

**The challenges and benefits of Remote Support for Eating Disorders throughout COVID-19:
Perspectives from service providers in the not-for-profit sector in England, UK**

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Abstract

The coronavirus disease (COVID-19) pandemic has necessitated a rapid migration to remote online services for eating disorders treatment and support. This has proved challenging for organisations within the not-for-profit sector. This preliminary study explores the experiences of not-for-profit eating disorders organisations in England (UK) that have adapted to the challenges of providing remote support during the pandemic. Semi-structured interviews were conducted with professionals working across 3 charities in England and 2 individuals with lived experience of eating disorders and experience of co-delivering online peer support for a not-for-profit organisation. Interviews focused on; the challenges and benefits of providing remote healthcare; key times during the pandemic when their service was most needed; how the pandemic impacted on their service users' or peers' wellbeing; and future recommendations for remote care. Reflexive Thematic Analysis was used to analyse the data. 3 final themes were generated: continuing support and widening access; home as therapeutic space; the impact of statutory and public health sector responses to COVID-19. Key findings were that whilst online support has offered a lifeline for service users, the home as a therapeutic environment proved a challenge, together with the impact of the reduction of statutory support available and the resulting increase on the demand for the not-for-profit sector's capacity to deliver. All providers stated that they plan to continue to offer remote support as a complement to – and not replacement for – face-to-face services. Further research is recommended to explore the longer-term implications for not-for-profit sector service providers in providing future remote support for eating disorders.

1. Introduction

The coronavirus disease (COVID-19) pandemic presented global rapid and unprecedented challenges for eating disorder (ED) treatment and recovery support in the United Kingdom (UK) as in most other countries [1–10]. The spread of the virus within the UK population and the resulting national lockdowns from March 2020 onwards necessitated the transition to online healthcare services, with many individuals left with a sudden break in service provision [4, 5, 11–13]. This has presented specific challenges for ED support, such as the importance of face-to-face

clinical support, particularly in the early stages of treatment, both from a physical health check and psychological support perspective [11–15].

In the UK, the role of the not-for-profit sector (NFP sector; also referred to as the voluntary sector in the UK), including e.g., charities and social enterprises, has grown exponentially within the last 30 years. This is in part due to the increased use of the sector in the delivery of community health services in the context of a succession of UK governments committed to public sector reform based on reduced state provision [16–20]. Services have shifted to focusing on the relationship between the National Health Service (NHS) and the NFP sector with the aim of supporting an effective pathway for individuals needing crisis support [20–22].

For ED treatment, the model of the provision of care has often been a combination of services provided by either the NHS and the NFP sector, and for individuals with less severe presentations of ED symptomologies typically supported by NFP organisations, including ED charities and mental health charities, often through, as examples, models of local social prescribing services, and collaborative approaches undertaken by local clinical commissioning groups (CCGs) [20, 23] with CCGs recently replaced by Integrated Care Systems (ICSs) [24, 25]. Many ED charities do not typically support an individual whose body-mass index (BMI) is dangerously low, or who is suffering acute mental distress. Through locally agreed pathways of care, a charity's remit would typically be to provide support for individuals at either the early intervention stage or at a later stage in their recovery, rather than the in-patient acute care provided within the NHS or private hospital setting. This is arguably in theory, as the national picture is variable and ad hoc in practice, with access to effective treatment and interventions experienced by many in need as a 'postcode lottery' even prior to the pandemic [5, 23, 26, 27]. The relationship between statutory and NFP organisations is made more challenging by limited funding, as many charities and NFP organisations rely on short-term contracts and grants from trusts and foundations to deliver their work [28]. In times of so-called normality, such challenges make it already difficult for ED charities to plan and deliver their services, and to build longer-term relationships with the public sector in their locality required for a multi-agency approach to be truly effective [21, 28, 29].

The importance of NFP health services has been highlighted by the COVID-19 pandemic. When several statutory services suspended or halted provision in response to the national lockdowns of 2020 onwards, the voluntary sector played a crucial role in local level emergency response, with a remarkable voluntary sector mobilisation to either continue, enhance, or replace existing frontline services [28, 30]. This proved crucial in the rapidly changing situation posed by the pandemic, where services were forced to adapt on a day-to-day basis. The expanding range of digital platforms that became more widely available allowed for at least some contact with service users during the pandemic, but the picture of how online services adapted within the NFP sector is currently not widely examined.

The existing literature focuses on the experiences of receiving and/or providing remote healthcare and support for ED support during the pandemic from statutory or public health sectors. Current knowledge of the experiences of NFP organisations is limited. The experiences

of NFP organisations in meeting the challenges of continuing ED support during the pandemic, including reconfiguring their services, and managing delivery online, is invaluable in gaining a greater understanding of lessons learnt from the pandemic. It is also important to consider the threats and opportunities ahead for future services which are likely to be both online and increasingly delivered by a proliferation of NFP and private sector services [17, 18, 21].

2. Method

The current study was conducted as part of the Remote Care for EDs throughout COVID-19 (RHED-C) project at Northumbria University, Newcastle upon-Tyne, England, UK. This initial study is part of a 3-year programme funded by the Medical Research Foundation focusing on key challenges and benefits to the provision of remote and digital support services for EDs throughout the COVID-19 pandemic. This research was approved by the Northumbria University ethics committee (ref: 45202).

A series of 7 semi-structured interviews (~45 mins each) took place via Microsoft Teams in May 2022. Participants were either a). Working for a NFP ED organisation in the UK or b). Individuals with lived experience of an ED volunteering with an NFP organisation to help deliver peer support. Questions focused on the following key aspects of remote support during the COVID-19 pandemic: i. Key challenges and benefits of providing remote healthcare (including how difficult or easy it was to adapt existing services), ii. Key timepoints during the pandemic proved particularly challenging for service users, iii. Reflections on how the pandemic impacted on the wellbeing of and support circles for services users, and iv. Thoughts and suggestions about future remote healthcare – including improvements that could be made to the usability of existing platforms (See appendix for full interview script).

Recruitment was via the RHED-C steering group and the project's social media platforms. Interviews were recorded and transcribed for data analysis purposes only. All data was anonymized, and recordings destroyed on completion of the analysis. Following participation, each participant was provided with study debrief information and remunerated with a £15 gift voucher as a thank you for their time.

2.1. Sample

Participants were aged between 23-65 years ($M=41.57$ years, $SD=14.86$). Five participants identified as female, and 3 as male. Six participants identified as White British/Irish and one as Irish/Ukrainian. Of the 8 participants, 5 were professionals working across 3 ED charities (1 = Northeast of England, 1 = Southeast of England, and 1 = South Yorkshire; with an average workforce of 16 people), and 2 were volunteer peer support providers with lived experience of EDs, one living in the North East of England and the other in the South East of England.

All participants reported using one or more remote platforms to provide an ED service or peer support since the start of the pandemic. Zoom was the most widely used platform across the

study sample (6 out of 7 participants). The demographic information of participants and platforms used by the services they represent is detailed in the table below.

Table 1: Participant Demographics (N = 7)

Age	Gender*	In-service role	Platform(s) used
31	M	Peer Support (PWLE)**	Meta FaceTime, Microsoft Teams, Zoom
33	M	Peer Support (PWLE)**	Google Hangouts, Microsoft Teams, Zoom
57	M	Chief Executive	Telephone, Zoom
39	F	Clinician	Microsoft Teams, Telephone, Zoom
43	F	Training & development	Microsoft Teams, Zoom
65	F	Chief Executive	VC (Video Consultations), Zoom
23	F	Specialist Support (EDs)	Chatwee, Telephone

**All participants self-identified their gender. **PWLE = People with Lived Experience*

2.2. Analytic Approach

Transcripts were analysed using Reflexive Thematic Analysis [31, 32]. An inductive approach was used to allow for flexibility in the interpretation or patterns of meaning across the dataset. This initial study will help researchers to develop and shape ways of engaging participants at workshop and one-to-one interviews stage later in the research programme, so the researchers were keen to adopt a process that was flexible enough to have an initial conversation and not to miss key points or experiences faced by professionals and peer-support facilitators working in the voluntary sector.

The first researcher initially familiarised herself with the dataset, manually generating initial codes and themes. The themes were then shared with the second researcher who provided critical feedback. Initially a set of 20 sub-themes and 7 first-stage themes were generated from the data: continuing support and widening access; protecting the therapeutic space; triggering governmental messages; lack of statutory support; widespread impact on ED symptoms; 'left with my own thoughts'; and 'going 50/50-the future of support.' Initial results were shared as part of a conference presentation at the International Conference for EDs (ICED 2022). This allowed transparency of sharing work in progress with peers in keeping with the project principles. Further exploration of the data set and further discussion has allowed 3 final themes to be generated for a richer and more cohesive sense of the key stories and concerns faced by

participants. The final 3 themes generated present a cohesive and more focused picture of the data set whilst not losing the nuances of the stories and allowing for a rich and in-depth sharing of participants experiences [32, 33]; i. Continuing support and widening access; ii. Home as a therapeutic space; and iii. The impact of statutory and public health sector responses to COVID-19.

3. Results

The three final themes reflect the complexity of experiences and issues in readjustment to remote services during the COVID-19 pandemic. Each theme is presented in more detail.

3.1. Continuing support and widening access

Research has so far illustrated the vital roles that digital and remote interventions have played in providing ED support services during the COVID-19 pandemic – despite these being ad hoc or rapidly executed [11, 13–15, 34]. This was also evident in our sample, where service providers and professionals felt that it allowed them to continue to offer a comparable service. There was a consensus across the study sample that online support, however imperfect, was better than nothing:

“{...} we could continue to offer a comparable. An equitable service.” (ORG1)

“Well, definitely with lockdown, it meant that people were actually able to receive a service {...} where they would not have been able to, we wouldn’t have been able to work face to face. So it meant, you know, a lifeline really, for people.” (ORG4)

This was especially important in terms of the exacerbation of EDs symptomologies and distress experienced by service users during, and in many cases, as a result of the pandemic:

“{...} we saw {...} people really struggling if they had {...} ARFID (Avoidant/Restrictive Food Intake Disorder) {...} when we got the point where supermarkets were just being wiped out and they couldn’t eat from their safe list.....I think particularly for people with anorexia was the gyms closing because {...} a lot of people with anorexia would compensate for food debt. And then the gyms closed.....(ORG3)

In some instances, online provision also allowed voluntary organizations to continue to offer wider pastoral and wellbeing care for service users often perceived as the ‘added extras’ that the voluntary sector provides:

“{...} one of the things that we realised were that people were really isolated and we had a lot of longer-term clients who lived on their own. And so what we did is we put on activities that were purely just about the social interaction {...} one of them {service users} designed and delivered a {online} quiz and we had people who came along and did that.” (ORG3)

There were also some advantages to providing online support from the point of view of increased capacity to deliver services:

“We are {...} third sector. So money is a continuous challenge and when we’ve been able to have people working remotely, it meant that we can increase the capacity so we have people working from home, so we’re not needing a physical room. And so we’ve been able to reach more people. We’ve been able to expand.” (ORG2)

The flexibility and affordability of platforms was also vitally important in the decision-making process about which to use. Familiarity of platforms to service users was also a significant factor:

“I think that Zoom was promoted very rapidly, very widely. I think you know when {...} all our private lives Zoom because {...} kind of on natural default and {...} into our families and our friendships circle. So, I think it just felt natural...” (ORG1)

However, there were issues with platforms in terms of affordability, data protection and the difficulties in ensuring that platforms used were, and continued to be, consistent with service need:

“After a while of working with VC (Video Consultations, as used by NHS and, in this instance, accessed by a local charity working with NHS partner) we encountered some issues. We hadn’t used other platforms because they weren’t as highly encrypted, but in fact the platform Zoom moved to {...} really beefed up its online safety and security elements. So we actually switched to Zoom which we are currently using. However, the costs of that are about to increase and the facility of uses {...} changed so it’s doesn’t lend itself so well to what we have to deliver.” (ORG4)

The picture across the sample is varied in terms of how quickly organisations were able to migrate to an online service at the start of the pandemic. Of the organisations represented, just one offered online support prior to the pandemic and continued to do so throughout with additional telephone-based support. One service was able to provide ‘imperfect’ and ‘off the cuff’ telephone support within a week of the first UK national lockdown (March 2020), quickly migrating to Zoom within a week, and one organisation took several weeks to migrate to an online service due to staff capacity constraints, training needs and the need to provide staff with equipment to work from home. The uncertainty of the situation also led to additional strain on already stretched services with difficult decisions needing to be made about service provision to take the wellbeing of already overstretched staff into consideration:

“We {...} made the correct appraisal not to expect or ask staff to continue in the same level of output when they were in many {...} cases you know having to juggle homeschooling {...} we were very clear that there would be a reduction in capacity that in turn {...} meant that the waiting time to access us will be longer {...} when there was a space, we didn’t automatically fill that space. It was all based on clinicians about their own individual capacity.” (ORG1)

There were also several difficult decisions that had to be made with finite resources, often as a small charity, with little standardised guidance or support on how to navigate the unprecedented:

“Think at the beginning {of the pandemic}. It was very much, to be honest, a period of limbo and people were thinking, have we got the time, the capacity to actually make a change? And do we need to because at the beginning people were like ‘in three months, this is going to be over and we’re gonna be back on.’ So we did spend a little bit of time kind of thinking, are we gonna make that change because we’ve already had reservations previous to that about doing digital work specifically because of the additional risks of people with eating disorders, we need to be able to physically see people in terms of any changes within their body shape and their weight.” (ORG3)

However, with threat comes opportunity. Some participants said that the pandemic acted as an impetus to provide an online service in order to further widen access to their service, something that they had discussed with colleagues but not yet investigated more fully:

“...we would never {pre-pandemic} have the time or the inclination to go, ‘oh, I wonder what it would be like to deliver a digital service’, and suddenly we were either forced to or we had the time. And now all of that hard work’s done.” (ORG3)

The data gathered from participants demonstrated a varied picture of being able to migrate to an online service due to issues of capacity, finite resources and affordability of online platforms. Nonetheless, all participants reported the value of being able to offer their service users at least some form of continued support, which, without the increasing number of online platforms available, would have been impossible during the pandemic.

3.2. Home as a therapeutic space

Participants reported that there were advantages to being able to provide therapeutic or support interventions remotely [11, 13, 35, 36]. Service users could access support from home if they needed to, which widened access to individuals who could not attend a physical appointment due to restrictions such as working hours, childcare responsibilities, geographical location or personal health:

“...we have a client group that we will only work with people from a therapeutic point of view if they have a BMI that’s over 17.5. And so we have some clients that are on the cusp which means that they really shouldn’t be exercising. So if somebody is living out in x {...} the travel, you know, the additional risks of actually coming into the office. Suddenly that wasn’t an issue anymore because you could do that online.”(ORG3)

However, there were also difficulties in protecting therapeutic space within the home environment. Not everyone had a quiet, safe or confidential place to meet with their therapist online, and many service users found themselves balancing their own needs with dependents and family life, including childcare. This was exacerbated by the fact that members of the

household were all in lockdown and therefore at home at the same time. This could make therapy sessions difficult to deliver:

“If you’ve got a client in the counselling room {...} You think the confidentiality is just there – it’s implicit. But if you’ve got somebody in their own home...Confidentiality means different things to different people, so making sure that they have space, and we’ve had clients who’ve had children and {...} we’ve actually had to say {...} we need to make sure you’ve got some childcare so you can access their service and sometimes that’s been quite challenging” (ORG2)

There were challenges in monitoring people’s wellbeing remotely. Not having face-to-face meetings allowed some service users to conceal how unwell they were during a consultation. One of the participants with lived experience reflected on this opportunity for service users to mislead providers about their symptoms, potentially exacerbating the often-secretive nature of many EDs:

“(Being online) can enable the ED to deceive the medical professional {...} to pull the wool over your eyes, it can enable that you know, if they’re further on (in their recovery journey) {...} they’ll be open and honest but if they’re still held back by an ED {...} could just lie {...} and tell the professional online” (IND1)

This was also reflected in the experience of service providers:

“There is the issue of assessment, so if you’ve got somebody who is quite poorly. If you’re actually seeing them in person, you can see all of them. So you’re kind of doing your sort of continuous risk assessment, which is much harder” (ORG2)

There were also difficulties in picking up the nuances of how someone is feeling on screen, compared to being with them in the same room. This also had implications for aftercare or ensuring the wellbeing of the individual after a meeting:

“There’s a mindset, certainly with counselling anyway, that there’s value in being in the room with somebody and there’s a safety in how contained the work is in having somebody in the room because {...} you know that the session is not being overheard. You have a sort of visceral sense of how they {service user} are {...} When you’re ending the session {...} hopefully you’ll know that they’re grounded and that they’re going back out into their life.” (ORG2)

This raises interesting questions around the impact of the sudden transition that takes place once the online call is concluded, from the point of view of both the service user and the service provider. There are not necessarily time-based or physical boundaries to mark the start and end of the conversation (e.g., walk or drive home), which may act as a healthy demarcation for the beginning and end of a therapeutic moment or space.

For some poor internet connection was a huge issue for disrupting therapeutic and peer support sessions. The online process itself could in some cases add to the sense of isolation:

“...to be honest {...} I think, in a weird way {online peer-support sessions} added to that isolation as well. It was lovely to see people. It was lovely to talk to them and whatnot, but everything was done on screens and it kind of felt like your horizons were getting nearer and nearer...” (IND2)

Unfamiliar online platforms did not always make appointments or peer support sessions easy to access, with the process of logging online causing additional stress and anxiety for some service users:

“...for some individuals, the anxiety of {...} digital platforms {...} we know that there are kind of those comorbidities of EDs, thinking of service users I’ve worked with who struggle with anxiety {...} they’re not always the most user-friendly kind of interfaces or platforms for those individuals who are seeking ED support.” (ORG5)

However, all participants said that, despite the complexities, they would continue to offer online support and were keen to look at how the experience could be improved for service users, striking the balance between user preference and health needs:

“I think that a lot of it is {...} trying to offer choice {...} between modalities of that digital and online platform {...} and I think {...} just asking about preference {...} not always assuming that that video call is going to be the easiest for that person. You know just as a kind of before arranging that appointment asking would you prefer for this to be phone call, email consultation, video consultation {...} would be really positive.” (ORG5)

These findings highlight that, whilst there are many advantages to service users being able to access support remotely from home, there are several challenges for service providers in terms of ensuring affective risk assessment and safeguarding of service users. There were issues in terms of confidentiality, such as effective and remotely accessible digitized systems to be able to store information and to ensure end-to-end encryption to ensure confidentiality comparable to the public sector (e.g., NHS). Poor internet connectivity for many participants also reduced the effectiveness of the online therapeutic experience for many, and, in some cases, exacerbated their sense of loneliness and isolation: a situation on which EDs symptomologies can thrive.

3.3. The impact of statutory and public health sector responses to COVID-19

The stretch on NHS and public health services during the pandemic meant that referral criteria for NHS or in-hospital support became more stringent. Though this was a pre-existing upward trend, it was accelerated by the pandemic [5, 27, 37, 38]. This has had implications for the NFP sector, which was left to plug the gap for individuals suffering from more acute symptomologies and mental distress than their services were originally designed for:

“People with more complex mental health presentations {...} were very badly affected because of the general context in mental health {...} services weren’t available {...} we had increased suicide ideation for some people {...} And we were having to do more work in terms of multidisciplinary approaches, being more in contact with GPs just to

ensure that people were {...} being held because so many more people...were turning to us because they had nowhere else to go.” (ORG4)

COVID-19 lockdown restrictions had an impact on the mental wellbeing of many people with EDs. Individuals found themselves torn between their own mental wellbeing and preventing the spread and staying safe from the COVID-19 virus. This often exacerbated the loneliness and isolation often associated with an ED:

“It’s all well and good {...} the government saying {...}, don’t leave your house, lock your doors. You’re only allowed about half an hour outside. You can’t meet people. {...} Though that was the best thing for COVID, that was the worst thing for someone with mental health because {...} it’s only going to go one way” (IND1)

Triggering governmental messages from the UK government’s Better Health campaign launched during the pandemic focusing on encouraging the public to adopt healthier lifestyles, and with an emphasis on exercise and weight loss, although well-meaning, did in fact cause a great deal of anxiety amongst people living and recovering from EDs [39]:

“When the government {...} did its anti-obesity strategy {...} framed within the context of COVID, {...} spurious and sometimes unproven links between weight and vulnerability {...} that was extremely destabilising for a large number of people who felt yet further stigmatised, yet further vulnerable felt {...} that they were being blamed.” (ORG1)

There was also confusion about public health messaging more generally, which had a practical impact on what type of advice services felt they could give:

“The other factor that affected people in terms of uncertainty was differing {...} public health messages. And that came up quite a lot for service users and staff and for us as an organisation. So to be sure that we were actually doing, you know, the right thing. {It was} sometimes hard because the public health messages were sometimes at odds with the political messages and so on {...} It really adds, you know, really the additional layer of challenge and stress.” (ORG4)

Orientating towards the future, participants reported that their services were keen to consider a ‘hybrid’ approach of online and face-to-face support. Participants felt that this could be best achieved by working with the statutory NHS and public sector partners going forward:

“I think there’s more we could do around being joined up with statutory services about how they’re working with people {...} We are part of a collaborative platform online which debates and discusses some of those issues {...} but I think there’s more we could do around that. So we can kind of help us to understand what people are experiencing elsewhere so we can fit. {...} What {are} their experiences? {it would} track through those if there are issues. And similarly, the other way round. You know if something that we’re doing is problematic for people that other services

could kind of flag that up with us. {...} you know some mutual learning, I suppose. I think that would be really helpful.” (ORG4)

These findings show that many NFP organisations were forced to provide for acutely unwell individuals they would not otherwise provide a service for, due to the pressure on NHS services. This had huge implications for them in terms of staff capacity, and the need for crisis management. This situation was, in many cases, exacerbated by confusing, and in some cases unhelpful public health messaging.

4. Discussion

Our findings highlight the benefits and challenges faced by NFP organisations and peer support workers providing remote online support for EDs during the pandemic. There was increased demand for NFP support which added to the already existing stress on finite resources. The organizations represented were able to continue to provide support due to commitment and the ability to adapt, in most cases, quickly, but at different stages and often without guidance on how to do so. This only added to the disparity of provision geographically for EDs support that was already the case [5, 27].

Nonetheless, service providers were keen to stress the advantages of newly ubiquitous digital interventions that allowed them to provide some form of comparative service during the pandemic, and in some instances added new cost-effective, inclusive choices to their service for the future. Online appointments that could be offered at more convenient times for service users who were working or had full-time care responsibilities and without the cost or time-commitment to travel to an appointment. Whilst travel was not permissible during lockdown, the convenience and affordability of an online service continues to be an attractive option for many service users and service providers. As one participant reported, the COVID-19 emergency necessitated the transition to an online service which, without COVID-19, would not have been embarked upon, but which now holds the promise of positive long-term application.

However, providing therapeutic support to someone in their home has presented challenges from the point of view of confidentiality and data protection. Most ED charities rely on short-term funding and finite resources, and, in many cases, without the effective and remotely accessible digitized systems to be able to store information and to ensure end-to-end encryption to ensure confidentiality comparable to the public sector (e.g., NHS). This continues to be a challenge, not only from the point of view of the service user, but also from the viewpoint of the commitment required in resourcing staff to work remotely (e.g., equipment and training). Despite these challenges, all participants reported that their service was committed to continuing to provide an online service as a complement to face-to-face services in future. In many cases remote platforms have in fact enabled small charities to expand their services at negligible cost.

The impact of public health messaging and the increase in the demand for acute NHS services meant that the services represented were faced with providing support for individuals in a way that their service was not designed for. They found that they were ‘holding’ more acutely unwell

individuals who had nowhere else to go, and some participants reported that they had to make difficult decisions to temporarily suspend intake of new referrals. This will arguably continue to be a challenge for the NFP sector, who will be further relied upon against a backdrop of the squeezing of the public purse and reduction of services within the NHS [16–18, 20]. It is worth noting that the organisations within our study expressed an appetite to build on existing relationships with local NHS and public sector services, and future online resources arguably have the potential for improvement and coherency of overlapping services. Our participants shared a cautious optimism about online resources as potential tools to work collaboratively and more effectively with the NHS and public sector. Future research should investigate ways to promote and develop more coherent, efficient service delivery. This would take time and has so far not been helped by the pressures of the pandemic, but the digital resources now widely available may provide future opportunities.

There were limitations to the study. It was a small sample size lacking in diversity. We wish to encourage the inclusion of minority and/or underrepresented groups in future research. The data does not reflect those individuals who could not, who did not, make use of online support during the pandemic. The need may have been much greater than is currently understood, and barriers may have been more substantial than illustrated in this study.

There is scope to further consider the comparable experiences of the NFP sector at both regional and national levels, considering the varied regional responses to the challenges posed by the pandemic and the opportunities presented by remote and online support. It also is important to consider the NFP sector in thinking about how to develop and deliver accessible and cost-effective interventions going forward.

5. Conclusion

NFP ED support organisations have faced unprecedented challenges in the transition to, and the provision of, remote and online support for their service users during the pandemic. The ability to transition has been hampered by finite resources including staff capacity and financial constraints, combined with limited guidance on how to manage the change to an online service.

Nonetheless, the professionals and peer support providers interviewed reported that, despite the challenges, online platforms enabled their services to continue during the pandemic and, in some cases, they were able to support a greater number of individuals at minimal cost.

A systematic approach is recommended to investigate the experiences of the role of NFP ED organisations in adapting to digital and online working environments during the COVID-19, and to examine the gaps in provision and good practice approaches of collaboration with the statutory sector, most notably the NHS. This is with a view to exploring potential future interventions for online and remote ED support.

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Acknowledgements

This research is funded by the Medical Research Foundation [MRF-058-0016-F-BRAN-C0868].

PRE PRINT

Appendix

Interview Questions

RHED-C: Preliminary interviews with service users

Thank you for taking the time today to speak to us.

During this interview we will ask some questions about:

- What for you have been the benefits and challenges of accessing remote or online support during the COVID-19 pandemic
- The reasons why the support was important for you
- The impact of the pandemic on your wellbeing and social connections
- What would your views be about the remote health care of the future

The interview will ask questions about both eating disorders and the pandemic. You are free to pass on any questions you do not wish to answer, and we can take a break at any time.

This interview will take approximately 45 minutes. It will be recorded for transcription purposes only. The interview will be erased once it is transcribed.

All interviews will be anonymised, and data will be treated in the strictest of confidence in line with data protection legislation and ethical guidance from Northumbria University

Thank you for completing and returning the consent form prior to this interview.

Do you have any further questions?

Do you give your consent to proceed with the interview today? *(If yes, press record and ask participant to confirm their consent at the start of the interview, if not, thank them for their time, do not press record and close the meeting).*

Section A: Key challenges and benefits of receiving remote healthcare

Q1. What remote / online support specifically related to eating disorder support services have you accessed since the pandemic began?

Q2: What digital platforms has this support been provided through? *(Prompts if needed – Zoom, Teams, WhatsApp etc.)*

Q3. How long did it take for you to access this online / remote support? Was it before, immediately after or sometime after the first UK lockdown of March 2020?

Q4. How did you come to, or decide to, access the support at this point? *(Prompts if needed – the availability of the support, I was ready for the support etc.)*

Q5. What was accessing this digital / remote support like for you in *practical* terms? *(Prompts if needed – access to a computer or device, ensuring privacy at home etc.)*

Q6. What for you have been the main advantages of the digital / remote support you have received?

Q7. What for you have been the challenges of receiving digital / remote support?

Section B: Key times when support was particularly needed

Q8. Were there peak *moments* during the pandemic when you really needed support? If so, when were these key points? (*Prompts if needed – first major lockdown, introduction to Govt ‘Eat out to help out’ scheme etc.*)

Q9. How easy or difficult was it for you to access remote / digital support at these peak times

Section C: Reflecting on how the pandemic impacted on my wellbeing and support circles

Q10. What were the key *aspects* of the pandemic that were particularly challenging for you? (*Prompts if needed – changes to daily routine, social isolation, food choice restrictions due to panic buying etc.*)

Q11. How did the pandemic impact on any additional support that you had (e.g., seeing family, friends, colleagues, mental health support services etc.)?

Q12. Were there specific strategies or coping mechanisms that you developed to deal with the adverse effects of the pandemic? If so, what were they? (*Prompts if needed - staying in touch with family on Zoom, mindfulness activities, meal sharing online etc.*)

Section D: Thoughts about remote healthcare of the future

Q13. Thinking about the digital platforms you have received support on is there anything that you think could improve its usability? (*Prompts if needed – easier to use chat function, not having camera switched on as default etc.*)

Q14. Would you accept remote / digital support again in future? Please explain your answer.

Q15. If you could offer general feedback to the organisation(s) that have offered you remote support during this time, what would you say?

RHED-C: Preliminary interviews with service providers

Thank you for taking the time today to speak to us.

During this interview we will ask some questions about:

- What have been the positives and negatives of remote healthcare during the COVID-19 pandemic
- Identifying when support was particularly needed
- The impact of the pandemic on your service user's wellbeing and social connections
- What your organisations views would be about the remote health care of the future

This interview will take approximately 45 minutes. It will be recorded for transcription purposes only. The interview will be erased once it is transcribed.

Thank you for completing and returning the consent form prior to this interview.

Do you have any further questions?

Do you give your consent to proceed with the interview today? *(If yes, press record and ask participant to confirm their consent at the start of the interview, if not, thank them for their time, do not press record and close the meeting).*

Section A: Key challenges and benefits of providing remote healthcare

Q1. Can you give a brief overview of the online support your organisation has been providing for your service users since the pandemic began?

Q2: What were the reasons that led your organisation to decide to select the digital / remote platforms that you use? *(Prompts if needed - e.g., affordability, accessibility for clients etc.)*

Q3. How long did it take for your organisation to decide to provide remote support? Was it before, immediately after or sometime after the first UK lockdown of March 2020? What were the factors that contributed to this decision?

Q4. What was transitioning to remote support like for your organisation in *practical* terms? *(Prompts if needed – capacity, digital skills set within the staff team, managing key priorities etc.)*

Q5. What for your organisation have been the main advantages of the remote support you have provided?

Q6. What for your organisation have been the key challenges of providing remote support?

Section B: Key times when support was particularly needed

Q7. Were there key points during the pandemic when you saw an increase in the need for your service? If so, when and what were these key points? *(Prompts if needed – first major lockdown, introduction to Govt ‘Eat out to help out’ scheme etc.)*

Q8. Were there key points during the pandemic that affected people with different eating disorders in diverse ways? If so, what were those key points and what support did people with varying diagnoses or presenting certain symptoms need? *(Example prompt if needed – did people with bulimia nervosa need support at contrasting times to people struggling with binge eating?)*

Q9. To what extent did the remote / digital platforms you chose help your organisation to provide the support that was needed at the time?

Q10. What were the limitations of the support your organisation was able to provide remote at the time?

Section C: Reflecting on how the pandemic impacted on service user's wellbeing and support circles

Q11. What were the key aspects of the pandemic that were particularly challenging for your service users? *(Prompts if needed – changes to daily routine, social isolation, food choice restrictions due to panic buying etc.)*

Q12. How did the pandemic impact on service users' mental wellbeing more generally?

Q13. How did the pandemic impact on any additional support that service users had (both additional professional and personal)?

Q14. Were there examples of specific strategies or coping mechanisms that service users themselves produced to deal with the adverse effects of the pandemic? If so, what were they? *(Prompts if needed - staying in touch with family on Zoom, mindfulness activities, meal sharing online etc.)*

Section D: Thoughts about remote healthcare of the future

Q15. Thinking about the digital platforms your organisation has been using, is there anything that you think could improve the platform from the point of view of both yourselves and your clients / service users? *(Prompts if needed – easier to use chat function, not having camera switched on as default etc. Also, do you intend to continue with the original platforms used so far or are you looking at other or additional options going forward?)*

Q16. Will your organisation continue to offer remote support? Please explain your answer.

Q17. Are there any more general improvements would you or your organisation like to see in the delivery of remote healthcare services for eating disorders or eating distress?