# TRANSITION TO VIRTUAL CARE

## An evaluation of changes to child and youth mental health service delivery in Ontario in response to COVID-19

**Final Report**
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CMHO
Children's Mental Health Ontario
Santé mentale pour enfants Ontario

Ontario Centre of Excellence for Child & Youth Mental Health
Centre d'excellence de l'Ontario en santé mentale des enfants et des adolescents

# Acknowledgements

This report presents findings from an evaluation conducted from April to September 2020 on the shift to virtual care among agencies providing child and youth mental health services in Ontario. This evaluation project was a joint effort between the Ontario Centre of Excellence for Child and Youth Mental Health (the Centre) and Children's Mental Health Ontario (CMHO).

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# Executive summary

In recent years, service providers in Ontario's child and youth mental health sector have been exploring how best to integrate virtual care options into service delivery as a complement to providing in-person supports. The emergence of the COVID-19 pandemic, however, has accelerated these efforts. To continue to meet the needs of children, youth and families, many service-providing agencies are rapidly moving to deliver care using a range of telecommunication technologies.

Given these shifts, the Ontario Centre of Excellence for Child and Youth Mental Health (the Centre), in partnership with Children's Mental Health Ontario (CMHO) and sector partners, launched an evaluation study to learn about both the process of implementing virtual care during the COVID-19 pandemic as well as the impacts on clients and service providers. Understanding what has worked well and identifying areas for improvement will enable the sector to take planful and deliberate steps post-pandemic to add virtual care options to their suite of available mental health services for children, youth and families. We define virtual care broadly, as any type of service delivered using telecommunication technology. This includes services and support provided over videoconference, phone, texting and apps.

We used implementation science and quality improvement approaches to frame the areas that we examined. Using a mixed methods approach, we surveyed 97 organizations and held interviews and focus groups with 13 agency leaders and 14 direct service providers. In addition, 192 respondents took part in a youth and family survey.

Results showed that despite limited time to plan for and consult with others, agencies undertook similar implementation activities. These activities included conducting a needs assessment, selecting virtual platform(s), revising or developing policies and procedures, revising workflows, providing staff training and developing strategies to support evaluation and continuous improvements. Service providers focused on familiarizing themselves with the new policies and protocols, accessing the right equipment and tools, getting trained, coaching clients to use the new tools and technology and engaging in ongoing problem-solving with peers.

Agency leads and service providers identified similar facilitators to implementing virtual care, such as ensuring staff engagement, ample resources and a collaborative team approach. Agency leaders brought to light challenges such as limited access to internet and resources, technical challenges, limited staff capacity, privacy concerns and changes to workflow. Direct service providers echoed the importance of ensuring access to the internet and resources. They discussed challenges around developing therapeutic rapport, conducting sessions with younger children, ensuring fidelity to evidence-based practice and dealing with fatigue. The culture of ongoing problem-solving and collaboration was apparent as agency leads and direct service providers discussed various strategies used to address challenges.

Clients' experiences with virtual care were largely positive; they felt the technology was easy to use and intended to continue to use virtual services. Clients listed several advantages to virtual care, such as increased convenience, increased comfort expressing themselves, reduced travel time and reduced need for childcare.

Looking ahead, most agencies indicated that virtual care would continue to be offered on an ongoing basis. Based on the above findings, we offer several recommendations to support the integration of virtual care into current services as we continue to deal with the pandemic and plan for post-pandemic:

1. Offer virtual care as part of a menu of services.
2. Ensure accessibility of virtual care.
3. Consider how best to engage a greater number of diverse children, youth and families in virtual care.
4. Enhance staff training and support knowledge exchange.
5. Promote staff wellness and prevent fatigue from delivering virtual care.
6. Provide system-level guidance and oversight to ensure high quality virtual care.

As child and youth mental health organizations integrate virtual care into their suite of services, it will be important to leverage opportunities and resources, and have a planful approach for sustained high quality virtual care. A more coordinated effort across the system is needed so that children and youth across all communities in Ontario have access to high quality, consistent and equitable services.

# Introduction

In recent years, service providers in Ontario's community-based child and youth mental health sector have been exploring how best to integrate virtual care options into service delivery as a complement to providing in-person supports. The emergence of the COVID-19 pandemic, however, has accelerated these efforts. To continue to meet the needs of children, youth and families, many service-providing agencies are rapidly moving to deliver care through telecommunication technologies.

Given these shifts, the Ontario Centre of Excellence for Child and Youth Mental Health (the Centre), in partnership with Children's Mental Health Ontario (CMHO) and sector partners, launched an evaluation study to learn about both the process of implementing virtual care during the COVID- 19 pandemic, as well as the impacts on clients and service providers. Understanding what has worked well and areas for improvement will enable the sector, post-pandemic, to take planful and deliberate steps to add virtual care options to their suite of mental health services for children, youth and families. We define virtual care broadly, as any type of service delivered using telecommunication technology. This includes services and support[1] provided over videoconference, phone, texting, and apps.

We used implementation science and quality improvement approaches to frame the areas that we examined (e.g. organizational culture, change management, training strategies, clinical supervision and monitoring of fidelity to evidence-based programs). In particular, the Consolidated Framework for Implementation Research [CFIR] (Damschroder, Aron, Keith, Kirsh, Alexander & Lowery, 2009) proposed five categories for implementation: the outer setting, the inner setting, innovation characteristics and characteristics of individuals and processes. The Nonadoption, Abandonment, Scale-up, Spread and Sustainability [NASSS] framework (Greenhalgh, et al. 2017) identified several elements to examine at the client, provider, organizational and larger environmental levels. We engaged with partners in the province (i.e. senior management from agencies, researchers, youth and families) to guide areas of focus based on these frameworks and to inform

1 Services and support may refer to counselling and therapy sessions, brief services, family capacity building and support, crisis support, specialized consultations and assessments, targeted prevention, or day treatment programs.

recommendations for longer-term system-wide implementation. A more detailed description of the evaluation framework is available on the Centre's website (Danseco, Brown, Sundar & Khan, 2020).

The specific evaluation goals were:

1. To hear in general about agencies' overall experiences with transitioning quickly to virtual care; (process)
    - To understand what worked well and potential reasons why (including which services/supports were well-suited to a virtual approach); (process)
    - To identify challenges experienced, and the way these were managed (including which services/supports were difficult to transition to a virtual approach); (process)
2. To understand how service providers have experienced the transition to virtual care (process + outcome);
3. To understand how clients have experienced the transition to virtual care (process + outcome);
    - To better understand the populations which may benefit the most from virtual care and those populations where virtual care is either contraindicated or needs more careful consideration; and
4. To identify potential areas of knowledge and resource needs to support the implementation of virtual care post-pandemic.

# Methods

We used a mixed-methods approach, which included an organizational survey, key informant interviews with implementation leads, focus groups with clinicians/service providers and a survey for youth and families. The surveys, interview and focus group guides can be found in appendix A-D. Detailed profile of respondents to the youth and family survey can be found in Appendix E. This evaluation has ethics approval through the CHEO Research Ethics Board.

The organizational survey was sent to the executive leads of an initial list of 182 agencies providing child and youth mental health services in Ontario. The number of eligible agencies was reduced to 166 as a result of organizational mergers. The survey was open for seven weeks, from June 17 to August 5, 2020.

We heard from 97 out of 166 agencies (58% response rate), with all lead agencies[2] responding to the survey. The respondents were mostly executive leads (67%). Response rates varied by region, with the Toronto region having the lowest response rate (17/33 agencies, or 52%) and the central region with the highest response rate (19/28 agencies or 68%). See Appendix F for response rate by region. The margin of error was 7%, indicating that the results from the survey demonstrate general trends from the population of all child and youth mental health agencies in Ontario.

Key informant interviews with those who led the organization's implementation efforts were held from June 18 to July 17, 2020. Thirteen agency leads were interviewed and represented agencies from the central, northern and western regions of the province.

For the service provider or clinician perspective, focus groups were initially scheduled, and when there were fewer than three participants, these were scheduled as interviews instead. We held two focus groups consisting of service providers from the western (n=8 service providers) and central regions (n=3 service providers), two interviews with service providers from the eastern region, and one interview in French from a Francophone agency. These were held from June 24 to June 30, 2020. Although there were no

2 Lead agencies are responsible for child and youth mental health service delivery in each of the 33 service areas in Ontario. See https://rb.gy/fgkd72 for complete list of lead agencies.

participants from the Toronto region for the key informant interviews or focus groups, data saturation was reached.

For the survey to youth and families, there were 192 respondents indicating a 7% margin of error (i.e. generally acceptable for identifying trends). Of these participants, 34 (18%) indicated they had not sought services in the past three months (i.e. during most of the lockdown due to the COVID-19 pandemic). Of the 130 who received services and provided their age, 15 indicated their age as 12 to 17 years (16%), and 15 as 18 to 24 (16%). Most respondents identified as female (95/112 or 73%), 8% as male, 3% transgender, 1% other and 4% chose not to answer. Most respondents identified as having European heritage (50/119 or 42%), 17% as First Nations, Inuit or Metis, 13% as other heritage, and 16% indicated they did not know their heritage. A smaller percentage of respondents indicated their heritage as South American (6%), South Asian (3%), Middle Eastern (3%) and East Asian (1%).

# Results

## Transitioning to virtual care

***What were agencies doing regarding virtual care prior to COVID-19?***
Prior to the physical restrictions imposed by the government of Ontario in response to the COVID-19 pandemic, 45 of 97 organizations (46%) reported providing virtual services. Agencies reported using videoconferencing (n=16), phone (n=50), texting (n=28), chat (n=8) and apps (n=11).

During the lockdown, 94 of the 97 agencies (97%) provided core services virtually, representing about 50% more agencies providing virtual care than prior to the pandemic. Virtual care was delivered primarily for counselling and therapy services (87 agencies or 94%) and brief services (74 agencies or 80%). See Appendix F for further details.

Many agencies selected several platforms, often using one platform for delivering services to clients and another platform for internal communications (e.g. staff meetings). The most common platform selected for delivering virtual care was Zoom (57 agencies or 61%), followed by Microsoft Teams (33 agencies or 35%).

***What did agencies do to prepare for implementing virtual care?***
To shift towards providing virtual child and youth mental health services, agency leads engaged in the following activities:

1. Assess the needs of clients, clinicians and those of the organization.
2. Select virtual platform(s).
3. Revise or develop policies.
4. Revise workflows.
5. Provide training.
6. Reflect, evaluate and improve.

Agency leads identified people or teams who would be involved in these various activities. While these activities seem linear, these were iterative and needed to be adapted so that the agency or clinicians could be responsive to the emerging contextual issues.

Agency leads noted that costs and resources required to implement virtual care included the registration or licenses for the virtual platform as well as upgrading the computer and office equipment of staff. There were also costs related to staff time for training, developing the policies and procedures, and providing phone plans or internet sticks to staff and clients for enhanced data access. Some agencies noted the need to upgrade their cyber-insurance, hire technical support specialists and invest in marketing to ensure that members of the community knew how to access services.

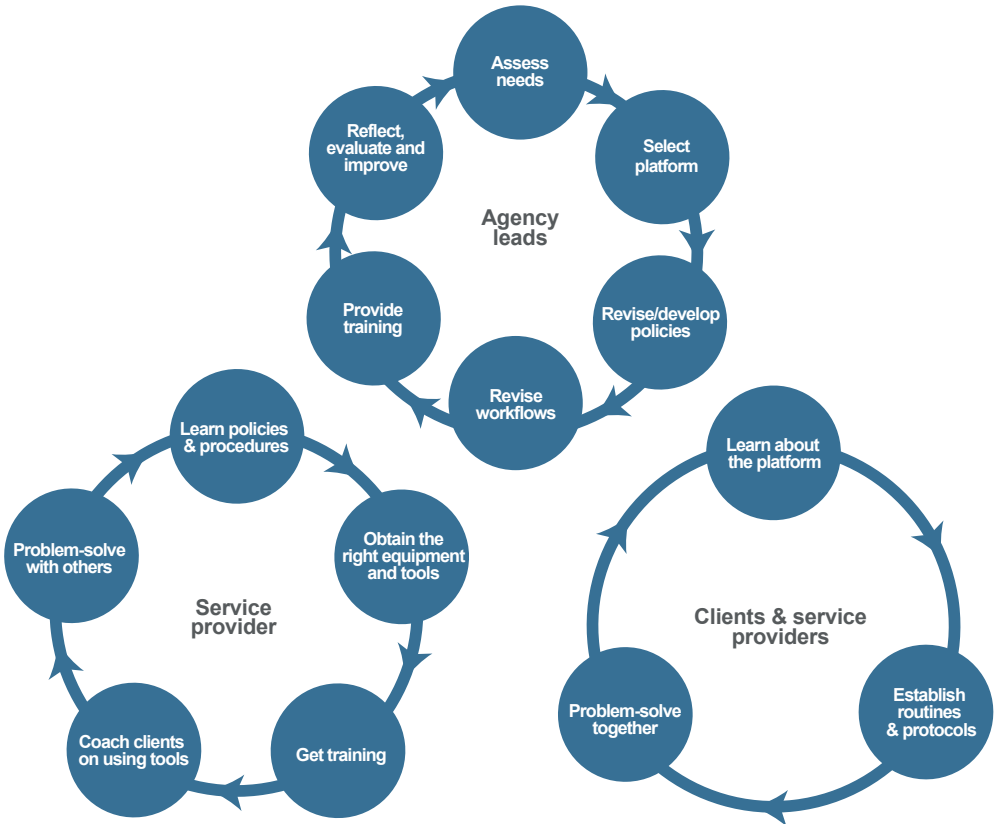
***What did service providers do to get ready to deliver virtual care?***
Service providers carried out the policies and procedures laid out by the agency leads. To prepare for these virtual sessions, they focused on the following activities:

1. Learn the organizational policies, procedures and guidelines from their professional associations.
2. Obtain the right equipment and tools.
3. Get training on the tools or platforms that they would use.
4. Coach clients on how to use the new tools or technologies; ensure there is a safe, private and confidential space for each session.
5. Be open, flexible and resourceful; learn and problem-solve with others.

These were iterative processes, with service providers checking in with clients and with their colleagues to problem-solve in an ongoing way. Service providers noted the steps they took to ensure client safety protocols at the start of each session and along the way, learned what cues or situations to watch out for:

> *" [E]specially at the beginning, we were very diligent about those team meetings to kind of check in about what's working for people, what's not working for people, how can we support people maybe struggling a little bit more with the tech and kind of doing a lot of that troubleshooting… So, when I first started, one of my questions was not, 'Is there anyone else in the room with you?' And then I had a co-worker who had an experience where the mom was behind the screen coaching the client, and she had no idea and wasn't able to account for that. So just really working on a lot of that open communication…like, 'Oh, you've had that experience now, how can I kind of shift my sessions so that I can just be proactive about having to deal with that?'"*
> Service provider

Both agency leads and service providers noted the speed of the shift to virtual care, the overall engagement of service providers and clients' willingness to embrace this change. The child and youth mental health sector showed resilience and creativity in responding to the needs of children, youth and their families.




## Facilitators to implementing virtual care

### *Agency leads' perspectives on facilitators*

Based on data from the organizational survey and the interviews with agency leads, the following factors were identified as areas that contributed to the successful implementation of virtual care:

- staff engagement and motivation
- leadership support
- tip sheets and training materials, primarily on delivering virtual care
- necessary resources such as platforms or programs to stay connected, facilitate file sharing and conduct sessions; devices and accessories such as laptops, phones, internet sticks and headsets
- collaborative approach and supports for ongoing problem-solving

Agency leads expanded on the theme of collaboration and discussed the importance of ongoing communication between all levels of staff to ensure problems were solved quickly and effectively. At the onset, many teams met daily to problem-solve and discuss updates. Gradually, this was reduced to weekly, bi-weekly or as needed.

> *"[It] wasn't just the voice of the management team. It was a collective voice about what were best practices what would make sense. And we had really, a participatory process at that working group around problem solving [when issues came up]"*
> Agency lead

> *"That peer-to-peer thing was an important element; I talked about these team leads, and they would support their different service areas. But there was a lot happening where peers were helping peers, and [a spirit of] 'just let's figure this out, and we'll figure out a way to do things'. So, it was kind of a parallel thing."*
> Agency lead

***Service providers' perspectives on facilitators***

Service providers identified similar facilitators as agency leads, such as the importance of resources, access to training and the value of a collaborative team approach and learning climate. Given their focus on their relationship with clients and the delivery of virtual mental health services, service providers also highlighted two additional facilitators: the advantage of having previous experience and existing relationships to enhance clients' and their own self-efficacy in using the technology, and the focus on client-centred care and responsiveness to clients' needs and preferences.

Service providers described the importance of having designated champions and identified having a community of colleagues with whom they could learn as helping with their learning curve. For example:

> *"…we ended up moving into a system of delegating champions. So, there was a champion for Doxy … they were the ones that really got up and running with Doxy at the start. And and it kind of helped [to] delegate that so that it wasn't all on one person, with just so many changes that we were navigating at the same time."*
> Service provider

Being responsive to clients' needs was important to many service providers as they moved towards virtual care during the pandemic. For example:

> *"…it's like, 'Hey, we were providing a really comprehensive service for a really long time. And now we're kind of being thrust into this virtual care'…you have these high needs clients, where the service is basically dropped off. So, when you think about, you know, ethically and kind of morally, who we are as people in a helping profession was kind of like that thrust to be able to…figure something out to take that leap [to virtual care]. So I think that was a strength and it wasn't really met with much resistance…from my team specifically, [and] we had to continue to provide that care right, because it is a high risk group."*
> Service provider

## Challenges to virtual care and strategies for addressing these

From the perspective of agency leads through the organizational survey and interviews, the following were the primary challenges their agencies faced in implementing virtual care:

- lack of a reliable and accessible internet connection to engage in virtual services; particularly in rural and remote areas and among clients with low socioeconomic status (SES)
- lack of appropriate resources for staff and clients to provide and access virtual services (e.g. laptops, tablets, phones, webcams and speakers)
- the complexity of some platforms and frequent technical challenges (i.e. some platforms were particularly cumbersome to register with and use).
- limited staff capacity to provide services, as they faced challenges balancing childcare and work responsibilities
- privacy concerns, in particular, related to clients' lack of a safe space to conduct a session
- changes to workflow and time required to adjust to new technology, processes, protocols and strategies to engage with clients.

To address the above challenges, agency leads offered the following strategies:

| Challenges | Strategies |
|---|---|
| limited access to internet<br>• poor internet strength, connection problems and expensive fees standard in rural and remote areas<br>• the closure of public spaces with free internet | • alternative engagement approaches, like porch drop-offs (i.e. physically dropping off materials and worksheets to clients' homes), phone calls<br>• improving internet quality (e.g. internet sticks, top-ups on data plans, community hotspots) |
| limited availability of resources for staff and clients<br>• limited number of devices in the home and competing demands<br>• devices without video capabilities | • upgrading software and hardware for staff<br>• providing tablets, laptops, phones to clients in need, often by partnering with other community agencies |
| complexity of platforms and technical challenges<br>• some platforms not user- friendly<br>• glitches and interruptions in connectivity | • conducting focused workshops and training sessions to orient clients and staff to the platform(s) and support troubleshooting |
| limited staff capacity<br>• balancing childcare and work responsibilities | • offering flexible hours of service during evenings and weekends to accommodate service providers' other responsibilities |
| privacy concerns<br>• lack of safe space for clients<br>• siblings, parents in the home who may overhear conversations in clients' homes | • offering flexible modality of services such as chat function on virtual platforms and texting |
| changes to workflow<br>• many new processes and protocols established in a short period of time<br>• steep learning curve for staff as they used new technology | This resolved over time as staff became more familiar with the new routines and new technology. |

One of the most common challenges discussed was a lack of access to the internet among clients, particularly those in rural and remote areas. A variety of creative approaches were used to engage clients with limited access to the internet, such as porch-drop offs and phone calls. Staff also purchased internet sticks, topped up data plans and coordinated for virtual sessions to be hosted at community hotspots:

> *"So we would, you know, print off some sheets go to the office or a home and then put it on their front porch or mail to them…even if it was like a reminder or positive message or even some activities for them to do."*
> Agency lead

Another interesting finding was that although agency leads initially found the changes to workflow challenging, they quickly adapted to new routines and new technology. Furthermore, they came to appreciate the advantages of virtual care:

> *"Initially it was more of a challenge for both staff and [clients], but once we were able to get some comfort with the technology aspects, it ended up being very patient-focused and easy to access for patients"* Organizational survey respondent

> *"It's also showed us therapists who were more resistant at first how much we can do right now or even in the future. You know, if families can't get here for a family meeting, we do have this option…it's really opened our eyes to how much we can do."*
> Agency lead

***From the perspective of service providers***

Delivering virtual care has some inherent challenges, and delivering virtual care during the pandemic is even more complicated. There was consensus that virtual care was effective but also provided unique challenges and dilemmas for service providers and clients.

According to service providers, a number of challenges surfaced as they shifted to virtual care in response to the COVID-19 pandemic:

- having a reliable and accessible environment in place to ensure safety, privacy and confidentiality during the session (including equipment and internet accessibility, safety and privacy and establishing routines)

- establishing rapport, trust and therapeutic relationships, given the limited ability to respond to nonverbal cues, body language or presentation through the virtual platform
- conducting sessions with younger children
- conducting group sessions
- ensuring fidelity to evidence-based practices (EBP), where materials or resources may not be readily available to support adaptation
- clinicians' fatigue from intense online sessions, their own experiences of social isolation and the challenges of establishing boundaries while working from home

When explicitly asked about challenges relating to equity, service providers noted that virtual care (despite the above challenges related to having reliable internet) can enhance access to services for many clients. However, the interviews were conducted relatively early in the summer and agencies were still gathering data or developing their data systems to identify which clients were or were not being reached with their virtual services.

To address the challenges they noted, service providers offered the following strategies (see table below).

| Challenges | Strategies |
| --- | --- |
| lack of reliable structures and environment in place to ensure safety, privacy and confidentiality<br>• equipment and internet accessibility<br>• safety and privacy<br>• establishing routines | • enhancing the quality and availability of technology<br>• checking-in with clients<br>• establishing safety protocols with clients<br>• increasing familiarity with technology<br>• having flexible appointments or services<br>• sending more reminders |
| difficulties establishing rapport, trust and therapeutic relationships | • checking-in with clients<br>• conveying empathy by acknowledging feelings<br>• acknowledging client preferences and needs and adapting services to align with these |
| difficulties in having sessions with younger children or group sessions | • having several facilitators with prescribed roles<br>• managing group size, conducting shorter sessions or flexible appointments<br>• providing workshops targeting parents or families to help them understand how they could play a supporting role for their children |
| concerns in ensuring fidelity to evidence-based practices | • sharing resources (includes using unique features of the virtual platform)<br>• planning ahead to have electronic copies of resources available during the session |

| Challenges | Strategies |
| --- | --- |
| fatigue from intense online sessions; social isolation and difficulties establishing boundaries in working from home | • managing group size, breaking up sessions<br>• practicing self-care and managing expectations<br>• having a learning climate within the organization<br>• having meetings, check-ins and support from team or colleagues |

## Clients' experiences with virtual care

Results from the survey to youth and families show that most clients have opted to use virtual services (n=130, 82%). This openness to use virtual services was consistent with the interviews and focus groups, where service providers talked about being surprised by the high level of engagement of clients.

Clients who did access virtual services felt that the technology was easy to use (83%), felt confident about what to do after their virtual session (70%) and believed they had a better plan for how to handle their concerns (58%). A majority of respondents also reported feeling confident in using e-mental health technologies (84%) and intended to continue to use virtual services (68%).

Responses to the open-ended questions were consistent with these ratings. Clients and their family members reflected on the convenience of accessing virtual services from their homes and the time and cost savings associated with this (e.g. childcare, parking, commuting time and time off work). They also discussed the flexibility of virtual care and the various of ways of accessing this care, such as using video, audio-only or telephone calls. Some clients even reported feeling more comfortable expressing their feelings over virtual means than during an in-person session.

Clients and family members had several suggestions to improve virtual care and reduce challenges, many of which overlap with the challenges and strategies listed above. These include improving internet connection, resolving technical issues and ensuring privacy during a session. Improving

communication between providers in order to streamline services was also mentioned as an area for improvement:

> *"Knowing what other access points for service might also be available or having a group conference with multiple service providers at once to maximize the session"*
> Family and youth survey respondent

> *"There are a variety of different platforms used by different providers. Sometimes the differences between the platforms can be a little confusing/time-wasting."*
> Family and youth survey respondent

A handful of clients or family members requested more frequent virtual check-ins and sessions. The quote below speaks to the importance of checking in with clients from a youth's perspective. Conversely, some clients simply wanted to return to in-person sessions.

> *"I believe [social workers] could be doing more check-ins. As a youth during COVID it's much easier for me to avoid seeking mental health (support) than when the world was normal."*
> Family and youth survey respondent

## Organizational plans for integrating virtual care

As agencies developed their re-entry plans, most indicated that virtual care would continue to be offered as an ongoing service. Work is continuing to take place within each agency to determine what this model of care will look like and will require a further examination of how best to match modality with client needs and preferences. Where relevant, agencies are consulting with their community partners and involving clients in their re-entry plans.

Perspectives from agency leads and service providers were generally congruent. They were both paying attention to the evolving needs of children and youth, and to making sure clinicians are supported, including a focus on service providers' own mental health. Some agencies were beginning to formally evaluate their processes, including surveying staff and clients, while others were just beginning to plan their evaluations of virtual care.

# Limitations

This evaluation study was designed and deployed relatively quickly, with little opportunity to engage a wide range of stakeholders in co-developing methods and tools. The surveys were disseminated during the summer months when many activities tend to wind down, and when attention was rightly focused on activities aimed at containing and preventing the spread of COVID-19 through the community. There were many competing demands among agency leads and service providers.

When we began this project, there were a number of surveys being sent to youth and families, each focused on understanding the impact of COVID-19 on their health and mental health; this may have caused some confusion for families and could have led to “survey fatigue”. Moreover, the perspectives of clients who responded to our survey cannot be linked to the actual services provided. Despite the limitations with participant recruitment, we were still able to draw general trends from the survey results (margin of error of 7%) and explore these further through the key informant interviews and focus groups. This evaluation did not include lines of inquiry relating to virtual mental health services for children and youth in Indigenous communities in Ontario. There are a handful of core service provider agencies that responded to the organizational survey who provide services to Indigenous families, however, we are planning a future study to evaluate virtual care services for this population. Our team intends to engage community members in co-developing the evaluation framework and methodology.

# Summary and recommendations

As a result of the pandemic, agencies had to shift to providing virtual mental health services rapidly. Despite limited time to plan for and consult with others, agencies undertook similar implementation activities. Agencies conducted needs assessments, selected one or more virtual platforms, revised or developed policies and procedures, revised workflows, provided staff training and developed strategies to support evaluation and continuous improvements. Service providers focused on familiarizing themselves with the new policies and protocols, accessing the right equipment and tools, getting trained, coaching clients through the new tools and technology and engaging in ongoing problem-solving with peers.

Agency leads and service providers identified similar facilitators to implementing virtual care, such as ensuring staff engagement, ample resources and a collaborative team approach. Agency leads brought to light challenges such as access to internet and resources, technical issues, limited staff capacity, privacy concerns and changes to workflow. Service providers echoed the importance of access to the internet and resources. They discussed challenges around developing therapeutic rapport, conducting sessions with younger children, conducting group therapies, ensuring fidelity to evidence-based practice and dealing with their own fatigue. The culture of ongoing problem-solving and collaboration was apparent as agency leads and service providers discussed various strategies used to address challenges.

Clients' experiences with virtual care were largely positive; they felt the technology was easy to use and intended to continue to use virtual services post-pandemic. Clients listed several advantages to virtual care, such as increased convenience, increased comfort expressing themselves, reduced travel time and reduced need for childcare.

Looking ahead, most agencies indicated that virtual care would be offered on an ongoing basis. Based on the above findings, we offer several recommendations to support the integration of virtual care into current services as we continue to deal with the pandemic and plan for services post-pandemic.

### Recommendation 1: Offer virtual care as part of a menu of services

Virtual care enhances service providers' ability to meet clients wherever they are at any point in time. We recommend that virtual care be offered as an ongoing part of a menu of services that a client, in consultation with their service provider, can choose. In addition to client preference, the service provider should consider the complexity of mental health concerns, efficacy of the intervention, privacy issues and potential access issues when creating an individualized treatment plan for their client. The service provider and client may decide on in-person services, virtual services or a combination of the two approaches.

At the organizational level, risk management and cyber-security policies will need ongoing improvements. Families and youth can also continue to be involved (e.g. in developing policies, tools and resources on virtual care services). Organizations will need to strengthen peer support programs so that families and youth can address information gaps and help new clients in navigating both virtual and in-person services.

### Recommendation 2: Ensure accessibility of virtual care

Service providers and clients alike reported internet connectivity issues (e.g. lags and glitches), which hampered the quality of sessions. High-speed internet is not available in many rural and remote locations in Ontario and, when available, may be cost-prohibitive. For virtual care to be a viable and equitable option, it needs to be accessible. Agencies can mitigate access issues for clients by providing them with internet sticks, top-ups for phone and data plans and loaner devices. Partnerships with community organizations should be encouraged as a cost-effective way to meet clients' needs and reduce access issues.

### Recommendation 3: Consider how best to engage a greater number of diverse children, youth and families in virtual care

While agencies made concerted efforts to identify and address barriers to engaging in virtual care, not all children and youth engage in virtual care. These may be reflected as no-shows or these individuals may not even be referred to mental health services in the first place. It is well established that certain populations experience more barriers in access to mental health services than others, such as newcomers (Thomson, Chase, George &

Guruge, 2015), individuals identifying as 2SLGBTQI+[3] (McKinney, Desposito & Yon, 2020; Su et al., 2016) and those from Indigenous communities (Marrone, 2007). In particular, homeless youth, children and youth in rural and remote locations where the internet is not easily accessible and those with older parents or guardians who may have low technological skills are more difficult to engage in virtual care. Youth in these smaller communities may also experience more stigma and have privacy concerns when accessing services in their local community. As mental health needs continue to rise due to the pandemic (Radomski, Cappelli, Sundar & Moran, 2020), it is increasingly important to consider how virtual care can meet the needs of a greater number of diverse children, youth and families.

Virtual care has the potential to be the front door for many children, youth and families as the pandemic continues. However, ongoing monitoring of when and for whom virtual care is most appropriate needs to be examined. For example, no-shows across core services may show lower engagement for those requiring intensive services. This is consistent with the NASSS framework where complexity of the health condition limits adoption of technological interventions (Greenhalgh et al, 2017).

**Recommendation 4: Enhance staff training and support knowledge exchange**

As agencies rapidly shifted to providing virtual mental health services, they immediately offered staff basic training. With virtual services becoming the new norm, service providers' needs have moved beyond basic to more advanced training. High quality, evidence-based training focused on specific types of therapy and population groups is necessary to ensure that staff have the skills and competencies needed to continue to meet clients' needs effectively and with confidence.

In speaking with agency leads and service providers, it was evident that many felt excited about virtual care as a new method to deliver mental health services. An expert in a place-based model of service delivery can now provide consultations or be a resource to others when geography is no longer a barrier. There was a general eagerness to learn more and do more. The creation of an online community of practice would support peer-to-peer knowledge exchange and innovation across the sector.

3 The Centre is using this term in alignment with our partners' practice of placing "2S" for "two spirit" at the beginning of "LGBTQI+" to demonstrate solidarity and strengthen our commitment to Indigenous communities.

### Recommendation 5: Promote staff wellness and prevent fatigue from delivering virtual care

Service providers were vocal about their fatigue at the pace of change, need to balance childcare and work and the additional energy required to conduct virtual sessions. Agencies responded to this by encouraging staff to take frequent breaks throughout the day, flex their hours and engage in self-care activities. Despite these efforts, service providers still reported feeling exhausted. Infection control processes for those returning to the physical office also affect direct service times which can exacerbate stress for clinicians and managers in meeting service targets. To prevent burnout[4], it may be necessary to re-evaluate caseloads, conduct targeted education around self-care or plan periodic wellness activities for staff. Funders will also need to adjust expectations on service targets as the child and youth mental health sector continues to navigate demands for services and balancing these with their staff's mental wellness.

### Recommendation 6: Provide system-level guidance and oversight on quality

Agency leads reported often feeling like they were "going at it alone" in the transition to virtual care. A lack of system-level guidance meant that agencies were duplicating efforts revising and creating their own policies and protocols. To monitor the quality of care provided, agencies increased their staff supervision hours, reviewed sessions for learning purposes, deployed staff and client surveys or examined no-shows and wait times for trends. There were many differences between agencies in the number and type of activities used to evaluate the quality of care. Clear guidelines around delivery and ongoing monitoring of the quality of care would ensure consistency across agencies. These guidelines can enhance the sector's capacity for having better data on the effectiveness of virtual care and making data-informed decisions about integrating virtual care into the suite of mental health services across service areas. The outcomes for virtual care can be assessed along the quality dimensions of safety, effectiveness, efficiency, timeliness, client-centredness and equity (Health Quality Ontario, 2017; Powell, Proctor & Glass, 2014).

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4 An evidence brief on supporting the wellbeing of mental health service providers during the COVID-19, including links to supports is available at the Centre's resource hub

# Conclusion

The emergence of the COVID-19 pandemic has accelerated efforts to use digital technologies in Ontario's child and youth mental health sector. To continue to meet the needs of children, youth and families, many service-providing agencies rapidly shifted to deliver virtual mental health services. Within two weeks of the lockdown, most lead and core service providing agencies in Ontario were delivering virtual mental health services. This evaluation report documented the processes involved in this rapid implementation of virtual care across the child and youth mental health sector, from the perspectives of agency leaders, service providers, youth and families.

As child and youth mental health organizations integrate virtual care into their suite of services, it will be important to leverage opportunities and resources and have a planful approach for sustained high quality virtual care. A more coordinated effort across the system is needed so that children and youth across all communities in Ontario have access to high quality, consistent and equitable services.

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# Appendices

## A. Organizational survey questions

1. Position:
2. Organization name:
3. Service area(s):
4. What is the approximate budget of your agency?
    a. Under $2 million
    b. Between $2 and $5 million
    c. Over $5 million
5. Prior to the lockdown, was your organization providing virtual mental health services?
6. Prior to the lockdown, what types of e-mental health services were you providing?
    a. Virtual sessions (service provider and client interacting at the same time through a platform such as Zoom, BlueJeans, Skype, etc.)
    b. Text services
    c. Telephone counseling
    d. Chat services
    e. Apps, please describe:
    f. Other e-mental health services, please describe:
7. For the lockdown, what platform has your agency adopted, if any (please identify all and how you are using if more than 1)
8. During the lockdown period due to the physical restrictions from the COVID-19 pandemic, was your organization able to implement and deliver virtual mental health services?
    a. Yes
    b. No
    c. Other, please explain:

9. During the lockdown, what core services were you able to provide virtually? (Check all that apply)
    a. Targeted prevention
    b. Brief services
    c. Counseling and therapy services
    d. Family capacity building and support
    e. Specialized consultations and assessments
    f. Crisis support services
    g. Day treatment programs
    h. Other, please describe:
10. What worked well with the implementation of these virtual mental health services?
11. What are some areas that could have been strengthened in the delivery of virtual mental health services?
12. What types of resources or costs did you incur (for example, hardware for staff or clients, time for training, etc.)?
13. What are some additional things we need to consider when implementing virtual mental health services as an ongoing offering?
14. Is there anything else you would like to say about delivering virtual mental health services?

## B. Key informant interview questions to organizational leaders

1. What is your role in your agency and your role in implementing virtual care services in your agency as a result of COVID-19 (e.g. project lead, clinician providing virtual services)?
2. What were the virtual services your agency was doing prior to (the lockdown from) COVID-19?
3. Looking back at the recent events when your agency had to shift to delivering virtual services, what were some of the things you did or took into consideration before delivering any virtual services? [Prompts: deciding on platforms, training of clinicians, looking into privacy and security of the platforms, training, reviewing guidelines from professional association]
4. What made the shift to virtual care go seamless or go fairly smoothly? [Prompts: deciding on platforms, training of clinicians, looking into privacy and security of the platforms, organizational culture, organizational policies, previous experiences]
5. What were some of the challenges or issues that stood out, and made it difficult for you to rapidly shift to virtual care? How did you or your agency address these or plan to address these?
    a. How were you able to convince some of your service providers that might have been previously unconvinced about doing virtual services, to do virtual services?
    b. What types of organizational policies did you have to create or revise in order to shift to virtual services?
    c. How is your agency assessing fidelity to treatment, clients' perceptions of care, therapeutic alliance or outcomes?
    d. What were some of the considerations in terms of costs or resources? Did you need to think about providing some phones or tablets to some clients?

6. Who are the clients that you have not been able to reach through these virtual services? Who are not showing up?
    a. How are you ensuring you are addressing issues around equity to reach those clients who may not have the best access to virtual mental health services?
    b. What types of shifts or changes did you have to make? (e.g. expand available time, update organizational policies)

The next questions relate to virtual mental health services for the future.

7. With the eventual lifting of the lockdown and transitioning to a new normal, what are some activities or plans your agency has in ramping up or ramping down virtual services?
8. If you were to provide recommendations to the Minister of Health about improving virtual mental health services for children, youth and their families in response to COVID-19, what would you recommend?
9. Is there anything that you would like to share that you didn’t get a chance to say?

## C. Focus group questions to service providers

1. Tell us your first name, your typical role in your agency and your role in delivering virtual care services in your agency as a result of COVID-19 (e.g. project lead, clinician providing virtual services)
2. Looking back at the recent events when your agency had to shift to delivering virtual services, what were some of the things that helped you prepare to deliver any virtual services? [Prompts: training, reviewing guidelines from professional association]
3. What made the shift to virtual care go seamless or go fairly smoothly? [Prompts: support from other staff, previous experiences]
4. What were some of the challenges or issues that stood out, and made it difficult for you to shift to virtual care? How did you or others in your agency address this?
    a. How would you describe the therapeutic alliance with clients during these virtual services?
    b. What challenges did you experience relating to working with families or younger children? In working with groups?
    c. What challenges are you facing when trying to adhere to EBP protocols and fidelity? Are you able to maintain adherence to the model? What do you change and why?
5. What were some of the ethical dilemmas you were faced with which were specific to virtual services?
    a. How did you address any issues relating to boundaries in terms of working from home for both you and the clients?
    b. Did you experience any fatigue or “Zoomzaustion”? How did you deal with this?

6. Who are the clients that you have not been able to reach through these virtual services? Who are not showing up?
    a. How are you addressing issues around equity to reach those clients who may not have the best access to virtual mental health services?
    b. What types of shifts or changes did you have to make? (e.g. expand available time, update organizational policies)
7. Are there any client populations you have found virtual care has been more difficult or is more of a challenge than for most clients (i.e. ages, types of mental health issue, etc.)
8. Were there some things that surprised you or things that happened that you did not expect? What were these?

The next questions relate to virtual care for the future.

9. With the eventual lifting of the lockdown and transitioning to a new normal, what are some activities or plans your agency has in ramping up or ramping down virtual services?
10. If you were to provide recommendations to your executive director about improving virtual mental health services for children, youth and their families as an ongoing offering, what would you recommend?
11. Is there anything that you would like to share that you didn't get a chance to say?

## D. Youth and family survey questions

1. Do you live in Ontario?
    a. Yes
    b. No
2. Did you seek child and youth mental health services for yourself or someone else here in Ontario within the past 3 months?
    a. For myself
    b. For my child
    c. Other (e.g. my sibling, grandchild, significant other, etc.), please describe:
    d. I did not seek services in the past 3 months

*If answers to #1 is yes and a, b or c in #2, respondents proceed to the other questions. All others end the survey.*

1. Did you participate in a virtual session for a mental health program or service (for example using Zoom) during the lockdown period due to the COVID-19 pandemic (since from March 16th, 2020)?
    a. Yes
    b. No

Why not? [Skip to Q#11]

2. If you are a family member who participated in a virtual session for a child, did you:
    a. participate with my child
    b. participate without my child
    c. If you would like, please explain:
3. Did you receive in-person services before the COVID-19 restrictions?
    a. Yes
    b. No, this was my first time to meet with the service provider/counselor
    c. Other, please describe
4. Which of these services did you access during the COVID-19 physical restrictions? [Check all that apply]

a. Telephone session with a therapist/ counselor
b. Videoconference (audio and video) with a therapist/ counselor
c. Texting with a therapist/ counselor
d. Chat with a therapist/ counselor
e. Kids Help Phone
f. Crisis Text Line
g. Virtual emergency room visit
h. Other, please describe (e.g. an app or internet-based program such as BounceBack):

5. I found the virtual mental health session easy to use.
    a. Strongly agree
    b. Agree
    c. Neither agree or disagree
    d. Disagree
    e. Strongly disagree
    f. Choose not to answer
    g. If you would like, please explain:
6. I intend to continue using this service rather than stop using it.
    a. Strongly agree
    b. Agree
    c. Neither agree or disagree
    d. Disagree
    e. Strongly disagree
    f. Choose not to answer
    g. If you would like, please explain:

7. I felt more confident in my ability to do something about the concern I talked about.
    a. Strongly agree
    b. Agree
    c. Neither agree or disagree
    d. Disagree
    e. Strongly disagree
    f. Choose not to answer
8. I had a better plan for how to handle my concern.
    a. Strongly agree
    b. Agree
    c. Neither agree or disagree
    d. Disagree
    e. Strongly disagree
    f. Choose not to answer
9. I feel confident in using e-mental health technologies.
    a. Strongly agree
    b. Agree
    c. Neither agree or disagree
    d. Disagree
    e. Strongly disagree
    f. Choose not to answer
10. What did you like about the virtual mental health session(s)?
11. What can make the virtual mental health session(s) better?
12. Is there anything else you want to say about virtual mental health sessions?

***About me***

1. What gender do you most identify with?
    a. Female
    b. Male
    c. Genderqueer
    d. Transgender
    e. Other:
    f. Choose not to answer
2. How old are you?
3. My family has a(n) (select all that apply):
    a. First Nations, Inuit or Metis heritage
    b. African heritage (such as Kenya, Liberia, Chad)
    c. European heritage (such as Scotland, England, Poland, Germany)
    d. Central American heritage (such as Guatemala, El Salvador, Panama)
    e. South American heritage (such as Brazil, Trinidad and Tobago, Peru)
    f. Middle Eastern heritage (such as Syria, Kuwait, Turkey)
    g. South Asian heritage (such as Afghanistan, India, Pakistan, Bangladesh)
    h. East Asian heritage (such as China, Mongolia, Taiwan)
    i. Other Asian heritage
    j. I don’t know
    k. Other (please specify)

4. What region of Ontario do you currently live in?

    a. **Toronto** (including Durham)

    b. **Central West** (including Peel, York, Dufferin, Simcoe)

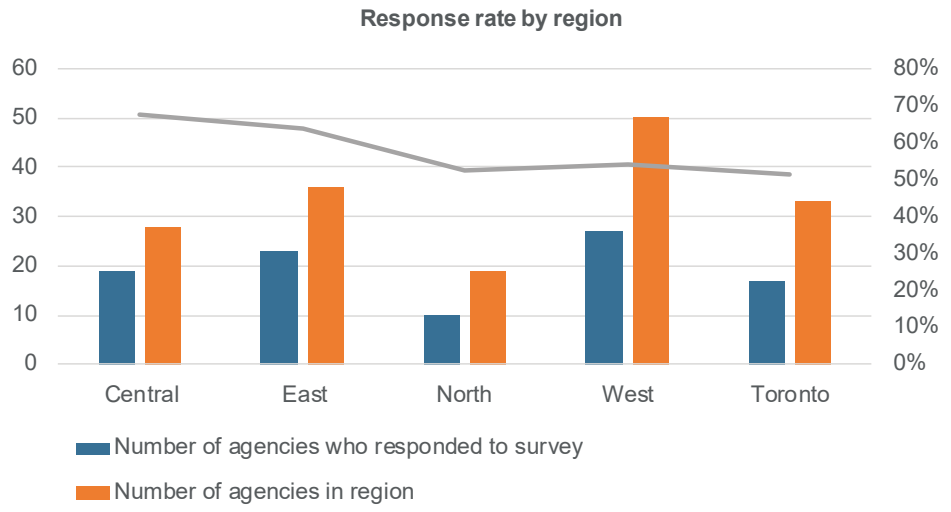
    c. **East** (including Prescott and Russell, Stormont, Dundas and Glengarry, Ottawa, Renfrew, Lanark, Leeds and Greenville, Frontenac, Lennox and Addington, Hastings, Prince Edward, Northumberland, Peterborough, Haliburton, Muskoka and Kawartha Lakes)

    d. **North** (including Nipissing, Parry Sound, Manitoulin, Timiskaming, Sudbury, Algoma, Cochrane, Thunder Bay, Rainy River and Kenora)

    e. **West** (including Hamilton, London, St. Catharines, Waterloo and Windsor)

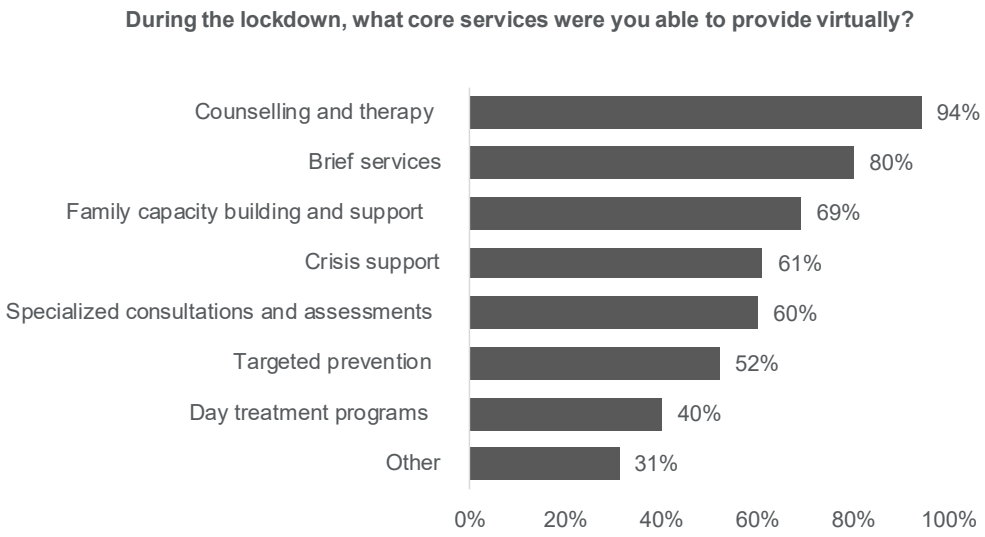
    f. Other: please describe

## E. Organizational survey: Response rate by region




| Region in Ontario | Number of agencies who responded to survey | Number of agencies in region | Response rate |
|---|---|---|---|
| Central | 19 | 28 | 68% |
| East | 23 | 36 | 64% |
| North | 10 | 19 | 53% |
| West | 27 | 50 | 54% |
| Toronto | 17 | 33 | 52% |
| Missing | 1 | Not applicable | |
| **Total** | **97** | **166** | **58%** |

## F. Organizational survey: Percent of agencies providing core services virtually




Note: This is a multiple response item, including 452 responses from 93 organizations

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mentale des enfants et des adolescents