Transitioning to Telehealth for COVID-19 and Beyond: Perspectives of Community Mental Health Clinicians

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Abstract

In response to COVID-19, mental health clinics transitioned to telehealth to maintain psychotherapy delivery. Community mental health (CMH) settings, which are often under-resourced, likely experienced many barriers. This study examined CMH clinicians' experiences transitioning to telehealth. Data came from a state-funded initiative training CMH clinicians in cognitive behavioral therapy. Participants (N = 197) completed pre-training and post-consultation surveys which included questions about their experiences with telehealth. Most clinicians found telehealth beneficial and effective. Clinicians strongly endorsed wanting telehealth as an option even after in-person services

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resume. CMH clinicians rated "engaging younger children" as the most significant barrier to telehealth. Despite some telehealth barriers, clinicians generally viewed telehealth favorably and prefer having it as a long-term option. Future work should continue to understand when telehealth may be advantageous and for whom in order to improve the accessibility and quality of behavioral health services.

Due to the COVID-19 pandemic and its resulting safety guidelines, mental health care settings had to rapidly transition to telehealth to maintain access to psychological services. Telehealth refers to delivering health care services remotely via electronic systems and telecommunications technology.[1] Delivering evidence-based treatments (EBTs; e.g., cognitive behavioral therapy (CBT)) via telehealth has a robust evidence base across various modalities (e.g., phone or videoconferencing), mental health conditions, and age groups, but has infrequently been used as a primary modality of delivering care pre-COVID-19.[2–4] Further, the literature suggests that delivering EBTs via telehealth has been found to be feasible, acceptable, and cost-effective, while resulting in treatment outcomes comparable to those of in-person therapy.[3,5]

Despite the effectiveness and efficiency of utilizing telehealth, transitioning from delivering EBTs in-person to telehealth requires various supports (e.g., technology support, financial resources, organizational implementation models), and some systems may experience greater challenges than others in their transition. This could be because of limited resources, the populations they serve (e.g., their access to and proficient use of virtual or internet-based methods), or some combination of both. Community mental health (CMH) clinics, serving children and adolescents, are settings likely facing many of these challenges, compared to medical centers and private practice settings, given their more limited resources, focus on individuals who are under-insured, are uninsured, or have public insurance, as well as possible difficulties engaging children in virtual therapy sessions.[6]

A growing body of work has examined medical centers and private practice clinicians' experiences transitioning to telehealth, revealing that clinicians were successfully able to transition to telehealth, received adequate and timely training, and were satisfied with telehealth.[7,8] However, to the authors' knowledge, very little is known about CMH clinicians' experiences transitioning to telehealth, particularly for those that serve children and adolescents. The goal of this study was to describe CMH clinicians' perspectives on transitioning to telehealth due to COVID-19 as well as their initial challenges to delivering an EBT via telehealth.

Methods

Participants are CMH clinicians who were part of a Washington State-funded EBT training initiative called CBT + .[9] Clinicians participating in CBT + were trained in cognitive behavioral therapy for youth with depression, anxiety, trauma impact, and behavior problems. Five 3-day, in-person trainings took place across Washington State (October 2019–February 2020). After training, clinicians completed 6 months of twice-monthly video or phone-based group consultation with an expert consultant. To receive a completion certificate, clinicians must attend the in-person training, attend 9 of 12 consultation calls, present one case on a consultation call, and enter deidentified data online for cases in which CBT + was used for consultant review.

All participants completed a pre-training survey ($N = 197$), and 92.9% ($N = 183$) completed a post-consultation survey. Data were collected from September 2019 to September 2020. The pre-training survey included demographic and background information. The post-consultation survey included questions about clinicians' experience and use of telehealth.

In the post-consultation survey, clinicians were asked about their experience with and use of telehealth. Specifically, clinicians were asked if telehealth was offered by their organization, the percentage of their client caseload that used video in telehealth, approximately what date their organization switched to the use of telehealth, what types of training/ongoing support were available to clinicians, and whether they felt telehealth therapy was beneficial. Clinicians were also asked to rate a list of 11 barriers (e.g., engaging younger children in treatment) from 0 (not a barrier at all) to 10 (a very significant barrier). This list of barriers was derived from a review of the literature and expert opinions (i.e., CMH clinicians and researchers). Lastly, clinicians were asked to rate their agreement with 8 statements assessing their experience with telehealth (e.g., I believe telehealth sessions can be an effective way to deliver therapy) from 0 (strongly disagree) to 5 (strongly agree). See Table 1 for a full list of items given to assess clinicians experience with and use of telehealth. Study activities were determined exempt from review by the University of Washington Institutional Review Board. Analyses were conducted using R version 3.6.2. Descriptive statistics were calculated to summarize clinicians' experiences with telehealth.

Results

Participants were predominantly White (70.1%, $n = 138$) and female (74.6%, $n = 147$), and reported that their most advanced degree was a master's degree (96%, $n = 189$). Other participants' most advanced degrees included a bachelor's or doctoral degree. Half noted cognitive-behavioral as their primary theoretical orientation (50.8%, $n = 100$). Participants, on average, were 35.92 years of age ($SD = 10.57$), delivered psychotherapy for 3.61 ($SD = 4.15$) years, and had an active client caseload of 29.22 ($SD = 18.25$).

The majority of the clinicians' organizations offered telehealth services to their clients (92.9%, $n = 183$), which consisted of the use of either video and/or audio platforms. Most clinicians received telehealth training and ongoing support from their organization (69%, $n = 136$). Overall, most clinicians found the use of telehealth beneficial (78.2%, $n = 154$) and effective. Importantly, clinicians, on average, highly rated wanting telehealth as an option even after their organization is able to provide in-person services ($M = 3.98$, $SD = 1.18$). Table 1 summarizes clinicians' degree of agreement to statements describing their experiences using telehealth to provide psychotherapy.

The most endorsed barrier to telehealth was engaging younger children ($M = 8.03$, $SD = 2.63$), followed by youth not being able to talk freely while participating in therapy from their home ($M = 6.60$, $SD = 2.68$). However, clinicians did not find engaging caregivers to be a very significant barrier ($M = 5.27$, $SD = 2.54$). The least endorsed barrier to telehealth was clinicians' organizations' inability to provide a work device to deliver virtual psychotherapy ($M = 2.85$, $SD = 2.96$). Table 1 summarizes clinicians' ratings of potential telehealth barriers.

Discussion

Telehealth is a tool that was essential at the start of the COVID-19 pandemic to deliver psychotherapy when in-person services were unavailable, but has shown promise that it can make EBTs more accessible and their delivery more feasible and acceptable. Clinicians in CMH reported finding delivering CBT via telehealth beneficial and effective, which is consistent with telehealth's evidence base.[3,5] Further, clinicians wanted to continue using telehealth even when in-person services become

Table 1

Community mental health clinicians' perspectives on transitioning to telehealth (N=183)

Barriers transitioning to telehealth	M (SD)	Experiences with telehealth	M (SD)
Engaging younger children in treatment	8.03 (2.63)	When my organization is able to provide in-person mental health therapy again, I would still want to have telehealth sessions as an option for some clients	3.98 (1.18)
Youth being able to talk freely while participating in therapy from their homes	6.60 (2.68)	I believe telehealth sessions can be an effective way to deliver therapy	3.93 (0.97)
Client access to internet or technology to engage in telehealth	5.96 (2.71)	I can still provide effective CBT treatment for a CBT+target (depression, anxiety, trauma, etc.) through telehealth sessions	3.92 (0.83)
Incorporating handouts/worksheets in session (e.g., emailing/mailing, screenshare)	5.89 (2.80)	I can still provide effective assessment through telehealth sessions	3.86 (0.93)
Issues with the technical performance (sound and/or video) of the software used for telehealth	5.34 (2.91)	Children/youth are less engaged in telehealth sessions than in-person therapy sessions	3.79 (1.01)
Engaging caregivers in treatment	5.27 (2.54)	In your view, in comparing telehealth to in-person therapy, establishing and maintaining a therapeutic relationship is harder	3.75 (0.74)
Conducting initial clinical assessments that meet organization requirements	5.17 (2.81)	It takes longer for me to prepare to deliver a telehealth therapy session than an in-person therapy session	3.25 (1.10)
Administering and using standardized assessments	4.49 (2.74)	Caregivers are less engaged in telehealth sessions that in-person therapy sessions	2.98 (1.02)
Finding a confidential space in *your* home to deliver telehealth sessions	4.04 (3.10)		
Consenting clients for telehealth delivery	3.85 (2.65)		
Organization could not provide you with a work phone, laptop, or other needed device; had to use personal equipment	2.85 (2.96)		

M, mean; *SD*, standard deviation

available in their organization. Telehealth may offer certain benefits that in-person services do not. While clinicians were not directly asked to report advantages of telehealth over in-person psychotherapy, this study's findings suggest that telehealth, for the most part, did not seem to drastically inhibit clinicians' ability to provide effective services. For example, even though clinicians found preparing for telehealth sessions to be slightly more time-consuming compared to in-person, they still reported being able to deliver effective assessments and CBT treatment for youth via telehealth.

While clinicians had favorable views towards telehealth, they also endorsed certain barriers. The most significant barrier was engaging younger children (i.e., not adolescents) in treatment — a barrier that has been commonly documented in the literature.[10,11] In-person sessions provide an opportunity for therapy sessions to be more engaging and interactive in ways that may not be possible via video or phone. Children's engagement in therapy is one factor that can contribute to successful treatment outcomes, and thus, it could be useful to identify potential solutions and strategies to better engage young children via telehealth. A systematic review of virtual psychotherapy studies found that many studies used website interventions, games, apps, and virtual reality experiences to engage children in telehealth psychotherapy.[12] While clinicians found engaging younger children in telehealth psychotherapy a significant barrier, clinicians did not find engaging caregivers in treatment a significant barrier. In fact, they found caregiver engagement via telehealth to be comparable to if not slightly better than in-person therapy. Research suggests that caregiver involvement in psychotherapy has been linked to greater improvements in child mental health outcomes,[13] and therefore, this study's findings point to telehealth as a potential medium to increase caregiver engagement, which could in turn improve child clinical outcomes. Thus, studying ways to increase caregiver engagement through telehealth deserves as much attention as increasing child engagement.

Clinicians also endorsed other, less frequent barriers. For example, clinicians found youths' ability to talk freely via telehealth to be a somewhat significant barrier. Due to the pandemic forcing many families to work from home and limit recreational activities outside the home, limited space or privacy may be exacerbated during the period of data collection. Additionally, families receiving care in CMH may be experiencing economic stress and reside in homes with more limited options for children to have a private room or space to speak with their therapist. Thus, youth may have a limited sense of privacy and feel less able to open up freely. Another theme of clinician-noted barriers includes technology-specific barriers (e.g., client technology access and clinician technology troubleshooting). Other studies have similarly found that while technology can improve the accessibility of treatment, it does pose these aforementioned challenges, which can potentially be overcome by technology support provided by organizations and alternating between telehealth and in-person psychotherapy.[8,14,15] In the future, it is likely that more organizations will offer both in-person and telehealth psychotherapy services. Allowing families to choose the modality that fits their needs may alleviate some of the barriers to telehealth services while also increasing access for families who would find in-person services burdensome. Research and practical guidance will be necessary to appropriately tailor service modality to meet families' needs.

There are some limitations to this study. First, it only focused on CMH clinicians' transition to telehealth and not their experiences months or a year after their transition, when barriers may have been overcome. While this limits the clinicians' reported experiences to the *time of transition*, it is crucial to understand CMH clinicians' experiences during that time as it offers a unique window into the rapid uptake of a new practice. Second, this study may have limited generalizability due to its smaller sample size and lack of clinicians' demographic diversity. Third, the sample represents clinicians from one state which adopted multiple evidence-based community health COVID-19 policies. This may be important to consider as different states adopted a range of policies in response to the pandemic, which influenced both the need to transition to telehealth services and the support received to do so. Last, the measures of clinicians' perceptions of telehealth mostly included Likert scale surveys which can be limiting and lack rich details. It would have been beneficial to

have other forms of data collection (e.g., follow-up qualitative interviews) that would complement the quantitative measures and provide more in-depth content.

Implications for Behavioral Health

To the authors' knowledge, this study is one of the first to examine CMH clinicians' experiences transitioning to telehealth to deliver behavioral health services in response to COVID-19. Despite experiencing some telehealth barriers (e.g., engaging younger children in therapy), clinicians generally viewed telehealth favorably and found some benefits over in-person behavioral health services (e.g., engaging caregivers in treatment). Notably, clinicians would like to continue having telehealth as a long-term option. Future work should examine CMH clinicians' perceived telehealth experiences beyond the transition period. Specifically, it is important to assess the sustainability of delivering behavioral services via telehealth since most clinicians would like to have telehealth as an option moving forward. One challenge that CMH settings may experience in sustaining telehealth services post-pandemic is the ability to continue to bill for telehealth services, which varies by both state and insurance type—particularly given the diversity of patient population in CMH settings. Thus, it is imperative to consider and address this potential challenge. Moreover, future work should continue to understand when telehealth may be advantageous and for whom in order to improve the accessibility and quality of behavioral health services. Continuing to offer telehealth services in conjunction with in-person services may allow families to receive behavioral health services that best support their needs and resources.

Declarations

Informed Consent Informed consent was acquired from all study participants.

Conflict of Interest Dr. Dorsey has received honoraria and consultancies for Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) in addition to grants funding research on TF-CBT. Moreover, WA DBHR paid Dr. Dorsey and Ms. Berliner to provide training, consultation, and evaluation as part of this study. The other authors have no conflict of interest.

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