Appendix E: Raw Data long responses and comments from the electronic survey described in Chapter 4.

Question 3: Uses for videoconferencing

Please click on the purpose (s) for which you most frequently use videoconferencing technology within a mental health related role.

Other Option [Other]

Psychotherapy research
Interview portion of neuropsychological assessment; training mental health generalists in brain injury issues
Rural link with a taskforce project based in Perth
research
Discharge planning/Review Board Hearings
Intake/case allocation meetings
daily
Clinical review meetings weekly
Monthly journal club
Urgent triage assessments
Psychiatrist -use extensively for al aspects of work including over 3000hrs of direct clinical work
Reviews of Community Treatment Orders with the Mental health review Board, identified client present
patient reviews with the Mental Health Review Board
court liaison

(Note: All respondents' answers are presented as written/submitted in original survey)

Question 4: Approaches that work

If you have used videoconferencing for a psychological intervention or psychotherapy, what model or approach have you found most successful? (e.g. manualised CBT)

No.	Data
1	manualised CBT; individualised (non-manualised) CBT; schema-focused therapy; hypnosis
2	Manualized CBT in research protocol
3	
4	Manualized CBT for BN
5	Psychoeducation, supportive pstx for pts; case supervision and education for PCPs.
6	NA--I use vtc for training of professionals and neuropsychological assessment interviews only.
7	
8	N/A
9	
10	
11	safety assessment, CBT, DBT, crisis intervention, mental state assessment
12	assessment
13	
14	narrative, CBT, general counselling
15	mindfulness based CBT (Clients), supervision- person centred model
16	v/c used mainly foe assessments not psychotherapy
17	CBT-but need to have worksheets faxed ahead of time; have used behavioural intervention with parents but only after an initial face-to-face consultation
18	No I have only used in clinical setting for assessment of clients with psychiatrist
19	CBT programme offered by SCSEP (Dr Claire Rees)
20	all limited due to low technology -i.e. delayed transmission. Need real-time transmission-broadband or fibre optic speeds to not be distracting
21	general supportive psychotherapy; had registrar undertaking CBT

22	
23	
24	Haven't used VC to provide treatment
25	
26	
27	
28	
29	CBT
30	cbt for obesity
31	
32	medication management
33	Solution Focused, Brief Therapy
34	

(Note: All respondents' answers are presented verbatim)

Question 5: Approaches that don't work

What model or approach have you found least successful when used in videoconferencing compared to face-to-face consultations? Please describe in the box below

No.	VERBATIM RESPONSES
1	EMDR - haven't found a way of doing this yet by videoconferencing, although I'm sure we will find a way (maybe using a light strobe)
2	
3	
4	NA
5	None.
6	psychotherapy among older adults with dementia. I tried this work and quickly abandoned it because patients found it too disorienting.
7	
8	N/A
9	
10	
11	AIA - especially with technical problems
12	
13	
14	play, art and physical therapies; more difficult with younger children
15	DK as yet
16	
17	doesn't work with younger children (primary age and under)
18	generally if you stay with clients during VC there are little or no problems
19	it's not so much the model it's the technologies that fails at times
20	as above - not sure if this question is about the intervention per se or the technology. Face-to face is best - video is more impersonal therefore less effective
21	nil. One needs to make adaptation to work via video, often using a case manager at the other end and best if other worker face-to-face. Ideally work should be a mix of face-to-face and video(though not essential) but need a good ide of location.
22	
23	

24	Haven't used VC to provide treatment
25	
26	
27	
28	
29	? play therapy
30	none as it is equal
31	
32	N/A
33	Psycholanalysis, some aspects of CBT
34	

Question 6: Necessary changes

What modifications to your usual approach or work practices have been necessary in a videoconferencing medium, compared with face-to face consultations? (e.g. greater time required for session preparation?) Please describe in the box below .

No.	VERBATIM RESPONSES
1	Need to be more organised and email/ send handouts in advance. Use of document camera is useful for discussing formulations, thought diaries etc during sessions. More time is definitely needed for preparation of sessions, especially allowing a few minutes at the start for the initial link-up.
2	
3	
4	None
5	Collateral info in advance; increased use of non-verbal gestures.
6	does not require more prep time, but does require more schedule time (i.e. need to arrive early to establish connection), need to allow for time to reach the teleconferencing site, etc. Also need to speak at a lower rate, with more clear diction, and must look at CAMERA, not patient, to simulate eye contact. More info given on medium.
7	More planning and bookings.

	Room needs to be appropriately set up - lights,background etc.
8	On-going education in how to 'dial-up' and whose resposability it is to dial-in i.e receiver or service provider (educator)
9	
10	
11	good collateral Hx, identified support to reaffirm plans
12	increased prep time, increased awareness of clarity of speech and non-verbal cues, impact of "extras" - eg. Excessive furniture, décor that distracts attention from focus of the interaction
13	learning new technology and rectifying problems to ensure clear communication before a meeting can commence
14	increase in session preparartion time organising the switching on of the remote site and setting up the equipment
15	prepare by emnail interaction before hand; increased session preg email as link between sessions
16	booking v/C in advance; flexibility with assessments if v.c. link fails
17	I spend more time warming up a client to establish a connection. Most other things are the same. More preparation ahead of time - just in case info needs to be faxed etc.
18	email or fax information as needed
19	when technology fails we use the telephone to carry on with clinical discussions
20	really only useful foe assessments or urgent reviews - not ideal for personal counselling as yet. Good for tribunals and panel reviews (CTO board, state admin - i.e. administrative processes. OK for learning/teching use
21	be aware of time delays in the conference and explain to patient and adapt. Understand the geography issues as may be very different to city issues etc
22	planning time -booking appointments and participants. Ensure introductions are clear and state purpose of session. Distributing paperwork prior to starting VC
23	
24	getting the equipment to work properly
25	Haven't used VC to provide treatment

26	Preparation of client and families. Time spent in familiarising consumers to building where conference housed and process involved. At present case manager manages connection to gain access to MHRB rather than joint action. Feels empirical.
27	
28	Need more time - takes longer for educational concepts to be covered Greater time for session preparation
29	
30	lighting, sound, booking equipment
31	None explaining confidentiality and layout of home site- eg who else is in the room.
32	more time needed to gain rapport
33	None other than the camera equipment
34	Technology Preparation, Fluency of communication is slower, there is less scope to accelerate or slow the momentum of therapy, particularly relating to discussing emotions and feelings.

Question 7: Differences

What are the main differences (if any) between videoconferencing consultations and face-to face consultations? Please describe in the box below.

No.	VERBATIM RESPONSES
1	Clients tend to feel less intimidated, less pressured, and often comment that they like having more personal space and control (than they would on a face-to-face basis in a therapist's office). With high quality videoconferencing you still feel that you can have a good level of eye contact and both verbal and non-verbal communication. With low bandwidth there is more necessity to allow for sound delays, more problems with lip synchronisation, and often a less clear image. Although there are differences in communication and the therapeutic relationship, I would not say that it is any better or any worse than face-to-face - just different.
2	
3	
4	None
5	T: inability to do physical examination; harder to detect negative symptoms (eg, schizophrenia); more effort to connect with pt at beginning of session.
6	Fewer words per minute from both patient and provider. Numerous technical problems and line disruptions, even on dedicated lines. conversation is more focused, with fewer nonessential comments. VTC is somewhat stilted compared to F2F, but is better than driving 2 hours for a clinical visit. When in group/family, you may not pick up on all participants. Body language is very important in MH which will be much less on VC. Attitude to not having a 'real' counsellor.
7	
8	Adjusting to the time gap between communication and not having full body posture (communication) present.
9	I have found meetings with a number of people attending in each office to be very difficult but a one to one session may be different
10	Organizational issues. There is some variation in the 'doing' of health which requires different resources to schedule, set up, etc.
11	rapport more readily established via face-to-face
12	none if working well
13	if connection is good, no difference; if connection is bad, conversation is disjointed and picture unclear

14	depending on the clarity of the bandwidth (i.e.IP or ISDN), visual assessments, eye contact and affect can be hard to see and assess. MSE very difficult in the first instance
15	the human element of proximity, i.e. capacity to reach out, the other cues such as fine motor somatic responses, "mirroring".critical trauma experiences I have felt some sense of helplessness in not being with the client
16	rapport establishment harder, frequent interruptions due to equipment/connection problems e.g. freezing --> patient frustration
17	can't give tip sheets etc., on the spot, harder to see interactions between family members. I feel the level of discolsure very similar. Harder to console an upset adolescent - but can be done
18	face to face is always the preferred option! More personal. Less "strange" for clients that haven't used VC before
19	face to face much preferre , but due o the vastness of an area, VC is a second option. VC seems impersonal at times and clients /families find it strange talking to a screen
20	less nuances detected in video - due to lack of detail with closeup and broadband - high speed this may improve
21	the voice delay. Can be out of touch with the local area. Developing language that covers being at patients location but not being there
22	videoconferencing is one dimensional and doesn't provide the opportunity for accurate assessment of the patient
23	
24	tendancy for there to be a lapse between speech and hearing the sound on the teleconferencing.
25	Haven't used VC to provide treatment Consultations remain somewhat broken and not smooth i.e. movement and sound not concurrent - development of technology.
26	Personally took a long time to feel moderately relaxed during consult feels more like an interview.
27	You need to be more engaging, more dynamic. Turn-taking occurs and is a useful aspect of VC because people tend to listen more carefully and also think more about their responses
28	Less interaction during videoconferencing, tend to keep conversations brief
29	very few. it is a suitable medium in the absence of face to face services
30	rapport takes 1-2 sessions longer to build
31	loss of subtle nuances in mental state examination.Worse vision- cannot pick up neurological side effects as easily. Safer- cannot be hit
32	None
33	The initial motivation and 'investment' that the client places on therapeutic change.
34	More considered questions and answers, more emphasis on turn-taking

Question 8: Advice

What advice would you give practitioners who are intending to use videoconferencing as a regular component of their practice? Please describe in the box below.

No.	VERBATIM RESPONSES
1	Don’t expect everything to run smoothly from the start. It takes time to set up a new clinic and to sort out logistical issues. Ensure that clients have access to tissues and a note book at the remote site. Block book sessions with different locations to avoid problems with double bookings or having to chop and change with calls. It is important to ensure that all users have training in the use of equipment and supervision in its use. It is also worthwhile to have a technician on hand to sort out hitches with ISDN lines etc.
2	
3	Attention to camera placement/suicidality backup
4	Get training on interviewing with it, how to enhance communication and understand its limitations.
5	Make sure you use high enough bandwidth (i.e. at least 384 kbit/sec), and accept that there will be technical glitches. Have a backup phone contact plan with the patient in case the equipment or line goes down. Know about privacy issues and encoding standards for VTC. Accept that it is not the same as F2F and get over the limitations, unless you want to drive or have your patient drive to make contact. Invest in cameras that can be controlled from the provider end. Enjoy being on the bleeding edge!
6	Consult with participants well in advance.Be concise and explain the process in user friendly talk. Do not have outside interruptions in the room. Be attentive to all participants. Have facility prepared in good time. Ask for feedback on this medium and how the participants would make any changes. This medium will need to be selective on participants, depending on MH diag. Make the room comfortable and not too clinical. If possible bring participants in for a 'dummy run'.
7	Use regularly if possable, perhaps connect with other rural outreach centre's for social interaction. Thus familiarising and getting comfortable with this form of communication
8	Ensure that you have adequate technology. Fuzzy pictures or sound or drop outs are very frustrating
9	
10	use it regularly
11	practice with a colleague first; knowledge of the equipment and most effective use of same; backup plan in case of failure
12	to look at monitor when speaking; speak clearly and concisely. If asking a question be aware sometime time delay in response

13	learning V/C etiquette and proper machine operation as a part of service orientation. Practice, practice practice
14	Initially the "idea" of teleconferencing computers had a more mechanised feel. Once I had a shift in attitude away from the interface more towards the client focus of one:one face:face, I felt much more connected. Being tolerant of technical glitches, see it as part of the process.
15	accept interruptions
16	If possible have an initial face to face consultation. Have some technical support at the other end. Have a fax at other end so info can be sent immediately. Spend more time easing a client into and out of a session.
17	always make sure booking is done. Check equipment prior to time booked
18	check bookings first. Turn equipment on 10 minutes prior ti using
19	not for intial assessments or engagement -if you know the client and they know you and are comfortable; it may be better. Younger people appear more able to accept VC interventions than older persons
20	visit area. After a while it will become a normal part of work and can adapt. It becomes very normal.
21	assessments via videoconferencing are useful in an emergency but should be interspersed with face-to-face assessment for routine management. Not all patients respond well to being assessed by videoconference so this needs to be considered
22	
23	get another job
24	Haven't used VC to provide treatment
25	Keep practising as familiarity assists in accepting this style of communication. For the younger practitioners, is there any difference between this and a web cam, except the picture is clear!?
26	
27	Become familiar with the technology so that you can focus on the person at the other end. Be natural. Know that a real connection is absolutely possible.
28	Preparation before the session starts is essential.
29	don't be shy pre-plan don't be limited by the lack of face to face
30	that it is equally effective
31	use it- the clinicians are usually more concerned about the technology then the patients
32	Develop a clear-cut set of protocols before starting.
33	To use it in adjunct to face-to-face consultation (if possible)
34	You will learn to rely on dfifferent sensory modes and you can still make excellent connections with people despite the technology