Saskatchewan Health Authority

Final Report

Formative evaluation of virtual care in Youth Mental Health and Addiction Services in Saskatoon

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Saskatoon

Executive summary

The COVID pandemic accelerated the shift towards virtual delivery of mental health care in an effort to minimize disruption to care and meet the growing demand for services in the youth population. Funding was mobilized through a virtual care innovation (VIC) grant from Frayme to support an evaluation of client and clinician experiences using new modalities for virtual delivery of mental health therapies. This evaluation is intended to inform priorities for interventions to improve client outcomes and care experiences.

A sequential mixed method design integrated clinician interviews with focus groups with clients and families, and an online client survey. Qualitative data were collected through 11 clinician interviews and four focus groups with clients and families. An invitation including a link to the online survey was sent via text message to all active client contact numbers. One hundred and sixteen responses were received for a response rate of 31%.

Highlights

- Virtual care was perceived as convenient but less effective than in-person care.
- Virtual delivery is a viable future option for some clients as part of a client centered approach to therapy selection that best meets client needs.
- Clinicians need increased training related to virtual delivery of specific therapies to improve their effectiveness.

Overall, virtual care was seen as a way to minimize disruption to care. Neither clients nor clinicians perceived it as a replacement for in-person care; however, it was thought to be a useful alternative when clinically appropriate. Among survey participants, the most common mode used to communicate with counselors was the telephone (72.1%), followed by texting (44.1%), Pexip (40.5%) and email (15.3%). Both counselors and clients valued the ability to see each other's faces during sessions. Clients and families expressed interest in user-friendly video conferencing options to maximize benefits. Virtual visits were attractive for several reasons, including increased access to counselling support, convenience of care, greater flexibility of scheduling appointments, and time savings. The comfort of a familiar space enhanced self-disclosure and openness for some clients. Both clinicians and clients reported better adherence to appointments and fewer cancellations. Clinicians valued the opportunities to observe and work through issues with clients in real settings than would otherwise not be possible. For some clients, virtual visits reduced psychological barriers such as stigma that prevent persons from seeking care.

Despite the advantages of virtual care, several challenges were also encountered. Distractions in clients' surroundings and lack of availability of a private space were common barriers. With virtual appointments, some clients found it easier not to attend appointments. Poor access to reliable internet also limited client options for receiving virtual care. Some clients and clinicians also experienced technological issues with connection to virtual platforms. Clinicians found it difficult to adapt some therapeutic approaches for virtual delivery; as a result, virtual care was not clinically appropriate for all clients. The quality of the client-counselor relationship was sometimes reduced for clients with virtual delivery as some new clients found it difficult to establish rapport and build trust in virtual settings. Other clients felt that clinicians underestimated the severity of their condition or did not intervene when clients deflected attention from difficult issues.

Virtual care worked best when clinically appropriate, when it was the client's preferred option and both clients and clinicians had the appropriate platform conducive to a positive therapeutic experience. It was suggested that initial interactions occur in-person to initiate rapport and allay client and family concerns. It was also helpful for clinicians to be more intentional in their communication strategies and to invest time in explaining the differences between in-person and virtual interactions and any implications this might have for building trusting relationships. Clinicians should be aware of key challenges that can undermine virtual therapy such as distractions, privacy, difficulty with expressing feelings and perceptions of interactions as optional because of their more informal nature. More guidance and training is needed for clinicians who work with specific clinical problems and therapies in virtual adaptation to improve confidence and effectiveness. There is also a need to improve access to virtual mental health care for vulnerable youth who may be disproportionately affected by barriers.

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Acknowledgements

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Funding for the project was provided through the Virtual Innovations in Care (VIC) Grant from Frayme. We greatly appreciate their support to implement the project.

Formative Evaluation of Virtual Care in Youth Mental Health and Addiction Services

1. Background

The COVID-19 pandemic has transformed the mental health care field. Concurrent with the infectious disease pandemic, a parallel mental health pandemic occurred due to disruptions in mental health care, business and school closures, loss of employment, restrictions on social gatherings, mandatory quarantine measures and a high degree of uncertainty about the future (Sullivan et al., 2020). For instance, one online survey study of 1803 Canadians found that self-reported depression had more than doubled (from 4% to 20%) and severe anxiety had more than quadrupled (from 5% to 20%) since the onset of the COVID-19 pandemic (Dozois et al., 2020). Research suggests that the loss of social connection, personal freedoms and economic livelihoods have led to rising rates of depression (Dozois et al., 2020; Ettmsn et al., 2020). Similarly, rates of anxiety have risen due to fears of transmission, a lack of clear public health guidelines, and less reliable media sources that have heightened confusion and fearmongering (Brooks et al., 2020; Liu et al., 2020).

Research has also shown that the COVID-19 pandemic has led to wide ranging consequences for the mental health of youth. At an individual level, youth have lost the activities that provide structure, meaning, and purpose, such as school, work, peer interactions, extracurricular activities and physical activity (Courtney et al., 2020). Additionally, youth online schooling challenges, such as technological challenges, the struggle to understand learning materials and inability to ask for guidance from teachers, have been associated with an increased risk of depressive symptoms (Magson et al., 2020). Moreover, it may be more difficult for youth to cope with these losses since they rely more on peer connections for emotional support than other age groups (Magson et al., 2020). Importantly, parents are experiencing their own stresses, such as job losses, deaths of loved ones, worsening of their own mental health and substance use, which reduces their ability to buffer their children's stress (Brown et al., 2020). These factors increase the likelihood of poor mental health among youth during the COVID-19 pandemic and may lead to enduring emotional consequences later in life (Wade et al., 2020).

It is important to note that youth from low socioeconomic backgrounds are at the greatest risk of worsening mental health during the COVID-19 pandemic. For instance, youth who are under the care of social services tend to report more mental health risks as well as increased risk of COVID-19 infection due to crowded living conditions (Rosenthal et al., 2020). Additionally, vulnerable youth living with family are at an increased risk of being exposed to domestic violence during the pandemic (Gunnell et al., 2020; Chandan et al., 2020). School closures have meant that vulnerable youth no longer have access to regular school meals, supportive adults, a physically safe environment, referrals to support services and mandatory reporting to child protection services (Dooley et al., 2015). Given that comorbid trauma significantly worsens the prognosis of other mental health disorders (Mauritz et al., 2013), the pandemic is likely to exacerbate existing mental health disorders among vulnerable youth.

In order to maintain mental health services for youth during the pandemic, mental health systems and service providers quickly transitioned to providing virtual mental health care. In April 2020, the Saskatchewan Health Authority (SHA) Youth Mental Health and Addiction Services (YMHAS) Department implemented virtual services using online platforms such as Pexip, phone calls and text messaging to maintain mental health and addiction services for youth aged 12 to 18 years and their families. While there is a large body of research on virtual models of service delivery, the speed of the COVID-19 pandemic did not allow YMHAS to develop evidence-based virtual service delivery models or implement virtual services according to the implementation science literature (Damschroder et al., 2009). As a new SHA initiative, it is essential to understand the experiences of clients, families and clinicians with virtual care to identify benefits, challenges and opportunities to enhance care delivery. Similarly, input is required to determine how to integrate virtual services with traditional care to deliver evidence-based client centered care. Therefore, the purpose of this evaluation was to examine the experiences of clients, clinicians and families with new methods of virtual mental health care delivery models in YMHAS.

2. Evaluation aims

The aims of the evaluation are as follows:

1. To examine client and family experiences, benefits, and challenges of virtual youth MH&A care
2. To examine clinician experiences, benefits, and challenges with providing virtual youth MH&A care
3. To identify and provide recommendations for future implementation of virtual youth MH&A care

2.1. Evaluation Matrix

The Evaluation Matrix below outlines key evaluation questions, indicators and anticipated data sources.

Evaluation Questions	Indicators	Data Sources
Aim #1		
What challenges do clients face with virtual care? (e.g., accessibility, relationship building, etc.) What benefits do clients find with virtual care? Does virtual care enhance or limit the accessibility of mental health care (e.g., location, technology, etc.)?	Self-reported challenges of virtual care. Self-reported benefits of virtual care. Self-reported accessibility, benefits, and challenges. # Appointments attended and missed.	Client Survey Client/family Focus groups YMHAS records

Evaluation Questions	Indicators	Data Sources
Does virtual care change the therapeutic relationship between clients and clinicians? Does virtual care reduce stigma when seeking mental health care?	Self-reported quality of therapeutic relationship (comparison with face-to-face interactions). Self-reported feelings of stigma towards seeking virtual versus in-person MH&A care.	
Aim #2		
What challenges do clinicians face with providing virtual care? (e.g., relationship-building, etc.) What benefits do clinicians find with virtual care? Does virtual care enhance or limit the accessibility of mental health care? Does virtual care change the therapeutic relationship between clients and clinicians? Does virtual care change the delivery of mental health therapies?	Self-reported challenges of virtual care. Self-reported benefits of virtual care. Self-reported accessibility benefits and challenges. Self-reported quality of therapeutic relationship (comparison with face-to-face interactions). Self-reported adaptations in the delivery of therapeutic methods.	Clinician Interviews
Aim #3		
For which client groups does virtual care work better? (i.e. age group, income, etc.) For which types of mental health therapies is virtual care appropriate? What are client, family and clinician recommendations for the future implementation of virtual mental health care? What training do clinicians feel would be necessary to provide virtual care in the future (e.g.., Pexip)?	Identification of appropriate client groups for virtual care Identification of the types of therapies (i.e. CBT, DBT, EMDR) for which virtual care is appropriate Recommendations for improved virtual MH&A care delivery. Identification of future training needs	Client Survey Client/family Focus groups Clinician interviews

Evaluation Questions	Indicators	Data Sources
What are the best (i.e. reliability, ease of use, time saving) platforms for delivering virtual care (e.g., Pexip, FaceTime, texting)?	Identification of most suitable platforms for delivering virtual care	
What is the preferred format of MH&A care? i. Only face to face care ii. Only virtual care iii. Combination of face-to-face and virtual care	Identification of preferred format of MH&A care	

3. Program Overview of Youth Mental Health and Addiction Services

Youth Mental Health and Addiction Services (YMHAS) provides integrated team-based mental health and addiction services for youth and their families. Services are offered through the Saskatchewan Health Authority in Saskatoon and are both office and community based. Services for youth and parents/caregivers address mental health and substance use problems, using individual, family and group formats. Youth outreach staff provide crisis and support to youth who are marginalized, racialized, and facing difficult life circumstances. Inter-disciplinary services are offered by social workers, psychologists, addiction workers, recreation therapists, nurses, and a dietitian. Youth clients aged 12-18 and their families, from across the socio-economic continuum can access services through a range of entry points. Clients can self-refer or be linked to service through primary health or education. Partnerships with settlement agencies and youth-based organizations and agencies that support homeless youth and those involved in street culture give youth direct access to YMHAS services.

4. Methods

4.1 Evaluation design

A mixed methods research methodology was used to gather in-depth information about client, family and clinician experiences of mental health and addiction (MH&A) virtual care. Qualitative and quantitative data were collected using a sequential exploratory research design. In the first phase, interview and focus group discussions with clinicians and clients respectively were used to understand touchpoints of participants' experience with delivery and receipt of virtual mental health care. This method was particularly useful as the service was newly introduced during COVID and fits well with a developmental approach to researching virtual mental health care. The qualitative data was also used to develop a local theory about how and when virtual

delivery of mental health care might work best. In the second phase, a survey was developed based on the qualitative findings from the first phase of the project. The survey was distributed to all clients and families who accessed services through YHMAS during the period when virtual services were offered.

4.2. Evaluation Team & Advisory Committee

An Evaluation Team consisting of personnel from the SHA Research Department was responsible for carrying out the evaluation. An Advisory Committee was established, consisting of five patient-family partners (PFPs), the SHA Patient and Family Centred Care (PFCC) Lead Specialist for Saskatoon, as well as the YMHAS manager. Patient-family partners were recruited through the Saskatoon Youth Mental Health and Addictions Advisory Council (SYMHAAC) and through outreach to interview and focus group participants. The PFPs received appropriate orientation and support to participate as partners in the evaluation. This committee provided guidance about the evaluation design and advised on issues such as focus group logistics and activities, survey instrument development and administration, and knowledge translation strategies.

4.3. Participants

4.3.1. Clinicians

All clinical staff who work directly with clients to provide virtual MH&A care were invited by email to participate in one-on-one interviews. Information was also provided about the project at a staff meeting where any concerns could be addressed directly by members of the evaluation team.

4.3.2. Clients

Clients from all three programming areas (i.e. Mental Health & Addictions, Addiction Treatment, and Outreach) were invited to participate in virtual focus group discussions. Eligible clients included those aged 14 years and older who have received at least three virtual care encounters. The program contacted eligible clients and families by telephone; if they expressed an interest in participating in a focus group discussion, they were scheduled in an available time slot. The evaluation team sent out emails or texts with the link or information to connect to the virtual discussion. There were two focus groups with clients from general Mental Health and Addiction services and one for youth receiving outreach services. The latter discussion included less than three participants as it posed greater recruitment challenges. A single focus group was conducted with parents of clients who received virtual mental health services.

4.4. Data Collection & Analysis

4.4.1. Interviews and Focus Group Discussions

In-depth, semi-structured interviews and focus group discussions were conducted to learn about participant experiences with service delivery as well as recommendations about how to improve the delivery of youth MH&A virtual care. Questions included in interview and focus group guides were developed in collaboration with patient-family partners (PFPs). A consent form with information about the study was provided to participants. All interviews and focus groups were conducted virtually via WebEx or telephone. Interviews

lasted 20-60 minutes and group discussions lasted 45 to 95 minutes depending on the group, and were audio recorded for transcription by a third party university vendor.

A randomized sample of clients and their family members were recruited to participate in one of four focus-group discussions. A dual informed parental consent and youth assent process was observed. Prospective participants received information in writing as well as verbally at the beginning of each focus group. Each group discussion was conducted by a two-member team composed of a facilitator and note taker. Group size was limited to 10 to reduce participant competition for the opportunity to comment during the session. In some instances, participants connected by telephone while others engaged using video conferencing functionality of the platform. Although it was desirable to be able to see participants to fully appreciate affective nuances of visual cues, they could choose whether to turn their camera on. Additionally, participants had the opportunity to privately share information using the chat function with any of the evaluators. Some groups had more cohesive group dynamics as they found commonality in the need to seek mental health services.

NVivo software was used to manage and assist with analysis of qualitative data (i.e. transcripts and notes). A deductive approach was applied with creation of a coding framework based on research questions and existing literature. Two independent coders applied the framework to the entire corpus of text after familiarization with transcripts. The codes were reviewed to identify patterns and themes that convey meaning of the data based on manifest content. Team members worked together to describe the context of all themes. Exemplary quotes were used to illuminate core aspects contained within named themes. Crosschecking ensured that themes were based on evidence within the data and represent the participants' accounts of their experiences.

4.4.2. Surveys

The online survey instrument was developed by the research team using the qualitative results in phase I to inform the selection of items and scales. The advisory committee provided feedback about the questionnaire including content, flow and ease of understanding by the target population. Once the questions were finalized, the survey was uploaded to the online platform of REDCap and pre-tested by peers to ensure that survey formats functioned as expected. An invitation including a link to the survey was sent as a text message to all active client contact numbers. All participants were given the opportunity to receive an incentive ($20 gift card) for completion of the survey. The survey included Likert-scale and open-ended questions to gather information on client experiences and recommendations for virtual care. Survey data were exported to SPSS for coding and analysis. Descriptive statistics such as frequencies and percentages were used to summarize participant responses. Where sample sizes were adequate additional inferential statistics were performed to assess associations between sociodemographic characteristics and perceptions or experiences with virtual care. Open-ended survey responses were analyzed using content analysis.

Qualitative and quantitative data were integrated during data analysis to draw inferences from both types of data that related to the same research questions. We also considered where findings corroborated each other or offered contradictions. The local theory of how virtual delivery of mental health care might contribute to positive or negative care experiences was based mostly on qualitative data.

4.4.3. Program Theory

As virtual care delivery is a part of the YMHAS program and not a program in itself, it was more difficult to create a program theory around this. However, we created a series of *if-then-because* statements to summarize different aspects of the context around virtual care, the underlying mechanisms that lead to successful or less successful virtual care, and the outcomes arising from each scenario. These are contained within the Results section and are helpful in pinpointing issues that underpin success as well as those that require further attention.

5. Results

Twenty (20) youth clients participated in focus group discussions. Eleven (55%) participants were female. All parents who attended focus groups discussions self-identified as female. Several parents described complex mental health needs of their children and the majority had been engaged with youth mental health and addiction services prior to the pandemic. A total of 11 clinical staff members agreed to be interviewed including Psychologists, Social Workers, Addiction Counsellors, Youth Outreach Workers, and Recreational Therapists. While several clinicians reported that they were new to their role at the beginning of the pandemic, most had previously held positions with YMHAS. Additionally, many clinicians reported they had previous experience within the mental health field. The findings have been organized by broad themes based on research objectives and questions.

5.1 Client Focus Group and Interview Results

5.1.1 Virtual Care Platforms

Many people found the telephone and texting to be convenient ways to communicate with their counselors. FaceTime was used in the early stages of the pandemic until it was deemed to have security flaws and usage disallowed. However, it should be noted that clients liked the video chat option of FaceTime. Pexip was the official video platform approved for clinical use by the SHA. Nevertheless, not many people had used Pexip and those who had used it did not have good experiences with it as they found it created lags and glitches. People generally preferred a platform that allowed for video options as they felt it was beneficial to see the other person's facial expression. Another convenient option for parents in particular was email, as they liked the ability to read communications from the counselor and respond in their own time as well as keep a record of interactions.

5.1.2 Benefits of Virtual Care

Accessible and convenient care

Virtual care was often seen as quick, easy to access, and helpful for regular check-in sessions or fast contact in a situation that requires a rapid response. Having the option of virtual care meant that clients had someone to talk to who cared about how they were coping and dealing with their situations.

> *"I was able to talk to her more on things that I was absolutely needing someone. If I needed to I could just send a text and she'd be like, "Yes, I have 30-minutes, I'll call you," and stuff like that. That was really nice to have."*

> *"So my son, he just came down and he said that the best part is having somebody, especially during all this time, checking up and being consistent. And so it's been a really good positive that even during all this that everybody switched and made it professional, and made it comfortable – especially for kids, teenagers. And in a crazy time, to make them feel like somebody's there taking care of them, right? So just a thumbs up!"*

Some clients appreciated the convenience of virtual care as there was less travel time and less disruption to their day.

> *"At the time when they were opening it back up so we could do in-person sessions, we actually chose to just stay at home. Again, for my son, he just really seemed to connect really well with our counsellor through his iPad. So, for myself, kind of a little bit selfishly, as a parent, there's no travel time. So there's less time pulling him out from school, so he'd just run home from school and he'd have his session. But also for coordinating for me and work and everything else, I felt like it took a little bit less away from our schedules. So that was, I think, an advantage for us, in that respect."*

Flexibility of virtual care

Appointment availability became more flexible with virtual care and clients were more able to choose a time convenient to them. Some felt that virtual appointments were easier to keep when circumstances would otherwise have led to cancellation of in-person appointments.

> *"One of the problems we had was getting [my son] to go to the appointments. So it was like a screaming battle, forcing him in the car. Whereas if I could message her, you know what I mean, an hour before my appointment, and be like, "Hey, can we do this virtually, he's just not having it today," that would've been a really great option. We've missed tons of appointments and wasted time. Or by the time we got there he's just so flustered he doesn't even want to talk anymore, right?"*

Comfort of a familiar space

Some people felt more comfortable being in their own space while speaking to their counselor without the pressure of in-person communication.

> *"I think [my son] preferred texting and calling, just because he's at that age where, "I don't want to look at anybody," you know what I mean? Hair in the face, 'don't talk to me kinda thing.' So I really feel like that was beneficial."*

Some also found that virtual care helped to relieve the anxiety created by talking to another person or talking about certain issues.

> *"I like virtual better 'cause when I'm talking about sensitive things I get embarrassed and don't like being seen when that happens."*

> *"It definitely makes me feel more confident to talk to people over the phone than it is to be in person, 'cause I do get anxiety about talking to people in person."*

Increase client autonomy and control

Attending a virtual appointment also took pressure off some youth as their parents were not as involved in their care through taking them to in-person appointments.

> *"One thing was that I kind of liked about being at home, is that I always felt so awkward and uncomfortable when my parents would drive me back to school or back home from counselling sessions,*

because they would kind of try to read me, and be like, "Was it bad, was that good?" There's some days where I have really bad [issues], and I'll be like, "Can I go home? And they'll kind of be like, "Oh, did you have a bad day? Was it bad? What did you guys talk about?" And it wasn't- I don't know. It's easier to avoid my mom taking me to stuff like that, because they really try to grill me, "what were you talking about?" There's a reason I'm talking to someone else and not you! So there was that one pro."

Increased clinician understanding of client context

Some clients used their virtual appointments to bring counselors into their world and to help counselors understand their experiences.

"I think one of the positives was, for my son and his counsellor, is that I think in certain times it helps them connect on a more personal level. So whatever her homework was from the preceding session, instead of then having to write about it or talk about it, he would literally grab the iPad and then use the camera to facilitate, "This is what I did and this is how it made me feel." So it was, just again, it was something that you would never be able to experience sitting in an office."

Removal of some communication barriers

The Public Health requirement to wear a mask to an appointment was difficult for some clients. In this case, virtual care was seen as preferential.

The mask wearing in the beginning was a very difficult thing. My oldest son, he has sensory issues big time, and it took him a very long time to be comfortable in a mask. And the beginning of school was very, very hard. And if you were asking this question then, I would say yes, these online and virtual would be preferable to him wearing a mask.

Helps parents with record keeping

Some parents liked the fact that they now had a record of their interactions with the counselor that they could look at when they needed reminders of what had been discussed. Email exchanges meant that parents did not have to make their own notes of interactions and could ask questions as they needed.

"This has given us an opportunity- I email with the psychologist now, and that is something I've never been able to do before…Because then I can look at it in my own time and we can communicate. You know what I mean? And she responds when she needs to respond, and I can respond when I need to respond. But we're still on the same page and I feel like I'm learning more about what is happening in the sessions with the email than I did before."

5.1.3 Challenges of Virtual Care

Privacy not always available

Privacy was a big issue for many people. Family members were often at home during appointments and it was difficult to find a quiet place where they were able to talk freely.

> *"But I feel like another downside is my family is right behind my wall, and they were there this whole time, and that's where they always are right behind that wall pretty much. Walls aren't that thick, so when you're trying to talk about your family, that might backfire pretty dang hard."*

Virtual care not appropriate in some cases

Virtual care was not seen as beneficial for some mental health disorders. In addition, leaving the house to go to an appointment was seen as part of the exposure therapy as it gave a chance to develop coping skills and learning how to manage anxiety-provoking situations.

> *"But the accessibility wasn't there for my son who struggles with phone conversations, struggles with social interactions, it's all a part of his diagnoses, and these platforms simply don't do it at all for him. We had to go to the store to get a candy or treat every time he went for his appointments pre-COVID. And we got him out of the house, he had to socialize with people, got to a store, got to buy candy. And this is a child who doesn't leave the house. And so that was extremely beneficial to be leaving the house. Not having that has been a huge backwards step for us, for him. So the access to services isn't the same depending on your problems, your diagnoses, however you want to state those words."*

Virtual care sometimes created barriers for keeping appointments

Some clients felt that virtual appointments somehow became more of an option and were easier to decline or avoid than in-person appointments.

> *"Because I had a really heavy course load…So having to- They were just like, "Find a place in the school and just go, and your call." I was like, I had this anxiety about leaving class. [I had anxiety] with counselling as well. But when it's over the phone somehow it felt more optional. So that's how I ended up ghosting my counsellor."*

Distractions in the environment

Some youth felt they were more easily distracted by the things around them or they could ignore what the counselor was saying when they were not in the same room.

> *"Just, I guess, back to the distraction part of it…Because I need to keep my hands busy. But I would draw or do something while I was on the phone. Which isn't an issue for my attention, really. But it made my brain kind of wander…And then I would be like, "Oh, I forget what you were just saying. I don't know what you just said." In one ear, out the other. Like, I'm doing something else where, versus being in-person, again, gotta sit with the person, so talk and listen. Which is more beneficial for me, I think, to be in that space. Where it's like, this is time to talk, we're gonna talk and we're gonna try to sort things out. Kinda stuff like that rather than over the phone I can be, I dunno, like baking…I found that I kind of*

would lose focus. So that was kind of difficult just in the sense that I felt like it was a lot of repetition because I'd get sidetracked."

Additionally, some youth felt that it was easier to divert attention away from their issues during a virtual session if they did not want to discuss it. They felt they were more able to channel the discussion to less threatening topics or to be less honest about their feelings or what was happening in their lives.

> *"For me, when I would have to do the online, the calls, it was really easy for me to fake a lot of things. So it wasn't easy having the online calls. I think what was in my best interest was to have an in-person meeting."*

> *"I think, sometimes it feels too much just like a conversation. Which is sometimes nice. Sometimes I do just want to have a conversation and causally let it flow. So I don't think it's a bad thing. But I think that sometimes there needs to be a little bit of, "Okay, no. Let's talk about this. Let's get back to this." It's a little bit more… I guess not strict, but let's talk about what we need to talk about, let's not talk about cats for a half-hour. You know, 'cause I think a lot of the times with getting distracted and stuff, it was, I don't want to talk about this, so again, was just easier to do over the phone. So I think having a little bit more, 'Well no, let's continue on this topic. We're getting off topic,' just getting back to where we were talking about what we were talking about would be a little bit more helpful."*

Easier to deflect from discussing difficult issues

However, although youth felt that they were able to divert attention away from their issues and be less honest about things during virtual care sessions, they did not like this and wanted to be held to account.

> *"I feel like always in-person is better, just 'cause I feel like in-person they can also read you better, in a sense. Like I know with my mom, when I'm-over the phone with her, well it's bad that I say this, but I could lie to her really easily and she wouldn't be able to tell. Whereas if I was face-to-face with her, she can tell."*

> *"So for me, when we would do my virtual meetings, they would just trust me when I'd say, "My weight is this," and I could fake my weigh ins. So I think knowing the boundary between trusting me versus actually having to get my parents to confirm it, I think that having that say in it too. So getting a parent to confirm some things, or stuff like that, I think that's a lot better than just trusting me, because I didn't say the right things."*

Virtual care interferes with quality of assessment of severity

Some youth felt that counselors did not understand the severity of their situation with virtual care. Issues were underestimated or not addressed during sessions and clients felt they did not receive the care they needed at the time.

> *"I don't think it met my needs at all. And I know my counsellor's trying her best, and everyone around me is trying their best. But I'm worse now mentally than I was before all this started. And it's like, to the seriousness thing, I would say something quite-I was trying to bring up to my counsellor something quite bad that I was thinking of, having some bad thoughts, and it was just so easy for her to run away*

to a different topic, it never got dealt with. You know, it's so easy to tiptoe around things that would be hard to talk about over the phone, in-person."

"It was really easy for me to fake a lot of things. So I wasn't getting the help that I needed at first, until it was life-threatening. So kinda doing the online meetings, they didn't really see the seriousness of what was going on. So I don't think that the virtual meetings really met my needs."

Virtual care perceived as less effective than in-person care

Most clients felt that virtual care had not met their needs or provided the same benefits as in-person care.

"Counselling for me, when I went in-person it was crazy emotional; it was really intense. And after it felt so refreshing. And it literally felt like after you're done a cold and your sinuses are cleared. And it sucks 'cause I have never felt that way during online. And I just feel like when I leave [virtual care], I'm not really left with that great feeling anymore."

Virtual care may reinforce social isolation

An issue of concern is that for some, virtual care had even contributed to the feeling of being alone and cut off from other people.

"I know this is supposed to be the positives or whatever, but someone like me, there's nothing positive about any of this to me in the virtual care, the virtual learning or anything. I'm in full-time online school. And personally, I think just the different problems and issues that I have, I rely on other people's presence and being social for my own happiness. And so doing this online and all that, and not being able to see anything, I just find myself always saying, "It's okay, I don't need to talk. It's fine." And then I'm just in there by myself, and then you start lying and then it gets tough."

5.1.4 Client-Counselor Relationships

More difficult to establish trusting relationships

Some clients felt that it was difficult to create a trusting relationship with their counselor when they had not met together in person. They felt that it was difficult to know what the counselor was thinking and how they were responding to what the client was saying without being able to see their facial expressions and body language.

P: "I had just started counselling a couple weeks before the school shutdown. And it's not through the school, but my counsellor would travel to the school, and I only got that once, and then everything shutdown. So I just met her and then didn't really get to see if I'm able to trust her, and see if she's okay with me. And then it went to straight to online. And then in the back of my head, on the phone, like, is this girl annoyed, is she rolling her eyes at me? What's going on? So I don't know. It's like a trust factor."

I: "Yeah. You want to feel that somebody's taking what you're saying when you're being really vulnerable, they're being careful with that. And you trust them with that."

P: "Yeah… But it's better in person, and you can feel their energy and how they're reacting. And over the phone it's like you don't know. You're just left with this big gap which you wish you could fill, but you can't."

Some people felt that having at least one in-person session greatly helped to build or maintain a therapeutic relationship with their counselor. It was generally felt to be more difficult when they had to begin interactions virtually. Some clients also found it difficult to overcome the logistical issues of coordinating virtual care.

> *"[My daughter] just gave up on it. There was a miscommunication with phone calls, and then calling people back, and then just talking to somebody she didn't know. And she didn't form a relationship with them. And then they tried FaceTiming, and she just wasn't getting what she needed from it, and so she ended up quitting."*

Counselor characteristics are important

However, some clients also noted that the success of virtual care greatly depends on the connection the counselor has with the client and the way they facilitated the session.

> *"We were originally assigned with someone. And actually that first time was just by phone, a few times by speakerphone, and I think it was more individual based because the next session was still virtual, although it was face-to-face, but was with a different counsellor and it was completely different. So I don't think it was necessarily because it was virtual. So we had some great virtual experiences and really negative ones. And I don't know if it was necessarily the platform, I think it was more the connection with the individual."*

5.1.5 Stigma

There were mixed responses when asked whether virtual care had reduced the stigma often associated with accessing mental health care. Some felt that mental health was discussed more now due to the COVID-19 pandemic, which had brought the issue more into the open and reduced the stigma surrounding it.

> *"With COVID too, a lot of people dropped out of going to counselling just because everyone was getting locked inside. So it became a lot less stigmatized to go to counselling or have counselling during the lockdown, because everyone was like, "You need someone to talk to. Everyone's alone right now. If you need a counsellor, talk to one." It was brought up so much more. I've hear it on radio stations, I heard it on TV, I've heard it everywhere. So I felt like that was a big plus. And it made people probably that weren't already getting help to be like, 'Oh, I can go get help now.'"*

Others felt that they had not experienced much stigma previously around accessing mental health care in the time they had been doing so.

> *"Yeah, it's really normal. And also all of my friends and I, we're all a little cuckoo-bananas, for a lack of a better word. We're not okay! And so a lot of us seek counselling and it's kind of very openly discussed within my friends at least. There's never really that much of a stigma for me."*

Reduction in perceived stigma

However, some did feel that not having to go to a building to receive therapy did help to reduce the anxiety of experiencing stigma.

> *"For my daughter, it would help in reducing the stigma because of her social anxiety she does constantly worry about somebody else that she knows seeing her when she's out, basically at any point from our*

house. But also, especially if she's to go to an appointment for something like this. So keeping it within our house so that she can sort of keep it more hidden, maybe, in some ways would increase access for some people that are worried about, 'I don't want somebody to see me on Queen's Street' or at the hospital, or whatever, in those scenarios.

5.1.6 Suggestions to Improve Virtual Care

More intentionality and time invested in relationship building

It was suggested that counselors take some time at the start to invite clients into their personal space and to find commonalities between them. This would help to overcome the difficulties in creating a relationship across a virtual space.

> *"I think it would be easier to make it more personable, especially in children services, to ask them to show you around. To invite that person into their space. And vice-versa, I think it helps a lot if- because you are missing out on a lot of different cues that when you're face-to-face. If they showed my son around. One counsellor did. He introduced the counsellor to his puppy and his birds, and he's an animal lover, a huge animal lover. So he picked up on that cue immediately and was like, 'Oh, I should go get my dog!' And it was kind of a weird interruption, but guess what, he's stickin' it out with this guy because they both like dogs and they both like animals, and they made connections. So using what could be a distraction or what could be different, can actually work too. So just trying to make something that feels sometimes a bit cold, warm."*

Similarly, counselors could talk about things in the client's space to build rapport and trust before delving into therapy.

> *"Yes, I'm a Harry Potter fan, by the way – he would bring stuff up like that too, just randomly. If it's a poster, whatever I have in my hand, to try to build that I could talk to him kinda thing. Which was nice and it kinda helped. So I feel like that's a plus if you don't have major trust issues, you can kinda build that rapport of normal human conversation. Before, hey, "Let me tell you all my deep, dark secrets.""*

> *"And for us, I found it also really almost enhanced some of the treatment, because [my son] would talk about something and then he would get his iPad and he'd be like, "And see, there's the Christmas tree! That's what we put up and that's what made me happy this week." So it was really neat that you could actually, literally bring the counsellor into your space."*

Some clients felt that they were overwhelmed with having to deal with issues created by the COVID-19 pandemic and they needed the counselors to take more responsibility for the success of virtual care.

> *"We're in counselling for a reason. And so whether that reason be – weigh-ins, or you need to deal with the issue that you've been avoiding for whatever reason – me – kind of like we're already getting more responsibilities put on us from being online for school, even partially or fully. We're already having more people put more accountability onto us. We need our therapists to take as much accountability for our therapy as they humanly can at this point, because we are drowning under a pile of accountability right now. We have to trust ourselves not to go see people when we're invited, if our friends are breaking the rules, we still can't, necessarily. We still shouldn't. A lot of times we have that accountability. Accountability of keeping up with schoolwork at home. I get that you guys might be struggling too, as therapists, and then people. But you're helping these kids for a reason a lot of the time, so try to take as much accountability as is possible, off of them, I think will help a lot."*

Work with parents to plan for virtual engagement

Parents felt it would be useful for the counselor to work with them and make suggestions to help keep their child engaged in the virtual session.

> *"[Some] things that the therapist could do when they first kind of set up the virtual care is maybe giving the examples of things that might keep the kids engaged on the other side. Again, just from my work-hat being on, I would have my son bouncing on a therapy ball, or I'd have him playing with hand fidgets and all sorts of things. So I was giving him the sensory stim that he needed from our end, virtually. But that's because by nature that's what I do for work. So it kind of came natural to me to actually set those things up within our environment. The same thing as which room we picked and how we set things up. But maybe that would be something that would be a cheat sheet or a tip sheet that the therapist could provide to the parents and the family when they're first starting. And I mean, sometimes it might backfire and that might not be the thing that they might need. But for some they need that to stay engaged, so I think maybe starting off the sessions with, "Try these things," might be helpful."*

5.1.7 Future Virtual Care Options

Preference for in-person care when available

Although virtual care was often seen as filling a gap created by the COVID-19 pandemic, people generally preferred in-person care for various reasons. However, many people said they would like to have the option of virtual care available if they needed it.

> *"I definitely prefer the in-person. That being said, I'm thankful that we have the option for calls and stuff, because it sucks not being able to be face-to-face and having what I felt proper sessions. I needed somebody to talk to during quarantine and stuff like that. So I was thankful to have the option and to be able to have it. However, I do think in-person is a lot more beneficial."*

Virtual care as an option when appropriate

Virtual care was seen as a different option that would add to the strategies of providing mental health care, without replacing in-person care. However, participants mentioned that some people who need mental health care do not have the required devices or Internet connection and may require additional help to overcome these barriers. Virtual care has limits and so would only be utilized where it would be beneficial to clients.

> *"I guess all that I could just summarize would be that it seems to me that it's just one more tool in the toolbox. For some kids it's obviously a great option, and for other kids it's not. And it might depend on their diagnosis, it might depend on their age, it might depend on if they've already met with the counsellor face-to-face before this all happened. There's so many factors... But it doesn't have to be all or none. It doesn't have to be, 'Let's all move to everything online.' It's just another tool in the toolbox. If it works for a kid, then great. If it doesn't or maybe every third time they come in face-to-face, great... But for some kids it obviously doesn't help them, but it's okay to try, you know."*

5.2 Clinician Interviews

5.2.1 Care Delivery Preferences

In-Person vs. Virtual Care

At the beginning of the pandemic, clinicians reported that a small number of clients were completely opposed to receiving mental health care virtually and stopped engaging with services.

> *"Sometimes people are just completely opposed to virtual services. They want to sit down with another human being, and again, have that felt sense. And I don't blame them. So that's, sometimes people are just completely opposed to it from the jump."*

However, clinicians reported that many clients who preferred in-person care did participate in virtual care and transitioned to in-person care once in-person sessions resumed.

> *"I think for some kids they definitely benefit from in-person, and will request, maybe start it off virtually as new clients in the summer. Then once we were able to open our doors to having in-person sessions, they requested that and preferred that."*

Pexip

Clinicians reported that Pexip was rarely used as a platform for delivering virtual mental health care due to a myriad of technological issues, such as connection issues, video lags, choppy video, inconsistent sound, and dropped video calls. Due to these issues, clinicians often resorted to phone calls to deliver virtual mental health care.

> *"You know, Pexip is lagging or I've had people get kicked out of the room, obviously something with an internet connection, and then I've gotta unlock the room, and they're texting me too, "Let me back in*

the room." Those sorts of little things that it's just like, it doesn't happen super often, but when it does it's like, this is so disruptive."

Telephone Calls

Some clinicians reported that it was difficult to establish rapport with new clients during phone call appointments as they were unable to see one another. This made it difficult for clinicians to use humor, express interest, make sense of moments of silence, and to sound authentic during phone appointments. It was also difficult for clinicians to assess a client's desire to speak and their level of engagement during the counselling appointment.

> *"Often, in person, when there was silence, we'd sort of just lean into that and you can sit in silence and observe what's happening. On the phone, there would be silence and you didn't know why the silence. And I got better at I guess, figuring it out. Almost like interpreting the silence. 'Cause at the beginning there was times I thought we were, you know, just sort of leaning into the silence, and I just realized they were not even participating in the appointment anymore. They were playing video games."*

5.2.2 Benefits of Virtual Mental Health Care

Client Benefits

Clinicians reported that virtual care was sometimes more convenient for clients and their families and improved access to mental health care by reducing the need for transportation. It also increased accessibility of mental health care for clients with depression who are struggling to get out of bed and begin their day. Virtual care allowed for more flexible and autonomous mental health care for clients as it was easier for them to choose their appointment times and platform preferences as well as reach out to clinicians for support.

> *"And they also got to manage their own appointments a little bit more than when they have to rely on someone else to get them there, so they could kind of choose when an appointment would work from them without having to run it by mom or dad or whoever was gonna to bring them. So then, in that way, we enhanced it for some of those kids."*

> *"Like if the idea now, even if I book a face-to-face appointment in office, and somebody has something come up, and then I'll get a text that says, "Hey, can we just do it over the phone?" Like, there's no reason we couldn't do that before, but we didn't. And so that's really nice."*

Clinicians reported that virtual care seemed to foster a sense of safety and comfort amongst clients during at-home virtual care appointments.

> *"And I think, again, I think that there is a new level of comfort for someone sitting in their bedroom. And it's like, yeah, I don't have to go to a strange environment. I'm in control. If things get too intense, I haven't had it happen, yet, but we'd just have a kid click off and be like, 'Nope. Not doin' that.' They get to pick where they feel safe, what they want to talk about. Show up if they want to; that's the other thing is the buy-in is completely in their corner. There's no parents dragging kids to virtual stuff."*

Clinicians reported that some clients found it easier to open up during virtual counselling appointments rather than in-person counselling appointments.

> *"I had a young person, their line to me was, "Well I can talk to you about anything because you don't exist." And I said, "What on Earth does that mean?" And they're like, "Well I've never met you in person." So, in their mind, to feel safe, I only existed on the screen. So it was kind of like an avatar. That there was this other that was in this screen, that they could feel safe and connect to, that you didn't exist in the same reality. So it was okay to talk about the hurt, the trauma, all of those other things."*

Clinician Benefits

Overall, most clinicians reported that they enjoyed being able to provide virtual care while working from home. Many clinicians reported that the money and time savings of not having to commute to work was an added benefit of providing virtual care from home. Furthermore, their physical and mental health was enhanced by providing virtual mental health care from home. Clinicians indicated that they were able to engage in more health-promoting activities and took fewer sick days since they were able to continue to work from home with minor ailments. They also mentioned that working from home allowed for more flexibility and work-life balance.

> *"I have found that doing virtual care, you can sort of modify your schedule. It is almost like you have a portable office. Therefore, I can be at the office, bring my laptop, and do a virtual session in between if that person can't show. So it's nice having both options."*

However, many clinicians also indicated that they appreciated the option of going into the office to provide mental health care.

> *"I really enjoy, currently, I come to the office more than the one day a week and I enjoy the work-life balance I have with the choice to come to the office or not. I think there's some really good things about getting to work from home, but I also am not the kind of person that wants to work from home every day. So it was difficult to work from home every day. Now the choice of moving between the two is really nice."*

Clinicians also mentioned that virtual care has fostered more independence, creativity, skill building and productivity within their team.

> *"I mean, this is a skill or delivery that wasn't in my bag before. I built one. So whatever future, technology doesn't go away. If virtual services are something that people want, I feel comfortable doing it."*

Some clinicians reported that virtual care made it easier to meet with other mental health providers.

> *"I do a lot of meetings and coordinating, so a lot of the times I would want to meet with maybe four different school counsellors out in [name of school division]…It's totally difficult to plan to get together when distance is in the way. And I can't believe the amount of relationships that have been enhanced as a result of having a regular, rural counsellor consultation meeting. So it's really enhanced client care as well, in that way, because we really get to lean into what's best for clients, people have ideas, so on and so forth."*

Clinicians also reported that virtual care delivery led to fewer late and missed appointments and allowed clients to reschedule appointments through text.

> *"I know you don't tend to have the 15, 20-minute late people because they were stuck in traffic, or that sort of thing, which is not really a big deal, but just, well they're at home and just waiting to do the video call. I guess that's maybe an added plus I actually hadn't thought about until this minute. Of just being punctual and being able to stay on schedule, and stuff."*

Clinicians reported that virtual care allowed them to get a different view of their clients that they would not normally have had during in-person care. Virtual care also allowed clinicians to intervene in the real life events of clients.

> *"Virtual services, especially if say someone's in their room, has such an incredible amount of information and intimacy to it that you don't get if someone was to come to my office. I'm a fly-on-the-wall sometimes, where I'm in someone's safe space. Well why did they pick this space? Why is that picture on their wall important? But it also can kind of offer some information on family dynamics, where I'd had a young person that their parent just came in and just lit this kid up, out of nowhere – I mean, granted, based on my context – and it was, I got to see what living their life was like, just through this little phone."*

5.2.3 Challenges of Virtual Mental Health Care

Client Challenges

Clinicians reported that virtual care reduced access to mental health care for certain clients, such as those who respond better to the in-person connection, or those who did not have access to technological equipment or who had poor internet or limited cell data plans.

> *"Some [clients] didn't have the technology or the connection that they had wasn't great. Like their Wi-Fi wasn't good. Some of them used a data plan with their family's internet. So we had tried it and it ate up a bunch of their data, so then they got extra charges and things. So we switched to not using it."*

Clinicians also highlighted that virtual care limited accessibility of mental health care for youth accessing addiction treatment. It was difficult to engage these clients as they were less interested in virtual care.

> *"I think with the population I work with, in particular, looking at the kids that access Addictions Services, there tends to be a lot of barriers, and some of those barriers are highlighted when they need to access care remotely."*

Clinicians also emphasized that many clients, particularly those from low socioeconomic backgrounds, had privacy concerns at home, which limited accessibility to care.

> *"So it's only the clients who are just living with few resources where you might find there are privacy issues, there are four adults in the same room at the moment when you're taking the video, or when you're on Pexip, I mean. They could be very distracted, and there's nothing I can do about that."*

Clinician Challenges

A challenge that some clinicians reported was professional isolation. Clinicians tended to report less consultation with other team members and found it difficult to reach out for support when necessary.

> *"Isolation is another thing for clinicians. You don't feel as connected to the team when you are working at home. Although that support is there, I feel that I didn't reach out for it as often and during the weekly team meetings, people don't engage that much. It doesn't feel like you have connected with anybody. So you feel very isolated I guess."*

> *When you get off of a call that was particularly heavy or challenging, you don't have anyone there to sort of process with or come up with ideas. And I think as a counsellor, basically, you're sort of always just giving of your emotional resources, and I think part of what fills people up is being part of a team and being in an environment where, I don't know, sort of camaraderie and being able to speak to your coworkers and all that. And at home, none of that is there, so it's sort of like you're pouring from your cup all day and it's just on you to sort of figure that out, which was really hard."*

Clinicians also reported that virtual care has created more casual attitudes towards mental health care among clients, which led to fewer clients preparing appropriately for their counselling appointments.

> *"There's also a portion of clients where due to the increase in accessibility, it's also increased the casualness of approaching therapy. And what I mean by that is that, for example, I'll call a family for an 11 o'clock appointment, and the parent or the caregiver will answer the phone and say, "Oh, we totally forgot about it today!" And then kind of expect to roll into it, despite maybe not being organized to do so, not having it on their mind. Whereas in face-to-face, or coming into office therapy, that wouldn't be happening, that would be a missed appointment."*

> *"And my phone call is their wake-up alarm, which is not conductive to therapy. For me to say, "Oh you're just waking up, okay yeah, let's jump into this stuff. It's not practical. It's not effective"*

5.2.4 Delivery of Mental Health Therapies

At the beginning of the pandemic, clinicians reported experiencing difficulties adapting to delivery of virtual mental health care. Counselling appointments were shorter as clinicians adjusted to delivering care virtually.

> *"I felt like I had to learn a whole new skillset, to be totally honest. I first started phone counselling, I was telling my supervisor, "I don't know how to do this."*

Clinicians frequently reported that virtual care has changed the way in which psychoeducational resources are shared with clients and their families. Clinicians were able to share resources with clients over text or email or directly on the screen. However, scanning and emailing resources was considered to be more time consuming than providing handouts to clients.

> *"I do find it helpful though, with the older kids there is the advantage of being able to directly share the screen and being able to share attention on the same document. That's actually more clear than in person, to both be staring at the same document together. So that's more helpful. And I can go right to websites, and they can see it right there. I think that's actually better in the virtual context."*

Clinicians reported that virtual care has limited their ability to provide certain mental health therapies, such as arts-based therapy, drumming, trauma therapy (i.e. accelerated resolution therapy and eye movement therapy), experiential processing therapy, and family therapy with clients and their families. It was more difficult to provide care to younger clients who required more interactive and hands-on activities. Clinicians also reported modifying their therapeutic approaches due to the challenges of virtual care. For instance, they tended to gravitate to more concrete forms of psychotherapy, such as CBT and DBT and psychoeducation, which were easier to deliver over virtual platforms. While group DBT was delivered virtually, interactive activities were limited and clients reported missing informal interactions with other clients. Virtual care also made it challenging to recognize and address unconstructive behaviours within the group setting.

> *"I found myself almost lesson planning in a CBT or DBT delivery, because it made me feel like, okay, well at least we can accomplish these things. And I became very frustrated with my work because it was, to me, it felt inauthentic. Yeah. I certainly found some barriers that way, for sure."*

> *"And we'd be able to address things in groups. So if someone was on their phone, not paying attention, and that can be experienced as invalidating, we'd talk about it as a therapy interfering behaviour with them outside of group, later, and make adjustments. But online, you can't even really tell if people are paying attention or if people are walking on and off camera*."

Clinicians mentioned that virtual care had implications for the treatment of social anxiety. While they acknowledged that virtual care reduced barriers for clients with social anxiety to access services, the lack of in-person visits limited the social exposures necessary to promote recovery.

> *"I think too, and this could just be a COVID thing too, but we see a lot of kids who have social anxiety. So part of that, getting them to our office, is a big deal for them. So we're essentially doing an exposure for them when they come to see us. And after a while they're used to coming to us and we can use that as a really good example of how, "You used to be anxious coming here, and now you're not, and that's what we need to do with other scenarios that cause anxiety for you." That's harder to do virtually. Some of those exposures, it's harder to do."*

Clinicians reported that virtual care had changed how guardians/parents connected with the counsellor. Since guardians/parents were no longer driving their youth to counselling appointments, there were fewer in-person interactions with guardians and family members. This made it difficult to establish rapport and develop collaborative relationships with guardians/parents. However, clinicians reported that they tended to communicate more with guardians/parents over text messages more since virtual care began.

> *"I find the virtual is difficult with parental involvement. So, parents would usually have to drive the client to the appointment so they are there anyways so you can have them come into the first appointment and explain what you are going to do. It helps to build rapport with the family as well. With virtual, you get a link to your counselor and I might not even meet the parent. So, I feel there is a bit of a disconnect with family support virtually."*

5.2.5 Client-Counselor Relationships

Clinicians reported that virtual care has made it more challenging to ensure that clients feel comfortable in a new therapeutic relationship. Clinicians addressed this challenge by acknowledging the strangeness of the situation and by emphasizing the steps that they were going to take to protect the client's confidentiality.

> *"And part of that began became just acknowledging how weird it was that we had to talk on the phone, and how it must be scary for them because it's weird for me, and it's hard to not see their face. So that became a big part of the beginning for me, in the end, was just to acknowledge how hard it was. And it must be scary to talk to this sort of random person that was just this voice in the abyss."*

Clinicians reported that virtual care made it more difficult to establish a sense of safety during appointments, particularly amongst clients who experience addiction issues or who live in unstable households. Clinicians emphasized the importance of in-person appointments that allow clients to escape difficult living situations and establish a therapeutic relationship with a counsellor in a safe environment.

> *"I think with everybody, but addictions I think particularly, we – so much of our beginning work is just creating a safe space that they feel they can even open up. And when you're remote, it was so much harder to build that safe space primarily because they weren't even physically safe where they were, so they're in their chaos, and you're trying to create this sense of a safe space over the phone or over the Pexip, but in reality they're physically in the chaos. But also, yeah, so much of the addiction work is the first four or five sessions is just establishing that you're someone that they want to talk to or that you're someone safe to talk to. And that was a lot harder over the phone or Pexip."*

5.2.6 Suggestions for Improving Virtual Care

In order to facilitate building rapport and a sense of connection with clients, clinicians suggested that at least the initial counselling appointments should be done in-person.

> *"I think it really helps. They can picture you and you can picture them. You just get more connected in that sense. So I think most of my new clients since September I have tried to do in-person at first then we can move to a combination."*

Clinicians mentioned that there is a need for more training and support for clinicians, particularly more resources and allocated time for remote counselling training. Clinicians also emphasized a need for additional training to maintain positive mental health and to ensure proper ergonomic setups while working remotely.

> *"I guess maybe more sort of specific training around remote delivery. I think we all individually found resources and came up with ways to improve our delivery, but, we didn't really get any sort of unified learning that way."*

Many clinicians indicated that there was a need for a better video platform for delivering virtual care. Alternative platforms should be accessible to clients who may have limited technology equipment and internet access.

"My understanding of why Pexip works so well is that it doesn't store data on external servers, and so it stores it all within the video call. But that requires a really fast and solid internet connection that I don't have, and a lot of my clients don't have. And so yes, confidentiality is number one for importance. And also, we need to find some ways that there's a platform that actually works for people in their homes. It doesn't work when someone's telling me that they're suicidal and the video and sound is cutting out, and I have to keep saying, "Sorry, can you repeat that? I didn't catch that." It's just, that's hard. So the right technology would help."

Clinicians felt that clients should be able to choose their preferred virtual platform for receiving mental health care, such as FaceTime, which was a convenient and desirable platform for many clients. They felt that if clients wanted to use FaceTime while aware of the privacy risks, they should be able to do so.

"I know lots of different private services use Zoom or other things. I think the University uses WebEx for virtual care. You know, I think maybe- I don't know. I don't know, maybe that would be more complicated to have a number of different options. But sometimes when people are comfortable with the platform already, maybe they're more likely to use it."

5.2.7 Future Virtual Care Options

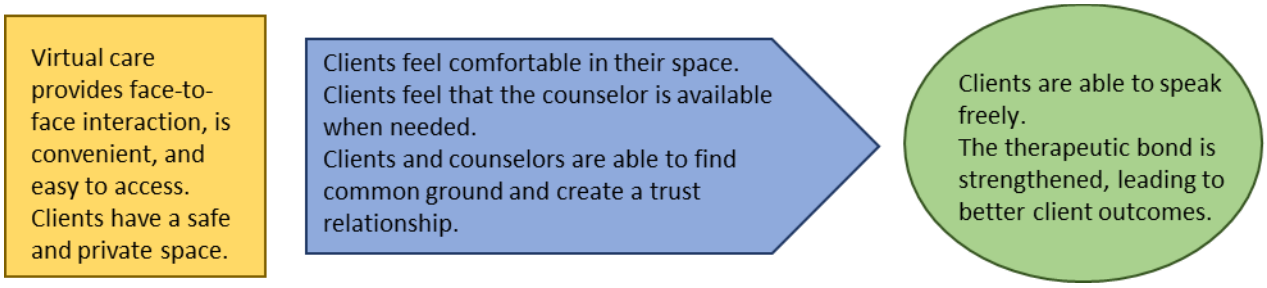
Overall, clinicians indicated that in the future they would like to see a flexible model of care that includes virtual care options when deemed beneficial for clients and families.

"I also do like the idea of having sort of a flexible- like if we'd introduced virtual care in a different circumstance, where it wasn't pandemic-related, and we could sort of integrate face-to-face with virtual and all these other things, maybe that's ideal. Because then we can build a plan that's based on their individual factors, and that actually works for them, and is sustainable and flexible, right?"

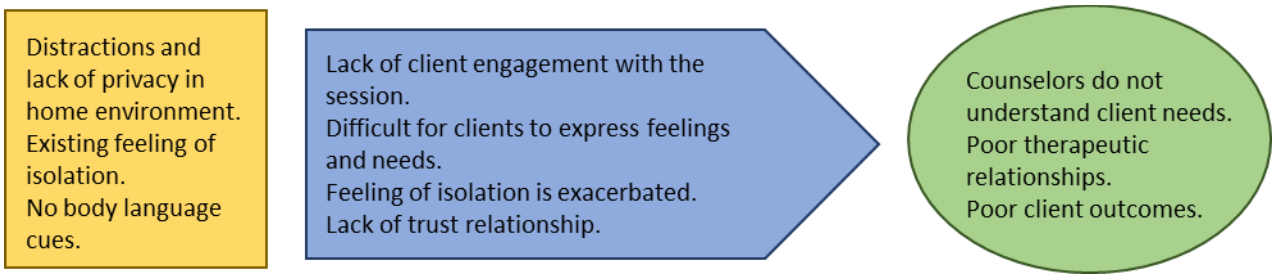
5.3 If-then-because Statements

The following paragraphs help to amalgamate different aspects of the context around virtual care, the underlying mechanisms that lead to successful or less successful virtual care, and the outcomes arising from each scenario.

5.3.1 Successful Virtual Care

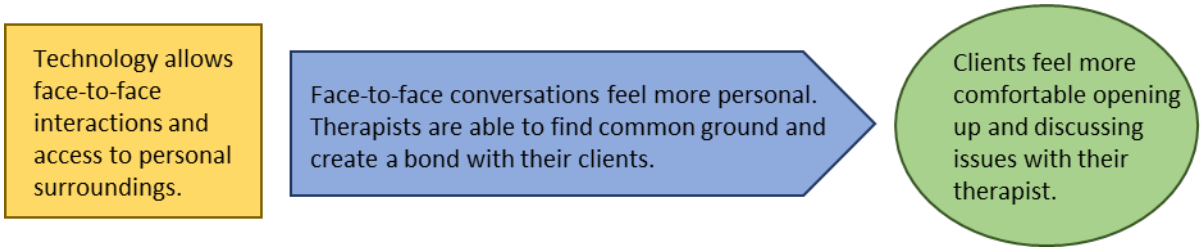


5.3.2 Non-Successful Virtual Care



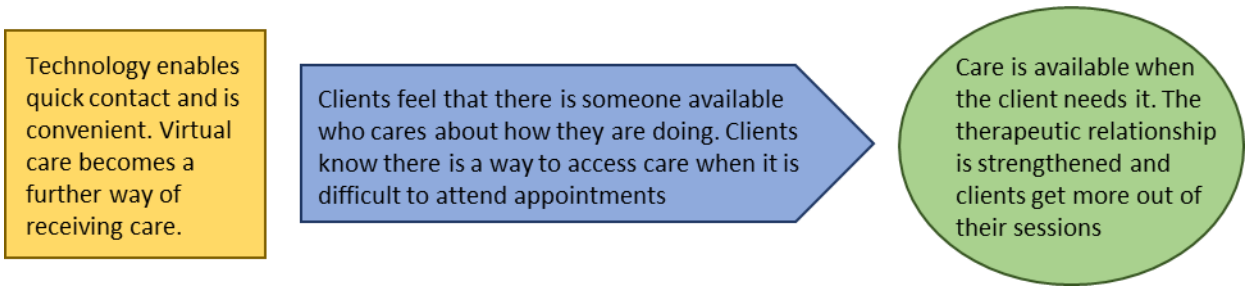
5.3.3 Virtual Care Platforms

If video technology allows face-to-face interactions and access to personal surroundings, ***then*** clients feel more comfortable opening up and discussing issues with their therapist ***because*** face-to-face conversations feel more personal. Therapists are able to talk to clients about their home life, using the on screen cues. Therapists are able to find common ground and create a bond with their clients.



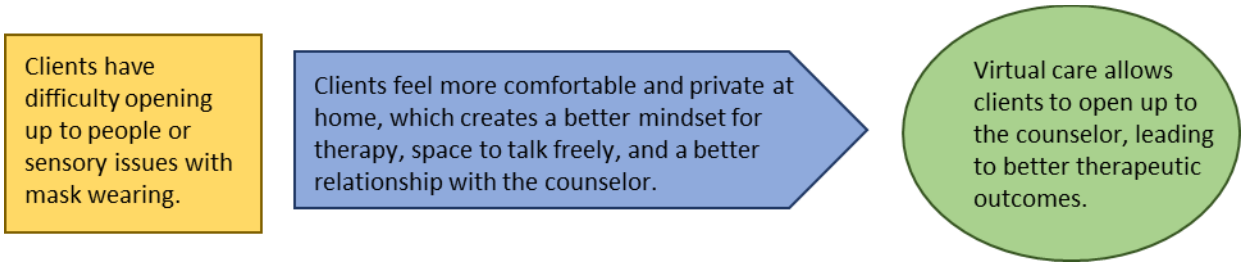
5.3.4 Virtual Care Benefits

If use of technology enables a quick contact and response from a counselor and is more convenient to access care as it is easier to fit sessions into busy schedules. Many youth are doing online schooling so do not have to leave school to access appointments. Virtual care becomes a further way of receiving care. ***Then*** there is increased access to care that is available when the client needs it. The client-counselor relationship is strengthened and clients are able to get more out of their sessions ***because*** clients feel that there is someone available who cares about how they are doing. The counselor is accessible and clients know there is a way to access care when it is difficult to attend appointments, either for logistical reasons or mental health constraints. Clients do not have the logistical issues with accessing care, such as travel and parking.



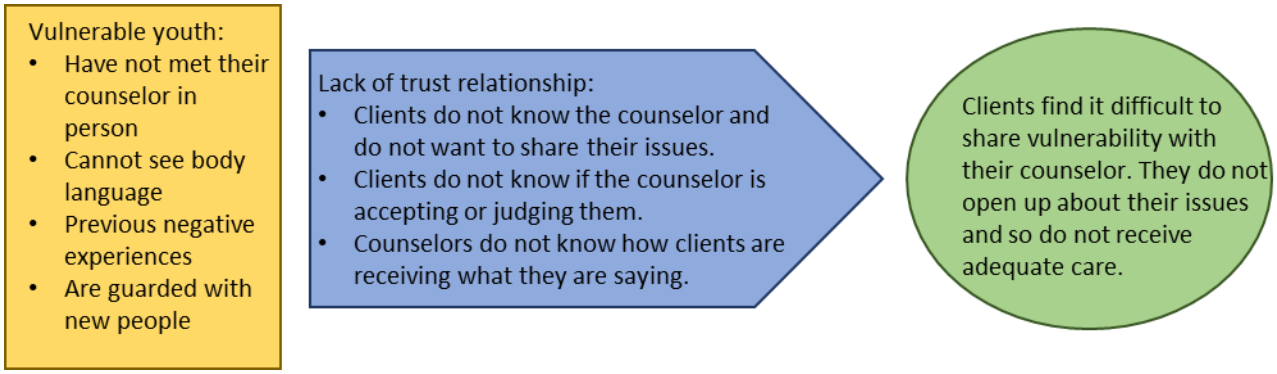
If clients have difficulty opening up to people or sensory issues with mask wearing, ***then*** virtual care allows clients to open up to the counselor, leading to better therapeutic outcomes, ***because*** the screen provides a

buffer. The client feels more comfortable, protected, and private at home, which creates a better mindset for therapy, space to talk freely, and a better relationship with the counselor.

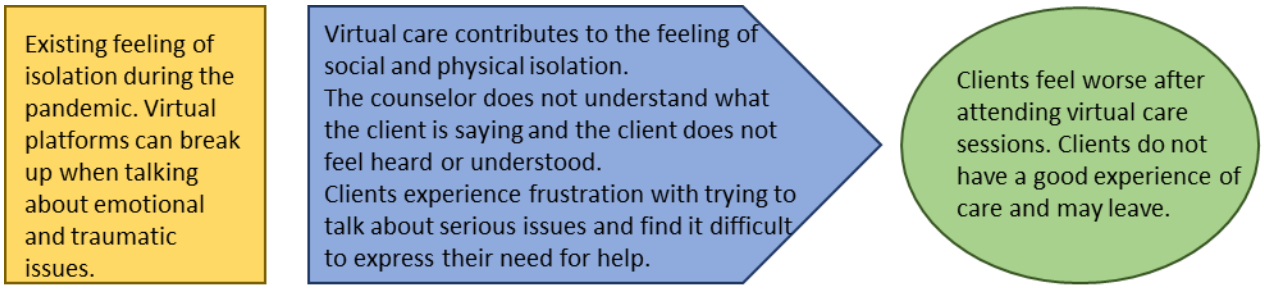


5.3.5 Virtual Care Challenges

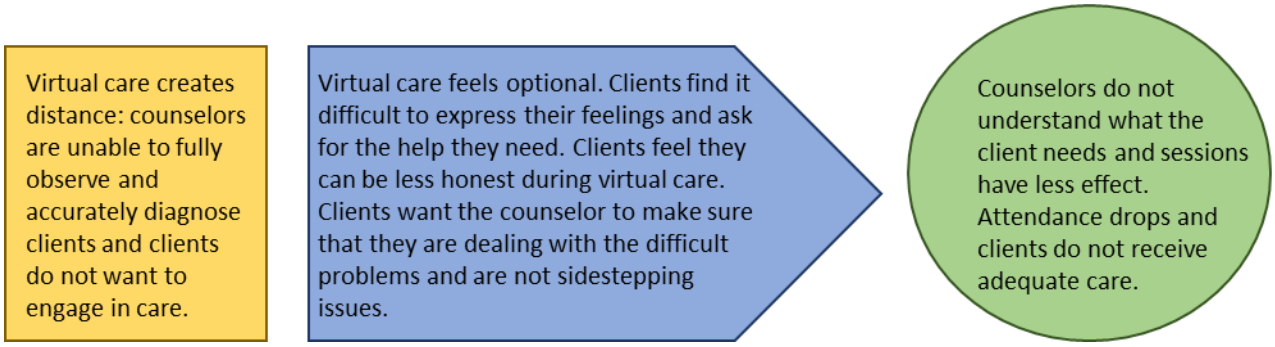
If vulnerable youth have not met their counselor in person, are unable to see facial expressions or body language during sessions, have had negative experiences and are guarded in allowing new people into their world, ***then*** clients find it difficult to share vulnerability with their counselor. They do not open up about their issues and so do not receive adequate care ***because*** clients are unsure of the counselor's response to what they are saying and whether the counselor is accepting or judging them. Clients do not know the counselor and do not want to discuss their issues over the telephone. The counselor finds it difficult to build a trusting relationship with clients and do not know how clients are receiving what they are saying. Clients need to trust their counselor before they fully share their issues.



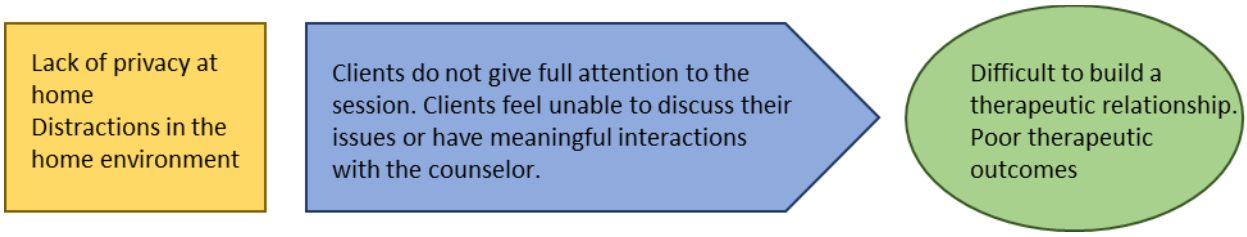
If many things cause a feeling of isolation during the pandemic, such as on-line schooling. Virtual platforms, such as Pexip, can lag and break up as people are trying to talk about emotional and traumatic issues ***then*** clients feel worse after attending virtual care sessions. Clients do not have a good experience of care and may leave ***because*** the counselor does not understand what the client is saying and the client does not feel heard or understood. Attending virtual care sessions contributes to the feeling of social and physical isolation. Clients experience frustration with trying to talk about serious issues and find it difficult to express their need for help. The therapeutic relationship may be damaged.



If virtual care creates distance between the client and counselor, where counselors are unable to fully observe and accurately diagnose clients and clients do not want to engage in care for different reasons, ***then*** counselors are not aware of what is happening in their clients' lives and do not understand what the client needs. Clients' mental health care needs are not met and sessions have less effect. Clients do not attend some sessions and do not receive adequate care ***because*** virtual care feels more optional to the client and it seems easier to decline calls than to miss in-person appointments. Clients feel they can hide issues or be less honest about their experiences or feelings during virtual care. Clients find it difficult to express their feelings to help their counselor understand the severity of their situation and ask for the help they need. Clients want the counselor to make sure that they are dealing with the difficult problems and are not sidestepping issues.



If there is a lack of privacy at home or clients find it difficult to focus on the virtual therapy session when distracted by things in the home environment, by not seeing the counselor on camera, or by seeing their own face on screen, ***then*** clients have poor therapeutic outcomes, ***because*** online platforms exacerbate social difficulties. Clients do not give full attention to the session and it is difficult to build a client-counselor relationship. Clients feel unable to discuss their issues or have meaningful interactions with the counselor.



If travel and wait time for an in-person appointment normally provide time for clients to prepare for the session, with access to a virtual care session occurring immediately, ***then*** clients find it difficult to engage and do not gain much from care, ***because*** clients may be distracted and not mentally prepared to engage fully in the

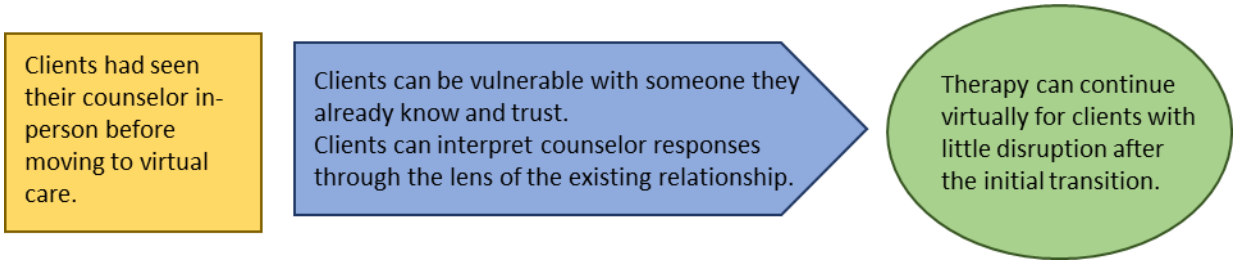
session. They may not have thought about what they want to discuss and not fully receive what the counselor is saying.

If there is difficulty coordinating the logistics of virtual care, such as timings of telephone calls, ***then*** clients may not persist and leave mental health care, ***because*** the lack of relationship makes it difficult to persevere.

If therapists do not have access to their physical props, for example a whiteboard, ***then*** clients may receive inadequate care, ***because*** clients do not fully understand what the therapist is trying to convey.

5.3.6 Client-Counselor Relationships

If clients had seen their counselor in-person before moving to virtual care, ***then*** therapy can continue virtually for clients with little disruption after the initial transition logistics are worked out, ***because*** clients had built up a relationship with their counselor and were able to keep this going during virtual care. It is easier for clients to be vulnerable and share experiences with someone they already know and trust. Clients can interpret counselor responses through the lens of the existing relationship.



5.4 Client Survey results

There were 116 responses to the survey giving a response rate of 31% (116/373) after three reminders. Unfortunately, it is not possible to determine whether the characteristics of survey participants differed from those who did not participate. Among participants, five responses were excluded as they reported either no virtual care or only in-person care during the study period. For each question, five percent or less of participants preferred not to answer.

5.4.1 Demographic characteristics

The majority (93.6%) of participants were 13 years and older. Almost two-thirds (60.4%) self-identified as female and 6.3% were nonbinary. It was noted that almost all (85.7%) participants in the youngest age group (10-12 years) were male. The majority of participants described their racial group as White, First Nations or Métis. Almost three quarters of participants resided in the city of Saskatoon (Table 1).

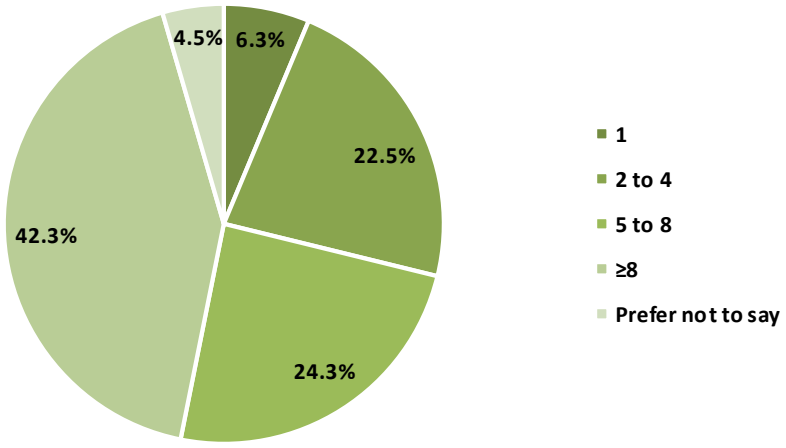
Table 1: Sociodemographic characteristics of study participants

Variable	No (%)
Age (years)	
10-12	8(7.3%)
13-15	53(48.2%)
16-18	47(42.7%)
Prefer not to answer	2(1.8%)
Gender	
Female	67(60.4%)
Male	33(29.7%)
Nonbinary	7(6.3%)
Prefer not to answer	3(2.7%)
Other	1(0.9%)
Racial/ethnic background	
Arab	0
Asian	4(3.6%)
Black	4(3.6%)
Inuit	0
First Nations	13(11.8%)
Hispanic/Latino	2(1.8%)
Métis	12(10.9%)
White	86(78.2%)
None of the above	1(0.9%)
Prefer not to answer	3(2.7%)
Place of residence	
Saskatoon	81(73%)
Surrounding town or city	21(18.9%)
Rural and remote(farm, acreage)	7(6.3%)
Prefer not to answer	2(1.8%)

5.4.2 Clinical context

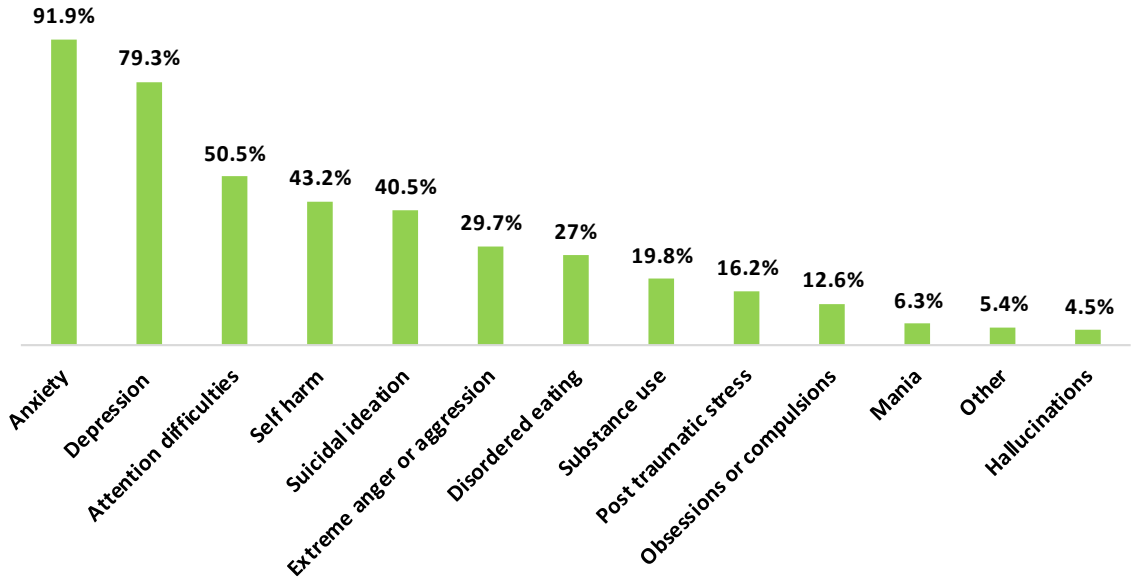
As anticipated, the majority of participants had either only received virtual care (52, 46.8%) or combination of virtual and in-person care (59, 53.2%) during the pandemic. A minority of participants only had one virtual care appointment (7, 6.3%) and just under half had eight or more virtual care appointments (Figure 1).

Figure 1: Number of virtual care appointments



Participants had a wide range of mental health symptoms but the most common included anxiety (n=102, 91.9%), Depression (n=88, 79.3%), attention difficulties (n=56, 50.5%), self-harm (n=47, 43.2%) and suicidal ideation (n=45, 40.5%) (Figure 2). Other symptoms mentioned included executive dysfunction, personality disorders, bipolar disorder, autism, and attention deficit hyperactivity disorder.

Figure 2: Symptoms experienced by participants

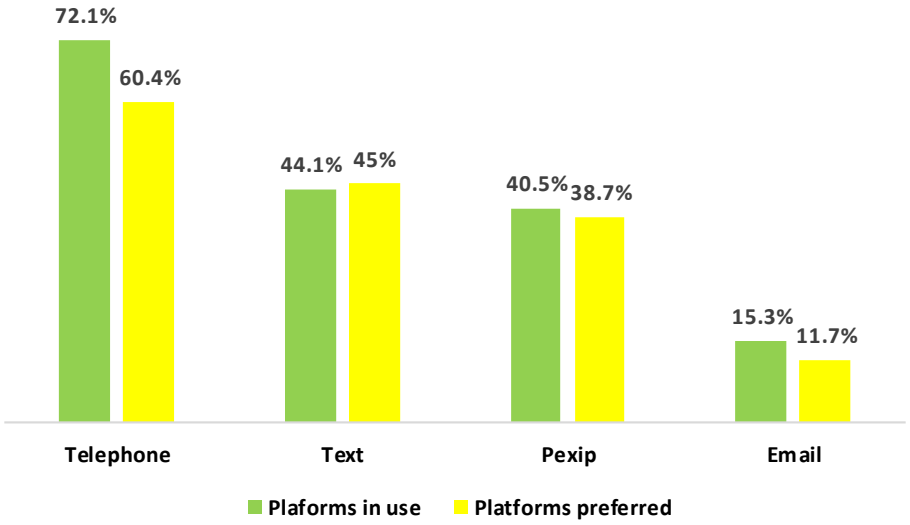


Most participants felt that their mental health struggles affected their daily lives somewhat (n=56, 50.5%) or a lot (n=46, 41.4%).

5.4.3 Virtual platforms

Participants were asked about the types of virtual platforms that they used as well as those they preferred. Their responses were similar except for telephone where a smaller proportion preferred to have virtual visits over the phone than were currently using the phone ($p<0.0001$) (Figure 3).

Figure 3: Percentage of participants disaggregated by platform in use versus preferred

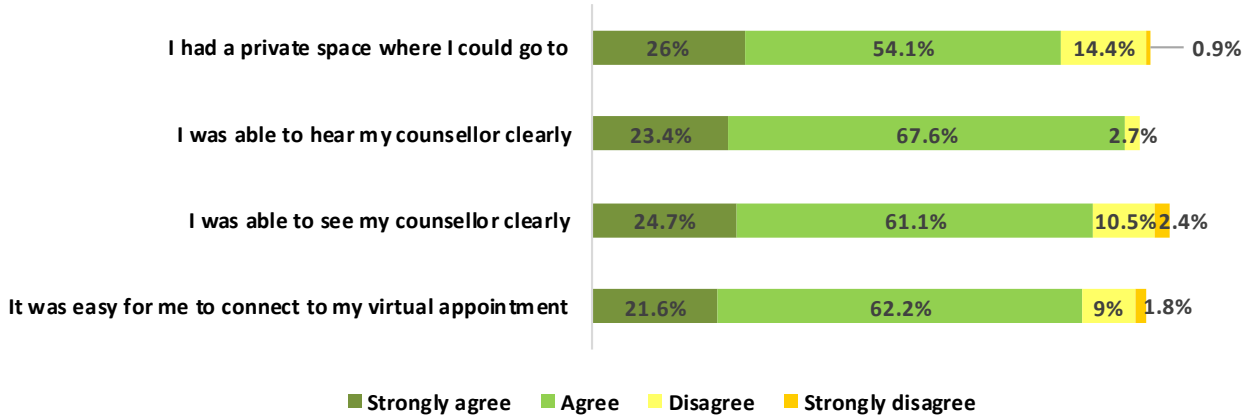


Participants were also asked whether they preferred to use other platforms for virtual care than were currently offered. Just under a third (32.4%, n=36) did not prefer another platform; while 34.2% (n=38) preferred FaceTime or Zoom (36.9%, n=41). A small percentage would like to use Facebook messenger (11.7%) or WhatsApp (6.3%).

5.4.4 Virtual care processes

Participants were asked about key processes enacted during virtual care encounters. This included whether it was easy to connect to the platform, if they could hear and or see the counselor as well as if they had access to a private space (Figure 4). About 9% of participants had difficulty connecting during their virtual care appointment and about 10% reported difficulty seeing the counsellor during their appointments. The overwhelming majority (91%) reported being able to hear the counselor well. While most persons had a private space for their virtual visit, 14.4% reported that they did not have such a space.

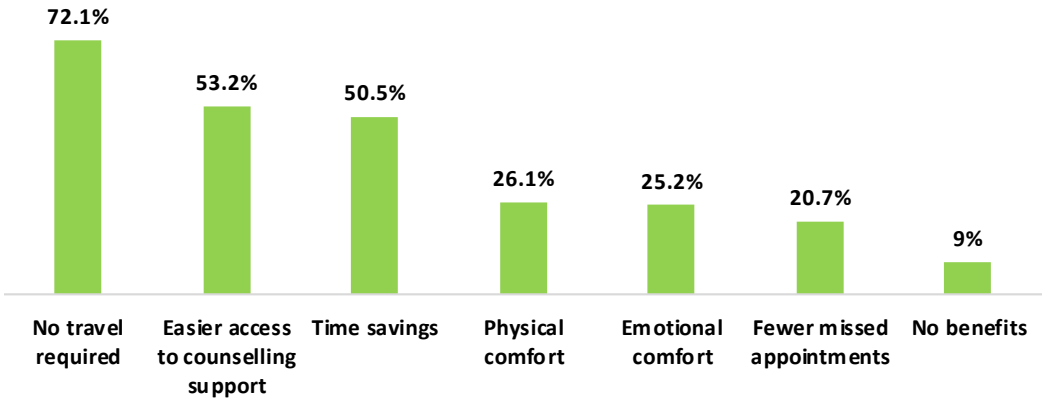
Figure 4: Client experiences with virtual care processes



5.4.5 Benefits of virtual care

The most frequent benefit of virtual care endorsed by participants was not needing to travel to and from appointments (n=80, 72.1%). Just over half (n=59, 53.2%) thought that virtual appointments made it easier to access counseling support. Over half of participants (n=56) also valued the time saved through virtual care appointments. The physical and emotional comfort of a familiar space were also reported as key benefits. Almost a quarter (n=23, 20.7%) of participants reported that they had fewer missed appointments with virtual care delivery (Figure 5).

Figure 5: Perceived benefits of virtual care

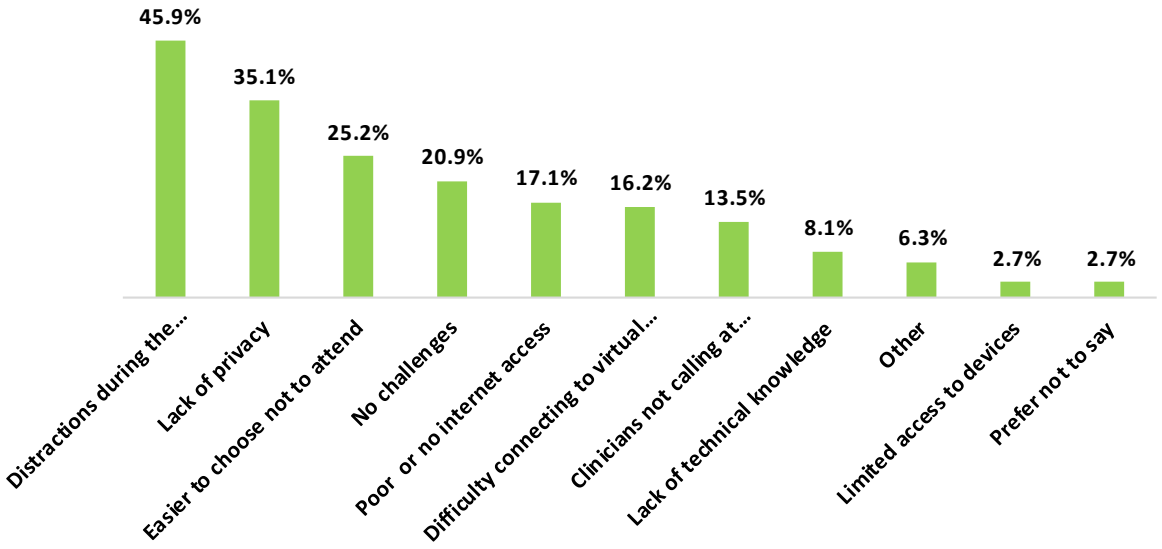


Perceived benefits of virtual care did not differ by participant characteristics including gender, age group or place of residence (Saskatoon compared to other locations). A lower proportion (55%) of participants who self-identified as Indigenous compared to non-Indigenous (76%) endorsed "no travel required" as a perceived benefit of virtual visits ($\chi 2=4.187$; $p=0.041$). There was no association with any other perceived benefits including easier access to counseling, time savings, emotional and physical comfort.

5.4.6 Challenges of virtual care

Despite the benefits, participants also experienced challenges with virtual care for mental health needs. The most frequently reported problems included distractions in the environment during appointments, lack of privacy, poor or no access to the internet or difficulties connecting to virtual care platforms (Figure 6). For some participants it was easier to choose not to attend virtual appointments. Twenty-three (20.9%) participants reported no challenges with virtual care. Other reported challenges included cancellations by the counsellor, inability to communicate thoughts and feelings when not in person and perceived formality or virtual care interactions.

Figure 6: Perceived challenges encountered with virtual care

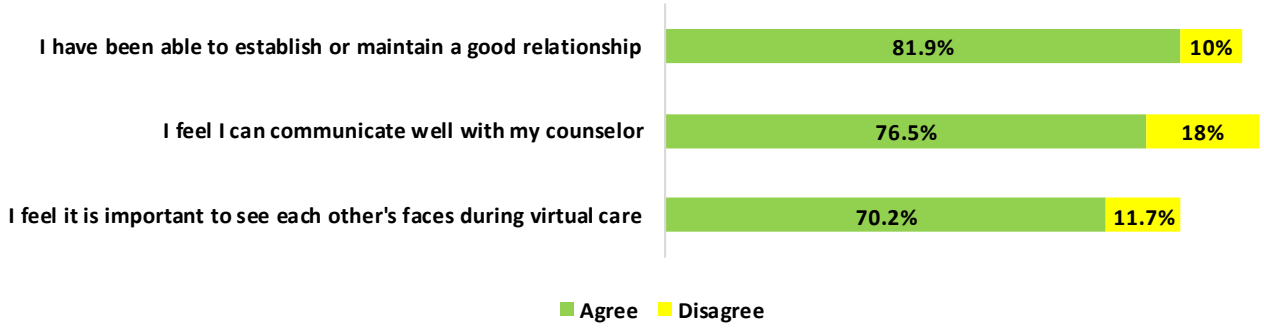


Two perceived challenges of virtual care were more frequently reported by females compared to males. The small number of participants who self-identified as nonbinary were excluded in these analyses. Lack of privacy was reported by 40% of females compared to 18% of males (χ^2=4.891, p=0.027). Difficulty connecting to the virtual platform was reported by only 3% of male and 22% of female participants ($\chi 2$ =6.165, p=0.013). Other perceived challenges were not associated with gender, age or place of residence (Saskatoon versus other locations).

5.4.7. Client-counselor relationships

Participants were asked about their experience establishing and/or maintaining quality relationships with a counselor during virtual visits. More than three quarters of participants reported that they could communicate well with their counselor (n=85, 76.5%) and had been able to establish good client-counselor relationships (n=91, 81.9%). It was also important to most clients to see their counselor's face during virtual care (Figure 7).

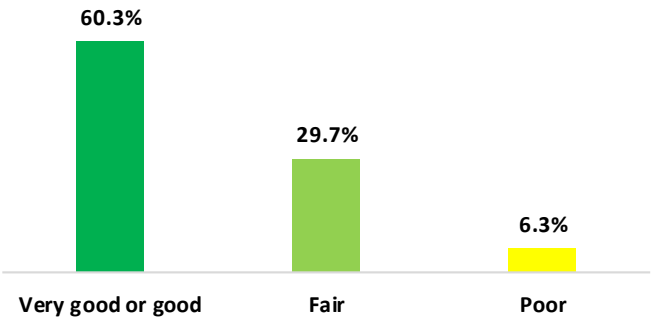
Figure 7: Quality of client-counselor relationships



5.4.8. Overall virtual care experience

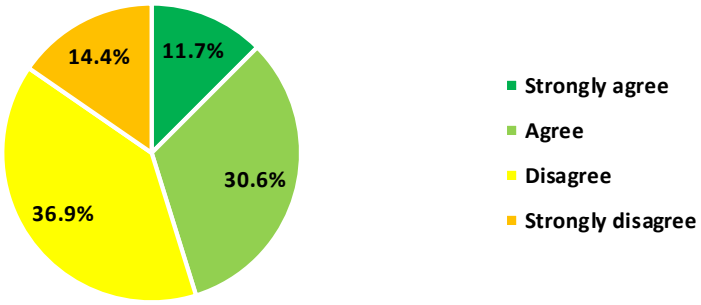
Over half (n=67, 60.3%) described the overall care experience as good or very good while 33 (29.7%) rated their experience as "fair" and seven (6.3%) had a poor experience. There was no association between the overall rating of participants' virtual care experience and gender, age group or place of residence. (Figure 8)

Figure 8: Overall virtual care experience



Just over two thirds of participants (n=75) felt that virtual care had helped them while 23 (20.7%) did not. Despite positive experiences with virtual care, just over half of participants (n=57, 51.4%) did not feel that it was as effective as in-person care (Figure 9). Perceptions of whether virtual care helped were not associated with gender, age or place of residence. Beliefs about the effectiveness of virtual care did not differ by age group, gender or location (supplementary analyses in appendix).

Figure 9: Virtual care is as effective as in-person care



6. Discussion

The emergence of the COVID pandemic and public health restrictions resulted in local Mental Health and Addictions services pivoting to deliver care virtually, without much time to plan for the transition. This gave little opportunity to prepare clients and providers for the adjustment to almost complete virtual service delivery. However, it was critical to minimize disruption to services at a time when the need for mental health and behavioral services would increase due to psychological, social, and economic consequences of the pandemic. This evaluation offered the opportunity to gather information about clients, families, and clinicians' experiences with virtual mental health care as well as document lessons about whether and how to integrate new modalities alongside traditional approaches. To the best of our knowledge, this is the first local study of youth perceptions and experiences with virtual mental health care and contributes to understanding their needs, preferences and expectations for future service delivery.

Overall, clinicians and clients felt that having virtual mental health care during the pandemic was a good adjunct, but it would not serve to replace in-person care in the future. Pexip, the locally approved platform for therapy, was problematic and created challenges to providing care. For example, having the connection break up as a client is attempting to describe their suicidal thoughts is extremely concerning, and clients who experience such connection issues may not want to continue with mental healthcare. Face-to-face conversations felt more personal and clients valued the ability to see the counselor's facial expressions and body language. As such, a better video platform for delivering virtual care is necessary. It was also recognized that alternative platforms should be accessible to clients who may have limited technology equipment and internet access. As such, telephone calls were often the medium of care despite the limitations of this method. Clinicians also felt they needed more resources and allocated time for virtual counselling training.

Virtual care was seen as accessible, convenient, and helpful for fast contact or regular check-in sessions, lining up with other studies that have reported these factors as key advantages of virtual care (Boydell et al., 2014; Sweeney et al., 2019). Virtual visits also meant fewer late and missed appointments as some clients were able to reschedule appointments through text. This finding has been reported in another study (Hilty et al., 2013).

This might also add value for the health care system as fewer opportunities are missed to deliver needed care without reducing the overall volume of care (Miller & Ambrose, 2019). Some clients felt more comfortable in their own space and experienced less anxiety and pressure than when speaking to a person face-to-face. This is consistent with the 'online calming hypothesis' that claims that clients may experience the virtual environment as more comfortable and less threatening that in-person encounters particularly for those with anxiety-based disorders and other groups who find close contact overwhelming (Reynolds, Stiles, Bailer, & Hughes, 2013). However, virtual visits reduced opportunities to develop coping skills or learn to manage anxiety-provoking situations. Clinicians also found virtual care beneficial as it provided unique insight into their clients' lives that they would not otherwise have had during in-person office visits. The opportunity to observe and work through behaviors in settings where they occur was another advantage of virtual visits.

For many clinicians there was a learning curve with the adoption of virtual care delivery. The ability to provide certain types of therapies was limited and clinicians could not use interactive or hands-on approaches with clients who needed it. Some therapeutic approaches were modified to enhance virtual communication and to compensate for loss of visual cues. Clinicians raised concerns about the opportunity to verify the client's location during virtual visits (Rochlen, Zack & Speyer, 2004). It was also challenging to recognize and address unconstructive behaviours within the virtual therapy setting. Some clinicians reported that virtual care presented challenges with parental engagement and development of collaborative relationships. Additionally, although there were regular virtual team meetings for clinicians, the loss of physical proximity to colleagues contributed to a feeling of professional isolation and difficulty reaching out for support when necessary.

The importance of positive therapeutic relationships was recognized by both clients and clinicians as a central ingredient for successful outcomes (Horvath et al., 2011; Wampold & Imel, 2015). For some clients, virtual care environments facilitated self-disclosure and openness and allowed for discussion of difficult issues (Lingley-Pottie et al., 2013). The disinhibiting effects of an online medium have been recognized in several studies (Suler, 2004; Hu, Kumar, Huang, Ratnaevelu, 2017). However, some clinicians and clients found it more difficult to build rapport and create a trusting relationship without a prior in-person interaction. Clinicians and clients felt that having at least one in-person session greatly helped to build or maintain a therapeutic relationship. However, clients also noted that the success of virtual care greatly depends on counselor characteristics, capacity to connect with the client and the way they facilitated the session. These findings are supported by CAMH policy recommendations to personalize care to meet client needs (Gratzner et al., 2020).

Lack of privacy and distractions in the environment were common challenges for clients during virtual sessions and have been described in other studies (Hawke et al., 2021; Langarizadeh et al., 2017). When clients are not able to speak freely or do not give full attention to their counselor, they are less likely to have meaningful therapy sessions. These barriers are important to consider in selection of clients who benefit from virtual visits.

Both clinicians and clients felt that virtual sessions were perceived as more casual or optional and were easier to avoid than an in-person session when clients did not want to attend. While this observation acknowledges client autonomy and control in the therapeutic relationship, it might also undermine client outcomes (Hanley et al., 2012). Some youth found it easier to avoid discussing difficult issues and conceal their feelings or what was

happening in their lives. Clients felt that it was important for clinicians to notice these patterns and hold clients to account.

Clients had mixed responses when asked whether virtual care had reduced the stigma often associated with accessing mental health care. There was a sense that the COVID-19 pandemic had increased awareness about mental health, encouraged open discussions and reduced the stigma surrounding it. Some felt that they had not experienced much stigma previously around accessing mental health care in the time they had been doing so. However, others felt that not having to go to a building to receive therapy helped to reduce the anxiety of perceived stigma. This is consistent with advantages of virtual care in reducing the stigma barrier reported in other studies (Knaak, Mantler & Szeto et al., 2017; Radez et al., 2020).

Some youth felt that counselors did not understand the severity of their situation with virtual care. In these instances, issues were underestimated or not addressed during sessions and clients felt they did not receive the care they needed. Although most clients had a positive overall experience with virtual delivery of care, they felt that it did not provide the same benefits as in-person care. Of concern is that, for some, virtual care actually contributed to the feeling of being alone and disconnected from other people. These findings suggest that although virtual delivery of mental health therapy is promising, more work is needed to understand how to tailor available technologies to clients' situations and needs.

6.1 Strengths and limitations

The evaluation had a number of strengths including the use of multiple methods of inquiry and sources of information to understand different perspectives about virtual care delivery. A collaborative process with youth and family engagement was valuable throughout various project phases to ensure relevance, transferability and credibility.

Although findings are transferable to the local youth population, they may not be generalizable to all subgroups. The survey and focus groups were conducted on-line, thereby likely excluding those who do not have the resources to easily access these technologies. Additionally, some clients had only experienced virtual care and could not offer a comparison to in-person encounters. The questionnaire was checked for face validity by peers and the youth population; however, the questions were not tested for reliability. There also might have been additional barriers for participation for some youth as the survey invitation was sent to parents who may not have bothered to share it with their children.

7. Recommendations

Based on the results of the evaluation, the following recommendations are made:

- A client-centered approach should guide clinicians' selection of the therapy formats that best meet client needs and preferences.
- A platform that is easy to use, does not tend to lag or have glitches, and allows for face-to-face interactions would help to create and maintain the therapeutic relationship between client and counselor. Use of additional platforms, such as email or texting, would create more variety of options and allow clients to use what works for them.
- Increased training around the virtual delivery of different types of therapeutic approaches would help clinicians to be more effective in their use of virtual care. Additionally, increased team collaboration and greater support within the YMHAS team would help to combat professional isolation, increase the feeling of support for clinicians, and facilitate the exchange of ideas for successful virtual care.
- Although creation of a trusting relationship is part of all therapeutic processes, recognition of the difficulties in establishing a relationship virtually and the use of deliberate practices to overcome these difficulties should be established.
- A purposeful discussion at the start of virtual care about the idiosyncrasies of virtual care compared to in-person care, including the tendency for distraction and the perception of optionality of virtual care, could help to address these issues before they become problematic.
- Greater clinician awareness of the difficulties sometimes experienced by clients in expressing themselves over virtual platforms and the potential for misunderstandings may help clinicians to ensure they understand the needs of their clients and how they would best benefit from mental healthcare.
- Greater efforts are needed to increase access to care for marginalized groups for whom virtual visits may be appropriate but remain unfeasible.

8. Conclusions

Virtual delivery of mental health care was experienced as a necessary alternative to minimize disruption to care particularly during the COVID pandemic. The consensus emerged that client-centered approaches should inform selection of therapy delivery formats that best meet clients and families' care needs and preferences. Both clients and clinicians acknowledged the benefits and limitations of virtual options and expressed interest in seeing integration into existing care pathways post pandemic. However, greater efforts are needed to increase access to technology for marginalized groups for whom virtual visits may be appropriate but remain unfeasible. A better understanding of longer-term outcomes and impact of utilization of virtual care is needed to inform implementation going forward.

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Appendix I: Clinician Interview Guide

1. What type of virtual care platform have you used to deliver care (for example, Pexip, texting, telephone calls)?
    a. What types of virtual care platform(s) have worked best for you?
2. Do you feel that virtual care limits accessibility to mental health care? In what ways?
3. Do you feel that virtual care enhances accessibility to mental health care? In what ways?
4. How has virtual care changed the delivery of mental health therapies?
5. How has virtual care changed the therapeutic relationship between clients and clinicians?
6. Is there a difference in the therapeutic relationship between new clients whom you have not met in person and existing clients with whom you may have had a couple of in-person sessions before moving to virtual care?
7. What are some benefits you encountered with virtual care as opposed to in person care?
8. What are some challenges you faced with providing virtual care? Have you been able to overcome these challenges?
9. Assuming that you are able to offer both virtual care and in-person care, what kind of mix of care do you think would be best? Should it be either/or, or a combination of both?
10. If you feel that both virtual care and in person care would be a good path forward, when would you suggest that virtual care be utilized and when should in-person care be utilized?
11. We've talked about some of the benefits and challenges, but what would your preference be for providing care when we're not in a pandemic?
12. Do you have any other comments or suggestions for improving virtual care?
13. Those are all the questions I have, but is there anything else you'd like to mention before we close?

Appendix II: Client focus group discussion guide

1. What type of virtual care platform have you used? (i.e. Pexip, texting, telephone)
2. What type of virtual care platform do you prefer? (i.e. Pexip, texting, telephone)
3. Other platforms, such as FaceTime or zoom, might be more convenient but they are also less secure. Would you prefer to use a different type of virtual platform?
4. Do you feel that virtual care has made it more difficult for you to access mental health care? In what ways? (I.e. access to technology, comfortability, privacy, etc.)
5. Do you feel that virtual care has made it easier for you to access mental health care? In what ways? (i.e. transportation, scheduling, and keeping appointments, etc.)
6. Do you think that virtual care helps to reduce the stigma around getting mental health care? How so?
7. What have you found positive about virtual care? Do you have any examples of this?
8. What have you found difficult about virtual care? Do you have any examples of this?
9. Has virtual care affected your relationship with your counsellor? If so, in what ways?
10. It's not always easy to build a relationship with someone online. What has helped you to connect with your counsellor and build a sense of trust and safety?
11. Overall, do you feel that virtual care is meeting your mental health needs?
12. What kind of mix of in-person and virtual care would you like to see in the future?
    a. Should it be either/or, or a combination or both?
13. Do you have any other suggestions on how to improve virtual care?

Appendix III: Client Survey Questionnaire

The Saskatchewan Health Authority would like to learn more about your experiences with virtual mental health care through Youth Mental Health and Addiction Services (YMHAS) to improve your care. Please reflect on your experiences with virtual mental health care with YMHAS, including emails, text messages, phone calls and Pexip appointments when answering the following questions.

Since the COVID-19 pandemic began in March 2020, what type of mental health care have you received with Youth Mental Health Addiction Services (YMHAS)?

☐ Only virtual care (including telephone texting and other platforms such as Pexip)
☐ Only in-person care
☐ A mix of in-person and virtual care
☐ None

Approximately how many virtual care appointments through YMHAS have you attended (includes telephone, texting, and other platforms, such as Pexip)?

☐ 0
☐ 1
☐ 3 to 4
☐ 5 to 8
☐ 8 or more
☐ Prefer not to say

What symptoms do you experience? Please check all that apply.

☐Anxiety
☐Depression
☐Attention difficulties
☐Extreme anger or aggression
☐Substance use
☐Disordered eating
☐Post-traumatic stress
☐Obsessions or compulsions
☐Self-harm
☐Suicidal ideation
☐Hallucinations
☐Mania
☐ Prefer not to say
☐Other (please specify)

Please specify other symptoms not on the list above. _____

How much do your mental health struggles affect your daily life?
☐Not very much - You have a small number of symptoms that have a limited effect on your daily life
☐Somewhat - You have more symptoms that make your life much more difficult than normal
☐A lot - You have many symptoms that can make your life extremely difficult
☐Prefer not to say

What types of platforms(s) do you use to access virtual care through YMHAS? Please select all that apply.
☐Text
☐Email
☐Telephone
☐Pexip
☐Prefer not to say
☐Other (please specify)

Please specify other platforms not on the list above: _____

What virtual care platform(s) would you prefer to use? Please select all that apply.
☐Email
☐Text
☐Telephone
☐Pexip
☐Prefer not to say

Would you prefer to use any other platforms for virtual mental health care? Please check all that apply
☐FaceTime
☐Zoom
☐Skype
☐WhatsApp
☐Facebook messenger
☐None
☐Prefer not to say

Experiences with Virtual Care

It was easy for me to connect to my virtual care appointments
☐Strongly agree
☐Agree
☐Disagree
☐Strongly disagree
☐Not applicable to me
☐Prefer not to say

During my virtual care appointment(s), I was able to see my counsellor clearly.
☐Strongly agree
☐Agree
☐Disagree
☐Strongly disagree
☐Not applicable to me
☐Prefer not to say

During my virtual care appointment(s), I was able to hear my counsellor clearly
☐Strongly agree
☐Agree
☐Disagree
☐Strongly disagree
☐Not applicable to me
☐Prefer not to say

During my virtual care appointment(s), I had a private space where I could go to.
☐Strongly agree
☐Agree
☐Disagree
☐Strongly disagree
☐Not applicable to me
☐Prefer not to say

I feel I can communicate well with my counselor during virtual care
☐Strongly agree
☐Agree
☐Disagree
☐Strongly disagree
☐Not applicable to me
☐Prefer not to say

I feel it's important to see each other's faces during virtual care
☐Strongly agree
☐Agree
☐Disagree
☐Strongly disagree
☐Not applicable to me
☐Prefer not to say

I have been able to establish or maintain a good relationship with my counsellor through virtual care.
☐Strongly agree
☐Agree
☐Disagree

☐Strongly disagree
☐Not applicable to me
☐Prefer not to say

I believe that virtual care is as effective as in-person care
☐Strongly agree
☐Agree
☐Disagree
☐Strongly disagree
☐Not applicable to me
☐Prefer not to say

Overall, I feel like virtual care has helped me.
☐Strongly agree
☐Agree
☐Disagree
☐Strongly disagree
☐Not applicable to me
☐Prefer not to say

What are some of the benefits you have experienced through virtual care? Please check all that apply:
☐Easier access to counseling support
☐No travel required
☐Time savings
☐Fewer missed appointments
☐Physical comfort
☐Emotional comfort
☐None
☐Prefer not to say
☐Other (please specify)

Please specify other benefits not listed above: _____

What are some of the challenges you have experienced with virtual care? Please check all that apply:
☐Lack of privacy
☐Limited access to devices
☐Poor or no internet access
☐Lack of technical knowledge
☐Difficulty connecting to virtual care platforms
☐Distractions during the appointment
☐Easier to choose not to attend appointments
☐Clinicians not calling at the appointment time
☐None
☐Prefer not to say

☐Other (please specify)

Please specify other challenges not listed above: _____

Overall, how would you rate your experiences with virtual care?
☐Very poor
☐Poor
☐Fair
☐Good
☐Very good
☐Prefer not to say

Demographics
What is your age?
☐10-12
☐13-15
☐16-18
☐Prefer not to answer

Please describe your gender:
☐Male
☐Female
☐Nonbinary
☐Prefer not to answer
☐Other (please specify)

Please describe your gender if not listed above: _____

Where is your home located?
☐Saskatoon
☐Surrounding town or city (e.g. Martensville, Warman)
☐Rural and remote (e.g. farm, acreage)
☐Prefer not to answer

People in Canada come from many different racial and ethnic backgrounds. Do you consider yourself to be? (Please check all that apply)
☐Arab
☐Asian
☐Black
☐Inuit
☐First Nations
☐Hispanic or Latino
☐Métis
☐White

☐None of the above
☐Prefer not to answer

Appendix IV: Supplementary survey analyses

Table 1: Cross tabulations for gender and perceived benefits

Perceived Benefits of virtual care	Gender		Test statistic	value
	Female N=67	Male N=33		
Easier access to counseling support			0.244	0.621
Yes	36	16		
No	31	17		
No travel required			0.695	0.273
Yes	50	22		
No	17	11		
Time savings			0.407	0.523
Yes	32	18		
No	35	15		
Fewer missed appointments				
Yes	15	6	0.236	0.627
No	52	27		
Physical comfort			0.190	0.663
Yes	19	8		
No	48	25		
Emotional comfort			0.136	0.713
Yes	16	9		
No	51	24		
None			0.586	0.444
Yes	5	4		
No	62	29		
Prefer				
Yes	4	0	*	*
No	63	33		
Other			*	*

***Not valid due to small cell sizes**

Participants who self-identified as Nonbinary were excluded from analyses due to small numbers

Table 2: Cross tabulations for association between age group and perceived benefits

Perceived challenges of virtual care	Age group		Test statistic	P-value
	13-15	16-18		
Lack of privacy			3.660	0.056
Yes	15	22		
No	38	25		
Limited access to devices				
Yes	2	1	*	*
No	51	46		
Poor or no internet access			0.079	0.778
Yes	9	9		
No	44	38		
Lack of technical knowledge				
Yes	3	4	*	*
No	50	43		
Difficulty connecting to virtual platforms			1.323	0.250
Yes	10	5		
No	43	42		
Distractions			1.109	0.292
Yes	27	19		
No	26	28		
Easier to choose not to attend			0.582	0.446
Yes	16	11		
No	37	36		
Clinicians not calling at appointment time			0.672	0.412
Yes	6	8		
No	47	39		
None			0.846	0.358
Yes	13	8		
No	40	39		

*Not valid due to small cell sizes

Age group 10-12 was excluded from these analyses due to small numbers

Table 3: Cross tabulations for associations between location and perceived benefits of virtual care

Perceived benefits of virtual care	Location		Test statistic	p-value
	Saskatoon N=81	Other N=30		
Easier to access counseling support			0.204	0.652
Yes	42	17		
No	39	13		
No travel required			2.590	0.108
Yes	55	25		
No	26	5		
Fewer missed appointments			0.013	0.909
Yes	17	6		
No	64	24		
Time savings			1.500	0.221
Yes	38	18		
No	43	12		
Physical comfort			0.166	0.684
Yes	22	7		
No	59	23		
Emotional comfort			1.597	0.206
Yes	23	5		
No	58	25		
None			*	*
Yes	9	1		
No	72	29		

***Not valid due to small numbers and violation of test assumptions**

Table 4: Cross tabulations for gender and perceived challenges of virtual care

Perceived challenges				
	Female	Male	Test statistic	P-value
Lack of privacy	N=67	N=33		
Yes	27	6	4.891	0.027
No	40	27		
Limited access to devices				
Yes	1	1	*	*
No	66	32		
Poor or no internet access				
Yes	13	3	1.749	0.186
No	54	30		
Lack of technical knowledge				
Yes	6	3	*	*
No	61	30		
Difficulty connecting to virtual platform				
Yes	15	1	6.165	0.013
No	52	32		
Distractions				
Yes	33	11	2.274	0.132
No	34	22		
Easier to choose not to attend appointments				
Yes	15	8	0.043	0.836
No	52	25		
Clinicians not calling at the appointment time				
Yes	10	3	*	*
No	57	30		
None				
Yes	13	9	0.798	0.372
No	54	24		

Table 5: Cross tabulations for the association between age groups and perceived challenges pf virtual care

Perceived challenges of virtual care	Age group		Test statistic	P-value
	13-15	16-18		
Lack of privacy				
Yes	15	22	3.660	0.056
No	38	25		
Limited access to devices				
Yes	2	1	*	*
No	51	46		
Poor or no internet access				
Yes	9	9	0.079	0.778
No	44	38		
Lack of technical knowledge				
Yes	3	4	*	*
No	50	43		
Difficulty connecting to virtual platforms				
Yes	10	5	1.323	0.250
No	43	42		
Distractions				
Yes	27	19	1.109	0.292
No	26	28		
Easier to choose not to attend				
Yes	16	11	0.582	0.446
No	37	36		
Clinicians not calling at appointment time				
Yes	6	8	0.672	0.412
No	47	39		
None				
Yes	13	8	0.846	0.358
No	40	39		

Table 6: Cross tabulations for associations between location and perceived challenges

Perceived challenges	Age group		Test statistic	P-value
	13-15	16-18		
Lack of privacy	N=81	N=30		
Yes	28	11	0.042	0.837
No	53	19		
Poor or no internet access				
Yes	13	6	0.241	0.624
No	68	24		
Difficulty connecting to virtual platforms				
Yes	13	5	*	*
No	68	25		
Distractions during appointments			0.009	0.926
Yes	37	14		
No	44	16		
Easier to choose not to attend appointments				
Yes	20	8	0.045	0.831
No	61	22		
None				
Yes	16	7	0.171	0.679
No	65	23		

Table 7: Cross tabulations for association between gender, age group and location and perceived virtual care helped

Variables	Virtual care helped me		Test statistic	P-value
	Yes	No		
Gender	N=69	N=20		
Female	47	13	0.069	0.793
Male	22	7		
Age group	N=68	N=21		
13-15	31	14	2.852	0.091
16-18	37	7		
Location	N=75	N=23		
Saskatoon	57	14	2.019	0.155
Other	18	9		

Table 8: Cross tabulations for associations between gender, age group and location and overall positive virtual care experience

Variables	Overall virtual care experience is good		Test statistic	P value
	Yes	No		
Gender Female Male	N=61 41 26	N=39 20 13	0.003	0.955
Age group 13-15 16-18	N=62 32 30	N=38 21 17	0.126	0.723
Location Saskatoon Other	N=67 49 18	N=44 32 12	0.002	0.962

Table 9: Cross tabulations for association between gender, age group and location and beliefs about effectiveness of virtual care

Variables	Virtual care as effective as in-person care		Test statistic	P-value
	Yes	No		
Gender **Female** **Male**	N=43 31 12	N=50 33 17	0.400	0.527
Age group **13-15** **16-18**	N=45 20 25	N=48 29 19	2.377	0.123
Location **Saskatoon** **Other**	N=47 37 10	N=57 40 17	0.979	0.322