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Experiences of remote consultation in UK primary care for patients with mental health conditions: A systematic review

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Abstract

Objectives: There has been a rapid shift from face-to-face to remote consultation across healthcare settings. 90% of patients with mental health conditions are cared for entirely in primary care. Remote consultation can present challenges and benefits for patients with mental health conditions. The aim of this systematic review was to collate and examine the evidence relating to remote consultation in UK primary care on the experiences of patients with mental health conditions.

Methods: Six major databases were searched for empirical studies published in the English language between 1 January 2010 and 21 October 2022. Studies were included where remote consultation occurred between a patient and primary care clinician. Outcomes of interest include mode of remote consultation, patient experiences and characteristics. Final included studies were assessed for quality, and results analysed with narrative synthesis.

Results: Six studies met the inclusion criteria, covering a range of mental health conditions and remote consultation modalities (telephone, video, online, email, text-based). Patients were overall satisfied with remote consultation, with particular benefit for certain mental health conditions or anxious patients. However, several studies found that face-to-face was the preferred method, with highlighted negatives to remote consultation, such as inflexibility of online formats. Acceptability of remote consultation is context specific and influenced by the purpose of the consultation and individual patient. Remote consultation may reduce anxiety in some patients, but is potentially less acceptable than face-to-face for relational appointments.

Conclusions: Acceptability of remote consultation is context dependent. There is a lack of evidence surrounding patient characteristics and access to remote consultation.

Keywords

Primary care, remote consultation, mental health, patient acceptance of health care, patient satisfaction

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Introduction

90% of people with mental health conditions are cared for entirely in primary care.[1] A UK survey of general practitioners (GPs) found that 40% of all primary care consultations involved mental health.[2] The COVID-19 pandemic has potentially increased the need for mental health support, with lockdowns, self-isolation, financial and health concerns reducing well-being.[3] Implementation of remote consultation in primary care increased during the COVID-19 pandemic.[4] Remote consultation modalities include telephone, internet video, online e-consult systems, email or other web-based asynchronous text-based communication. Consultations were made remote unless there was a clinical reason for them to be face-to-face, to

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reduce the burden on the health service, save patient and clinician time and reduce infection risk.[5] Although the relative number of face-to-face consultations has increased since lifting lockdown restrictions in 2021, levels of remote consultation in UK general practice are still higher than before the COVID-19 pandemic.[6]

Remote consultation offers perceived benefits for patients and clinicians such as convenience[7,8] and the ability to provide care for underserved populations in geographically remote areas.[9] However, GPs have reported it may be less suitable for vulnerable patients or those with safeguarding concerns,[10] and patients with chronic conditions may find remote consultation less satisfactory.[11]

As well as remote consultation being less suitable for certain patients or situations, issues with access and usage have been reported. Patients with mental health conditions have described difficulties accessing mental health services during the COVID-19 pandemic and challenges with remote consultations,[12] particularly for emotional appointments such as during counselling.[13] An interview study with patients receiving telemental health during the COVID-19 pandemic showed that patient experiences differed; remote consultation was perceived as less intrusive, lacking in connection and less personal. Remote care offered the benefit of reduced travel but posed barriers via difficulty with device use and limited access to private spaces for conducting consultations.[13]

Considering the rapid shift to remote services, understanding the experiences of patients, barriers to access and patient characteristics are essential in ensuring that patients' needs are met and to reduce potential inequality such as through digital exclusion. This is the first systematic review synthesising the evidence regarding the experiences of patients with mental health conditions with remote consultation in UK primary care.

Methods

A systematic review was conducted and is reported according to the Preferred Reporting Items for Systematic Reviews and Meta-Analysis (PRISMA) framework.[14] The protocol for this review was registered on the Open Science Framework (https://doi.org/10.17605/OSF.IO/YC82P).

The research question was: 'What are the experiences of patients with mental health conditions using remote consultation in UK primary care'?

Inclusion criteria

The population of interest was patients with mental health conditions experiencing remote consultation in UK primary care. The setting was focused on the UK, as this review formed part of a wider programme of work which examines digital primary care in the UK and was intended to inform practice and policy in the UK.[15] The intervention of interest was two-way remote consultations with a primary care clinician, this included telephone, video consultation, email and online or text messaging. Comparison of interest was none or face-to-face. All types of empirical studies, both qualitative and quantitative and published from 1 January 2010 to 21 October 2022, were included. Studies were filtered from 2010 based on reviews showing minimal previous studies on this topic,[16,17] and research surveying general practices showing low remote consultation usage pre-2010.[18] Only studies conducted in the UK were eligible for inclusion.

Exclusion criteria

Studies were excluded where remote consultations were: not based in UK primary care; used as a method of treatment; between clinicians or in the context of conditions which had an organic cause such as dementia, neurodevelopmental conditions or primary sleep disorders, unless in the presence of another mental health condition. Studies were excluded when: published in a language other than English or only a speaker or conference abstract was available. The search did not include reviews of literature, grey literature or unpublished research.

Outcomes of interest were patient characteristics, patients experiences of remote consultation, including usage and factors influencing acceptability of remote consultation.

Search strategy

Advice on the search was sought from an Academic Support Librarian. A search strategy was devised using MeSH indexing and free text of keywords to identify studies involving experience of patients with mental health conditions, remote consultation and primary care. The search was restricted to studies conducted in the UK using a modified search filter.[19] See Apendix 1 for Medline search strategy. The following databases were searched: Medline, EMBASE, Web of Science Core Collection, Cochrane Library, CINAHL and PsycINFO.

Hand searching was conducted to identify additional studies meeting the inclusion criteria. This was conducted by Google Scholar search (10 November 2022) with the keywords 'mental health', 'remote consultation' and 'primary care', and screening the titles, and where necessary, the abstracts, of the first 100 results. Reference lists of the included studies were also searched.

Selecting studies for inclusion

All results were imported into Covidence web platform (Melbourne, Australia) and duplicates were removed. Titles and abstracts were screened by two researchers

independently. Full-text articles were screened for eligibility, and any discrepancies were resolved by discussion with a third researcher. Progress was recorded in Covidence and a final list of studies generated.

Data extraction and quality appraisal

A custom data extraction form was developed to capture outcomes of interest, assuming data heterogeneity and piloted before use. Data relevant to the research question were extracted on study design, setting, remote consultation modality, patient characteristics, mental health condition and patient experiences with remote consultation. See Appendix 2 for data extraction from variables.

The final included studies were individually assessed for quality, by two independent researchers using the Mixed-Methods Appraisal Tool (MMAT).[20] This tool was used as it is appropriate for quantitative, qualitative and mixed-method studies. Quality appraisal was used to add context to the findings and not as a means to include or exclude studies. Studies were given a rating of high quality if four or five criteria were met, moderate quality if three criteria were met, and low quality if two or fewer criteria were met.[21]

The search decision process is presented using a PRISMA flow diagram[14] (see Figure 1).

Synthesis

The review examined both qualitative, quantitative and mixed-methods studies. Due to variation in study design of included studies, data were heterogeneous. Thus, a narrative synthesis[22] was conducted. Findings were summarised by developing categories, and presenting the main findings in tables and with a textual approach due to heterogeneity of outcomes.

Results

The results of the search and screening are outlined in Figure 1. Database searching and hand searching identified 2454 and 3 studies, respectively. Following removal of duplicates, 1708 studies were screened at the title and abstract stage. Thirty-seven full studies were assessed for eligibility. Six studies were included in the review.

Four studies recruited patients from general practices,[16,23–25] one from mental health trusts and clinical research networks[26] and one from the community.[13] Three studies were conducted before the COVID-19 pandemic[16,23,24] and three studies included information gathered during the pandemic.[13,25,26] Of the six studies, two were descriptive quantitative studies using surveys/questionnaires,[23,26] two were qualitative studies,[13,24] using semi-structured interviews and two were mixed methods studies[16,25] combining semi-structured interview and collection of patient data from practice systems. See Table 1 for characteristics of studies. In three studies, the majority of patients were female[13,16,23] and two studies had by a narrow margin a larger male population.[24,26] The studies looked at patients with unspecified mental health conditions,[16] agoraphobia,[24] depression,[23] severe mental illness[26] and mood, personality, bipolar and psychotic disorders.[13] One study did not specify gender split or breakdown of specific conditions.[25] See Table 2 for further details.

In all six of the included studies, people with mental health conditions experiencing remote consulting in primary care, were not the sole sample; data regarding these participants was instead embedded in larger target populations. Three studies looked at primary care patients with a range of conditions, including mental health conditions.[16,24,25] Two studies looked at patients with mental health conditions who had experience with remote consultation in different settings, including primary care.[13,26] One study looked at primary care patients with depression, or raised cardiovascular disease risk, some of whom had prior experience of remote consultation.[23] Two studies included varied remote consultation modalities, such as telephone, text-based/online triage, video and email.[13,16] The other four studies included both telephone and online consultation,[26] telephone only,[23] video consultation only[24] and website and mobile application for online consultation,[25] respectively.

Quality assessment

Included studies were assessed for quality using the MMAT (see Table 1 for summary of studies and Appendix 3 for MMAT results). Of the six studies included, five were high quality and one was moderate quality. Edwards et al. was a high-quality study that did not meet all domains due to limited generalisability of the sample population.[23] The moderate-quality study, Leung and Qureshi, did not meet the domains of methods (sampling, analysis and presentation) and synthesis of results of qualitative and quantitative components. Moreover, this study was also a quality improvement project, focusing on 12 patients of whom, it was reported, that the majority had mental health conditions but exact numbers were not given.[25]

Positive patient experiences

Five studies highlighted positive experiences or satisfaction with remote consultation,[13,16,23,24,26] see Table 2 for summary of findings. One study included satisfaction with prior use of NHS direct,[23] a historical urgent care telephone service in England, which at that time was delivered by clinical call handlers.[27] This study found that survey respondents with depression reported high levels of

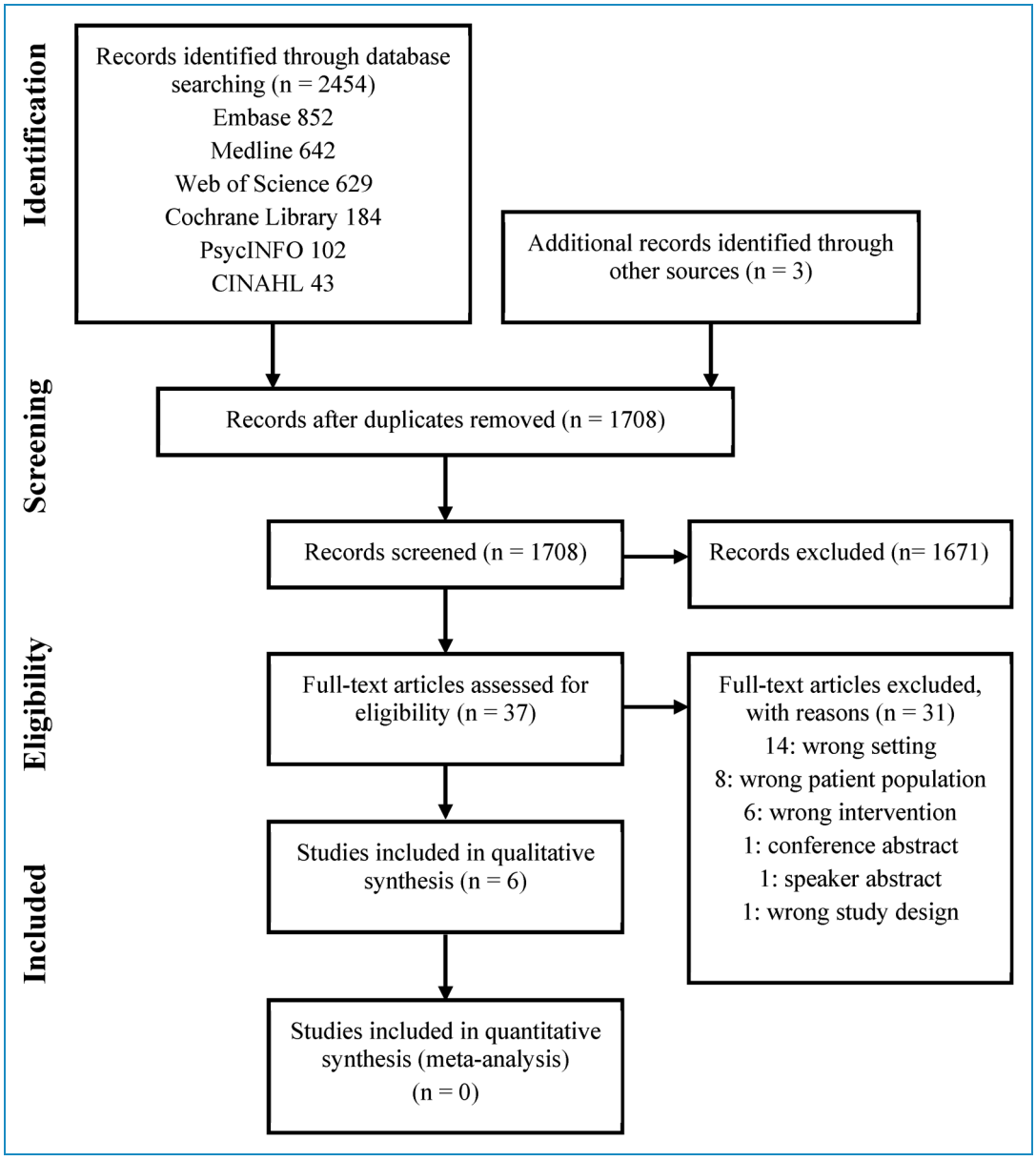

Figure 1. PRISMA diagram of included studies.

satisfaction, with a mean satisfaction of 3.4 (SD 1.2, n = 336, range 1.0–5.0, higher score indicates greater satisfaction).[23] Similarly, another study identified that 66.4% of survey respondents with severe mental illness were completely satisfied with the support they received by remote consultation. However, they were more likely to be satisfied with face-to-face care ($p = 0.008$), with 86.2% of patients completely satisfied with the in-person support they received.[26]

One study reported that a patient with mental health problems appreciated, and felt empowered by, the choice of consultation modality.[16] Two studies reported that remote consultation reduced anxiety,[13,24] such as via reduced waiting times or increased flexibility:

> I suffer from agoraphobia. There's times I've got to cancel appointments. I know [with video consultation] that it's okay. I'm sitting here at home. I open my laptop, sign in. My stress levels weren't sky high. (58 year old female patient with agoraphobia)[24]

Moreover, some patients described the benefit of being able to express themselves better using textual and asynchronous methods. One patient with mental health problems reported that written communication was easier when unwell.[16]

Another study described that remote consultations with the GP were valuable during the COVID-19 pandemic for prescription requests, urgent access to physical health

Table 1. Characteristics of included studies.

Author, year	Setting	Study design	Sample/number of patients	Remote consultation modality	Quality assessment
Atherton et al.[16]	8 general practices (Bristol, Oxford, Scotland)	Mixed methods ethnographic case study (semi-structured interviews) and collection of consultation data	6 with mental health conditions (39 overall). Purposive sampling for varied characteristics. Age ≥18.	Telephone, online triage tool, video, email	5/5 high
Donaghy et al.[24]	6 general practices sites (Lothian, Scotland)	Patients who selected video consultation with GP were followed up with semi-structured interview. Thematic analysis was conducted	1 patient with agoraphobia. 21 overall.	Video consultation using Attend Anywhere (a web-based platform)	5/5 high
Edwards et al.[23]	34 general practices in the south west and north east England	Practice records used to identify patients with depression. Postal questionnaire was sent to 54 patients using stratified random sampling.	336 patients with depression had experience with NHS direct. 1589 overall. Age ≥18.	NHS Direct (telephone service that provided health assessments, information and advice)	4/5 high
Leung and Qureshi[25]	1 inner city London general practice	High frequency users identified and underwent cycles of semi-structured telephone interview and proposal/uptake of regular scheduled telephone/face-to-face consultations with named clinician. Usage rates were compared before and after intervention cycles. Study followed a quality improvement audit format – refer to paper	Study reports that many of the patients had mental health conditions. 12 overall.	Dr iQ (website and mobile application): a platform for online consultations	3/5 moderate
Newbronner et al.[26]	Mental health trusts and 6 clinical research networks (setting not specified)	Survey (online, postal or telephone)	119 used phone/online GP practice services. 367 overall with serious mental illness.	phone/online (e.g. video call)	5/5 high
Vera San Juan et al.[13]	Recruited from the community via social media and organisations and networks	Semi-structured interviews. Collaborative framework analysis.	8 mental health patients from GP. 44 overall.	varied (video, telephone, text-based, online support groups, text and phone helplines, recovery colleges)	5/5 high

Table 2. Summary of findings.

Author, year	Mental health condition	Other patient characteristics	General experience	Positive experience	Negative experience
Atherton et al.[16]	Not specified	• 24–91 years old. • 1 transgender, 13 male, 25 female patients. • Included disadvantaged groups: 6 patients with mental health conditions, 1 parent carer of disabled child, 1 vulnerably housed asylum seeker, 2 men aged <30 years, 4 patients living in very rural areas, 9 patients with restricted mobility, 2 patients with hearing loss, 3 ethnic minority patients with English as a second language. 41% educated to degree level or above. Patients often had other chronic conditions and comorbidities. 25.6% were carers.	Textual remote consultation was suitable for simple consultations, rather than emotional ones.	Feeling of empowerment by choice of consultation methods. Textual/asynchronous methods useful for anxious patients or when face-to-face/ expressing themselves is difficult.	inflexibility of formats (alternatives to face-to-face consultation were adapted by patients in order to get the treatment they wanted).
Donaghy et al.[24]	Agoraphobia (1 patient)	• 22–76 years old. Patients choosing video consultation were on average 10 years younger, had more experience with online communication. All had access to technology. • 11 male, 10 female patients.		Video consultation was less stressful than visiting the GP practice, video consultation saved time, transport cost and anxiety Patients and clinicians generally felt follow-up video consultation would be particularly useful for mental health (among other uses)	
Edwards et al.[23]	Depression	• Mean age 49.1 years old (SD 15.9) • 96.8% Caucasian • 74.6% female • 53.1% not employed, 36.6% had higher education, 68.9% homeowners.		Satisfaction with telehealth, mean (SD): 3.4 (1.2). Range: 1.0–5.0, higher scores indicate greater satisfaction.	

(continued)

Table 2. Continued.

Author, year	Mental health condition	Other patient characteristics	General experience	Positive experience	Negative experience
Leung and Qureshi[25]	Study reports patients often had mental health conditions including anxiety, depression, post-traumatic stress disorder, and medically unexplained symptoms	• Average 32.8 years old. • Gender not specified.			Those with complex chronic conditions and mental health issues had health needs unmet and felt Dr iQ lacked continuity of care, with the potential for underlying problems to be missed by clinicians
Newbronner et al.[26]	Severe mental illness (schizophrenia or delusional/psychotic illness or bipolar disorder): 51.2% Psychosis, 29.4% Bipolar, 6.3% other severe mental illness, 13.1% not recorded.	• Range 20–86 years old. 50.5 mean age (SD 15.69). • 77.4% White British, 6.5% Asian British/Asian, 4.9% Other White, 4.1% Black/Black British, 3.3% Other non-White, 1.4% mixed White/Black, 1.4% mixed White/Asian, 1.1% other Mixed. • 51.0% male, 47.4% female, 1.6% transgender. • 48.5% high or very high deprivation, 18.3% moderate deprivation, 29.2% low or very low deprivation. See paper for breakdown.		66.4% of respondents felt completely satisfied by the care they received on the phone/online. People were more likely to be completely satisfied by face-to-face care (86.2%, $p = 0.008$)	
Vera San Juan et al.[13]	45% mood disorders, 14% Personality disorders, 11% Bipolar disorder, 14% Schizophrenia/ psychosis, 7% other, 23% not stated	• 7% 18–25 years, 32% 26–35 years, 29% 36–45 years, 14% 46–55 years, 7% 56–65 years, and 7% 66–75 years old, 4% information not available. • 63% White/White British, 14% Black/Black British, 14% Asian/ Asian British, 7% mixed/ multiple ethnic groups, 2% other. • 73% female	Previous familiarity with GP facilitated remote contact and improved acceptability. Remote consultation being more acceptable for transactional rather than relational appointments, such as for medication review with a GP.	Remote consultation was valued for prescriptions, urgent access to physical health care, and reduced physical health anxiety. Felt that remote consultation provided efficient and reliable support when other services were unavailable. Regular remote consultation with the GP in the form of	Registering on apps and online forms was a barrier to accessing care. Face-to-face was preferred by many patients.

(continued)

Table 2. Continued.

Author, year	Mental health condition	Other patient characteristics	General experience	Positive experience	Negative experience
		• 68% Heterosexual, 18% LGBTQ, 14% not specified. • Regions of UK: 18% North (NE, NW, Yorkshire, Humber), 11.5% Midlands (West and East midlands), 11.5% South (SE, SW, East of England) 57% London, 2% Wales. • Living location: 80% City, 18% Town, 2% Village. • 48% Lived alone, 50% lived with other(s): see paper for breakdown. 2% Lived in mental health specific accommodation for homeless people.		check-ups and email reduced anxiety about decreases in other services	

care, mental health support and reduced health anxiety. A strategy used by GPs of regular scheduled remote consultation, such as via email, was highlighted by patients as useful to reduce anxiety related to reductions in other services. One patient valued the efficiency of email consultation:

> From GP I have done email consultation online form and then he emails me back. (. . .) It feels much more efficient at times. Like, just get to the point. (Patient, female, White British, age and mental health condition not specified)[13]

One study noted generally that, based on patients' experiences of video consultation, they felt follow-up video consultation would be useful for mental health management. This study also noted that for housebound or working patients, as well as those with mental health conditions, video consultation was especially appealing, and reduced time, costs and reduced anxiety.[24]

Negative patient experiences

Three studies reported negative experiences of remote consultation.[13,16,25]

One study reported that alternatives to face-to-face were adapted by patients so that they could receive the required care. One patient reported the time-consuming nature and inflexibility of an online triage tool, which required more time and responses in order to access a specific treatment which could have been requested verbally in less time.[16] Similarly, another study identified filling out complicated online forms and registering with apps as barriers to care.[13]

Another study reported that for patients with both complex chronic conditions and mental health needs, an online and app-based consultation system lacked continuity of care and resulted in unmet needs. Patients also expressed concern that chronic conditions would be missed by clinicians.[25]

General experiences of remote consultation

Two studies[13,16] reported that patients perceived advantages to remote consultation for certain situations but not others. One patient described textual alternatives to face-to-face to be more suitable for 'simple' consultations rather than relational ones.[16] This is in line with another study reporting that whilst face-to-face is preferrable for relational appointments, remote consultation was viewed by patients as suitable for functional appointments, for example, when reviewing medication in a telephone follow-up appointment.[13]

Similarly, acceptability of remote consultation was dependent on factors such as relationship and familiarity with the GP. One patient described remote consultation being facilitated by having an already established relationship with their GP.[13]

Together, these findings indicate that acceptability of remote consultation may be context dependent.

Discussion

Summary

Together, the studies report patients to be satisfied with remote consultation, with positive descriptions of experiences including feelings of empowerment, improved self-expression, efficiency and reduced stress and anxiety. However, acceptability of remote consultation was context dependent and influenced by factors such as specific mental health condition, presence of comorbidities, relationship with healthcare professional and purpose of the consultation. Similarly, the type of remote consultation influenced patient experiences. Text-based formats were described as more suitable for functional consultations, and facilitated consultations when anxiety made communication difficult. Video consultation was described as less stressful than visiting the GP. Drawbacks to online systems in particular included reduced continuity of care and inflexibility/inaccessibility. Remote consultation was generally described as less suitable for consultations regarding emotions, face-to-face consultations were often preferred.

Strengths and limitations

The COVID-19 pandemic resulted in a rapid adoption of remote consultation, in the absence of clear evidence on how this would be experienced by certain patient groups. This study is timely in the current context as healthcare adapts after the lifting of COVID-19 restrictions.

Patients in the included studies often had other conditions and comorbidities which could affect experiences, and may have influenced the findings here. Similarly, the studies in this review were restricted to recent research focused on UK Primary Care. Thus, the findings cannot be applied to other cultural or healthcare settings. Expanding the search to include studies published in other countries may have retrieved results on usage and experiences of other types of patients. Similarly, expanding the search to include research on views of clinicians may have provided additional insight into the acceptability of remote consultation in care of patients with mental health conditions.

We aimed to identify patient characteristics, and usage of remote consultation. Whilst the included studies described patient characteristics, this was regarding the larger patient samples, rather than our population of interest. We were therefore unable to summarise this data in our review. This highlights a gap in the literature regarding

experiences and characteristics of patients with mental health conditions using remote consultation in primary care.

When interpreting patient satisfaction, it was difficult to distinguish between satisfaction with the modality of remote consultation, versus satisfaction with the interaction generally. Three of the included studies collected data during the COVID-19 pandemic. Whilst satisfaction with remote consultation may be high in a pandemic setting, this may not apply when access to services is not reduced. Similarly, there may be an element of participant self-selection in these studies. Patients' prior experience levels and access to technology may affect reported satisfaction. For example, patients choosing video consultation were on average younger, had access to devices, and had more experience with online communication.[24] Lastly, the mode of data collection can influence satisfaction participants report, with face-to-face and telephone interviews resulting in higher acquiescence bias or yes-saying than self-administered surveys.[28] Four of the six included studies were either face-to-face or telephone interviews; however, the remaining two showed high satisfaction levels as reported through self-administered questionnaires.

Comparison with existing literature

This review presents a specific scope of findings regarding patient experiences as we looked at UK primary care only; we found a high overall satisfaction with remote consultation.[23,26] This is in line with other studies that have looked at broader populations and settings. International evidence has been examined in an umbrella review of studies pre-pandemic[29] and a systematic review of evidence during the COVID-19 pandemic.[30] As in our review, reasonable acceptability of remote consultation was found,[29] particularly where the alternative was reduced services.[30]

This review found that remote consultation was more acceptable to patients for 'simple' consultations, rather than relational ones, and that patients were more likely to be completely satisfied by face-to-face care. This correlates with an interview study looking at experiences of patients with mental health conditions during the COVID-19 pandemic which described remote consultations as inferior to in person for expressing emotions, and that the lack of physical presence was challenging.[12]

This is in contrast to our finding that some patients are better able to express themselves through alternatives to face-to-face.[16] A study conducting anonymous online discussion with mental health service users found that written alternatives to face-to-face were perceived to promote disinhibition, allowing greater emotional expression.[31] It is likely that facilitators to self-expression are dependent on the individual patient.

We found that remote consultation may be beneficial for certain conditions, such as for patients with phobias or anxiety.[13,24] However, these benefits may not extend to patients with other mental health conditions, or when there are complex, chronic physical and mental needs. Studies have reported that for certain mental health conditions, such as paranoia[32] or psychotic conditions,[13] remote consultation or technology could have a negative effect on symptoms.

Implications and future directions

Studies examining experiences specifically in mental health patients in primary care were lacking. However, evidence of this was embedded in broader studies. Whilst remote consultation may be convenient and have some benefits for reducing patients' anxiety and facilitating self-expression, face-to-face was reported as being preferred. In practice, care should be given to discuss with patients their preferred consultation format and communication needs, whilst considering their familiarity with the practitioner and the emotional context of the appointment.

Despite the majority of included studies being of high methodological quality, many had low patient numbers of our population of interest. This review thus identifies a gap in the literature regarding patients experiences with remote consultation in primary care. Patient characteristics and barriers to care in particular will need to be further explored, with larger samples of patients with mental health conditions in primary care settings. The role of characteristics such as specific mental health condition and patient demographics on acceptability and uptake of remote consultation requires further research. Specifically, studies comparing experiences of remote consultation for patients with conditions such as depression, anxiety, phobias and psychotic disorders may identify different needs and preferences of these patients. Integrating routine data on consultation format, patient characteristics and rate of missed encounters, with qualitative findings may elucidate specific needs and experiences. This understanding may indicate which patient groups can benefit from remote consultation, guiding planning, implementation and adaptation of remote consultation to better meet patient needs.

Conclusions

Remote consultation is promising as an option to widen access and meet increasing demands in primary care for patients with mental health conditions. This review identified overall high satisfaction with remote consultation in UK primary care for patients with mental health conditions; however dedicated research on experiences of this specific population is lacking. As demand for mental health support increases, and with continued implementation of remote consultation in primary care, further research is required to evaluate the efficacy of remote consultation for this group. Lastly, alternatives to face-to-face care should be

co-designed by patients, practitioners, and other stakeholders to ensure that care meets the needs of people with mental health conditions.

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