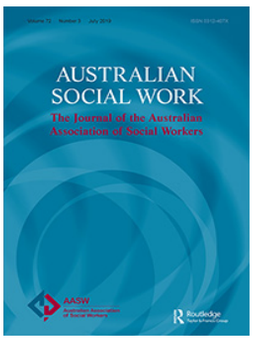

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Telehealth for Social Interventions With Adolescents and Young Adults: Diverse Perspectives

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ABSTRACT

This article describes the telehealth experiences of adolescents, young adults, and youth workers during the first and second waves of the COVID-19 pandemic in the province of Québec, Canada, where remote appointments was the recommended alternative to in-person meetings due to various public health restrictions. Four main themes emerged from individual interviews with nine adolescents and young adults (aged 15–25 years) and focus groups with 35 service providers: the trust relationship, loss of nonverbal communication, confidentiality concerns, and youth disengagement. Participants agreed that face-to-face psychosocial intervention is the preferred option for quality care and service. However, with appropriate support and infrastructure, telehealth could be a reliable alternate modality for reaching adolescents and young adults in remote and rural areas as well as for follow-up care for adolescents and young adults who have an established and trusted relationship with their service provider. For interventions to remain youth-friendly and person-centred, adolescents and young adults must always be offered a choice of modality.

IMPLICATIONS

- Perspectives of adolescents, young adults, and youth workers intersect to provide a unique understanding of telehealth in a specific context.
- There is scant literature on the use of telehealth as a social work practice modality, specifically with adolescents, young adults and their families. This article attempts to fill this gap by providing an early look at the experiences of telehealth during the first two waves of the COVID-19 pandemic in Québec, Canada.

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In Québec, social work professionals comprised 6.5% of health and social service workers in late 2019. This number is steadily increasing (MSSS, 2021). On 14 March 2020, following a significant increase in COVID-19 cases, the Québec government declared a public health emergency. Measures such as physical distancing, school closures, and work-from-home orders were implemented to reduce the number of infections.

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Since the beginning of the COVID-19 pandemic, social workers have been considered essential workers. Québec's crisis response to the long-standing structural deficiencies in senior and long-term care facilities during the first wave of the pandemic (March to May 2020) was unique. In fact, throughout the first two waves, social workers and other service providers were required to cease all "non-essential" interventions and assist in these long-term care facilities and in hospitals. This shift of human resources created a shortage of professionals, including social workers, in all other sectors (Guillette et al., 2020). Professionals remaining in their regular service sector were asked to develop ad hoc triage and prioritisation scales to continue to provide care.

At this time, due to the public health measures in place and the lack of personal protective equipment, social workers across all sectors were instructed to prioritise telephone interventions over in-person appointments (Guillette et al., 2020; OTSTCFQ, 2021). Whereas research on the professional practices of social workers in Québec within the context of the COVID-19 pandemic shows a shift to telehealth (Bourque & Avenel, 2020), the perspectives of service users and service providers on this transition and its impact are lacking, particularly concerning psychosocial services.

Drawing on findings from two connected research projects within the Évaluation des actions publiques à l'égard des jeunes et des populations vulnérables Research Chair (CREVAJ) COVID-19 research program, this article explores the lived experience of engaging with telehealth interventions, from the perspectives of adolescents, young adults, and service providers during the first and second waves of the COVID-19 pandemic in Québec. This research program, funded by the Québec's ministry of health (MSSS) and Society and Culture research funding (FQRSC), aimed to explore the effects of the pandemic and of shelter-in-place measures on the global health, mental health, and wellbeing of vulnerable adolescents and young adults as well as the challenges in service organisations. The objectives were achieved through the deployment of several studies, two of which are discussed in this article. In this article, the term "telehealth" refers exclusively to remote encounters (by telephone or videoconference) between adolescents, young adults, and service providers. Talkspace and other software applications designed for telehealth intervention are not included because they were not used by the Québec government or the participants during the study.

The Contemporary Context of Telehealth in Psychosocial Youth Practice

Initial accounts of using digital health technology as a way to increase access to care, particularly in rural settings or within underserved communities, are found in the medical and psychological literature (Chalmers et al., 2018; Levy & Strachan, 2013). This technology is employed to decrease costs and increase productivity (Snoswell et al., 2020). An international scoping review of technology use in the delivery of child and youth mental health services indicates user and practitioner satisfaction along with successful outcomes (Boydell et al., 2014). Similarly, drawing on evidence from randomised controlled trials, several authors concluded that psychotherapy delivered by videoconference is not inferior to standard clinic-based, face-to-face therapy (King et al., 2020; Turner et al., 2014).

The social work literature concerning telehealth practice is emerging. In 2014, Ramsey and Montgomery (2014) reported an absence of research regarding technology use in

mental health social work practice. However, recent studies have found that social workers use technology informally with service users as an adjunct to in-person practice, mostly for practical purposes, such as scheduling appointments, but also for interventions (Mishna et al., 2020; Mishna et al., 2021). The few existing empirical contributions in the youth-in-care or youth mental health fields suggest that youth and their service providers prefer face-to-face appointments and that they may be reluctant to transition from in-person service delivery to telehealth (Haig-Ferguson et al., 2019; Levy & Strachan, 2013; Sweeney et al., 2019).

The barriers and challenges to telehealth and hybrid digital social work practice (Pink et al., 2020) cannot be ignored. They include internet connection and hardware upgrade issues; privacy and confidentiality concerns, especially for youth living in crowded homes (Haig-Ferguson et al., 2019; Saberi et al., 2013; Sweeney et al., 2019); the loss of emotional nonverbal cues (Haig-Ferguson et al., 2019; Levy & Strachan, 2013); and discomfort and anxiety (Haig-Ferguson et al., 2019).

Transformation of Professional Practices

The COVID-19 pandemic accelerated the use of telehealth and other digital social work practices when personal protective equipment was not readily available (Bourque & Avenel, 2020) and work-from-home orders were in place. Literature examining the practitioner, family, adolescent, and young adult perspectives on the shift to remote work during the COVID-19 pandemic found mixed feelings about this transition. Several authors highlighted the opportunities afforded by digital practice, such as safety, ease of making appointments without having to travel, and allowing practitioners to check in with their service users more often (Bentham et al., 2021; Clinicians in Child Welfare, 2021; Cook & Zschomler, 2020). However, while studies reported that some service providers perceived improved relationships with service users through online communication, they also identified telehealth as a barrier to building trust with youth and families, particularly with new service users (Bentham et al., 2021; Cook & Zschomler, 2020; Pink et al., 2020; Shklarski et al., 2021). Studies conducted during the COVID-19 pandemic indicated that service providers across a variety of practice domains perceived a decrease in reliability and validity of professional evaluations conducted via phone interview and videoconference compared with face-to-face meetings (Bentham et al., 2021; Cook & Zschomler, 2020). Cook and Zschomler (2020) suggested that many social workers were concerned that the most at-risk young people and families, often those facing social and economic inequities, would not have access to the technology needed to participate in telehealth interventions. After reviewing the social work literature, Reamer (2015) raised ethical concerns about issues such as the ability to provide informed consent, guarantee confidentiality, ensure service-provider competence, complete adequate assessments, maintain record keeping, and engage in appropriate termination.

A review of the literature demonstrated that the voices of adolescents and young adults and their experience of telehealth during the COVID-19 pandemic have not yet been adequately documented. Health and social care systems around the world continue to seek ways to rebound from the ongoing COVID-19 pandemic. The authors argue that there is an urgent need to examine adolescents' and young adults' experiences with

telehealth services to better understand the impact on care delivery and the therapeutic relationship. It is imperative to describe the opportunities and challenges telehealth poses. Doing so will help social work practice continue to evolve in a digital age and during this ongoing pandemic while remaining attentive to lived experiences.

The overarching research questions guiding our analysis of two studies mentioned below are:

- How did adolescents, young adults, and service providers experience phone and videoconference appointments in the context of the COVID-19 pandemic?
- What are the common features (advantages and disadvantages) reported by the two parties?

Method

Research Design

This paper presents a secondary analysis of qualitative data (Ruggiano & Perry, 2019) obtained by two studies that aimed to understand the impact of the COVID-19 pandemic and subsequent public health measures on adolescents, young adults, and on youth service providers. One of the studies explored the effects of the pandemic from the perspective of vulnerable adolescents and young adults and the other through the lens of youth service providers. The sampling followed a nonprobabilistic snowball strategy using key informants for both the adolescent and young adult study and the service provider study. The research design for the study with adolescents and young adults employed a mixed method approach, and the study with youth service providers used an exploratory, qualitative approach. This article analyses qualitative data only.

Data Collection and Participants

The objective of our data collection was to capture the impacts of the pandemic on health and social services targeting adolescents and young adults aged 14–25 years using health and social services in Greater Montréal, the most highly populated area of Québec. To do so, we conducted two parallel studies: one with adolescents and young adults and the other with youth service providers. Because these two studies were conducted within the same research program, their ultimate objectives intersected. However, participant recruitment and data collection were independent. All research participants were from the same major urban centre.

Study 1: Data From Adolescents and Young Adults

Data were collected from adolescents and young adults in two phases: (i) an online quantitative questionnaire and (ii) a semistructured interview. First, an anonymous online quantitative questionnaire was sent to institutional and community agencies working with the target population, in accordance with our research ethics certificate. Service providers in these agencies were asked to share the link to the questionnaire with adolescents and young adults. It is worth noting that as of the age of 14 in Québec, individuals are able to independently consent to and make choices about their health and social services

care (Civil Code of Québec, 1991, c. 64, a. 14). Between July 2020 and February 2021, 196 adolescents and young adults completed the questionnaire. No financial compensation was associated with participation.

At the end of the short online questionnaire, participants were asked to provide their contact information to follow up with a one-on-one virtual interview. Compensation (CAD$20) for participation was offered. Of the 196 participants, 19 agreed to participate in a semistructured interview. The interviews averaged 45 minutes and were conducted from August 2020 to January 2021 via the Zoom platform using a secure account. Of the 19 respondents, nine had experienced telehealth as a psychosocial intervention due to COVID-19. Of these nine, eight identified as women and one as a man. They were aged 15–25 years. In terms of ethnocultural identification, participants were asked to self-identify based on Canadian census categories. Six self-identified as White, two as Latin American and one as Southeast Asian; no youth identified as Indigenous (First Nations people, Métis, or Inuit). All of the participants were currently receiving health, mental health or social services. During the interviews, they were asked about their level of satisfaction using telehealth, perceived advantages and disadvantages, as well as any issues they encountered. The quantitative questionnaire had not addressed telehealth: this subtheme emerged from the first interview conducted and became part of the thematic interview grid.

Study 2: Data From Youth Service Providers and Youth Workers

Data were collected from service providers through focus groups. Although an online quantitative questionnaire was sent to service providers across the province, the response rate was insignificant. Therefore, this article focuses on data from the qualitative focus groups. Recruitment for the qualitative component of the study was conducted through key informants (managers) from health and social services centres in Greater Montréal. From August 2020 to November 2020, nine focus groups, lasting 60 minutes each, were conducted using the Zoom platform. No financial compensation was offered for participation. The agencies agreed to allow the youth workers to participate in the project during their regular work hours. These focus groups collected data regarding the experiences and reflections of 35 service providers working in four different services (youth protection, youth mental health, youth at risk, and primary care). In Québec, youth workers work with people aged 0–25 years. Focus group questions covered changes in service providers' practices during the first wave and the beginning of the second wave of the pandemic; their perceptions of changes in the needs of adolescents, young adults and families; and their own needs for training and support.

Data Analysis

Data from the two studies were initially analysed in parallel. Interviews with the adolescents and young adults were transcribed verbatim by two research assistants who were not present during the interviews. They inductively coded each interview separately and simultaneously coconstructed a code book during weekly meetings. The purpose of these intercoder reliability meetings was to compare analyses to ensure replicability (Paillé & Mucchielli, 2012). The coding was cross-validated by the person who conducted most of the semistructured interviews. The final grid was divided as follows: (1)

transformation of daily life, (2) social representations of the COVID-19 pandemic, and (3) access to health care and social services (telehealth). The service providers' focus groups were transcribed verbatim by a research assistant who conducted some of the groups and by two other assistants who did not participate. The transcripts were thematically coded using an inductive process (Mayer & Ouellet, 1991). They were cross-analysed between groups for comparison and cross-validated by the principal investigator and research assistants. The grid was divided as follows: (1) changes in professional work between 14 March and August 2020, (2) service users' needs, and (3) youth workers' needs. Telehealth emerged from the focus group analysis as a topic in each category. The unexpected result of telehealth as a transversal subtheme led the authors to revisit this code in a secondary analysis. The authors cross-analysed the data from adolescents and young adults and from youth workers for the code "telehealth". Four key issues emerged, all of which are related to the relational component of social work practice: difficulty establishing a bond of trust, difficulty understanding each other's nonverbal communication, confidentiality issues, and increased youth disengagement.

Ethical Approval

This study obtained ethical approval from the Research Ethics Board of the CIUSSS Centre-Sud-de-L'Île-de-Montréal for the adolescent and young adult component and from the École nationale d'administration publique and the Université de Montréal for the service provider component. To ensure free and informed consent, each participant was emailed a consent form, which was explained to them prior to the interview or focus group. Consent was reobtained verbally at the beginning of the interview or focus group. All interviews were carried out by Zoom, but only the audio was saved for the purpose of transcription. Participants were assured that their information would remain confidential. All names mentioned in the results section are fictitious.

Findings

The results indicate that participants prefer in-person services, although they acknowledge that telehealth provided continuity in several cases. We explain this preference and how paying attention to it can inform and improve future telehealth in the practice of social work. We present the advantages of telehealth; however, we begin with four main constraints: difficulty in building a bond of trust, difficulty in understanding each other's nonverbal communication, issues around confidentiality, and increased disengagement in follow-ups.

Relationship of Trust

Our study highlighted the difficulty of establishing a trust relationship when initial contact with the adolescent or young adult is virtual. Due to the public health measures and recommendations from the Order of Social Workers, Family, and Marriage Therapists of Québec, service providers engaged with new referrals virtually and therefore did not have the opportunity to meet the adolescents or young adults in

person. This initial "distanced" interaction made it more difficult to establish a trust relationship. In addition, adolescents and young adults expressed frustration as they experienced this distance from the service provider. Paula, 17, said: "I would say that it is a less personal relationship, no strong and close contact is created". For service providers, initiating contact virtually had an impact on their ability to build a therapeutic alliance. Their main concern was that the bond of trust took longer to develop virtually than in person.

> There were certain appointments that were possible to carry out because we had, I found that my bond was very, very solid in terms of trust with that family … But that [development of trust] was really a clinical issue that I found to be major in the [online] encounters. (Tamara, service provider, youth protection)

Participants interviewed agreed that the first meeting, which can be decisive in building the therapeutic alliance, was limited by the difficulty in creating a warm and trusting atmosphere through platforms such as Zoom.

Absence of Nonverbal Communication

Another factor that affected the trust relationship was the difficulty in conveying and interpreting nonverbal communication, be it due to network lags or the absence of an in-person human connection. Adolescents and young adults felt that they were engaged in a one-way conversation; they were talking but they did not feel that the service providers could easily understand their emotions and actions. The young participants reported that this created misunderstanding. The problem was exacerbated by telephone interventions, wherein there was no access to a visual representation of the other person. As mentioned by two participants:

> On the phone, an infinite number of other meanings are missed that may also be important to the service provider and doing only telehealth consultation could hamper the quality and accuracy of the work they do. (Justin, 22)

> When it's face to face, you have more motivation to talk, you seem more active, you seem more there. But when you're on the phone, you find that at the end, the psychologist becomes annoying, she gets on your nerves. Because it doesn't seem like she understands as if you were in front of her … in fact, I think she doesn't see the emotions on my face, and she doesn't understand the whole situation either. (Grace, 16)

This frustration was shared by the service providers who only had access to a fragmented view of the adolescent or young adult provided by the camera's framing.

> And to just see a torso like we see there, but we don't see the hands, we don't see the feet … you know, we don't see the nonverbal which is essential, in my opinion, to understand someone well when they speak less, or they are silent. I lost it all at once, and I found it not easy. (Paul, service provider, youth-at-risk program)

There was consensus among both the adolescents and young adults and the service providers that the absence of nonverbal communication can create a cognitive and affective gap between the two interlocutors. Interpreting silences, gestures, and emotions virtually or by phone was difficult and directly impacted the development of a relationship and the construction of practice.

Confidentiality

The sudden pivot to telehealth as a practice modality meant that spaces and places were not adapted. That is, it was difficult for participants to find a confidential space to talk. Calling from home, adolescents and young adults did not always have a private place to share or communicate safely. Thus, the intervention location was inadequate. Léa, 18, said:

> The negative issues were that my home is very small … It was hard to talk about my personal life when a family member could have heard me very well. It was hard to feel close and safe with the social worker or the counsellor remotely. It seemed like the information I was giving them was not safe.

Service providers sometimes dreaded the presence of parents during their virtual meeting. Some even feared that they would be recorded without their knowledge and would not have control over the confidential information said during the meeting:

> Like, you don't know if the parents are behind the computer. Even on the phone, you know even less. And so, sometimes … [in] these meetings, it feels like there's, there's something prevents them from telling us, you know, what's going on because, definitively, the parents are listening, or the parents are standing behind. Like, you know, making sure that they are saying the right things. You know, like things like you want to hear. (Helen, service provider, youth protection)

Adolescents and young adults often could not attend in-person meetings at the agency. However, without adequate space or privacy at home, they felt that they were not safe from being overheard. As a result, they did not open up as much as they would have liked. To address this issue, some service providers said that they sometimes agreed upon a signal or code they could use to indicate they were no longer in a safe or private space. Adolescents and young adults were also encouraged to verbally state that they would prefer to continue the meeting later if they were not alone or not able to talk.

Disengagement From the Intervention

A final issue, frequently identified by participants as a disadvantage of telehealth, was that adolescents and young adults could more easily disengage from the intervention. Because they were at home, some young participants mentioned that the meetings were less formal, and they felt more detached from the process. Adriana, 15, said: "It's definitely harder because she may keep asking me questions, I might just leave if I don't like it or something. Sometimes when I find it really long, I put on my headphones and listen to music".

Preventing disengagement was even more challenging when service providers were using the telephone. Young participants reported being distracted by their surroundings and less attentive to the service provider and the conversation. Service providers also worried that they were unable to assess adolescents' and young adults' engagement:

> I find that the biggest challenge was to reach the youth, because yes, the phone, yes Zoom, but they also can easily cut the conversation short. To not answer the phone or to not be there during the Zoom meeting. I think the biggest challenge was to maintain contact to reach the youth. (Kate, service provider, youth-at-risk program)

It was more difficult to maintain the concentration and interests of adolescents and young adults when the intervention was not in person, especially because it was harder for service providers to synchronise, assess, and engage with the young service user and adjust accordingly.

Benefits and Advantages of Telehealth

Adolescents, young adults, and youth service providers in Québec have a clear preference for in-person interventions after experimenting with telehealth interventions during the first and second waves of the pandemic. Service quality and care were reported as superior during in-person services, specifically because sharing a physical space allowed for a stronger human and relational connection. However, some benefits emerged from the use of telehealth when working with adolescents and young adults. Many participants are interested in retaining telehealth as an optional modality, as Annie, 20, said: "I would like to have the choice. Some weeks, I would prefer face-to-face, while others I would like to do them remotely. It all depends on my physical and psychological state". Offering telehealth as an option alongside traditional in-person care was identified as having the potential to ensure accessibility, particularly when living far from the agency. In addition, telehealth interventions reduce travel time. Participants mentioned this logistical consideration as a reason to refine and improve telehealth so that it can be integrated with traditional practice. Another compelling aspect of telehealth is that some adolescents and young adults did not want to be seen at the agency to receive care, often due to fears of stigma or increased stress from being in an institutional setting. Béatrice, 15, stated:

> The advantages were that I wasn't at the hospital. The hospital was more stressful. You go in. You spend time in the waiting room. You wait. You go into the room. You do your thing and then you leave. It was relaxing to be at home and be in front of a screen instead of being in a hospital.

Nonetheless, many service providers, particularly those working in youth protection, noted the importance of home visits for performing their duties ethically and professionally.

> You really want to get a feel for what the family is like and their environment. And so, having that at home is valuable to get a sense of that. And you are not going to get the same impression with Zoom. (Richard, service provider, youth protection)

Despite their strong preference for in-person meetings, all participants said that telehealth was essential during the pandemic. It made follow-ups possible regardless of public health measures that limit in-person social interactions, particularly when personal protective equipment was not readily available. Nevertheless, the issues of access to technology must be resolved, adequate training must be given, and ethical standards in telehealth must be established to provide high-quality interventions.

Discussion

This qualitative study sought to explore the experiences of adolescents, young adults, and youth workers with telehealth in social interventions. Consistent with qualitative

methodology and in-depth analysis, the sample size was small. Thus, generalising the results to different contexts could be problematic. Moreover, the authors acknowledge the imbalance in the adolescent and young adult voice in this analysis, with nine participants compared with 35 service provider participants. The authors strove for reliability by making use of detailed field notes, recording devices, and transcribing digital files. Validity was ensured through triangulation of data sources, methods, and investigators to establish credibility.

Telehealth in this particular context was imposed by the pandemic. It was implemented quickly, without training, support, or buy-in. This may explain why the participants saw it as a way to maintain continuity of care during an exceptional time rather than as a long-term, sustainable option. As Pink et al. (2020) noted, during the first two waves of the pandemic all participants were deprived of human contact to some degree and may have felt that "digital intimacy" (p. 29) could not fill the larger than usual void. Nevertheless, service providers shared moments of adaptability and creativity in using their relational skills to sow the seeds of connection and authenticity. For example, as also observed by de Kam (2020), they harnessed the intimate settings of being on a video call (i.e., getting a window into the young person's home or space) to discuss personal likes, dislikes, and tastes, such as a pet or a poster on the wall. Service providers additionally offered adolescents and young adults alternatives, such as taking a walk in a park. This not only addressed public health measures but also pushed forward more outreach and community-based intervention modalities that were perhaps previously frowned upon by the agency. Telehealth can be seen as an additional modality to be carefully considered, rather than as a substitute for care as usual.

Limitations

One limitation of this study is that we met our participants exclusively over the Zoom platform, meaning that we automatically excluded participants without access to a device and reasonable bandwidth. This limitation is mirrored in our findings—many participants agree with a "hierarchy of communication" (Haig-Ferguson et al., 2019, p. 48) yet express a clear preference for in-person interventions. Videoconferencing appointments were considered preferable to phone calls. Consequently, the adolescents and young adults interviewed mentioned that the quality of service and care was lower when provided by phone or videoconference than when provided in person. While the visual elements of videoconferencing offer some degree of nonverbal communication, participants identified several difficulties in conveying emotions through the screen. This was partly due to technological issues, the lack of comfort with the use of technology, and the sudden adjustment to a new modality, but also to a lack of the human connection that emerges from sharing a physical space. Social workers have expressed mixed feelings about remote care, which they described as an incomplete sensory experience (Cook & Zschomler, 2020; Pink et al., 2020). Our findings reflect youth workers' concerns regarding their ability to provide quality intervention remotely (Bentham et al., 2021; Cook & Zschomler, 2020). Telehealth in its current form in Québec should not be the first option offered to adolescents and young adults because it can make individuals feel disengaged and often disconnected. Further, service providers require more support and training to effectively and sustainably engage with telehealth as part of their clinical toolkit.

Our data identify significant confidentiality issues during telephone calls and video-conferences. Some service providers were deeply concerned that intervention through digital devices allows parents to eavesdrop on the conversation or adolescents and young adults to record their intervention without their knowledge. The creation of a sustainable and enhanced telehealth option is needed for social workers to provide frequent but brief, regular follow-ups, to conduct triage or preassessments through a virtual interface rather than over the phone, and to provide a more consistent and accessible follow-up for adolescents and young adults living outside the urban centre.

Conclusion

Including the voices of adolescents and young adults in this research allowed us to highlight specific concerns and offer a balanced reflection on telehealth. We should not assume that, because we live in the digital age, adolescents and young adults prefer telehealth to in-person meetings. By performing a cross-analysis of interviews with the study participants and focus groups with service providers, we identified four key issues that affect the cognitive, affective, and relational components of social work practice. Our findings suggest that in-person human contact is an irreplaceable component of social work practice. In a context where familiar reference points have been lost due to school closures, job loss, and social isolation, the COVID-19 pandemic underscores that access to quality social interventions should be a priority.

Disclosure Statement

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