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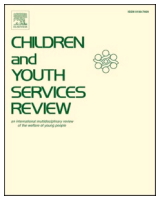

# Youth care in time of COVID-19: Experiences of professionals and adolescent clients with telehealth

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ABSTRACT

Measures aimed at preventing the COVID-19 virus from spreading restricted all aspects of public life, including possibilities for meeting in-person. Youth care professionals were forced to turn to telehealth tools, such as video calling and e-health methods, to be able to continue support and treatment of children, adolescents, caregivers, and families. This study consists of two qualitative interview studies on the experiences with and transition to telehealth during COVID-19: (1) interviews with youth care professionals ($N = 20$), and (2) interviews with adolescents who used mental health care support ($N = 14$). We specifically asked participants about five themes which were selected based on pre-COVID literature on telehealth: (1) tools (i.e., which programs are being used), (2) privacy, (3) methods (i.e., what was the same and what was different compared to in-person sessions), (4) relationship/therapeutic alliance, and (5) effectiveness (i.e., what was their impression of effectiveness of telehealth). The majority of professionals reported that they had very little to no experience with telehealth prior to the pandemic. Both professionals and adolescent clients mentioned benefits and limitations of telehealth. On several themes professionals and adolescent clients mentioned similar barriers in the transition to telehealth during COVID such as limitations of the available hard- and software (theme 1: tools); forced changes in the content and methods of the sessions (theme 3: methods); and difficulties with non-verbal communication (theme 4: alliance). However, whereas most professionals expressed the intention to keep using several aspects of telehealth after restrictions due to COVID are lifted, most adolescent clients expressed they see telehealth as a temporary solution and prefer meeting professionals in person. Their experiences and the barriers and enabling aspects they mentioned may provide important insights in the acceptability and usability of telehealth for youth care organizations, youth care professionals, researchers and higher educational training programs.

On March 11th, 2020, the World Health Organization (WHO) declared the Coronavirus 2019 virus (henceforth COVID) a global pandemic. To stop COVID from spreading, public life was heavily restricted (i.e., multiple "lockdowns") in many countries. These restrictions have impacted all aspects of daily life of children, adolescents and their caregivers (Weeland et al., 2021). For example, schools were closed, and many caregivers were urged to work from home as much as possible. These restrictions also limited the possibilities for in-person youth care (e.g., parenting support and child and adolescent mental health care). Youth care professionals turned to telehealth tools, such as video calling and e-health methods, to be able to continue support and treatment of children, adolescents, caregivers and families (Nicholas et al., 2021; Svistova et al., 2022).

Although in general youth care professionals have positive attitudes towards the possibilities of telehealth, prior to the pandemic most of them had had little experience with working online and had been reluctant to start to do so (Cipolletta & Mocellin, 2018; Connolly et al., 2020). This may be partly explained by the fact that working online had received little attention in the education and training of professionals and by their concerns regarding the effectiveness of online treatment, its technical challenges and their ability to build a strong therapeutic relationship online (Aafjes-van Doorn et al., 2020; Vincent et al., 2017).

*Abbreviations:* COVID-19, CoronavirusDisease 2019.

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Moreover, few youth care organizations had the needed hard- and software in place to facilitate remote working and/or working online with clients.

The forced and sudden transition from in-person to remote and online care during COVID presented many challenges and required much flexibility from youth care organizations, professionals and their clients. At the same time, this transition may have presented us with opportunities to widely implement online and online-hybrid methods that may have important advantages for both health care professionals and clients. Telehealth may increase access to, acceptability, feasibility and flexibility of mental health care (Gloff et al., 2015). Moreover, pre-pandemic studies on the effectiveness of online versions of behavioral parenting programs (Dadds et al., 2019,2017), cognitive behavior therapy for children and youth (Vigerland et al., 2016), as well as psychotherapy for adults (Norwood et al., 2018) have shown effects comparable to those found in in-person delivered versions. Also, satisfaction with telehealth has been shown comparable to in-person care (Aafjes-van Doorn et al., 2020; Owen, 2020), specifically in adolescent populations (Richardson et al., 2009).

The aim of the current study is to explore how two groups of important users, namely youth care professionals and adolescent clients, experienced the sudden transition to telehealth during the early waves of the COVID pandemic. We explored what they feel contributed to a successful transition, what prevented it, and what is needed in order to further implement and continue with telehealth. This can help us understand both their unique experiences of a forced and sudden transition to telehealth, as well as teach us lessons for future training in, and use of, telehealth.

More specifically we conducted two interview studies: (1) with youth care professionals during the first wave of COVID infections in The Netherlands and (2) with adolescents who used mental health care support during the second wave of COVID infections in The Netherlands. In these periods the country had relatively high numbers of COVID cases and stringent government response, such as closure of schools and restaurants, restrictions on in-person contact and the urgent advice to work from home as much as possible. We specifically asked participants about five themes which were selected based on pre-COVID literature on telehealth: (1) tools (i.e., which programs are being used, Nelson et al., 2017), (2) privacy (Hale & Kvedar, 2014; Hall & Mcgraw, 2014), (3) methods (i.e., what was the same and what was different compared to in-person sessions, Nelson et al., 2017), (4) therapeutic relationship/ alliance (Berger, 2017), and (5) effectiveness (i.e., what was their impression of effectiveness of telehealth, Abuwalla et al., 2018; Nelson et al., 2017).

## 1. Methods

This study consisted of two qualitative interview studies on telehealth: (1) interviews with youth care professionals on their experiences with working online and (2) interviews with adolescents on their experiences with online mental health care.

Procedures were approved by the ethical committee of the Ethics review Committee of the Department of Psychology, Education and Child Development of the Erasmus University Rotterdam, the Netherlands (reference 20–037, on April 15, 2020). Study 2, with adolescents, was also approved by the committee of scientific research of a large Dutch regional Mental Health Care Institute through which participants were recruited (reference CW02012, on October 16, 2020). No funding was received for conducting this study.

### 1.1. Setting

Both studies were conducted in the Netherlands, a small country with a high population density. The Dutch youth care system is governed by the Youth Act and is part of the Dutch healthcare system (Ministry of Health, 2016). This system is based on several principles, among them "access to care for all" and "solidarity through medical insurance (which is compulsory for all and available to all)" (Ministry of Health, 2016, p. 3). See Ministry of Health (2016) for more information on the organization of support, assistance and care for children, adolescents and their families.

### 1.2. Participants study 1

Twenty professionals from all over the Netherlands (both rural and urban) participated in this qualitative interview study (19 women; $M_{age}$ = 37.50; $SD$ = 10.00). All participants were highly educated, with a professional education degree ($n$ = 2; 10%), an academic degree ($n$ = 10; 50%) or a post-academic degree ($n$ = 8; 40%) (for an explanation of the different levels see: https://www.idw.nl/en/complete-description-educational-system.html). They all worked with children, youth, caregivers and/or families. Most of them worked in outpatient mental health care settings (85%), the other 15% worked in inpatient care settings. Of those working in an outpatient setting half ($n$ = 8, 47%) worked in community health care centers or as a school psychologist, 35% ($n$ = 6) in an outpatient clinic, and 12% ($n$ = 2) in a private health care setting. They had on average 6.80 years of experience ($SD$ = 7.77), with a minimum of less than one year and a maximum of 35 years of experience in the current function.

The majority of participants reported that they had very little to no experience with telehealth prior to the pandemic. However, some mentioned they did previously use some of the tools they now used to contact clients, such as telephone or online message service (e.g., WhatsApp). Some also mentioned that they had been previously working on the development of telehealth methods or had been encouraged to do so (e.g., by health insurance companies).

### 1.3. Recruitment and procedure study 1

The recruitment of professionals was part of a broader research project on experiences of providing telehealth to children, youth and families during the pandemic. We recruited professionals for the broader project between March and June 2020, which was during the first wave of COVID infections in the Netherlands. During this period, the government put in place measures to prevent the virus from further spreading. Public life and opportunities to meet each other in-person were heavily restricted. Recruitment was done through announcements on relevant (professional) social media pages and in newsletters of education, training and professional associations focusing on care for children, youth and families. Professionals responded by sending an email to the research group, upon which they were sent an information letter about the study and a link to an online consent form (i.e., active informed consent). Participants were asked to answer several questions about their demographic background (age, gender) and their educational and work background (training, position, work field, years of experience). Twenty-two professionals agreed to participate in the qualitative interviews, after which they were contacted to set a date for a telephone interview. As one participant couldn't be reached and one respondent had a focus on adult mental health care, our final sample consisted of 20 participants.

Interviews were conducted by telephone. Approval was obtained to audiotape the interview to facilitate verbatim transcripts. Interviews lasted 43.74 min on average ($SD$ = 6.56, min. 33.00 - max 57.40 min). After the interviews the interviewers filled out a short form to reflect upon the quality of the interview. Recruitment was stopped when preventive measures by the government to stop the virus from spreading were further limited after the first wave of COVID and professionals were partly going back to in-person care, reducing their use of telehealth methods. However, data saturation may not have been reached, specifically since we included a broad range of professions within youth care.

### 1.4. Participants study 2

Fourteen adolescents between 12 and 22 years old (13 girls, $M_{age}$ = 17.50, $SD$ = 2.71) who received mental health care during the pandemic were interviewed. All received care from professionals working in one of two outpatient departments of a large regional health care institution; one department specialized in treatment of children and adolescents up to 18 years who have problems at home, at school or in contact with peers, the other department specialized in treatment of adolescents and young adults (16 to 23 years old) who have serious and complex psychological problems. All adolescent client participants received outpatient telehealth services during the lockdown period. The form of their treatment differed, but always included one-on-one meetings with their practitioner. Most of the participants were still following education at the time of the interview: secondary school (various levels, $n$ = 4; 29%), post-secondary vocational education ($n$ = 4; 29%) or higher education ($n$ = 4; 29%). Two participants (14%) did not study or work at the time of the interview, of which one did have a voluntary job.

Participants reported receiving or having received treatment for a large variety of disorders and or mental health complaints: depressive disorders, mood disorder, post-traumatic stress disorder, suicidal thoughts or attempts, anxiety disorders, autism spectrum disorder, eating disorders, attachment problems, attention deficit disorder, sensory overload, emotion regulation problems, signs of Borderline Personality Disorder. The majority reported to have had symptoms for multiple years and have received care for these complaints before the pandemic. A few participants reported that they started care or treatment around the start of the pandemic. Half of the participants had contact with more than one practitioner. This often concerned less frequent contact with a psychiatrist, in addition to a main therapist.

### 1.5. Recruitment and procedure study 2

We recruited participants between October and December 2020, during the second wave of COVID infections in the Netherlands, where public life and opportunities were again heavily restricted. Recruitment was done via mental health care professionals at a large regional organization that provides inpatient as well as outpatient services. Adolescents with insufficient Dutch language skills, who were in an acute crisis or had no or limited experience (one session) with telehealth were excluded from participation. We used a three-step recruitment strategy. First, mental health care professionals were informed about the aims, procedures and exclusion criteria of the study (through an information letter and presentation). Second, professionals informed adolescent clients within their case load about the study. We explicitly asked them to inform all eligible clients, both clients who were more or less satisfied with telehealth. Third, if adolescent clients were open to receive more information about the study, they were asked permission to be contacted by the researchers for more information. In cases where participants were younger than 16, their caregivers also received an information letter. Adolescents, and when younger than 16 also their caregivers, were asked to provide active informed consent via an online consent form. After receiving all necessary consent forms, an interview was scheduled. Of the 19 adolescents who initially agreed to be contacted, five later decided not to participate. Our final sample consisted of 14 adolescents.

Interviews were conducted via telephone. At the start of the interview consent was asked to audiotape the interview to facilitate verbatim transcripts. The interviews lasted between 21.33 and 41.53 min ($M$ = 29.54, $SD$ = 5.68). After participation there was a raffle for a gift voucher (worth 50 euros). Recruitment stopped after no new themes emerged in two concurrent interviews and data saturation was reached.

### 1.6. Instruments

The structured interviews were conducted by three interviewers using self-constructed topic lists based on a literature review regarding experiences with telehealth. In both studies, after the first two interviews (conducted by two interviewers) minor changes were made to the topic list in sequence and phrasing. The in-depth interviews started with introductory questions asking (1) professionals to describe their work experience and their daily work prior to the pandemic and the transition to telehealth; and (2) adolescents to describe their age, education/work and their hobbies. This was followed by questions regarding their experiences on five domains: (1) tools; (2) content and working methods of sessions; (3) privacy, (4) relationship and alliance with clients/professionals; (5) effectiveness. Within each topic participants were asked about their general experiences, possible barriers and enabling factors and necessary conditions to provide proper care. The interviews ended with a question regarding what was necessary to provide good quality telehealth in the future (the complete topic list can be obtained from the researchers).

### 1.7. Analytic strategy

After entering all verbatim transcripts in Atlas.ti 8 (2020), a computer program used to structure qualitative data, we used multiple stages and cycles to analyze our data guided by the Constant Comparative Method (Boeije, 2002). By constantly comparing the codes within as well as between the interviews we aimed to conceptualize the content of the transcripts into structured categories. Two researchers were involved in the coding and analysis of study 1 and three researchers the coding and analysis of study 2. The researchers started with each coding the same interview line-by-line. This was followed by (a) organizing segments from the transcripts according to the general domains on the topic list (deductive coding; e.g., “tools” or “content”); (b) adding new (sub)codes based on the transcripts/data (inductive coding, e.g., “difficulties with non-verbal communication”); (c) comparing and discussing the coding with each other to come to clear and meaningful codes, as well as discussing further possible organization of the codes with each other. Next, to maximize internal coherence and consistency one of the researchers conducted all the coding, following the same multiple stages and allowing for new codes and a further organization of categories; for instance the superordinate theme “alliance” contained, among others, the theme “barriers”, which contained among others, “difficulties with non-verbal communication” (study 1). After coding the last transcript, all transcripts were reread by the same researcher, and, if necessary, additionally coded. The other researcher(s) then checked whether the superordinate themes and subthemes were grounded in the transcripts. Any discrepancies were discussed with the other researcher(s) until consensus was met, and transcripts were recoded following this consensus.

To order the findings, we used, next to describing themes (superordinate themes, theme, subthemes), operationally defined verbal counting (Sandelowski, 2001) and supported this by verbatim extracts from the transcripts. In study 1, we used “a few” if such was found in less than 4 transcripts, “some” regarding 4–6 transcripts, “several” if found in 7–9 transcripts, “many” if found in 10–13 transcripts, and “most” or “the majority” if found in 14 or more transcripts. In study 2 (containing fewer participants than study 1), “one participant” or “a single participant” was used if a certain theme was distinguished in 1 transcript, “some” if found in 2–3 transcripts, “several” if found in 4–5 transcripts, “many” if found in 6–7 transcripts, and “most” or “the majority” if such was found in 8 or more transcripts. We used representative quotes to illustrate the findings. These quotes were translated from Dutch to English by using the back-and-forth method to ensure accuracy. Moreover, we adhered to criteria for reporting qualitative research Association, 2018; Tong et al., 2007 (COREQ)).

### 1.8. Researcher-participant relationship

Three researchers were involved in conducting the interviews. In the

interviews with professionals (study 1) four participants had a pre-existing working relationship with (at least) one of the researchers. Participants were aware of this before joining the study. In the interviews with adolescents (study 2), one of the researchers worked at the organization through which participants were recruited. This researcher had a pre-existing working relationship with one participant. This participant was therefore interviewed by the other interviewer. After all interviews, researchers filled out a form reflecting on the course of the interview. Reflection forms were discussed among the researchers, upon which no interviews were excluded.

## 2. Results

### 2.1. Study 1

We distinguished eight domains, of which two were explicitly related to the pandemic, namely: general changes regarding client situation and general experience with transitioning to telehealth. The other domains were tools, privacy, alliance, content and working methods, perceived effectiveness, and telehealth in the future. Each of these domains also consisted of several themes and subthemes (see also Table 1). We described the eight domains, the themes, subthemes and relationships between the distinguished themes.

#### 2.1.1. General changes regarding client situation

The majority of participating professionals indicated that they were able to reach all or at least three quarters of their clients with telehealth tools. Reasons they mentioned for not being able to reach clients were because clients were having difficulties setting up the appropriate hard- and software, because they simply did not answer or reply to messages, or because clients themselves indicated their needs changed (e.g., because the pandemic caused their needs to decrease or because they felt they had "other things on their mind").

The majority of professionals mentioned that the development of symptoms or problems of their clients changed during the pandemic. Some specifically mentioned that whether it changed, or the way it changed, differed between clients. Several mentioned that the severity of the problems increased for some clients, while some mentioned they decreased for other clients. Reasons for the increasing severity of problems that were mentioned were mostly related to the pandemic and the related lock-down measures: the fact that families were "stuck at home", children did not go to school, adult clients had to combine work and home-schooling their children, and clients worried about their health or that of their loved ones or their financial situation. As a result, professionals sometimes had the impression that during client contact they were mainly concerned with stabilization of the problems, instead of the original treatment goals.

> *"For some children, school was a source of support, and the stress increased during the lockdown, the complaints worsened. So you are indeed mainly concerned with stabilizing the treatment." (ID 37)*

However, for other clients, the pandemic brought relief from to their symptoms, or they experienced more (head) space to work on treatment goals.

> *"So that you see a complaint in remission and that there is often more room to work specifically on those traumas, for example." (ID 38)*

#### 2.1.2. General experience with transitioning to telehealth

The experiences of professionals with the transition to telehealth were strongly intertwined with other transitions caused by pandemic-related preventive measures, such as the closure of schools and workplaces. Several professionals explicitly mentioned struggles with transitioning their day-to-day work to online. The majority of professionals, first of all emphasized the importance of technical preconditions for telehealth, such as a stable and fast internet connection, good quality

**Table 1**
Coding tree including domains, themes and/or subthemes of professionals' experiences of telehealth.

| Domains | Themes | Subthemes |
|---|---|---|
| General changes regarding client situation | Reach | # |
| | Development of symptoms/problems clients | Varies, stable, increases, decreases |
| General experience with transitioning to telehealth | | Uncertainty about which software to use; access to the needed software, mental energy, job satisfaction and/or workload, relationship with their colleagues |
| Tools | Barriers | Poor connectivity, poor accessibility, more distraction, not able to see everyone or everything, clients less committed, physical distance, working online costs more mental energy compared to offline, difficulties interpreting typed messages |
| | Enabling factors | Connectivity, accessibility, informing and preparing clients, being explicit/ask more clarification, proficiency in working in online environment, a back-up plan for when online environment does not work, one-on-one meetings, support from employers and software providers |
| Privacy | Barriers | Third parties can listen in, work and personal life intertwine (meetings from home), use of unsafe programs, lack of information on security of software, use of personal devices |
| | Enabling factors | Clear agreements with clients and housemates, information about software and privacy, headphones, consent from parents and clients, appropriate spot for meeting |
| Alliance | Barriers | No physical contact possible, no eye-contact, difficulties with non-verbal communication, less informal chit-chat, age, severity or type problems client |
| | Enabling factors | Existing alliance, (extra) contact between meetings, lowered threshold to contact therapist, providing room for chitchat, clients are in familiar/safe space |
| Content and working methods | Barriers | Difficulties concentrating, less professional enjoyment/ fulfillment, lack of experience, cannot see everything, cannot talk freely difficulties with non-verbal communication, being interrupted, losing time to technical preconditions, clients being less committed, diagnostics, less possibilities for exposure/ modeling/ practice possible |
| | Enabling factors | Functionalities of tools, being explicit, structuring the meeting, focusing more on cognitive aspects treatment, creativity, lowered thresholds seeking help, online in vivo observing and practicing, more autonomy client |
| Perceived effectiveness | Barriers | Unable to treat, clients have increased problems or new problems due to the pandemic, severity of the problem, age, less |

(*continued on next page*)

**Table 1** (*continued*)

| Domains | Themes | Subthemes |
|---|---|---|
| | | time for actual treatment, poorer alliance |
| | Enabling factors | Client has more autonomy/ control, more distance, treatment in familiar/safe space, less problems/more room for treatment due to lock-down |
| Telehealth in the future | Retain | Use of video-calling, flexibility for clients, efficiency, additional contact with clients between meetings |
| | Gaps to be filled | Preconditions workplace, skills and experience professionals, development of diagnostic research and remote risk assessment tools, coordination of working with other parties, research on effectiveness tools, attention for work-life balance, guidelines and protocols |

*Note.* # No further subthemes.

image and sound. Secondly, they mentioned the importance of security, accessibility, and user-friendliness of the used tools. Some professionals mentioned negative consequences of forced working online and/or from home: it negatively affected their mental energy, job satisfaction, and/or experienced workload and the relationship with their colleagues, as illustrated by the following quote:

> *"Normally you can just walk into a colleague's office and say: "I'm worried, did I handle this properly, what would you do?" And that is also lost when you're at home alone behind your laptop. I also think that this makes work a bit heavy. That consultation with colleagues is not a matter of course." (ID 60)*

### 2.1.3. Tools

Professionals first and foremost mentioned connectivity and accessibility as both important barriers or enabling factors in their transition to telehealth (see also General experience with transitioning to telehealth). Stable and fast internet connection, good quality image and sound is crucial according to the professionals. They also mentioned that it is important that the programs are easy to use, can be used in the secure, digital environment of the employer, and that it is easy to invite others to use the tools (for example via a link) so that clients do not have to install all sorts of software on their device. The next most often mentioned barrier of using the online tools was distraction, the fact that they themselves and their clients seemed more easily distracted during online sessions.

> *"That you are much more easily distracted, that you are not actually in a conversation." (ID 16)*

The majority of the professionals mentioned not being able to see everyone (e.g., when meeting with their colleagues) and/or everything (e.g., the surroundings, the body language) (see also Alliance) as a barrier of successfully transitioning to working online.

> *"Such an open door: the non-verbal. If someone doesn't open up and is anxious. Then you see someone on a screen, without context. I think it feels more contrived." (ID 46)*

Also, several professionals stated that clients seemed less committed to telehealth which hampered the transition to using the telehealth tools.

> *"Then you had an appointment, and the child picks up and then he is suddenly in the car. Then you can have a really nice plan what you want to do, but then you can't. You also have less control over the process." (ID 55)*

Some also explicitly mentioned the physical distance between them and their clients (see also Content and working methods), the fact that working online was experienced as draining (i.e., costing a lot of mental energy), and the fact that typed messages (in texts, in online modules) were sometimes difficult to interpret as barriers for a successful transition.

Professionals also mentioned further enabling factors, specifically things they could do themselves to use the available tools as effectively as possible. The majority of professionals explicitly mentioned informing and preparing client for the use of the programs by discussing online etiquettes, making clear agreements with clients about, amongst others, the start and end time of a meeting and privacy (see Privacy), and stimulating clients to use appropriate hardware (the use of headphones and laptops instead of smartphone)for better sound and visuals. According to the professionals, online etiquettes were having a quiet place to sit, a quiet background, the microphone on mute when you are not speaking, and having your torso and arms well in view. This applied, according to the professionals, to both the professional and the client. Many professionals also emphasized that during client contact it is important to express, explain and check things more explicitly. For example, expressing what you do and think yourself, and checking whether you are interpreting what the other person is doing and thinking in the right way, as illustrated in this quote:

> *"And that you also clarify: if I look away now, I'm writing. That you make more explicit what you are doing." (ID 10)*

Informing and preparing clients and making clear arrangements are perhaps extra important when meeting online because professionals indicated that they experienced clients to be more noncommittal to online appointments compared to in-person meetings.

Other factors that they could do themselves mentioned by some or a few professionals were improving their proficiency in the program used, having a back-up plan for when things go wrong (e.g., having a phone number ready if the connection is lost), and having one-on-one meetings instead of meeting with multiple clients or colleagues at the same time. Several professionals also mentioned the importance of support from their employer or the software providers.

### 2.1.4. Privacy

In the interviews, professionals indicated that there are aspects of online contact with children and parents that may endanger privacy. Most professionals mentioned that, because both professional and client conducted the meetings from home during the lockdown, they had concerns about third parties listening in on the conversation.

> *"Which is also a point of attention, and people don't even do that consciously, but then suddenly someone walks through the image with the client. Then you think: huh, who is that? Or a brother or sister and then I think: o yes, just ask, where are you [sitting]?" (ID 38)*

Related to this, a few professionals expressed a concern that sessions would be recorded (and shared) by the clients without asking permission.

Many professionals also indicated that working online with clients from home made it more difficult to keep work and private life separate, for example because their home could be seen in the background.

> *"I think we may need to be even more alert. Ask the client beforehand: 'Who is with you, where are you now and how are you?' Make it clear in advance that you are having a therapy conversation and that privacy is important, so discuss privacy even more, at the beginning of video calls and repeat that." (ID 18)*

Another frequently mentioned concern is the use of unsafe programs. Professionals indicated, among other things, that programs that are

easily accessible and user-friendly- such as WhatsApp, Facetime and Zoom - are not always regarded as sufficiently secure and that these programs are sometimes nevertheless chosen because of the low threshold. This resulted in dilemmas for professionals, as illustrated by the following quote:

> *"And then it's also about whether clients are able to install such a program on their computers. Well, and communication with vulnerable families, who don't even have a computer yet. Let alone that they understand how to make video-calls and organize a program in this way. Well, let's just call via WhatsApp. I think I'll take that risk. But my employer asks to comply with it [security regulations]. So how do you weigh your integrity, your employer who asks to take that [security] into account, against the interest of your client who just needs the treatment?" (ID 55)*

Relatedly, some professionals indicated that after the start of the first lockdown, there was for a long time uncertainty about which programs were safe or that information about the security of the programs was inconsistent or difficult to find. A few also mentioned that using their own personal devices (as they did not have hardware from the organizations yet) may endanger privacy.

Professionals also mentioned things that helped them to ensure their own privacy, such as clear arrangements with clients and housemates (e.g., about others walking in); clear information on software security/privacy; the use of headphones; consent from parents and that of the client on using certain tools and software; and thinking about an appropriate spot to talk.

#### 2.1.5. Alliance

Professionals experienced the quality of their connection with clients during telehealth differently: Several participants experienced the general quality of connection with clients as positive during online meetings. Specifically, in cases in which they already had an existing alliance with a client, when working online enabled (extra) contact between meetings, when telehealth lowered the threshold for clients to contact them, when they consciously provided room for chit chat, and because some clients were more relaxed in their familiar/safe space.

> *"I noticed that if you don't sit together in a room, but if someone is just in their own environment, and can talk in a place that is familiar to him or her, that actually led to very open conversations, in which they also dared to say things they hadn't said before in the in-person conversations." (ID 60)*

Some explicitly mentioned it differed between clients. They felt that with some clients, online contact was less successful than in-person contact, but with others it was just as good as in-person, or even better. A few participants experienced that the quality of the relationship with their clients in general was lower than in-person, they must work harder for it and were more dependent on what client spontaneously shared instead of being also able to observe things. They mentioned several barriers they experienced in establishing a relationship online: the fact that no physical contact and eye-contact was possible, difficulties with non-verbal communication, and less informal chit-chat.

In addition, several client factors were mentioned that may explain the differences in online contact, including age and severity or type of problems. It was specifically mentioned that connecting with young children was more difficult than with adolescents or adults. With children, it was more difficult to maintain attention or to create a situation in which they could speak freely. For example, because they needed help from family members to start the technology or because they walked around and then encountered other members of the family.

> *"The connection with small children was very difficult. They cannot sit still for long, behind a screen. These are normally not "talk therapies". You do a lot, filling out sheets together. They can't actually write well enough to do it themselves." (ID 30)*

This seemed easier with adolescents, but it was also mentioned here that it is difficult for adolescents to maintain attention and that adolescents sometimes find video calling (with themselves in the picture) confrontational. Professionals mentioned that they had the impression that it was more difficult to maintain or expand the alliance online when clients had more complex problems, personality problems, anxiety problems, depression, suicidal thoughts, trauma, attachment problems, attention deficit disorder or showed avoidance behavior.

#### 2.1.6. Content and working methods

The majority of professionals mentioned the fact that their online meetings with clients were more cognitive, verbal or "talk" oriented compared to face-to-face meetings. As one of them put it:

> *"So I am a practitioner who does a lot in the room. With children, for example, we role play or do activities. [online] Now we are talking much more…" (ID 54)*

Nevertheless, professionals indicated that several methods could be applied online in (almost) the same form as during in-person contact, such as psychoeducation, psychotherapy and highly protocolled treatments. A number of functionalities of tools were mentioned that according to them improved their effectiveness in telehealth, such as being able to share your screen, making recordings, using an online whiteboard. In some cases, they were able to use existing e-health modules or platforms for (parts of the) the care they provide. For other working methods, the content and form needed to be adapted to the medium, for example because during online contact there are fewer opportunities for physical activities and a session is therefore generally more linguistic. Professionals mentioned a few things that are important or can help make these adjustments, such as being explicit and structuring the meeting (see also online etiquettes, Tools), and by focusing more on cognitive aspects of treatment. Many professionals mentioned creativity as an important enabler of these changes:

> *"And furthermore, a lot of creativity and not giving up too quickly, I think. I am really positive about what is possible." (ID 37)*

Moreover, the majority of participants also noted that working online positively influenced the content and form of a meeting, for example because it lowered some thresholds for some clients, the fact that you can directly observe behavior in clients' home situation, and immediately practice skills in vivo, and that clients have more autonomy, for example because an online (e-health) platform enables them to contact their therapist themselves, or to write down their own story.

Professionals also experienced barriers to apply their methods online, among which: experienced difficulties concentrating, less enjoyment/fulfillment, lack of experience with telehealth, the fact they cannot see everything and/or cannot talk freely, difficulties with non-verbal communication, being interrupted, losing time to technical preconditions for a meeting and the fact that clients were less committed online.

There are also several things that, according to professionals, are not or less well possible online, such as diagnostics, some forms of exposure, modeling and things that involve physical exercises or physical contact, as illustrated by the following quote:

> *"But what we also do a lot is non-verbal forms of therapy. If you want to start that now, PMT but also Shereborn play, or rhythmic massage, and that is simply not possible via video calling." (ID 38)*

#### 2.1.7. Perceived effectiveness

Professionals painted a mixed picture of how they perceived the effectiveness of telehealth during COVID. Some professionals experienced telehealth as equal to, and some as more effective compared to, in-person treatment. For example, because clients had more control over the process, there was some distance between professional and client or because meetings took place in a familiar place (see also the examples of

enabling factors under Content and working methods).

*"My impression is that parental guidance is easier with video calling. That parental guidance I give can be very constructive. More to the point. Because there may be more distance, I also dare to put my finger on the sore spot." (ID 18)*

"*Sometimes they have the cat or dog on their lap and then they feel a bit more free. They don't have to leave the house, they feel less watched. That was an unexpected advantage." (ID 46)*

A few professionals experienced telehealth as generally less effective compared to in-person treatment. The majority of professionals mentioned two important (potential) barriers for effectiveness of telehealth during COVID: (1) simply not getting to treatment at all because clients had other things on their mind due to the pandemic (see Development of symptoms/problems of clients) or because the planned treatment method could not continue online and (2) because the problems of their clients worsened and/or because new problems emerged due to the pandemic. However, they also mentioned that some groups had more room to focus on the treatment (see also Development of problems).

Some professionals explicitly mentioned that they feel the effectiveness of telehealth differs between clients and that telehealth was not always compatible with the type or severity of the problem or the client's characteristics, such as their age. Moreover, professionals mentioned that client contact was often shorter and less in-depth, partly because professionals spent a lot of time creating the (technical) preconditions for treatment (see Tools), because clients were less able to talk freely, were more easily distracted, the appointment was seen as a less real treatment appointment.

*"Suddenly people are sitting with the dog on their lap, or the doorbell rings. It's that "noise" around it that takes you out of the process and means that you can't always meet the therapy preconditions as well. You really have to keep guarding them more." (ID 46)*

A few professionals also mentioned a poorer alliance having a negative influence on the effectiveness.

#### 2.1.8. Telehealth in the future

Professionals mentioned several things they wanted to retain for the future. The use of video calling was often mentioned and, partly related to this, the flexibility and efficiency that working online gives themselves and the clients. For example, professionals indicated that video calling with clients who live far away or who are difficult to schedule gives more flexibility. But also, for example, that a conversation with multiple parties, such as a multidisciplinary meeting, is easier to schedule online. Several professionals also indicated that working online, and specifically (partially) working from home, also offered them many advantages, such as saving travel time and being able to concentrate better on reporting.

*"I foresee that there will be some kind of combination in more families. So that can be that you only see, for example, father and mother remotely, or that you do some sessions live and some remotely. That yields a lot in terms of travel time and agenda, for both parties." (ID 53)*

In addition, several professionals indicated that they would like to continue to have (extra) contact moments in between via online means, such as e-mail, calling, video calling and online modules.

*"I do think that I will call in between [as during the lockdown]. We don't really have a very appointment-loyal target group and sometimes they were too late. Then I usually just moved the appointment to the next week or so, but now I think: I can also make a video call right away." (ID 10).*

Professionals also indicated that there are still gaps to be filled and improvements needed in order to be able to work remotely with clients for a longer period. The most frequently mentioned aspects concerned preconditions regarding the workplace, like the availability of hardware, a suitable physical work environment, and the availability of tools. They also mentioned that they themselves would like to learn even more and perhaps need to gain more experience with online methods and techniques. Specifically, several professional explicitly mentioned they would like more tools to build up a relationship with new clients online and to maintain them with existing clients.

*"What do I still want to learn? Build or restore that working relationship the moment you notice that someone is withdrawing. And someone is gone very quickly on the screen, emotionally that distance is there very quickly. And yes, there are probably techniques for that. I know there are people who have been doing this for a long time and they work that way and with success." (ID 30)*

They also indicated that for them to continue with telehealth in the future, tools for diagnostic research and remote risk assessments need to be developed, coordination with third parties and referrals (which were sometimes at a standstill) need to be further elaborated, and research into the effectiveness of online assistance is necessary. Some also mentioned more attention for keeping a healthy work-life balance and developing further guidelines and protocols for using telehealth are needed.

### 2.2. In summary

Youth care professionals painted a nuanced picture of their experiences with telehealth at the start of the COVID pandemic. Within all themes both barriers and enabling factors for telehealth were discussed. Importantly, most themes appeared to be related. For example, the limitations and advantages of the tools used for telehealth affected the quality of the relationship between professional and client; the content and form of their meeting, and eventually how professionals experienced the effectiveness of the care. Moreover, although most professionals could see some advantages of telehealth, they also seemed to agree that it may not be suitable for all clients or all types of treatment.

### 2.3. Study 2

We distinguished seven domains based on the narratives of the youth receiving telehealth during the lockdowns. One of these domains was mental health, which focused on the perceived influence of the COVID preventive measures on their mental health. The other six domains concerned their experiences with telehealth and their wishes for future care: tools, privacy, alliance, content and working methods, perceived effectiveness, , and telehealth in the future. Each of these domains consisted of several themes and subthemes (see also Table 2). We described the seven domains, the themes, subthemes and relationships between the distinguished themes.

#### 2.3.1. Mental health

Participants reported various influences of the COVID preventive measures (i.e., lockdown) on their mental health. While some reported no changes, some others reported further deterioration of their complaints, mainly due to the limited options for distraction or social support, as illustrated by the following quote:

*"But due to the lockdown, they [mood complaints] deteriorated. Because otherwise, I could have talked for a bit about it with my friends at school, or just socialize. And as soon as the lockdown started, you could not do anything actually." (ID 1)*

Some others, however, reported improvement due to the changed context.

*"There was little to stress about. Because I did not go to school. During the lockdown it really… really improved rapidly. Finally, I could have a rest, so to speak, because I really did not have to do anything. That really helped me." (ID 6)*

**Table 2**
Coding tree including domains, themes and/or subthemes of experiences of telehealth of youth with mental health complaints.

| Domains | Themes | Subthemes |
|---|---|---|
| Mental Health | Development of symptoms/problems | No change*, deterioration*, improvement* |
| Tools | Transition period | # |
| | Enabling factors | Traveling time, flexibility*, functionality*, comfort of own home* |
| | Barriers | Practical* (functionality*, internet connection problems*, screen too small for multiple family members*), personal* (concentration*, feeling self-conscious on screen*), therapist inexperienced with telehealth* |
| Privacy | Concerns | Housemates being able to listen in*, privacy aspects software* |
| | Trust | Information about tools*, tools, location/immediate surroundings of therapists |
| | No concerns | Not considered, not important |
| Alliance | Enabling factors | # |
| | Barriers | Distance, having difficulties sharing heavily negative issues and feelings*, non-verbal signs*, less commitment*, less personal, less interaction, less safe, less room for chitchat*, more time needed to develop bond |
| Content and working methods | Content | Type of treatment, sequence, postponing |
| | Working methods | In vivo practice impossible due to lockdown*, working method more difficult or impossible online* |
| | Frequency | Same, decrease, increase |
| | Length | Same, decrease* |
| Perceived effectiveness | Enabling factors | Stabilization*, improvement* |
| | Barriers | Less effective* |
| Telehealth in the future | Temporary solution | Continuation |
| | Advice for improvements general | Better internet connection*, simplified system*, assignments, information about setting therapist |
| | Advice for improvement during lockdown | Reassessment of current client needs |

*Note.* # No further subthemes. * Similar subthemes as in study 1.

### 2.3.2. Tools

At the start of the pandemic participants had contact with their therapist through several different tools (various online video tools, WhatsApp, phone, email). However, after this first transition period the majority used a secured e-health platform provided by the mental health care organization to have contact with their therapist. This contact was mainly via video calls.

Themes related to the tools used could be divided into difficulties in the transition period, enabling factors and barriers for the use of these tools in the context of youth care. A majority reported some benefits of telehealth in general and/or enabling qualities of the tools used specifically. Regarding the first, many reported saving traveling time. Increased flexibility (i.e., family members being able to digitally join sessions) was mentioned by one participant. Also, a participant emphasized that telehealth also made it possible to have the treatment in a more trusted environment, which she liked.

> *"I liked it for that treatment, because I was in my own safe environment and it was quite a intens sort of treatment. So I am actually quite glad that I coud do that from home." (ID 7)*

Regarding the tools used, some reported mostly aspects that are seemingly minimum requirements for their use (e.g., the tools working properly). Enabling factors that were mentioned for the functionality of the platform used were reminders, being able to contact the therapist directly through the program, and easy ways of accessing,

> *"It is just much easier. Everyone knows how WhatsApp works. At least… that is what I think, you know. And you just must press one button and you know, you already ring/speak with each other. And that is just fine. And with the other site you must do very much to as I just said, access it and you have to find out how you have to phone each other." (ID 2)*

Nevertheless, all participants also reported negative aspects of the tools that hampered the provision of their telehealth. Aspects related to the functionality of the tools were mentioned by several participants, either referring to having trouble with accessing it (e.g., not receiving notifications, unable to access, experiencing barriers because of all the security measures) or with functional limitations or lack of suitable alternatives to certain aspects of their in-person care. Internet-connection problems was the most often mentioned barrier, which in various degrees of seriousness and frequency were mentioned by all participants. Connection problems caused delayed or faltered sound and or visuals, trouble hearing each other, or even interruptions to the call.

Many also reported having difficulties concentrating while receiving telehealth. They related this to internet connection problems, the small screen and having no real person in front of you. Other hampering aspects mentioned by one participant were the fact that their therapist also had to find out how to use the tools at the start (but improving along the way), not being able to fit within the screen (with family therapy) and feeling self-conscious about being on screen.

> *"Yes, I don't know. Then I am less… Because of my insecurity you know I am often more concerned with how she sees me, than with the story I must tell. So, that did not work so well." (ID 15)*

### 2.3.3. Privacy

Participants differed as to what extent they considered their privacy during telehealth. Most participants did consider privacy related aspects, specifically the issue of other people in their immediate surroundings being able to listen in (i.e., being at home with parents, other family members, or roommates). This point was made when explicitly asked about their privacy, but also when asked about how and where they received online therapy sessions. Examples of phrases about their location which showed they consider their privacy were: "nice with the door closed", "there I will not be disturbed", "my own safe place", "my own room … because of course you want to sit a bit private". Many participants reported to have had difficulties finding a place where they could not be heard by family, roommates or other people and where other people would not disturb them. They related this issue to the content of the sessions, for example because they felt they were less open, did not talk about certain topics such as their family, or being less able to focus on the conversation.

> *"I also think that the fact that your are at home, because here – if you are at home, you know – your parents or other people can always hear you and then you talk more careful than when you are at your therapist's, you know." (ID 15)*

Several participants also mentioned concerns about the security of the tools used. However, these concerns were mainly related to the start of the telehealth:

> "*Yes, a bit at the start, it crossed my mind [safety of the tool]. But soon it diminished, because uhm yes. I just trusted the security of the program and on the other side I didn't think it would be an interesting thing for other people to hack and listen in or something like that, you know." (ID 13)*

As in the above citation, the concept of trust also came back in many transcripts. Participants mentioned they trusted the information they got about the IT, trusted the security of the tool, and/or trusted the

therapist to provide a secure tool and a secure environment to talk.

*"I just trust her, privacy and respect for the content of the conversation." (ID 13).*

Nevertheless, because both clients and therapists were at home (i.e., due to the advice to work from home), disruptions by family members or roommates at both ends of the line were mentioned.

*"And when we video called, she [the therapist] was in her attic and every time she gave me a warning: 'hey, my little son is running upstairs, sorry for this'. So, then it was like okay, there is someone coming. So I always received a warning for this." (ID 5)*

Some reported to have no concerns, either because they have not considered privacy aspects of the tool used or because these aspects did not worry them.

*"No, I do not care, no. I did not even consider this [privacy]. And even if they hear it all, I do not care at all." (ID 2).*

#### 2.3.4. Alliance

Although most participants reported positively on the alliance they had with their therapist during the telehealth period, the majority also mentioned several aspects that negatively influenced the alliance with their therapist. Three aspects appeared most prominently in their narratives: (physical) distance, having difficulties with opening up and sharing negative feelings online, and difficulties with non-verbal communication. With respect to the first, this was very dominant in the narratives of the participants about their experiences of telehealth. They used several words to describe the distance they felt (or using the opposite when comparing it to in-person care): not real, not here, distance, not in-person, not being in the same room, no real human contact, talking to a screen, less close.

*"Yes, humm.. the conversations are actually still the same. Only there is.. you do feel the distance because… yes of course you are anyhow not in one room, but also with the screen in between and possibly in a totally different city. Because.. I do not know where she lives, but not near. So, you do feel that difference really and that makes it actually really different to talk with each other." (ID 4)*

Moreover, a majority reported having more difficulties with discussing serious topics and/or sharing negative emotions or experiences during online compared to in-person care. This affected the interactions with their therapists. Additionally, some mentioned that conversations were more superficial because of this.

*"Well… you know… the real difficult questions I cut short you know, because I find it difficult, you know, to tell when not in-person." (ID 10)*
*"Yes, I also noticed that I did not talk about the bad things, but only about the good things, as a result the bad things weren't solved….. because I did not see her, you know." (ID 6)*

Many also mentioned having difficulties with interpreting non-verbal cues during online therapy which influenced the interaction. They reported having difficulties with reading hand gestures, facial expressions, and other body language of the therapists. As a consequence of this, they mentioned being less able to see when they could start talking, to see and feel how the therapist reacted to their stories, to use non-verbal cues to see if they understood the therapist correctly or to know what kind of person the therapist was. All participants who mentioned this, also mentioned feeling a distance and having difficulties with discussing heavy topics and sharing negative emotions or experiences. Several also mentioned that this also applied the other way around: that it made it more difficult for the therapist to read their cues.

*"Not so much the facial expressions, but more the feeling. Because if you are in the same room together than it is a lot easier to sense what the other is really like. Because it is really easy to pretend behind a screen. The patient or therapist doesn't feel it, you know." (ID13)*

Another aspect mentioned by several participants that was related to the alliance between the participants and the therapists, was that they felt less commitment to the telehealth meetings, as illustrated by the following quotes:

*"If someone [a therapist] is coming [on a home visit], then it feels more like an appointment." (ID10)*
*"Nice if someone actually comes here at home, than you can't ditch them. Yes, now you can just hang up. If they come around, then I have to accept their help. When online I have the feeling I do not have to." (ID 6)*

In some cases, participants did not actually hang up, but only thought about it or parents supported them not to do this. Other aspects that were mentioned by single participants were that the contact felt less personal, consisted of fewer interactions, felt less safe, gave less room for chitchat and laughing, and that more time was needed to develop a bond.

#### 2.3.5. Content and working methods

The change towards telehealth resulted in changes in content and working methods. When discussing their experiences regarding the content of their treatments, many participants reported that content changed with the transition to telehealth. Several reported that therapies focusing on trauma were more difficult to continue online, either because they found techniques such as EMDR hard to use online, or because they felt it was more difficult to discuss traumata. This sometimes resulted in changes in the type of treatment to deal with traumas (e.g., from Eye Movement Desensitization and Reprocessing therapy (EMDR) to Cognitive Behavioral Therapy), in taking up other parts of treatment first or in postponing certain treatments (as the planned treatment was not possible).

With respect to methods, most participants reported they were forced to make changes. Some participants mentioned that certain tasks they had to perform outside their telehealth as part of their treatments were not possible to practice due to the lockdown measures (e.g., exposure in real life). The majority also referred to changes in working methods during the telehealth, as online tools made certain working methods more difficult or impossible. This specifically applied to working methods where they or the therapist used drawing, work with things on paper, or where they also did things together like playing a game or taking a walk.

*"Well, sometimes is is more difficult… we had for instance situations during my treatment where she normally would draw a picture, but that is actually quite difficult, to really, you know, do that through video calling, so that makes it more difficult now and then." (ID 1)*
*"Yes, there were several exercises, for instance that we had to lie on the floor and that she would lie down on the floor also and that we then did a certain exercise. And yes, you can not do that with video calling, because you do not see each other anymore, or you have to put in a lot of effort to adjust the camera and stuff. But it doesn't really work with video calling." (ID 4)*

Nevertheless, this latter participant also explicitly mentioned: *"In my treatment we did proceed. So we have different assignments, but we still have the same goal."*.

Regarding frequency of contact with therapists, some participants reported changes. While one participant reported a decrease (without knowing the reason), some participants mentioned an increase in the frequency of contact, as the pandemic and preventive measures had intensified their problems.

*"At that moment, I was really in crisis, so she had to call me more often, but I also think that this was partly due to Corona itself and staying at home." (ID 15)*

Although for most the frequency remained stable as compared to previous in-person contact, most did report shorter online meetings. Participants related this to changes in working methods and content, to feeling less committed to the meetings, to not sitting in-person (see Alliance), to having more difficulties with sharing emotions (see Alliance), to factors related to therapist (see Tools and Privacy), and to the lockdown situation.

*"Actually, the therapy I was engaged in with [therapist name], that was… we were writing. I have to type a [life] story myself. And that is really difficult to do through video calling. So my meetings were shorter." (ID 8)*
*"Slowly, they became shorter. I do not know exactly why, maybe it is because, if you are not actually in-person, it is more difficult to think about things to talk about. And then you say: it is enough for today." (ID 4)*
*"No, shorter. […] I think because of me, you know. At a certain moment, I clam up and then she could not do anything with me. […] I did clam up [during in-person meetings], but then she had a way of getting me out of that state and then a session took longer, you know.*
*Interviewer: The way to get you out, didn't it work at distance?*
*No." (ID 11)*
*"I had less experiences, you know. I had less to tell and I only told the good things." (ID 6)*

Some participants referred to the working environment of the therapist, such as children of the therapist being also at home because of the lockdown, or the lack of experience of their therapist with working online as the reason for changes in the content or methods of the treatment.

*"And everyone just did something, because nobody knew well what to do. So I got tasks that did not make sense. If they [the therapists] would have been more prepared, I believe that would have been different." (ID 15)*

#### 2.3.6. Perceived effectiveness

Although not extensively, all participants reflected upon their perceptions to what degree online treatment had helped them. Experiences ranged from positive to negative, and sometimes participants mentioned both related to effectiveness (e.g., working for some complaints, but not for others). Of participants mentioning positive effects, most reflected on their experiences with improved mental health due to the telehealth, although the reported effects ranged from "a bit" to participants "clear improvement". Some participants mentioning positive effects reported that telehealth did not help to further improve their mental health but helped their mental health not to deteriorate during the lockdown period.

*"Helped? I don't know, it didn't help me to get better. But I do think yes, I do think I needed this to keep going at all. So in that it maybe helped me." (ID11)*

In a few cases participants explicitly mentioned perceiving no differences in effectiveness of care or treatment compared to in-person, as illustrated by: *"But I think it [telehealth] did not cause a problem regarding my improvement" (ID4).*

Many participants perceived telehealth as less effective than in-person care and/or that it delayed their treatment process. In some cases, these participants were mostly negative about their experience of telehealth.

*"But I also had things that maybe would have been solved earlier if we would have been able to see each other in real." (ID 6)*
*"…. Yes, for me it just does not work. I am really sure it can't be better. And really, a lot of people think like this, because I discussed it with other people, you know." (ID 2)*

#### 2.3.7. Telehealth in the future

In general participants were positive about the possibility of continuation of their treatment during the COVID lockdowns. They related these positive general experiences to continuation of the care or treatment using terms as "nice" and "happy", to their overall positive assessment of the used tools (see also Tools) and to positive alliances with their therapists (see Alliance). Nevertheless, they saw telehealth as a temporary solution for the continuation of their treatment in times of the pandemic. No participants preferred telehealth as a substitute of in-person care post-pandemic. Nevertheless, some were neutral or positive towards having the option of "blended" care, in which online tools are used as an addition to in-person care. For example, as this would allow them to stay home or it would make it easier for a family member to join in on a session through video calling.

*"To once in a while use telehealth, I would not find that a problem." (ID 14)*
*"At moments I have a bad day I would find it nice not to have to go to [location of organization] but have treatment from home." (ID 11)*

Moreover, many participants thought in general telehealth could be further improved by (ordered from mentioned by several to a few): better internet connections, more accessible/simpler tools, further improvements of online method and assignments, and informing the client about the place where the therapist is sitting to make it more personal and increase alliance. Specifically, in case of a future pandemic or situation in which in-person care is not possible, some participants suggested that telehealth could be improved when therapists assessed what kind of care that is necessary at that moment given the circumstances, instead of sticking to the treatment plan.

*"Well, I think first that it would be important to give attention to how I feel at that moment instead of treating all kinds of old things." (ID 5)*

### 2.4. In summary

Participants were new to telehealth when the COVID related lock downs started. Overall, they appreciated the continuation of care during the lockdowns. Although all were able to mention some positive aspects related to the overarching themes, they were also all confronted with negative aspects, leading to a clear preference by all for in-person care above telehealth.

## 3. Conclusion and discussion

The COVID pandemic caused a sudden transition to telehealth in youth care. We interviewed youth care professionals and adolescent clients on their experiences with telehealth in youth care during the pandemic and specifically on their experience with the tools utilized, privacy, working methods, therapeutic alliance and perceived effectiveness. Both professionals and adolescent clients in this study had little or no experience with telehealth prior to the pandemic. Both mentioned advantages and disadvantages of telehealth. Interestingly, there is some important overlap between the themes that professionals and adolescent clients describe. In line with previous studies (Hopkins & Pedwell, 2021; Jeffrey et al., 2020), professionals mentioned increased flexibility, opportunities to include multiple family members in a session, some which may not be able to join a session when it would have been in-person, comfort for clients of being in their own home, and increased opportunities to observe and coach families in their own homes. Adolescent clients mentioned similar advantages, and in addition mentioned decreased travelling time as positive aspect of telehealth. At the same time, both adolescents and professionals mentioned downsides of working online, such as difficulty to concentrate on the conversation or to interpret nonverbal communication and problems due to bad internet connections or difficulties accessing a secure platform. Moreover, some professionals also mentioned that for some clients, online appointments seemed to be experienced as less formal and/or some clients seemed more avoidant. This observation is endorsed by adolescent participants

who experienced telehealth as less committal and less of a “real appointment” (see also Isautier, 2020).

When it comes to privacy, both adolescent clients and professionals mentioned relatively few worries about the tools used for telehealth, even at a time in which little was known about security and privacy features. This is contradictory to for instance findings among adolescents in a bigger sample in Western Australia (McQueen et al., 2022). Additionally, some professionals in our study specifically mentioned that at the beginning of the pandemic, they sometimes put user-friendliness above security. Since both professionals and adolescents were mostly home due to the pandemic-related restrictions, both mentioned taking measures to increase privacy regarding their immediate surroundings, such as using headphones, closing the door, arranging privacy with family members or roommates. Despite these measures, professionals mentioned that they felt some clients could talk less freely due to being at home during the session. This was also mentioned by the adolescents. This has also been observed in other studies (e.g., AlRasheed et al., 2022).

When it comes to the working methods, professionals indicated that some methods can be applied online in (almost) the same form as during in-person contact, such as psychoeducation, psychotherapy, parenting advice and highly protocolled treatments. For other working methods, the content and form must be adapted in order to use it online, for example because there are fewer opportunities for physical activities. Most adolescents reported that the form and content of their treatment changed due to the transition to online. They discussed changes in frequency (both more and less sessions), length (often shorter sessions), and form. Regarding the latter, adolescents mentioned that some methods were more difficult or even impossible online (e.g., exposure, EMDR), but that others were more easily replaced by online versions.

One topic that we know less about from pre-pandemic literature, is how the therapeutic relationship or alliance between youth care professionals and clients are experienced during telehealth (Berger, 2017). A review and meta-analysis of studies on online alliance concluded that included studies have reported equal, lower, as well as higher alliance when communicating online, but that on average online alliance was experienced as inferior to alliance in-person (Norwood et al., 2018). In our study, professionals reported that their experiences with their alliance with clients differed widely. In general, they were satisfied with the quality of the therapeutic alliance, specifically with clients they already formed an alliance with pre-pandemic and with adult clients (vs. children or adolescents). Adolescent clients were also generally satisfied with the quality of their relationship with mental health care professionals. However, they mentioned the (physical) distance, having difficulties with opening up and sharing negative feelings online, and difficulties with (interpreting) non-verbal communication sometimes negatively affected the quality of the online conversations with these professionals. An important question for research on telehealth may therefore be how the quality of the relationship and the therapeutic alliance is experienced when professionals and clients start their relationship online. Worries about starting up care trajectories with new clients online are also raised by some professionals in this study.

In general, although the standards for care are the same when using telehealth as when using in-person meetings, it may be that different skills are needed for building a therapeutic relationship with new clients online, compared to in-person. Indeed, previous research found that professionals who successfully use telehealth show strong clinical flexibility, rapport building skills, and creativity (Simpson & Reid, 2014). These professionals also adapt their pace and nonverbal responses (exaggerating changes in tone and gestures), attend more closely to nonverbal cues such as facial expressions, ask more questions in order to clarify nonverbal cues of their clients, and verbal communication may be more deliberate (Nelson et al., 2017; Simpson & Reid, 2014). Such "online etiquettes" were also mentioned by most of the professionals in our study. Moreover, when working with children, telehealth may require additional creativity and behavior management (e.g., positive reinforcement). Children learn and communicate primarily through play and activities and this may be more difficult via a screen (AlRasheed et al., 2022; Jeffrey et al., 2020). Indeed, in our study professionals mentioned that children seemed more easily distracted online. This may also mean that in training youth care professionals we need to include knowledge and skills in telehealth practice. It has been previously noted that technology can both positive and negative impact professional practice and that in general there is a lack of training (Aafjes-van Doorn et al., 2020; Vincent et al., 2017). Here may lie an important task for education institutes: to provide future youth care professionals with the needed attitudes, knowledge and skills for the use of telehealth.

The knowledge on telehealth we gained during the COVID pandemic could contribute to this, specifically the importance of (a) availability of needed hardware (for both professional and client), accessible, safe and user-friendly software, and support from youth care employers and software developers in their use; (b) investing in properly preparing clients for telehealth (e.g., by acknowledging that this is a new and different way of receiving care, assisting clients with the setup of their hardware (e.g., video quality, lighting, audio), and more actively checking their experiences and feelings during sessions); (c) altering professional behavior (e.g., narrating your actions, more regularly check whether you comprehended what the client is telling you and be slightly more animated to demonstrate your own thoughts and feelings), and (d) specifically when working with children and adolescents, creativity to keep clients engaged (e.g., by providing visual positive reinforcement, using active and playful exercises and providing them with opportunities to get up and move around) (see also Jeffrey et al., 2020; Martinez et al., 2022).

In our study as well as previous studies (Berger, 2017; Norwood et al., 2018; Owen, 2020), there are large individual differences in how youth care professionals and clients experience the effectiveness of telehealth. Professionals in our study stress that how appropriate or effective telehealth is may differ per client and may depend on client characteristics such as age or diagnosis and treatment goals. This diversity is also reflected in the perceived effectiveness by adolescents of the telehealth treatment on their mental health (ranging from effective to non-effective). Moreover, the adolescents in our study reported that although they appreciated that online tools facilitated continued treatment during a lockdown, they preferred in-person treatment when possible. This is different from an earlier study on telehealth during COVID among a similar population in the United States (Nicholas et al., 2021), where they preferred telehealth as they felt more ‘seen’ and respected. Two aspects that were not brought up by the adolescents in our study. This might be due to the small sample size of our group (see also limitations). However, this may also mean that -in line with experiences of adolescents with residential youth care and online youth work activities during COVID- after an initial relief about the possibility of continuation and the novelty factor of online solutions, initial enthusiasm about the possibilities of telehealth may have waned (Carvalho et al., 2022; Shaw et al., 2022). It may also indicate differences between individual adolescents or between different adolescent populations. Future research could explore possible moderators of experiences with telehealth, such as clients age, type, and severity of symptoms, needs and motivations. Moreover, for practitioners it may be important to discuss the needs and preferences of clients when deciding on the possibilities of telehealth for that specific client.

Overall, our study gives a first impression of the experiences of professionals and adolescent clients with telehealth in youth care in a time they were forced to rely on online methods because of the COVID pandemic. The picture they paint of the usability of telehealth is very nuanced: there are benefits and there are limitations, and these may differ from person to person. Their experiences may provide important insight for youth care organizations, professionals, educational institutes training youth care professionals and researchers, in terms of experiences, barriers and enabling aspects, as well as points for future practice and research.

Moreover, pre-pandemic studies reported that mental health care professionals were largely undecided as to whether they planned to use video counseling in the future and that the likelihood of endorsing telehealth increased with the amount of experience professionals had with telehealth (Aafjes-van Doorn et al., 2020). It may thus be that the pandemic will increase the acceptance, endorsement and use of online methods since most professionals gained experience. In order for professionals to continue the use of telehealth more research is needed on the possibilities of behavioral assessment and different forms of treatment via telehealth, specifically for children (Ros-DeMarize et al., 2021). However, it should be noted that even when these are available and effective, professionals will only be able to maintain telehealth practices when policy and funding allow them to continue using telehealth.

### 3.1. Strengths and limitations

Strengths of this study are first of all, the focus on the first experiences of professionals as well as adolescent clients during the forced transition to telehealth due to the COVID pandemic. Both experiences are important for optimizing future telehealth (both during and after COVID). Moreover, our sample of professionals covers a large part of the broad field of youth care: from professionals working in homes for severely intellectually disabled people to preventive neighborhood teams, giving a general and broad impression of the experiences of these professionals.

Nevertheless, at the same time, this may be a limitation since experiences may strongly differ between different forms and intensity of care for youth and their families. Some of the voiced experiences may therefore be specific to a certain context and, although still meaningful, some of the identified minority themes may not generalize to other contexts. Future research should further study the eligibility and effectiveness of telehealth within different target groups. Another limitation is that our sample of youth care professionals is a convenience sample since it has been recruited through newsletters of professional organizations as well as through our own network via social media. Our sample of adolescent clients was recruited via one large specialized mental health care organization. Our findings on this group may not generalize to adolescents receiving other types of care.

Also, both samples of our studies included more females than males. Males are underrepresented in both studies. This appears to be a general tendency in social science research among adults and youth (e.g., Nederhof et al., 2012). For the professional sample in study 1 it may partly reflect the gender makeup of the professional workforce in this field. For example, 83.4 percent of registered clinical psychologists in The Netherlands are female and for those specialized in working with children and youth this is even 95.8 percent (BIG register, 2022). For the adolescent sample in study 2 it may also partly reflect a gender bias in mental health care. Adolescent girls report more mental health problems than adolescent boys in the Netherlands (2022). As some studies among other telehealth users (e.g., Isautier et al., 2020; Polinski et al., 2016) showed a more positive attitude towards telehealth among females than males, the findings of study 2 may be limited to girls and young women and may not be generalizable to other populations. It is important that future studies include a representative proportion of male adolescent clients, for example through oversampling male clients. Furthermore, our findings on the eligibility and effectiveness of telehealth in youth care are based on *experiences* of professionals and clients. Therefore, our study reflects perceived effectiveness of telehealth on behavior and wellbeing of children, youth, caregivers and families. Effectiveness studies are necessary to assess the effectiveness of telehealth and to reveal what kinds of telehealth will work for whom.

Importantly, our findings should be interpreted in the context of the pandemic, which not only caused a (sudden and forced) transition from in-person to online youth care but also impacted the daily life of youth care professionals and clients. This may have affected how professionals and clients have experienced telehealth. Relatedly, the pandemic and related preventive measures may have had a negative effect on family functioning, and for some exacerbated problems for which help was initially sought. Indeed, studies on the effects of the pandemic suggest that it disproportionally affects children, caregivers and families who are already at risk (Weeland et al., 2021). Perceptions of telehealth and its effectiveness during the study might have been colored by the circumstances and the development of symptoms may also be directly, and negatively, affected by the pandemic itself. Therefore, our findings may not generalize to telehealth post-pandemic, for example in situations where in-person options are also available.

### 3.2. To conclude

The literature on telehealth, such as video calling, e-mental health, and computer-mediated interventions, has been vastly growing over the last decades. This process was further accelerated by a forced transition to online methods due to the COVID pandemic and preventive measures taken to slow down spreading of the virus. The knowledge and experience we gained during this period may contribute to the quality of online youth care after the pandemic or during possible future pandemics. Moreover, it may help increase the general acceptability, usability and effectiveness of telehealth in youth care. This is important, since for some families, caregivers and children, telehealth may offer advantages, including less self-consciousness about seeking help, being able to get help from the comfort of your own home and decreased practical obstacles to attend appointments compared to in-person (Hopkins & Pedwell, 2021; Jeffrey et al., 2020; Nelson et al., 2017). At the same time, it is important to realize that in times we depend on online solutions, such as in times of the COVID pandemic, inequality and inequity within youth care may increase (Henderson, 2020; Shadmi et al., 2020). For example, because not all families, caregivers and children may have access to the needed hardware for effective telehealth (see also AlRasheed et al., 2022). This means some clients, possibly those most in need, are at risk of falling through the cracks. An investment in inclusive and effective solutions for future telehealth now may increase the general accessibility to mental health care and may be important for supporting both youth care professionals and their clients during future disasters.

*CRediT authorship contribution statement*

**Floor B. van Rooij:** Conceptualization, Data curation, Formal analysis, Methodology, Writing – original draft, Writing – review & editing. **Joyce Weeland:** Conceptualization, Data curation, Formal analysis, Methodology, Writing – original draft, Writing – review & editing. **Carlo Thonies:** Formal analysis, Writing – original draft.

## Declaration of Competing Interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

## Data availability

Data will be made available on request.

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