Preferences for telehealth: A qualitative study with people accessing a new mental health service

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Abstract

Background: The COVID-19 pandemic triggered a sudden increase in the need for mental health services and a rapid escalation in the delivery of these services via telehealth. Little is known about how people experience telehealth as part of a new mental health service, where relationships with service providers have not yet been established. In this paper, we present data from a qualitative service evaluation relating to people's experiences of telehealth and their preferences regarding future use.

Methods: Data are drawn from semi-structured interviews with 45 participants (32 people who accessed mental health services, 7 informal support people, and 6 people who had accessed services themselves as well as identifying as informal supports). Data relating to experiences of telehealth, comparisons with in-person services, and preferences were coded inductively and analysed using constant comparative analysis.

Results: Just over half of the people in our sample preferred telehealth or at least regarded it as a suitable option. Those who preferred telehealth were more likely to have had direct experience with it, particularly via videoconferencing, as part of their access to this new mental health service. Reasons for preferring in-person services included the belief that interpersonal communication was superior in these settings, compatibility with personal communication style, and discomfort with technology. Those who preferred telehealth modalities cited its convenience, elimination of the need to travel for services, the comfort and safety afforded by being able to access services at home, and the ability to communicate more openly online.

Conclusions: Our findings suggest that telehealth services have a legitimate place in future models of mental health care outside of pandemic situations. Many people who accessed services expressed a preference for participating in at least some of their mental health services remotely as it enhances choice and accessibility. Hybrid models of care may harness the unique benefits of both in-person and remote service modalities. These findings help to illuminate the potential of telehealth services when engaging with people seeking mental health help for the first time and in situations where existing relationships with those who provide services have not yet been established.

Background

Telehealth delivery of mental health services is a rapidly evolving field, and historically has been proposed as a promising way of addressing unmet need for clinical services, particularly for addressing service inequities in rural and remote areas (1). More recently, telehealth has rapidly emerged as a method of delivering real-time services in the face of the COVID-19 pandemic and public health restrictions on in-person contact (2). Research has suggested that telehealth delivery of mental health services is as effective as in-person services for a range of mental health concerns (3-7) and does not appear to compromise the quality of the clinician-client therapeutic relationship (8). Yet uptake and integration into routine care prior to the onset of COVID-19 had been slow (9).
In Australia, as in other parts of the world, COVID-19 triggered an escalation in the use of telehealth by mental health service providers (10). Increased rates of mental health distress associated with COVID-19 were experienced (11) and a range of strategies to improve access to needed psychological support were implemented. For instance, the Australian Government provided additional subsidies for mental health treatments, including telehealth, via the Medicare Benefits Schedule (MBS).

Since clinicians are often “gatekeepers of implementation” (12), most research on telehealth implementation has focused on understanding the perspective of clinicians and service providers. Much less is known about how people who access mental health services experience telehealth and the factors influencing their preferences for future service modalities. There is increasing recognition of the importance of understanding and incorporating the perspectives of people who access services in service planning and program development (13). As early telehealth experiences have a critical influence on people’s attitudes towards future telehealth engagement (14), it is important to understand how these are experienced and how this may shape ongoing service modality preferences.

Some evidence suggests that although people expressed divergent opinions and preferences about telehealth and in-person service delivery, telehealth is highly acceptable to many people who access mental health services (15-17). Many report that they are likely to access telehealth services in some form in the future (18, 19). However, this evidence on is primarily drawn from studies utilising survey methodology, a format that is not well-suited to deeper exploration of the experiences and perspectives of those who access services (18). There are few qualitative investigations of people’s perspectives of telehealth that employ interview methodology. Those that do have focused specifically on the experience of people who were already engaged with in-person services prior to adoption of telehealth (e.g., 20), on the experiences of people diagnosed with moderate to severe enduring and complex mental health conditions (e.g., 17), or have not included the perspectives of those attempting to access mental health services for the first time (e.g., 21). This is particularly important given the low proportion of people living with mental ill-health who access mental health support (22).

The current study adds to existing knowledge, not only by using qualitative techniques, but by reporting data from people within Australia accessing a new mental health service, some accessing mental health support for the first time. As pre-existing relationships established in-person between clinicians and their clients may influence the subsequent acceptability of telehealth services (21) it is important to understand how people new to a particular service experience telehealth. Tele-mental health services may hold particular benefit within an Australian context by overcoming intractable challenges of delivering specialist services to populations dispersed across large distances, so further exploration of Australians’ preferences for treatment modalities could help ensure that future services are designed in a way that best meet people’s needs (17). This paper addresses the following research question: What influences the preferences of people who seek mental health support for face-to-face or telehealth delivery in an unfamiliar mental health service?

**Methods**
Study design

This paper reports on data relating to preferences for in-person and telehealth services from a larger evaluation of a new mental health service, HeadtoHelp, in Victoria, Australia. The research team included lived experience researchers and a lived experience perspective informed all stages of the research. Ethical approval was granted by The University of Sydney Human Research Ethics Committee (Project #2021/222).

Context

HeadtoHelp was introduced in September 2020 in the state of Victoria, in response to extensive stay-at-home lockdown restrictions. Funded by the Australian Government, it represented a new model of care in which people contacted a single, central intake line and, following assessment of their needs, were connected to existing services or received care in-person or via telehealth at one of 15 new HeadtoHelp hubs. Data for this evaluation were collected between May and November 2021. Three lockdown periods occurred during the data collection period, with the most significant spanning 77 days (5 August – 21 October 2021). During these periods, people were encouraged to access mental health care via telehealth, but in-person, face-to-face services were permitted in cases of urgent care where telehealth was not deemed to be clinically appropriate.

Sampling and recruitment

Potential participants were all people who had completed a HeadtoHelp intake assessment between September 2020 and August 2021 and provided consent to be contacted (excluding those requiring acute services) as well as informal support people who had contacted HeadtoHelp in relation to mental health issues being experienced by a family member or friend. Potential participants were invited to express their interest in participating in an interview with the research team. A total of 3911 invitations were sent via text message from HeadtoHelp in May 2021 (for those accessing HeadtoHelp between September 2020 and March 2021) and September 2021 (for those accessing HeadtoHelp between April and August 2021). Those interested submitted an Expression of Interest (EOI) directly to the independent researchers either online or via phone or email. A total of 386 EOIs were received.

Maximum variation sampling (23, 24) was then used to select participants to obtain diversity in characteristics including age, gender, cultural and linguistic background, area type, service received, and service satisfaction. Selected participants were contacted by researchers via telephone, provided with an information sheet and given an opportunity to have any questions answered. Participants were selected and interviewed in batches until data saturation was reached; that is, when additional interviews were not generating new concepts and existing categories were well understood. A total of 119 potential participants were contacted of whom 78 provided written or verbal informed consent. The option for providing verbal consent was offered if potential participants found it to be more convenient; potential
participants may not have had access to, or be familiar with the technology required to give an electronic signature, and posting paper forms back to the research team may have been time consuming or inconvenient to participants. The ethics committee approved this procedure for gaining consent.

Data collection

In-depth, semi-structured interviews were conducted to explore participants’ unique perspectives and experiences (Rubin, 2005). All interviews were conducted by videoconference or phone, depending on the preference of each participant, and ranged in length from 16-110 minutes (mean = 40 mins), depending on how much the participant wished to share. Each interview was audio-recorded with participants’ permission and transcribed verbatim for detailed analysis. An interview guide was used flexibly to focus on issues of concern to participants. People were asked broad, open-ended questions about their experiences of accessing and receiving services from HeadtoHelp, such as “What would you say is the best thing about HeadtoHelp?” and “Are there things you didn't like or found frustrating about HeadtoHelp?” Probes were used to clarify the mode of service received (i.e., face-to-face or telehealth) and how people felt about that if relevant to the interview and not spontaneously mentioned.

Data analysis

Data were analysed as soon as possible after each interview to allow researchers to explore aspects or topics raised by earlier participants in more detail in subsequent interviews and to inform decisions about when data saturation had been reached. Interview data were analysed using constant comparative analysis, a systematic and well-regarded qualitative analysis method (25, 26). Transcripts were inductively coded line-by-line. Coding is the process of defining what is happening in the data by giving a short name to small parts of the transcripts that represent a particular idea. Each new chunk of data was compared to previous data and existing codes to determine whether the underlying concepts were the same or different. If different, a new code was generated. Codes were then compared to each other to group similar codes together into higher level categories and to identify the relationships between the codes. This type of analysis ensures concepts that emerge are grounded in the data rather than influenced by pre-existing ideas, increasing credibility of the findings by ensuring that they represent participants’ responses. Ongoing reflexive discussions in regular meetings within the research team ensured consensus on the interpretation of data. Having researchers with lived experience of mental health issues provided rigour, helped ensure that the analyses faithfully represented participants’ views and added depth and richness to the interpretation of data. NVivo qualitative data analysis software was used to facilitate data management and coding. This paper reports on the codes related to people’s experiences and preferences around face-to-face and telehealth services.

Results
A total of 78 people were interviewed, of whom 60 reported receiving a mental health service. The remainder were referred to another provider or did not progress beyond the initial call. Forty-five people who received services commented on their preferred service delivery mode. It is the experiences of this sub-group of participants that we are reporting on in this paper. Their demographic and program involvement characteristics are provided in Table 1. Quotations below are attributed by participant number and identified as people who accessed mental health services (A); informal support people (I), and those who identified as having both roles (AI).

Of the 45 people in our sample, 21 participants said that they preferred in-person services, 16 said that they preferred telehealth services, and 8 described merits of both modes of service delivery and appreciated a combination. Figure 1 describes participants’ preferences for in-person or telehealth services according to the service mode received. Those with direct experience of telehealth services were more likely to express preference for telehealth services in the future.

Figure 2 presents data on the preferences for in-person or telehealth services for the subset of participants who received telehealth services, according to the type of telehealth services they received, either via telephone or videoconferencing. While numbers are small, a higher proportion of people who had experienced videoconferencing compared to telephone only preferred it or liked a combination.

Reasons for preferred service delivery mode

Preference for in-person services

Participants who said they preferred in-person services described a range of reasons. The most common was the belief that personal human contact and connection was superior in in-person settings (n = 16). This was often described as related to personality and general preference, with some expressing the belief that their communication style did not suit telehealth formats.

*I'm not a person to talk to a machine or a program, you know. I like to be with people...I don't see the person I'm talking with, and the reaction is different when you are face-to-face.* (A43)

Four participants indicated a belief that face-to-face, in-person contact allowed clinicians and people accessing their service to better read each other’s facial and body language cues, which some believed
were particularly important for people commencing therapy for the first time.

I guess the face-to-face is probably even better. The counsellor can see our facial expressions, and you can read a bit about a person’s facial expressions at times. (A44)

One participant expressed the belief that group formats were not possible online. Another participant’s preference for in-person services appeared to be attributable to the clinician’s lack of skills with the format, rather than the format itself.

I hated it. It was so impersonal. It was just awkward and awful...It was just terrible because she had noise in the background. Her cat kept coming on the computer and it was so unprofessional. (AI35)

Other reasons for preferring in-person services included discomfort with using the telephone in everyday life (n=3); the privacy enabled by in-person services conducted outside the family home (n=1); the opportunity to get out of the house (n=1); a parent’s belief that telehealth services are inappropriate for school-aged children (n=1); and the advice of a clinician that in person services were more beneficial (n=1).

Preference for telehealth services

Participants who preferred telehealth services or a combination described a range of benefits of telehealth, predominantly the convenience (n = 14), for example, being able to access services despite busy work schedules and family responsibilities, and not needing to travel.

I think it was really good for me personally, just because [I’m] pregnant and then having a young toddler already, it was good to just be able to [use] the speaker over the phone or zoom. Having multiple options rather than rushing around and trying to find care for my baby. And then having to worry about leaving the house late and things like that. (A25)

Telehealth services eliminated the need to travel to access services, which was particularly important for those with mobility issues, those who relied on public transport, and those who lived in rural communities.

The clinic is a bit far from my house and I was working during that period so it’s a bit far for me to spend two hours on public transport. (A38)

Six of these participants also talked about feeling more emotionally comfortable and psychologically safer with telehealth as they were able to access services from home.

I felt a bit more comfortable at home with my family. And I had my animals there as well, which they’re kind of my other support network. (A15)
I don't have to stress myself out about going into an appointment and having to front up to somebody when I'm not feeling really well. I can be at home comfortable on my couch while I'm talking about the things that are difficult for me. It was a much less confronting experience. (AI4)

Three participants reported that they or their loved one were more able to be open and honest with telehealth. They said they were better able to focus on the objective of the telehealth session rather than being preoccupied with managing the interpersonal aspects of the interaction.

I think being on the phone was actually easier than him having to go in face-to-face for an appointment. I think for him, it was just that separation, perhaps not feeling as necessarily judged because you don't have that person in front of you, watching you as you're talking. He found it really, really good. (AI4)

When I know that I'm having a bit of an emotional day I'd prefer over the phone so that when I start crying I can mute myself and I can just get myself together. (A9)

Six participants highlighted the reduction in waiting times and immediate access to services facilitated by telehealth services, particularly during times of lockdown and for those living in rural and regional areas. Other reasons for preferring telehealth services less frequently cited included enabling access to services in their mother tongue (n = 1); and the ability to “multitask” during telehealth sessions (n = 1). Only three participants overall mentioned encountering occasional technical difficulties with telehealth, none of whom preferred face-to-face service overall.

Preference for a combination of service types

Participants who valued a mix of service types (n = 8) suggested that different formats may suit different people at different times. One participant summed it up this way:

On the phone it works quite well for my lifestyle, but face-to-face is nice sometimes too because you get to see them. But yeah, I liked having the blend. (A14)

Discussion

In this study, we examined people’s experiences of accessing a new mental health service during the COVID-19 pandemic in Victoria, Australia. Those who provide services have generally assumed people prefer in-person services and that telehealth services should only be offered as an option of last resort (27). While our evaluation partners reported from their consultations with service providers that many felt clients mostly preferred in-person services, this did not seem to be borne out by what we heard from participants in the study (27). Of participants who expressed a preference, just over half preferred telehealth or liked it as an option. Reasons for this preference included beliefs in the convenience of telehealth and the access it facilitated to necessary services. Others noted that they felt more comfortable and safer, and could express themselves more openly in telehealth services, which also challenged the belief of the inherent superiority of interpersonal interactions conducted in-person. Telehealth delivery of
mental health services therefore appears to have potential application beyond providing access for people in regional and remote areas, or solely in pandemic situations. Rather, it appears that many people accessing mental health supports regard telehealth as a legitimate service option. The option of telehealth may appeal to people who are reluctant or unable to access face-to-face services, potentially contributing to narrowing the gap between the number of people who would benefit from mental health support and the number of people currently accessing it (22).

Current indications suggest that the widespread use and uptake of telehealth related to COVID-19 has brought changes which are likely to be sustained beyond the end of COVID-19 public health restrictions (9). Despite some ongoing reservations, mental health practitioners express an intention to continue using telehealth for mental health service delivery beyond the end of COVID-19 (17, 28). Our findings suggest that this development is likely to be well-received by many people accessing mental health help as it offers enhanced choice and access exceeding that achievable via in-person services alone. Individual models of telehealth can be developed to reflect the specific needs and preferences of people accessing services, such as where telehealth service will be accessed from, whether inside or outside of the family home, whether video functionality will be utilised, and whether and how frequently in-person sessions will augment telehealth via hybrid models of service delivery. Since many people value having at least some in-person interactions with service providers prior to engaging in telehealth (29), hybrid models that combine both modes of service delivery may in particular be highly acceptable.

Telehealth delivery of mental health services also provides enhanced opportunities to extend the reach of service providers and help to ensure that resources are more fully and equitably utilised across geographic areas. Telehealth may help to overcome the challenge of matching people who have unique needs to clinicians with requisite skills and attributes living in different geographical areas. Such needs may relate to culture, language, age, gender or additional diagnoses such as autism or intellectual disability. Strict, state-based geographical approaches to service provision employing rigid criteria related to location may therefore become increasingly obsolete as services move to harness the benefits of telehealth in facilitating increased access and choice.

In our study, acceptability of telehealth appeared to increase with direct experience of telehealth services, with those with direct experience of telehealth more likely to prefer telehealth services in the future. While it is possible that this was at least partly due to people with positive perceptions of telehealth being more likely to receive telehealth services, previous research supports the notion that the acceptability of telehealth services increases with experience (14, 30). Findings in our small sample suggest that experience of videoconferencing rather than telephone may be especially effective at promoting positive views of telehealth. Further, some participants' comments about the limitations of telehealth relating to non-verbal communication and incompatibility with group-based formats appear to reflect the receipt of telephone-based services rather than videoconferencing, which can both allow some non-verbal communication and enable group-based sessions. It is unclear whether these participants would express similar beliefs regarding services provided via telehealth formats such as videoconferencing which enable face-to-face and group-based contact. Conversely, some participants experienced the lack of
visual input in telephone interactions as a benefit, highlighting the need for individuals to be provided with choice and a flexible trial and error approach where people lack experience with telehealth. A small number of participants indicated that they were deterred from engaging with telehealth either due to the lack of skill or the advice of service providers. This suggests a need for a greater understanding of the impact of service provider skills with, and attitudes towards, telehealth on the experiences and preferences of those accessing telehealth services. These findings also indicate that ongoing support and training will be required to ensure clinicians have the necessary strong professional skills required to deliver telehealth services that not only are effective, but that strengthen the beliefs of those accessing support in its suitability for them as they commence telehealth services for the first time (14).

Given increasing evidence of its value, telehealth should be a crucial consideration in the development of future mental health service models. Rather than viewing telehealth as an addition to or needing to fit within existing models, therapeutic environments should be developed to foster good telehealth arrangements and offer support to both those who access services and those that provide them to feel safe and comfortable with telehealth.

Limitations

Several limitations to this study should be considered. The participants were drawn from a population of people with mental health concerns who did not require acute care, but whose needs were also likely to be too complex to be adequately addressed by a general practitioner or minimal counselling support, the so-called "Missing Middle" (27). Further research is needed to understand to what degree the current findings apply to other diverse groups. Further, we sought to understand participants’ experiences of telephone or videoconferencing for service provision using interviews that were conducted using these same mediums. Thus, it is possible that those with the most negative attitudes towards telehealth may not have volunteered for the study. Finally, experiences and attitudes towards telehealth were not the primary focus of the larger study, so data saturation was not based on telehealth-related categories. Even so, we were able to capture a range of perspectives on telehealth and in-person services which provided sufficient coverage of the relevant issues.

Conclusions

The COVID-19 pandemic experience has profoundly shifted the ways in which health services, including mental health, are delivered. Service providers are now more clearly able to determine the potential of telehealth for expanding choice and equalizing access across vast geographical distances, without the fear of sacrificing quality of care or satisfaction. Whilst in-person services will always have an important and fundamental role in models of care, the current findings add to the growing evidence that telehealth should be included in flexible suites of service delivery options that ensure person-centred care.

Abbreviations
Expression of Interest (EOI)

Participants who had accessed mental health services (A)

Participants who identified as informal support people (I)

Participants who had accessed services themselves as well as identifying as informal supports (AI)

Declarations

Ethics approval and consent to participate

Ethical approval for the research was received from The University of Sydney Human Research Ethics Committee (Project #2021/222). Written or verbal consent was received by all participants. The option for providing verbal consent was offered if potential participants found it to be more convenient; potential participants may not have had access to, or be familiar with the technology required to give an electronic signature, and posting paper forms back to the research team may have been time consuming or inconvenient to participants. The ethics committee approved this procedure for gaining consent. The participant information statement and consent form provided to each participant included a clause stating that results of the study would be published, but that publications would not contain any identifiable information about participants.

Consent for publication

Not applicable

Availability of data and materials

The raw data are not available to members outside the research team as this is what was agreed to in the participant consent documents.

Competing interests

The authors declare that they have no competing interests.

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Authors’ contributions
AH led the study and conceptualised this paper. SW, KW, HG, and RB interviewed participants. All authors participated in coding or review of codes and identification of key topics and themes. AH and MH led the data analysis, verified themes and drafted the manuscript. All authors provided feedback on drafts and approved the final manuscript.

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References


Table

Table 1: Demographic and access data
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1Languages included Sinhala, Somali, Bengali, Thai, Cantonese, Filipino dialect, Arabic, Spanish, Serbian, Italian and Turkish

Figures
Figure 1

Preference for in-person or telehealth service by service received

- Received in-person only (n=12)
- Received telehealth only (n=17)
- Received in-person + telehealth (n=16)

**TELEPHONE ONLY (N=18)**
- 6 Saw benefits in both/liked combination
- 6 Preferred telehealth
- 6 Preferred in-person

**VIDEOCONFERENCING (N=12)**
- 3 Saw benefits in both/liked combination
- 7 Preferred telehealth
- 2 Preferred in-person
Figure 2

Preference for telehealth or in-person services by mode of telehealth experienced