four quadrants as a result of the interaction between *control* and work *demands*; high tension, active, low tension and passive (Karasek & Theorell, 1990). These are addressed in the three categories of analysis, as shown in Table 1.

Demand and control of work activities

1. Technological field

The implementation of teleconsultation during the first stage of the pandemic involved the use of software to establish communication and a new tool for file management. This scenario tested participants' ability to perform their work. On the one hand, there were difficulties with technological resources. Internet coverage sometimes interfered with adequate communication, although this element was found to be more present on the part of patients than health workers. And although the university provided technical support to improve the internet connection and solve problems, it was often decided to make a phone call to complete the session.

In general, the care team adapted to the scenario despite the lack of training for using the new care model. However, it is worth noting that they were not completely unfamiliar with the electronic clinical records used. Nevertheless, there were numerous reports of the difficulty of storing information on the session provided. Under pressure to continue providing care, health care workers used various strategies to record this information manually or on other

Table 1
Categories of analysis

Category	Category explanation
Demand and Control in the technological domain.	Describes the experiences regarding the interaction of demand and control when coping with technological limitations, which the WHO has described as access to the required equipment, skills and knowledge for the use of tools, Internet coverage, diversity of available software, security and confidentiality.
Demand and Control in the organizational domain.	Shows the experiences concerning the limitations in the organizational environment, which correspond to the redesigning of the care model and the training of its personnel. It also includes the correspondence between the areas involved in care delivery, changes in responsibilities that redefine existing roles and even the emergence of new profiles that create insecurity. Lastly it comprises conflicts of labor recognition and the situation of constant change caused by the speed of technological changes.
Demand and Control in the human domain.	Refers to the experiences of health professionals in response to limitations in the human sphere, in which the resistance of employees to change, lack of involvement, IT skills, opinions of telemedicine, skepticism, workload and changes in work routine occur.

Compiled by the authors based on the theoretical proposal of Saigí-Rubió et al. (2016).

software so that they could subsequently upload it to the system. Although using written notes that subsequently had to be transcribed into the file meant an additional workload, health workers were obliged to do this to avoid suspending patient care.

Additionally, work team communication due to the shift to teleconsultation required the use of different methods of electronic communication, such as e-mail and instant messaging via cell phone. The use of these tools had to be adapted during the course of the pandemic without prior training or protocols. As a result, electronic devices became saturated, as they were used to perform all tasks (whether work-related or personal).

In terms of safety, two issues emerged. One was the difficulty of handling at-risk patients. In this sense, participants were concerned about communication with the work team. In face-to-face mode, it sufficed to walk down the hall to attend cases of this nature. The greatest challenge in this regard involved maintaining the integrity of the patient at a distance, which is where the greatest source of stress lies for mental health professionals.

Another important aspect is the confidentiality of the data handled in consultations. Although it is possible to control the physical space of a MH professional, patients often lacked the conditions to guarantee confidentiality. In these circumstances, it was decided to use the teleconsultation chat, headphones and ask closed questions. Some of these experiences of health professionals involving demand and labor control in the technological field are shown in Figure 1.

2. Organizational field

Due to the nature of the pandemic, the most obvious change at the organizational level was observed when health professionals were obliged to adapt the face-to-face care model to teleconsultation without prior training. Most health professionals adapted a place in their homes that allowed them to convey warmth to patients, and attempted to avoid interruptions. A common issue encountered was the need to incorporate the daily life of both the patient and the therapist (such as pets and urban noises) into their consultations. This last scenario is out of MH practitioners' control, which creates stress due to the demand to ensure an uninterrupted session. At the same time, however, it has been acknowledged that this change of modality helped MH professionals to get to know the patient's context better.

Regarding the length of teleconsultations, they are usually shorter due to the time spent accessing the platform and the interruptions in communication due to technological issues. As for the approach to the patient, it is generally said to be similar to the face-to-face modality, given the information requested and other recursive elements in the conversation. In this respect, MH professionals mentioned the difficulty of expressing support when patients are vulnerable. At the same time, they acknowledged that the teleconsultation modality suited certain anxious patients. Remote care provided benefits for certain patient populations, although others would have preferred face-to-face care.

Unlike the interaction with patients, in the case of work team communication, there was a significant lack

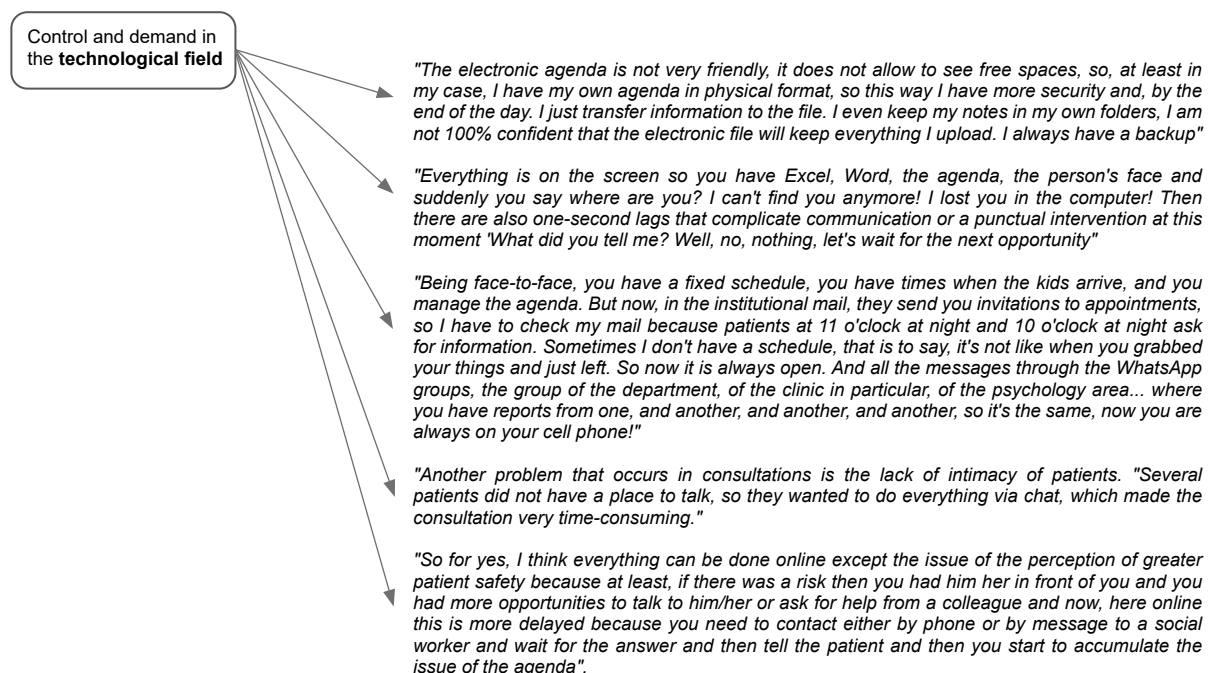


Figure 1. Experiences of the participants in terms of demand and control in the technological field.

of immediate means of communication to provide interdisciplinary support, since, in the day-to-day work before the pandemic, this type of interaction had taken place in the corridors. Attempts to establish contact with colleagues via email or cell phone instant messaging created a perception of stress in most participants, and they often failed to achieve the desired communication.

Although the activities and procedures to be performed by the clinical team were the same as they had been before the pandemic, there was a change in terms of consultation days and established schedules. In this respect, participants mentioned a feeling of exhaustion, which was not due to work overload in terms of the number of patients, but to

the change in routines that prevented them from organizing their own activities.

The incorporation of technology failed to simplify methods, particularly during the adaptation to digital tools for patient registration and follow-up. This situation created a higher level of stress in the healthcare team, as well as interfering with their communication with patients. Examples of these experiences are shown in Figure 2.

3. Human field

Regarding the human field, uncertainty was observed about the ability to establish a doctor-patient relationship

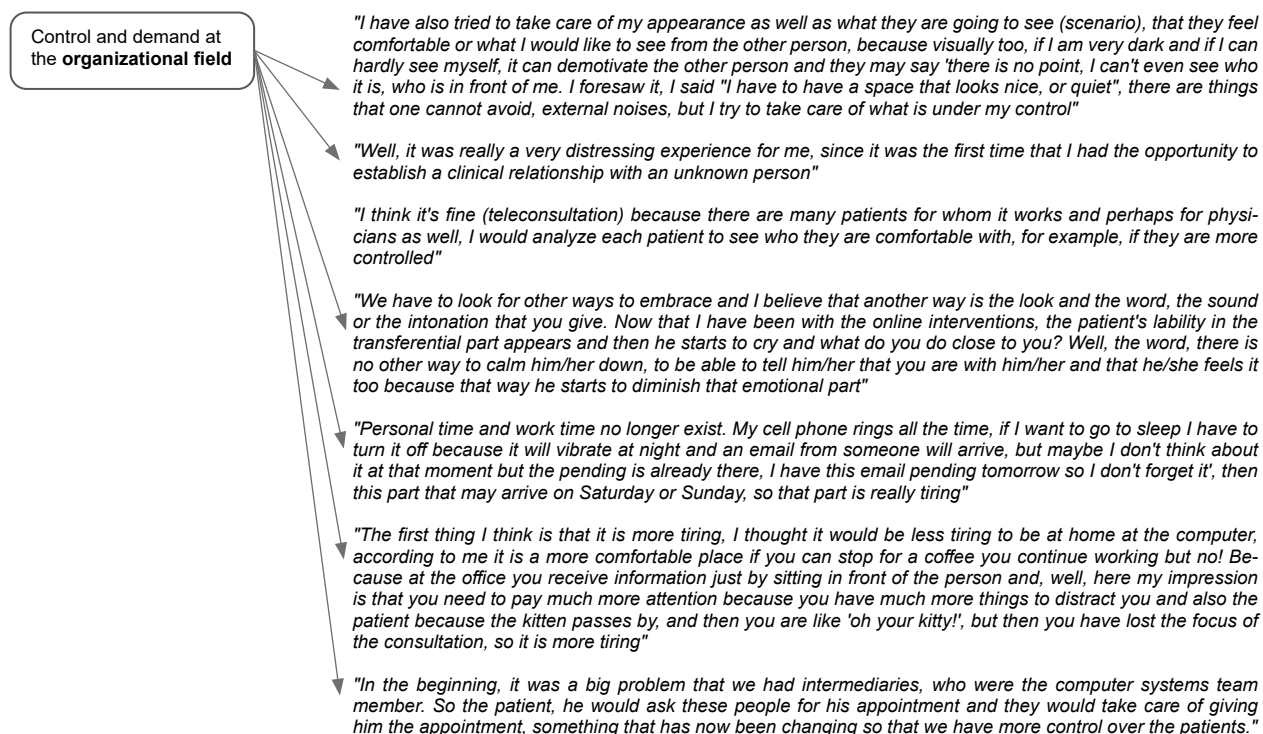


Figure 2. Experiences of the participants in terms of demand and control in the organizational field.

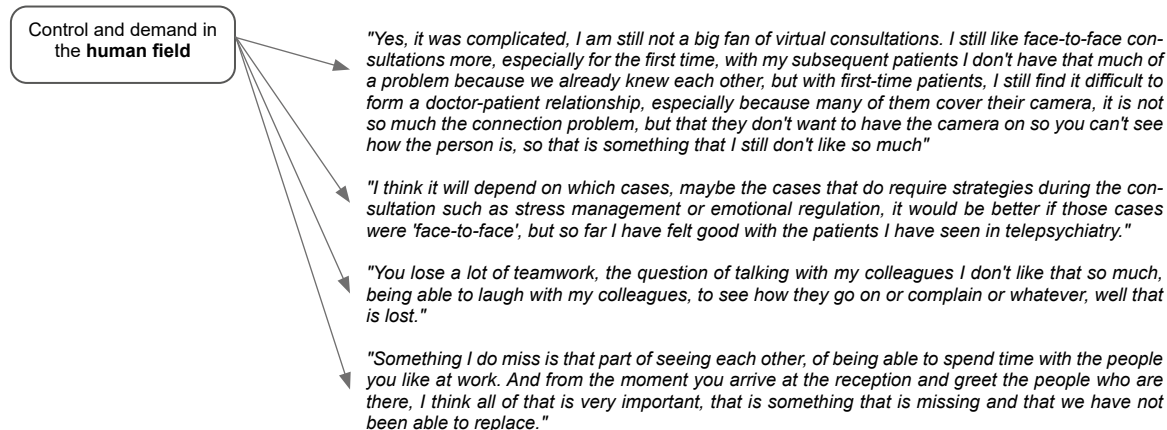


Figure 3. Experiences of the participants in terms of demand and control in the human field.

in teleconsultations. This tended to disappear over time and use of the computer and digital tools to deliver patient care became common. Participants mentioned that despite their being more familiar with teleconsultation, it could not be used in all cases, such as when there was violence or suicide risk. Although mental health professionals recognized the usefulness of this tool, the need for occasional face-to-face contact with psychiatric patients continued to be mentioned in the reports.

In the new work model, participants reported missing the social interaction they had enjoyed with their co-workers, recognizing the positive impact this had had on their day-to-day work. At the same time, they highlighted the benefits of teleworking in reducing commuting time and enabling them to manage their schedules. Examples of these experiences are given in Figure 3.

DISCUSSION AND CONCLUSION

The hasty implementation of MH teleconsultation during the first stage of the COVID-19 pandemic created a stressful scenario. Given the nearly universal lockdown, participants in this study lost almost any control they might have had over their work activities in terms of clinical services in MH. However, the demand to cope with the situation remained, underlining the need to develop and evaluate telemental health protocols. To our knowledge, this is one of the first studies to report mental health professionals' care experiences during the pandemic.

Telemental health delivery was implemented through a range of tools allowing communication with patients. This involved coping with technological problems with the technical support of a third party, undergoing a period of on-site learning they completed quickly yet which prevented them from maintaining control of their work situation. In addition, care protocols were adapted as along the way, meaning that participants did not have a guide to provide teleconsultations, putting their skills to the test in a complicated scenario (Olwill et al., 2020; Siegel et al., 2021). The tension created kept participants at a level that enabled them to cope with the situation. However, the use of multiple tools for work communication with an open schedule was perceived as a source of stress (Kane et al., 2022). It should be noted that, although mental health professionals experienced the saturation of their electronic media, since the latter constituted the means of answering their personal and work requests, they were unable to do without them. The lack of structure, irregular schedules, the inclusion of technical assistance conditioning their work, and the lack of control in the face of the need to resolve work demands created an enormous amount of tension.

In terms of safety management during teleconsultation, the care of high-risk patients constitutes a high-stress sce-

nario for the MH professional. On the one hand, mental health professionals are aware of the need to react immediately. On the other, they feel a lack of control due to the distance preventing them from protecting patients' integrity. This points to the need for care protocols that will help control situations with at-risk patients, both for institutional referrals and for communication with family members to provide MH support (Kane et al., 2022; Olwill et al., 2020; Siegel et al., 2021).

Regarding the management of privacy, it was observed that there is no strategy to control a space guaranteeing data confidentiality, either on the part of patients or health professionals. In face-to-face care, the MH professional was responsible for ensuring confidentiality. However, the shift to teleconsultation made it necessary to lose control of this issue, increasing tension levels for health professionals. Telephones were widely used because given the impossibility of a private space for having a consultation, users could move to a secluded place with their cell phones (Siegel et al., 2021). In this respect, it is essential to reflect on the legal consequences that may arise in telephone care (Olwill et al., 2020). The lack of privacy has required improvising actions between patient and MH professional, such as the use of instant messaging when a third party appears (Siegel et al., 2021).

For members of the clinical team, having to set up a consultation environment within their homes implied an additional workload (Kane et al., 2022; Siegel et al., 2021) as well as financial costs. This also enabled them to seek alternatives to offset their lack of control over technological elements, thereby alleviating stress.

The logistics of teleconsultation were found to reduce the length of the sessions. For this care modality, it would therefore be important to consider shorter but more frequent consultations and provide more detailed and explanatory medical prescriptions (Kane et al., 2022; Siegel et al., 2021).

Regarding the human factor, a common belief was the impossibility of establishing and developing a therapeutic relationship through teleconsultation, due to the supposed deterioration of both verbal and nonverbal communication, which does not occur in face-to-face interaction. Likewise, the traditional elements used to show empathy may be limited and make it difficult to provide the secure atmosphere of a consulting room (Kane et al., 2022; Siegel et al., 2021). It has always been said that face-to-face encounters with patients or users improve the interaction of the binomial, provide more information and generate better risk assessments and diagnoses (Kane et al., 2022; Olwill et al., 2020; Siegel et al., 2021). However, in response to the COVID-19 health crisis, health care providers found it necessary to innovate to bridge these gaps.

Uncertainty about the feasibility of teleconsultation also speaks of areas in which MH professionals experience loss

of control to be able to respond to work demands. However, the level of tension present allows the tool to be used, and doubts are dissipated through experience. Personalized hybrid care models are sometimes even proposed, based on geographical characteristics, as well as the patient's disorder.

In contrast to other studies, participants mentioned the need to naturally integrate the elements that occur in everyday life during teleconsultation to improve the doctor-patient relationship and the sense of closeness (Kane et al., 2022; Olwill et al., 2020; Siegel et al., 2021). In this way, the tension created by the lack of control of these elements is relieved and at the same time, mental health personnel's confidence is increased by being able to overcome these adversities. Likewise, observing a little of the patient's context can strengthen the relationship.

Finally, a sense of loss of community was observed as a result of the discomfort caused by social isolation (Kane et al., 2022; Siegel et al., 2021), in the absence of this moderator of tension, the perception of stress may increase.

In general, teleconsultation is observed to have benefits such as flexible time management and ease of geographic access, resulting in time savings and a decrease in the cancellation of appointments. It makes it possible to obtain a different type of information on patients from the context in which the consultation takes place. With certain disorders, teleconsultation reduces inhibitions (Kane et al., 2022; Olwill et al., 2020; Siegel et al., 2021).

It is important to design care guidelines incorporating the needs detected through the use of new technological tools. These include patient safety, ensuring privacy and creating the appropriate virtual environment to achieve a better therapeutic alliance. In this way, the MH professional will have greater control over how to respond to the demands of work performed with this modality. In organizational terms, the training of MH professionals should include these elements to ensure better patient care in this modality. In this respect, in addition to training MH professionals in the use of the various platforms used, it would be desirable for workplace authorities to specify the use of communication media for work purposes, adhering to the guidelines issued by the national authorities on this subject.

Lastly, in the human sphere, it is important to promote social interaction among workers while maintaining safety measures, so that these social relationships can mediate the stress produced by work demands and control over work tools.

Considering these experiences can contribute to further work on detecting and developing strategies to provide quality telemental health and safeguard the MH integrity of health professionals.

It is important to continue the discussion regarding the steps to follow in MH care, particularly with specific populations and in emergency conditions. In this way, tools can be created to control the situation and ensure better man-

agement. Along these same lines, it is possible to provide the care team with alternatives to cope with the obstacles to privacy.

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Conflict of interest

The authors declare that they have no conflict of interest.

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