MEDWAVE
PEER REVIEWED MEDICAL JOURNAL

RESEARCH

Mental telehealth in a public child and adolescent psychiatry unit during the pandemic: A qualitative implementation study

Francisca García[a, b], Melannie Klagges[a, b], Fanny Leyton[a, c, d*], Ingrid Nogales[a, b], Carolina Mickman[a, b], Claudio Martínez[c, e], Alemka Tomicic[c, e]

[a]Departamento de Pediatría, Escuela de Medicina, Facultad de Medicina, Universidad de Valparaíso, Valparaíso, Chile; [b]Unidad Infanto-Juvenil, Hospital Psiquiátrico del Salvador, Valparaíso, Chile; [c]Instituto Milenio para la Investigación en Depresión y Personalidad (MIDAP), Santiago, Chile; [d]Centro Interdisciplinario de Estudios en Salud (CIESAL); [e]Facultad de Psicología, Universidad Diego Portales, Santiago, Chile

ABSTRACT

BACKGROUND The COVID-19 pandemic led to a prompt implementation of remote care, especially in mental health care. The evidence supporting this modality of care is still emerging, with few qualitative studies describing its implementation in Latin American countries. This study aims to understand the perspectives of therapists and patients regarding the use of telehealth in a child and adolescent mental health unit of a Chilean public service.

METHODS This is a qualitative study. Two focus groups were defined with 14 professionals, and 16 in-depth interviews were conducted with users of an outpatient child and adolescent psychiatry unit. The data were analyzed using the grounded theory model.

RESULTS In the group of therapists, four main categories emerged: background of mental telehealth, implementation, mental telehealth from the therapist's position, and projections. Three main categories emerged in the patient's group: implementation, evaluation of mental telehealth users, and projections.

CONCLUSIONS There are elements in common between the opinions of patients and therapists. Something to note within the patient's group is that, despite accepting remote care and recognizing its positive aspects, aside from the pandemic context, they prefer face-to-face or mixed care.

KEYWORDS Telepsychiatry, Child Psychiatry, COVID-19

INTRODUCTION

The COVID-19 pandemic posed a challenge: meeting the growing demand for medical care while maintaining physical distance [1]. An increased number of mental health problems associated with the lockdown of children and adolescents was documented [2]. Caregivers of children with special needs, on the other hand, also faced increased levels of stress, anxiety, and depression [3]. This crisis prompted a shift in healthcare delivery from face-to-face to virtual consultations [4–7]. Previously, telemedicine adoption was slow due to barriers such as patient and provider resistance, security and privacy concerns, lack of regulations, and technical limitations [8–12].

There are studies supporting the use of mental telehealth, but most are focused on its applicability and acceptability [11,13]. During the pandemic, participants expressed gratitude for these virtual consultations, but evidence of their efficacy is still developing [11]. Some comparative studies have found no significant differences in clinical outcomes between face-to-face and virtual treatments [14–16].

Considering that 22.5% of the child-adolescent population already had psychiatric disorders before the pandemic, coupled with existing barriers to mental healthcare, telehealth is a valuable option to improve access and quality of care. However, studies assessing the feasibility and limitations of telehealth in local settings are lacking [7,17].

Given the above, this study aims to know the perspective of therapists and patients regarding the use of telehealth in a child

* **Corresponding author** fanny.leyton@uv.cl
Citation García F, Klagges M, Leyton F, Nogales I, Mickman C, Martínez C, et al. Mental telehealth in a public child and adolescent psychiatry unit during the pandemic: A qualitative implementation study. Medwave 2024;24(2):e2777
DOI 10.5867/medwave.2024.02.2777
Submitted Sep 13, 2023, **Accepted** Jan 22, 2024,
Published Mar 21, 2024
Postal address Álvarez 228, Viña del Mar, Chile

MAIN MESSAGES

- The COVID-19 pandemic led to a prompt implementation of telemedicine.
- To date, there is a lack of studies evaluating the feasibility and limitations of telehealth in local contexts.
- Some limitations of this study are that it is not possible to extrapolate its results since it was conducted in a single mental healthcare center; most of the experiences reflected are telephonic interventions and not by video; the researchers were working in the same clinical unit, but they did not attend to any of the participants in this study.

and adolescent mental healthcare unit of a public service in the Valparaiso Region, Chile.

METHODS

Study design

The approach of this study was that of grounded theory in its constructivist version. This theory allows us to establish inductively, systematically, and iteratively understand how the participants mean and organize their daily experiences. Using this analysis model, we sought to establish emergent categories to access the participants' perspectives on the use of mental telehealth in a child and adolescent unit of a public healthcare service [18]. For this purpose, two focus groups with professionals and 16 in-depth interviews with users, including adolescents and children's main caregivers, were conducted. For both the focus groups and the in-depth interviews, semi-structured scripts were prepared with the topics of interest for this study.

Investigators

The group of researchers comprised a clinical team and an advisory team. The clinical team was composed of five female members of the same Child and Adolescent Mental Healthcare Unit. Four of them were child and adolescent psychiatry residents at the University of Valparaiso, in their second and third years, with an average age of 32 years. This team also includes a psychiatrist with teaching and assistance functions, with seven years of permanence in this unit and 11 years of experience in clinical research. The advisory team was comprised of two researchers, male and female, with an average age of 52 years and 25 years of research experience. Both are psychologists and university professors, with no connections to the group of professionals or the patients under investigation. They reviewed the study design, interview scripts, and focus groups. In addition, together with the clinical team, they participated in the data analysis.

Participants

In the sample selection process, therapists and patients participating in remote mental healthcare were sought. In the group of therapists, psychiatrists, and psychologists were invited to participate, and all of them accepted. In addition, a social worker was included because of her family's therapeutic work (Table 1).

Regarding the users, a list was requested with all those currently in mental health care. A diverse sample of ages and diagnoses was sought for convenience, defining a first selection of 16 users, eight aged 13 years or more, and eight aged 12 years or younger. In the latter group, the responsible adult (mother, father, or grandmother) was interviewed [19,20]. Patients were randomly selected from the list according to age, and subsequently, the treating psychiatrists were consulted about the diagnoses. Once the selection of users had been made, the residents made telephone contact with the users and their relatives to invite them to participate in the study. All of them agreed to participate (Table 2). Users attended by the research team were excluded from participating. This is because the interviews were conducted by the Child and Adolescent Psychiatry residents of the University of Valparaíso, who attend to patients under supervision. For this study, participants attended by the professional team of the hospital's child and adolescent unit were sought.

Table 1. Child and Adolescent Mental Health Unit professionals.

Participants	Gender (Female:Male)	Years of experience
Psychiatrists = 6	5:1	from 3 to 27 (mean 15)
Psychologists = 6	5:1	from 4 to 14 (average 12.1)
Social worker = 1	1:0	10

Source: Prepared by the authors.

All participants, both therapists and users, were informed of the reasons for the study and agreed to be included in it by signing the informed consent or assent form, according to their age. This research was approved by the Scientific Ethical Committee of the Valparaiso San Antonio Health Service, labeled Ord. 1285 01/09/20.

Data collection

Focus groups with professionals: a semi-structured script was prepared to guide the conversation focused on the experience of providing telematic care. The topics addressed were the media and therapeutic setting, the relationship in remote care, the advantages and disadvantages of mental telehealth, user profiles, and general experience. The starting question was "How was your experience of remote care?" waiting for different topics to appear spontaneously, and then asking more specific questions, for example, "Do you think that the services were useful for the patient?

This semi-structured script allowed sufficient flexibility to accommodate emerging themes in the development of the

Table 2. Patient characteristics.

Participants	13 years or more	12 years or less	Total
Internalizing[1]	4	3	7
Externalizing[2]	4	5	9
Total	8	8	16

[1]Anxiety disorders, depressive disorders, and somatic symptom disorders.
[2]Disruptive, impulse control and conduct disorders, Attention deficit and hyperactivity disorders.
Source: Prepared by the authors.

focus groups. It also made it possible to ensure the revision of the defined topics to be addressed in each of the focus groups.

The focus groups were conducted simultaneously in August 2020, with a duration of 90 minutes. The moderators were the four residents of the research team. They were conducted in videoconference mode. The sessions were recorded and then transcribed for later analysis.

Interviews with patients and family members: all interviews were conducted by telephone. They began with an initial broad question regarding the experience of mental health care. Then, more specific questions were asked about the media and setting, the relationship in remote care, the advantages and disadvantages, and a general evaluation. Some of these topics were taken from emerging themes in the focus groups. The starting question was: "How was your experience with remote care?" and then probed through more specific questions. An example was "How did you feel when participating in the remote care services? As in the focus groups, the individual interviews combined a flexible approach to accommodate emerging themes while ensuring the review of the topics defined to be addressed in each of them.

The interviews were conducted between April and June 2021 by the residents of the research team, with an average duration of 25 minutes. None of the residents who conducted the interviews were direct caregivers to the patients. All interviews were recorded and transcribed for later analysis.

Analysis

Following the grounded theory procedures, two to four researchers coded the transcripts of the focus groups with the open coding system [18,21,22]. The coding process was developed with the ATLAS.ti software, version 8.4.5, consisted of assigning codes to expressions, in this case, those of the therapists, through an inductive process of constant comparison. This process was validated through a triangulation procedure of the analysis carried out with another researcher in all instances where no consensus was reached [23]. This involved working initially with provisional emerging codes and properties, which were consolidated as they became saturated in the iterative processes of coding and triangulation.

Once the coding was completed, the codes were classified into categories and subcategories to generate classification schemes that allowed the central topics of the telemedicine experience to be raised [18,21,22].

Subsequently, the patient interviews were coded following the same procedure described above. However, this time, the coding was guided by the codes, subcategories, and categories emerging from analyzing the therapists' focus groups. Although a first selection of 16 users was defined, it was not necessary to incorporate more interviews due to saturation.

RESULTS

Therapist's perspective

The descriptive analysis of the focus groups allowed us to extract four main categories:

1. History of mental telehealth.
2. Implementation of mental telehealth.
3. Mental telehealth from the therapist's perspective.
4. Projections.

1. History of mental telehealth: This refers to the knowledge about mental telehealth before the pandemic and its expectations. Here, there is concern about the resources needed for its implementation, the lack of training, the scarcity of research in the area, and clear guidelines. It also recognizes doubts about the possibility of psychotherapy in this context and ethical questions related to this type of care.

2. Mental telehealth implementation: This section describes how care is carried out, both from a practical and therapeutic point of view. Changes in the framing of care are seen and how this may influence the therapist-patient relationship. Differences between remote care modalities are also described.

3. Mental telehealth from the therapist's perspective: This category refers to the impact of the telematic modality of care on therapists and the potential risk to their mental health, resulting in a loss of boundaries between personal and work life. On the other hand, it points to the emergence of new resources in therapists, work teams, users, and families.

4. Projections of mental telehealth: It describes the current and future technical and clinical challenges, alluding to the need to adapt to new technologies in therapeutic care, to the changes derived from its use over time, and to the consequences of fewer face-to-face consultations. It also highlights the need to identify a profile of less suitable users for distance care.

Table 3 shows these categories, with the subcategories and codes extracted from the analysis. An illustrative vignette is provided for each category.

User's perspective.

The descriptive analysis made it possible to extract three main categories:

1. Implementation of mental telehealth.
2. Mental telehealth users evaluation.
3. Projections of mental telehealth.

Table 3. Open coding of therapist focus groups.

Main categories	Subcategoríes	Codes	Vignette
History of mental telehealth	Resources needed for its implementation	• Lack of training in mental telehealth • Lack of research in mental telehealth • Need for guidelines to implement mental telehealth	I work with child confidentiality, so when the parents come in with me, I tell them that I am not going to tell them what the child says since he is my patient, so I don't tell them [SIC] what they say, although I share impressions and everything, it is never like this: 'Look, he said this', so now I have a hard time telling them: 'I want to talk to Juanito or X, is it possible to leave him in a room with the cell phone alone for a while?' Focus Group 2 (Psychosocial team). Code: Ethical questions
	Preconceptions	• Initial pessimism regarding mental telehealth • Is mental telehealth psychotherapy? • Ethical issues	
Implementation of mental telehealth	Changes in the setting	• Increased participation of caregivers • Ensure the privacy of the session is protected • Need for support elements (stories, figures) • Variability in the hours of care • Variability in the attention schedules • Presenteeism • Greater sense of availability of the therapist for users • Longing to physically see the therapist	"With young children in the hospital, I think I would prefer, if there is a choice, I would prefer the traditional approach of seeing each other in person and having the playing space that I think is very important, and that is the biggest challenge I have found in this virtual space, as that transitional space, I think I don't know if... I think it is also a topic to investigate how that transitional space is built in virtuality" Focus Group 2 (Psychosocial team). Code: Need for support elements
	Differences between video calls and phone calls	• Video calls last longer than phone calls • Phone calls lose non-verbal cues • Greater user comfort on phone calls without the other's gaze • Greater user honesty in phone calls • Possibility of user deceiving by the telephone	
Mental telehealth from the therapist's perspective	Mental health risk for the therapist	• Loss of boundaries between work and personal life	I have had to supervise myself more than in other opportunities and value teamwork more in circumstances of an institution such as the hospital because I need to be connected with others. Focus Group 2 (Psychosocial

Main categories	Subcategoríes	Codes	Vignette
		• Use of own resources (such as telephone number) • Lax schedules • Feeling of increased physical and mental fatigue • Feeling that work encroaches on home and vice versa • Therapists are also experiencing a pandemic	team) Code: Feeling of greater physical and mental fatigue "I feel that it has also been important to make it more flexible, maybe on one's part, like trying to make the patient as comfortable as possible, I don't know, for example, sometimes I have had to attend a patient who is taking care of her little nephew next to her and well, if that is the way she can have that space at that moment and she can and it suits her, I think that at least for me it has made sense to leave it a little more on the patient's side, like trying to make the space as comfortable as possible, but if it is not possible or if she feels comfortable that way, I think it can be". Focus group 2 (Psychosocial team) Code: Adapting to remote care and user's needs
	Emergence of new resources	• Emergence of new resources • Learning the use of communication technologies • Adapting to remote care and user needs • Possibility of group services • Less absences • Greater confidence in teamwork and intersectoral coordination • Greater receptiveness of parents • Facilities for users in terms of economic resources and time • Knowing the user's environment through phone and video calls.	
Mental telehealth projections	Technical and administrative challenges	• Need to adapt to the use of technologies • Improve coordination of care • Users are more easily able to refuse care (they disconnect or hang up) • Users without access to ICTs • A paradigm shift is anticipated: permanent	"Not seeing them, not having a face-to-face encounter detracts a lot from the quality of the encounter with the other, and in our ability to get to know them, to incorporate information from the non-verbal, from the visual and also in the containment, that is, I believe that nothing can replace a hug, or that someone sits next to you and can display a look of compassion or affection" Focus Group 1 (Psychiatrists) Code: Loss of the magic of the face-to-face encounter. "There is something that I am missing, especially in the children's space, of playing, of interaction, of

Main categories	Subcategoríes	Codes	Vignette
		incorporation of mental telehealth	what one hears, of the way one looks at how they manipulate objects, for example, children, that I cannot see it so much online, perhaps with adolescents it may be easier in some senses that are more related to the word, but I would not rule it out at all as an option" Focus Group 2 (Psychosocial Team) Code: Nonverbal elements difficult to assess, Loss of the magic of the face-to-face encounter. "I also have some antisocial who disengage and then, the more severe borderline ones, it is also difficult for them to organize themselves in the chamber, then it ends up being a very concrete dialogue where the answers are 'yes and no', where it is not very clear to me what is genuine about her, then those are the ones that have made it more difficult for me. Focus Group 1 (Psychiatrists). Code: Specific Disorders, Borderline Personality Disorder
	Clinical challenges for mental telehealth	• Loss of the "face-to-face magic" • Nonverbal elements are difficult to assess • Concern about therapeutic bonding • Difficulty in performing emotional support • Worsening global mental health in pandemics	
	Perfil de pacientes complejos para atender en telesalud mental	• Specific disorders • Borderline personality disorder • Substance Use Disorder • Intellectual Disability with Communication Disorders • Severe Attention Deficit Hyperactivity Disorder (ADHD) • Negativistic Defiant Disorder • Severe Social Anxiety Disorder (fear of the camera) • Lower educational level • Dysfunctional families	

ICTs: information and communication technologies.
Source: Prepared by the authors.

1. Implementation of mental telehealth: describes how care is carried out from the practical point of view, referencing the means of communication used and the environmental and family elements that condition its performance.

2. Evaluation of mental telehealth users: This includes users' positive or negative evaluations based on their experience with remote mental health care. It also includes the interviewees' comparisons between face-to-face and remote modalities, identifying advantages and disadvantages.

3. Projections refer to the possibility of maintaining mental telehealth in the future based on the user's current and future preferred modality, their profile, and the difficulties identified in its implementation. These may be environmental, privacy-related, or technical and technological.

Table 4 shows these categories, with the subcategories and codes extracted from the analysis with illustrative bullets.

DISCUSSION

Our study focused on the rapid transition to mental telehealth in the context of a healthcare crisis, with little previous research and no clear guidelines. In the process, we report shared experiences among therapists and users, reflected in three central categories: implementation of mental telehealth, perspectives of therapists and users, and projections of this modality.

Table 4. Open coding of user and family interviews.

Main categories	Subcategories	Codes	Vignette
Implementation of mental telehealth	Communication media used	• Video and phone calls - Phone calls only - Messaging services	Interviewer: Hey, and at this time, when you attended via telephone, tell me a little bit about that; what space were you in? What was it like? Patient: I am in a space by myself because my parents gave me my space so I could talk better; that's it. Adolescent 16 years old, female. Codes: A respectful family environment allows privacy.
	Care conditioning factors	• Not having a camera or not knowing how to use it • Caregiver does not know how to use the communication platforms - Positive assessment of seeing the therapist's face in the video call - Respectful family environment allows for privacy	
Evaluation of mental telehealth users	Satisfaction with remote care	• A safe environment is generated - It is possible to talk comfortably - Relief and respite are found. - The professional's concern is perceived - Trust in the therapist can be maintained • A respectful family environment allows for privacy	"It has been like psychotherapy, so to speak. Being able to talk to people I trust that they are not going to tell anyone else has been a good way to let off steam, not the best way, but yes, it has been a good way". Adolescent 16 years old, female. Codes: Trust in the therapist can be maintained, Relief and respite can be found "Because I feel that regardless of whether the help is there, whether in person or not, the help will continue to be there and it depends on each person whether to take it or not and in my case, I would take it blindly because the help of a psychiatrist is not something I go through every week" Adolescent, 16 years old, male. Code: The act of help is perceived at a distance. "I feel that face-to-face care is a super close contact between the patient and the specialist, so I feel that being face to face is super important because if it were not so, the specialist and the patient could not have the same connection and the same trust as over the phone" Adolescent, 16 years old, male. Codes: The same intimacy is not achieved, Lack of "face-to-face" contact, Face-to-face consultations provide a climate of greater closeness and trust.
	Conformity and resignation with remote services	• Satisfaction with the duration of care • Satisfaction with care	
	Disapproval of remote care	• Lack of "face-to-face" contact - Going to the hospital and talking in person is perceived as a therapeutic act • Higher expectation of care	
	Elements not considered for preferring remote care	• Transfer to the hospital (e.g., lives nearby) • No worries about getting infected - Scheduling and timetable	
	Similarities between the two care modalities	• The user feels understood • Therapeutic bonding is achieved - The act of help is perceived from a distance • Pharmacological indications are understood • Characteristics of the therapist and not the modality of care are what determine the level of intimacy	

The users' assessment of remote care ranges from acceptance and conformity to dislike. Our study attempts to detail the interviewees' experiences to understand this variation. For patients and therapists, the idea of patient profiles less suitable

Main categories	Subcategories	Codes	Vignette
	Advantages of remote care	• Being able to choose the place of care (bed, room) - Not having to travel to the hospital • For caregivers to maintain the care of other children • Greater communication between caregivers and professionals • Feeling of greater availability of the therapist in remote care • Prevention of COVID-19 contagion	
	Differences and disadvantages of mental telehealth compared to face-to-face care	• Face-to-face sessions last longer - Face-to-face sessions allow and encourage play as a clinical tool • Face-to-face sessions are more spontaneous - Face-to-face sessions provide a climate of greater intimacy and trust • The same intimacy is not achieved - More time is required to trust the therapist • The therapist takes more time to respond to your needs • Contact is initiated without prior notice	
Projections	Current preferences	• No preference between face-to-face and remote • Prefer face-to-face services • Prefer telephone services • Accept the remote as temporary	Why I don't like video calls, I mean, it's not that I don't like them ... I don't like, for example, showing my face all the time here, no more calls. 15-year-old male adolescent. Code: Prefers telephone attention. "It would be convenient because that way we would have... that is, for the girl to come and talk on the phone, it would be convenient to have both, in person and by phone; it would also be good". Mother of a girl under 12 years old. Code: Prefers mixed care "No, because it hasn't helped the child because he gets the same as he did with you...as he is now, he doesn't want to talk on the phone, they ask him questions, and he says he doesn't know, he gets angry and starts crying, very similar to what he did now" Mother of a child under 12 years old with cognitive difficulties.
	Preferences without Pandemic	• Prefer face-to-face service • Prefer mixed service	
	Challenges	• Interference and distraction by the environment • Achieving privacy • Mistrust of talking to someone without knowing them in person	
	Complex patient profile for mental telehealth care	• Young and/or restless children • Serious patients	

Main categories	Subcategories	Codes	Vignette
		• Patients with occupational therapy indication	Code: Prefers face-to-face care, Young and/or restless children.
	Problems in the use of ICTs	• Poor phone or internet signal • Lack of knowledge of the use of ICTs • Higher expenditure on ICTs (e.g., internet plan)	

ICTs: Information and communication technologies.
Source: Prepared by the authors based on the study results.

for this care modality emerges. Therapists and users coincide in pointing out the challenges of caring for young children and seriously ill patients. In particular, this is a topic widely studied in psychiatry and other healthcare areas [24–26].

Both groups, therapists and users, pointed out that remote care involves greater parental participation, which is considered valuable when working with children and adolescents. They also agree in pointing out difficulties in terms of privacy and the influence of their environment on the sessions. Regarding time and space limitations, users and therapists state that there is a perception of greater willingness on behalf of the therapist. It is relevant that users evaluate this aspect positively, while therapists consider it a risk to their mental health with the loss of boundaries between personal and work life. At this point, therapists emphasize that they also experienced the pandemic with physical and emotional effects. Therapists also point this out in a review published in 2023, where they describe visual to physical fatigue, increased emotional vulnerability, and doubts regarding their abilities to maintain full-time attention [27]. Another study conducted in an Italian psychology center highlighted the perceived changes in the sense of professional identity. It also relieved some therapists' fear of a possible "unstable framing" through mental telehealth, as opposed to the usual formal framing, and how this could lead to a dissolution of the analyst's role. At the same time, they pointed out the possibility of building a new form of real and virtual intimacy together with the analyzed users [28].

Despite the positive aspects that users recognize in mental telehealth, such as perceiving the professional's help or feeling comfortable and listened to, no user preferred exclusively remote care in the future scenario. Without the pandemic context, users would opt for face-to-face or mixed care. This is similar to a systematic review of 39 mixed studies, which concludes that providers and patients supported a "hybrid" model of mental health care in the future, considering patient eligibility, preferences, and type of consultation [11]. Our work is also consistent with a qualitative study conducted in France with a sample of adolescents and caregivers. The latter indicates that the pandemic context facilitated the incorporation of mental telehealth. In turn, this study agrees that therapists and users positively valued the integration of parents in the sessions. This is consistent with our work, which even suggests generating a mixed system in which care for parents can be virtual and for children and adolescents face-to-face. It also mentions elements related to physical distance and its consequences, such as difficulty identifying non-verbal communication and bonding elements. Additionally, they coincide in identifying a profile of patients more suitable for this modality of care. For example, when there are phobic or avoidant symptoms, they would be more comfortable with the distant relationship, as opposed to patients with severe symptomatology and/or little bonding with the therapist. The study also proposes that, for some users, attending face-to-face interventions can be therapeutic in itself, which is in line with what was mentioned in our work [12].

The study raises ethical issues such as lack of privacy, the need for training in telemedicine, distrust when exposed to unknown professionals, crisis management, and inequity in access to mental healthcare. In addressing the inequity of access, challenges such as lack of coverage, lack of internet access, and being inexperienced with information and communication technologies are evident, which is consistent with a study on the North American reality [29]. Despite the above, some participants value the convenience of avoiding travel and allowing caregivers to assist other family members during the consultation, which is in line with efforts to reduce the gap in mental health care. This reflects the particular needs of each user.

In legal terms, our work raises concerns about the lack of guidelines for remote care, the security of platforms with no guarantee of sensitive data encryption, and the environmental conditions that affect care, especially for those who lack a quiet environment. It also coincides with the literature, which adds the use of informed consent, licensing, and regulations on drug prescribing [30,31].

The American Psychiatric Association and the American Telemedicine Association developed a guideline to provide effective and safe medical care. The guideline includes administrative, technical, and clinical considerations. For example, legal recommendations, use of protocols, informed consent, and patient and setting issues are presented [30]. This guide provides suggestions, which should be implemented

according to the regulations of each country at that time. Nowadays, despite the existence of formal guidelines and recommendations on the use of mental telehealth, there is a lack of studies on the application of these guidelines.

Regarding the limitations of our study, we consider that, since it was carried out in a single mental health center, the results are focused on the local reality or could only be extrapolated to other centers with similar characteristics. Another limitation is that, among the patients interviewed, ten received telephone calls, three had the experience of making video calls along with other modalities, and only three were attended exclusively by video call, so most of the experience reflected in this study is related to telephone care and not by video.

It should be noted that the researchers were working at the same child psychiatry unit. This allowed for a closer knowledge of the research topic and generated questions more pertinent to the context in which it was developed; however, this could also introduce biases in the research. Finally, the data from users and professionals were collected at different times and, therefore, at different moments of the pandemic. This indicates a moment of less adaptation on behalf of the therapists to this modality of care.

CONCLUSIONS

In summary, this study provides a detailed overview of the telehealth transition in a child and adolescent mental healthcare service during the COVID-19 pandemic. It highlights the importance of communication between therapists and caregivers and the challenges and benefits of remote care. The results are relevant for mental health professionals and future care planning in similar situations. Similarly, these data are important for the adoption of mental telehealth as a daily care option.

Contributor roles FG, MK, and FL: Conception and design of the work, obtaining results, analysis and interpretation of data, drafting of the manuscript, technical review of the manuscript, approval of the final version, contribution of patients or study material. IN and CM: Conception and design of the work, obtaining results, analysis, and interpretation of data, drafting of the manuscript, contribution of patients or study material. TA and CM: Analyzing and interpreting data, technical review of the manuscript, approval of the final version, and technical or administrative advice.

Acknowledgments To the members of the Child Psychiatric Unit at Hospital Psiquiátrico del Salvador in Valparaíso, as well as the patients and their families who wish to participate in this study.

Conflictos de intereses The authors declare no potential conflicts of interest related to this study's research, authorship, and/or publication.

Funding

Language of submission Spanish.

Peer review and provenance Not commissioned. Externally peer-reviewed by three reviewers, double-blind.

REFERENCES

1. O'Brien M, McNicholas F. The use of telepsychiatry during COVID-19 and beyond. Ir J Psychol Med. 2020;37: 250–255. https://doi.org/10.1017/ipm.2020.54
2. Rajkumar E, Rajan AM, Daniel M, Lakshmi R, John R, George AJ, et al. The psychological impact of quarantine due to COVID-19: A systematic review of risk, protective factors and interventions using socio-ecological model framework. Heliyon. 2022;8. https://doi.org/10.1016/j.heliyon.2022.e09765
3. Dhiman S, Sahu PK, Reed WR, Ganesh GS, Goyal RK, Jain S. Impact of COVID-19 outbreak on mental health and perceived strain among caregivers tending children with special needs. Res Dev Disabil. 2020;107: 103790. https://doi.org/10.1016/j.ridd.2020.103790
4. Thornton J. Covid-19: how coronavirus will change the face of general practice forever. BMJ. 2020;368. https://doi.org/10.1136/bmj.m1279
5. Corruble E, Paris F. A Viewpoint From Paris on the COVID-19 Pandemic: A Necessary Turn to Telepsychiatry. J Clin Psychiatry. 2020;81. https://doi.org/10.4088/JCP.20com13361
6. Olwill C, Mc Nally D, Douglas L. Psychiatrist experience of remote consultations by telephone in an outpatient psychiatric department during the COVID-19 pandemic. Ir J Psychol Med. 2021;38: 132–139. https://doi.org/10.1017/ipm.2020.51
7. Sunjaya AP, Chris A, Novianti D. Trends in Psychiatry and Psychotherapy Efficacy, patient-doctor relationship, costs and benefits of utilizing telepsychiatry for the management of post-traumatic stress disorder (PTSD): a systematic review. APRS | CC-BY Trends Psychiatry Psychother. 2020. https://doi.org/10.1590/2237-6089
8. Gray B, Smith P. Emotional labour and the clinical settings of nursing care: the perspectives of nurses in East London. Nurse Educ Pract. 2009;9: 253–61. https://doi.org/10.1016/j.nepr.2008.08.009
9. Cowan KE, McKean AJ, Gentry MT, Hilty DM. Barriers to Use of Telepsychiatry: Clinicians as Gatekeepers. Mayo Clin Proc. 2019;94: 2510–2523. https://doi.org/10.1016/j.mayocp.2019.04.018
10. Cain S, Sharp S. Telepharmacotherapy for Child and Adolescent Psychiatric Patients. J Child Adolesc Psychopharmacol. 2016;26: 221–8. https://doi.org/10.1089/cap.2015.0039
11. Galvin E, Desselle S, Gavin B, Quigley E, Flear M, Kilbride K, et al. Patient and provider perspectives of the implementation of remote consultations for community-dwelling people with mental health conditions: A systematic mixed studies review. J Psychiatr Res. 2022;156: 668–678. https://doi.org/10.1016/j.jpsychires.2022.10.051
12. Carretier E, Bastide M, Lachal J, Moro MR. Evaluation of the rapid implementation of telehealth during the COVID-19 pandemic: a qualitative study among adolescents and their

parents. Eur Child Adolesc Psychiatry. 2023;32: 963–973. https://doi.org/10.1007/s00787-022-02108-1

13. van Leeuwen H, Sinnaeve R, Witteveen U, Van Daele T, Ossewaarde L, Egger JIM, et al. Reviewing the availability, efficacy and clinical utility of Telepsychology in dialectical behavior therapy (Tele-DBT). Borderline Personal Disord Emot Dysregul. 2021;8. https://doi.org/10.1186/s40479-021-00165-7
14. Bulkes NZ, Davis K, Kay B, Riemann BC. Comparing efficacy of telehealth to in-person mental health care in intensive-treatment-seeking adults. J Psychiatr Res. 2022;145: 347–352. https://doi.org/10.1016/j.jpsychires.2021.11.003
15. Myers K, Vander Stoep A, Zhou C, McCarty CA, Katon W. Effectiveness of A telehealth service delivery model for treating attention-deficit/hyperactivity disorder: A community-based randomized controlled trial. J Am Acad Child Adolesc Psychiatry. 2015;54: 263–74. https://doi.org/10.1016/j.jaac.2015.01.009
16. Xie Y, Dixon JF, Yee OM, Zhang J, Chen YA, Deangelo S, et al. A study on the effectiveness of videoconferencing on teaching parent training skills to parents of children with ADHD. Telemed J E Health. 2013;19: 192–9. https://doi.org/10.1089/tmj.2012.0108
17. Vicente B, Saldivia S, Rioseco P, De La Barra F, Valdivia M, Melipillan R, et al. Epidemiología de trastornos mentales infanto juveniles en la Provincia de Cautín. Rev méd Chile. 2010;138. https://doi.org/10.4067/S0034-98872010000800004
18. Charmaz K. In: Constructing Grounded Theory [Internet]. SAGE Publications; 2014. https://books.google.cl/books?id=v_GGAwAAQBAJ
19. Hill CE, Knox S. Essentials of consensual qualitative research. Washington; 2021. http://content.apa.org/books/17205-000 https://doi.org/10.1037/0000215-000
20. Hennink M, Kaiser BN. Sample sizes for saturation in qualitative research: A systematic review of empirical tests. Soc Sci Med. 2022;292: 114523. https://doi.org/10.1016/j.socscimed.2021.114523
21. Soneira AJ. La Teoría Fundamentada en los datos (Grounded Theory) de Glaser y Strauss. Primera edición, primera reimpresión. Estrategias de investigación cualitativa. Primera edición, primera reimpresión. Buenos Aires: Editorial Gedisa; 2007. pp. 153–173. https://books.google.cl/books?id=upPsDwAAQBAJ
22. Strauss A, Corbin J. Bases de la investigación cualitativa: técnicas y procedimientos para desarrollar la teoría fundamentada. Universidad de Antioquia. 2002. https://books.google.cl/books?id=TmgvTb4tiR8C
23. Flick U. In: An Introduction to Qualitative Research [Internet]. SAGE Publications; 2009. https://books.google.cl/books?id=tvAMAQAAMAAJ
24. Jiménez-Rodríguez D, Santillán García A, Montoro Robles J, Rodríguez Salvador MDM, Muñoz Ronda FJ, Arrogante O. Increase in Video Consultations During the COVID-19 Pandemic: Healthcare Professionals' Perceptions about Their Implementation and Adequate Management. Int J Environ Res Public Health. 2020;17: 1–14. https://doi.org/10.3390/ijerph17145112
25. Barkai G, Gadot M, Amir H, Menashe M, Shvimer-rothschild L, Zimlichman E. Patient and clinician experience with a rapidly implemented large-scale video consultation program during COVID-19. International Journal for Quality in Health Care. 2021;33: 1–6. https://doi.org/10.1093/intqhc/mzaa165
26. Izadi R, Bahrami MA, Khosravi M, Delavari S. Factors affecting the acceptance of tele-psychiatry: a scoping study. Arch Public Health. 2023;81: 1–10. https://doi.org/10.1186/s13690-023-01146-8
27. Tajan N, Devès M, Potier R. Tele-psychotherapy during the COVID-19 pandemic: a mini-review. Front Psychiatry. 2023;14. https://doi.org/10.3389/fpsyt.2023.1060961
28. Agnello I, Giubellini C. Clinical experiences during the COVID-19 pandemic. J Anal Psychol. 2021;66: 379–398. https://doi.org/10.1111/1468-5922.12688
29. McBain RK, Cantor JH, Kofner A, Stein BD, Yu H. Ongoing Disparities in Digital and In-Person Access to Child Psychiatric Services in the United States. J Am Acad Child Adolesc Psychiatry. 2022;61: 926–933. https://doi.org/10.1016/j.jaac.2021.11.028
30. Shore JH, Yellowlees P, Caudill R, Johnston B, Turvey C, Mishkind M, et al. Best Practices in Videoconferencing-Based Telemental Health April 2018. Telemedicine and e-Health. 2018;24: 827–832. https://doi.org/10.1089/tmj.2018.0237
31. Kheir DYME, Alshamsi RA, Alalwi ST, Alshammari RZ. "Webside" healthcare from medical interns' perspective: Telemedicine implementation and need for training. J Family Community Med. 2022;29: 145–154. https://doi.org/10.4103/jfcm.jfcm_105_22

Telesalud mental en una unidad pública de psiquiatría infanto-juvenil en pandemia: estudio cualitativo de implementación

RESUMEN

ANTECEDENTES La pandemia por COVID-19 generó una implementación súbita de las atenciones a distancia, especialmente en atenciones de salud mental. La evidencia que sustenta esta modalidad de atención es aún emergente, con escasos estudios cualitativos que representen su implementación en países latinoamericanos. El objetivo de este trabajo es conocer la perspectiva de terapeutas y de usuarios, respecto del uso de la telesalud en una unidad de salud mental infantil y de la adolescencia de un servicio público chileno.

MÉTODOS Estudio cualitativo. Se establecieron dos grupos focales con 14 profesionales en total, y 16 entrevistas en profundidad con usuarios de una unidad ambulatoria de psiquiatría infanto juvenil.. Los datos se analizaron utilizando el modelo de teoría fundamentada.

RESULTADOS En el grupo de terapeutas surgen cuatro categorías fundamentales; antecedentes de la telesalud mental, implementación, telesalud mental desde la posición del terapeuta y proyecciones. En el grupo de usuarios surgieron tres categorías principales: implementación, evaluación de los usuarios de la telesalud mental y proyecciones.

CONCLUSIONES Existen elementos en común entre la opinión de los usuarios y terapeutas. Un elemento importante dentro del grupo de los usuarios es que, a pesar de aceptar la atención remota y reconocer aspectos positivos en esta, fuera del contexto de pandemia prefieren atenciones presenciales o mixtas.