The TeleViews Study

Children’s Mental Health in Rural Communities: Young People’s Perspectives on Receiving Services via Televideo

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Table of Contents

MAIN MESSAGES AND RECOMMENDATIONS .................................................................1
INTRODUCTION ...........................................................................................................4
BACKGROUND ...........................................................................................................5
  Emotional and Behavioural Disorders in Children and Youth ..............................5
  Telepsychiatry .........................................................................................................5
  Paediatric Telepsychiatry .........................................................................................7
GOALS AND OBJECTIVES .......................................................................................8
RESEARCH METHOD ...............................................................................................9
  Conceptual Framework .........................................................................................9
  Study Sites ..........................................................................................................10
  Participants .........................................................................................................10
  Recruitment .........................................................................................................12
  Data Collection ...................................................................................................13
  Analysis ................................................................................................................14
  Research Rigor .....................................................................................................15
  Ethics ...................................................................................................................16
RESULTS ..................................................................................................................16
  Phase 1 Focus Groups .........................................................................................16
  Phase 2 Interviews .............................................................................................20
DISCUSSION .............................................................................................................30
  Challenges of Conducting Research in Rural Communities .............................34
FUTURE RESEARCH ...............................................................................................36
QUALITATIVE RESEARCH AND POTENTIAL FOR IMPACT .................................37
REFERENCES ..........................................................................................................39
APPENDICES ...........................................................................................................48
MAIN MESSAGES AND RECOMMENDATIONS

This research uses an interpretive interactionist approach to understand the perspectives of child and adolescent service users in seven rural children’s mental health organizations that provide telepsychiatry consultation services. Study results from focus group and in-depth interviews with young people revolved around a number of issues concerning the experience of receiving psychiatric services via televideo, with four key areas emerging as of particular interest to participants: 1) the encounter with the psychiatrist and the experience of having others in the room; 2) the perceived helpfulness of the session; 3) the sense of personal choice and individual responsibility (or lack thereof) during the consultation; and, 4) the technology itself as a key aspect of the psychiatric consultation. The following main messages and recommendations emerged from our analysis of the data:

The Encounter

• Participants made many references to the expertise and valued qualities of the psychiatrist, particularly that the psychiatrist listened to them and “did their homework”. They appreciated the opportunity to release pent-up emotions and thoughts, as well as having these thoughts heard and understood by the psychiatrist. A number of participants noted the psychiatrist’s ability to listen to them without being judged.

• Young people expressed the strong desire to have a more extended relationship with the psychiatrist. Participants wanted to know something about the psychiatrist “as a person”, to start off the session “small, and build up to the big issues”. With some warm up and small talk, participants felt that trust and rapport would be enhanced.

• Participants highlighted the importance of talking to psychiatrist one-on-one, without parents in the room, providing them with more freedom “to say stuff”. On the other hand, some found it reassuring to have others present with them as it provided comfort by a positive figure during the stressful consultation.

• Strategies for developing these ‘helpful’ aspects of the consultation could be further developed during consultations with young people. One strategy to increase young people’s comfort level includes informing them that the psychiatrist has received their case history and is ‘prepped’ for their session.
Helpfulness of the Session

- Participants who found the consultation helpful pointed to the new knowledge gained around diagnosis, medications, and coping mechanisms. Others suggested that the session was most helpful for others who were in the room during the consultation, but not necessarily for them directly. They mentioned that their parents or case workers may have benefited from increased insight into the issues with which they were grappling.

- Some believed the session was of limited helpfulness, due to the single-session consultation model, as well as the relatively short time with the psychiatrist. Participants suggested that more than one meeting with the psychiatrist would be helpful. This would allow the psychiatrist the opportunity to understand them better, and provide a more informed perspective of their issues and what is going on in their lives before being provided with a diagnosis and/or recommendations for treatment. Consequently, the program should focus on exploring an expansion of the service model from a single-session consultation to include the option of a consistent series of consultations for a young person.

Personal Choice and Responsibility

- Young people expressed a sense of personal choice and responsibility (or lack thereof) and the importance of feeling in control during the session. Young people’s narratives were replete with examples of the ways in which they were able to exert ‘control’ within the encounter, as well as after. In some cases, young people denied the existence of a problem. In other instances, participants who indicated that they were opposed to taking medication chose not to follow through on recommendations made in this area.

- Results suggest that if young people are not comfortable, or do not buy into the service model and treatment recommendations, the likelihood of treatment adherence and successful outcomes are reduced. It is thus critical that during the consultation, emphasis be placed on asking young people about the ways in which they define their problem. Recommendations be thoroughly explained to young people and an opportunity be provided for them to openly express their concerns and discuss possible alternatives. The Toronto Paediatric Telepsychiatry Program has undertaken, through its Quality Assurance process, to ensure that consultants ask whether all recommendations made are both feasible and acceptable to all participants,
including parents, young people, and others. Further efforts to include young people may include ensuring alternate treatments are offered and/or negotiated when recommended treatments are not acceptable and/or resisted.

*The Technology*

- Participants were enthusiastic about the technology’s ability to connect them, both aurally and visually, with someone relatively far away. Levels of discomfort with the technology were replaced by comfort fairly quickly and most certainly by end of session. Young people in this study explained that the most positive facet of their telepsychiatry consultations was the opportunity to be exposed to a new form of technology. They referred to the novelty of the experience as the “best part” of the process for them and repeatedly used the term “*cool*” to describe their encounter. It would be useful to capitalize on the novelty aspect by highlighting the cutting edge technology used in the session.

- Study results suggest pragmatic strategies that would help to make the telepsychiatry consultation a better one for the young people involved. A lay language, user-friendly brochure or postcard could be used to prepare young people for their consultation. It could detail the specifics of what to expect during the consultation. As our participants suggested, including the words of other young people who have experienced this form of treatment would help to make it a more engaging way of transmitting information. Although a standard protocol for preparing young people before the consultation has been recommended for all remote sites, our findings suggest that it is not being implemented consistently. The telepsychiatry program could communicate to agencies the importance of the protocol, and work with them to find ways of improving adherence to the protocol, or assisting with any barriers to implementation. Further, consultations could be extended by 5-10 minutes to allow time for informal chatter, to establish rapport and identify the reasons for the consultation.
The TeleViews Study

Children’s Mental Health in Rural Communities: Young People’s Perspectives on Receiving Services via Televideo

INTRODUCTION

This study builds on a multi-phase program of research in paediatric telepsychiatry\(^1\) that focuses on including the voices of a diverse range of stakeholders in the evaluation and delivery of children's mental health services. The research program takes a participatory approach and has several aims: to assess the degree to which these stakeholders feel the goals of delivering mental health services via televideo technologies are being met; to enhance service access and utilization for children and youth with mental health problems; and to increase research and knowledge exchange capacity in rural communities (Boydell, Greenberg & Volpe, 2004; Greenberg, Boydell & Volpe, 2006; Boydell, Volpe, Kertes et al., 2007; Goering, Boydell & Pignatiello, 2008; Boydell, Volpe & Pignatiello, in press; Pignatiello, Boydell, Teshima et al., 2008). To date, research priorities have included: 1) development of a participatory framework for evaluation (Boydell, Greenberg & Volpe, 2004); 2) a study of the perspectives of service providers and family members (Greenberg, Boydell & Volpe, 2006); 3) a study of the opinions of consulting psychiatrists and community general practitioners and paediatricians (Boydell, Volpe, Kertes et al., under review), and 4) a case study of recommendations made in a telepsychiatry consultation and whether or not they were successfully implemented (Boydell, Volpe, Kertes et al., 2007). One group of voices yet to be heard, though, is that of the young people who receive telepsychiatry services. This study provides young people the opportunity to voice their experiences and understandings of receiving psychiatric services via televideo, and to describe in their own words the role such services played in their mental health treatment. The research uses an interpretive interactionist approach to understand the perspectives of child and adolescent service users in seven rural children’s mental health organizations that provide telepsychiatry consultation services.

\(^1\) Telepsychiatry is defined as the use of electronic communication technology to eliminate or reduce geographic barriers to receiving psychiatric services (Urness, 2003).
BACKGROUND

Emotional and Behavioural Disorders in Children and Youth

Children’s mental health is closely related to physical health, successful achievement in a school setting, responsible behaviour towards others, and decreased delinquency (Child Mental Health Committee, 1997). In the epidemiologic literature, prevalence rates of at least one psychiatric disorder in community samples of children and adolescents range from 15 to 25 percent (Parker, Steele, Junek et al., 2003). In an internationally recognized study of the prevalence of mental health problems among children in Ontario, Offord and his colleagues (1989) demonstrated that 18 percent of children and youth (452,500 individuals) suffered from a diagnosable psychiatric disorder in the years four to 16 and that two-thirds of those suffered from more than one disorder. These emotional disabilities seriously disrupt the child’s ability to interact effectively with family, at school, and in the community. These children are diverse: they live in cities, suburbs and rural areas; come from wealthy, middle-class and poor families; and from every race and culture. Evidence compiled by the Global Burden of Disease Study indicates that by the year 2020, childhood psychiatric disorders will increase proportionately by over 50% internationally, to become one of the five most common causes for morbidity, mortality and disability among children (Murray & Lopez, 1996). Such anticipated growth far exceeds that of any other paediatric causes of morbidity and mortality (e.g. accidents, asthma, diabetes, physical disabilities, etc.). This startling forecast reflects the urgency for research in children’s mental health systems.

Telepsychiatry

In Ontario, rural and northern communities suffer from a severe shortage of psychiatric expertise (Parker, Steele, Junek et al., 2003). These communities are currently served by two and one-half on-site full time equivalents of child psychiatric time, supplemented by child psychiatrists who fly in for short periods of time or adult psychiatrists who are willing to see children and adolescents, as well as some paediatricians and family doctors who are prepared to address the mental health needs of their patients (Broder, Manson, Boydell et al., 2004). Given this problem, the delivery of mental health services for adolescents (and adults) using new
technologies is a growing area of practice and research interest. Telemedicine has been used in child and adolescent mental health services around the world. Yet, qualitative and quantitative research into the benefits, drawbacks, and outcomes of telepsychiatry services remains limited. Descriptive literature on existing programs tends to espouse goals of improved access to necessary services, decreased costs to the consumer and the health system, reduced inconvenience and displacement for patients, and increased knowledge among local practitioners. However, little is written about how to achieve these goals, and whether these goals are being met (see, for example, Hailey & Jennett 2004; Jennett, Hall, Hailey et al., 2003; Liss, Glueckauf & Ecklund-Johnson, 2002; Stamm & Perednia 2000; Hailey & Crowe, 2000; Dossetor, Nunn, Fairley et al., 1999; Jennett, Person, Watson et al., 2000; Keller, Murray & Hargrove, 1999).

There is a strong and repeated call for solid quantitative and qualitative data of all types on telemedicine programs, and telepsychiatry in particular (Farrell & McKinnon, 2003; Hailey & Crowe, 2003; Hailey & Jennett 2004; Pesamaa, Ebeling, Kuusimaki et al., 2004; Hilty, 2002; Monnier, Knapp & Frueh, 2003; Hailey & Crowe, 2003; Liss, Glueckauf & Ecklund-Johnson, 2002; Stamm & Perednia, 2000; Alessi, 2000; Schneider, 2001; Aas, 2001; Gammon, Sorlie, Bergvik et al., 1998; May, Gask, Ellis et al., 2000; Miller, 2001; Siden, 1998). Key articles on telepsychiatry reveal that it fills a service gap inherent in remote and rural regions (Cruz, Krupinski, Lopez et al., 2005). Both patients and clinicians typically report high levels of satisfaction with telepsychiatry services (Cruz, Krupinski, Lopez et al., 2005; Frueh, Deitsch, Santos et al., 2000; Mair & Whitten, 2000; Mucic, 2008; Shore, Brooks, Savin et al., 2008). Telepsychiatry is also found to improve accessibility of services and education, as well as reduce time, costs and travel for those in rural communities (Pesamaa, Ebeling, Kuusimaki et al., 2004).

Little in the literature on telepsychiatry offers clear guidelines, protocols, standards, and policy frameworks for establishing and supporting successful programs (Picot, 2000; Osorio, 1998). Furthermore, attempts at creating standardized guidelines for implementing and assessing telepsychiatry programs have demonstrated that local contexts and conditions vary too greatly for these guidelines to be successfully applicable across the board. Flexibility and adaptability are keys to developing context-appropriate telepsychiatry services, and to developing nuanced
assessments of how, when and why telepsychiatry services are successful (Hailey & Crowe, 2003; Greenberg, Boydell & Volpe, 2002; Finch, May, Mair et al., 2003; Slade, 2002; Jennett, Hall, Hailey et al., 2003). One factor demonstrated to be critical in the successful operation of telepsychiatry programs is strong organizational and staff support, and integration into existing health systems (see, for example, Lehoux, Scotte, Denis et al., 2002; Kavanaugh & Hawker, 2001; Campbell, Harris & Hodge, 2001; Aas, 2000, 2001; Johnston, Stavely, Olfert et al., 2000; Frueh, Deitsch, Santos et al., 2000; Mair & Whitten, 2000; Tanriverdi & Iacono, 1999; Berg, 1999; Hawker, Kavanaugh, Yellowlees et al., 1998; Shore, Savin, Novins et al., 2006).

Paediatric Telepsychiatry

Compared to adult telepsychiatry, paediatric telepsychiatry research is in its infancy, although it has received increased attention in recent years (Elford, White, St John et al., 2001). A 2004 review article on videoconferencing in child and adolescent psychiatry demonstrates that most studies on paediatric telepsychiatry examine satisfaction with telecare or describe specific program regimens (Pesamaa, Ebeling, Kuusimaki et al., 2004). Elford et al.’s (2000) randomized control trial of child psychiatric assessments using videoconferencing demonstrated that in 96 percent of cases, the diagnosis and treatment recommendations made through teleconferencing were the same as those made during face-to-face assessments, and no significant differences between assessment types were found for child or parent satisfaction levels. Two recent studies by Myers and colleagues found that referring clinicians (2007) and parents (2008) show high levels of satisfaction with the care received through telepsychiatry.

Of particular note is the marked absence of the voice of young people in the research literature. One exception is Grealish et al.’s (2005) study that examined adolescent perspectives regarding the quality of inpatient assessments and support via videoconferencing. A satisfaction questionnaire was administered to users (N=5) following each consultation (N=20). Adolescents reported heightened empowerment when using the equipment, and felt that they were spoken “to” rather than “at”. They also reported that telemedicine promoted the transfer of power and control by making them feel more comfortable about ending the consultation or walking out. They found the process more structured, and as a result, felt better informed, which resulted in enhanced understanding of their problems. They also experienced increased participation in, and
a shared responsibility for, decision-making regarding their health care. There is a clear need to further explore the perspectives of a larger group of young people regarding their experience with psychiatric services delivered via videoconferencing.

The importance of consulting children and young people about the experiences that affect them is clearly identified in the literature on paediatric mental health services, and there is a growing commitment to listening to their voices (Borland, 2001; Buston, 2002; Claveirole, 2004). Traditional perspectives conceptualize children and young people as developing beings who are not yet able to speak in their own voices (Balen, Holroyd, Mountain et al., 2000). This perspective has led inquiries to focus on human development and data to be collected either by proxy, from adults close to the child, or by objective measures where the child remains passive (Balen, Holroyd, Mountain et al., 2000; Claveirole, 2004). Although this approach has its place, it is controlled by adults and neglects the competence of young people to contribute. More recent beliefs among researchers emphasize the recognition that children need to be given the opportunity to share their feelings and wishes about issues affecting them (Gladstone, Boydell & McKeever, 2006). According to this new paradigm, children are social actors in their own right, in possession of competencies that may be different from adults, but are no less valid, and they are the most reliable source of information about their own experiences and perceptions (Morrow & Richards, 1996; James & Prout, 1997). There has been a recent call for child health researchers to reconsider the critical importance of including the perspectives of young people within research venues (Irwin & Johnson, 2005). This study addresses the significant gap in the current literature, namely the paucity of research on the perspective of young people in general, and in paediatric telepsychiatry research specifically.

GOALS AND OBJECTIVES

Goals
To describe and understand the experience of young people receiving psychiatric services through a paediatric telepsychiatry program (see Appendix A for a description of the Toronto Paediatric Telepsychiatry Program).

Objectives
To explore the young person’s perspective on:
(1) the experience of the psychiatric encounter;
(2) positive and negative aspects of receiving psychiatric services via televideo;
(3) technological barriers and facilitators.

RESEARCH METHOD

Conceptual Framework

A qualitative approach was employed in this study. Qualitative methodology enables theory to be grounded in participants’ experiences and facilitates a meaningful understanding of the complexities concerned with implementing social change (Creswell, 1998). It allows people to speak in their own voice, yielding a richly textured understanding of the phenomena under study. Following the work of Denzin (1989), an interpretive interactionist framework was used to guide the study. Interpretive interactionism is both a perspective and a method, and seeks to highlight the world of problematic lived experience of individuals. These worlds are collected through thick description and personal experience stories, which are then interpreted to reveal the voices, emotions and actions of those studies. Thick description involves capturing the meaning and experience that have occurred in a situation in a rich and detailed manner, creating the conditions for interpretation and understanding (Denzin, 1989, p.144). A personal experience story is a narrative which relates the self of the teller to a significant and personal experience that has already occurred (Denzin, 1989, p.38). A major aim of the interpretive interactionist researcher is to grasp the subjective meanings of the individual positioned within a social context. Like other qualitative research methodologies, the epistemological posture taken by interpretive interactionism questions the possibility of value free inquiry, an objective researcher, and interpretation based on causality (Guba, 1990; Lather, 1990). It assumes that knowledge is socially constructed and the concept of truth depends on the perspective one takes in interpretation (Greene, 1990; Lincoln, 1990).

The study proceeded in two phases. Phase 1 was a preparatory stage wherein three focus groups were conducted with young people who had previously received telepsychiatry services to inform them about the study and to obtain their feedback on a study logo and the guideline interview schedule. Phase 2 focused on in-depth interviews with young people receiving
telepsychiatry services for the first time.

Study Sites

Phase 1 Focus Groups
The study sites in both phases were selected to specifically target the diverse characteristics of the telepsychiatry program sites and the clients they serve. The study sites in the first focus group phase included a sub set of the entire study group: Dilico Ojibway Family Services in Thunder Bay, Jeanne Sauve Family Services in Kapuskasing and Bruce-Grey Children’s Services in Owen Sound.

Phase 2 Interviews
At the outset of the study, our community partners included Tikinagan Child and Family Services in Sioux Lookout (remote), Bruce-Grey Children’s Services in Owen Sound (southern rural), Dilico Ojibway Family Services in Thunder Bay (aboriginal) and Jeanne Sauve Family Services (francophone) in Kapuskasing. Due to shortfalls in recruiting during the first four months of data collection (discussed under recruitment), three additional sites were included in order to increase participant numbers: Muskoka-Parry Sound Community Mental Health Service in Bracebridge, Timiskaming Child and Family Services in Kirkland Lake and Algoma Family Services in Sault Ste. Marie. The Executive Director from each of the study sites acted as a co-investigator on the study and played a critical role in project development, hiring and supervision of a research assistant, participant recruitment, and knowledge translation and exchange.

Participants

Phase 1 Focus Groups
Inclusion criteria for the focus groups were young people aged seven to 18 years, English or French speaking, having received at least one telepsychiatry consultation, and willing to be involved in a focus group. Nine participants from three study sites participated, seven of whom were male. Participants ranged from seven to 17 years of age (mean age=12.7 years), and all had received at least one psychiatric consultation via televideo. Additional demographic information, including diagnosis, was not collected for this phase of the study.

Phase 2 Interviews
A theoretical approach to sampling was adopted using the following criteria: (a) young
people aged seven to 18 years; (b) English or French speaking; (c) no history of Pervasive
Developmental Disorders; (d) no previous experience with a telepsychiatry consultation (later
changed to include those receiving a follow-up consultation; see recruitment below); and, (e)
distribution across geographical regions. The original target of ten interviews from each of the
four study sites proved untenable, as the result of a variety of recruitment challenges (described
below). Upon adjusting the recruitment strategy, 30 participants\(^2\) were successfully recruited, 21
of whom completed a second interview. The age, sex and location of the participants in this
phase of the study are shown in Tables 1 and 2. Eight participants had received a previous
psychiatric consultation. Seven participants from the Kapuskasing site completed interviews in
French.

**Table 1: Interviews: Participant Age and Sex**
(Parentheses indicate number of second interviews completed)

<table>
<thead>
<tr>
<th>AGE</th>
<th>MALE</th>
<th>FEMALE</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>7-12 years</td>
<td>8 (6)</td>
<td>3 (1)</td>
<td>11 (7)</td>
</tr>
<tr>
<td>13-18 years</td>
<td>9 (6)</td>
<td>10 (8)</td>
<td>19 (14)</td>
</tr>
<tr>
<td>Total</td>
<td>17 (12)</td>
<td>13 (9)</td>
<td>30 (21)</td>
</tr>
</tbody>
</table>

**Table 2: Interviews: Study Sites and Participants**
(Parentheses indicate number of second interviews completed)

<table>
<thead>
<tr>
<th>SITE</th>
<th>PARTICIPANTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Owen Sound</td>
<td>11 (8)</td>
</tr>
<tr>
<td>Kapuskasing</td>
<td>10 (10)</td>
</tr>
<tr>
<td>Sault Ste. Marie</td>
<td>5 (2)</td>
</tr>
<tr>
<td>Thunder Bay</td>
<td>3 (1)</td>
</tr>
<tr>
<td>Sioux Lookout</td>
<td>1 (0)</td>
</tr>
<tr>
<td>Bracebridge</td>
<td>0</td>
</tr>
<tr>
<td>Kirkland Lake</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>30 (21)</td>
</tr>
</tbody>
</table>

The most frequent reasons for scheduling the telepsychiatry consultations were: querying
the existence of a psychiatric disorder, medication suggestions or reviews, and dealing with

\(^2\) A decision was made to halt recruitment after 30 interviews as saturation of thematic content had been achieved.
aggressive behaviours. Every participant in this phase either had a previous diagnosis confirmed or, more often, a diagnosis applied for the first time during the consultation. The following diagnoses were confirmed: Oppositional Defiant Disorder (N=13), Attention Deficit/Hyperactivity Disorder (N=9), Mood Disorder (N=9), Learning Disability (N=5), Anxiety Disorder (N=4), Conduct Disorder (N=4), Attachment Disorder (N=3), Developmental Disability (N=2), Fetal Alcohol Syndrome/Fetal Alcohol Effects (N=1), Personality Disorder (N=1), Psychotic Disorder (N=1), and Adjustment Disorder (N=1). More than half (16 of 30 participants) had more than one identified disorder. Two participants were noted to have substance abuse and dependence concerns. Thirteen participants also had psychosocial issues regarding relationship problems (N=9) and problems of abuse and neglect (N=6), with two participants having both of these as listed concerns.

**Recruitment**

**Phase 1 Focus Groups**

Executive directors of the study sites enlisted the help of case managers to identify young people who had had a previous psychiatric consultation and inquire whether they would be interested in participating in a research focus group about receiving services via televideo. Focus groups took place in December 2006 and January 2007.

**Phase 2 Interviews**

Between April 2007 and July 2008, young people scheduled to receive a consultation through the Toronto Paediatric Telepsychiatry Program were approached by agency staff for possible participation in the study. An information letter outlining the purpose and details of the study was distributed to staff to help inform potential participants and their families and aid in the recruitment process. Initial discussions with young people about potential involvement in the study were conducted by their case managers. If the young people expressed interest in learning more about the study, the community-based research assistants contacted them to further explain the study and receive oral consent for participation. Full, written consents were acquired on the day of the interview. A $25 honorarium was provided to participants who were involved in the study and records of participation for community service hours were given to secondary school students.
Significant challenges were encountered in recruiting young people into the study. They included communication difficulties between the research assistants and agency staff, problems for the research team working remotely with research assistants, reduced number of referrals to the paediatric telepsychiatry program during the data collection period (due to summer holidays, for example), potential participants who were outside our age range, refusals, consultations ending early resulting in participants leaving prior to research assistant arrival on site, and fatigue following the consultation, leading to last minute drop outs. There were also difficulties associated with recruiting new research assistants due to turnover. Seven months after beginning data collection, recruitment numbers were well below projected targets and the decision was made to add three study sites and broaden the inclusion criteria to include young people for whom the telepsychiatry consultation was a follow up.

Data Collection

Phase 1 Focus Groups

Focus groups were conducted via televideo with young people from a sample of three of the participating rural communities. The purpose of these focus groups was to engage youth in selecting a visual logo for the study (see Appendix B) and to solicit input and feedback on the semi-structured interview schedule. An agency staff member sat in on the focus groups along with the participants.

Phase 2 Interviews

In-depth interviewing, described by Charmaz (1991) as a “directional conversation that elicits inner views of respondents’ lives as they portray their worlds, experiences and observations” (p.385) was used. The qualitative interview is a particularly useful approach for accessing the perspective and experience of the individual (Devers, 1999; Sandelowski, 1997; Shortell, 1999). Two interview guides for the first and second interviews were developed and modified following input from youth in Phase 1, with different sets of questions for older and younger participants (McCracken, 1988) (see Appendix C and D). The interview guides were further modified for participants who had previous experience with telepsychiatry (see Appendix E and F). The semi-structured interviews allowed flexibility to maximize information gathering, of particular importance when interviewing younger individuals who might have a limited
attention span (Gubrium & Holstein, 1997). The guides were used to invite participants to
describe their perceptions and experiences of participating in a paediatric telepsychiatry
consultation. In addition, basic demographic data was collected for the participant group
(including age and gender of the young person as well as diagnosis).

Two interviews were scheduled with each young person. The first interview took place
immediately following the consultation and lasted from five to forty-five minutes. These
interviews were intended to solicit young people’s immediate responses and impressions of the
telepsychiatry session. The interviews were conducted by community-based research assistants
(not involved in the young person’s care) at the agency following the consultation. Second
interviews were conducted by the research assistants over the phone 4-6 weeks later, and lasted
up to twenty minutes. These follow-up interviews were intended to solicit participants’ views
after some time had passed since the consultation. We hypothesized that given some time to
reflect on the experience, and having some of the recommendations implemented, young
people’s impressions could have changed. Due to difficulties in reaching participants for their
second interviews, 11 participants could not be interviewed within the 4-6 week timeframe,
although 16 of the 21 second interviews were completed within 8 weeks. In one extreme case, a
participant was contacted 13 months after the original consultation. Both the first and second
interviews tended to be shorter when the young person was 12 years of age or less and/or when
the young person had been given a diagnosis of ADHD. There was also variability in length of
the interviews across research assistants.

As noted above, 30 participants completed first interviews, and 21 completed the second,
follow-up interviews. The most common reason for incomplete second interviews was an
inability to contact the young person due to a change in telephone number, a move out of the
community, or unreturned phone calls, despite several attempts. Three participants in the study
deprecated a second interview.

Analysis

All focus groups and interviews were audiotaped and transcribed verbatim. These
transcripts were then analyzed via a series of steps in keeping with the interpretive interactionist
framework (Denzin, 1989). The first step of the analysis is bracketing, followed by construction
and finally contextualization of findings. Bracketing involves isolating the essential elements under investigation. Data were bracketed by repeatedly reading through the transcripts in order to develop a detailed coding system. All transcripts were reviewed by two members of the research team (KB and JWG) and key text was bracketed. Analysis meetings then ensued to discuss the categories identified and agree upon common terms. The next stage, the process of construction, classifies orders and reassembles the phenomenon back into a coherent whole. This involved taking some of the more discrete categories or codes (such as psychiatrist understanding of problems, valued qualities in the psychiatrist) and reassembling into a larger analytic category (such as comfort with the psychiatrist). Contextualization, a process in which greater meaning is sought across individual experiences, followed.

Research Rigor

The issue of the quality of qualitative research is of critical importance (Devers, 1999; Eakin & Mykhalovskiy, 2003; Mays & Pope, 2000; Popay, Rogers & Williams, 1998). In this study we address rigor in three ways: 1) research practice rigor, 2) analytic or theoretical rigor and, 3) procedural rigor. Rigor commonly refers to the reliability and validity of research in a general sense (Davies & Dodd, 2002), however, qualitative research aims to be reliable, not in the sense of replicability over time and across contexts, but rather, based on consistency and care in the application of research practices, and reflected in the visibility of research practices (Fossey, Harvey, McDermott et al., 2002). Moreover reliability in our analysis and conclusions are represented in an open account that is mindful of the partiality and limits of the research findings. Research practice rigor is conceptualized in terms of reflection, conscientiousness, engagement, awareness, openness and sensitivity to context. Analytic rigor generalizes from a particular empirical instance to a theoretical one. The analysis and interpretation of the data provides theoretical insights, which possess a sufficient degree of generality to allow projection to other comparable contexts. Parallels are recognized at the conceptual and theoretical level; as comparability between two contexts is a conceptual one, not one based on statistical representation (Sim, 1998). The following table indicates the ways in which procedural rigor was addressed, traditionally understood within qualitative research methodology as a way of establishing the ‘trustworthiness’ of findings (Erlandson, Harris, Skipper et al., 1993).
<table>
<thead>
<tr>
<th>Quantitative Term</th>
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<th>Current Project Techniques</th>
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<tr>
<td>Internal validity</td>
<td>Credibility</td>
<td>Prolonged engagement: Team members from diverse backgrounds (psychiatry, sociology, social work, public relations, psychology) with history of research with youth experiencing mental health problems as well as front-line clinical work</td>
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<td>Triangulation: A series of interviews with young people; team approach to analysis</td>
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<tr>
<td>External validity</td>
<td>Transferability</td>
<td>Sampling to saturation: A series of interviews to ensure theme saturation</td>
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<td>Purposive sampling to ensure that the data set provides insight into the studied phenomenon by balancing appropriately broad scope and intimately thick description and rich detail</td>
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<tr>
<td>Reliability</td>
<td>Dependability</td>
<td>Audit trail: Minutes of team meetings, documentation of analysis decisions, and final report</td>
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<td>Reflexive journal: Observational and interpretive field notes throughout research process by research team</td>
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<tr>
<td>Objectivity</td>
<td>Confirmability</td>
<td>Peer Review: Regular co-investigative team meetings, peer debriefing, team approach to analysis</td>
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**Ethics**

Ethics were carefully considered throughout the research process. Institutional Review Board approval was gained before the onset of this study. Each participant signed two consent forms prior to the focus groups and interviews: one form giving general consent, and another form giving consent for the interview to be audio recorded. In cases where young people were judged (by their case manager) to lack capacity to consent, parental consent was obtained, followed by assent from the participant.

All participants were advised that participation in the research was voluntary; they did not have to answer any question that made them uncomfortable and could stop the interview at any time. Special care was taken to ensure the anonymity of study participants and the confidentiality of the data. In cases where a research assistant knew the potential participant or had been involved in the young person’s care, the decision was made to exclude the participant from participating in the study.

**RESULTS**

**Phase 1 Focus Groups**

The nine young people who participated in the focus groups represented a wide range of ages (7-18), geographic locales, and reasons for receiving a psychiatric consultation. In the
‘icebreaker’ task they were invited to respond to a series of schematic diagrams that were created by the research coordinator as potential logos for the study (see Appendix B). All young participants readily engaged in this process and provided a great deal of input regarding the logos they liked best. They also indicated that a visual symbol would help promote the study and engage young people in the process. Surprisingly, there was unanimity across the three focus groups regarding the preferred logo. The logo selected was one of the more sophisticated of the options and young people specifically referred to some of the other images as being “too babyish”. Participants contributed ideas about the ways to change the logo that would better represent the study. For example, the preferred logo was a globe representing the world with a person on top; the suggested change was to incorporate a young person along with the adult-looking figure on the globe. The image conveyed the idea of connection, something that focus group participants felt was important to telepsychiatry and to the study. As well, participants agreed that it was a very good idea to shorten the title of the research to “The TeleViews Study”, rather than use the formal, more unwieldy title.

Focus group participants also provided feedback on the study design, interview process, and semi-structured interview guides. They highlighted the importance of talking to young people one-on-one, without their parents in the room, and indicated that it was important that the researcher assure participants that everything said in the interview would remain confidential. With respect to the interview guides, young people suggested that the language could be simplified in certain cases, and made recommendations as to the ordering of the questions. They also had much to say regarding the physical setting and the importance of comfort level during the interview, suggesting that the process be as informal as possible. Furthermore, they agreed with our suggestion that participants might need a break or a time-out between the telepsychiatry session and the start of the interview.

Focus group participants were asked to reflect on their first telepsychiatry experience and talk about some of the topics they felt would be important to explore with Phase 2 participants. Overwhelmingly, young people stressed that the sessions were too formal, and that the room was uncomfortable. Specifically, they indicated that the table separating them from the psychiatrist on the television screen was experienced as a barrier that rendered the encounter too formal.
They also identified the size, wall colour, and seating arrangements in the room as important considerations.

*I find that the more space in the room, the better I feel. Like, not closed in. Not feeling like that and not hallucinating. A tiny, dinky space makes me feel like I have a metre squared to go. The more room you have, the room to have to breathe. If it’s so small, you feel like the walls are closing in on you.*

*Like, comfier chairs like you people got.*

*If our room was blue just like yours it would be more comfortable for us instead of always seeing white.*

Participants revealed that they felt a bit awkward during the telepsychiatry session because they knew absolutely nothing about the psychiatric consultant. They clearly indicated that they would like to know something about the psychiatrist “*as a person*” and they extended this to include the importance of the research interviewer revealing something personal about them before beginning the interviews for this study.

*Like, at the beginning I think it would be much better if you’d actually know one another better. Know more about the other person. Like, that you’re talking to. I find it would be easier like that. To actually know more about the other person instead, “Here’s the doctor. Talk to him.”*

*Well, I’d like to like, [know] about him. Why he’s doing this. Like, what does he do in his spare time. What kind of person is he? Like, if he (inaudible) which I wouldn’t be happy with, I’d like to know that so I don’t have to give him any secret information.*

*When we’re only told about a person’s work or something, we don’t really see them in their life so we think that’s all they are sometimes. So, it’s good to get to know the person and know it’s more than just their work.*

The fact that the consultant was a stranger was sometimes intimidating and young people

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3 In response to this recommendation, the research team made an effort to introduce themselves to subsequent focus group participants and include personal information such as hobbies, interests, and family details. This was incorporated into the training of research assistants in Phase 2 of study.
offered some strategies to help ease this discomfort. They indicated that the consultant should start off the session “small, and build up to the big issues”. With some warm up and small talk, participants felt that trust and rapport would be enhanced.

Well, the last time I went, I knew the person and like, we got straight to the bigger stuff and then we went to the smaller stuff. I’d like, prefer to go to the smaller stuff and then slowly work our way up to the bigger stuff. Like, if you were launching a nuclear missile, I’d like to leave that till the end. So, I’m more comfortable with talking about some…and then the nuclear missile out.

I think that going from smaller issues to bigger is to help build a trust even if you’ve never really met that person. Then your reaction to the little stuff you say, it’s more comfortable if you tell them bigger stuff after. If their all series and stuff and you can’t really talk to them…You think you’re not comfortable, then it’s harder to tell them the more important stuff.

For some youth, the psychiatric encounter was experienced as something that was unfamiliar, which created some uncertainty. Some focus group participants mentioned that they did not really know beforehand what to expect and stated that prior preparation would have been helpful.

I think it was like, two years ago and I thought it was scary because I didn’t know the guy and he was just asking questions and I didn’t know this guy so I was just answering him. I was scared though.

Participants indicated that they would have preferred to be alone with the psychiatrist, specifically mentioning that it was uncomfortable to have their parents(s) present during the consultation. They specified that they felt that they would have more freedom “to say stuff” without their parents in the room.

With me, it was with mom and sometimes when they ask you questions that are personal and you don’t really tell your mom. I don’t tell my mom everything and you kind of have hold things back because you’re scared of your mom’s reactions and stuff. If you’re alone you can tell them instead of being, yeah.
Yeah. Same with me. It’s just…If your mom wasn’t in the room I could tell people but then my mom…If my mom was there, she’d freak out.

Phase 2 Interviews

In-depth interviews with young people revolved around a number of issues concerning their consultations, but four key areas were of particular interest to participants and arose repeatedly in the analysis of transcripts:

(i) The encounter with the psychiatrist and the experience of having others in the room. The encounter with the psychiatrist centred on young people’s perspectives on the length of the consultation, the experience of being listened to, and acknowledgement of their expertise. The presence of other people in the room during the encounter posed a barrier for many, particularly when it was a parent.

(ii) The perceived helpfulness of the session. Participants expressed a range of opinions that included recognition of the limited nature of the session.

(iii) A sense of personal choice and individual responsibility (or lack thereof) during the consultation and the importance of feeling in control of the situation.

(iv) The technology itself as a key aspect of the psychiatric consultation. Participants addressed issues of its novelty, the barriers and benefits of televideo, and the technical issues associated with the consultation.

The Encounter

An important objective of the interview was to gain the perspective of the young person regarding the televideo encounter with the psychiatrist delivering the consultation. Young people made many references to the expertise of the psychiatrist, the valued qualities of the psychiatrist, the fact that the psychiatrist listened to them and “did their homework”. Several commented that they felt that they were able to “open up” despite admitting that they don’t usually talk about their personal troubles.

It was nice to actually get to talk to somebody, like somebody professional about what’s going on and what I might be able to do to make things easier on myself. (F, 15)
It seemed like he understood a lot ‘cause he was writing it all down and he had a lot written down. (M, 16)

Though an initial discomfort with the technology was the principal source of anxiety for young people, the experience of meeting a psychiatrist seemed to make some participants nervous as well. This was often related to their fear that they would get into trouble if they said something “bad”. However, invariably, this had a temporal aspect to it – that is, it changed very quickly. Levels of discomfort were replaced by comfort fairly quickly and most certainly by end of session. The exchange between an interviewer and one participant below shows the participant’s apprehension with both the technology and meeting the psychiatrist:

Interviewer: Okay so were you comfortable at the beginning of the session?
Respondent: Well, I don’t know really, well it was somewhat weird, like, and what do you say to someone you don’t know?
Interviewer: Yes it was the first time that you saw that person and you had to tell her a lot of personal stuff, and you find it weird. Was there anything else that made you feel uncomfortable at the beginning?
Respondent: Well, the T.V., it’s weird, but after a while it’s like when you talk to someone on the internet. It’s not that bad.
Interviewer: And if we compare like towards the end, how did it feel?
Respondent: I was comfortable, it was not...that bad, like at the beginning I did not feel at ease, but towards the end I felt a little bit more comfortable. It was like a normal consultation...(F, 18)

Some young people viewed the psychiatrist as someone with whom they had difficulty engaging. They viewed the manner of the psychiatrist as unnecessarily reserved, which hampered their ability to relax and to make a connection with him/her. One participant observed,

Sometimes you feel like you were treated like a product or something that needs to be repaired. They talk in a very formal way. It’s more comfortable when a human talks to you in a more normal way, it’s more casual. (M, 15)

As a group, young people seemed divided about the issue of having others in the room with them at the time of the consultation. As mandated by the Toronto Paediatric Telepsychiatry Program, every young person is required to have an agency-based case manager present during
the consultation (as the official ‘client’ of the telepsychiatry program), but many also have their parents and/or other family members with them, as well as school personnel (e.g. teacher, principal). Some young people spoke about being quite uncomfortable with other people in the room at the time of the consultation and explained that they wanted to keep their discussions private. A seven-year old male indicated that the fact that his school principal was in the room caused him some discomfort. He responds to the interviewer below:

Respondent: …myself, with nobody in there.
Interviewer: Can you explain why?
Respondent: Because I want to talk to him alone about my behaviours. I don’t want anybody to know. I just want to talk with him alone.

For another young person,

I didn’t like the fact that my parents were there. I don’t know, there were some things that I would have preferred discussing without my parents’ presence. (F, 13)

One 15-year old male, who had his mother, teacher, and youth worker in the room with him, stated that he didn’t like talking when too many people were around. He alluded to the fact that the session would have been more helpful had he been alone with the psychiatrist and his case worker.

Some young people, on the other hand, found it reassuring to have others present with them. This comfort was often explained to be a result of feeling supported by a positive figure during the stressful consultation.

Respondent: Well, like when I started crying and when I was talking, I was not paying attention so they brought me back to reality, kind of.
Interviewer: And when you were crying, the fact that they were there…?
Respondent: Well my father especially, it was helpful. He knew where I was coming from; he understood me. (F, 17)
Helpfulness of the Session

Young people discussed their perceptions around the degree to which they found the telepsychiatry consultations helpful concerning the problems they were experiencing. Generally, participants’ responses on this issue ranged from those who felt that the consultation had been very helpful, to those who were more equivocal, finding the help of limited value to themselves, or uncertain about the overall or long-term helpfulness of the consultation.

A number of participants believed that the session was, or would be, helpful for them. The opportunity to release pent-up emotions and thoughts, as well as having these thoughts heard and understood by the psychiatrist were mentioned as being important. A number of participants also noted that the psychiatrist’s ability to listen without being judgmental was a positive and helpful aspect of the consultation.

It, it felt good because I felt like he wasn’t judging me or anything and I could actually talk to him without him getting angry or, or thinking something bad about me. (F, 15)

I felt that I was able to open up. I usually don’t talk about that kind of thing. (F, 15)

It was nice to actually get to talk to somebody, like, somebody professional about what’s going on and what I might be able to do to make things easier on myself. (F, 15)

Many of the participants who found the session helpful mentioned new knowledge gained around diagnosis, medications, advice and possible coping mechanisms as being a positive outcome. These participants also believed that the psychiatrists’ expertise and ability to assist case managers/teams in proper diagnosis and treatment was a benefit of the consultation.

Well, the first time it was good because they gave me a diagnosis and they gave me medication and stuff and they gave me something to deal with it. (F, 17)

Yeah, it was helpful, ‘cause a lot of the time when something goes wrong, I blame it on myself, and he talked about how I shouldn’t do that, that it’s not all my fault. (F, 15)
I think he understood me really well because at the end he did a whole summary of what we were talking about and my experiences and that, and he just got it right on. (F, 18)

In their second interview, young people often identified that they had the opportunity to use coping strategies suggested in the consultation.

Whenever I’m getting in an argument, I just try to walk away and play with another one of my friends…and, I haven’t wrecked my room in a very, very, very very long time. (M, 8)

I don’t lose my temper that quickly anymore…. In situations where I used to get really angry, now I barely do. (M, 15)

Things don’t bother me anymore. It’s going better. (F, 14)

Some participants believed that the session might be helpful for others who were in the room during the consultation, but not necessarily for them directly. The young people mentioned that their parents or case workers may have benefited from increased insight into the issues with which they were grappling. One young person described the experience in this way:

I think that the fact that she could talk to someone else about it helped to go further in what she thought [about her problems] and to get a new perspective on exactly what she was thinking and to be able to consult about me with somebody else. Like if I needed to take some medications, if I was really depressive, my health or if my life was in danger and if something was about to happen to me. So she knew exactly because she became maybe too close to me, so she could take a step back and exactly know what was going on. (F, 18)

In cases where young people indicated that they believed their session to be of limited helpfulness, the stated reasons included the single-session consultation model, as well as the associated relatively short period of contact with the psychiatrist during the consultation. They acknowledged that they can feel different from day-to-day and these shifts in mood would be

4 Telepsychiatry consultations are typically one hour in length.
difficult for the psychiatrist to understand from a single meeting (“especially for teenagers, we’re in different moods everyday”). Many indicated that this brief encounter did not allow sufficient time to form a helping relationship. As noted by one 14-year old female,

*You don’t really know the person. You can’t really judge by that...how can you help someone that you don’t really know? That’s how I was thinking, unless she is the one that talks to me all the time...*

Another participant expressed a similar sentiment:

*How can they give me a diagnosis after only an hour of knowing me, you know? ...you couldn’t just in one hour know what’s wrong with somebody...it doesn’t seem right at all. (F, 17)*

There was often contradiction in the narratives presented by the participants, wherein they initially stated that the consultation was unhelpful, but would later identify components which they believed might have been helpful. One example comes from an interview with an 18-year old female, who early in the interview noted,

*Well, I think it could be useful but it would have to be more repetitive because just an hour, it’s not enough. It didn’t help me.*

This participant, however, later went on to acknowledge:

*I don’t think it was completely not useful...like for some points it was useful... because I knew I would not have other contact with her, I could ask her some direct questions.*

For some youth, it was difficult to ascertain what they really thought of the experience and its overall or long-term helpfulness. One 16-year old male alluded to the potential helpfulness of the session when he stated that, “it could help”. Uncertainty was often related to denial of a problem or issue in the first place.
Interviewer: Do you think that the psychiatrists were able to help you with your problems?
Respondent: What problems? (M, 14)

The interviewer tries again:

Interviewer: So, do you think talking to the psychiatrists helped you at all?
Respondent: What do you mean by that, like help me?
Interviewer: After you talked to them, did it make you feel better or worse?
Respondent: Hm, the same.

This lack of knowledge (or acknowledgement) of the problem was also evident in other interviews, as was the tendency to minimize the problem, as the examples below convey.

Interviewer: Okay, do you think the psychiatrist was able to help you with your problems?
Respondent: I have no idea because I don’t even know what my problems are.
Interviewer: Okay
Respondent: I think I am a normal person just like everybody else, but apparently I’m the only one that thinks so. (F, 15)

I don’t know why I came. (M, 14)

Well compared to what we see everywhere, and what I know about other people, things like that. According to me, my problems are not as important as a lot of people. (F, 14)

In the first interview, conducted immediately following the telepsychiatry session, the recency of the consult made it difficult for young people to state whether or not it had been helpful. As one participant reflected, “Well it did not bring me further, but... I don’t know if it helped me so far; I don’t know sometimes just talking about it is helpful, but it’s too recent for me to tell if it helped.” (F, 18) At the time of the second interview, many of these youth were still uncertain as to the helpfulness of the experience. Some participants, particularly younger ones, stated that they had forgotten all about the consultation and required several probes to stimulate their recall.
**Personal Choice and Responsibility**

A recurrent theme throughout the interviews with young people was their sense of personal choice and responsibility (or lack thereof) and the importance of feeling in control during the consultation session. Young people’s narratives were replete with examples of the ways in which they were able to exert ‘control’ within the encounter.

*You know you are separated by the [T.V.] screen and if you want to stop, you can stop ... I can go and leave, if I don’t like what I hear.* (F, 18)

*It’s my case worker and me who decided to do this [have a consult].* (F, 17)

*If you don’t want to talk about this subject, you don’t talk about it.* (F, 14)

A young six-year old male tells the interviewer about the picture of his family that he drew while in the session. She asks him if the doctor asked him to draw his family and he responded emphatically, “*It’s me who decided to draw this*”. Many participants indicated that they were opposed to taking medication and, in fact, chose not to follow through on recommendations made in this area.

*She [psychiatrist] did recommend taking some medications...but I didn’t want to because my sister-in-law is bipolar and when she takes her medication she becomes really weird and I didn’t want to be like this. I didn’t want to and I said no to this.* (F, 18)

*Also when you think about it, I’m not saying that she thought that I was not someone smart, but we are still smart because I realized that someone who comes to counselling or whatever, it’s because it’s easy, not like lying, but... because if you don’t want to talk about this subject, you don’t talk about it. If she asks some questions, like for example if she asks if you had some suicidal thoughts or whatever, things like that, you can easily say no, but bottom line it was yes, but you can say no or yes. You can play it. Even in those moments, I don’t know, you can... I think that a psy [psychiatrist] can be good, but at times they can be fooled. It’s complicated to say but... (Laughs). I came to realize this. I had a friend who didn’t want to go [to counselling] and she was told to go to the office [at school], she was giving a piece of paper telling her to go see someone, and when she got there, she was upset that she had to meet someone but she went and*
she acted like everything was fine and great, and she never returned after this. (F, 14)

She recommended medication, but I don’t want that. I don’t want to be like strange because I never liked feeling different...always trying to blend in with my friends. (M, 13)

She recommended taking some pills...I didn’t follow what she said, but I thought it was not really necessary. (F, 14)

Some young people described their feelings of lack of control over the situation, as a result of being coerced to attend the session, or feeling that they could not speak up during the encounter to voice their opinion, particularly when they did not agree with someone in the room.

Some of the things my mom and dad said to him, I didn’t agree with... but I kept that inside. (F, 15)

I just like, didn’t want to go in the first place... I didn’t want to deal with it. (M, 17)

**The Technology**

The majority of participants expressed excitement and interest in recalling the experience of speaking to a psychiatrist over televideo, and suggested that the novelty of the experience was the “best part” of the process for them. One word used repeatedly in the interviews to describe the overall experience with telepsychiatry was “cool”. Participants were enthusiastic about the technology’s ability to connect them, both aurally and visually, with someone relatively far away. As one young person expressed,

I got to speak to the um, I got to speak into a T.V. and um, talk to someone and that, I’ve never really done that before and it was so exciting to do it. (M, 8)

I thought it was really cool talking over the television. I just really liked that and that was basically the main thing I liked about this, just trying something new. (F, 15)

Several participants alluded to the fact that the consultation caused them to feel somewhat “removed” from the process, likened to “feeling like watching a show”.

28
You kind of zone out because you think he’s not always there, like, you think he’s just a television program. (M, 13)

Many young people articulated their preference for the consultation to be held over televideo, suggesting that this format alleviated some of their anxieties regarding the meeting. They explained that meeting mental health professionals in person is intimidating, arousing more anxiety than what they had experienced during the consultation over televideo.

I think the T.V. is better because it makes you feel less nervous. Because if the person is right in front of you, it can make you feel more nervous. But on T.V. they are really far so what can they do if something goes wrong? (M, 13)

This is better. I felt way more comfortable talking to the T.V….sometimes if I meet these doctors or something face-to-face they kind of look at me and I get scared. So, I just like this better. (F, 15)

It’s sure that face-to-face is harder according to me because she’s right there and on the T.V. you can say like I don’t mind, you don’t know her and you won’t see her again. I prefer it that way.” (F, 17)

Participants also identified the benefit of having the psychiatrist in a distant location, making it very unlikely that they would encounter the doctor in their community, close to home. In the words of the previous participant, “You won’t see her in town!” (F, 17). Some believed this anxiety arose from the fear of “judgements” being made by the psychiatrist and meeting over televideo seemed to dampen their concerns regarding this. In some communities, young people spoke of their friendships with the children of the local doctor, which they felt could cause a problem with confidentiality and anonymity. The televideo option eliminated this issue. Furthermore, the fact that telepsychiatry did not involve travel was a key benefit for many participants.

Several young people expressed their desire for face-to-face contact with the psychiatrist. While the televideo component was an exciting aspect of the consultation for many, they identified the difficulties in establishing a true “connection” without having the psychiatrist in
the same room. In the words of one participant, talking to the psychiatrist in person,

...would have been more pleasant. That would be more real. It's always more pleasant to talk to someone face to face.” (M, 15)

For another young person,

It's just a better connection like talking to a person that's in front of you and you're in the same room as each other and stuff, because it's just weird, odd, talking to a T.V. (Laughs) (F, 13)

While participants exhibited excitement at the prospect of talking to a doctor via televideo, some identified an initial period of hesitation and discomfort with the consultation, and stated that it took some getting used to. As one 13-year old male stated, “it kind of feels weird when you’re talking to a T.V., but like, you get used to it after”. Though an initial sense of disorientation was described by participants of all ages, they quickly adjusted and often within 10-15 minutes were not acutely aware of any discomfort with the technology.

Participants made only very brief comments about the quality of the technology during the session. Some spoke about difficulties with picture and sound quality, but most problems were considered to be short in duration. Even when the duration was longer than several minutes, participants did not seem to believe that these difficulties adversely affected the session as a whole.

**DISCUSSION**

This research uses an interpretive interactionist approach to understand the perspectives of child and adolescent service users in seven rural children’s mental health organizations that provide telepsychiatry consultation services. Study results from focus group and in-depth interviews with young people revolved around a number of issues concerning the experience of receiving psychiatric services via televideo, with four key areas emerging as of particular interest to participants: 1) the encounter with the psychiatrist and the experience of having others in the room; 2) the perceived helpfulness of the session; 3) the sense of personal choice and individual
responsibility (or lack thereof) during the consultation; and, 4) the technology itself as a key aspect of the psychiatric consultation.

In talking about the telepsychiatry session itself, all participants highlighted the importance of the relationship between the psychiatrist and young person. This relationship between a care provider and care recipient has been shown in the psychological literature, but is less often explored in the psychiatric literature. Recent qualitative work by Shattell and colleagues (2007) noted three commonalities with mental health service recipients’ expressions of elements of a positive therapeutic relationship: feeling “related” to (interpersonally connected), feeling “known” as a person (as opposed to a number, diagnosis, etc.) and feeling that the problems which brought the clients into care were being addressed. Young people in our study identified these factors as being critical to a successful telepsychiatry session.

The young people in our study who indicated that their session was helpful expressed similar ideas as to why they believed it was helpful: the psychiatrist’s expertise and ability to make recommendations, concrete suggestions for coping with presenting symptoms or issues, and understanding the problem or issue being discussed. Those who believed the consultation was helpful explained that they appreciated the opportunity to release pent-up emotions and express them to someone who was listening. Much like the questionnaire responses presented by Grealish and his colleagues (2005), these young people also noted that they felt understood and respected by the psychiatrist, as well as feeling they had a better understanding of their problems following the consultation. Strategies for developing these ‘helpful’ aspects of the consultation could be further developed during consultations with young people.

Some young people expressed reservations about the degree of helpfulness of their telepsychiatry consultations. This doubt was directly associated with the temporal aspect of the consultation, namely, that it was one-time only. Participants suggested that more than one meeting with the psychiatrist would be helpful. This, they explained, would allow the psychiatrist the opportunity to understand them better, and provide a more informed perspective of their issues and what is going on in their lives before being provided with a diagnosis and/or recommendations for treatment. Additionally, informing young people that the psychiatrist has received their case history and is ‘prepped’ for their session would contribute toward their overall
comfort level. Shattell and colleagues (2007) have also noted the essential need for service providers to take time with care recipients.

Those who believed that the consultation was helpful often noted that they felt respected and understood by the psychiatrist, but many expressed that they were unsure that it was going to be of help to them because it was just a one-time event. They often believed this to be the case because of a lack of regular and ongoing contact with the psychiatrist. This suggests that the relationship between the young person and his/her consulting psychiatrist needs to be more fully developed within the consultation, ideally by including multiple sessions. Consequently, the program should focus on exploring an expansion of the service model from a single-session consultation to include the option of a consistent series of consultations for a young person.

Participant’s narratives were replete with examples of ways that they were able to actively take responsibility and exert control within the actual consultation session itself, whether it was offered to them or not. Grealish and her colleagues (2005) found that young people found that telemedicine promoted the transfer of power and control by allowing them to feel more comfortable about ending the consultation or walking out. The sense of feeling that they could leave at any time was also expressed by a few participants in this study. Young people also demonstrated their capacity for decision-making regarding the uptake of recommendations made for them. As Prout (2000) has suggested, children are actors participating in social processes, and are not simply outcomes of these processes. He states that “whilst, like all social actors, children can be seen as shaped and constrained by the circumstances of their lives, they also shape them and are enabled by them. They are limited by the social conditions of their lives, but also find ways of creatively managing, negotiating and extending the possibilities” (p.7).

The denial of a problem by some young people may represent an attempt to feel in control of the situation or perhaps could be a response to the stigma related to mental illness. It is possible young people are in denial, but it is also possible they just disagree with how adults have defined the problem, or responded to it. This suggests that we place emphasis on asking young people about the ways in which they define the problem, recognizing and accounting for the issue of stigma and discussing it with them. An inclusive view of children that has been put forward in this study must address the issue of their perspectives and their needs and desires; ‘the
right to have [their] definition of reality prevail over other people’s definition of reality’ (Rowe, 1989, p.16). This encapsulates the typical power relationships between adults and young people, that is, it is the adult view of the world that is most frequently the framework for understanding (John, 2003, p.47).

This study supports some of our earlier research on uptake of telepsychiatry recommendations which addressed the importance of buy-in from both family members and young people themselves (Boydell, Volpe, Kertes et al., 2007). Clearly, young people have a significant role to play in their own care, including adherence to suggested medication. It is thus critical that such recommendations be thoroughly explained and that there is an opportunity for young people to openly express their concerns and discuss possible alternatives. The Toronto Paediatric Telepsychiatry Program has undertaken, through its Quality Assurance process, to ensure that consultants ask whether all recommendations made are both feasible and acceptable to all participants, including parents, young people, and others. Further efforts to include young people may include ensuring alternate treatments are offered and/or negotiated when recommended treatments are not acceptable and/or resisted.

Young people in this study explained that the most positive facet of their telepsychiatry consultations was the opportunity to be exposed to a new form of technology. They referred to the novelty of the experience as the “best part” of the process for them and repeatedly used the term “cool” to describe their encounter. Consequently, it would be useful to capitalize on the novelty aspect by highlighting the cutting edge technology used in the session. Although some young people were initially uncomfortable with the technological aspect of the consultation, they noted that this feeling abated very quickly, after about ten to 15 minutes. After this period, participants indicated that the technology was the most positive aspect of their consultation. Some also expressed an initial discomfort and sense of nervousness regarding meeting the psychiatrist, however, very basic strategies for overcoming this, such as having the psychiatrist talk to the young person directly about non-mental health related issues, could help alleviate this nervousness.

Study results suggest pragmatic strategies that would help to make the telepsychiatry consultation a better one for the young people involved. A lay language, user-friendly brochure
or postcard could be used to prepare young people for their consultation. It could detail the specifics of what to expect during the consultation. As our participants suggested, including the words of other young people who have experienced this form of treatment would help to make it a more engaging way of transmitting information. Although a standard protocol for preparing young people before the consultation has been recommended for all remote sites, our findings suggest that it is not being implemented consistently. The telepsychiatry program could communicate to agencies the importance of the protocol, and work with them to find ways of improving adherence to the protocol, or assisting with any barriers to implementation. Further, consultations could be extended by 5-10 minutes to allow time for informal chatter, to establish rapport and identify the reasons for the consultation.

**Challenges of Conducting Research in Rural Communities**

There were several challenges in conducting the study, specifically related to the recruitment process, communication between the research team and the study sites, and the data collection methods. Recruitment of young people to the study proved more difficult than originally anticipated. Some of the challenges were related to the recruitment period itself, which straddled the summer months, when telepsychiatry sessions are at their lowest. The challenge related to recruitment also involved both the difficulties related to finding suitable and/or willing participants as well as the process of hiring and retaining community-based research assistants. With respect to hiring, the Executive Directors in the study communities interviewed and hired the research assistants, who were then trained by the research team both in person and via televideo. The research team’s priority of hiring research assistants living in the study site communities often meant that research assistants lacked previous experience with qualitative research methodologies. This may have posed difficulties with regards to successfully scheduling and conducting the interviews. The training involved a half day session, and perhaps this did not provide enough time to adequately cover the essential elements of study recruitment and data collection. Retaining assistants was another challenge. As they were hired on a variable, part-time basis, it was impossible for them to anticipate the number of hours of work they might receive in a given week. Consequently, on several occasions, a research assistant moved on to more permanent employment and was unable to continue in the position. It may
have been fruitful to budget for involving the research assistants more fully in the research process, which would both assure them guaranteed weekly hours as well as giving them increased involvement with the study and research process overall, as funding limits prevented this in the current study.

A second challenge concerned ensuring regular communication between the study’s research coordinator and research assistants, and their communication with agency case managers, telepsychiatry assistants and executive directors. At the outset of the study, research assistants were responsible for regularly checking with the agency’s telepsychiatry assistants to ascertain whether there were upcoming consultations and to inform the executive directors of their progress. Case managers were asked to inform eligible young people and their families of our study and to then let the research assistants know who was interested in hearing more about the study. These roles proved difficult to sustain over the first half of the study. Consequently, the research coordinator, based in Toronto, took a more active role in apprising all parties of upcoming consultations and reminding case managers of the study. This approach resulted in increasing participant numbers in the second half of the data collection period.

A final challenge regarded successfully conducting second interviews with young people. Seventy percent of our participants completed a second interview. As noted above, the research assistants conveyed that the primary reason for the incomplete second interviews was an inability to contact the young person. In the remaining cases, the young people chose not to participate in the second interviews. Of the completed second interviews, the research team often found that very little new information emerged. Many participants could not clearly recall the original consultation when the second interview was conducted, though recollection was aided by specific interviewer prompts (e.g., In our first interview, you said...). It appears that 4-6 weeks may have been too long for many young people to effectively recall their consultations, and thus the second interviews should possibly have been scheduled sooner. In those cases where young people did remember their consultations, virtually all participants expressed the same sentiments which they had conveyed in the first interview. This may suggest that not enough time had passed, or that young people were not aware of the recommendations that had emerged from the consultation and whether they had been implemented.
Despite significant advances in conducting research with rural and remote communities (Boydell, Pong, Volpe et al., 2006), the challenges of doing so must be acknowledged (Boydell, Stasiulis, Barwick et al., 2008). There is no question that enormous time, energy and effort is necessary to promote the ‘buy-in’ of qualitative research. There is a process of relationship building that occurs and this also takes time and resources. Committed champions within these communities serve to act as ambassadors of the research; however, they are constantly challenged by the demands on their time. It must be acknowledged that these communities are seriously under resourced and must deal with high staff turnover rates. These factors act as barriers to participation in research projects. Although funds were budgeted to offset staff involvement in this research study, it remained difficult to secure coverage to allow staff to be involved in any significant manner.

**FUTURE RESEARCH**

Since this is the first study we know of to qualitatively explore the perspectives of young people who receive help via a paediatric telepsychiatry program, further studies of this nature need to be undertaken with young people in other geographical locales and cultural contexts. For example, conducting qualitative inquiry with a sole focus on young Aboriginal people who receive help through this program, as well as recruiting a sample of individuals who live in more remote communities, would be a fruitful next step in understanding how young people view being a part of these consultations. Articles from the adult telepsychiatry literature (e.g., Shore, Savin, Novins et al., 2006) suggest that cultural formulations during telepsychiatry consultations may require the psychiatrist to attend to different types of concerns and questions.

Given that many of the interviews were of limited duration and younger participants in particular often indicated that they were ready to terminate the interview soon after it began (*are we done yet? and can I go now?*), it might be fruitful to explore new methodologies that offer more opportunities for engagement. Our own recent (as yet unpublished) experience with arts-based methods indicates that many young people find working with the arts as a way of exploring phenomena under study highly satisfying.

Another area of research could employ qualitative methodology to explore the
similarities and differences between young people’s experiences of conventional, face-to-face psychiatric consultations with those conducted over televideo. This might provide researchers and practitioners a more specific understanding of how the technology itself influences the manner in which young people are involved in these consultations.

Recent data has shown that parents endorsed high satisfaction with their children’s telepsychiatric care, with an indication of increasing satisfaction upon return appointments (Myers, Valentine & Melzer, 2008). This, coupled with our findings that there is a strong desire on the part of young people to have a more extended relationship with the psychiatrist, suggests the need to further explore this option. In addition, longitudinal investigations are needed to understand the temporal nature of telepsychiatry on young people, their families and the communities which are served by this method. It would provide an opportunity to address the multiplicity of factors in the lives of young people, of which telepsychiatry is just one component.

**QUALITATIVE RESEARCH AND POTENTIAL FOR IMPACT**

This study is one among a number of studies examining the impact of the delivery of paediatric telepsychiatry services to rural communities in the province of Ontario. (Boydell, Greenberg & Volpe, 2004; Greenberg, Boydell & Volpe, 2006; Boydell, Volpe, Kertes et al., under review; Boydell, Volpe, Kertes et al., 2007). This impact is both instrumental and conceptual (Sandelowski, 2004).

These studies have shown that qualitative research has great potential to help inform program and policy change regarding mental health issues (Goering, Boydell & Pignatiello, 2008). The utility of qualitative research lies in its ability to direct the development of culturally sensitive theories, culturally appropriate research tools, patient-centred interventions that are effective, feasible and acceptable to users; and to redirect or reframe future research and research use (Sandelowski, 2004). For example, earlier research by the team (Greenberg, Boydell & Volpe, 2006) demonstrated that case managers felt that it was critical for the program to offer a follow up session if needed. Originally the Ontario Ministry of Children and Youth Services (the funder of the program) would not reimburse for any follow up consultations, but upon being
apprised of the research results, decided to change their mandate and offer limited funds for follow up consultations. Currently, 25 percent of the psychiatric consultations are follow up sessions. Similar examples of programmatic impact of qualitative inquiry are described in the work of Davidson and his colleagues (Davidson, Ridgway, Kidd et al., 2008).

The research has had an impact at the conceptual level as well. There have been noted (and notable) shifts in ways of thinking on the part of several telepsychiatry stakeholders. For example, research uptake by the consulting psychiatrists has reinforced their understanding of the importance of the contextual and environmental influences that affect the types of recommendations they can make; they are aware of the need to see each community as unique and to understand the mental health system that operates in each. In addition, service providers in the rural communities have a stronger sense of the value of research specifically, and a culture of learning more generally (Boydell, Greenberg & Volpe, 2004).

This study addresses a gap in the literature about the experiences of young people undergoing a psychiatric consultation via televideo. Unique contributions of the study include the perspectives of young people regarding the paediatric telepsychiatry session in general and their encounter with the consulting psychiatrist, the perceived helpfulness of the session, the importance of personal choice and individual responsibility for young people, and the use of televideo technology as a medium for interaction. Although the client of the Toronto Paediatric Telepsychiatry Program is the agency (Pignatiello, Boydell, Teshima et al., 2008), ultimately the purpose of the service is to improve the health and well-being of young people and their families. If young people are not comfortable, or do not buy into the service model and treatment recommendations, the likelihood of treatment adherence and successful outcomes are reduced. Consequently, no matter who the official client is, young people’s opinions and perspectives matter.
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APPENDICES
Appendix A

Description of the Toronto Paediatric Telepsychiatry Program

The Toronto Paediatric Telepsychiatry Program (TPTP) was initiated in 2000 by the Division of Child Psychiatry at the University of Toronto. The program is funded by the Ministry of Community and Social Services (currently the Ministry of Children and Youth Services) to function through The Hospital for Sick Children (SickKids). This Program uses televideo to provide psychiatric consultations, case consultations (professional-to-professional) and education to children’s mental health agencies (CMHA) and their clients in rural and remote Ontario. The mandate of the program is to provide bilingual (English and French) psychiatric consultations and education to under-serviced children’s mental health community agencies and their clients, utilizing interactive videoconferencing technology (ITV). As an academic site within the Division of Child Psychiatry at the University of Toronto, SickKids is also required to fulfill clinical, teaching, and research mandates.

Clinicians at the CMHAs are responsible for referring a young person for a consultation through SickKids. Referrals are typically not accepted directly from physicians. During the consultation, the young person’s case manager must be present to ensure that knowledge between the consultant and the young person is exchanged effectively, and for legal prudence. The consultant provides verbal feedback and recommendations at the end of the young person’s consultation, and a written report is sent to the agency soon afterwards (Boydell, Volpe & Pignatiello, in press).
Appendix B
Logos for the Research Study
Appendix C
Semi-Structured Interview Guide for Initial Consults (First Interview)

The questions are intended as prompts only, to assist in the development of a conversation about the telepsychiatry session.

For participants 10-18 years old:
Can you tell me a bit about how you came to receive help by televideo?
What happened during your session with the psychiatrist?
Who was in the room with you when you met with the psychiatrist?
How easy was it to see and hear the psychiatrist?
How comfortable was the room?
What were you told would happen during the session before it started? Did you know what to expect?
How comfortable were you? At the beginning/end of the session?
What kinds of things did you talk about?
   -With the psychiatrist?
   -With others in the room?
How well do you think the psychiatrist understood you?
Was there enough time to talk about everything you wanted to talk about during the session?
Do you think that the psychiatrist was able to help you with your problems?
Overall, what did you think of the telepsychiatry session?
How are things going for you right now?
   -At school?
   -At home?
Did talking to the doctor about _________ help? Why/why not? (These questions will be

53
reworded during the interview to reflect the language used by participants in their response to the previous question; please refer to examples provided above).

What did you like most about the telepsychiatry session?
What did you like the least?
How would you improve the session?
Preference for seeing doctor in person? Or over the TV? Why/why not?
Would you want to have another session? Why/why not?

For participants 7-9 years old:

What made you get to come here and talk to the doctor through the TV?
What did you talk about?
  -School? Friends? Family? Games?
How did talking to the doctor about ________ help/not help? (These questions will be reworded during the interview to reflect the language used by participants in their response to the previous question; please refer to examples provided above).
How easy was it to see/hear the doctor on the TV?
Overall, what did you think of the session?
Was it fun? Scary? Would you do it again?
Would you rather be in the same room with the doctor? Why/why not?
What was the best part of talking to someone over the TV screen?
What was the worst part of talking to someone on the TV?
What would you do to make talking to the doctor on TV more fun/easier?
Appendix D

Semi-Structured Interview Guide for Initial Consults (Second Interview)

The questions are intended as prompts only, to assist in the development of a conversation about the telepsychiatry session.

For participants 10-18 years old:

What has been happening since we last spoke?
   - At school? With your grades? Home? With your friends?

Last time you told me __________, how do you feel now that some time has passed? (These questions will be worded differently to reflect the language used by participants in their first interview; please refer to examples provided previously).

What happened during your session with the psychiatrist last time?
What recommendations were made by the psychiatrist? How have they been implemented? Any updates?

Do you see a change at school? Home? Etc.?

These ______ people were in the room with you last time when you had your consultation, was that helpful? (These questions will be worded differently to reflect the language used by participants in their first interview; please refer to examples provided previously).

How well do you think the psychiatrist understood your problems? Did he or she answer your questions?

Was there enough time to talk about everything you wanted to talk about during the session?

Overall, what did you think of the telepsychiatry session?

How are things going for you right now?

What did you like most about the telepsychiatry session? What did you like the least?

What kinds of things would you recommend to improve the session now that you have had time to think about what happened?
For participants 7-9 years old:

Last time, you told me about __________, how do you feel about __________ now? (These questions will be reworded during the interview to reflect the language used by participants in first interview; please refer to examples provided previously).

Did anything happen to you since last time we talked?
  - At school?
  - At home?

How easy was it to see/hear the doctor on the TV last time?

Overall, what did you think of the session last time?
  Was it fun? Scary? Would you do it again?

What was the best part of talking to someone over the TV screen?

What was the worst part of talking to someone on the TV?

Now that you have had time to think, what would you do to make talking to the doctor on the TV more fun/easier?
Appendix E

Semi-Structured Interview Guide for Follow-up Consults (First Study Interview)

The questions are intended as prompts only, to assist in the development of a conversation about the telepsychiatry session.

**For participants 10-18 years old:**

What happened during your session with the psychiatrist?

When did you first have a session with a psychiatrist by televideo (*approximate date of initial consult*)?

Was it the same psychiatrist then as it was today?

How was this session different for you compared to the first time?

For example,

In what ways was talking to the psychiatrist the same/different?

In what way was your experience during the session the same/different?

How did your previous experience with a telepsychiatry session help you this time?

Who was in the room with you this time when you met with the psychiatrist?


Who was there the first time you had a session?

If different people, ‘How did these new people change your experience?’

What were you told would happen during the session before it started today? In what ways was this preparation the same/different from the first time?

How easy was it to see and hear the psychiatrist?

How did your first session influence your understanding of and comfort with the technology this time?

How comfortable was the room?
What kinds of things did you talk about this time?
- With the psychiatrist?
- With others in the room?

How well do you think the psychiatrist understood you?

Was there enough time to talk about everything you wanted to talk about during the session?

Do you think that the psychiatrist was able to help you with your problems?

Overall, what did you think of the telepsychiatry session?

How are things going for you right now?
- At school?
- At home?

Did talking to the doctor about __________ help? Why/why not? (These questions will be reworded during the interview to reflect the language used by participants in their response to the previous question; please refer to examples provided above).

What did you like most about the telepsychiatry session?
What did you like the least?

How would you improve the session?
- Preference for seeing doctor in person? Over the TV? Why/why not?

Would you want to have another session? Why/why not?

For participants 7-9 years old:

What made you get to come here and talk to the doctor through the TV?

What did you talk about?
- School? Friends? Family? Games?

How did talking to the doctor about __________ help/not help? (These questions will be reworded during the interview to reflect the language used by participants in their response to the previous question; please refer to examples provided above).

How easy was it to see/hear the doctor on the TV?

Overall, what did you think of the session?
- Was it fun? Scary? Would you do it again?
Would you rather be in the same room with the doctor? Why/why not?
What was the best part of talking to someone on the TV screen?
What was the worst part of talking to someone on the TV?
What would you do to make talking to the doctor on TV more fun/easier?
How was talking to the doctor through the TV this time different from last time?
   - Was it easier? More fun?
Appendix F

Semi-Structured Interview Guide for Follow-up Consults (Second Study Interview)

The questions are intended as prompts only, to assist in the development of a conversation about the telepsychiatry session.

For participants approximately 10-18 years old:

What has been happening since we last spoke?
  - At school? With your grades?
  - Home?
  - With your friends?

Last time you told me________, how do you feel now that some time has passed? *(These questions will be reworded during the interview to reflect the language used by participants in their first interview; please refer to examples provided previously).*

What happened during your session with the psychiatrist?

How did your first (initial) session influence how you thought about and/or reacted to what the psychiatrist said during the recent session?

In what ways did your first (initial) session, and the weeks after, influence how you’ve reacted to your recent session?

What recommendations were made by the psychiatrist? How have they been implemented? Any updates?

Given your previous experience with telepsychiatry, how did your first experience influence your approach to the recommendations made this time?

These_______ people were in the room with you last time when you had your consultation, was that helpful? *(These questions will be reworded during the interview to reflect the language used by participants in their first interview; please refer to examples provided previously).*

Do you see a change at school? Home? Etc.?

How well do you think the psychiatrist understood your problems? Did he or she answer your
questions?
Was there enough time to talk about everything you wanted to talk about during the session?
Overall, what did you think of the telepsychiatry session?
How are things going for you right now?
  - At school?
  - At home?
What did you like most about the telepsychiatry session?
What did you like the least?
What kinds of things would you recommend to improve the session now that you have had time to think about what happened?

For participants approximately 7-9 years old:
Last time, you told me about__________, how do you feel about ________now? (These questions will be reworded during the interview to reflect the language used by participants in first interview; please refer to examples provided previously).
Did anything happen to you since last time we talked?
  - At school? At home? Etc.?
How easy was it to see/hear the doctor on the TV last time?
Overall, what did you think of the session last time?
  - Was it fun? Scary? Would you do it again?
What was the best part of talking to someone on the TV screen?
What was the worst part of talking to someone on the TV?
Now that you have had time to think, what would you do to make talking to the doctor on the TV more fun/easier?
How was it different talking to the doctor on a TV this time versus last time?