Virtual Youth and Family Engagement Program for Adolescents who Receive Outpatient Mental Health Services: Qualitative Evaluation

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Abstract

Background: Incidents of depression, anxiety, and suicidal ideation among adolescents have increased in recent years. Mental health interventions tailored to adolescents and families need to consider mechanisms for increasing enrollment and sustaining program engagement. A telephone-based, health coach intervention for adolescents and families was implemented at a southeastern U.S. health system with the goals of improving psychiatric appointment attendance, medication adherence, reduction in ED visits, and assisting with crisis management ("Youth and Family Engagement" program; YFE).

Objective: This qualitative evaluation explored perceptions of the YFE program, experiences working with health coaches, suggestions for program changes, and program goals.

Methods: Semi-structured interviews were conducted with adolescent patients (N=9), parents (N=11), and clinicians who placed patient referrals (N=6). Interviews were in English (N=19) or Spanish (N=7 parents), depending upon participants' preference. The data was analyzed using inductive coding methodologies, with thematic analysis employed to organize emergent themes. Two qualitatively trained researchers, one bilingual in English and Spanish, facilitated all data collection and collaboratively performed data analysis.

Results: The YFE program's structure was often mentioned as promoting engagement, with telephone appointments and health coaches' ability to accommodate inflexible work/school schedules alleviating participation barriers. Skills learned from health coaches were frequently referenced, with adolescents generally citing internal processes, such as positive thinking and mindfulness. Parents discussed behaviors relative to their child[ren], such as improvements with discipline, setting boundaries, and improved parent-child communication. Many participants discussed the importance of health coaches assisting families in navigating social systems, such as accessing resources (e.g., housing) and navigating school processes (e.g., IEPs), with clinicians suggesting an increased emphasis on adolescents' nutrition and engagement in primary care. Spanish-speaking parents highlighted numerous advantages of working with bilingual health coaches, emphasizing both enhanced communication and cultural understanding. They specifically noted the coaches' ability to grasp their lived experiences and challenges as immigrants in the U.S., which significantly enriched their participation in the program.

Conclusions: Prioritizing convenient engagement for adolescents and families may be important for sustained program participation, as inflexible schedules and competing priorities pose barriers to traditional appointments. Future programs should carefully consider health coach-participant relationships, specifically cultural competency, providing services in native languages, and assisting families with wraparound care, as these may be crucial to sustained engagement.

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A Qualitative Evaluation of a Virtual Youth and Family Engagement Program for Adolescents who Receive Outpatient Mental Health Services

Abstract

Background: Incidents of depression, anxiety, and suicidal ideation among adolescents have increased in recent years. Mental health interventions tailored to adolescents and families need to consider mechanisms for increasing enrollment and sustaining program engagement. A telephone-based, health coach intervention for adolescents and families was implemented at a southeastern U.S. health system with the goals of improving psychiatric appointment attendance, medication adherence, reduction in ED visits, and assisting with crisis management (“Youth and Family Engagement” program; YFE).

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Keywords: virtual care, telemedicine, adolescent, mental health, psychiatry

Introduction

There is clear evidence of a growing mental health crisis among youth ages 10-24 years. Suicide rates among this age group increased 52.2% between 2000-2021, making it the 2nd leading cause of death among this age group and accounting for 15% of all suicides [1]. Even prior to the COVID-19 pandemic, studies noted a significant increase in anxiety and depression, with a 27% and 24% increase in anxiety and depression respectively between 2016-2019 [2]. The COVID-19 pandemic further exacerbated this crisis, with evidence of increased difficulties with schoolwork, emotional abuse, physical abuse, and food insecurity among youth [3]. Pooled estimates during the pandemic suggest a doubling of clinically elevated anxiety and depression symptoms among youth [2], along with a rise in eating disorders and self-injurious behaviors [4, 5].

Various digital mental health interventions have been developed to address the growing mental health needs of adolescents [6, 7]. As digital connectivity continues to expand, virtual engagement with mental health services provides multiple benefits, such as improved accessibility, cost effectiveness, increased flexibility, and reduced stigma for patients [8, 9]. There is evidence that youth exhibit a higher level of comfort and satisfaction with receiving treatment through technology platforms when compared to previous generations, including their parents [9, 10]. Studies have shown that clinicians are able to establish similar rapport and therapeutic alliance with youth and their families through virtual mental health services, due to increased client vulnerability when behind a screen [12, 13]. One study even suggested the possibility of developing stronger rapport virtually due to clients feeling more comfortable and vulnerable when behind a screen [12]. Virtual delivery of mental health services also allows for greater connectivity to patients' families, as clinicians are able to see patients in their home environments, which is particularly important in the youth population [12].

Using a virtual mental health coach is one of the various forms of digital mental health interventions that have been developed [14, 15]. Mental health coaching offers accountability and support, while self-pacing and flexibility allow individual needs to be met [15, 16]. Patients appreciate the comfort and convenience of web- and/or telephone-based mental health interventions, and although technical issues can be common, they are often manageable [15, 16]. Several studies have demonstrated the effectiveness of virtual mental health coaching at improving mental health symptoms and overall quality of life [14, 17, 18]. Whereas most of the current literature on virtual mental health coaching focuses on adult populations [14-19], this qualitative study evaluates a telephone-based mental health coaching intervention for adolescents and their families.

We employ qualitative methodologies to assess the effectiveness of the Youth and Family Engagement program (YFE), specifically highlighting the factors that impact participant enrollment, sustained engagement, and patients' and parents' overarching experiences in the program. Building upon the limited previous qualitative research exploring virtual mental health interventions for adolescents [16, 20], this study captures patient, parent, and clinician feedback. Exploring the facilitators and barriers to program enrollment and engagement, this study also examines cultural and language barriers, an aspect that has received limited attention thus far in the literature on virtual mental health interventions [16].

Methods

Intervention

The YFE program is a telephone-based, health coach intervention tailored to meet the needs of adolescents and their families who need additional help (e.g. access to food, housing, etc.) or adolescent patients who could benefit from case management. The program goals include improving adolescent patients' psychiatric appointment attendance and medication adherence, while reducing ED visits and assisting with crisis management (e.g., suicidal ideation). The YFE program was implemented in Winter 2022 at a large, academic learning health system (aLHS) in the Southeastern U.S. All adolescent participants in the YFE program receive mental health services through the aLHS, regularly meeting with a counselor, therapist, and/or psychiatrist, which can occur in either outpatient or school-based settings. YFE referrals are placed by patients' clinicians via the electronic health record (EHR), with YFE staff enrolling interested patients and families. Once in the YFE program, patients independently meet with health coaches biweekly, while parents have monthly meetings, which occur for the duration of the 6-month program. One of the two health coaches is bilingual, and services are in either Spanish or English, depending upon the preferences of patients and families.

Study Design, Setting, and Participants

From July to October 2023, we conducted semi-structured telephone interviews with adolescent patients (N=9) and parents (N=11) that participated in the YFE program, as well as video interviews (Microsoft Teams) with clinicians that placed program referrals (N=6). All participants were referred by YFE program staff, with the project team conducting recruitment outreach to explain the purpose and scope of the project and to schedule interviews. All participants provided verbal consent prior to being interviewed. Patients and parents were interviewed separately. This project was approved and deemed quality improvement by the Wake Forest University School of Medicine Institutional Review Board (#IRB00088503). We followed the COnsolidated criteria for REporting Qualitative research (COREQ; Appendix 1) [21].

Data Collection

Of those referred, semi-structured interviews were completed with 9/16 patients (56%), 11/12 parents (92%), and 6/6 clinicians (100%). While we were successful in interviewing most of the individuals referred, scheduling conflicts and an inability to connect by telephone hindered the recruitment of some potential participants, particularly among adolescent patients. Interviews lasted between 15-30 minutes, with all patient and clinician interviews being conducted in English, while 7/11 parent (64%) interviews were in Spanish. Semi-structured interview guides were collaboratively developed by the team (Appendices 2-5), which included researchers trained in qualitative methods and who had expertise in adolescent mental health. Interview guides explored participants' perceptions of the YFE program, experiences working with health coaches, suggestions for program changes, and program goals. Demographic characteristics were obtained from the EHR and via pre-interview questionnaires to provide descriptive information about participants (Table 1). Two researchers with graduate-level training in qualitative methodologies, one a bilingual female and one male, performed all data collection and analysis (AR and JK).

Analysis

Semi-structured interviews (N=26) were audio recorded, transcribed verbatim, de-identified, and analyzed using ATLAS.ti software [22]. Inductive coding methodologies were employed to capture emergent themes in the data, with thematic analysis strategies used to systematically organize data [23]. The project team collaboratively developed a codebook, which included eight parent codes and twenty subcodes, that AR/JK then used to independently code the same three transcripts (>10%). Any discrepancies were reconciled, and the codebook was refined as necessary, with the remaining transcripts being independently coded by either AR/JK. Questions that arose during analysis were presented to the wider team for review. Our sample size was sufficient to reach thematic saturation. Participants did not assist with data analysis, interpretation of findings, or transcription verification processes, as these were handled by the study team.

Results

Sample

Interviews were conducted with 26 participants – 9 patients, 11 parents, and 6 clinicians. All patient and clinician interviews were conducted in English, while most parent interviews (7/11, 64%) were conducted in Spanish. Patients were demographically diverse across sex (5 female, 4 male), race (3 Black/AA, 3 White, 1 American Indian or Alaskan Native), and ethnicity (4 Hispanic, 4 Non-Hispanic), with an age range of between 11-18 years (mean 13.4 years). Participating parents were mostly female (9/11, 82%) and Hispanic (8/11, 73%), with an age range between 31-48 years (mean 39.5 years). All clinician participants were non-Hispanic females; however, they were diverse across race (3 White, 2 Asian, and 1 American Indian or Alaskan Native), clinical role (3 psychiatrists, 3 therapists), and years of clinical practice, which ranged from 10 to 21 years (mean 14.8 years). Further demographic data can be found in Table 1.

Table 1. Participant Demographics and Characteristics.

	Adolescent Patients	Parents	Referring Clinicians		Parents
Language for Interview				**Education**	
English	9 (100%)	4 (36%)	6 (100%)	Less than HS	3 (27%)
Spanish	0 (0%)	7 (64%)	0 (0%)	HS Diploma	4 (36%)
				Some College	2 (18%)
Mean Age (in Years)	13.4 range 11-18	39.5 range 31-48		Associates Deg.	1 (9%)
				Declined	1 (9%)
Mean Years in Practice			14.8 range 10-21		
				Employment	
Sex				Full-Time	7 (64%)
Female	5 (56%)	9 (82%)	6 (100%)	Part-Time	2 (18%)
Male	4 (44%)	2 (18%)	0 (0%)	Not in Labor Force	2 (18%)
Race				Unemployed	0 (0%)
American Indian or Alaskan Native	1 (11%)	0 (0%)	1 (17%)		
				Living Situation	
Asian	0 (0%)	0 (0%)	2 (33%)	Steady Place	7 (64%)
Black or African Amer.	3 (33%)	2 (18%)	0 (0%)	Steady Today, but Worried	4 (36%)
White	3 (33%)	2 (18%)	3 (50%)		
Other	0 (0%)	6 (55%)	0 (0%)	No Steady Place	0 (0%)
Two or More Races	0 (0%)	1 (9%)	0 (0%)		
Declined	2 (22%)	0 (0%)	0 (0%)		
Ethnicity					
Hispanic	4 (44%)	8 (73%)	0 (0%)		
Non-Hispanic	4 (44%)	3 (27%)	6 (100%)		
Not reported	1 (12%)				
Adolescents' MH Services					
Counseling					
In-School Only	4 (44%)	2 (18%)			
External to School Only	4 (44%)	7 (64%)			
Both In-School and Ext.	1 (12%)	2 (18%)			
Medication Management					
In-School Only	0 (0%)	0 (0%)			
External to School Only	0 (0%)	4 (36%)			
None	9 (100%)	7 (64%)			
Self-Reported Health					
Excellent	4 (44%)	0 (0%)			
Good	3 (33%)	6 (55%)			
Fair	2 (22%)	4 (36%)			
Poor	0 (0%)	1 (9%)			
Mental Health Position					
Outpatient Psychiatrist			3 (50%)		
School-Based Therapist			3 (50%)		

Themes

When qualitatively analyzing our interview data, several themes emerged about participants' experiences in the YFE program, including (1) the convenience of virtual appointments, (2) the importance of health coaches providing effective and tailored support to meet participants' needs, (3) the capacity of health coaches to teach participants key mental health skills, (4) improved parent-child communication, (5) and the benefits associated with partnering Spanish-speaking participants with bilingual health coaches (Table 2). Further, we identified suggestions for the expansion and improvement of our virtual mental health program with health coaches (Table 3).

Table 2. Perceptions of the YFE Program: Themes and Illustrative Quotes.

Themes	Illustrative Quotes
Theme 1: Convenience of virtual appointments (e.g., scheduling, telephone, health coaches)	• I think when most people think of therapy, they think of having to drive up to a place and sit there, but really, like I said, the great thing about it is just having the calls and being able to call back. Really, the main pro of it is just convenience. (16, NH-White male patient) • The fact that it is available over the phone not that I'm so busy, but it's just not always a good time for me to be available to come to an appointment so that's really appreciated. It works well for both of us. (47, NH-Black mother) • I think that YFE, having that shifted schedule—because I think they make calls until 7:00 or something like that. I think that's so amazing, especially for this mom that I'm thinking of. She can't always answer the phone during work. A lot of times, it's after work. I think just that flexibility that the YFE Program provides that I can't necessarily provide as a therapist. (NH-White female therapist)
Theme 2: Coaching provides tailored support to effectively address participants' needs.	• My son was going to school since he was seven in a special education school. Then when I got here, they don't have those types of programs. […] That's why I wanted to have more information, and that I can have somebody if I got any doubts, they can guide me and tell me if it is anything else out there that I can do to help him. (37, Hispanic mother) • She [the health coach] started the process of giving me names to find a place like a shelter. [..] That's how I got into Charlotte Family Housing. On top of it, she helped me to get food and stuff like that, so yes. She's been my friend. She's my angel. (46, NH-Black mother) • Yeah, the parent[s], they love talking to [the health coach]. They love—they talk about the support. It's a nice bridge, yes. I think it's been a huge resource. As far as what I heard from the parent, it's been a massive resource for them. (NH-White female therapist)
Theme 3: Health coaching equips participants with key mental health skills.	• Yes, she says to spend more time together, if she wants to go to the gym to let her go, cook together, watch a TV show together, go for walks. All that would help our father/daughter relationship […] everything she said we should do, it all worked. (36, Hispanic father, Spanish-speaking) • Yeah, so my health coach, really, we like to emphasize positive thinking and doing what you can with what you have. […] Look at the variables that you can control, and fixing those, but the things that you cannot control, not worrying about them. (16, NH-White male patient)

Theme 4: Improved parent-child communication	• Well, the first goal was when we had—because when we started going to Atrium because of her suicidal attempt and stuff, it was basically parent and child conflict […] When [the health coach] started calling me, she was telling me what to say to her. (46 NH-Black mother) • Yes, she says to spend more time together, if she wants to go to the gym to let her go, cook together, watch a TV show together, go for walks. All that would help our father/daughter relationship […] everything she said we should do, it all worked. (36 Hispanic father, Spanish-speaking)
Theme 5: Spanish-speaking participants value bilingual health coaches	• We're all alone in this country and I find the support that you provide super useful. All the emotional support; the fact that they care about them. I think that's super useful. (35, Hispanic mother, Spanish-speaking) • Thankfully, we did not need an interpreter because she speaks my language. She tells me that if I need anything translated, she can do that for me, too. I think that's why I like her so much. (43, Hispanic mother, Spanish-speaking)

Theme 1: Convenience of virtual appointments

A salient aspect of the YFE program that patients, parents, and clinicians pointed out is the convenience of virtual appointments (e.g. scheduling, access to health coaches, etc.). Both parents and adolescent patients underscored the ease and flexibility of reaching health coaches through telephone calls rather than in-person sessions. For example, several parents explained that their work and life schedules can complicate attending in-person sessions, therefore the virtual appointments in the YFE program made their participation easier and, arguably, possible. Students similarly expressed balancing their school schedules and extracurricular activities after school, so they also valued the virtual calls with health coaches. Additionally, one clinician lauded the program's flexible schedule which allowed health coaches to meet with participants after standard business hours. Overall, this virtual aspect of the YFE program helps to provide convenient and accessible mental health support to both parents and adolescent patients.

Theme 2: Coaching provides tailored support to meet participants' needs

A strength of the YFE program is the one-on-one tailored support health coaches provide to participants. Both parents and patients expressed that they valued meeting with their health coaches at the beginning of their time together and identifying goals with the adolescent patients, parents, and health coaches involved in creating their goals during their time together. This tailored support made their sessions more intentional and gave participants clear goals to work towards. For example, a Hispanic mother participated in the program and shared that her key goals in the program were clarity and help in navigating her son's special needs at school. She had recently moved to the area and was unfamiliar with how to help her son in the new school setting. In her case, the health coach was able to provide more information and direct her to the necessary resources. Other parents in the program expressed similar support where their health coach aided them in securing other resources such as access to shelter or food while being friendly advocates for them. Clinicians have similarly observed that health coaches'

tailored support effectively bridges the gap between families and community resources, serving as a crucial source of support for families.

Theme 3: Coaching equips participants with key mental health skills

Both parents and patients have highlighted the transformative impact of health coaching on mental health and well-being, such as fostering stronger relationships and resilience. A common theme among parents is that health coaching strengthens familial bonds between parent and child which leads to noticeable improvements in their relationship. The unique aspect of the YFE program is that health coaches work with both parents and students, meeting with them separately and working on interrelated goals. Patients have also expressed how skills such as positive thinking and proactive problem-solving has empowered them to focus on actionable steps within their control while letting go of stressors beyond their influence, thus promoting mental resilience and self-care.

Theme 4: Improved Parent-Child Communication

Improved parent-child communication is an outcome of the YFE program that we observed. Through personalized guidance from health coaches, parents are equipped with strategies to navigate conflicts and foster understanding with their children. Several parents remarked that their health coaches encouraged them to find shared activities to do with their child as a way to build their relationship such as cooking, exercising, or doing an activity outside. These activities not only strengthen the parent-child bond but also serve as therapeutic tools. Furthermore, several parents remarked that setting intentional time to do an activity together with their child led to improved parent-child communication. These interventions facilitate a supportive environment where adolescents feel heard and valued, ultimately enhancing their mental well-being.

Theme 5: Spanish-speaking participants value bilingual health coaches

Bilingual health coaches for Spanish-speaking participants, especially parents, is crucial in programs such as the YFE program. Spanish-speaking parents expressed the value of emotional support, enhanced communication, and cultural understanding that came from working with bilingual health coaches. One Hispanic mother highlighted the significance of feeling supported and not alone in a foreign country, emphasizing the usefulness of such bilingual support. Another mother appreciated the ability to communicate directly with her health coach in her native language, eliminating the need for an interpreter and fostering a deeper connection. These experiences underscore the pivotal role that bilingual health coaches play in providing culturally sensitive and effective support, which enhances the accessibility and effectiveness of mental health services for Spanish-speaking families.

Suggestions for Change:

In analyzing our data, several valuable insights and suggestion emerged for enhancing program effectiveness such as (1) video and facetime expansion for health coach meetings, (2) flexible program duration and health coach meeting intervals, (3) expanded program content, (4) increased emphasis on connecting patients with PCPs and mental health care, and (5) expanding recruitment efforts to target schools with lower socio-economic status (SES). Drawing from these key suggestions and quotes (Table 3), we share actionable

recommendations that may benefit similar programs:

Table 3: Suggestions for YFE Program Changes.

Suggestions	Illustrative Quotes
1: Video and facetime expansion for health coach meetings	• The only thing I could think of would be home visits, because in the two cases, one was disabled. Both of them did not have transportation. I know it's just on the phone, but they're people that have difficulty connecting and establishing rapport, so I think a face-to-face type situation where someone went to them might be good. (NH-White, female, licensed social worker) • [Health Coach] told me that the next call they were going to use a video call, through Zoom and that is very good, honestly. Because you interact much better like this. To be in a video call and know who you are talking to. (34, Hispanic father, Spanish-speaking) • I would usually prefer in-person, but Zoom could probably work too. […] I'm usually used to in-person since I used to always do it in person. Normally now I just do virtual just like phone. […] People would probably mostly like in-person because you wouldn't know their face, and you would probably want to know them. (13, NH-White female patient)
2: Flexible program duration and health coach meeting intervals	• [LONGER] It really depends on the issue that you're having, but I'm just unsure about the time limit [6 months], I guess. I feel like it could be longer. Some people probably need longer than that to talk when they're getting out of a rough spot, and some people may not need that much. I think just putting a timestamp on that isn't really the best way. (16, NH-White male patient) • [SHORTER] I feel like shorter, maybe a couple months but I feel like six months is a lot. (14, female patient)
3: Expanded program content (e.g. bullying, nutrition, etc.)	• Something that helps me with that bullying thing so it's not the same this year. […] I would say that providing better opinions to my son. […] Because of all that he's been going through. To make it different; giving him advice. (31, NH-White mother) • If there was more health coaching in terms of diet and nutrition, along those lines, and just managing the health of kids, that would be important. […] People with lower socio-economic status have higher risk of childhood obesity and stuff like that. (NH-American Indian, female psychiatrist) • Any type of liaisoning with schools, because a lot of these kids have trouble both at home and at school. A lot of the

	stress and trouble seems to happen with school. I don't know how much they help the families navigate some of that. […] More behavioral. The behavioral, emotional concerns that arise with school. (NH-Asian, female psychiatrist)
4: Increased emphasis on connecting patients with mental health care and PCPs	• Expanding it to make sure, 'hey, are they getting primary care checkups,' and really that case management through a lens of mental health. I just think that's really cool. (NH-White, female therapist) • There's one I'd say probably has some medical issues. They need to make sure they're getting treatment and following up with their primary care doctor. (NH-American Indian, female psychiatrist) • With the program, what exactly are they hoping to accomplish from this? If it is to get connected with therapy, I think they need a different referral-coordination process because I don't think that that's happened with some patients. (NH-Asian, female psychiatrist)
5: Recruitment efforts to include other school officials/leaders and target schools with lower SES	• I'm really excited for them to expand to getting referrals from the school. […] The school counsellors obviously can't see their notes, but I just think in terms of connecting with the community and getting more people into these types of things. That's so helpful. My hope would be that type of thing can help get some of those kids before they fall through the cracks. I'm excited for the growth and expansion and everything it can do. (NH-White, female therapist) • My other school is certainly—it's a Title 1, low-income school, and I think there's more of a need there. […] The families are a little more high-need, that I'm thinking more of how the YFE Program could be beneficial if the parents on board and the kids on board. (NH-White, female therapist)

Suggestion #1: Video and Facetime Expansion for Health Coach Meetings

Although most participants valued the telephone calls with health coaches, clinicians, parents, and patients all mentioned expanding beyond telephone meetings with health coaches, whether in-person or video sessions. One parent expressed excitement over incorporating video calls with his health coach since it will let one know who "you are talking to." Although video or in-person sessions may not work for every participant, we suggest other programs consider expanding their virtual meetings with health coaches. Embracing video platforms could facilitate the connection between participants and health coaches and increase rapport and engagement. This face-to-face interaction can be especially impactful for participants with transportation challenges or difficulty in establishing rapport over the phone.

Suggestion #2: Flexible Program Duration and Health Coach Meeting Intervals

Parents and patients come to mental health programs with a range of needs that may require

different levels of support. For example, in our evaluation, some adolescent patients wanted to focus on exercises to better control their emotions while other families were working through pressing issues such as finding stable housing or helping their child through suicide ideation. Given these diverse needs, we strongly encourage flexibility in program duration and the frequency of meeting intervals to better address parent and/or patient needs. Some families may necessitate longer-term support beyond the standard six-month timeframe, while others may benefit from shorter-term support to meet their needs. Also, some families may benefit from meeting more frequently with health coaches beyond the standard monthly meeting for parents and biweekly meetings for adolescent patients. For example, one parent remarked that their child does not like to talk, so meeting less frequently would be more beneficial. Meanwhile, another parent observed that her child is going through more peer pressure at school so meeting more frequently with her health coach would help her at school. Therefore, assessing parent and patient needs and determining program duration and meeting interval frequency should remain flexible and open.

Suggestion #3: Expanded Program Content

The YFE program currently focuses on supporting the behavioral health of adolescent patients alongside parents. Moving forward, we advocate for a more holistic range of topics to be addressed within the program such as bullying, nutrition, and school-related stressors. A broader range of topics will enrich program experiences and better address the needs of adolescent patients. Furthermore, we also suggest increased behavioral health support for parents. Several parents shared that having someone to candidly discuss their parenting experiences in a non-judgmental space meant a lot to them and even gave them the confidence to move forward in parenting an adolescent child. Therefore, cultivating more space for parents to honestly share their experiences may prove fruitful to other programs. Increased program content around behavioral health and emotional support can increase program effectiveness, especially for vulnerable populations.

Suggestion #4: Increased Emphasis on Connecting Patients with Mental Health Care and PCPs

Given the rapport that is built between health coaches and participants, there is a strong potential for connecting participants with primary care providers (PCPs) and mental healthcare services. For example, ensuring participants are getting primary care checkups if a medical issue is discussed or helping make a referral if there is a need for a therapist. Doing so would ensure comprehensive patient care beyond the telehealth program.

Suggestion #5: Recruitment efforts to include other school officials/leaders and target schools with lower SES

Given the pervasiveness of mental health issues like anxiety and depression among adolescents, a program such as YFE will be beneficial to many. However, in our evaluation, the YFE program was especially impactful to families navigating several social stressors such as migration, language barriers, special needs support, unstable housing, etc. Therefore, expanding recruitment efforts by connecting with school officials and leaders, especially at schools with lower socioeconomic status (SES), can help families who most need our resources and support. By partnering with school counselors and actively doing outreach in underserved communities, we can identify and support adolescents and families who may benefit from

additional support.

In conclusion, by implementing these suggestions for change, telehealth mental health programs for adolescents can enhance accessibility, flexibility, and effectiveness, ultimately improving outcomes and advancing the well-being of young patients facing diverse mental health challenges.

Discussion

Principal Results

This study contributes to the literature on telehealth programs, specifically related to mental health, by qualitatively examining key themes that impact patient experiences. Results from this study may help providers interested in programs that use health coaches or virtual health programs tailor inventions that increase patient care. Our key findings were as follows: (1) participants and clinicians valued the convenience of virtual appointments; (2) health coaches provide tailored support to meet the needs of patients and parents; (3) coaching equips participants with key mental health skills such as positive thinking and proactive problem-solving; (4) there is value in a program that works with parents and children and can lead to improved parent-child communication; and (5) bilingual and bicultural health coaches can enhance accessibility and effectiveness of mental health services for Spanish-speaking patients.

Additionally, we highlight suggestions for change from our program which may be useful to similar programs. Actionable recommendations from our work were the following: (1) Video and facetime expansion for meetings to facilitate stronger connections between patients and health coaches; (2) flexible program duration and tailoring the timeframe of the program can better meet the diverse needs of patients; (3) addressing a broad range of program content can enrich the program experience for patients; (4) connecting patients with mental health care and primary care providers (PCPs) can ensure that patients receive support beyond the telehealth program; and (5) expanding recruitment efforts to involve school officials and leaders, in particular in schools with lower socioeconomic status, can increase the reach of similar telehealth programs.

Limitations

A limitation of our evaluation is selection bias. Our interview sample was composed of parents and patients involved in the program and referred to the evaluation team by health coaches. These participants were more likely to have the time and motivation to participate in interviews about their program experience. These factors may contribute to more positive experiences with the YFE program. Furthermore, this was not a randomized study, nor did we have a control group to compare program experiences of those who dropped out of the YFE program. Nevertheless, our qualitative evaluation provided descriptive details of participants' experiences with the YFE program and suggestions for change which may be helpful to providers and researchers interested in telehealth programs and interventions.

Conclusions

In this evaluation, we identified key themes and suggestions for improving a telehealth mental health program for adolescents. The themes underscored the convenience of virtual appointments, the tailored support provided by health coaches, the acquisition of essential mental health skills,

enhanced parent-child communication, and the value of bilingual health coaches. These findings offer valuable insights for similar programs seeking to enhance effectiveness and accessibility. Looking ahead, our suggestions for change can help other telehealth programs better meet the diverse needs of patients and improve outcomes in virtual healthcare programs. Moving forward, further research on similar topics is warranted to continue advancing the field and refining telehealth interventions for mental health.

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Conflicts of Interest

None declared.

Multimedia Appendix 1

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Supplementary Files

Multimedia Appendixes

Consolidated criteria for reporting qualitative research.
URL: http://asset.jmir.pub/assets/28bd3c0e3d6a8a078865cb6c5cb3c56b.docx

Patient interview guide.
URL: http://asset.jmir.pub/assets/f1301d5f663b43d4ad3a14b107dfd619.docx

English parent interview guide.
URL: http://asset.jmir.pub/assets/20c6040c3117b38be133335f69299eef.docx

Spanish parent interview guide.
URL: http://asset.jmir.pub/assets/ae0e8a724ceb44488c93c72801e22b19.docx

Referrer interview guide.
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