The Benefits and Challenges of Shifting to Telehealth During COVID-19: Qualitative Feedback from Kentucky's Sexual Violence Resource Centers and Children's Advocacy Centers

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Abstract

The onset of the COVID-19 pandemic presented novel challenges for service providers addressing mental health issues with a large shift to the utilization of telehealth. While previous research has examined the benefits and challenges of providing mental health and crisis services remotely through telehealth, little research exists examining the use of telehealth in children's advocacy centers (CACs) and sexual violence resource centers (SVRCs). CACs and SVRCs are multi-disciplinary agencies taking a holistic approach to addressing interpersonal violence, making them unique in that they provide a range of direct services beyond mental health counseling (e.g., legal advocacy, medical exams, and prevention education) but all geared toward public health and safety. The current study explored the experiences of direct service providers in Kentucky CACs and SVRCs and their opinions about the most significant challenges and benefits of adapting their practices at the onset of the COVID-19 pandemic. A total of 118 providers participated in the study, and 88 reported using telehealth (defined as communicating with clients via technology such as videoconferencing, phone calls, or email) since the onset of COVID-19. Qualitative data from those 88 respondents regarding the challenges and benefits of using telehealth were collected and coded using a thematic content analysis. 78.6% of the sample indicated that they served primarily rural areas. Benefits noted included increasing treatment access, increasing treatment flexibility, and advancing continuity of care, while challenges included difficulties with technology, client engagement, privacy, and logistical challenges. Responses highlighted that telehealth presented both a number of advantages and difficulties and that more formal guidance for providers at CACs and SVRCs was desired.

Keywords Telehealth · COVID-19 · Trauma · Child advocacy centers · Sexual violence resource centers · Rural

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Introduction

Interpersonal violence is a serious social problem throughout the world with various negative consequences for individual life and functioning (Centers for Disease Control and Prevention, 2019; Devries et al., 2013; Pemberton & Loeb, 2020). Interpersonal violence may be physical, sexual, or psychological, and may also include neglect and deprivation of basic human necessities. Some known negative outcomes of interpersonal violence include increased susceptibility to all forms of health problems, disruption in family functioning, and negative economic impacts at the societal level (Krug et al., 2002; Mercy et al., 2017).

Two of the main program models for addressing interpersonal violence in the USA are sexual violence resource centers (SVRCs) and children's advocacy centers (CACs). SVRCs, traditionally referred to as rape crisis centers,

support survivors of sexual violence with services such as advocacy, accompaniment to medical exams or meetings with law enforcement, education and prevention services, counseling services, and referrals (Kentucky Association of Sexual Assault Programs, 2022; National Sexual Violence Resource Center, n.d.). Children's advocacy centers (CACs) address all types of child maltreatment, including but not limited to sexual abuse, through a range of services such as forensic interviews; advocacy; coordination with law enforcement, the courts, child protective services; and mental health counseling for children and their families (Children's Advocacy Centers of Kentucky, 2020).

Kentucky has 15 CACs and 13 SVRCs, including 2 programs which provide both CAC and SVRC services. Kentucky holds the unfortunate distinction of having one of the highest rates of child abuse in the USA, holding the top place for 3 years and most recently being ranked fifth (United States Department of Health & Human Services, 2022).

The COVID-19 pandemic initiated clear increase in use of telehealth to provide health-related services and in more diverse settings. For the purposes of this study, telehealth is defined as communication between providers and recipients of healthcare using technology such as video conferencing, phone calls, or email. Healthcare includes services related to physical and emotional well-being provided by a professional and can include the array of services provided in SVRCs and CACs (e.g., mental health counseling, advocacy, education and prevention services, and crisis services).

A variety of possible challenges to the use of telehealth have been noted in previous research by both individual service providers and recipients of this modality. These include issues with technology, client engagement and professional boundaries, privacy and safety, accurate assessment, and difficulties for providers due to the nature of remote work (e.g., lack of child care). Technological concerns include poor or non-existent internet access which may be either related to poverty or rurality (Gerber et al., 2020; Hardy et al., 2021; Lieneck et al., 2020; McKenny et al., 2021; Stewart et al., 2020), client lack of access to, knowledge about, or comfort with technology (Gerber et al., 2020; Lieneck et al., 2020; McKenny et al., 2021; Mishna et al., 2021a; Perry et al., 2020), and costs and logistical challenges for providers of managing information technology (Canady, 2020; Holland et al., 2018). Existing literature cites potential barriers to establishing rapport with specific groups such as young children (Hoffnung et al., 2021; Moorman, 2021; Racine et al., 2020), older adults, individuals with social and communication difficulties, and those whose religious beliefs may prohibit use of certain technologies (McKenny et al., 2021; Mishna et al., 2021a). Questions about efficacy for those with substance use disorders, developmental disabilities (Schoebel et al., 2021), and those with trauma backgrounds who experience dissociative

symptoms (Racine et al., 2020) are also raised. Some providers also expressed concern that clients would have poor compliance with homework or follow-up tasks between meetings or lack adequate support outside of the provider's physical office (Schueller et al., 2016).

Previous research also highlights potential boundary issues caused by reduced formality when providers may be providing care from settings other than an office space, ethical dilemmas related to client safety, confidentiality, and cyber security (Hardy et al., 2021; McKenny et al., 2021; Mishna et al., 2021a; Perry et al., 2020; Simpson et al., 2020). Being unable to observe things like hygiene issues (Holland et al., 2018), facial cues and nonverbal cues, or signs of maltreatment (Cruz et al., 2021; Hardy et al., 2021; Moorman, 2021) are some of the challenges raised about provider ability to accurately assess a client's status via telehealth.

Finally, previous studies have identified how providing telehealth services may uniquely affect providers in adverse ways. Fatigue from using technology to communicate, isolation from coworkers, difficulty with time management, and challenges with training and supervision guiding the use of telehealth implementation have been raised as concerns (McKenny et al., 2021; Mishna et al., 2021a, b).

Benefits to Providing Telehealth

Benefits of providing services through telehealth discussed in existing literature include advantages for both recipients and providers of services (e.g., Craig, 2021; Moorman, 2021; Racine et al., 2020; Stewart et al., 2020). Benefits to recipients focus on improved accessibility and convenience while benefits to providers expand beyond convenience to include new opportunities for assessment and interventions, improved work efficiency, and income stability (Gray et al., 2015; Titov et al., 2019; McKenny et al., 2021; Perry et al., 2020; Simpson et al., 2020).

Telehealth's impact on expanding equitable access to services is seen not just as pragmatic but also a justice issue for human service professionals (Garfin, 2020). Telehealth services potentially expand access for individuals from rural areas who may face multiple barriers to access related to geographic isolation (Gray et al., 2015; Holland et al., 2018; Racine et al., 2020; Titov et al., 2019). Remote services also decrease costs associated with transportation, child care, and time off work to attend appointments (Moorman, 2021; Racine et al., 2020; Stewart et al., 2020) and may improve access to services for those who avoid or have limited options for in-person care due to stigma (Craig et al., 2021; Moorman, 2021). Telehealth also potentially increases access for certain groups such as teens (Moorman, 2021), veterans (Perry et al., 2020), and those whose capacity to seek care outside of their home may be limited by physical or emotional ability

(e.g., those with significant physical limitations or those with extreme anxiety) (Dorsey & Topol, 2016; Schoebel et al., 2021; Titov et al., 2019). Additional benefits for service recipients include the opportunity to receive services in the comfort of their own homes where they may feel more relaxed (Simpson et al., 2020). Other benefits of telehealth include positive clinical outcomes, high client satisfaction with services (Gray et al., 2015; McKenny et al., 2021; Schoebel et al., 2021), better rates of attendance, and lower rates of attrition (Moorman, 2021; Stewart et al., 2020).

Some benefits of telehealth exclusive to the pandemic have also been identified in the literature. During the height of the COVID-19 pandemic, many human service offices were closed at least temporarily as a way to minimize disease transmission. Telehealth allowed continuity of care while also protecting public health (Banducci, 2021; McKenny et al., 2021). In addition to protection from exposure to COVID-19, the literature points to other benefits such as seeing and assessing clients in their natural environments, expanded opportunities for intervention, such as real-time exposure therapy (McKenny et al., 2021; Perry et al., 2020; Simpson et al., 2020), and the flexible scheduling (Banducci, 2021; Moorman, 2021).

With fewer missed appointments and lower rates of client attrition, providers using telehealth may experience more efficient use of their time. Additionally, reduced expenses for travel to work, improved work/life balance (McKenny et al., 2021; Racine et al., 2020), and training and supervision opportunities are also cited as potential benefits to providers (McKenny et al., 2021; Perry et al., 2020).

Purpose of the Study

Although past research has examined the benefits and challenges of telehealth, little research exists examining the use of telehealth in CAC and SVRCs. The purpose of the current study was to focus on the benefits and challenges of shifting to telehealth during COVID-19 in Kentucky's CACs and SVRCs. A qualitative exploration of feedback from providers across the state will serve as a catalyst for better understanding the implications of this dramatic shift, while using the words of providers. This study is unique in its examination of service adaptations in the specific settings of CACs and SVRCs as well as its focus on rural service delivery. Existing literature related to practice adaptations during the COVID-19 pandemic is organized around discipline, setting, or treatment modality. In contrast, CACs and SVRCs are organized around the goals of preventing and responding to interpersonal violence. CACs and SVRC service providers represent multiple disciplines (social work, psychology, law, nursing, etc.) providing diverse services (mental health treatment, crisis intervention, forensic interviewing and medical services, legal advocacy, case management, etc.). In addition to the unique challenges of coordinating multi-disciplinary

teams offering multi-modal interventions, Kentucky CACs and SVRCs also operate heavily in rural areas. While a little more than half of Kentucky's residents live in urban areas, approximately 2/3 of Kentucky land is considered rural, and 70% of Kentucky's 120 counties are considered rural (United States Department of Agriculture, n.d.; Kentucky League of Cities, n.d.; Rural Health Information Hub, 2021). In this study, 78.6% of respondents indicated they serve primarily rural areas.

The study will add to the literature by addressing the following two research questions:

1. What were the benefits of shifting to telehealth during COVID-19, as reported by a statewide sample of providers in Kentucky's CACs and SVRCs?
2. What were the challenges of shifting to telehealth during COVID-19, as reported by a statewide sample of providers in Kentucky's CACs and SVRCs?

Methodology

Sample

All direct service providers in Kentucky's CACs and SVRCs were invited to participate in a study examining how they adapted their practices during the COVID-19 pandemic, and 118 responded to the survey. A total of 88 (74.6%) of the 118 respondents indicated that they had provided telehealth services (i.e., communicating with clients via technology for the purposes of client advocacy or therapy) since the onset of COVID-19. There were significant differences ($p < 0.001$) among the respondents who said they provided telehealth and those who did not. The majority of advocates/case managers (70%, $n = 35$) and all therapists (100%, $n = 43$) completing the survey indicated they utilized telehealth while only 40% ($n = 10$) of those who identified their job role as "other" (administration, prevention/education, peer support, etc.) reported using telehealth. The 30 respondents who indicated they did not use telehealth (50% of advocates/case managers ($n = 15$) and 50% of those in other roles ($n = 15$)) completed an abbreviated version of the survey that did not ask specific questions about telehealth. The likelihood of using telehealth between providers serving rural or urban areas was not found to be statistically different ($p \geq 0.35$).

Table 1 provides an overview of relevant demographics broken down by those who participated in the survey overall, those who reported delivering telehealth services, and reporting that they did not deliver telehealth services. With respect to the purpose of this manuscript, a total of 57 of the 88 (64.77%) who provide telehealth services contributed qualitative responses to the research questions. Participants who contributed to the qualitative responses primarily identified as female (96.5%, $n = 55$)

Table 1 Sample characteristics of employees at Kentucky's CACs and SVRCs	Participant characteristics by service delivery type	All ($n = 118$)	TH services ($n = 88$)	Non-TH services ($n = 30$)
	Gender			
	Female	111 (94.0)	83 (94.3)	28 (93.3)
	Male	3 (2.5)	3 (3.4)	0 (0.0)
	Gender variant/non-conforming	3 (2.5)	1 (1.1)	2 (6.7)
	Trans	1 (0.9)	1 (1.1)	0 (0.0)
	Race/ethnicity			
	Non-Hispanic/White	109 (92.3)	83 (94.3)	26 (86.7)
	Black or African American	3 (2.5)	2 (2.3)	1 (1.3)
	Other*	6 (5.1)	3 (3.4)	3 (10.0)
	Role			
	Advocate/case manager	50 (42.4)	35 (39.8)	15 (50.0)
	Therapist	43 (36.4)	43 (48.9)	0 (0.0)
	Other	25 (21.2)	10 (11.4)	15 (50.0)
	Administration	10	6	4
	Volunteer/peer specialist	5	2	3
	Prevention services	4	1	3
	Other specialists	4	1	3
	Outreach	2	0	2
	Education			
	Less than bachelor's degree	15 (12.8)	6 (6.8)	9 (30.0)
	Bachelor's degree	33 (28.2)	25 (28.4)	8 (26.7)
	Master's degree	66 (56.4)	54 (61.4)	12 (40.0)
	Doctoral degree	3 (2.6)	3 (3.4)	0 (0.0)
	Population served**			
	Children 12 and under	68 (26.9)	62 (70.5)	6 (20.0)
	Teens (13–17)	85 (33.6)	71 (80.7)	14 (46.7)
	Adults (18 +)	100 (39.5)	76 (86.4)	24 (80.0)
	Region			
	Rural	92 (78.6)	71 (80.7)	21 (70.0)
	Urban	25 (21.4)	17 (19.3)	8 (26.7)

*Hispanic or Latino, Native American or Alaska Native, Multiracial or Biracial, race/ethnicity not listed, or prefer not to answer

**Many respondents serve more than one population. In order to capture all data, they were asked to select each population served. For this reason, the total number of responses for this question (n) is higher than the number of total respondents for the survey

and non-Hispanic/White (93.0%, $n = 53$). They reported serving in various professional roles, including as case managers/advocates (31.6%, $n = 18$), therapists (61.5%, $n = 35$), and 7.0% served in other roles (e.g., administration, prevention specialist, outreach, etc.), indicating that respondents provided a range of services beyond mental health treatment. They primarily worked in rural areas (80.7%, $n = 46$). Additionally, the participants averaged 37.88 years of age ($SD = 10.82$), 3.8 years of working in their current positions ($SD = 4.4$), and 9.7 years of experience of working in human services ($SD = 6.9$).

Design and Data Collection

An online survey was distributed to collect feedback from a statewide sample of service providers at Kentucky's CACs and SVRCs in July 2021, and data were collected from August to September of 2021. The electronic survey used both open and closed-ended items and was administered through Qualtrics. The current submission examines qualitative responses related to the challenges and benefits of telehealth. Two university Institutional Review Boards approved the study. The research protocol began with an

email to executive directors of the state level CAC and SVRC consortiums. Specifically, the hyperlink for the survey was embedded into an approved email that described the study and how to participate. This email was then distributed by the state consortiums to regional CAC and SVRC executive directors in August 2021. After receiving this email, the executive directors willingly forwarded the IRB-approved emails to all of the direct service providers at each of their member regional agencies across the state (e.g., 13 CACs, 12 SVRCs, and 2 combined CAC/SVRC programs) to provide access to their employees to voluntarily participate in the study. Three weeks later, a one-time reminder email was sent through the same process.

Data Analysis Process

A thematic content analysis was used to analyze the qualitative contributions to the open-text questions (1) "What do you see as the most significant benefits you experienced/experience in providing telehealth?" and (2) "What do you see as the most significant challenges you face/faced in providing telehealth?" To receive these questions in the online survey, respondents had to answer "yes" to the question "Did you engage in telehealth since COVID-19 began? 'Telehealth' means communicating with clients via technology such as video conferencing (Zoom, FaceTime, Spruce Health, etc.), phone calls, or even email focused on client advocacy or therapeutic issues?" The six-phase process of Braun and Clarke (2006) was used, beginning with data familiarization, and then moving through the coding process by identifying and defining themes. Themes were generated inductively, using a data-driven approach (Fereday & Muir-Cochrane, 2006). The research team used investigator triangulation (Carter et al., 2014), as the second and third authors conducted independent reviews following the first author's initial coding to assess for and assure validity. MaxQDAPlus 2020's advanced qualitative data analysis software was used to assist the research team in open coding, line by line, response by response (VERBI Software, 2019). To capture robust contributions, participants were encouraged to provide comprehensive qualitative insight to each prompt with the expectation that this may result in their individual responses contributing to multiple themes. For that reason, the n associated with each theme in the results section reflects the total number of contributions and not the number of individuals who made those contributions.

Results

Conceptually, the qualitative data regarding both benefits and challenges of using telehealth may be regarded as either issues specifically related to the COVID-19 pandemic or issues that relate more generally to the use of telehealth. Issues specific to using telehealth during the pandemic included the benefit of limiting COVID transmission and thus improving public health protection and the challenges of hasty telehealth implementation, which some respondents found stressful or for which they felt ill-prepared. The vast majority of the data seem to relate more to general issues with telehealth that transcend the pandemic. These include but are not limited to aspects such as how telehealth impacts accessibility for various populations (both positively and potentially negatively), impacts of providing telehealth on providers, logistical concerns (e.g., staff training on telehealth, cybersecurity, and technology issues), continuity of care during unusual situations, client engagement and safety, and applying various modalities of treatment in a telehealth setting.

Benefits of Shifting to Telehealth During the Pandemic

Fifty-six participants offered 95 discreet responses to the following open-text item "What do you see as the most significant benefits you experienced/experience in providing telehealth?" Responders to the open-ended questions were more likely to have a graduate degree [X^2 (1, $N = 88$) = 5.6, $p = 0.01$] and to identify as therapists [X^2 (1, $N = 88$) = 10.2, $p < 0.001$] compared to non-responders. Themes were partitioned into 8 categories: (1) increased access for clients, (2) increased sense of safety from COVID-19, (3) increased flexibility, (4) continuity of care, (5) creativity and innovation in service delivery, (6) positive impact on the provider's well-being, (7) other benefits, and (8) increased work efficiency (see Table 2 for additional details).

Increased Access for Clients ($n = 22$) The largest category related to the most significant benefit to providing telehealth was related to an increased access for clients. When respondents talked about access, they not only described this with respect to the value of the perceived logistical benefits to connecting with clients in a new way but also about the possibility for reducing psychological barriers that may prohibit participation in treatment. Comments focused on the rural nature of service delivery and how telehealth may serve as a significant strategy for addressing challenges. One provider stated that telehealth "took down a lot of barriers for my rural and/or impoverished clients who struggle with transportation and funds to come into the office for their sessions (Participant 26)." Another mentioned that it "increased access for our more rural counties (Participant 51)." Statements about alleviating problems with transportation remained consistent, but providers also mentioned that "attendance has increased, (its) easier for clients to make appointments (Participant 53)." Additionally,

Table 2 Thematic content analysis: benefits of telehealth themes and number of items (*n* = 95)

Theme	*n*
Increased access for clients (e.g., not having to drive long distances)	22
Increased sense of safety from COVID-19 (e.g., social distancing and protection)	17
Increased flexibility (e.g., better able to accommodate family and professional needs)	13
Continuity of care (e.g., no risk of lapse in services due to pandemic)	12
Creativity and innovation in service delivery (e.g., enhancing services with tech)	10
Positive impact on the provider's well-being (e.g., better work-life balance)	10
Other benefits (e.g., convenient and easy to use, etc.)	6
Increased work efficiency (e.g., less travel time resulted in more productivity)	3

quotes described how access was improved by the reduction in costs. Examples include "clients (are) more easily accessing services despite barriers (i.e., transportation, gas money, child care, etc.) (Participant 38)" and "not using expenses to travel to the office (Participant 114)." While this robust theme of increased access spoke to several different contributing factors, it also highlighted the importance of breaking down psychological barriers related to the negative perception of attending treatment at a facility. Specifically, "clients don't need to worry about transportation or stigmatism due to being in a more private setting (Participant 75)" and "using telehealth we reached many more clients than we would have before because the clients did not have the stigma of coming into the office (Participant 56)."

Increased Sense of Safety from COVID-19 (*n* = 17) The second largest category related to the most significant benefit to providing telehealth was related to an increased sense of safety from COVID-19. Comments indicated that providers felt "safety from COVID-19 exposure (Participant 117)" and "safety from COVID in my home (Participant 92)." Also, providers mentioned that providing services through telehealth helped as "clients tend to report feeling more comfortable and safer in their own space (Participant 75)." Furthermore, some mentioned the mutually beneficial aspect of this process related to safety. Specifically, "the health providers as well as clients were better protected (Participant 64)" and "practicing social distancing and safe practices during COVID-19 (Keeping my family and clients safe) (Participant 38)." Another response noted "it is safer health wise to be exposed to less people in person. This goes for the client and worker (Participant 70)." Finally, one provider discussed that remaining safe also helped them to engage with their clients, stating that they were "safe from spreading virus/didn't have to wear masks to engage in therapy treatment with clients (Participant 12)."

Increased Flexibility (*n* = 13) Flexibility was a clear theme that was identified by the providers in this study. The utilization of telehealth was beneficial because it provided "greater flexibility for clients (Participant 99)," "flexibility of

scheduling sessions with clients (Participant 92)," and "flexibility in personal scheduling (Participant 113)." One provider stated that there were "less no-shows and easier scheduling with clients. Could more easily work around client's schedule and have later appointments (Participant 24)." Another mentioned that they "enjoyed having more flexibility with my physical locations because of family needs (Participant 96)." This theme may be best expressed by one comment from a provider who simply said "flexibility! (Participant 46)".

Continuity of Care (*n* = 12) Providers stated that benefit of using telehealth was the continuity of care. Whether it was "keeping in touch with clients during stressful times (Participant 84)," or being "able to see clients safely instead of not seeing them at all (Participant 4)," they felt that "telehealth allowed us to continue serving clients when the reality may have been that we would not have been able to otherwise. So, the concept of "better than nothing" was there (Participant 1)." One provider reflected that "during the pandemic, it made me feel better knowing I was able to still provide quality services to families without risking their or my own health (Participant 89)." The ability to "continue with therapy services (Participant 30" and "work and provide a service (Participant 13)" resonated with these professionals.

Creativity and Innovation in Service Delivery (*n* = 10) Telehealth implementation resulted in enhanced creativity and innovation in service delivery. Providers stated that "it allowed me to increase creativity and find new ways of serving clients (Participant 96)." A few gave examples, including "I worked with a client [with a very specific mental health issue for which the therapist provided a very specific intervention]. If it was not for telehealth I would not had been able to provide that healing process with him (Participant 40)." Another response stated "I was able to utilize new programs such as remote EMDR to enhance service provision and found this program to be very effective (Participant 31)." Some responses mentioned the value of conducting "soft room interviews" (Participant 4) with remote clients and how "using the telehealth technology also allowed our agency to pursue the use of satellite offices (Participant 1)."

Positive Impact on the Provider's Well-being (*n* = 10) Providers stated that using telehealth resulted in a positive impact on their well-being. Examples include a "slower pace of life, easier to maintain self-care (Participant 91)," "reduced vicarious trauma (Participant 101)," the "[ability to] balance personal needs and work obligations (Participant 59)," and "personal growth in areas of adaptability and flexibility which greatly helped me as a provider (Participant 37)." Also, providers mentioned that telehealth afforded aspects of balance that they found beneficial to their well-being. One mentioned that they were "able to balance working and having to ensure my children had childcare during the day during the pandemic by working from home which was helpful (Participant 86)." Another mentioned that they were "able to take breaks outside in between clients for 5 min, being able to cook my own meals for lunch, clients being comfortable in their space (Participant 73)." Finally, a provider stated that it was beneficial "to be home with my child (Participant 6)."

Other Benefits (*n* = 6) Other benefits of telehealth include a variety of unique contributions. One reported that they enjoyed "being able to see pets of clients (Participant 73)" and another stated that "teenagers seemed more comfortable in sessions (Participant 24)." Additionally, comments from two other individuals identified a level of "ease (Participant 53)" and "convenience (Participant 115)" associated with using telehealth to facilitate services. One provider reported that they found value in having "access to self-care tools in the home (such as, animals, etc.) (Participant 51)." Lastly, one stated that they felt that "most of [the clients] have reported enjoying Telehealth or therapy via phone (Participant 114)."

Increased Work Efficiency (*n* = 3) Providers mentioned that telehealth assisted in their work efficiency. This was the smallest theme, consisting of three quotes. One provider stated that they were "able to serve clients from all over the service region without an increase in driving time (Participant 99)." Another stated that they were "able to increase my actual work time, by decreasing my travel time to work (Participant 64)." In that same vein, one person stated that

"working from home negated travel time. I experienced less interruptions when working from home (Participant 36)."

Challenges of Shifting to Telehealth During the COVID-19 Pandemic

Fifty-three participants shared 85 contributions to the following open-text item "What do you see as the most significant challenges you face/faced in providing telehealth?" Themes were partitioned into 8 categories: (1) technology, (2) client engagement, (3) privacy, (4) adapting services to telehealth (5) logistical challenges from working at home, (6) negative impact on provider, (7) other consequences, and (8) challenges in addressing client safety (see Table 3 for additional details).

Technology (*n* = 22) The largest category of the most significant challenge to providing telehealth was related to technology. Many comments specifically focused on the internet. Examples included "bandwidth issues with internet provider (Participant 41)," "internet access (Participant 33)," "internet instability (Participant 24)," "internet connection (Participant 4)," and "issues with internet connectivity (Participant 3)." Other comments focused on other challenges with technology, including "technical issues (Participant 114)," "computer challenges (Participant 38)," and that "many of my clients have limited access to technology (Participant 78)." Of concern, one provider described "clients not having access to materials and technology necessary to engage in telehealth sessions (Participant 8)." Challenges related to effectively utilizing technology were also identified, as one provider said that "the most significant challenge I faced was working with the older generation (grandparents raising children) and their lack of knowledge in using technology to do video conferences (Participant 89)." Another provider supported this theme by stating that their clients had the "inability to use technology (Participant 34)" and that "clients without tech "know how" struggled to connect even with support from advocates (Participant 99)." One statement summarized both the challenges and implications, mentioning that "I found it difficult for clients to be willing

Table 3 Thematic content analysis: challenges of telehealth themes and number of items (*n* = 85)

Theme	*n*
Technology (e.g., internet connections and adequate hardware)	22
Client engagement (e.g., distractions and cancelled appointments)	15
Privacy (e.g., concerns about access to private communication)	11
Adapting services to telehealth (e.g., learning curves on multiple fronts)	10
Logistical challenges from working at home (e.g., personal responsibilities)	9
Negative impact on provider (e.g., zoom fatigue and exhaustion)	7
Other consequences (e.g., preferred face to face, obtaining client buy-in, etc.)	7
Challenges in addressing client safety (e.g., ability to assess risk)	4

to try Zoom. I only used email to make/confirm appointments or send handouts as I was concerned about privacy. My clients were comfortable with the telephone but limited in what we could do as far as interventions, and it is exhausting using the phone all day (Participant 36)."

Client Engagement ($n = 15$) Client engagement was identified as the second largest challenge related to the use of telehealth. Clear indicators of this difficulty include provider statements about difficulties in "keeping clients engaged (Participant 100)" and "too many distractions from family and environment (Participant 42)." Providers mentioned a difficulty in "not being able to read body language and true comfort of an individual due to not being able to be face to face or in person (Participant 13)" and that "it is very easy to people to just not show up to telehealth appointments as opposed to in person (Participant 10)." Providers also described the unique difficulty of engaging younger children through telehealth. Examples include "keeping children under 6 occupied on therapy when all their toys are around and other siblings. Children wanted to do a tour of the house or show all their toys and not focus on therapy (Participant 49)." Another provider mentioned that they are "no longer able to engage younger children as I once was able to in the office (Participant 12)." One statement simply stated that "the most challenging to work with was small children. It was hard to keep them focused more because they were home around their toys and pets (Participant 40)."

Privacy ($n = 11$) Providers identified the ability to assure and maintain privacy as a significant challenge when utilizing telehealth services. Statements described problems with "maintaining HIPAA compliant space in my own home (Participant 59)" and "not being as private as being in the office (Participant 42)." Also, they mentioned that it was difficult to obtain "space away from family (Participant 34)." Several responses simply included the word "privacy (Participants 3, 8, 11, 36, 74, 117)." Another individual stated a concern about "not knowing who was in the room with client with limited field of vision. Not sure if others were overhearing (the) therapy session (Participant 24)." Finally, one provider encapsulated both sides of this dilemma by asserting that "not only was I concerned about my clients having privacy, I was also concerned about my privacy as I was trying to provide them therapy services (Participant 9)."

Adapting Services to Telehealth ($n = 10$) The need to adapt services when shifting to telehealth during COVID-19 was challenging. Providers identified difficulty in "adapting interventions to be effective via telehealth (Participant 59)" and "not knowing how to adapt from providing in-person services to Telehealth services (Participant 118)." Also, they mentioned challenges with "altering curriculum and

activities with children to meet the online setup (Participant 12)" and "learning the new platforms being used to provide services and changing the way services were provided (Participant 14)." Providers also shared insight into changes related to certain modalities, including "providing TF-CBT via telehealth even though I have no training on how to implement TF-CBT virtually (Participant 49)." They shared that it was difficult when "learning how to provide EMDR through Telehealth (Participant 75)" and "adapting play therapy modalities for younger populations (Participant 8)." Well attuned to the gravity of such a change to telehealth, one provider described difficulties in "adapting therapeutic modalities to telehealth when I was 100 percent in-person prior to COVID restrictions (Participant 96)."

Logistical Challenges from Working at Home ($n = 9$) Providers stated that the shift to telehealth services resulted in logistical challenges associated with working from home. Several comments described the struggle of creating an effective environment, including having an "inadequate work space (Participant 9)" and "children in the home using internet/doing virtual school while trying to also access the internet to do sessions (Participant 92)." More comments described how this new reality of working at home was impacted by their personal responsibilities. Examples include "I live in a house with other people. I also live with animals who would make noise often and be a disturbance to sessions (Participant 9)." Another individual stated that "navigating work from home was not a challenge…working from home during shut downs while my child was also at home was a challenge. I believe remote work while my child was in school would have removed a lot of remote work challenges (Participant 38)." It was clear that some of these providers had a difficult time balancing this circumstance, as one mentioned that working while their child was at home was difficult. "We would have considered child care during this time but all child care facilities were closed as well (Participant 29)."

Negative Emotional Impact on Provider ($n = 7$) The negative impact on the provider was identified as a significant challenge of shifting to telehealth during COVID-19. Specially, one provider stated "I additionally struggled with my own [mental health problem] (Participant 86)" and another described an "increase of compassion fatigue (Participant 53)." In that same vein, providers identified "Zoom fatigue (Participant 73)" and "telehealth/screen fatigue (Participant 8)." Respondents also shared that performing services via telehealth resulted in the disengagement from their systems of support. One mentioned the "loss of connection with coworkers/colleagues due to working from home/remotely (Participant 118)." Another stated that "being at home and away from colleagues and not being able to consult with

them as readily as I was used to. I did not feel that I had as much access to support from co-workers and leadership just because I was not in a position to share physical space with them (Participant 86)."

Other Consequences (*n* = 7) Other negative consequences were identified by providers because of shifting to telehealth during COVID-19. Some referred to operational challenges such as "getting paperwork returned (Participant 115)." Others described having "a hard time having clients agree to using telehealth while at home (Participant 27)." Additionally, it was reported that telehealth was "time-consuming (Participant 4)" and that there were difficulties in "adapting outcome measures to be done via telehealth (Participant 37)." Seemingly dissatisfied with the change, one provider simply stated that "face to face (services) provides so much more benefits and information (Participant 2)."

Challenges in Addressing Client Safety (*n* = 4) Providers mentioned that it was difficult to address client safety when they shifted to telehealth due to COVID-19. They identified challenges in "safety planning in crisis situations (Participant 26)" and "addressing safety or crisis concerns (Participant 3)." Also, they stated that there were concerns about "changing the way services were provided based on unknown safety risks of the clients (Participant 14)." Finally, an individual described the challenge of "ensuring clients had adequate privacy and psychological safety to do trauma work as some clients were attempting to do therapy in environments where trauma occurred (Participant 8)."

Discussion

The COVID-19 pandemic resulted in a sizeable shift in the numbers of institutions and providers delivering services remotely, including SVRCs and CACs. Although the challenges and benefits of telehealth service delivery have been examined in previous research, this is one of the first studies to specifically focus on the use of telehealth in Kentucky SVRCs and CACs. Additionally, this study utilized providers who were delivering services primarily to individuals in rural settings, where efficient delivery of telehealth services may be especially difficult. The purpose of the current study was to examine benefits and challenges of shifting to telehealth service utilization during the onset of the COVID-19 pandemic at Kentucky CACs and SVRCs.

Benefits noted included increasing access for clients, increasing a sense of safety from COVID-19, increasing flexibility, furthering continuity of care, innovating service delivery, improving provider well-being, and increasing work efficiency. Many of the benefits highlighted by providers in the current study, such as promoting continuity of care

and increasing a sense of safety from COVID-19, have been reported by providers in other healthcare settings (Gray et al., 2015; Holland et al., 2018; Racine et al., 2020; Titov et al., 2019). Notably, in the current study, the most commonly cited benefit of the shift to telehealth was increasing access for clients. This likely reflects the large proportion of rural populations served by providers at CVCs and SVRCs in the current study, for whom access to services is typically more limited compared to individuals in urban areas (Douthit et al., 2015). Multiple providers acknowledged that the use of telehealth reduced financial and logistical barriers (e.g., transportation) that may negatively impact client attendance for in-person services, challenges which are often exacerbated for clients in rural areas who have to travel further distances to receive services. Additionally, multiple providers also noted that one mechanism through which access to care was increased was through reduction of stigma. Mental healthcare in particular has been highlighted as a healthcare service that is more likely to be attached with negative stigma, particularly among individuals in rural areas (Knaak et al., 2017; Rost et al., 1993). Remote delivery of mental healthcare in settings such as CACs and SVRCs may serve to encourage individuals to seek out mental healthcare in instances where they would have otherwise avoided doing so (Aboujaoude et al., 2015). Additional research is needed in this area, but data from CACs suggest that telehealth is aiding in outreach. Over 386,000 children received services at CACs across the USA in 2021, the highest number reported over the past decade (National Children's Alliance, 2021). While multiple factors may have led to the increased reach of these centers, these numbers are especially impressive in light of the pandemic. Telehealth will clearly be an important tool moving forward for increasing the service network of CACs and SVRCs.

Although a number of benefits of telehealth were reported by providers, they also noted a number of challenges encountered in using telehealth for service delivery. Challenges included technology issues, challenges with client engagement, privacy concerns, difficulties adapting services to telehealth, logistical challenges working from home, provider fatigue/negative emotions, and challenges with client safety. As with the benefits reported by providers, many of these challenges with telehealth have also been experienced by providers in other settings (Gerber et al., 2020; Lieneck et al., 2020; McKenny et al., 2021; Mishna et al., 2021a; Perry et al., 2020). Despite the capacity for telehealth to increase the reach of services, technological barriers exist which can make successful implementation of these services difficult. These challenges may become particularly problematic at CACs and SVRCs, who often do not have dedicated IT departments to help resolve technology issues. Comments from providers indicate barriers both in terms of lack of access to necessary technological resources as well as lack of client knowledge regarding how

to use the technological tools available to them. Relatedly, recent data indicate that 36% of children and adolescents in Kentucky do not have access to internet at home, which is among the highest of any state in the USA. Furthermore, approximately a third of students do not have the devices necessary for receipt of telehealth, such as computers or laptops (Chandra et al., 2020). Until considerable investments have been made to improve broadband access in Kentucky, particularly in rural regions, many individuals in need of services at CACs and SVRCs will be unable to benefit from telehealth.

Of note, one of the particularly common challenges endorsed concerned issues with client engagement. Although documented as an issue in other settings (Hoffnung et al., 2021; Moorman, 2021; Racine et al., 2020), that this concern was commonly reported by providers in the current sample likely reflects CACs and SVRCs often working with populations who may be less amenable to remote delivery of serves, such as young children and individuals in acute distress. One recent study comparing mental health services before, during, and after the onset of the pandemic at a community-based outpatient clinic found that while children were the main recipients of services pre-pandemic, adults comprised the majority of encounters when services transitioned to telehealth, highlighting the challenges experienced in adapting children's services to telehealth (Hoffnug et al., 2021). Additionally, whereas the number of psychotherapy visits decreased for children with the use of telehealth, the number of psychiatry visits increased. Thus, the impact of telehealth on services may be moderated by the type of service provided. Relatedly, one study found that mental providers in rural areas preferred in-person formats over telehealth when conducting child assessments (Levy & Strachan, 2013). While psychotherapy and other services for young children and families (e.g., forensic interviews) may be difficult to implement via telehealth, other services may be more easily delivered via this modality (e.g., advocacy services). Additional research is needed in this area to see which sectors of services are most and least amenable to telehealth formats.

Taken altogether, results are consistent with past research highlighting that there are many benefits as well as challenges that exist regarding the use of telehealth services, both for providers and clients at SVRCs and CACs. Feedback from providers indicate that telehealth is a mixed bag. For example, respondents noted that telehealth had both a positive and negative impact on themselves via improved self-care at the expense of building relationships with coworkers. Telehealth services may increase access for clients at the potential cost of reduced client engagement. Despite this dichotomy, studies thus far indicate minimal differences between psychotherapies delivered in person or remotely (Greenwood et al., 2022). However, whether this extends to other services provided by CACs and SVRCs is unclear.

Responses suggest that providers at CACs and SVRCs perceive numerous benefits of telehealth and that this modality will continue to be used moving forward. It should be noted that because responses were collected at the onset of the pandemic, some of the benefits and challenges noted by providers are likely to be more transient than others as the pandemic evolves to have a less severe impact on daily life and users become more accustomed to telehealth services. Thus, COVID-19-specific benefits and challenges to telehealth, such as perceived safety from COVID-19, learning how to adapt services to telehealth, and providing child care while schools were remote, are likely to have less impact on the long-term adoption of telehealth services. Non-pandemic-related benefits (e.g., increased access for clients, increased flexibility, positive impact on well-being) and challenges (e.g., technological issues, decreased client engagement, privacy concerns) will likely remain regardless of the state of the pandemic and determine the long-term fate of telehealth service utilization in CACs and SVRCs. However, additional research is needed to track the progression of these benefits and challenges over time to determine which are more transient than others.

Responses suggest several valuable ways to improving telehealth service delivery and receipt in CACs and SVRCs. Responses indicate that formal training regarding how to best adapt mental health services to telehealth, troubleshooting technological barriers, and managing ethical dilemmas that are likely to occur in telehealth would be beneficial. Despite several evidence-based mental health treatments for conditions related to trauma and abuse (Lancaster et al., 2016), clear guidelines on how to implement these interventions via telehealth is lacking, leaving providers to make their own determinations about how to modify treatment. Additionally, resources are needed to improve CAC and SVRC provider mental health. Past studies have documented high rates of stress and emotional difficulties in individuals working in the child welfare field, which may partially explain the high turnover rates documented in several studies (Griffiths et al., 2018; Mor Barak et al., 2006). Given the broad increases in stress and emotional difficulties since the onset of the pandemic, workforce initiatives to improve the mental health of CAC and SVRC workers could aid in workforce retention.

In addition to the contributions of the current study, some limitations should be noted. The sample size in the current study was modest. Additionally, the current study focused on CACs and SVRCs in one specific state in the USA. Given the many rural and impoverished areas in the region, Kentucky CACs and SVRCs may be faced with more pronounced barriers regarding utilization of telehealth. Thus, additional research in this area is needed in larger and more geographically diverse CAC and SVRC providers. Another limitation of the current study is that the data was cross-sectional and

collected during one of the peak periods of the pandemic. Perceptions and challenges of telehealth may evolve over time as providers become more accustomed to this modality and more resources are invested in improving telehealth services. Longitudinal studies are needed to examine the use of telehealth at SVRCs and CACs over time to evaluate how provider views of telehealth change and which obstacles to effective delivery of telehealth persist. Finally, we did not collect data on the specific services offered by respondents nor their training background. Future studies obtaining this information at CACs and SVRCs will further elucidate services that are more and less challenging to implement via telehealth.

The onset of the COVID-19 pandemic has created a paradigm shift for CACs and SVRCs regarding delivery of services. Feedback from Kentucky CAC and SVRC providers in the current sample indicate a host of benefits as well as difficulties in adapting services to digital formats during the pandemic. Responses suggest an eagerness among providers for additional training to improve delivery of CAC and SVRC telehealth services, which will benefit both providers and service recipients. Regardless of the course of the pandemic, telehealth is likely to continue to be used by providers in these settings. If telehealth is treated as an additional tool worthy of institutional investment rather than as a temporary stopgap at a moment of crisis, CACs and SVRCs have will have increased ability to adapt services as needed to the populations they serve.

Declarations

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