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Clinicians' Perceptions of Telehealth Services During the COVID-19 Pandemic in Virginia

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This is to certify that the doctoral dissertation by

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Abstract

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MSW, Walden University, 2019

BSW, Virginia Union University, 2014

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Barbara Solomon School of Social Work

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Abstract

The onset of COVID-19 introduced unprecedented changes to how U.S. public health services were delivered. Many public and private agencies faced mandatory closures, social distancing mandates, and rapid transitions to telehealth interventions and treatment. Mental health clinicians witnessed disruptions in continuity of care and an increasein mental health risks overall. Although some studies have been conducted to survey clinicians' perceptions of the usefulness and ease of use of technology-based interventions, knowledge about mental health clinicians' experiences and perceptions in Virginia was sparse. The purpose of this generic qualitative study was to explore how mental health clinicians in Virginia described their experiences and perceptions of using telehealth in providing services to clients during the COVID-19 pandemic. The social ecological systems and technology acceptance models were used to explore the experiences and perceptions of clinicians. Data analysis led to identification of themes: (a) pre-COVID-19 treatment and services (b) adjustments to rapid implementation of telehealth, (c) convenience and flexibility to providing services following acclimation, (d) technological barriers to providing telehealth services, (e) challenges with limited understanding and exposure to technology, (f) protocols and managing expectations, (g) acceptance and aversion to telehealth service, and (h) lessons learned for future practice. The findings of this study have potential implications for positive social change by providing insight into the ease of use of telehealth models, encouraging ongoing training for clinical professionals, and informing future research and practice in the mental health field.

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Dedications

To my loves: Polly Alice Hill, Romeo, Carter, and the Hill-Guishard-Stephens Tribe, I dedicate this vision to you and keep pushing.

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Table of Contents

List of Tables

List of Figures

Chapter 1: Introduction to the Study

Introduction

Telehealth prevention, intervention, and treatment delivery in public health continue to evolve globally. Mental health clinicians and practitioners often represent the first line of defense for supporting and assisting individuals, groups, and communities facing issues associated with substance abuse, mental health, and co-occurring disorders by providing evidence-based mental health services (Chigangaidze, 2021; Davis et al., 2021). Clinical mental health practice involves using evidence-based interventions and treatment to promote client-centered harm reduction in individual, group, and community clients. Additionally, clinical researchers acknowledged that mental health challenges often inhibit clients' ability to effectively conduct daily social, personal, or employment tasks (American Psychiatric Association, 2013). The onset of COVID-19 ushered in the widespread use of telehealth; however, the unexpected nature of the COVID-19 pandemic led to a rushed adoption with limited advanced training for mental health clinicians. Clinicians faced the challenges associated with navigating these unexpected changes requiring an understanding of practitioners' responses to these models in adopting telehealth services. As a result, it is necessary to explore clinicians' perceptions and experiences implementing telehealth during the COVID-19 pandemic in Virginia.

This qualitative study aimed to understand clinicians' experiences with rapid transitions to telehealth and to explore their perceptions of the ease of use, challenges to use, and overall efficacy of telehealth services in mental health practice during the COVID-19 pandemic. Evidence-based mental health treatment models support the

delivery of treatment and intervention geared toward empowering clients to develop coping skills that assist them in returning to optimal functioning mentally, physically, and biologically (Abramson, 2021; Blanco et al., 2020; Croke, 2020; Harvey et al., 2019; Ohannessian et al., 2020; Portz et al., 2019). However, current research offers conflicting views and limitations regarding the acceptance and ease of use of telehealth models implemented during the COVID-19 pandemic, as well as the experiences of clinical specialists providing services in Virginia (Chiauzzi et al., 2020; Davis et al., 2021; Erbe et al., 2017; Wijesooriya et al., 2020). Some researchers have suggested that the implementation of telehealth services during COVID-19 was widely accepted by clinicians and clients (Gentry et al., 2021; Hadjistavropoulos et al., 2020). Conversely, other studies have highlighted the significant challenges within underserved populations, citing concerns with accessibility, limited training before and during implementation, and reduced engagement (Cornell et al., 2021; Gentry et al., 2021; Hadjistavropoulos et al., 2020). Researchers have continued to examine alternative variations to traditional in-person interventions and treatment to aid service availability while easing the heavy caseloads of mental health clinicians and practitioners during COVID-19 (Figgatt et al., 2021; Lapão et al., 2017; Shigekawa et al., 2018).

In this chapter, I introduce the study by highlighting background and context information, followed by the research problem, the purpose of the study, and the research questions. Additionally, I highlight the research aims and limitations and describe the study's theoretical framework.

Background

The American Psychiatric Association (2013) described clinical practice as multidisciplinary, including social workers, physicians, psychologists, nurses, and other health specialists. Additionally, mental health clinical practice includes the delivery of assessments, diagnoses, evidence-based intervention, and treatment services to identify the severity of the observed symptoms to determine the necessity and level of treatment required (American Psychiatric Association, 2013). The emergence of COVID-19 presented significant challenges for clinical professionals working in mental health, introducing an opportunity to expand the implementation or continuation of alternative methods of service delivery (Chen et al., 2020; McQueen et al., 2022; Pierce et al., 2021). Telehealth provides care or services to individuals using technology-based equipment, such as telephones, computers, or other devices when the parties are in different locations (Mayo Clinic Staff, 2020). Telehealth has become increasingly used to deliver mental health treatment and intervention. However, many agencies and organizations opt to predominantly use in-person services (Erbe et al., 2017; Freeman et al., 2017; Wijesooriya et al., 2020).

The COVID-19 pandemic ushered in mandatory closures and social distancing measures, requiring mental health clinicians to transition to technology-based models rapidly (McQueen et al., 2022; Pierce et al., 2021). Before the COVID-19 pandemic, researchers conducted studies to examine the use of telehealth models to support and accompany traditional in-person models, resulting in a mixture of acceptance and aversion to the implementation or continuation of telehealth models during the crisis

(Gentry et al., 2021). However, many U.S. public and private agencies opted to maintain in-person services as their primary method of service delivery (Sasangohar et al., 2020). Additionally, barriers associated with the pre-COVID lack of insurance reimbursements and regulatory prescription protocols for medication-assisted treatment (MAT) presented challenges that discouraged implementing technology-based mental health services (Centers for Medicare & Medicaid Services, 2018). Chen et al. (2020) discussed that the relaxation of insurance restrictions due to the COVID-19 pandemic aided the transition to telehealth.

Clinicians, clients, and providers may incorporate telehealth for clients and patients experiencing transportation challenges, medical challenges that may reduce mobility, and other crises providing services in proximity (Blanco et al., 2020; Lynch et al., 2020). Additionally, some considerations highlight the opportunity to save time, limit no-shows, and reduce the cost associated with travel to and from appointments. Clients faced challenges related to limited access to the necessary technology for telehealth services and agencies' inability to provide technology resources to fill these needs (McQueen et al., 2022; Pinero de Plaza et al., 2021). However, only a tiny portion of agencies incorporated telehealth models, preferring the in-person methods of service (Harvey et al., 2019). The announcement from the World Health Organization in 2020 declaring COVID-19 a pandemic shifted agencies' approach to client care and demanded alternative approaches to intervention and treatment (Ohannessian et al., 2020; Sasangohar et al., 2020). Although many clinicians specialize in mental health-related fields, concerns emerged due to the impact of COVID-19. For example, these

developments ushered in complications associated with accessibility, ease of use, and the introduction of telehealth treatment and intervention models for mental health and substance abuse (Chigangaidze, 2021; Hadjistavropoulos et al., 2020). In 2020, the Mayo Clinic staff provided a brief review of the benefits and challenges of accessibility and the reduction in face-to-face visits associated with telehealth services. Some benefits included the potential increase in accessibility for clients (Mayo Clinic staff, 2020).

Additionally, the conceptualization of technology-based practices in public health presented regulatory changes. These changes highlighted concerns concomitant with mandated closures and inaccessibility of MAT for substance use disorders (Costello, 2020; Figgatt et al., 2021; Frank et al., 2021). Finally, clients' inaccessibility to technology remained a significant concern for some clinicians throughout the pandemic (Chiauzzi et al., 2020; Costello, 2020; Gentry et al., 2021).

Due to regulatory changes, clinician turnover rates, training issues, and accessibility, clients who face issues associated with mental health, substance abuse, and other co-occurring concerns often experience barriers to treatment (Chen et al., 2020; Costello, 2020). Although the expansion of telehealth models of treatment presents an opportunity to expand access to some clients, many clients and practitioners face concerns associated with the ease of use and acceptability of technology-based platforms (Abramson, 2021; Campbell et al., 2017; Croke, 2020; Figgatt et al., 2021; Gentry et al., 2021). Despite these observations and acknowledgments, studies describing clinicians' actual experiences and perceptions are sparse due to the newness of the COVID-19 crisis. Telehealth has been widely adopted in healthcare, psychology, and psychiatry, but

limited information is available on the specific experiences of professionals providing mental health as their primary function (Pierce et al., 2021; Wijesooriya et al., 2020). Due to the urgency of implementation, additional research remains necessary to examine the experiences and perceptions of mental health professionals since its adoption and primary use during the COVID-19 pandemic.

Gentry et al. (2021) considered clinicians' experiences; however, the demographic of the participants highlighted practitioners who faced limited challenges while providing services for clients with adequate employment and insurance. Therefore, this study presents an opportunity to explore the perceptions and experiences of clinicians serving diverse clients to promote social change through awareness of issues associated with technology-based interventions, ease of use of telehealth models, and the overall accessibility to alternative services during periods of crisis.

Although researchers have investigated this issue, incorporating qualitative research focusing on understanding the experiences and perceptions of mental health clinicians in central Virginia has not been explored. Additionally, the introduction of rapid telehealth services for substance abuse and mental health treatment during the COVID-19 pandemic remains challenging to locate. Recent studies aimed to gain the perceptions of stakeholders using quantitative survey tools that presented limited in-depth information from participants (Burnell et al., 2020; Chen et al., 2020; Gentry et al., 2021). Many clinicians had no experience with telehealth models before the COVID-19 pandemic (Myers et al., 2021; Molfenter et al., 2021; Moloi et al., 2020). Hadjistavropoulos et al. (2020) highlighted the perceived benefits of many stakeholders

following the implementation of telehealth treatment models. However, other researchers highlight the need for additional research to determine the benefits and challenges observed during the crisis (Kalayou et al., 2020; Sasangohar et al., 2020; Wijesooriya et al., 2020). This study aimed to understand the experiences and perceptions of mental health professionals during the rapid transition to telehealth services for treatment to help fill gaps in the literature.

Problem Statement

The impact of COVID-19 on mental health treatments for vulnerable populations highlighted ongoing challenges for rural populations, minorities, and low-income communities (Pillay & Barnes, 2020). Although many researchers have posited that the implementation of telehealth services during COVID-19 increased accessibility, many vulnerable clients and communities continued to face issues related to limited access to the required technology, limited knowledge on how to engage with new technology, and limited technical support services (Gentry et al., 2021; Pillay & Barnes, 2020). Additionally, the barriers to research highlighted regulatory restrictions, social distancing, and limited contact measures (Blanco et al., 2020; Frank et al., 2021; Khan et al., 2021). The expansion of telehealth measures to maintain continuity of care for clients and patients during an uncertain time presented diverse outcomes, especially for those experiencing challenges associated with mental health and substance abuse concerns pre-COVID-19 (Blundell et al., 2020; Pillay & Barnes, 2020). Challenges were associated with internet accessibility, clients' limited knowledge and experience with internet-based platforms, and concerns related explicitly to continuing toxicology screenings for clients

participating in substance abuse treatment programs (Blundell et al., 2020; Pillay & Barnes, 2020).

Additionally, concerns related to ethnicity and pre-existing inequalities amplified following the pandemic reveal challenges due to previous recessions and increased budget cuts (Blundell et al., 2020; Office of Behavioral Health, 2020; Pillay & Barnes, 2020; Uustalu et al., 2015). With the onset of COVID-19, many individuals, groups, and families faced even more significant reductions in earnability along with navigating family responsibilities, shut downs, and mandated isolation/shelter in place (Blundell et al., 2020). However, benefits noted included the ability to telework to decrease the anxiety associated with exposure to the COVID-19 virus. Unfortunately, Blundell et al. (2020) noted that a significant portion of Black, Latino, and immigrant populations lacked the type of employment that allowed working from home, increasing the concerns associated with maintaining viable income during the pandemic.

Studies focused on understanding the benefits and challenges associated with the trial and implementation of technology-based treatment and intervention models demonstrated the potential alternatives of technology-based services (e.g., telephone and videoconferencing) to traditional in-person services (Bouchard et al., 2004; Cowain, 2001; Manchanda & McLaren, 1998; Sims, 2018). The situation or issue that prompted me to search the literature is the rapid transition of mental health treatment and interventions from face-to-face to virtual/telephone in central Virginia following COVID-19 restrictions and despite the limited preparedness of providers to adopt telehealth services. Researchers indicated that many agencies implemented telehealth services

following COVID-19 social distancing mandates, including telephone, videoconferencing, or a mixture of both (Blundell et al., 2020; Liang et al., 2020; Moloi et al., 2020). Although telehealth was available before COVID-19, clinicians faced challenges with insurance regulations and reimbursement claims (Costello, 2020). In March 2020, the World Health Organization declared a global pandemic leading to large-scale closures of mental health services and treatment facilities, social distancing guidelines, and mandatory personal protective equipment while in public (Croke, 2020; Davis et al., 2021; Vogel, 2020). Many mental and public health providers faced similar challenges specific to closures that presented additional barriers to accessing medically assisted treatment, mental health prescriptions, and required medications (Molfenter et al., 2021; Moloi et al., 2020; Sasangohar et al., 2020; Wijesooriya et al., 2020).

Due to the regulatory restrictions of Medicaid, clinicians initially faced challenges surrounding approval and other constraints for alternative treatment modalities and continuing MAT models (Chen et al., 2020; Costello, 2020; Lynch et al., 2020).

Studies concerned with understanding the benefits and challenges associated with the trial and implementation of technology-based treatment and intervention models demonstrated the potential alternatives of technology-based services (e.g., telephone and videoconferencing) to traditional in-person services (Bouchard et al., 2004; Cowain, 2001; Manchanda & McLaren, 1998; Sims, 2018). The situation or issue that prompted me to search the literature is the rapid transition of mental health treatment and interventions from face-to-face to virtual/telephone in central Virginia following the implementation of COVID-19 restrictions and despite the limited preparedness of

providers to adopt telehealth services. Researchers indicated that following the social distancing mandates, many agencies implemented telehealth services, including telephone, videoconferencing, or a mixture of both (Blundell et al., 2020; Liang et al., 2020; Moloi et al., 2020). Although telehealth was available before COVID-19, clinicians faced challenges with insurance regulations and reimbursement claims.

In March 2020, the World Health Organization declared a global pandemic leading to large-scale closures of mental health services and treatment facilities, social distancing guidelines, and the mandatory donning of personal protective equipment while in public (Croke, 2020; M. T. Davis et al., 2021; Vogel, 2020). Many mental and public health providers faced similar challenges specific to closures that presented additional barriers to accessing medically assisted treatment, mental health prescriptions, and required medications (Molfenter et al., 2021; Moloi et al., 2020; Sasangohar et al., 2020; Wijesooriya et al., 2020). Additionally, due to the regulatory restrictions of Medicaid, clinicians initially faced challenges surrounding approval constraints for alternative treatment modalities and continuing MAT models (Costello, 2020; Lynch et al., 2020).

Purpose of the Study

Outpatient treatment programs for Virginia's underserved populations traditionally involve in-person assessments, treatment, and intervention models (Wijesooriya et al., 2020). The concept/phenomenon of interest consists of telehealth use and clinicians' experiences and perceptions in providing client services during the COVID-19 pandemic. COVID-19 presented significant risks for in-person services due to social distancing requirements and mandatory closures of businesses. These concerns

resulted in a swift transition to telehealth models for mental health and substance abuse interventions and treatment. Additionally, many clinicians and mental health professionals faced challenges in learning and implementing new technologies while providing beneficial services to clients in isolation (Gentry et al., 2021; Molfenter et al., 2021).

The rapid shift to telehealth during the COVID-19 pandemic also presented potential barriers due to the limitations associated with clinician and client experiences with the digital software, unknown usefulness due to reduced familiarity, and overall accessibility to clients scheduled to include these models as a part of their overall treatment plans (Davis, 1989; Figgatt et al., 2021; Wodarski, 2020). There is little research knowledge about the experiences and perceptions of clinicians regarding the provision of telehealth services to clients.

The onset of the COVID-19 pandemic posed significant challenges for many clinicians providing public health services. Additionally, the impact of reduced socialization and fear highlighted an increase in mental health and substance abuse services. However, many public and private agencies faced unprecedented strains related to mandatory closures, social distancing measures, and concerns related to personal safety and the abrupt discontinuation of traditional services (Lynch et al., 2020; Reeves et al., 2021; Reilly et al., 2020). Although researchers acknowledged the implementation of telehealth services before the COVID-19 crisis, many regulatory constraints prevented some clinicians from using these alternative measures (Adler et al., 2014; Freeman et al., 2017; Palfai et al., 2019; Reeves et al., 2021). The prevailing transition to telehealth also

prevented issues associated with MAT for substance abuse services requiring modification to licensing requirements for prescriptions, compounding the existing strain on mental health service treatment and delivery (Abramson, 2021).

Therefore, in this study, I aimed to describe the use of telehealth services and the experiences and perceptions of mental health professionals providing telehealth services to clients during the COVID-19 pandemic. The goal of this study is to help generate useful knowledge for developing best practices for future implementations of telehealth models. The specific research problem addressed through this study was to understand how mental health professionals describe their experiences providing telehealth services. Additionally, understanding how they describe their perceptions of the efficacy and ease of use of alternative models (e.g., virtual, telephone) for providing services to clients during the COVID-19 pandemic was a vital component of this study (e.g., Gentry et al., 2021).

Research Problem

The COVID-19 pandemic created significant challenges for clinicians grappling with the rapid implementation of new mandates and regulations. Although social distancing measures expanded the usage of telehealth services, many studies highlight the utilization of technology-based services prior to the COVID-19 pandemic (Bouchard et al., 2004; Erbe et al., 2017). However, researchers acknowledged the limited utilization of these services due to the lack of insurance reimbursements for underinsured clients (Lapão et al., 2017). Recent studies highlighted the need for a rapid shift to telehealth in service delivery to maintain a continuity of care for diverse clients (Abramson, 2021;

Blanco et al., 2020; Chigangaidze, 2021; Costello, 2020; Croke, 2020; Gentry et al., 2021; Hadjistavropoulos et al., 2020; Lapão et al., 2017). However, due to the limited utilization or exposure to telehealth services for underserved clients, clinicians faced concerns with implementing and delivering technology-based interventions and treatments (Baldacchino et al., 2020; Chen et al., 2020).

Many clinicians in central Virginia have used face-to-face interventions and treatment to provide mental health services to clients (Wijesooriya et al., 2020). However, the COVID-19 crisis forced closures of treatment facilities, social distancing measures, and additional uncertainties for public and private practice (Ohannessian et al., 2020). Additionally, these concerns compelled the expansion of telehealth service delivery while healthcare and mental health professionals grappled with understanding and implementing new platforms (Gentry et al., 2021; Kalayou et al., 2020; Mayo Clinic Staff, 2020).

The specific research problem addressed through this study was exploring how mental health professionals described their experiences with the use or rapid implementation of telehealth services during the COVID-19 pandemic. Additionally, understanding mental health professionals' perceptions of the efficacy and ease of use of virtual/telephone models during the COVID-19 pandemic adds to the field of mental health by expanding the limited understanding of the benefits and challenges observed with implementing telehealth for mental health services with diverse populations (e.g., Gentry et al., 2021).

Research Questions

The following research questions were examined in the study:

RQ1: What are clinicians' experiences and perceptions of providing services to clients during the COVID-19 crisis?

RQ2: How do clinicians describe their experiences and perceptions of the use of telehealth in working with clients?

RQ3: What do clinicians perceive about the efficacy and effects of telehealth services to clients and their access to services during the COVID-19 crisis?

Theoretical Foundation

I aimed to combine the ecological systems theory and the technology acceptance model (TAM) to understand clinicians' experiences and perceptions of the rapid transition to telehealth services during the COVID-19 pandemic in Virginia. The concepts that ground this study included Bronfenbrenner's (1977) ecological model and the TAM (Davis, 1989). Bronfenbrenner's (1977) ecological theory addresses interconnected relationships and the impacts of changes on systems due to change, disruption, or the introduction of external properties. Bronfenbrenner presented an approach to human development that offers a more diverse view of the interactions of systems and their connections. The ecological model moves from the medical model of research. The social ecological model highlights the interconnectedness of the social environment into four categories: (a) microsystem; (b) mesosystem, which focuses on the interactions and relations between two or more microsystems (client-clinician); (c) exosystem, which focuses on things that often indirectly affect microsystems

(COVID-19 pandemic); and (d) macrosystem. By incorporating the social–ecological model, this study presents an opportunity to explore the perceptions and experiences of mental health clinicians implementing new telehealth services.

Additionally, considering the impact of COVID-19 by incorporating the nested systems of Bronfenbrenner's (1977) ecological theory expands research by understanding the effects of multiple systems on one another while exploring their interconnectedness. Bronfenbrenner presented an approach to human development with a more diverse view of the interactions of systems and their connections. Researchers have suggested that Bronfenbrenner's social–ecological perspective focused on the ecological development of individuals, moving away from the previous medical style model (Eriksson et al., 2018).

Through this seminal work, the researcher can conceptualize the components of the introduced perspective to provide researchers with an alternative view of human development and interactions with each other and the environment. In this study, the social–ecological model highlights the interconnectedness of the social environment as follows: (a) microsystem, which focuses on the individual (mental health professionals) in their role as a clinician; (b) mesosystem, which focuses on the interactions and relations between two or more microsystems (client–clinician); and (c) the exosystem, which focuses on things that affect microsystems (COVID-19 pandemic and the implementation of telehealth). Finally, macrosystems consider the broader scope of culture and subcultures that affect society, such as legislation and policies and the inner meanings and beliefs derived from micro-, meso-, and exosystems (Bronfenbrenner, 1977). This framework assisted in the conceptualization of the strengths, challenges, and

interactions of systems while implementing alternative service models during the COVID-19 crisis and providing insight into potential modifications to future policies and practices. Additionally, considering the impact of COVID-19 on benefits was viewed by incorporating Bronfenbrenner's (1977) ecological theory.

Conceptual Framework

Davis's (1989) TAM presented an opportunity to understand end users' perceived ease of use and the usefulness of new information systems. Both models have been incorporated into qualitative and quantitative research by novice and veteran researchers in management, technology, and public health (John et al., 2020; Kalayou et al., 2020; Portz et al., 2019). Additionally, integrating these models allows for understanding of the benefits and challenges observed in telehealth services implementation during the COVID-19 crisis (e.g., Molfenter et al., 2021). Davis (1989) discussed the proposed challenges to accepting information technology systems by introducing the TAM. Davis suggested that participant acceptance relies heavily on perceived ease of use, technology's usefulness, and intended use. Researchers have explored clinical practice information to assist in discovering clinicians' perceptions of the ease of use of telehealth programs and their perceived ideas surrounding their usefulness in treatment with clients (Burnell et al., 2020; Figgatt et al., 2021; Kalayou et al., 2020). An evaluation of the literature presented an opportunity to incorporate the TAM and Bronfenbrenner's (1977) social–ecological model to evaluate the nestled group of systems involved with clinicians and their use of telehealth during the COVID-19 pandemic. Davis's (1989) TAM

presented an opportunity to understand end users' perceived ease of use and the usefulness of new information systems.

For this study, Davis's (1989) TAM provided an opportunity to explore the rapid implementation of telehealth models for mental health services. Additionally, integrating these models presented an opportunity to examine clinicians' experiences with providing primarily telehealth models during the COVID-19 crisis to understand clinicians' perceived benefits and challenges observed in telehealth services implementation during COVID-19 (e.g., Molfenter et al., 2021). Davis (1989) discussed the proposed challenges to accepting information technology systems by introducing the TAM. Participant acceptance can rely heavily on the participant's perceived ease of use, usefulness, and intended use of the technology. The information explored through Davis's TAM assists in discovering clinicians' perceptions of ease of use of telehealth programs and their perceived ideas surrounding their usefulness in treatment with clients.

Nature of the Study

In this study, I used a basic qualitative research method to address the research questions. In conducting the research, Bronfenbrenner's (1977) ecological model and Davis's (1989) TAM were incorporated to conceptualize the challenges associated with the rapid implementation of telehealth services across four social–ecological systems. The ecological model combined with the TAM provide an opportunity to understand the phenomena of providing mental health treatments and interventions in central Virginia during COVID-19. Semi structured, in-depth remote interviews with mental health professionals using a Zoom technology-based platform were conducted to collect data.

Relevant themes associated with effectiveness and efficacy of telehealth services were explored in data analysis (see Archibald et al., 2019; Fink et al., 2020; Morse, 1995; Wilkerson et al., 2014). In my data analysis, I adopted the basic qualitative methods used by Navarro-Moya et al. (2020). By incorporating similar qualitative methods for this study, I obtained rich data from participants by incorporating thematic data analysis to increase understanding of clinicians' perceived benefits and challenges and their experiences associated with the rapid implementation of telehealth for mental health services. Finally, Bronfenbrenner's (1977) social–ecological model provided an opportunity to explore clinicians' experiences and perceptions of the technology's ease of use and usefulness during COVID-19.

Definitions

This section contains a list of key terms pertinent to this study.

Clinician: Trained practice professionals providing intervention, treatment, and other services to patients and clients. This study used the terms *clinicians* and *mental health professionals* interchangeably. These professionals include physicians, psychiatrists, social workers, psychologists, counselors, nurses, and forensic specialists (American Psychiatric Association, 2013).

Mental health: A disruption to psychological, biological, and developmental processes across the life span that limit or inhibit an individual's ability to regulate their thoughts, emotions, or behaviors, preventing normal daily functions and activities (American Psychiatric Association, 2013).

Telehealth: A method of providing care or services to individuals using technology-based equipment such as telephone, computer, or other devices, wherein the parties are in different locations (Mayo Clinic staff, 2020; Wodarski & Frimpong, 2013).

Assumptions

One of this study's assumptions was that Virginia clinicians faced significant challenges implementing telehealth models for mental health services during the COVID-19 pandemic. Another assumption was that clinicians did not have experience with telehealth to provide services to clients prior to the COVID-19 restrictions. An additional assumption was that there is a need for additional training and support of technology-based models to assist with the most effective delivery of mental health services. Many clinicians in the Virginia area provide mental health services for underserved clients who could not qualify for technology-based services before the COVID-19 pandemic. Further, the rapid changes to delivery methods led to challenges with client accessibility and acceptance of telehealth models (Blundell et al., 2020; Miu et al., 2020). Finally, due to changes to caseloads, delivery methods, and time constraints, it was challenging to locate clinical professionals with beneficial knowledge who would be available and willing to share their perceptions and experiences. Additionally, the relaxation of mask mandates and the potential re-opening of many agencies and organizations presented scheduling challenges for mental health clinicians (Gentry et al., 2021; Sasangohar et al., 2020). These assumptions highlight observed gaps in the research showing a need for further inquiry.

Scope and Delimitations

Some considerations incorporated in this study include understanding the experiences and perceptions of mental health clinicians who provided telehealth services during the COVID-19 pandemic. To understand clinicians' roles, responsibilities, and barriers before COVID-19 is necessary to understand fully the impact of rapid telehealth implementation during the COVID-19 pandemic on mental health treatment and service delivery. Therefore, an integral component of this study included a fundamental review of the history of mental health, substance abuse, and telehealth services, as well as an understanding of the evolution of the Mental Health Parity Act and other policies associated with insurance authorizations and billing for mental health services (e.g., Barry et al., 2016; Broderick & Lindeman, 2013; Druss et al., 2018; Nesbitt & Katz-Bell, 2018). Although telehealth models, specifically video conferencing, were available before the COVID-19 pandemic, clinicians providing mental health services for underinsured clients faced challenges with insurance reimbursement. These issues presented barriers to treatment, revealing an overall rejection of telehealth models. Studies highlighted that those clinicians with previous exposure or telehealth experiences before COVID-19 primarily served mid- to high-income clients with adequate insurance (Gentry et al., 2021; Hadjistavropoulos et al., 2020).

Some delimitations included that I planned to conduct interviews with mental health clinicians in central Virginia as study participants. The participants' experiences and education levels varied among social workers, psychologists, substance abuse clinicians, mental health/psychiatric nurses, and mental health peer support specialists.

Clinicians with no primary role in mental health did not meet the inclusion criteria. Additionally, incorporating the Zoom online videoconferencing tool for one-to-one interviews as an alternative to in-person interviews could have created apprehension in participants (see Archibald et al., 2019). Some participants could have faced concerns about being recorded during the interview process. Thus, the participants could turn off their cameras to reduce the adverse effects on disclosure quality. Finally, the small sample size hindered me from obtaining enough data to produce a robust study (see Morse, 1995, 2000). Each step has been presented to allow other researchers to conduct studies with populations to recreate this research. Additionally, studying multidisciplinary mental health clinicians promotes transferability to diverse participants.

Limitations

Some limitations of this study include time constraints, social distancing mandates, and lack of funding to compensate participants. A potential barrier when collecting primary data includes partner site agreement and potential difficulties in recruiting participants for interviews. A significant consideration for this study consisted of the impact COVID-19 had on mental health service delivery. Although previous restrictions have been relaxed, many clinicians have begun transitioning to hybrid (face-to-face and videoconferencing) services. However, these transitions create a potential logistical challenge that may reduce the ability to conduct in-person interviews. Due to these challenges, it was more advantageous to conduct virtual Zoom interviews to reduce additional stress and inconvenience to participants. These methods presented the potential for ethical considerations associated with participant anonymity. These considerations

required me to submit specific instructions regarding eliminating names and extending participants' options to keep their cameras off during the recorded interview. Additionally, using Atlas.ti, a qualitative data analysis tool, required me to incur a fee for the use period.

Significance

This study fills a gap in understanding clinicians' perceptions of the challenges clients faced during the COVID-19 crisis by focusing on the changing trends in client engagement and alternative delivery models during the implementation of the telehealth model. Additionally, the study provides information on clinicians' experiences with learning and navigating the new technology associated with telehealth services (Freeman et al., 2017; Hadjistavropoulos et al., 2020; Huskamp et al., 2018). The results of this study may aid stakeholders by providing new information highlighting the benefits and challenges associated with the telehealth treatment models in Virginia while providing insight into strategies to improve training and the continued enhancement of future telehealth models. Additionally, the knowledge gained through this study promotes social change efforts by promoting the development of accessible treatment models and technology for vulnerable populations, especially in times of crisis. Also, this study assists agencies in understanding how rapid implementation affects client outcomes, presenting an opportunity to explore less disruptive integration methods. Finally, this study allows mental health professionals, agencies, and other stakeholders to embrace technology as a sustainable model for substance abuse treatment and intervention.

Summary

COVID-19 presented unprecedented challenges for public and private health practices throughout Virginia (Wijesooriya et al., 2020). Research has highlighted the rapid transition from in-person mental health services to telehealth models to maintain continuity of care. However, considerations of clinicians' limited knowledge and training, conflicting views of client accessibility, and concerns about ease of use during a period of social distancing reveal causes for continued concern (Hadjistavropoulos et al., 2020; Huskamp et al., 2018; Molfenter et al., 2021). In this study, I aimed to explore the experiences and perceptions of clinicians implementing rapid telehealth services during the COVID-19 pandemic in Virginia. Chapter 2 contains a literature review on the implementation of telehealth services during the COVID-19 pandemic. This chapter also presents the literature related to clinical practice in general and mental health.

Chapter 2: Literature Review

Introduction

In this generic qualitative research study, I aimed to explore the experiences and perceptions of clinicians providing telehealth services during the COVID-19 pandemic in Virginia. Additionally, I aimed to understand clinicians' perceptions of the efficacy, ease of use, and accessibility of telemental health models during the COVID-19 pandemic in Virginia. A literature review provides an opportunity to understand the current research regarding mental health practices, benefits, and challenges observed during the implementation of telehealth services and an understanding of gaps in clinical practice.

Significant data exist regarding the impact of the COVID-19 pandemic on public health services. Additionally, researchers have acknowledged the ancillary concerns associated with mental health and substance abuse services (Cowan et al., 2019; Dunlop et al., 2020). Due to regulatory changes, mandated closures, and social distancing measures, many mental health clinicians faced the challenge of involuntary suspensions of mental health treatment and services, unprecedented safety measures, and implementing alternative methods of care (Costello, 2020; Liang et al., 2020; Lynch et al., 2020; Reilly et al., 2020). Researchers have presented opposing interpretations of participants' perceived ease of using and applying telehealth models during the COVID-19 pandemic (Chiauzzi et al., 2020; Dunlop et al., 2020; Kleykamp et al., 2020; Miu et al., 2020). Although researchers have conducted studies on the execution of telehealth during COVID-19, a gap remains in exploring clinicians' experiences and perceptions of

the rapid implementation of telemental health services during the COVID-19 pandemic in Virginia.

This section is an analysis and synthesis of critical terms and literature related to the impact of the implementation of telehealth in public and mental health treatment during COVID-19. I render research about public and mental health practice, regulatory changes, and the impact of technology-based models for service in mental health practice. Additionally, I provide a brief history of mental health treatment, telehealth services, and a brief progression of policy changes before and after the onset of the COVID-19 pandemic. This chapter also highlights some practical benefits and challenges clinicians face by incorporating Davis's (1989) TAM and Bronfenbrenner's (1977) ecological systems lens to understand the effects of multiple issues presented to mental health and substance abuse treatment during the COVID-19 crisis. The literature review ends with a section summary and a preview of Chapter 3.

Literature Search Summary

The key databases used in my literature search were Academic Search Complete, Google Scholar, SocINDEX, and PsychINFO. To obtain the most important publications about implementing mental health and substance abuse treatments and clinicians' perceptions, I searched SocINDEX first because it has a high specificity for social science journals. Finally, I used the snowball research method to review studies and documents referenced in relevant studies. The search terms relevant to this study included *technology-based mental health treatment, clinicians' perceptions, trends in telehealth implementation, the impact of COVID-19 on mental health, alternative mental health*

treatment, *telehealth treatment for vulnerable populations*, and *telemental health*. My search resulted in primarily peer-reviewed articles published between 2017 and 2021. Some articles in the literature review were published before these years but were essential to include because they provided historical information, seminal studies, and theories pertinent to the study.

Theoretical Foundation

The theories and concepts that ground this study include Bronfenbrenner's (1977) social–ecological model and the TAM (Davis, 1989). Bronfenbrenner's (1977) ecological theory addresses interconnected relationships and the impacts of changes on systems due to change, disruption, or the introduction of external properties. Bronfenbrenner presented an approach to human development that offers a diverse view of the interactions of systems and their connections. Through this seminal work, the conceptualized components of the introduced perspective provide researchers with an alternative view of human development and interactions with each other and their environment.

Bronfenbrenner's (1977) ecological systems theory began as a framework geared toward conceptualizing the impact of internal and external systems on human development, specifically children and youth. Incorporating the ecological systems model allows researchers and change agents to evaluate the social and environmental challenges that impact diverse concerns (Swearer & Hymel, 2015). Swearer and Hymel (2015) incorporated the social–ecological model to understand the impact of social and environmental factors on a particular issue.

Bronfenbrenner (1977) highlighted that the development of his seminal work was due to the limitations of the existing rigidity traditionally observed in developmental psychology. The ecological systems model aids change agents in understanding and evaluating the internal and external risks present during the onset of the COVID-19 pandemic (Onwuegbuzie et al., 2013; Substance Abuse and Mental Health Services Administration [SAMHSA], 2020). Bronfenbrenner's (1977) ecological systems model supports diverse research approaches, highlighting the benefits of exploring one system's inseparable relationships and impacts on another (Onwuegbuzie et al., 2013). Eriksson et al. (2018) highlighted the benefits of incorporating Bronfenbrenner's (1977) ecological model in mental health treatment, highlighting the interconnected relationships between individuals, social interactions, and other systems interacting with the environment.

Microsystems

The microlevel involves the individual relationships of the clinician as a practitioner (Bronfenbrenner, 1977). Bronfenbrenner (1977) described the microsystems as a component that continues to be affected by changes in the environment and formal and informal settings that may affect changes and development. The focus on this level includes clinicians' role as mental health services providers and their interactions within their agencies and communities (Moloi et al., 2020; Pierce et al., 2021). Additionally, the clinical practice overall was impacted at the onset of the COVID-19 pandemic due to concerns related to personal health and safety, safety of clients, and adjustments to mandatory closures and social distancing guidelines (Cowan et al., 2019; Croke, 2020; Costello, 2020; Moloi et al., 2020; Pierce et al., 2021; Wodarski, 2020). Studies have

highlighted the challenges associated with clinician fatigue and navigating the onslaught of media coverage and mixed messaging (De Brier et al., 2020; Galehdar et al., 2020). Galehdar et al. (2020) discussed some of the challenges associated with clinicians facing personal–psychological distress, including personal anxieties and fear of contracting COVID-19 or infecting their loved ones (Reilly et al., 2020). These considerations highlight challenges of clinicians who may have continued to provide in-person care during the pandemic.

Additionally, many clinicians providing remote services began to face considerable challenges in implementing telehealth services. Chigangaidze (2021) explored the challenges social workers face during the COVID-19 pandemic by considering the connections of global systems through a lens of the biopsychosocial model and the social–ecological approach to viewing practice during the crisis. Furthermore, research has presented the benefits of understanding, exploring, and evaluating interconnected relationships among healthcare providers and mental health clinicians implementing technology-based platforms during crisis or trauma (Chigangaidze, 2021; Eriksson et al., 2018; Onwuegbuzie et al., 2013). Mental health treatment shows the interconnected relationships between individuals, social interactions, and other systems interacting with the environment.

Mesosystems

The mesosystem focuses on interconnected settings and relationships, such as clinician and client (Bronfenbrenner, 1977). Studies have highlighted the challenges associated with the temporary halt of services during the COVID-19 pandemic and the

risk of breaking continuity of care during mandatory closures (Gentry et al., 2021; Johnson et al., 2021; Khan et al., 2021). Researchers highlighted that the impact of social distancing measures provided benefits and challenges for mental health services (Figgatt et al., 2021; Gentry et al., 2021; Molfenter et al., 2021). One of these considerations involved the regulatory changes required to authorize prescriptions and distribute medications for substance abuse and mental health treatment. MAT involves the client-centered practice of combining cognitive behavioral therapies along with prescriptions (e.g., methadone, naloxone, buprenorphine, and naltrexone) to assist clients in reducing or eliminating their use of illicit substances (Figgatt et al., 2021). The American Society of Addiction Medicine (n.d.) presented recommendations for inpatient and outpatient substance abuse treatment during COVID-19 and currently. However, maintaining enhanced safety practices to reduce infection and exposure remained a central focus (Frank et al., 2021). Some of these considerations involved the pre-COVID methods for prescribing medications and the environment of the dispensing locations. Frank et al. (2021) discussed the crowded waiting areas and often long lines to pick up prescriptions for medication-assisted therapies.

During the COVID-19 pandemic, social distancing measures presented challenges in addition to the requirements for daily, in-person pick-up (Figgatt et al., 2021; SAMHSA, 2020). In a retrospective study, Khan et al. (2021) researched the benefits and challenges of MAT models. Through this study, researchers observed that the level of harm to clients incorporating MAT in conjunction with cognitive behavioral therapy models significantly reduced harm in clients (Khan et al., 2021). Researchers highlighted

the need for continued safety planning for challenges that may arise related to the pandemic (Frank et al., 2021; SAMHSA, 2020). Furthermore, discussions focused on evaluating lessons learned and expanding technical support and training highlighted critical focal points (Frank et al., 2021).

Abramson (2021) published an article with the American Psychiatry Association discussing the challenges associated with increases and initiations of substance use challenges during the COVID-19 pandemic. Additionally, there was an 18% increase in overdose rates in 2019, with a continued rise in 2020 (Abramson, 2021). The lifted restrictions of Medicaid and other insurers allowed telehealth treatment models for mental health and substance abuse (Costello, 2020; Lynch et al., 2020). Moreover, implementing telehealth measures provided access to treatment services, including medication-assisted therapies such as buprenorphine and methadone take-home programs. Some recommendations to enhance clients' positive outcomes included mental health professionals encouraging clients to seek assistance, including MAT. The current gap in medications to assist users of stimulants in the manner approved for substance abuse treatment remains a challenge for mental health services (Abramson, 2021). However, the suggestion remains to encourage the continuation of traditional cognitive behavioral therapy in conjunction with developing relapse prevention planning to reduce potential risks (Abramson, 2021). Although the challenges associated with medications initially impacted clinicians' ability to maintain continuity of treatment and care, these considerations highlighted the indirect concerns associated with regulations that required modification to improve treatment delivery and services during the COVID-19 crisis.

Exosystems

The exosystem of Bronfenbrenner's (1977) social–ecological model focuses on the formal and informal structures that indirectly affect the micro and mesosystems. These considerations include the impacts of social and mass media, the rapid implementation or primary use of telehealth models, and the overall changes to traditional operations (Bronfenbrenner, 1977; Rogers et al., 2018; Sasangohar et al., 2020). In May 2020, Lynch et al. discussed state and public health professionals' challenges regarding previous restrictions to managed care practices. Lynch et al. provided an informational bulletin to introduce guidance and examples for completing the necessary documents specific to temporary regulatory changes for providers. However, the care provided for funding increases and adoption of the impermanent changes specified client-centered services such as behavioral health to compensate for self-quarantine measures and other mandated restrictions associated with the COVID-19 public health crisis. In December 2020, Costello created a bulletin that discussed the regulations specific to Medicaid and Children's Health Insurance Program eligibility renewal. Additionally, Costello, as acting deputy administrator and director, highlighted the need for agencies to modify their operations to accommodate alternative methods for clients to submit documentation due to the challenges associated with the COVID-19 pandemic. Furthermore, Costello suggested that agencies review discrepancies or concerns that may deem applicants ineligible to assist them in resubmitting corrected information or documentation.

A significant change to current renewal procedures involved reducing the administrative strain of renewals by conducting periodic renewals to enhance the continuation of benefits. Some requirements associated with periodic renewals included states beginning to review their records between the initial application and the scheduled renewal. Costello (2020) discussed implementing a renewal cycle every 12 months to implement audit records using technology-based tools as an aid. Finally, the Families First Coronavirus Act promoted increased funding for services while expanding the authorization for alternative methods previously unavailable to underserved populations (Costello, 2020; O'Mahen & Petersen, 2021).

Macrosystems

Adams et al. (2019) examined telehealth models among the Veterans Health Administration care systems intending to fill a gap in understanding the needs and uses of these strategies. Further, the comparative data from veterans who used the services and those who had not assisted in understanding how a video platform was incorporated (Adams et al., 2019). Adams et al. (2019) incorporated secondary data from the agency's database covering fiscal years 2009 through 2015. A significant increase in veterans' utilization of telemedicine, but, in most cases, clients utilizing services lived in rural settings or localities that presented barriers to in-person visits; additionally, of the cases, 50% of visits included mental health services (Adams et al., 2019).

Baldacchino et al. (2020) discussed the effects of the COVID-19 pandemic on individuals facing challenges associated with substance use disorder. The challenges presented to agencies and communities facing mental health and substance use disorders

present populations with increased vulnerability for relapse and noncompliance with social distancing measures. In addition to the concerns associated with relapse and increased transmission of COVID-19, pre-existing barriers existed for vulnerable populations. Although regulations, licensing restrictions, and reimbursement issues were temporarily modified to accommodate the implementation of telehealth models, significant concerns exist surrounding the future of mental health services following the COVID-19 pandemic (Abramson, 2021). Additionally, although temporary measures assisted with some barriers, many clients could not access telehealth services due to limited (or nonexistent) connectivity challenges, limited knowledge about technology in general, or a combination of these factors (Abramson, 2021; Adams et al., 2019; Cowan et al., 2019; O'Mahen & Petersen, 2021).

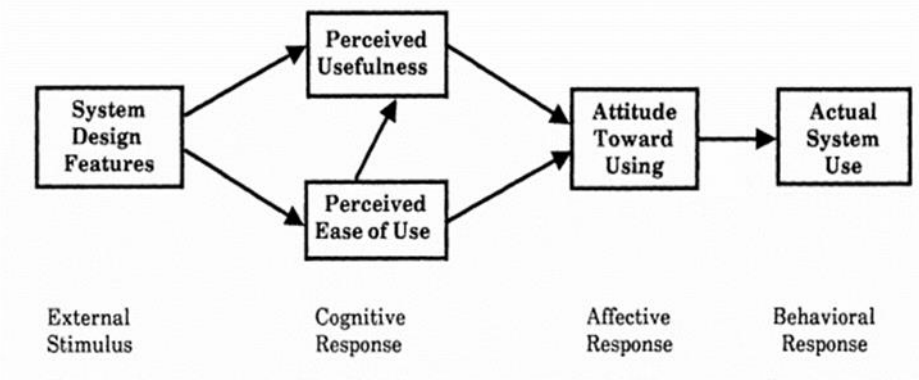
Kilanowski (2017) and Onwuegbuzie et al. (2013) acknowledged that representation of global connectedness was evident through the integral physical, social, and political components fundamental to understanding the effects on multiple systems during the COVID-19 pandemic. Researchers considered the diversity of the social-ecological model and the ability to incorporate the framework for multidisciplinary research during the COVID-19 pandemic (Eriksson et al., 2018; Swearer & Hymel, 2015). The current literature and explanation of the ecological approach provided a guide for contextualizing the interconnected systems involved in the rapid implementation of telehealth services and the perceptions and experiences of clinicians in Virginia (e.g., Chigangaidze, 2021; Eriksson et al., 2018; Kilanowski, 2017; Onwuegbuzie et al., 2013).

Conceptual Framework

F. D. Davis's (1989) TAM focuses on understanding how the combination of external stimulus or the overall system design connects with the perceived ease of use and usefulness of technology-based programs. F. D. Davis suggested that participant acceptance relies heavily on their perceived ease of use, technology's usefulness, and intended use. F. D. Davis originally proposed this model as his dissertation in 1986. As seen in Figure 1, the perceived ease of use and usefulness contribute to the end-users' attitudes toward benefits and challenges with using the technology-based model and ultimately determine their perceptions toward continued use (F. D. Davis, 1989). F. D. Davis's (1989) TAM was incorporated into qualitative and quantitative research by novice and veteran researchers in management, technology, and public health.

Figure 1

Technology Acceptance Model



Source: Davis (1989)

For this study, F. D. Davis's (1989) TAM provided an opportunity to explore the rapid implementation of telehealth models for mental health services. Additionally,

integrating these models presents an opportunity to examine clinicians' experiences with providing telehealth models during the COVID-19 crisis to understand clinicians' perceptions (Molfenter et al., 2021). The TAM model introduces an opportunity to explore the considerations associated with clinicians' previous (or lack of) knowledge of the telehealth intervention and treatment models during the COVID-19 pandemic. Additionally, the issues associated with training before, during, and after the rapid implementation of telehealth models speaks directly to the clinicians' perceived ease of use, attitudes toward using, and their potential attitudes toward continuing to use telehealth models following the COVID-19 pandemic (F. D. Davis, 1989).

Literature Review

Telehealth Pre-COVID-19

The Mayo Clinic Staff (2020) defined telehealth as providing care or services to individuals using technology-based equipment such as telephone, computer, or other devices, wherein the parties are in different locations. In a seminal study, Field (1996) created a guide to telecommunications for the Institute of Medicine, defining telemedicine as incorporating electronic technology-based communication and information to provide health treatment and support for patients and clients remotely. Telehealth embodies similar qualities; however, this model extends to additional services, such as education, assessments, interventions, and treatment (Mayo Clinic Staff, 2020; Nesbitt & Katz-Bell, 2018; Shigekawa et al., 2018; Wijesooriya et al., 2020). Early communication models beneficial for public health services began as early as the 1800s.

In 1912, research highlighting the use of two-way radios to diagnose a patient became available (Nesbitt & Katz-Bell, 2018; Wijesooriya et al., 2020).

Clinical practitioners continued to represent the primary source for interventions, treatment, and services throughout these transitions by maintaining continuities of care, introducing alternative methods of accessibility, and reducing client harm (Druss & Goldman, 2018). Telehealth was used but not predominantly adopted prior to the COVID-19 pandemic. Miu et al. (2020) highlighted that before the COVID-19 pandemic, teletherapy was not a predominant model for practice with clients facing challenges associated with severe mental illness. However, the immediate implementation of telehealth was focused on health care and psychiatry with clients from mid-to-high-income earners (Hadjistavropoulos et al., 2020; Sims, 2018).

In addition to the transformation of the mental health services landscape, the ongoing challenges of supporting and assisting individuals, groups, and communities presented additional challenges associated with homelessness, limited education, and the ongoing challenges of pre-existing substance abuse, mental health, and co-occurring disorders (Chigangaidze, 2021; M. T. Davis et al., 2021). Uustalu et al. (2015) presented challenges to adopting European telehealth models. Accessibility and affordability due to regulatory restrictions hindered clinicians' ability to provide adequate services for vulnerable populations with limited income and insurance (Barry et al., 2010, 2016; Uustalu et al., 2015). The most evident challenges involved the ongoing inequities due to third-party billing and health care for underinsured clients (Barry et al., 2016; Miu et al., 2020). These changes emphasized the lack of parity between traditional health and

mental health services and treatment insurance. Therefore, telehealth was used before the COVID-19 pandemic (Miu et al., 2020).

Shulver et al. (2016) examined the perceptions of frontline workers that implemented telehealth services for older adults. By incorporating a qualitative research study incorporating focus groups, Shulver et al. used semi-structured questions with 44 healthcare workers in urban and rural settings. Some findings indicated that previous exposure to technology-based models significantly influenced many participants' acceptance or aversion to the telehealth models. However, marked differences were observed between urban and rural areas and novice and experienced telehealth clinicians (Shulver et al., 2016). Healthcare workers in urban areas reported aversion to telehealth models, while rural participants reported positive perceptions of implementing technology-based services (Shulver et al., 2016).

Many studies before the COVID-19 pandemic highlighted client implementation in primary health and palliative care, revealing a gap in other human service professions (Shulver et al., 2016; Sims, 2018). These considerations present a basis for inquiry regarding how clinicians describe their telehealth experiences before the COVID-19 crisis with a more diverse client base. Additionally, this research study aimed to understand how practitioners' roles changed with the rapid transition of mental health service delivery models.

COVID-19 and Telehealth

With the declaration of COVID-19 as a global pandemic in March 2020, the delivery of mental health and substance abuse services changed. These changes presented

considerable challenges for in-person services due to social distancing mandates, increased health risks, and regulatory restrictions (Pierce et al., 2021; Wijesooriya et al., 2020). At the onset of the COVID-19 pandemic, clinicians faced concerns associated with their health and safety, in addition to mandatory closures, social distancing measures, and the rapid transition from in-person services to technology-based treatments following abrupt cessation of services (Hennein & Lowe, 2020; Lynch et al., 2020; Reeves et al., 2021; Reilly et al., 2020; Sasangohar et al., 2020; Wijesooriya et al., 2020).

Many clinicians providing public health services face the uncertainty of continuing treatment and interventions for their clients while providing remote resources (Gavin et al., 2020). Additionally, reduced socialization and fear highlighted an increase in mental health and substance abuse services throughout the United States (Abramson, 2021; Reeves et al., 2021; Shah et al., 2020). Cowan et al. (2019) highlighted some primary considerations and barriers associated with the implementation and acceptability of telehealth models.

Chigangaidze (2021) conceptualized the social, physical, and mental effects of the COVID-19 pandemic across clients' lifespans. Although the onset of COVID-19 directly impacted communities globally, the associated implications affected several aspects of daily life; individuals, groups, and communities attempted to navigate the changing landscape while adapting to new norms and operations (Chigangaidze, 2021). Many clients and clinicians face anxiety and stress from the sudden changes to policies and procedures in their daily lives.

Traditionally, clients might seek treatment and services in person; however, the health risks associated with the COVID-19 virus present barriers (Reeves et al., 2021). Researchers have discussed some of the challenges introduced following the rapid implementation of telehealth services and the concerns associated with their client's health and safety (Miu et al., 2020; Reeves et al., 2021). Miu et al. (2020) studied the rapid implementation of teletherapy for clients facing severe mental illnesses. The researchers highlighted that there was initially a limitation to staff training or being versed in telehealth before COVID-19. However, incorporating a quantitative study to evaluate whether the conversion from in-person therapy to telehealth therapy presented a significant difference between clients with serious mental illnesses and clients without a complete understanding of the impact or efficacy of the models. Miu et al. found no significant differences following telehealth implementation. Researchers maintained that some telehealth treatment models might provide beneficial alternatives for future practice; however, additional research remains the key to determining the efficacy of telehealth models of treatment and practice (Miu et al., 2020). However, Miu et al. (2020) acknowledged that the impact of temporary licensing and insurance waivers requires consideration for future practice to enhance the continuation or expansion of policies for mental health practice beyond the COVID-19 pandemic.

However, some limitations inherent in the study included the disproportionate number of Caucasian male clients compared to other ethnicities and genders. Additionally, using a quantitative method significantly reduces the ability to examine the specific experiences of clients and clinicians during the conversion to telehealth.

Additionally, the barriers to research existed due to regulatory restrictions, social distancing, and limited contact measures. Clinicians observed the limited ability to provide thorough health examinations, and concerns surrounding information security during assessments surfaced. Significant concerns were presented by a reduction in the development of meaningful client-clinician relationships and concerns related to navigating changing regulations and reimbursement policies to expand access to clinicians' telehealth services (Reeves et al., 2021). A review of the level of inequity highlighted during this period would enhance policies that aim to reduce inaccessibility and encourage social change across intervention and treatment platforms in the future of health service delivery models.

Challenges With Telehealth

Reeves et al. (2021) discussed the challenges associated with limited space, technical concerns, and other environmental barriers. Further, the authors discussed the concerns that telehealth undermined the client–clinician relationship, leaving some clients feeling the service was inadequate. Finally, many patients reported difficulties connecting and communicating with providers during the move to telehealth services. Kalayou et al. (2020) determined whether a modified TAM proved applicable when implemented in a health setting. Kalayou et al. conducted a cross-sectional study utilizing questionnaires for 384 healthcare professionals. The research aimed to determine if healthcare providers intended to adopt alternative technology models when other resources remained limited (Kalayou et al., 2020). A correlation between the participants' perceived usefulness and intention to implement eHealth platforms existed; additionally, there was an additional

correlation between the usability (ease of use) and the intent to adopt eHealth. Kalayou et al. (2020) and Gentry et al. (2021) presented beneficial models for assessing participants' ease of use of telehealth platforms and their perceived usefulness of the models.

The expansion of telehealth measures to maintain continuity of care for clients and patients during an uncertain time, especially for those experiencing challenges associated with mental health and substance abuse concerns, highlighted an integral component of the COVID-19 pandemic. However, Kalayou et al. (2020) pointed out the challenges associated with Internet accessibility, clients' limited knowledge or experience with Internet-based platforms, and concerns related explicitly to continuing toxicology screenings for clients participating in substance abuse treatment programs.

By understanding the impact of temporary licensing and insurance waivers on telehealth during the COVID-19 pandemic, stakeholders become more aware of the benefits and challenges of continuing or expanding policies for practice. Finally, reviewing the inequity highlighted during this period would enhance policies that reduce inaccessibility and encourage social change across intervention and treatment platforms. Blundell et al. (2020) gathered evidence from various data sources of inequalities highlighted during the pandemic. These considerations highlight issues associated with earnability, family dynamics, and health concerns (Blundell et al., 2020). The utilization of this research provides a basis for reproducing a similar study in central Virginia. This study presents relevant information highlighting challenges often observed in Virginia (Pierce et al., 2021; Wijesooriya et al., 2020). Additionally, the rapid implementation of

telehealth may present additional challenges and benefits that may be addressed through a more focused thematic analysis.

John et al. (2020) posited that evidence and research acknowledged the efficacy and benefits of telehealth models, including efficacy, suitability, and acceptance; many clinicians faced concerns about the appropriate methods of initiating the models. More specifically, a literature review highlighted challenges to accepting telepsychiatry that aligned with Davis's TAM. The findings presented limited studies related to acceptance, specifically with the clinicians' implementation, where feasible, as opposed to the clients' acceptability of the models (Burnell et al., 2020; Davis et al., 2021; Kalayou et al., 2020).

Montoya et al. (2022) conducted a quantitative study to understand the impact of telehealth services during the COVID-19 pandemic. The study incorporated surveys distributed internationally to mental health professionals providing services in 100 countries. The study revealed that many clinicians received limited training on the telehealth models before implementation. Additionally, many clinicians revealed mixed feelings about telehealth's effectiveness (Montoya et al., 2022). However, additional training remained a key factor for many clinicians. This study highlighted concerns related to training and clinicians' perceptions of the effectiveness of telehealth following the implementation.

In general, studies indicated pervasive challenges with the utilization of telehealth before and during COVID-19 (Barry et al., 2016; Kalayou et al., 2020; Pierce et al., 2021). However, many researchers specified challenges associated with logging in, limited technical support, and other limitations associated with clinicians' lack of

knowledge and training (Kalayou et al., 2020; Palfai et al., 2019; Portz et al., 2019). This study aimed to examine how mental health professionals adapted to or addressed those challenges by seeking to understand if telehealth enhanced or inhibited their ability to provide mental health services.

Telehealth and Mental Health Treatment

Studies related to implementing telehealth and telemedicine highlighted the increased incorporation of these models into practice in primary care, palliative care, and other health services (Fischer et al., 2021; Nicholas et al., 2021). Although many studies primarily focused on primary and specialized health care, qualitative research on mental health remains limited. Nicholas et al. (2021) conducted an online survey with clinicians and youth participants to understand their perspectives on the rapid implementation of telehealth during the COVID-19 pandemic. The study suggested that youth viewed the implementation and delivery of telemental health services more positively than clinicians overall. The limitations of this study included the lack of additional information to determine the participants' specific reasoning behind their selections. Additionally, a qualitative research study would present an opportunity to incorporate clarifying questions that reduce ambiguity.

Researchers suggested examining additional variables that might affect youth mental health because of the COVID-19 pandemic (Liang et al., 2020). Gavin et al. (2020) presented perspectives on mental health challenges resulting from the COVID-19 pandemic. Additionally, the authors highlighted the compounded effects of the rapid implementation of alternative service methods to assist in maintaining continuities of

care. Gavin et al. (2020) posited that vulnerable populations, specifically children, faced the most significant risks during the pandemic. Gavin et al. (2020) and Lynch et al. (2020) suggested an evaluation of the future of mental health practice, including the development of multidimensional models to address complex issues.

Hopkins and Pedwell (2021) examined the shift to telehealth for youth mental health services due to mandated restrictions following the onset of the COVID-19 pandemic. Researchers incorporated the use of closed- and open-ended survey questions t gather an understanding of the impact of these changes on youth mental health services (Hopkins & Pedwell, 2021). Additionally, the study revealed the perceived benefits and challenges of the transition to telehealth services, highlighting the convenience and flexibility of services (Hopkins & Pedwell, 2021). However, some challenging considerations included the limitation for younger and the most high-risk clients (Hopkins & Pedwell, 2021). The results revealed that less than 12% of respondents disliked working remotely. However, only 2% preferred working solely from home (Hopkins & Pedwell, 2021). Additionally, many respondents agreed that telehealth models were less effective for preschool-aged youth, clients facing technological disadvantages or limited skills, and clients benefiting from social contact. These considerations provide insight into potential challenges that may occur globally for mental health clinicians providing services for youth and adolescents during the COVID-19 pandemic.

Baldacchino et al. (2020) discussed the effects of the COVID-19 pandemic on individuals facing challenges associated with substance use disorder. The challenges to

agencies and communities facing mental health and substance use disorders present populations with increased vulnerability for relapse and noncompliance with social distancing measures. In addition to the concerns associated with relapse and increased transmission of COVID-19, pre-existing barriers existed for vulnerable populations. Although regulations, licensing restrictions, and reimbursement issues were temporarily modified to accommodate the implementation of telehealth models, significant concerns exist surrounding the future of mental health services following the COVID-19 pandemic. Additionally, although temporary measures assisted with some barriers, many clients could not access telehealth services due to limited (or nonexistent) connectivity challenges, limited knowledge about technology in general, or a combination of these factors. This study highlights the benefit of qualitative research in understanding the specific experiences and perceptions related to implementing mental health services using telehealth models during the COVID-19 pandemic.

Professionals' Perceptions of Access to Services During COVID-19

Adler-Milstein et al. (2014) discussed the potential decrease in barriers to health services by implementing telehealth services. Some of the factors associated with adopting technology-based alternatives hinged on the specific mission of the agencies, the technological capabilities of the locality, and the specific accessibilities of the clients/patients (Adler et al., 2014; Erbe et al., 2017). Some clinicians experienced fears associated with technological platforms reducing the need for physical platforms (Adler et al., 2014; Erbe et al., 2017; Reeves et al., 2021). Erbe et al. (2017) reviewed the benefits of hybrid, face-to-face, and telehealth models of delivering substance abuse

treatment and interventions. Researchers considered the implementation of hybrid (telehealth and face-to-face) as an option to increase client engagement (Erbe et al., 2017).

Huskamp et al. (2018) revealed minimal usage of telehealth services; however, mental health usage revealed more usage than substance abuse treatment models. Additionally, researchers revealed beneficial information regarding the limited usage of telehealth services for substance abuse treatment and interventions before the COVID-19 pandemic (Huskamp et al., 2018). Although many local, state, and government agencies provided guidance that promoted positive outcomes, many public and private agencies still faced challenges associated with limited external support, reduced client engagement/access, and training to improve outcomes. These considerations inform future research by highlighting significant macro-level challenges faced, specifically for vulnerable clients.

Professionals' Service Experience During COVID-19

Adams et al. (2019) examined using telehealth models among the Veterans Health Administration care systems intending to fill a gap in understanding the needs and uses of these strategies. Further, the comparative data from veterans that used the services and those that had not assisted in understanding to what extent a video platform was incorporated (Adams et al., 2019). Adams et al. (2019) incorporated secondary data from the agency's database covering fiscal years 2009 through 2015. A significant increase in veterans' utilization of telemedicine, but, in most cases, clients utilizing services lived in rural settings or localities that presented barriers to in-person visits; additionally, of the

cases, 50% of visits included mental health services (Adams et al., 2019). Although Adams et al. (2019) discussed the increase in telehealth services during the COVID-19 pandemic, many agencies provided telehealth services before the onset of the crisis. This study assists in understanding how clinicians implemented or continued telehealth services. Additionally, the use of secondary data by Adams et al. highlights challenges in understanding the individual perceptions and experiences faced by the participants.

M. T. Davis et al. (2021) studied understanding the perspectives of program directors regarding challenges they face with substance use treatment and intervention in their programs. M. T. Davis et al. incorporated surveys and in-depth interviews to understand the strategies incorporated by programs to improve treatment outcomes for clients. Researchers found that many programs faced similar challenges associated with clients' limited engagement and navigating policy constraints (M. T. Davis et al., 2021). However, the researchers' thematic analysis highlighted the use of incentives and the development of ways to increase retention. This study presented relevant information highlighting challenges often observed in central Virginia (M. T. Davis et al., 2021). Additionally, the rapid implementation of telehealth may present additional challenges and benefits through a more focused thematic analysis.

Sugarman et al. (2021) conducted a quantitative study to evaluate clinician satisfaction with the rapid transition to telehealth following the COVID-19 pandemic. In a survey of 107 clinicians from social work, nursing, psychology, and psychiatry, Sugarman et al. (2021) utilized surveys to ascertain their ability to develop an effective client-clinician relationship. Additionally, researchers considered participants' intent to

continue utilizing telehealth after in-person services become available and the accessibility of clients during the implementation of technology-based models (Sugarman et al., 2021; White et al., 2022). Overall, researchers found that clinicians were primarily satisfied with the implementation of telehealth models, but there were some significant differences regarding initial assessments and group therapy usage (Gentry et al., 2021; Hadjistavropoulos et al., 2020; Sugarman et al., 2021).

Additionally, White et al. (2022) echoed similar sentiments among clinicians providing services within the hospital during the COVID-19 pandemic. I incorporated a qualitative thematic analysis of clinicians' experiences in a healthcare setting, rapidly implementing telehealth services at the onset of the pandemic. Some critical components involved professionals' gratitude for the opportunity to maintain continuities of care. However, consistent with other research outcomes, clinicians suggested additional training and education for patients on appropriate etiquette for virtual appointments and additional training for clinicians providing services (White et al., 2022).

Findings indicate that experience varied during COVID-19. However, most studies are relatively quantitative, with limited information about the thoughts and perceptions of professionals about their experiences (Nicholas et al., 2021). Knowledge about thoughts and perceptions of experience is critical to developing and implementing effective models.

Professionals' Perceptions of Telehealth

Some studies yielded positive feedback regarding healthcare professionals' perceptions of telehealth. However, studies on mental health clinicians providing

telehealth services for vulnerable populations remain limited. Wood et al. (2020) conducted a quantitative research study to examine the outcomes of the rapid implementation of telehealth services for adolescent health and mental health services. Researchers compared the completion rates of adolescents using telehealth during the first 30 days of implementation (Wood et al., 2020). Wood et al. (2020) studied 392 telehealth visits for services ranging from contraception disorders and eating disorders to gender-affirming concerns and substance abuse challenges. Approximately 82% of scheduled clients completed their scheduled telehealth appointments, resulting in positive results for the study (Wood et al., 2020). Some limitations Wood et al. (2020) presented included that participants were predominantly female Caucasians with private insurance.

Additionally, the researchers concentrated their study on five states close to the researched clinic (Wood et al., 2020). Finally, incorporating the quantitative study within a limited timeframe limits the ability to understand the benefits and challenges observed during the rapid implementation of telehealth services. Additionally, Wood et al. (2020) presented limited information regarding the implemented model's perceived ease of use or usefulness. However, Wood et al. acknowledged the necessity to continue evaluations within low-resource clinical settings to sustain telehealth services during and after the COVID-19 pandemic.

Ervin et al. (2021) examined clinicians' perceptions of implementing telehealth services for clients during the COVID-19 pandemic. The researchers incorporated purposive sampling to recruit clinicians to complete surveys. Additionally, Ervin et al. incorporated the use of the normalization process theory to understand the perceptions of

use and the potential intent to maintain telehealth or normalize the models following the COVID-19 pandemic. During this study, 52% of participants revealed telehealth was a new model for them, and 58% agreed that telehealth would likely become a continued practice for their work with clients. This study provides insight into some clinicians' perceptions of telehealth services, often for the first time, during the COVID-19 pandemic. However, this study was conducted utilizing a survey that limited the ability to gain in-depth knowledge of the clinicians' perceptions and experiences during the rapid implementation of telehealth.

Some telehealth treatment models may provide beneficial alternatives for future practice; however, additional research remains the key to determining the efficacy of telehealth models of treatment and practice (Pierce et al., 2021; Uustalu et al., 2015). Additionally, this study explored how mental health professionals described their experiences before and during the COVID-19 pandemic. The goal was to show how they described their perceived benefits and challenges during implementation and daily use and to show some barriers clinicians observed in practice with their clients. This study enhances the opportunity to explore these goals while acknowledging emerging themes and trends from the clinicians' experiences and perceptions of implementing telehealth services during the COVID-19 pandemic in Virginia.

Clients' Experiences With and Perceptions of Telehealth

Goetter et al. (2019) conducted a quantitative research study with 253 veterans receiving outpatient telepsychiatry services. The range of treatment included deployment-related mental health services that affected clients' ability to return to pre-deployment

daily living activities (Goetter et al., 2019). Researchers aimed to understand clients' comfort levels and attitudes toward the shift to telepsychiatry. Although a significant number (one-third) of participants preferred telepsychiatry over in-person services, most of the remaining clients acknowledged their aversion to telepsychiatry overall (Goetter et al., 2019). Goetter et al. (2019) highlighted the consideration of mixed feelings about implementing telehealth services. However, this study's limitations included the specialized focus on Veterans and military personnel, which might not transfer to the civilian population. Additionally, the mixed findings of this quantitative study justified the incorporation of qualitative research to explore participants' specific experiences and perceptions.

Molfenter et al. (2021) used the TAM to frame a study toward determining the perceived ease of use and intent to continue using telehealth services during and after the COVID-19 pandemic. The researchers hypothesized the perceived usefulness of the technology. Many local, state, and federal agencies faced the rapid implementation of telephone and virtual therapies due to mandated closures and safety concerns. Information and research regarding the perceptions about the usefulness and intent to continue these alternative strategies remained limited. Molfenter et al. posited that many clients facing substance abuse and mental health challenges benefited from the alternative methods due to their increased access to mobile devices and telephone services.

Additionally, Molfenter et al. (2021) explored the perceived usefulness of telehealth services would correlate with ease of use and intent to continue services following the COVID-19 pandemic. Molfenter et al. developed a survey tool to evaluate

the responses of over 450 agencies across 43 states to determine the perceptions of clinicians providing health, mental health, and other specialty services. The results indicated that specialty services represented the highest results in using telehealth models (Molfenter et al., 2021). However, with the mandatory transitions of care due to social distancing mandates, Molfenter et al. (2021) noted that all services used telephone or video conferencing during the pandemic.

Palfai et al. (2019) explored the experiences of people living with HIV that faced co-occurring challenges associated with chronic pain and heavy drinking. Researchers aimed to understand participants' pain challenges, their level of alcoholism, and their use of technology (Palfai et al., 2019). Using one-on-one interviews provided a more comprehensive understanding of participants' thoughts. Palfai et al. (2019) recorded the interviews and transcribed the audio to obtain a thematic analysis. Palfai et al. revealed that patients benefited from the increased coping strategies introduced during telehealth interventions. However, researchers suggested that future interventions may require the consideration that participants be allowed to decide on their healthcare decisions (Palfai et al., 2019). Although researchers presented a beneficial model for generic qualitative research studies, there was a considerable gap in studies that highlighted mental health clinicians' perceptions and experiences, specifically clinicians providing services to vulnerable and underserved populations (Gentry et al., 2021; Hadjistavropoulos et al., 2020; Lynch et al., 2020; Palfai et al., 2019). Incorporating a model that aimed to understand participants' experiences and perceptions informed the current study while highlighting the incorporated framework and methods.

Gordon et al. (2020) conducted a qualitative research study with Veterans in rural localities that received telehealth services utilizing videoconferencing tools. The results of the stud indicated that participants felt more disconnected and rushed throughout the telehealth visits (Gordon et al., 2020). Gordon et al. (2020) used interviews with 27 participants receiving telehealth services for diabetes, using semi-structured questions to reduce challenges associated with traveling for interviews. Many participants expressed satisfaction with the telehealth methods but acknowledged some difficulties with physical exams and challenges associated with their involvement in the appointment process (Gordon et al., 2020). Some significant limitations included the specific nature of the telehealth services and Type 2 diabetes (Gordon et al., 2020). Additionally, the average age of the participants was between 67 and 70 years old, with a primarily male population. These concerns highlight the limitation of qualitative studies that speak to the diverse perceptions of clients in the general population.

Thomas et al. (2021) aimed to understand participants' experiences implementing telehealth services for patient monitoring. By incorporating a survey with closed- and open-ended questions, Thomas et al. discovered that most participants reported acceptance and a preference for telehealth models. Some limitations incorporated in this study included using secondary data. The participants represented only post-partum females. The open-ended questions incorporated in the study were conducted in isolation, limiting the researchers' ability to ask clarification or follow-up questions (Thomas et al., 2021).

These considerations presented in much of the research provided an opportunity to explore whether these findings would be similar for clinicians providing mental health services during the COVID-19 pandemic in Virginia. Additionally, studies indicated that all telehealth services implemented, whether telephone or videoconferencing, required additional exploration of the experiences and perceptions of more diverse services provided during the COVID-19 crisis.

Methodological Progression and Evolution of Research on Telehealth

Before the COVID-19 crisis, many studies incorporated quantitative methods to understand the benefits and challenges of telehealth implementation (Erbe et al., 2017; Freeman et al., 2017; Sims, 2018). Many studies before COVID-19 incorporated quantitative and qualitative research; the participants were not representative of the general population (Erbe et al., 2017). Since the onset of the COVID-19 crisis, many researchers have examined the implications of the rapid implementation of telehealth services during the pandemic (Erbe et al., 2017; Freeman et al., 2017; Hadjistavropoulos et al., 2020). In the early stages of the COVID-19 pandemic, researchers acknowledged the potential challenges of telehealth implementation while acknowledging the urgent need for additional information to inform practice. (Fischer et al., 2021). Many recent studies incorporated qualitative methods to aid in understanding the effects of rapid implementation on clients and patients; however, many studies related to primary healthcare or other specialized fields (Navarro-Moya et al., 2020).

Liang et al. (2020) studied the challenges associated with youth mental health following the COVID-19 pandemic. Liang et al. incorporated a cross-sectional study two

weeks after the onset of the public health challenge. By incorporating snowball sampling, along with smaller sample sizes. Liang et al. incorporated univariate analysis and univariate logistic regression to measure effects. Liang et al. found that approximately 40% of youth were susceptible to mental health challenges, highlighting a need for enhanced mental health interventions to mitigate these challenges. Some limitations Liang et al. observed included the inability to determine causality utilizing a cross-sectional design, suggesting the potential benefit of future research using a longitudinal design. These limitations showed the need for additional qualitative research to enhance and better understand the experiences and perceptions of clinicians providing telehealth services during the COVID-19 pandemic.

However, quantitative research studies have dominated the inquiries surrounding the acceptance, benefits, challenges, and accessibility of the implementation of telehealth (Gentry et al., 2021; Hennein & Lowe, 2020). Additionally, the self-reported questionnaires used in many studies presented concerns associated with the subjectivity and reliability of the reported information. Some methodological considerations observed in recent research revealed a significant gap in the diversity of participants and professions (Hadjistavropoulos et al., 2020; Molfenter et al., 2021; Pierce et al., 2021). Pierce et al. (2021) aimed to under the experiences related to the rapid implementation of telehealth in psychiatry. These results were like other fields outside of mental health. Pierce et al. acknowledged some considerations for implementing telepsychiatry that parallel the benefits of conducting additional qualitative research for mental health clinicians.

Summary and Conclusions

This chapter reviewed current literature to understand the effects of rapid implementation on delivering telehealth services before and during the COVID-19 pandemic. Through this comprehensive review, many researchers provided beneficial quantitative studies related to the mental health clinicians' acceptance of telehealth models during the COVID-19 pandemic. However, considerable limitations reflected a need for more in-depth research to understand the additional factors that presented obstacles for clinicians and clients during the rapid implementation of telehealth following the introduction of the COVID-19 pandemic (Liang et al., 2020). Mental health clinicians incorporated telehealth intervention and treatment services during the COVID-19 pandemic (Gavin et al., 2020; Miu et al., 2020). Much of the literature exists about the rapid transition to telehealth services due to mandated closures and social distancing guidelines (Liang et al., 2020; Miu et al., 2020).

However, many of the results of recent studies present ambiguous findings, exposing a gap in the understanding of diverse clinicians' experiences and perceptions of the rapid implementation of telehealth services during the COVID-19 pandemic in Virginia (Gentry et al., 2021; Gordon et al., 2020; Molfenter et al., 2021; Wood et al., 2020). Many studies on mental health speak to the role of clinicians and their efforts to reduce disruptions to client services (Blanco et al., 2020; Gavin et al., 2020; Molfenter et al., 2021; Wodarski, 2020). One of the significant considerations of the research highlighted the need for the continued development of accessible telehealth platforms for underserved and marginalized communities (M. T. Davis et al., 2021; Hadjistavropoulos

et al., 2020; Office of Behavioral Health, 2020). Although telehealth models existed before the COVID-19 pandemic, many regulations and policies prevented the widespread use of these models (Liang et al., 2020). Additional research provides an opportunity to explore how clinicians describe the barriers observed during the rapid implementation of the COVID-19 pandemic.

This study aimed to fill the gap in the literature by highlighting clinicians' experiences and perceptions of the rapid implementation of telehealth services during the COVID-19 pandemic. This study adds to the body of literature by informing clinical practice and social policies geared toward increasing the efficacy and accessibility of telehealth services in the future. Additionally, this research provides critical information for developing best practices for future crises in Virginia.

Chapter 3 consists of the qualitative research design, methodology, and data analysis. I will also discuss the issues of trustworthiness and the credibility of the study. Additionally, I incorporate the ethical considerations and procedures for the interviews with clinicians providing telehealth services during the COVID-19 pandemic in Virginia.

Chapter 3: Research Method

Introduction

In this study, I aimed to explore clinicians' experiences and perceptions of the use and rapid implementation of telehealth services for mental health. In the previous chapter, I highlighted studies in which researchers primarily used quantitative research. The rapid shift to telehealth during the COVID-19 pandemic presented potential barriers due to the limitations associated with clinician and client experience with the digital software, unknown usefulness due to reduced familiarity, and accessibility for clients scheduled to include these models as part of their treatment plans (Gentry et al., 2021; Molfenter et al., 2021; Pierce et al., 2021). The incorporation of predominately quantitative and mixed-methods approaches to understanding the impact of COVID-19 on mental health services presents a limited view of the benefits and challenges of telehealth during the pandemic (Croke, 2020; Gentry et al., 2021; Liang et al., 2020). By incorporating a basic generic qualitative model, I gained more in-depth views from participants in central Virginia (see Pierce et al., 2021).

Navarro-Moya et al. (2020) presented a qualitative study incorporating Bronfenbrenner's (1977) ecological model of psychosocial factors affecting workers. Additionally, the researchers conducted 12 to 15 semistructured, in-depth interviews using intentional and snowball sampling and thematic analysis, relying on Bronfenbrenner's (1977) model and NVivo software (Navarro Moya et al., 2020). This study informed my interview guide and methodology by presenting a realistic sample size to fit my study (e.g., Morse, 1995, 2000).

In this chapter, I present the research methodology, including the role of the researcher, the specific methods incorporated in the study, the participant inclusion criteria, and the logic of my selections. Additionally, I present the ethical considerations involved in data collection and the data analysis plan. The chapter ends with a summary.

Research Design and Rationale

This qualitative research study answered the following research questions:

RQ1: What are clinicians' experiences and perceptions of providing services to clients during the COVID-19 crisis?

RQ2: How do clinicians describe their experience and perceptions of the use of telehealth in working with clients?

RQ3: What do clinicians perceive about the efficacy and effects of telehealth services to clients and their access to services during the COVID-19 crisis?

I incorporated a generic qualitative research design frequently used to explore and understand a specific phenomenon from participants' perspectives (see Navarro-Moya et al., 2020; Cooper & Endacott, 2007). The research design provided a framework consistent with qualitative research by incorporating one-to-one interviews to understand clinicians' experiences and perceptions of implementing telehealth services during the COVID-19 pandemic in Virginia (see Creswell & Creswell, 2018).

Basic qualitative research is focused on describing, exploring, and understanding lived experiences, perceptions, and other concerns that may provide insight into a research problem or topic (Creswell & Creswell, 2018; Morse, 1995, 2000). I used semistructured interviews to explore clinicians' experiences and perceptions of using

telehealth models for mental health services during the COVID-19 pandemic (see Bronfenbrenner, 1977; Rubin & Rubin, 2012). Additionally, I gained an understanding of clinicians' perceptions about the efficacy and efficiency of telehealth models for the mental health treatment of clients, the ease of use of technology-based models, and their experiences and perceptions regarding the usability of these platforms during COVID-19 (see Davis, 1989; Huskamp et al., 2018; Molfenter et al., 2021). Conducting semistructured interviews allowed me to incorporate focused questions specific to the overall problem and follow-up questions from emergent data (see Creswell & Creswell, 2018; Patton, 2015).

In this study, I aimed to understand the experiences and perceptions of clinicians providing telehealth services during the COVID-19 pandemic in Virginia. I needed to make every effort to incorporate protocols that increased the validity and reliability of this comprehensive study (see Morse, 2000; Patton, 2015). Researchers increase their data's validity by incorporating methods such as members checking, providing interviewees with an opportunity to review the transcribed data to ensure the information presented reflects their statements or ideas accurately (Creswell & Creswell, 2018; Patton, 2015). Additionally, a study's reliability is enhanced by presenting accurate data reflections and being honest about the research processes (Creswell & Creswell, 2018; Morse, 2000).

Role of the Researcher

As the researcher, I took on the roles of active listener and learner throughout the research process. Each role played a significant part in ensuring the data collected

reflected the true spirit of the information received. Therefore, as an active listener, I listened to the words shared throughout the conversation while observing nonverbal body language and taking note of additional concerns that arose throughout the data-gathering process. I remained aware of any personal biases, preconceived notions, ideas, beliefs, and experiences by engaging in reflective practices and other strategies to eliminate challenges or concerns with the interpretation of data (see Creswell & Creswell, 2018; Patton, 2015; Saldaña, 2016). Additionally, I used active listening to aid in developing a rapport with participants and gaining insight through the participants' experiences and perceptions.

There was a potential for me to interview previous associates, classmates, or coworker professionals. There were minimal risks for conflict of interest due to the absence of work within agencies or organizations of the participants interviewed. However, due to my active participation in local and state professional development courses and conferences and the small network of mental health clinicians in Virginia, the potential to interview a professional acquaintance was possible. I addressed the previous concerns by following all guidelines according to the requirements of the Institutional Review Board (IRB) and the National Association of Social Workers (2017) *Code of Ethics*.

Methodology

In this study, I explored mental health clinicians' experiences and perceptions of the use and rapid transition to telehealth services during the COVID-19 pandemic. Mental health clinicians include social workers, psychologists, psychiatrists, substance

abuse treatment professionals, and others providing interventions and treatment for populations facing similar challenges (American Psychiatric Association, 2013; American Society of Addiction Medicine, n.d.). For this study, I interviewed social workers, psychologists, and substance abuse treatment professionals who provided telehealth services during the COVID-19 pandemic in Virginia. I developed inclusion and exclusion criteria for participants to aid in gathering specific data. A sample of seven participants whose primary work focus entailed providing services for mental health, substance abuse, or co-occurring disorders in central Virginia was included in the research (see Morse, 2000). Although qualitative research does not specify a specific sample size, the goal was obtaining a rich, in-depth understanding and saturation with this sample (e.g., Creswell & Creswell, 2018; Morse, 2000).

Participants were trained mental health professionals 18 years or older who worked with clients facing challenges with mental health, substance abuse, or co-occurring mental health and substance use disorders during the onset of COVID-19. Individuals working outside the Virginia area did not meet the criteria for inclusion. These criteria allowed me to gain diverse information aligned with the research's purpose (see Morse, 1995). I incorporated a brief overview of the purpose of the study, and the data collection method provided participants with a background of the study. I informed potential participants of the study's purpose and provided an understanding of the study's goal. Informed consent information was included per the verbatim IRB protocols. As the interviewer, my contact information was included in an email, along with instructions for submitting informed consent and an agreement to participate.

Prior to interviews, I introduced the study and provided the participants with my contact information, the verbatim IRB protocol for informed consent, and the purpose of the study. This strategy presented the participants with information that informed their decisions regarding participation. The plan was to incorporate semistructured interview questions aligned with a basic qualitative research study guided by the social–ecological model and TAM (see Bronfenbrenner, 1977; Davis, 1989; Morse, 1995; Rubin & Rubin, 2012). I reduced the inclusion of potentially embarrassing or emotional questions in the middle of the interview to reduce challenges associated with sensitive questions. This method promoted establishing a rapport at the beginning of the interview, reducing the risk of losing valuable information because the participant could shut down or become closed off (see Rubin & Rubin, 2012).

Instrumentation

Qualitative research methods provide researchers with an opportunity to collect data more collaboratively. I used Zoom videoconferencing to conduct virtual interviews to explore the experiences and perceptions of participants. Additionally, virtual interviews were preferred due to the uncertainty of the COVID-19 virus, social distancing restrictions, and time constraints (see Irani, 2019; Wilkerson et al., 2014; Zoom Video Communications Inc., 2019). Individual virtual interviews were developed with an intimate approach to the data-gathering process that acknowledges the remaining closures of many local, state, and federal mental health service locations (see Appendix A; Bowden & Galindo-Gonzalez, 2015; Fritz & Vandermause, 2018; Irani, 2019). I planned to record each video interview and produce a verbatim transcription of each conversation

(see Melis et al., 2021; Gray et al., 2020). Mental health clinicians are trained professionals who provide assessments, intervention, and treatment for individuals facing biological, psychological, or developmental disruptions. In this study, I interviewed social workers, psychologists, and substance abuse treatment professionals who provided mental health, substance abuse, or other treatments and interventions for co-occurring mental health concerns during the COVID-19 pandemic in Virginia (see American Psychiatric Association, 2013).

Participants were not required to appear on camera during interviews depending on their comfort level. Participants had the option of turning their cameras off before recording (see Gray et al., 2020). Some participants felt more comfortable with solely audio recordings. Additionally, this act promoted the anonymity of participants and enhanced my ability to gain more candid responses from some participants. During data analysis, I incorporated annotation of participants who opted to turn their cameras off during the interview. No participants refused audio and visual recordings before or during the interview process. The transcription process enhanced my ability to code and organize the conversation to discover overarching themes across the interviews (see Rubin & Rubin, 2012; Saldaña, 2016). The in-depth interviews allowed me to highlight descriptions of participants' thoughts, feelings, motivations, and challenges (see McGloin et al., 2014; Rubin & Rubin, 2012). Additionally, collecting data through interviews enhanced the opportunity to bring awareness to previous gaps in the literature and other unrecognized considerations (see Patton, 2015; Rubin & Rubin, 2012).

Procedures for Recruitment

To recruit study participants, I developed and executed a recruitment plan. During recruitment, I evaluated the inclusion and exclusion criteria to maintain the integrity of the overall study (see Creswell & Creswell, 2018). Using social media, professional networks, and snowball sampling, I recruited seven participants. I planned to interview 12 to 15 participants; however, saturation was reached following the sixth interview; no new information was established during the seventh interview. Creswell and Creswell (2018) maintained that recruitment procedures play a vital role in a researcher's ability to obtain participation from the most appropriately aligned candidates as outlined in the informed consent (see Appendix A).

I sent email invitations to mental health clinicians through public websites, public directories, LinkedIn, ResearchandMe, social media, my professional network, or snowball sampling to obtain participants. Due to the diversity of the mental health profession, I incorporated a heterogenous sampling design to gain a generic sample of mental health professionals (see Ravitch & Carl, 2016). I emailed participants who emailed an "I consent" response a list of the interview questions, which increased their ability to reflect on the questions and their experiences before the scheduled interview. Each interview question included a clear sequential pattern to enhance the clarity and richness of responses while reducing confusion (see Creswell & Creswell, 2018; Fitz & Vandermause, 2018; Morse, 1995, 2000).

Data Analysis Plan

Attempts were made to connect the data to the research questions. Research questions, for this reason, organize this section.

Research Question 1

RQ1 was the following: How do mental health professionals describe their experiences providing services to clients during the COVID-19 crisis? The goal was to determine how mental health professionals described their experiences providing services to clients during the COVID-19 crisis. Thus, responses to questions on the clinicians' roles, experienced changes, and thoughts about the provision of telehealth services during COVID-19 were examined to identify themes, common responses to questions, and patterns relevant to answering the research question. Some questions included the following:

1. Please tell me your initial thoughts about the rapid implementation of telemental health services?
2. Describe your experiences with training and technical support during the implementation of telehealth service.
3. Please share some of your ideas about the benefits and challenges of telemental health.

Research Question 2

RQ2 was the following: How do they describe their experience and perceptions of use of telehealth in working with clients? The goal was to determine how mental health professionals described their experience and perceptions of telehealth services. Thus,

responses to questions on their use of telehealth services provided an opportunity to examine and identify themes, common responses to questions, and patterns relevant to answering the research question. The pertinent interview questions included the following:

4. For example, discuss a time when you faced some difficulty or observed some difficulty with clients' access to telehealth services.

Research Question 3

RQ3 was the following: What do they perceive about the efficacy and effects of telehealth services to clients and their access to services during COVID-19 crisis? The goal was to determine mental health professionals' perceptions and the effects of telehealth services on clients. Thus, responses to questions about the reception of clients to telehealth, perceived efficacy on the use of telehealth, clients' outcomes on the use of telehealth, and benefits and challenges experienced during implementing and delivering telehealth services were examined to identify themes, common responses to questions, and patterns relevant to answering the research question. The pertinent interview questions included the following:

5. What are some of the changes you observed with your clients after the transition to telehealth?
6. What are some other concerns that I may not have addressed?

Following the interviews, the data analysis began after the transcription process utilizing Atlas.ti, a qualitative data analysis tool (QDAS). Each interview was approximately 45 minutes but did not exceed 1 hour. Interviews were conducted using

the Zoom videoconferencing platform. Participants were provided the link to log in to the platform securely utilizing a desktop, tablet, or smartphone web browser. The Zoom videoconferencing tool presented an opportunity to conduct interviews using video and audio to record data (see Archibald et al., 2019; Gray et al., 2020; Zoom Video Communications Inc., 2019). I transcribed each audio recording verbatim before transferring the data to Atlas.ti to discover codes and themes. After completing each interview, I aimed to reduce potential discrepancies associated with incorporating qualitative data analysis software.

Issues of Trustworthiness

Credibility

Careful consideration was implemented during the interview and analysis process to ensure that the richest representation of the data was obtained (see Patton, 2015). Additionally, the goal was to incorporate member-checking to allow participants to accurately review the analyzed information to represent their experiences and perceptions. The incorporation of Atlas.QDAS and the initial recordings enhanced the ability to verify the information obtained and the code and themes obtained (see Norwell et al., 2017). Additionally, participants had access to the questions before the one-on-one interviews to enhance their ability to consider the questions before the interview (see Lincoln & Guba, 1985; Norwell et al., 2017). I contacted three randomly selected interviewees by email for the member-checking step after transcription and initial coding. In the initial email, I offered to share takeaways from that participant’s interview via email to ensure my interpretations were accurate.

Transferability

To enhance the transferability of the study, I provided the specific procedures for selecting candidates, basic information regarding the specific groups interviewed, and a list of the specific questions (including clarifying questions) asked during the interview. Through the verbatim transcription of the data, along with a detailed process of coding the transcription for themes, the research presented multiple opportunities to meticulously analyze the detailed information obtained through the interviews, enhancing the likelihood that future researchers could reproduce the study in similar communities (see Morse, 1999; Norwell et al., 2017).

Dependability

I incorporated the use of an audit trail by engaging in reflection practices to recognize personal biases, field notes, and written observations obtained during the interview and data analysis process (see Patton, 2015). This strategy assisted with the establishment and maintenance of the dependability of the study.

Confirmability

To increase the potential confirmability, I incorporated the raw data and the methods and procedures to derive the overall themes (see Norwell et al., 2017). By incorporating the justification for selecting the theory, methodology, and specific measures for thematic analysis, I enhanced confirmability by presenting the conceptualization of the research (see Norwell et al., 2017).

Ethical Procedures

The profession of social work provides guiding principles that speak to ethics of practice and research (National Association of Social Workers, 2017). Therefore, the implementation of ethical procedures highlighted the necessity to conduct research within the ethical guidelines of the professional, in addition to the requirements established by Walden University's IRB. I completed the IRB approval checklist to ensure the ethical treatment of human participants throughout the study process.

I emailed consent forms to the participant volunteers. They replied with the words, "I consent." I interviewed participant volunteers via the Zoom online platform.

The data collected through the Zoom videoconferencing interviews were recorded and stored on my personal computer. The computer was secured when not in use. I maintained sole access to the Surface tablet. I utilized a two step-verification to log in to the computer. I will maintain the data associated with interviews for at least 5 years. I will destroy the data by deleting all information related to the study and destroying the hard drive.

I codified participants' information in an Excel document. I will destroy the information after a minimum of 5 years. None of the participant volunteers' names, phone numbers, email addresses, or agencies was identified in the study. I reported the number of years and locality of the participants. I did not share the information in a manner that allowed participant volunteers to be identified. The participant volunteers' agencies or organizations remained unidentified in the study. The Walden staff and I were the only authorized viewers of raw data. Additional information regarding

confidentiality is located on the consent form in Appendix A. There is no specific plan to share the result with participants and community stakeholders.

Summary

This chapter contained my process for selecting and recruiting participants, ethical considerations, and the methods for analyzing and collecting data. I also presented the process for one-on-one interviews using the Zoom videoconferencing tool. Further, I addressed strategies for enhancing the study's trustworthiness, including credibility, dependability, transferability, and confirmability. Finally, I incorporated semi-structured, open-ended questions to assist in observing codes and themes that produced rich, beneficial data that informs future practice.

In Chapter 4, I introduce the study, including the research questions. I provide information about the setting in which interviews occurred, along with the participants' demographics. I outline the data collection and analysis process, highlighting trustworthiness considerations. Finally, I present the results of the research and provide a summary.

Chapter 4: Results

Introduction

Traditionally, outpatient mental health services in Virginia are delivered in-person with limited availability for telehealth services. Some agencies have conducted telephone check-ins with clients. However, most often, telehealth services were unavailable to most underserved clients. Following the onset of the COVID-19 pandemic, however, mandated closures required modifications to delivery of mental health and substance abuse services. Researchers have acknowledged the benefits of telehealth services and the limited information on clinicians' experiences and perceptions of previously unavailable services. This research study aimed to understand the experiences and perceptions of mental health clinicians in Virginia who provided or implemented telehealth services for clients facing mental health challenges during the COVID-19 pandemic.

The purpose of this research study was to understand the experiences and perceptions of mental health clinicians in Virginia who provided or implemented telehealth services for clients facing mental health challenges during the COVID-19 pandemic. This research study sought to answer the following questions:

RQ1: What are clinicians' experiences and perceptions of providing services to clients during the COVID-19 crisis?

RQ2: How do clinicians describe their experience and perceptions of the use of telehealth in working with clients?

RQ3: What do clinicians perceive about the efficacy and effects of telehealth services to clients and their access to services during the COVID-19 crisis?

This chapter outlines an overview of the settings, demographics, and data collection methods. Additionally, a data analysis, along with discrepant cases, is highlighted. The overall results of the study and the study's connection to Bronfenbrenner's (1977) social ecological theory and Davis's (1989) TAM are presented to aid in understanding how the study fills the gap in the literature.

Pilot Study

A pilot study was conducted by performing mock interviews with two social workers. The preliminary study was conducted to gain insight into the amount and style of questions, to gain a general idea of the timing and length of the interviews, and to understand the overall perceptions of clinicians during and after the process. Participants were provided the confidentiality agreement, demographic questionnaire, and interview questions by email. Phone interviews were conducted at the convenience of the participants. Following these mock interviews, a debrief was conducted with the participants to discuss their perceptions and experiences. The overall process of interviewing and debriefing took approximately 3 hours per participant.

Following the interviews, some participants' main concerns included the repetitive nature of the questions. Participants commented they were asked the same questions several times. Additionally, participants stated they began to have feelings of fatigue due to the length and irritation with the line of questioning. One participant stated there might be difficulty promoting the snowball effect for additional participants due to the length and discomfort of the process. Another key point was that there was no compensation for the extensive interview process. Both participants agreed that the

overall interview should be truncated by reducing the interview duration and asking fewer questions.

The information gathered during this pilot study was beneficial in evaluating the length of time for individual interviews. As a result, I reduced the questions from 20 to seven. However, additional follow-up questions were required due to differences in participants' experiences. Participants for the final study were not offered compensation. Another mock interview was conducted to ascertain additional feedback after changes were implemented. The participants agreed the interview was more succinct and straightforward. Additionally, participants stated that the overall process was more comfortable and the timeframe was more manageable. Finally, participants stated that the purpose of the study was evident in the questioning as was valuing participants' time.

Setting

No personal or organizational conditions impacted the study. All participants were recruited through social media, email contact, snowball sampling, and professional networks. Additionally, no undue influence was involved in the participants' descriptions of their experiences or perceptions.

Demographics

The study consisted of seven participants. Participants provided clinical services for clients facing mental health and substance abuse challenges. Participants used a telehealth platform in Virginia's Central and Hampton Roads areas.

Table 1

Summary of Participant Demographics

Participant	Gender	Age range	Ethnicity	Degree/certifications	Current role	Years of experience
P9001	Female	50–60	African American	Master of social work	School social worker	20+
P9002	Male	20–30	African American	Bachelor of science, psychology	Intensive in-home youth clinician	Under 5 years
P9003	Male	50–60	African American	Master of counseling	Substance abuse clinician	16+
P9004	Male	50–60	African American	Bachelor of science, criminal justice	Substance abuse clinician	18+
P9005	Female	40–50	African American	Master of science, psychology		10+
P9006	Female	20–30	African American	Bachelor of social work/licensed professional counselor	Mental health/substance abuse clinician, private practice	10+
P9007	Female	30–40	African American	Master of science, psychology/licensed professional counselor	Mental health clinician, private practice	8+

Data Collection

Data collection began within 2 weeks of recruitment in February 2022. This was after IRB approval was obtained (approval number was 01-26-22-0725828). Recruitment of participants, including social workers, substance abuse treatment professionals, and psychologists, resulted in seven participants, distributed across each group, interested in participating in the interviews. Interviews were conducted between February 2, 2022, and March 20, 2022. Interviews lasted approximately 1 hour in length. The seven

participants' clinical experience ranged from 1 year to over 20 years in the fields of mental health and substance abuse. All participants had at least a bachelor's degree. Each participant also provided basic demographic information. Only one interview was conducted per participant to gather the data for this study.

Permission was granted from each participant to audio record their interview using the Zoom videoconferencing platform. All participants received an introduction to the study and its purpose and were asked if they had any questions before beginning the interview. After the interview, audio recordings were transcribed using Microsoft Word. Following verbatim transcriptions, the data were uploaded to Atlas.ti QDAS to begin the coding process. Following the interview transcription, the data with memos were shared with the participants for accuracy and approval to use the data.

Below are the questions asked of participants during the interview process. Each of the questions sought to answer the research questions, as outlined:

1. Please tell me about your role and typical caseload as a clinician prior to the COVID-19 pandemic? (RQ1)
2. Please tell me your initial thoughts about the use and/or rapid implementation of telemental health services? (RQ1)
3. Describe your experiences with training and technical support during the implementation of telehealth service. (RQ1)
4. Please share some of your ideas about the benefits and challenges of telemental health. For example, discuss a time when you faced some difficulty or observed some difficulty with clients' access to telehealth services. (RQ2)

5. Tell me about any additional challenges you observed during a typical group or individual session. (RQ2)
6. What are some of the changes you observed with your clients after the transition to telehealth? (RQ3)
7. Is there anything else that I have not asked you about that you would like to add? (RQ3)

Data Analysis

After obtaining IRB approval on January 26, 2022 (# 01-26-22-0725828), I initiated participant recruitment. First, I submitted the recruitment flyer to LinkedIn, Facebook, and Instagram social media sites. Also, I submitted the recruitment flyer to the Virginia chapter of the National Association of Social Workers and the National Association of Addiction Professionals. Finally, the recruitment flyer was submitted to social work, psychology, and substance abuse colleagues affiliated with me.

Over 20 people responded by email or phone call. However, only seven initial respondents met the study criteria (two substance abuse treatment professionals, two social workers, and three psychologists). Five additional participants agreed to participate in the study but did not schedule an interview. Additionally, following the sixth interview, no new information was revealed, highlighting a saturation point. The seventh interview was conducted to confirm saturation (see Creswell & Creswell, 2018; Morse, 2000).

After collecting the data, I downloaded the audio file to an external hard drive and began transcription. This process also included the incorporation of reflexivity. Each

interview and transcription occurred in the same week. Following the transcription, the completed Word documents were emailed to the participant for member checking. This allowed participants to correct and clarify any responses necessary. Throughout the interviews, I summarized their understanding of the statements to allow participants to confirm or modify any misrepresentations (see Patton, 2015). The identities of participants were stored on a password-protected external drive and replaced with a code to protect their privacy. The code was associated with a pseudonym participants were assigned for privacy.

Atlas.ti QDAS was incorporated to assist in organizing the research data for analysis (see Norwell et al., 2017). Following transcription, the data were transferred to Atlas.ti using a Word document. The first cycle of coding began with the creation of memos. The similarities discovered were placed into like groups. I could reduce the information into more manageable groups and discover patterns. Following the discovery of patterns, subthemes and themes began to emerge.

I engaged in practices to enhance the trustworthiness and credibility of the data by incorporating two forms of member checking. First, I asked clarifying questions. Second, I returned the transcribed interviews to participants for correction or clarification. The findings section presents a discussion of the demographics, profession, work function, and participants' experiences to enhance the transferability of the study. Additionally, I described each step of the research, from conception to reporting the findings, to enhance dependability. Finally, I included reflexivity to manage potential biases by keeping notes and memos throughout the data collection and analysis processes.

The interviews were transcribed following each interview. I reached saturation following the sixth interview; no new themes emerged. However, I interviewed a seventh participant for verification. After reviewing and verifying the transcripts, I presented the transcriptions to the participants for accuracy. The data analysis process began following the member-checking and verification processes. A total of 284 codes were recognized from the data, which were later organized into themes. From the answers to the research question, I identified eight themes (Table 2).

Following the discovery of the themes, I recognized a reoccurrence of some of the descriptions. These considerations provided by clinicians highlighted the overlap of some ideas relevant to more than one research question. For example, participants described the challenges related to connectivity issues and limited resources while describing their initial thoughts about telehealth services (RQ1) and when discussing the benefits and challenges (RQ2). However, initial concerns related to accessibility and connectivity during the initial implementation were related to clients' limited resources at the onset of COVID-19. Regarding RQ2, most clinicians described more challenges with service interruptions due to unstable connections.

Table 2

Major Codes and Themes

Research question	Major themes	Codes
RQ1: How do mental health professionals describe their experiences providing services during COVID-19?	Pre-COVID-19 treatment and services	Significant changes to caseload and no previous use or experience with telehealth
	Adjusting to the rapid implementation of telehealth	Difficult to implement at the onset/increased anxiety due to the uncertainty and newness of telehealth
	Convenience and flexibility to provide services following implementation	Convenient and relatively easy to implement after an adjustment period.
RQ2: How do they describe their experiences and perceptions of the use of telehealth in working with clients?	Barriers to gaining and maintaining access	Significant challenges with clients accessing technology
	Challenges with limited understanding and exposure to technology	Differing levels of knowledge and understanding technology and telehealth models
	Protocols and managing expectations	Protocols and re-establishing expectations
		Privacy/Confidentiality
RQ3: What do they perceive about the efficacy and effects of telehealth services to clients and their access to services during the COVID-19 crisis?	Clients' acceptance and aversion to telehealth services	Difficult to implement with youth and aging populations
		Effective for clients that adapted well to telehealth
	Lessons learned for future practice	Clinicians prefer hybrid options (telehealth and in-person) for future practice

Saturation Assessment

Following the data analysis process, I conducted a retrospective review of the individual interviews to calculate the number of occurrences for each code per participant (Table 3). While this presents frequency of the codes discovered during the interview and data analysis process, a review of the information highlights the reduction in occurrences of certain codes. Additionally, I used a thematic framework to analyze the discovery of new themes (Table 4). Both considerations present an opportunity to validate the

assumption of saturation (see Hennink et al., 2017). Guest et al. (2020) discussed that the incorporation of retrospective review of the themes in a more systematic manner aids in supporting and validating the level of saturation. I attained a level of confidence for saturation following the fifth interview. However, the sixth interview was conducted to ensure no additional themes presented. Finally, a seventh interview was conducted as a means of strengthening the level of confidence (see Guest et al., 2020; Hennink et al., 2017).

Table 3

Code Frequency

Code	Code frequency per interview						
	P9001	P9002	P9003	P9004	P9005	P9006	P9007
Confidentiality and privacy	7	9	9	9	8	6	6
Missing confidentiality	4	5	4	3	3	0	0
No privacy with camera	0	0	1	0	4	0	0
Uncomfortable	1	2	2	3	0	0	0
Unsecure locations	2	2	2	3	1	6	6
Connectivity issues	6	5	5	5	7	5	5
Wi-Fi doesn’t work	4	3	0	1	2	0	4
Lost signal	1	1	2	2	5	2	0
No equipment	1	1	1	1	1	1	1
No prior knowledge	0	0	2	1	1	2	1
Training and education limitations	4	3	8	7	5	3	3
No prior experience	0	0	2	1	1	1	1
Unfamiliar with technology	0	0	2	2	3	1	2
No experience with Zoom	0	0	2	2	0	0	0
In-house training	4	3	2	2	1	1	0
Accessibility	8	5	5	9	5	4	5
Lack of devices	5	1	1	2	0	1	0
No laptops or mobile device	1	1	1	1	0	2	0
No Wi-Fi	2	3	3	6	5	1	5
Can’t afford devices	0	0	0	0	0	0	0
Convenience	5	5	5	5	6	4	4
Meet clients anywhere	2	2	1	1	2	2	0
Flexible scheduling	1	2	0	0	2	0	1
No travel time	0	1	1	0	0	0	1
Direct access	2	0	2	2	0	1	1
Platform limitations	0	0	1	2	2	1	1
Effectiveness	3	2	5	5	3	3	5
Telehealth not the solution	0	0	0	0	1	1	0
Gradual progression	1	0	1	1	0	0	1
Improved attendance	0	0	2	0	0	0	1
Reduced treatment time	0	0	1	2	0	0	0
Even split	0	0	0	0	1	0	1
Challenging for clients	2	1	0	2	1	2	1
Need a hybrid version	0	1	1	0	0	0	1
Changes to caseload	0	4	5	4	5	2	2
Discontinuation of services	0	0	1	1	0	0	0
Increased caseload	0	1	0	0	2	1	1
Decreased caseload	0	0	2	1	0	0	0
Premature termination of services	0	0	1	1	0	0	0
Increased individual treatment	0	3	1	1	3	1	1
Distractions/session interruptions (apart from connectivity)	1	8	8	9	5	5	0
Outside interruptions	1	4	3	3	0	3	0
Crowded environment	0	2	2	3	3	1	0
In public places during session	0	2	3	3	2	1	0
Total	34	41	50	53	43	33	30

Table 4

Interview Thematic Framework

Theme/subtheme	# participants discussed
Pre-COVID-19 treatment and services	6
Adjusting to rapid implementation	7
Convenience and flexibility	7
Confidentiality and establishing protocols	5
Challenges with differing levels of education	5
Barriers to access	7
Clients' acceptance and aversion	5
Lessons learned and the future	6
Total	7

Discrepant cases found in this study were limited. The information obtained during interviews highlighted the necessity for further evaluation of the differences among client ages and specific treatment. Additionally, the discrepant cases revealed information about variations in client engagement that may require additional research in the future. However, the discrepant cases did not affect the overall data analysis regarding the perceptions of clinicians in Virginia providing telehealth during the onset of COVID-19.

Evidence of Trustworthiness

Credibility

The study's internal validity was enhanced through my implementation of careful consideration during the interview and analysis process to ensure that the richest representation of the data was obtained (see Patton, 2015). Additionally, the goal was to incorporate member-checking to allow participants to review accurately the analyzed information to represent their experiences and perceptions. The incorporation of Atlas.ti

QDAS and the initial recordings enhanced the ability to verify the information obtained and the code and themes obtained (see Norwell et al., 2017). Additionally, participants had access to the questions before the one-on-one interviews to enhance their ability to consider them before the interview (see Lincoln & Guba, 1985; Norwell et al., 2017). I contacted three randomly selected interviewees by email for the member-checking step after transcription and initial coding. In the initial email, I was asked to share takeaways from that participant's interview to ensure my interpretations were accurate.

Transferability

To enhance the transferability of the study, I provided the specific procedures for selecting candidates, basic information regarding the specific groups interviewed, and a list of the specific questions asked (including clarifying questions) asked during the interview. Through the verbatim transcription of the data, along with a detailed process of coding the transcription for themes, the research presented multiple opportunities to analyze the detailed information obtained through the interviews meticulously. This process enhances the likelihood that future researchers can reproduce the study in similar communities (see Morse, 1999; Norwell et al., 2017).

Dependability

I incorporated the use of an audit trail by engaging in reflection practices to recognize personal biases, field notes, and written observations obtained during the interview and data analysis process (see Patton, 2015). This strategy assisted with the establishment and maintenance of the dependability of the study.

Confirmability

To increase the potential confirmability, I incorporated the raw data and the methods and procedures utilized to derive the overall themes (see Norwell et al., 2017). By incorporating the justification for selecting the theory, methodology, and specific measures for thematic analysis, I enhanced confirmability by presenting the conceptualization of the research (see Norwell et al., 2017).

Results

The purpose of this study was to understand clinicians' experiences and perceptions of providing telehealth services during COVID-19. I carefully reviewed the interviews by organizing relevant and like terms and ideas to form codes and themes within and between the stories of clinicians. Following the thematic analysis, I identified eight major themes: (a) pre-COVID-19 treatment and services, (b) adjusting to the rapid implementation of telehealth, (c) convenience and flexibility to provide services following implementation, (d) barriers to gaining and maintaining access, (e) challenges with limited understanding and exposure of technology, (f) protocols and managing expectations, (g) clients' acceptance and aversion to telehealth services, and (h) lessons learned for future practice. The themes revealed more challenges during the initial implementation at the onset of the COVID-19 pandemic.

Table 5 contains a summary of themes, highlighting significant statements and overarching ideas contributing to the eight themes. The data analysis resulted in rich in-depth themes representing participants' overall expressions. Each theme is discussed in greater detail in the subheadings below.

Table 5

Summary of Themes

Themes	Supporting phrases
Pre-COVID-19 treatment and services	P9003 stated, "Prior to COVID-19, I managed a caseload anywhere from about 35 to, possibly, 40 clients at one particular time. When the COVID-19 pandemic came in 2020, we had to make some major adjustments." P9005 stated, "So, prior to COVID-19, with the community mental health, we were not able to do any telehealth sessions at all."
Adjusting to the rapid implementation of telehealth	P9003 stated, "When the COVID-19 pandemic came in 2020, we had to make some major adjustments. we stopped taking in new clients until we figured out what would be put in place in terms of protocols to be able to service the clientele. So, we didn't accept any newer clients." P9007 reported, "Following the onset of COVID-19, there was much apprehension as a result of the initial implementation of telehealth services." P9001 reported, The lack of needed devices, effective communication, a lot of my students at the time didn't have their laptops, and like I mentioned before, hotspots, for effective communication between providers and patients which can result in continuation or discontinuation of care services.
Convenience and flexibility to provide services following implementation	P9002 stated: So, it's like, I'm trying to do as much as I can, but having the ability to just take like a 10-minute break, do your review of your past session, and then you go right into the next one. And you basically knock all your clients out, in what, like five hours, and you still got the rest of the day. I'm able to work a lot into my schedule. P9006 stated, "I have done outpatient therapy in numerous different countries over the last year. I have been able to do staycations away from Virginia and still be able to see my entire caseload."
Barriers to gaining and maintaining access	P9002 stated, "Sometimes it's just not the day for a virtual session. It'll just keep freezing, and I've kind of taught myself not to get frustrated with that. Because if you seem to be getting frustrated with the issue, then the client is going to get frustrated with the issue, and it's going to become a whole other thing." P9007 reported, Honestly, initially, I felt for certain demographics it would be a struggle, and it is. It's still a struggle because a lot of the people that I was serving didn't have Internet access, reliable Internet access, didn't constantly have working cell phones, didn't have laptops, or didn't understand how to use technology anyway.
Challenges with limited understanding and exposure to technology	P9003 reported, If they use a tablet and/or phone we would ask them to bring it into the office, and we would work with them, socially distanced, just two individuals in a room, ensuring that they understood everything in terms of how to operate the camera, the phone usage, muting the line, everybody can be muted and the leader, which would be the group facilitator has the ability to mute everyone. P9006 reported, "I'm not tech savvy. Trying to get it hooked up and share your screen, get the camera on and make sure the mic was hooked up. Then finding an appropriate platform to render my services."
Protocols and managing expectations	P9005 stated, "On the flip side of telehealth, it would be that component of ensuring confidentiality, making sure there's no other people in the room when you're discussing their very personal information with your clients."
Clients' acceptance and aversion to telehealth services	P9004 stated, Redirection and redirecting them, or making the treatment group where its engaging, to want them to be receptive to participating, keeping it very interactive, to try to engage everybody, and allow everybody to be involved, all the participants to be involved in the actual session has been somewhat of a challenge. P9006 stated, It doesn't work well for my kids (adolescent clients). They can sit in front of a video game for an hour, but they don't want to sit in front of a screen and talk to me for an hour, which is understandable.
Lessons learned for future practice	P9007 stated, " I do feel like telehealth has changed the way people viewed services. So, I do think it is something that needs to stay. I think it has been a great benefit to a lot of people."

Research Question 1

RQ1: How do mental health professionals describe their experiences providing services during COVID-19? When participants were asked about their roles and typical caseloads before COVID-19. All participants highlighted that whether they were in private practice or working for an agency, none had used telehealth before COVID-19. Additionally, each of the participants provided mental health services during the pandemic. These considerations revealed three themes: (a) pre-COVID treatment and services, (b) adjusting to rapid implementation, and (c) convenience and flexibility to provide services following acclimation.

Theme 1: Pre-COVID Treatment and Services

When clinicians were asked Question 1 regarding their caseloads and treatment prior to COVID-19, seven participants stated that they had not provided telehealth services before the pandemic. Clinicians discussed providing mental health treatment and services solely in-person/face-to-face. Participant P9004 stated, “Prior to COVID, we weren’t doing it. Everything was in-house.” Similarly, P9005 stated, “Prior to COVID-19, with community mental health, we were not able to do any telehealth sessions at all.” Participant P9007 noted,

> So, it was a lot of face-to-face. It was a lot of meeting people where they are, whether that be a library, whether that be a park, whether that be at a bus stop, or their house. There was a lot of that. Just a lot of in-person communication, interactions, and treatment.

Many clinicians discussed that prior to the COVID-19 pandemic, many participants had limited experience providing telehealth services. P9005 reported, “I believe that in some instances, people were providing telehealth, but that was not something that was welcomed or appeared to be welcomed.” Participant P9005 stated, “In the outpatient world, you were still encouraged to see clients face-to-face.” Participant P9002 stated, “Some clients would to [*sic*] do physical activities to kind of help with emotional or impulse regulation.” Clinicians continued the sentiments related to mental health treatments and most effective in-person services. Participant P9005 stated, “In the outpatient world, you were still encouraged to see clients face-to-face.”

Clinicians described a steady influx of clients prior to COVID-19. Participant P9003 stated, “We received a lot of referrals from clients, whether through a recommendation of the judicial system, a judge, attorney, and/or a mental health agency who has the potential to refer clients to our particular agency.” These were built-in components of many mental health and substance abuse treatment programs. Additionally, clinicians described providing referrals to other agencies providing in-person services prior to COVID-19. Participant P9004 reported,

> Primarily, the role entailed providing substance abuse services, counseling, mental health, giving referrals to clients who needed services that we couldn’t provide at the agency, and for people who needed medications and things like that addressed any type of mental health concerns.

The descriptions provided during question one led to concerns related to the rapid implementation of telehealth and navigating the discovery of appropriate telehealth platforms.

Theme 2: Adjusting to the Rapid Implementation of Telehealth

During the onset of COVID-19, many clinicians described feeling anxious and apprehensive due to the rapid implementation of telehealth. After participants answered questions regarding the rapid implementation of telehealth, many clinicians described feeling rushed and uncertain. Clinicians described an uneasiness and overall discomfort with the marked differences between their pre-COVID and during- COVID practices, along with expected challenges with the implementation. Participant P9007 believed telehealth "would not work" for her population.

Many clinicians were not seeing clients virtually, and the initial apprehension stemmed from their initial belief that "this is not going to work." Many of these concerns developed out of the unchartered territory associated with the rapid implementation of telehealth and increasing concerns surrounding how to implement new models, establish expectations, and create new norms for operating under new mandates and social distancing measures.

Clinicians stated that they initially faced significant challenges establishing continuities of care following the onset of COVID-19. Participant P9002 stated, "It was hectic," regarding the pressure associated with assisting clients with transitioning to telehealth. Many clinicians and their agencies faced an expedient shift to telehealth without previous knowledge or experience. Some participants described the newness of

telehealth and the urgency of implementation. Participant P9004 stated, “The first thing we did, which was in probably March, we started to do our group meetings, and a lot of individual meetings by telephone.”

Telehealth was new and unchartered territory for many mental health clinicians, adding a layer of concern for professionals and their clients. Participant P9004 stated, “So, it happened so quickly there was not any course to get us started. We just went out and followed the directions on the computer, and that’s kind of where we ended up.”

Many clinicians described feeling rushed and overwhelmed by determining the best courses of action to maintain or recreate continuities of care for clients and their families. Participant P9004 shared, “So, when COVID basically hit, it was like we need to make some changes, and we needed to make those changes as quickly as we could.”

Clinicians also described how the pause in some services and referrals affected their ability to continue operations as they had before COVID-19. Clinicians’ experiences highlighted inevitable gaps during the initial transition and implementation period. Many participants described anxiety and fear due to the abrupt closures of agencies and organizations and the urgency for locating and implementing alternative measures for treatment and intervention. P9004 stated that at the onset of the pandemic, “That is pretty much what we did,” as he described the blind search and initiation of a new telehealth platform.

The rapid implementation also made participants feel “forced to make some changes.” Participant P9007 recalled, “We were forced to make those changes quickly. For everyone’s safety, the staff, and the clients, and so little was known at that time,

except safe distancing, wearing your mask, and things like that." Participant P9003 stated,

> When the COVID-19 pandemic came in 2020, we had to make significant adjustments. During that time, with COVID-19 and undergoing a shutdown. We stopped taking in new clients until we figured out what would be put in place in terms of protocols to enable us to service the clientele. So, we did not accept any new clients.

In addition to halting new client intakes, some clinicians described additional reductions to their existing caseloads. Participant P9003 stated, "Prior to COVID-19, I managed a caseload anywhere from about 35 to, possibly, 40 clients at one particular time." However, after the COVID-19 pandemic, P9003 described a significant reduction over time, reporting, "Quickly dwindled down from a 35 to 40 caseload being managed and getting down to the 20s. Then, the 20s getting down to below ten during this time period of the pandemic." Conversely, P9005 stated, "In the outpatient setting I will say, surprisingly, that my caseload increased during COVID-19 for telehealth services."

Clinicians described feelings of frustration and anxiety leading to concerns about the urgency of implementing telehealth. Participant P9003 stated, "We did research to try to find out what platforms that would be more [easily] accessible for the clients, what would be user-friendly for them." Additionally, clinicians described the uncertainty associated with their limited exposure to telehealth prior to COVID-19 and the added pressure of determining an appropriate platform. Finally, all clinicians discussed the challenges associated with establishing continuities of care and accessibility concerns;

however, following acclimation, most clinicians described the conveniences and flexibility of telehealth services leading to the discovery of Theme 3.

Theme 3: Convenience and Flexibility to Provide Services Following Acclimation

Clinicians described the convenience and flexibility of implementing telehealth. Participant P9002 stated, “It’s pretty easy just to hit a Zoom link instead of going all the way to their house. Because some of them live pretty far from me.” Similarly, participant P9005 noted, “Telehealth allows for those individuals who do not have transportation to still receive mental health services.” Additionally, clinicians believed that clients appreciated the relative freedom derived from telehealth services. Participant P9003 reported, “I would, probably, say the biggest benefit would be convenience because it gives the clients, as well as staff, the opportunity to be able to log on from multiple locations.” Similarly, Participant P9001 stated, “The benefits are the easy access to healthcare, cost savings, convenience, providers mobility, rural access for people who do not have access.”

Most participants discussed increased flexibility in practice and availability to provide services. Participant P9002, “I got to talk to their guardian or something, it’s pretty easy just to hit a Zoom link instead of going all the way to their house.” Similarly, Participant P9005 stated, “Also, you have individuals who have social anxiety and just anxiety overall which would normally deter them from coming into an office setting.” Likewise, Participant P9001 stated, “Changes observed after the transition to telehealth are factors such as convenience, efficiency, communication, privacy, comfort have been identified by my clients as important to usage.”

Clinicians described the personal and professional flexibility presented with the implementation of telehealth. Participant P9006 stated, “It has allowed me to be on the go. I just think it allowed me to continue to see my clients.” Additionally, Participant P9007 stated, “It’s been pretty convenient. It does allow a lot more people to have access to behavioral healthcare, which was not always the case, especially with not having transportation or not having childcare, things like that.”

Most clinicians described an easy transition to telehealth after becoming acclimated to the Zoom platform. Clinicians described their perceived ease of use when implementing telehealth due to the simplicity of incorporating the platform. Participant P9004 reported, “Well, we didn’t do any really special training per se … We just went out and followed the directions on the computer, and that’s kind of where we ended up.” Most clinicians discussed telehealth’s added benefits and flexibility after their acclimation to the new platform. However, clinicians also described significant barriers even after their adjustment period that highlighted risks for clients gaining and maintaining access to telehealth, introducing Research Question 2.

Discrepant Cases

Although most participants reported reductions to their caseload, one participant noticed an increase in theirs. P9005 stated, “My caseload increased during COVID-19 for telehealth services.” Some considerations include the increased anxiety and fear associated with clients. More clients had access to mental health treatment more conveniently and comfortably. The implementation of telehealth allowed clients to schedule appointments and engage in private sessions or groups remotely from anywhere

in the state. These considerations may be attributed to several factors; however, additional research may provide a more in-depth evaluation of discrepant cases.

Research Question 2

RQ2: How do they describe their experiences and perceptions of the use of telehealth in working with clients? Clinicians were asked their thoughts about the benefits and challenges they observed during the rapid implementation of telehealth services, and again, they discussed some of their perceived benefits and challenges. The overarching themes included (a) challenges with differing levels of capability and (b) confidentiality, establishing protocols, and managing expectations.

Theme 4: Confidentiality, Establishing Protocols, and Managing Expectations

Initially, no specific protocols offered clients and clinicians appropriate behaviors during treatment. The convenience of virtual sessions produced concerns related to confidentiality and clients' reduced concerns about privacy when selecting locations for treatment. Participant P9003 stated,

> So, one thing we spend a lot of time, previously, and still currently, reinforcing rules and what group rules would look like in terms of logging on from the groups to ensure that everybody is able to obtain what they need with logging on this virtual platform without interruptions and/or distractions, and a lot of times encouraging the clients to be in a confidential and quiet environment, during group that would not serve as an interference to other individuals who are logged on from a group perspective.

Many clients participated in treatment and services while engaged in other activities and surrounded by outside personnel (family, friends, strangers). More to this point, there was a reduction in the traditional decorum of meetings due to the clinicians' limited ability to control the clients' internal environment. Clinicians faced challenges establishing an understanding of appropriate behavior while engaged in individual and group treatment. Participant P9004 recalled,

> One other thing, it didn't happen often, but we had to deal with the fact of people being on the bus or walking down the street, getting off work, at home wanting to eat spaghetti dinner while we were doing the group meeting with you, or some of the men who decided they wanted to be shirtless, that kind of thing. So, you had some other unforeseen issue that you had to deal with to ensure things were done appropriately and professionally.

Clinicians discussed the benefits of incorporating telehealth services. However, they described significant challenges with managing expectations and introducing new protocols related to privacy and maintaining the confidentiality of individual and group treatment sessions. Similarly, Participant P9005 reported,

> While it has been constructive and beneficial on both ends, we have some people who take telehealth a little overboard, being in the grocery store trying to have telehealth sessions, understanding that you still want to have a sense of confidentiality, and things of that sort. Being in the grocery store, being at work trying to have a session, I guess the clients' understanding of how telehealth works and still needing to be in an area where it's just the clinician and the client

> … So, that has been a little bit challenging because you don't know until you get on the phone that they're not at a confined location where we can have that confidential, private session.

Additionally, Participant P9005 highlighted,

> Sometimes you're in your groove of addressing very important situations with your client, and either you have different family members or friends coming in and out of the session, which really can distract the flow of the session. Those two things would be out of my control.

Participant P9007 discussed the continuous need to reiterate and re-educate them:

> Letting them know this is a private, personal session. I need you to be in a place where you can hear me, and I can hear you. You can be honest. You know you don't have to hold back, and your private information won't just be gossip tomorrow.

Additionally, clinicians discussed the reduced level of situational awareness regarding appropriate behavior and decorum for individual and group sessions. P9003 stated,

> So, one thing we spend a lot of time, previously, and still currently, reinforcing rules and what group rules would look like in terms of logging on from the groups to ensure that everybody is able to obtain what they need with logging on this virtual platform without interruptions and/or distractions, and a lot of times encouraging the clients to be in a confidential and quiet environment."

Clinicians faced considerable challenges with the adjustments to telehealth while attempting to establish new policies and procedures to technology-based treatment. Many clinicians highlighted that many of their underserved and low-income clients faced more challenges than others. This consideration emphasized clients' acceptance or aversion to telehealth, leading to concerns about the potential effectiveness of telehealth treatment for mixed groups.

Theme 5: Challenges With Differing Levels of Capability

Following Question 4, regarding the benefits and challenges observed during the implementation of telehealth, clinicians discussed the varied technical knowledge levels of clinicians and clients. Participant P9001 stated, "However, the barriers are lack of access to technology, lack of digital literacy, a lot of my parents of the students, or even the students do not have hotspots and a lack of broadband and the Internet." This theme continued to appear in other interviews. Participant P9004 highlighted these concerns, stating, "From the standpoint of the technology piece, everyone has their own comfort zone in using it. There are some here who are more comfortable than others using it."

Participants described the necessity to train and educate many clients with limited knowledge of computers, smart devices, and Internet access. Each of these considerations was necessary to move forward with telehealth services. Participant P9007 suggested, "Many minorities and urban clients faced challenges due to limited connectivity issues and a lack of the technology (cell phones, computers, tablets)." Additionally, participants shared their perceptions that "patience was required during the transition to assist with the lack of knowledge, training, and awareness of how to effectively use the technology

for services" (P9007). Participant P9004 said, "I guess, from the standpoint of the technology piece, everyone has their own comfort zone in using it." Many clinicians described the initial limitations of technology as it related to learning, implementing, and teaching new technology-based models for mental health services. Participant P9004 stated, "Some here are more comfortable than others using it."

In addition to clients facing challenges with limited exposure or understanding of technology, some clinicians expressed limited knowledge and experience using technology. Participant P9006 stated, "I'm not tech savvy. Trying to get it hooked up and share your screen, get the camera on and make sure the mic was hooked up." These considerations highlighted additional anxiety for clinicians due to their limited capacity to accommodate clients.

The newness of telehealth combined with the steep learning curve for clinicians and clients revealed concerns related to privacy, confidentiality, and the redevelopment of expectations for mental health practice, opening discussions to consider the perceived effects and overall efficacy of telehealth during COVID-19.

Discrepant Cases

The only discrepant case for RQ2 presented consideration regarding the overall ease of use and implementation of telehealth following the initial adjustment period. Most clinicians discussed their ability to implement telehealth after a short discovery period of technology-based platforms. However, Participant P9006 stated, "I'm not tech savvy," presenting an additional consideration for clinicians during this period. Additional research may be required to determine to what extent clinicians felt

comfortable with technology before implementing telehealth services. Fortunately, this discrepant case did not adversely affect the results attained for the overall study.

Research Question 3

RQ3: What do they perceive about the efficacy and effects of telehealth services to clients and their access to services during the COVID-19 crisis? Clinicians were asked about the changes they observed in clients during the transition to telehealth. Many clinicians described challenges related to how clients adapted to their new normal while describing their thoughts regarding the future direction of telehealth post-COVID-19. The clinicians' responses led to the following themes: (a) barriers to gaining and maintaining access, (c) clients' acceptance and aversion to telehealth services, and (d) lessons learned for future practice.

Theme 6: Barriers Gaining and Maintaining Access

Following Question 4, participants shared barriers to treatment due to clients' limited access to reliable Internet services and the necessary equipment required to provide telehealth services. Participant P9004 recalled, "The biggest challenge was, especially with the clients, with different phone services and educating clients to using them. Their level of comfort in putting in passwords, maintaining those passwords, maintaining the contact information."

Similarly, Participant P9002 observed challenges with clients maintaining access to Internet services and connectivity, stating, "sometimes, Wi-Fi just doesn't seem to want to work," creating additional barriers for clients engaged in services. Clinicians observed that frequent Internet issues caused disruptions and distractions during

treatment. As stated by Participant P9005, “So, the Internet is a problem. People coming in and out of a session. So, you’re distracted.” Additionally, Participant P9005 commented,

> I would say sometimes has been a challenge, when you think about IT, not IT but Internet strength and signal. There’ve been times when I’ve been on a telehealth and the Internet starts to act a little wonky, and either the client can’t hear me, or I can’t hear them. It’s freezing up, and that’s a little frustrating sometimes when you’re unable to get a good signal to be able to complete a good telehealth session.

Other participants shared the same sentiments regarding the issues associated with maintaining uninterrupted mental health services due to challenges with connectivity. Participant P9006 stated, “Some of my clients don’t have Wi-Fi. Some don’t have smartphones; they have the government phone, hit end, and send.”

Finally, some concerns described led to the re-occurrence of concerns related to challenges navigating devices and Internet connections, presenting the consideration of clients’ and clinicians’ varied experiences with technology-based models and equipment. Participant P9001 noticed, “The barriers were lack of access to technology, lack of digital literacy, a lot of my parents of the students, or even the students do not have hotspots and a lack of broadband and the Internet.” Other clinicians echoed these concerns well after the telehealth implementation, highlighting a continued challenge to accessible services and reliable equipment.

The major consideration for Theme 4 involved recurrent challenges with maintaining access to the Internet and the availability of equipment that successfully interfaced with the selected telehealth platform. Additionally, clinicians transitioned to issues with clients' limited exposure to telehealth platforms and the technology necessary to access them, presenting Theme 5.

Theme 7: Clients' Acceptance and Aversion to Telehealth Services

Clinicians reported challenges implementing telehealth with younger clients. Participants reported significant concerns for clients under 10 years old and adolescent clients. Participant P9002 stated, "They don't like sitting down. So, it's a lot harder to have discussions sometimes, especially, if it's just a bad day for them." Clinicians discussed increased challenges for younger clients facing concerns related to impulse control. Participant P9002 recalled, "I mean he also has an issue with like impulse control, kind of just not paying attention to things." Clinicians working with younger populations observed that telehealth models presented challenges, especially for children with impulse control and hyperactivity issues. Participant P9006 stated,

> It doesn't work well for my kids (adolescent clients). They can sit in front of a video game for an hour. However, they don't want to sit in front of a screen and talk to me for an hour, which is understandable.

Additionally, Participant P9002 suggested, "A lot of them just want to be able to release that energy because they're very hyperactive, and that's just hard for them." These concerns echoed the concerns of other clinicians that, such as Participant P9002, who stated, "They can sit in front of a video game for an hour. However, they don't want

to sit in front of a screen and talk to me for an hour, which is understandable." However, many clinicians observed some of the same challenges with other populations highlighting the next theme related to the overall acceptance and aversion to telehealth services.

Clinicians expressed concern for the changes in client interactions, referrals for service, and an overall reduction in the number of clients served by their agencies. Participant P9003 acknowledged an alarming reduction in their caseload. In addition to reducing overall caseloads, many clinicians and their agencies faced significant reductions in their treatment sessions. Participant P9003 stated,

> We did not modify the Zoom. So, we are only operating from a 45-minute standpoint. So, trying to make sure where in times past, they were able to receive treatment for up to 90-minutes, now, you're receiving treatment for 40-minutes.

However, the reduced hours presented challenges with the rising anxiety and frustration of participants, necessitating additional one-on-one sessions. Participant P9003 recalled,

> So, if that meant outside of the normal treatment schedule from a group standpoint, I would implement more one-on-ones, and give them more individual treatment to ensure that it was able to help them in their process of recovery that would prevent them from going to a place of relapse.

Many clients became very relaxed, "and attention span is something that has been big to identify and recognize and help redirect clients," P9003 observed.

Additionally, telehealth provided many clients and clinicians an opportunity to minimize travel, face transportation difficulties, and be at home earlier than the in-person treatment schedule. Participant P9003 stated

> They don't drive and go back to various sections of town, recovery houses, so forth and so on. But virtually, it provided them the opportunity to already be at home after work at the recovery house, or any location of their choice and still be able to receive treatment.

Other clients faced significant challenges adjusting to virtual, resulting in the need for more individual sessions for this group. Participant P9003 stated, "More one-on-ones and give them more individual treatment to ensure that it could help them in the recovery process that would prevent them from going to a place of relapse." Many faced a sense of reduced effectiveness when introducing the virtual platform and experienced less connection to the treatment. Many clients faced issues with boredom and an increased risk for relapse. Clinicians described a sense of redundancy when reiterating the rules and procedures for telehealth sessions. Likewise, P9007 observed similar concerns, noting,

> The challenge would be the thing with telehealth is that it does offer you many conveniences. You can meet with them anywhere, and I can meet you in the bed with some people that became. I'm going to meet with you while I'm on the bus, in the car, you know, they have family around.

However, Participant P9007 also acknowledged that many clients were "more engaged because there is a lot of stress and pressure that can come around scheduling a session to meet with someone for whatever reason" in person. Additionally, telehealth

services took “away those barriers that extra layer of stress. You can be more engaged more often, providing clients with an opportunity to get the help without an extra barrier” (Participant P9007). Finally, clinicians highlighted the lessons they learned from the rapid implementation of telehealth services and discussed their perceptions of beneficial steps for future practice.

Theme 8: Lessons Learned for Future Practice

Although many clinicians expressed initial apprehension and doubt regarding the effectiveness of implementing telehealth, most look forward to the possibility of maintaining telehealth services. Some clinicians acknowledged that solely technology-based novels present challenges for younger clients. P9002 highlighted some of the conveniences of maintaining telehealth:

> So, telehealth isn’t my first solution when it comes to a lot of our clients, but it’s still a solution. I’m not like writing it out, of course. It’s still useful, especially like sometimes I got to talk to their guardian or something, it’s pretty easy just to hit a Zoom link instead of going all the way to their house.

However, participants agreed that telehealth services present a unique opportunity to provide services and treatment that connect stakeholders, family members, and other treatment professionals in multiple locations. Additionally, P9002 acknowledged that many clients benefited from “the use of smartphones, tablets, laptop computers, desktop computers … to connect to healthcare practitioners who potentially diagnose, monitor, and treat a multitude of acute and chronic conditions.”

Participants acknowledged concerns surrounding clients' limited access to telehealth services before the pandemic. P9007 discussed the idea that "telehealth has changed the way people viewed services. So, I do think it is something that needs to stay." Additionally, clinicians agreed that low-income, urban, and minority clients received "greater access" to treatment because of the transition to telehealth services. Likewise, P9005 acknowledged, "The option is available to a lot of people because we can reach more people in a telehealth fashion." P9007 discussed the convenience as a beneficial reason for maintaining telehealth services: "It does allow a lot more people to have access to behavioral healthcare, which was not always the case, especially with not having transportation or not having childcare, things like that."

Although many participants acknowledged the benefit and challenges associated with the implementation of telehealth, participant P9003 suggested the incorporation of "hybrid- being able to do a combination of both. Whereas individuals have an opportunity to do some in-person, as well as virtual." The overarching consideration of participants surrounded the idea that their clients would benefit greatly from a hybrid integration of mental health treatment and services.

Moreover, clinicians discussed that other services were more readily available to clients, but some challenges remained for those unable to maintain reliable access to the Internet and smart devices. Participant P9001 recalled,

> My initial thoughts about the use and or rapid implementation of telemental health have its pros and cons, such as services are more available, and healthcare can be accessible in isolated communities. However, there are sometimes difficulties

> getting an appointment, and technology such as videos and communication devices can sometimes be ineffective.

On the other hand, Participant P9006 opposed continuing telehealth services for her population, stating, “It’s not good for my adolescent population whatsoever.” Other clinicians that worked with adolescent clients agreed that telehealth was difficult for this population; however, they agreed that there were some benefits to maintaining some components of telehealth in the future. Participant P9002 stated, “It’s a lot tougher having discussions with them sitting down compared to if I’m there. We can have the same conversation playing catch that we’re having sat down on a Zoom meeting.” However, Participant P9002 stated,

> So, that’s so much easier than having to wake you early, go drive to a client’s school, then leave the client’s school and go to somebody else’s house, then keep doing that like three more times, and then coming home at like eight.

Most clinicians agreed that while there were some initial challenges with confidentiality, establishing new norms, and clients’ acceptance of the transitions, telehealth provided some benefits that should be considered for future mental health practice. P9007 observed,

> I do feel like telehealth has changed the way people viewed services. So, I do think it is something that needs to stay. I think it has been a great benefit to a lot of people … So, I do think it is something that has created greater access, which is essential, especially for certain populations, low-income populations, inner-city

populations, especially minority populations. Because I know it can be difficult to find a provider who looks like you.

Following the adjustment period and the establishment of new norms for decorum in an online treatment setting, clinicians favored the development of some hybrid (telehealth and in-person) treatments and services to accommodate clients' needs.

Discrepant Cases

Most clinicians believed that the transition to telehealth was efficient and effective for their clients. Additionally, clinicians observed that clients required additional redirection during the initial adjustment period. However, participant P9006 stated, "It does not work for kids." The clinician found telehealth convenient; however, she was opposed to continuing this model with her population stating, "They can't sit in front of you for three [hours]. It's not adding up." These considerations present the potential for future research related to the differences in acceptability among diverse clients.

Summary

The purpose of this chapter was to present the results of the study. Additionally, the researcher attempted to understand the experiences and perceptions of the rapid implementation of telehealth during the COVID-19 pandemic. Clinicians described a significant difference in service delivery compared to their pre-COVID services. Further, clinicians described some perceived benefits and challenges, personally and professionally, that affected the efficiency of service and treatment delivery. Some of these challenges were discussed by clinicians as ongoing challenges even after periods of

adjustment and acclimation. A summary of the results is highlighted below in the research questions subheadings.

Research Question 1

RQ1: How do mental health professionals describe their experiences of providing services to clients during the COVID-19 crisis? When considering clinicians' answers regarding how mental health professionals describe their experiences of providing services to clients during the COVID-19 crisis, the overarching considerations involved difficulty transitioning from pre-COVID to adjusting to the implementation of telehealth. None of the clinicians had prior experience with telehealth services causing significant anxiety and apprehension regarding their clients' ability to adapt to the swift change. Additionally, clinicians felt uncertain about the benefits technology-based models would offer for mental health and substance abuse treatment and services. Many clinicians described their initial apprehension about the potential benefits of telehealth. After implementing appropriate telehealth models, many clinicians discussed frustration as they attempted to normalize the new service model.

Clinicians described the marked differences between their roles prior to COVID-19 and during the implementation. Some changes included the process of researching and learning a new model for mental health treatment. Furthermore, many clinicians expressed concern about the rapid transition to telehealth while juggling the competing need to establish continuities of care and determine the most beneficial platform to initiate services. These concerns led to more pressure due to clinicians discovering significant limitations to clients' access to reliable Internet and equipment to successfully

conduct individual and group treatment. Due to the urgency and client needs, many clinicians began phone sessions to establish open communication while preparing to implement telehealth platforms for treatment and services.

Research Question 2

RQ2: How do they describe their experiences and perceptions of implementing telehealth services with clients? After the initial adjustment period, clinicians discussed feeling comfortable using telehealth platforms with clients. Clinicians described a sense of control over their time due to the increased flexibility inherent in the implementation of telehealth. Also, clinicians observed similar client conveniences due to the reduced need for travel and other personal considerations. However, clinicians discussed ongoing frustrations over time due to continued accessibility issues of some clients, highlighting challenges for clients maintaining reliable Internet connectivity.

Clinicians described experiences of frustration due to continued disruptions to services due to additional challenges with access following the initial adjustment period. Moreover, clinicians' perceptions of clients' acceptance and aversion presented concerns related to assessing individual clients' needs. Some clinicians expressed significant opposition to implementing technology-based treatment and services requiring alternative methods to address clients' needs. Some clinicians described frustration with implementation due to the need to re-establish protocols and manage their expectations.

Many clinicians discussed their challenges when establishing new protocols for clients in a virtual setting. Clinicians expressed the constant need to reiterate appropriate behaviors and decorum during group and individual treatment sessions. Although

establishing standard operating policies, procedures, and principles geared toward maintaining professionalism, many clients became comfortable taking advantage of the convenience of technology-based service models. Additionally, clinicians discussed the necessity to incorporate reminders during sessions to address concerns related to privacy and confidentiality during active individual and group treatment sessions, including reducing log-on in public or highly populated areas.

Research Question 3

RQ3: What do they perceive about the efficacy and effects of telehealth services to clients and their access to services during the COVID-19 crisis? Clinicians discussed concerns related to clients' acceptance and aversion to telehealth services after acclimation. Many clinicians described challenges they observed in some clients adjusting to technology-based models requiring additional one-on-one sessions. Others described some clients' aversion and refusal to participate in telehealth services. These challenges required the continuation of in-person services. However, most clients accepted telehealth services and appreciated the added convenience of participating in mental health services remotely. Clinicians expressed mixed feelings regarding the efficacy of telehealth services.

Some clinicians observed that many clients engaged more with their treatment online. However, most clinicians observed increased frustration and feelings of powerlessness associated with ongoing Internet disruptions and inaccessibility. These considerations disrupted services in addition to threatening newly established continuities of care. Clinicians stated that clients overall received the telehealth models well

following an adjustment period, but the overall efficacy of treatment depended greatly on the individual client and their circumstances. Finally, clinicians described their experiences with telehealth as challenging, convenient, and beneficial in some capacity for future mental health services.

In Chapter 5, I reiterate the study's overall purpose and summarize critical findings attained during data analysis. Additionally, an interpretation of the findings is revealed to highlight the connections between the study's findings, existing literature, and how the information enhances the existing body of knowledge. An overview of the connection findings related to the theoretical and conceptual frameworks is discussed. Finally, the limitation, implications, and recommendations are highlighted.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

The purpose of this study was to address the research questions about how social workers describe their experiences and perceptions of providing services to clients, how they use telehealth services in working with clients, and what they perceive about the efficacy and effects of telehealth services to clients. In this study, I used a basic qualitative research method. Bronfenbrenner's (1979) ecological model and Davis's (1989) TAM were incorporated as tools that aided in the conceptualization of the challenges associated with the rapid implementation of telehealth services across multiple systems. The ecological model combined with the TAM provided an opportunity to understand the phenomena of providing mental health treatments and interventions in central Virginia.

Semistructured in-depth remote virtual interviews were conducted with seven mental health professional participants using Zoom. Although 12 to 15 participants were proposed for the study, two factors presented the need to reduce the number of participants. I reached saturation following the sixth interview (see Creswell & Creswell, 2018). A seventh interview was conducted to confirm the absence of new themes. Additionally, an exhaustive recruitment process presented frequent cancellations and scheduling challenges with potential participants. This consideration ushered in delays to the completion of the study.

Eight themes emerged from the data analysis related to the overall transition from in-person to telehealth services. Additionally, the findings revealed valuable insight

associated with the effectiveness and efficacy of telehealth services during the COVID-19 pandemic in Virginia (e.g., Archibald et al., 2019; Fink et al., 2020; Morse, 1995; Wilkerson et al., 2014). I incorporated a data analysis model similar to the research of Navarro-Moya et al. (2020). Incorporating these qualitative methods for this study yielded rich data from participants. Analysis of the data revealed themes that increased understanding of clinicians' perceived benefits and challenges, along with their experiences associated with the rapid implementation of telehealth for mental health services. Finally, clinicians' perceptions of the technology's ease of use and usefulness during the COVID-19 crisis were shown.

The COVID-19 pandemic presented significant challenges for clients and clinicians (Wijesooriya et al., 2020). The rapid implementation of telehealth services presented significant concerns for clinicians during the onset of the pandemic. Many clinicians had limited experience, training, or knowledge of technology-based mental health services prior to the pandemic (Miu et al., 2020). The presence of regulatory and insurance restrictions for minorities initially presented challenges; however, the onset of COVID-19 forced changes to previous standard operations (Blundell et al., 2020). Many clinicians providing services for low-income urban clients and communities faced limitations in their ability to use telehealth services before the pandemic presented major concerns related to continuity of care.

Following the onset of the COVID-19 pandemic, clinicians faced significant anxiety and apprehension related to the uncertainty of technology-based service models. Many clinicians and their agencies attempted to navigate the initial challenges posed by

evaluating and implementing the most appropriate platforms for their clients. Limited knowledge, training, and exposure to these services affected some of these factors greatly. Additionally, following the selection of telehealth platforms, many clinicians faced challenges in learning the new platforms, training clients, and implementing new technology-based platforms for treatment and services (Cornell et al., 2021). Due to limited personal knowledge, skills, and exposure, clinicians faced concerns associated with reconciling their lack of knowledge while educating and training clients to assist them in maintaining continuity of care.

The implementation of telehealth presented significant concerns for clinicians and clients. In addition to their limited knowledge and skills, many clients had limited equipment and internet access. Initially, these considerations created barriers to access. Some clients also had limited access to smartphones and tablets and limited resources for mobile hotspots and other connectivity access. However, with increases in resources and funding, access to the internet and equipment became more readily available. Following the resolution of the accessibility challenges, clinicians needed to develop standards for operation and new policies for conduct during online sessions. Although many clients became accustomed to the policies, procedures, and operations of in-person treatments and services, most had no previous exposure to telehealth.

Participants discussed their initial apprehension and anxieties associated with the rapid implementation of telehealth services during the onset of the COVID-19 pandemic in Virginia. Many clinicians had limited exposure to technology-based mental health treatment and services prior to the onset of the COVID-19 pandemic. These

considerations led to concerns about continuity of care, efficacy of service, and limited faith in technology-based services and treatments. Some clinicians faced significant challenges with the transition to telehealth due to the absence of protocols for transitions, lack of knowledge and skills using telehealth platforms, and challenges associated with access to internet and equipment (Liang et al., 2020; Miu et al., 2020). Additionally, clinicians experienced additional challenges implementing technology-based treatment and services with clients under age 10 due to a lack of alternative methods for physical activities previously implemented during face-to-face sessions.

Interpretation of the Findings

Implementing telehealth services presented significant benefits and challenges for clinicians, clients, and agencies during the COVID-19 pandemic. The data from clinicians implementing telehealth services during the COVID-19 pandemic in Virginia revealed key components that confirm and align with the current literature. Additionally, some findings present beneficial information that extends mental health treatment and services knowledge. Before COVID-19, telehealth services and virtual mental health treatment platforms were available (Sasangohar et al., 2020). However, participants discussed the lack of availability or authorization to implement these measures with clients before the pandemic in Virginia.

Clinicians providing mental health and substance abuse services before COVID-19 incorporated in-person services with limited phone consultations. Participants experienced limited exposure to technology-based models before COVID-19, highlighting some of the limitations of treatment and services. Similarly, Miu et al.

(2020) noted that telehealth models remained limited despite the available research highlighting the benefits for some mental health populations. Telehealth practice for many clinicians before COVID was not authorized due to challenges with agency and regulatory restrictions. The regulatory barriers did little to assist in motivating interest and motivation for clinicians. These findings highlighted the disparities observed by Barry et al. (2016). Other researchers observed similar results in their studies highlighting additional concerns with low-income earners and populations with limited insurance (Miu et al., 2020). Shulver et al. (2016) highlighted a significant gap in the use of telehealth services prior to COVID-19, identical to this study's participants. Each of these concerns produced a greater desire to understand clinicians' experiences following the implementation of telehealth services.

The rapid implementation of telehealth services presented significant concerns for clinicians during the onset of the COVID-19 pandemic. Additionally, the swift transition produced feelings of anxiety for clinicians and clients. Hennein and Lowe (2020) observed similar concerns with the abrupt pause in services requiring a swift transition to telehealth services. Clinicians recognized the necessity of the transition to telehealth to maintain continuity of care. However, the initial transition added pressure for clinicians due to mandatory closures and limited prior experience.

Furthermore, Reeves et al. (2021) observed similar challenges in their study. As clinicians attempted to navigate the nuances of their transitions to telehealth, they experienced various challenges. Chigangaidze (2021) also observed that adjustments to new norms initially produced anxiety for clinicians and clients at the onset of

implementation. Conversely, some clinicians found the initial transition to telehealth easy and experienced limited difficulty during the transition, highlighting some variation from the literature. Additionally, many clients adapted to the implementation of telehealth seamlessly. Some clinicians gained access to the required resources; many enjoyed the convenience and increased safety of maintaining their mental health services and transitioning smoothly to telehealth models. These highlighted some positive revelations surrounding the convenience and flexibility of the technology-based mental health treatment models.

Many participants described the use of telehealth with clients as convenient, highlighting the ability to connect with clients in diverse locations. Hopkins and Pedwell (2021) reported similar results in their study. Additionally, many clinicians observed that the added convenience and flexibility reduced stress for some clients facing time constraints and limited available transportation (Hopkins & Pedwell, 2021). Participants lauded the ability to engage in sessions with clients, family members, and required stakeholders as an effective tool for multidisciplinary meetings and services. All parties could engage and participate regardless of physical location (Hopkins & Pedwell, 2021). Participants described their appreciation for the elimination of travel, concerns about planning logistics, and other potential barriers that hindered individual and group meetings. The comfort of clients and clinicians promoted the continued use and acceptance of telehealth models (Goetter et al., 2019). Unfortunately, many clients faced considerable difficulty transitioning from in-person to telehealth, favoring in-person, and reported reduced effectiveness with virtual treatment (Chiauzzi et al., 2020; Hopkins &

Pedwell, 2021). A possible reason for this may be that in-person provided connection and rapport for social workers; the new telehealth modalities presented increased adjustment challenges for many.

These concerns were heightened by barriers to services, such as limited access to the Internet, equipment, and smartphones (Blundell et al., 2020). Moreover, participants expressed frustration due to their lack of knowledge, skills, or experience with telehealth and other technology-based platforms (Kalayou et al., 2020; Palfai et al., 2019; Portz et al., 2019). Participants described feeling overwhelmed by the new responsibility of learning, teaching, and implementing telehealth services with their existing caseloads. Montoya et al. (2022) discussed clinicians' limited training during the pandemic, raising questions regarding the effectiveness of telehealth services. Additionally, participants described concerns regarding confidentiality, privacy, managing expectations, and clients' behaviors in the virtual setting (Chiauzzi et al., 2020). The emergence of COVID-19 was abrupt and unexpected; this issue contributed to potential increases in unpreparedness. These considerations highlight the possible need for clinicians and organizations to prepare technologically or integrate increased technology-based practices and service delivery models.

Similarly, the transition to telehealth services and treatment ushered in additional frustration and apprehension due to concerns associated with limited knowledge, skills, and prior exposure (Blundell et al., 2020; Chigangaidze, 2021; Montoya et al., 2022). Clinicians had minimal belief in the efficacy of telehealth models, fearing these services were not suitable or beneficial for underserved populations after the onset of the

pandemic. These considerations were echoed by descriptions of unfamiliarity with technology-based models and the uncertainty surrounding the selection of appropriate platforms (Gentry et al., 2021; Sasangohar et al., 2020).

Throughout the study, participants described changes to their clients' engagement and the sizes of their overall caseloads. Many participants discussed sharp reductions in their caseloads following the onset of the COVID-19 pandemic. Many clinicians in Virginia had limited experience, training, or practical knowledge of technology-based mental health services prior to the pandemic (Miu et al., 2020). Regulatory and insurance restrictions presented barriers for clinicians providing services to low-income, urban communities, limiting clinicians' ability to utilize telehealth services (Blundell et al., 2020). Before COVID-19, mental health services were provided in-person and face-to-face, leaving limited access to technology-based models. The onset of the pandemic caused clinicians major concerns that led to apprehension about telehealth and its potential effects on their clients.

However, participants described changes in group dynamics with the introduction of telehealth. Participants discussed their frustrations when attempting to implement rules and procedures for virtual meetings surrounding appropriate meeting decorum and appropriate behaviors during sessions (White et al., 2022). Some considerations involved being inappropriately dressed for individual and group sessions, logging in to treatment sessions while working, in the company of family and friends, and being engaged in other activities during scheduled treatment (White et al., 2022). These initial concerns highlighted considerable concerns like Ervin et al. (2021). Some concerns associated with

normalizing telehealth treatment resembled the findings of Ervin et al. (2021). However, this study revealed that following a period of education and acclimation, most clients adapted to the changes and new norms established for technology-based treatments and services. This finding may suggest that clients are adaptable to provisional changes of services without aversion to alternative methods of providing services with the caveat that the alternative approaches are properly implemented.

Clinicians agreed that the implementation of telehealth presented an opportunity to reach additional previously inaccessible clients. Additionally, while Internet and equipment issues presented an ongoing challenge following the implementation of telehealth, clients and clinicians were reasonably better prepared to provide beneficial treatment and services to clients following an acclimation period.

The incorporation of Bronfenbrenner's (1977) social-ecological model provided an opportunity to understand the effects of COVID-19 on clinicians and their clients as they participated in the rapid transition to telehealth models (Swearer & Hymel, 2015). The findings of this study reveal consistency with Bronfenbrenner's (1977) social ecological theory. The major social and environmental shift ushered in by the COVID-19 pandemic created a ripple effect throughout mental health and substance abuse services. The onset of the pandemic produced disruptions and discontinuities to services, resistance, and acceptance of services, in addition to forced transitions to new delivery methods. Furthermore, the marked shift between micro-systems became evident with the transition in clinicians' experiences before and after the telehealth implementation.

The findings highlight the significant changes in clinicians' roles from in-person clinicians to remote educators of new technology-based models, facilitators for the establishment and adoption of new norms, as well as mental health clinicians. Moreover, the findings of this study highlighted the interconnected relationships between the clinician's role as a mental health treatment specialist while attempting to navigate the re-establishment of beneficial relationships. In addition, the incorporation of Bronfenbrenner's (1977) social-ecological model enhanced the understanding of the effects of the pandemic on the diverse social and environmental factors that highlighted barriers to accessing services, redefined the specific model for rendering mental health treatment and services in addition to gauging clients' acceptance and aversion. Finally, Bronfenbrenner's social ecological model enhanced the ability to understand how the overall effects of the rapid implementation of telehealth informed future telehealth services for diverse populations while remaining cognizant of the overall interconnection of all systems combined.

Clinicians described their initial apprehension about the selection and implementation of new platforms. F. D. Davis's (1989) TAM highlights the initial challenges associated with telehealth due to the perceived difficulty of accessing technology-based platforms. However, following more education, use, and training, clinicians became more confident and perceived the telehealth model as more useful in their practices. Additionally, many clinicians faced personal challenges due to their limited exposure, knowledge, or skill in navigating technology-based models, presenting anxiety about learning, and teaching these platforms while attempting to recreate

continuities of mental health care for clients (Montoya et al., 2022). However, an overarching theme for clinicians consisted of significant shifts in mental health caseloads. In many cases, client reductions were as severe as a 75% loss in previous caseloads.

The findings in this study validate F. D. Davis's (1989) TAM regarding the importance of ease of use and the usefulness and intended use of technology in the adoption of telehealth by practitioners in providing services to clients during the pandemic. Despite the rapid implementation and initial uncertainty of telehealth, telehealth's increased convenience and flexibility augmented practitioners' willingness to adopt and navigate the challenges associated with its implementation. Additionally, F. D. Davis's TAM assisted in understanding the acceptance, aversion, and overall user experience of clinicians transitioning to telehealth models following implementation. Moreover, rapid closures and the limited availability of in-person services ushered in the necessity to incorporate telehealth as a beneficial service for maintaining continuous care. This act mandated the initial exposure to technology-based models. Telehealth models also enhanced their ability to address clients' acceptance, resistance, and aversion to telehealth services. Therefore, F. D. Davis's TAM becomes a useful tool for understanding practitioners' adoption of and clients' response to telehealth during the pandemic.

Limitations of the Study

Some limitations of this study included clinicians' scheduling, time constraints, and lack of funding to compensate participants. A barrier when collecting primary data included initial difficulties in recruiting participants for interviews. Another limitation of

the study was the sample size of the respondents and the generalizability of findings. As opposed to analyzing the qualitative data after interviewing all the participants, the data for the study were analyzed as each participant was interviewed. The saturation of themes was reached after the analysis of the sixth participant. The data collected from the seventh participant did not result in any new codes or themes. As a result, it was determined that a true saturation had been reached. However, due to the small sample size of respondents, it must be acknowledged that the findings cannot be generalized to represent the totality of clinicians' experiences and perceptions of telehealth services during the COVID-19 pandemic in Virginia.

A significant consideration for this study consisted of the impact COVID-19 had on mental health service delivery. Although previous restrictions were relaxed, many clinicians remained virtual or began transitioning to hybrid (face-to-face and videoconferencing) services. However, these transitions created a logistical challenge that reduced the ability to conduct in-person interviews. Due to these challenges, it was more advantageous to conduct virtual Zoom interviews reducing additional stress and inconvenience to participants during these transitions. These methods presented the potential for ethical considerations associated with participant anonymity. These considerations required me to submit specific instructions regarding eliminating actual names and extending participants' options to keep their cameras off during the recorded interview.

Additionally, the utilization of the Atlas.ti, qualitative data analysis tools required a fee for the utilization period. The participants were identified as African American,

presenting a limitation in understanding the perspectives and experiences of a diverse group of mental health clinicians. Furthermore, the participants recruited worked primarily in central Virginia and Hampton Roads, Virginia, reducing the ability to be considered truly transferrable to other locations throughout Virginia.

Recommendations

Despite the limitations, this study had some notable strengths, including the expansion of the limited presence of qualitative research highlighting the experiences and perceptions of clinicians. In addition, this study was one of the first to highlight the rapid implementation of telehealth services during the COVID-19 pandemic in Virginia. Knowledge about practitioners' thoughts, perceptions, and experiences generated insight into implementing telehealth during COVID-19. This knowledge can complement the knowledge generated by existing quantitative studies; this knowledge may be beneficial in informing future quantitative studies offering exploratory power on telehealth during COVID-19.

Some main considerations for this study include the need for continued training and education for clinicians and their clients. An increase in training assists clinicians with learning, teaching, and remaining up to date on current trends and technology-based models. Due to the clients' age diversity, additional research may be required when implementing telehealth services for small children and adolescents. This study provided an opportunity to understand the experiences and perceptions of clinicians providing and implementing telehealth services during COVID-19. Some of the recommendations for this study include conducting a more comprehensive exploration of clinicians'

perceptions and experiences with training and access to telehealth following implementation in Virginia.

Some recommendations for future research include expanding the existing research related to the implementation of telehealth to examine or explore the differences in mental health services provided to adolescent and aging populations. Clinicians acknowledged the benefits and challenges of the implementation of telehealth; however, specific information regarding how specific populations accepted telehealth services was limited and generalized. Additionally, future studies regarding the implementation of diverse telehealth platforms may add to the body of knowledge regarding the efficiency and ease of use of specific platforms. They may provide beneficial information for clinicians and their agencies. Each of these considerations presents an opportunity to enhance future services and treatment.

Additionally, evaluations of specific telehealth services utilized during COVID-19 provide an opportunity to compare the benefits and challenges of differing technology-based platforms. Many clinicians providing telehealth services to youth and adolescents discussed the potential challenges related to the reduced efficacy of telehealth services with youth and adolescents (Hopkins & Pedwell, 2021). Additional research on implementing telehealth services with youth and adolescents may provide beneficial knowledge that aids in developing more interactive platforms for younger clients (Hopkins & Pedwell, 2021).

Implications

This study fills the gap in understanding clinicians' perceptions of the challenges clients faced during the COVID-19 crisis by focusing on the changing trends in client engagement and alternative delivery models during the implementation of the telehealth model. In addition, the study provides information on clinicians' experiences with learning and navigating the new technology associated with providing telehealth services (e.g., Freeman et al., 2017; Hadjistavropoulos et al., 2020; Huskamp et al., 2018). The results of this study aid stakeholders by providing new information highlighting the benefits and challenges associated with the telehealth treatment models in Virginia while providing insight into strategies to improve training and the continued enhancement of future telehealth models. Furthermore, the knowledge gained through this study may promote social change efforts by promoting the development of accessible treatment models and technology for vulnerable populations, especially in times of crisis. Also, this study assists agencies in understanding how rapid implementation affected client outcomes, presenting an opportunity to explore less disruptive integration methods.

The incorporation of the Bronfenbrenner's (1977) social-ecological theory provides future researchers with an opportunity to examine the interconnected relationships between clients, their conditions, and the environmental effect that create barriers to treatment, services, and recovery. Additionally, incorporating F. D. Davis's (1989) TAM remains important in future research due to the challenges observed with accessibility, Internet connectivity, and the varying levels of understanding technology. These theoretical and conceptual frameworks remain vital to evaluating and examining

the acceptance of telehealth models while carefully considering how barriers may prevent access or efficacy. Also, other barriers to services in preparation for future crises may present an opportunity to evaluate additional obstructions to mental health and substance abuse treatment and services. Finally, this study allows mental health professionals, agencies, and other stakeholders to embrace technology as a sustainable model for substance abuse treatment and intervention.

Some considerations for practice include clinicians remaining cognizant of their clients' technical knowledge and skills as an initial method for determining the necessity for training and education. Also, the concern related to technical support, the availability of equipment, and Wi-Fi services may aid clinicians in determining and reducing barriers to services. Finally, clinicians may benefit from ongoing training and research related to new models and policies associated with technology-based models, implementation, and the availability of client-friendly models for diverse populations.

Conclusion

The COVID-19 pandemic highlighted unprecedented challenges for mental health treatment and services. I used qualitative thematic analysis to aid in understanding the experiences and perceptions of clinicians providing mental health services during the COVID-19 pandemic. Although the goal of mental health services involved the clinicians' role of connecting, assisting, and providing resources to assist clients with coping and recovery strategies, the onset of COVID-19 exacerbated pre-existing conditions and created new barriers (Abramson, 2021; Ohannessian et al., 2020). This study highlighted many benefits and challenges experienced by clinicians, as well as

some unexpected issues experienced during transition and adjustment. The rapid implementation of telehealth provided an alternative answer to the initial discontinuity of treatment and services.

However, the study highlighted significant disparities. Although technology-based models provide a level of convenience and flexibility, it remains important for clinicians to continue to evaluate the capacity and overall well-being of every client. Future research remains beneficial in discovering the experience and perceptions of clinicians serving diverse populations. Future research presents an opportunity to discover the vital information that may improve the efficacy and efficiency of telehealth models by understanding clinicians' experiences and perceptions of providing services to a client, as well as their perceptions of the overall efficacy of services and their delivery to clients during COVID-19 pandemic in Virginia.

References

Abramson, A. (2021, March 1). Substance abuse during the pandemic. Opioid and stimulant use is on the rise-how can psychologists and other clinicians help a greater number of patients struggling with drug use? *American Psychology Association*, *52*(2), 22–23. https://www.apa.org/monitor/2021/03/substance-use-pandemic

Adams, S. V., Mader, M. J., Bollinger, M. J., Wong, E. S., & Hudson, T. J. (2019). Utilization of interactive clinical video telemedicine. *Journal of Rural Health*, *35*(3), 308–318. https://doi.org/10.11111/jrh.12343

Adler, G., Pritchett, L. R., Kauth, M. R., & Nadorff, D. (2014). A pilot project to improve access to telepsychotherapy at rural clinics. *Telemedicine and E-Health*, *20*(1), 83–85. https://doi.org/10.1089/tmj.2013.0085

Adler-Milstein, J., Kvedar, J., & Bates, D. W. (2014). Telehealth among U.S. hospitals: Several factors, including state reimbursement and licensure policies, influence adoption. *Health Affairs*, *33*(2), 207–215. https://doi.org/10.1377/hlthaff.2013.1054

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.).

American Society of Addiction Medicine. (n.d.). *Caring for patients during the COVID-19 pandemic: ASAM COVID-19 taskforce recommendations*. https://asam.org/docs/default-source/covid-19/infection-mitigation_residential.pdf?sfvrsn=746d53c2_2

Archibald, M. M., Ambagtsheer, R. C., Casey, M. G., & Lawless, M. (2019). Using Zoom videoconferencing for qualitative data collection: Perceptions and experiences of researchers and participants. *International Journal of Qualitative Methods*, *18*, 1609406919874596. https://doi.org/10.1177/1609406919874596

Baldacchino, A., Radfar, S. R., De Jong, C., Rafei, P., Yunesian, M., Gerra, G., Brady, K., Ebrahimi, M., Vahidi, M., Zonoozi, A. K., & Farhoudian, A. (2020). COVID-19 and substance use disorder: Study protocol for the International Society of Addiction Medicine Practice and Policy Interest Group Global survey. *Basic and Clinical Neuroscience*, *11*(2), 155–162. https://doi.org/10.32598%2Fbcn.11.covid19.2545.1

Barry, C. L., Goldman, H. H., & Huskamp, H. A. (2016, June). Federal parity in the evolving mental health and addiction landscape. *Health Affairs*, *35*(6), 1009–1016. https://doi.org/10.1377/hlthaff.2015.1653

Barry, C. L., Huskamp, H. A., & Goldman, H. H. (2010). A political history of federal mental health and addiction insurance parity. *The Milbank Quarterly: A Multidisciplinary Journal of Population Health and Health Policy*, *88*(3), 404–433. https://doi.org/10.111/j.1468-0009.2010.00605.x

Blanco, C., Compton, W. M., & Volkow, N. D. (2020). Opportunities for research on the treatment of substance use disorder in context of COVID-19. *JAMA Psychiatry*, *78*(4), 357–358. https://doi.org/10.1001/jamapsychiatry.2020.3177

Blundell, R., Costa Dias, M., Joyce, R., & Xu, X. (2020). COVID-19 and inequalities. *Fiscal Studies*, *41*(2), 291–319. https://doi.org/10.1111/1475-5890.12232

Bouchard, S., Paquin, B., Payeur, R., Allard, M., Rivard, V., Fournier, T., Renaud, P., & Lapierre, J. (2004). Delivering cognitive-behavior therapy for panic disorder with agoraphobia in videoconference. *Telemedicine Journal and E-health*, *10*(1), 13–25. https://doi.org/10.1089/153056204773644535

Bowden, C., & Galindo-Gonzalez, S. (2015). Interviewing when you're not face-to-face: The use of email interviews in a phenomenological study. *International Journal of Doctoral Studies*, *10*, 79–92. http://ijds.org/Volume10/IJDSv10p079-092Bowden0684.pdf

Broderick, A., & Lindeman, D. (2013). *Scaling telehealth programs: Lessons from early adopters*. Case Studies in Telehealth Adopters.

Bronfenbrenner, U. (1977). Toward an experimental ecology of human development. *American Psychologist*, *32*(7), 513–531. https://doi.org/10.1037/0003-066X.32.7.513

Burnell, E. D., Wołk, K., Waliczek, K., & Kern, R. (2020, March). The impact of constant field of attention on properties of contextual neural networks. In N. T. Nguyen, K. Jearanaitankij, A. Selamat, B. Trowinski, & S. Chittayasothorn (Eds.), *Asian conference on intelligent information and database systems* (pp. 364–375). Springer.

Caelli, K., Ray, L., & Mill, J. (2003). 'Clear as mud': Towards greater clarity in generic qualitative research. *International Institute for Qualitative Methodology*, *2*(2), 1–13. https://doi.org/10.1177/160940690300200201

Campbell, J. T., Atrundinda, I., Mwesigwa, E., Burns, B., Santorino, D., Haberer, J. E.,

Bangsberg, D. R., Holden, R. J., Ware, N. C., & Siedner, M. J. (2017). The technology acceptance model for resource limited settings (TAM-RLS): A novel framework for mobile health interventions targeted to low-literacy end-users in resource-limited settings. *AIDS and Behavior*, *21*, 3129–3140. https://doi.org/10.1007/s10461-017-1765-y

Centers for Medicare & Medicaid Services. (2018). Medicare program; hospital inpatient prospective payment systems for acute care hospitals and the long-term care hospital prospective payment system and policy changes and fiscal year 2019 rates; quality reporting requirements for specific providers; Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs (Promoting Interoperability Programs) requirements for eligible hospitals, critical access hospitals, and eligible professionals; Medicare cost reporting requirements; and physician certification and recertification of claims. Final rule. *Federal Register*, *83*(160), 41144–41784. https://pubmed.ncbi.nlm.nih.gov/30192475/

Chen, J. A., Chung, W.-J., Young, S. K., Tuttle, M. C., Collins, M. B., Darghouth, S. L., Longley, R., Levy, R., Razafsha, M., Kerner, J. C., Wozniak, J., & Huffman, J. C. (2020). COVID-19 and telepsychiatry: Early outpatient experiences and implications for the future. *General Hospital Psychiatry*, *66*, 89–95. https://doi.org/10.1016/j.genhosppsych.2020.07.002

Chiauzzi, E., Clayton, A., & Huh-Yoo, J. (2020). Videoconferencing-based telemental health: Important questions for the COVID-19 era from clinical and patient-centered perspectives. *Journal of Medical Internet Research Mental Health*,

7(12), Article e24021. https://doi.org/10.2196/24021

Chigangaidze, R. K. (2021). Risk factors and effects of the morbus: COVID-19 through the biopsychosocial model and ecological systems approach to social work practice. *Social Work in Public Health*, *36*(2), 98–117. https://doi.org/10.1080/19371918.2020.1859035

Cooper, S., & Endacott, R. (2007). Generic qualitative research: A design for qualitative research in emergency care? *Emergency Medicine Journal*, *24*(12), 816–819. https://doi.org/10.1136/emj.2007.050641

Cornell, P. Y., Celardo, C., Chmelka, G., Giles, A. J., Halladay, C. W., Halaszynski, J., Montano, A. R., Rudolph, J. L., & Silva, J. W. (2021). Social work and telehealth: How Patient Aligned Care Team (PACT) social workers in the Veterans Health Administration responded to COVID-19. *Social Work in Health Care*, *60*(2), 131–145. https://doi.org/10.1080/00981389.2021.1904320

Cowan, K. E., McKean, A. J., Gentry, M. T., & Hilty, D. M. (2019, December). Barriers to use of telepsychiatry: Clinicians as gatekeepers. *Mayo Clinic Proceedings*, *94*(12), 2510–2523. https://doi.org/10.1016/j.mayocp.2019.04.018

Cowain, T. (2001). Cognitive–behavioural therapy via videoconferencing to a rural area. *Australian & New Zealand Journal of Psychiatry*, *35*(1), 62–64. https://doi.org/10.1046/j.1440-1614.2001.00853.x

Creswell, J. W., & Creswell, J. D. (2018). Research design: Qualitative, quantitative, and mixed method approaches (5th ed.). SAGE.

Croke, L. (2020). Fostering patient engagement can aid in infection prevention efforts.

AORN Journal, *111*(5), 2–6. https://www.ruh.nhs.uk/library/up_to_date/documents/Infection_Control_Current_Awareness_Bulletin_2020_05.pdf

Davis, F. D. (1989). Perceived usefulness, perceived ease of use, and user acceptance of information technology. *MIS Quarterly, 13*(3), 319–339. https://doi.org/10.2307/249008

Davis, M. T., Torres, M., Nguyen, A., Stewart, M., & Reif, S. (2021). Improving quality and performance in substance use treatment programs: What is being done and why is it so hard? *Journal of Social Work, 21*(2), 141–161. https://doi.org/10.1177/1468017319867834

De Brier, N., Stroobants, S., Vandekerckhove, P., & De Buck, E. (2020). Factors affecting mental health of health care workers during coronavirus disease outbreaks (SARS, MERS & COVID-19): A rapid systematic review. *PloS One, 15*(12), Article e0244052. https://doi.org/10.1371/journal.pone.0244052

Druss, B. G., Chwastiak, L., Kern, J., Parks, J. J., Ward, M. C., & Raney, L. E. (2018). Psychiatry's role in improving the physical health of patients with serious mental illness: A report from the American Psychiatric Association. *Psychiatric Services, 69*(3), 254–256. https://doi.org/10.1176/appi.ps.201700359

Druss, B. G., & Goldman, H. H. (2018). Integrating health and mental health services: A past and future history. *American Journal of Psychiatry*, *175*(12), 1199–1204. https://doi.org/10.1176/appi.ajp.2018.18020169

Dunlop, A., Lokuge, B., Masters, D., Sequeira, M., Saul, P., Dunlop, G., Ryan, J., Hall,

M., Ezard, N., Haber, P., Lintzeris, N., & Maher, L. (2020). Challenges in maintaining treatment services for people who use drugs during the COVID-19 pandemic. *Harm Reduction Journal*, *17*(26), 1–7. https://doi.org/10.1186/s12954-020-00370-7

Erbe, D., Eichert, H. C., Riper, H., & Ebert, D. D. (2017). Blended face-to-face and Internet-based interventions for the treatment of mental disorders in adult. *Journal of Medical Internet Research*, *19*(9), Article e306. https://doi.org.10.2196/jmir.6588

Eriksson, M., Ghazinour, M., & Hammarström, A. (2018). Different uses of Bronfenbrenner's ecological theory in public mental health research: What is their value for guiding public mental health policy and practice? *Social Theory & Health*, *16*(4), 414–433. https://doi.org/10.1057/s41285-018-0065-6

Ervin, K., Weller-Newton, J., & Phillips, J. (2021). Primary healthcare clinicians' positive perceptions of the implementation of telehealth during the COVID-19 pandemic using normalization process theory. *Australian Journal of Primary Health*, *27*(2), 158–162. https://doi.org/10.1071/PY20182

Field, M. J. (Ed.). (1996). Telemedicine: A guide to assessing telecommunications for health care. National Academy Press.

Figgatt, M. C., Salazar, Z., Day, E., Vincent, L., & Dasgupta, N. (2021). Take-home dosing experiences among persons receiving methadone maintenance treatment during COVID-19. *Journal of Substance Abuse Treatment*, *123*, Article 108276. https://doi.org/10.1016/j.jsat.2021.108276

Fink, J. B., Ehrmann, S., Li, J., Dailey, P., McKiernan, P., Darquenne, C., Martin, A. R., Rothen-Rutishauser, B., Kuehl, P. J., Häussermann, S., & Dhand, R. (2020). Reducing aerosol-related risk of transmission in the era of COVID-19: An interim guidance endorsed by the International Society of Aerosols in Medicine. *Journal of Aerosol Medicine and Pulmonary Drug Delivery*, *33*(6), 300–304. https://doi.org/10.1089/jamp.2020.1615

Fischer, S. H., Uscher-Pines, L., Roth, E., & Breslau, J. (2021). The transition to telehealth during the first months of the COVID-19 pandemic: Evidence from a national sample of patients. *Journal of General Internal Medicine*, *36*(3), 849–851. https://doi.org/10.1007/s11606-020-06358-0

Frank, H. E., Grumbach, N. M., Conrad, S. M., Wheeler, J., & Wolff, J. (2021). Mental health services in primary care: Evidence for the feasibility of telehealth during the COVID-19 pandemic. *Journal of Affective Disorders Reports*, *5*, Article 100146. https://doi.org/10.1016/j.jadr.2021.100146

Freeman, D., Reeve, S., Robinson, A., Ehlers, A., Clark, D., Spanlang, B., & Slater, M. (2017). Virtual reality in the assessment, understanding, and treatment of mental health disorders. *Psychological Medicine*, *47*(14), 2393–2400. https://doi.org/10.1017/S003329171700040X

Fritz, R. L., & Vandermause, R. (2018). Data collection via in-depth email interviewing: Lessons from the field. *Qualitative Health Research*, *28*(10), 1640–1649. https://doi.org/10.1177/1049732316689067

Galehdar, N., Ehsani, M., Irajpour, A., & Jafari-Mianaei, S. (2020). Evaluation of in-

person continuing education programs from the perspective of ward nurses. *Journal of Education and Health Promotion*, *9*, Article 258. https://doi.org/10.4103%2Fjehp.jehp_58_20

Gavin, B., Lyne, J., & McNicholas, F. (2020). Mental health and the COVID-19 pandemic. *Irish Journal of Psychological Medicine*, *37*(3), 156–158. https://doi.org/10.1017/ipm.2020.72

Gentry, M. T., Puspitasari, A. J., McKean, A. J., Williams, M. D., Breitinger, S., Geske, J. R., Clark, M. M., Moore, K. M., Frye, M. A., & Hilty, D. M. (2021). Clinician satisfaction with rapid adoption and implementation of telehealth services during the COVID-19 pandemic. *Telemedicine and e-Health*, *27*(12), 1385–1392. https://doi.org/10.1089/tmj.2020.0575

Goetter, E. M., Blackburn, A. M., Bui, E., Laifer, L. M., & Simon, N. (2019). Veterans' prospective attitudes about mental health treatment using telehealth. *Journal of Psychosocial Nursing and Mental Health Services*, *57*(9), 38–43. https://doi.org/10.3928/02793695-20190531-0

Gordon, H. S., Solanki, P., Bokhour, B. G., & Gopal, R. K. (2020). "I'm not feeling like I'm part of the conversation:" Patients' perspectives on communicating in clinical video telehealth visits. *Journal of General Internal Medicine*, *35*(6), 1751–1758. https://doi.org/10.1007/s11606-020-05673-w

Gray, L. M., Wong-Wylie, G., Rempel, G. R., & Cook, K. (2020). Expanding qualitative research interviewing strategies: Zoom video communications. *The Qualitative Report*, *25*(5), 1292–1301. https://www.iths.org/wp-content/uploads/2.-

Expanding-Qualitative-Research-Interviewing-Strategies.pdf

Hadjistavropoulos, H. D., Gullickson, K. M., Adrian-Taylor, S., Wilhelms, A., Sundstrom, C., & Nugent, M. (2020). Stakeholder perceptions of Internet-delivered cognitive behavior therapy as a treatment option for alcohol misuse: Qualitative analysis. *Journal of Medical Internet Research Mental Health*, *7*(3), 1–10. https://doi.org/10.2196/14698

Harvey, J. B., Valenta, S., Simpson, K., Lyles, M., & McElligott, J. (2019). Utilization of outpatient telehealth services in parity and nonparity states 2010–2015. *Telemedicine and e-Health*, *25*(2), 132–136. https://doi.org/10.1089/tmj.2017.0265

Hennein, R., & Lowe, S. (2020). A hybrid inductive-abductive analysis of health workers' experiences and wellbeing during the COVID-19 pandemic in the United States. *PLoS ONE*, *15*(10), Article e0240646. https://doi.org/10.1371/journal.pone.0240646

Hopkins, L., & Pedwell, G. (2021). The COVID PIVOT–Re-orienting child and youth mental health care in the light of pandemic restrictions. *Psychiatric Quarterly*, *92*(3), 1259–1270. https://doi.org/10.1007/s11126-021-09909-8

Huskamp, H. A., Busch, A. B., Souza, J., Uscher-Pines, L., & Rose, S. (2018). How is telemedicine being used in opioid and other substance use disorder treatment? *Health Affairs*, *37*(12), 1940–1947. https://doi.org.10.1377/hlthaff.2018.05134

Irani, L. (2019). *Chasing innovation*. Princeton University Press.

John, B. V., Love, E., Dahman, B., Kurbanova, N., Konjeti, V. R., Sundaram, L. T.,

Deng, Y., Aubuchon, S., Heuman, D., Bajaj, J. S., & Siddiqui, M. S. (2020). Use of telehealth expedites evaluation and listing of patients referred for liver transplantation. *Clinical Gastroenterology and Hepatology*, *18*(8), 1822–1830. https://doi.org/10.1016/j.cgh.2019.12.021

Johnson, S., Dalton-Locke, C., San Juan, N. V., Foye, U., Oram, S., Papamichail, A., Landau, S., Olive, R. R., Jeynes, T., Shah, P., Rains, L. S., Lloyd-Evans, B., Carr, S., Killaspy, H., Gillard, S., & Simpson, A. (2021). Impact on mental health care and on mental health service users of the COVID-19 pandemic: A mixed methods survey of UK mental health care staff. *Social Psychiatry and Psychiatric Epidemiology*, *56*, 25–37. https://doi.org/10.1007/s00127-020-01927-4

Kalayou, M. H., Endehabu, B. F., & Tilahaun, B. (October 2020). The applicability of modified technology acceptance model (TAM) on the sustainable adoption e-health systems in resource-limited settings. *Journal of Multidisciplinary Healthcare*, *2020*(13), 1827–1837. https://doi.org/10.2147/JHDH.5284973

Khan, A., Khan, Q., & Kolb, E. (2021). Supportive alternate site provision of buprenorphine: Overcoming barriers and improving patient outcomes. *Journal of Substance Abuse Treatment*, *123*, Article 108256. https://doi.org/10.1016/j.jsat.2020.108256

Kilanowski, J. F. (2017). Breadth of the socio-ecological model. *Journal of Agromedicine*, *22*(4), 295–297. https://doi.org/10.1080/1059924X.2017.1358971

Kleykamp, B. A., Guille, C., Barth, K. S., & McClure, E. A. (2020). Substance use disorders and COVID-19: The role of telehealth in treatment and research.

Journal of Social Work Practice in the Addictions, *20*(3), 248–253. https://doi.org/10.1080/1533256X.2020.1793064

Lapão, L. V., Dussault, G., & World Health Organization. (2017). The contribution of eHealth and mHealth to improving the performance of the health workforce: A review. *Public Health Panorama*, *3*(03), 463–471. https://apps.who.int/iris/handle/10665/325262

Liang, L., Ren, H., Cao, R., Hu, Y., Qin, Z., Li, C., & Mei, S. (2020). The effect of COVID-19 on youth mental health. *Psychiatric Quarterly*, *91*(3), 841–852. https://doi.org/10.1007/s11126-020-09744-3

Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry*. Sage.

Lynch, V., Winiski, E., & Clemans-Cope, L. (2020). Medicaid prescriptions to treat opioid use disorder under fee-for-service and managed-care arrangements in 2018. Urban Institute.

Manchanda, M., & McLaren, P. (1998). Cognitive behaviour therapy via interactive video. *Journal of Telemedicine and Telecare*, *4*(1_suppl), 53–55. https://doi.org/10.1258/1357633981931452

Mayo Clinic Staff. (2020). *Telehealth: Technology meets health care*. https://www.mayoclinic.org/healthy-lifestyle/consumer-health/in-depth/telehealth/art-20044878

McGloin, R., Nowak, K. L., & Watt, J. (2014). Avatars and expectations: Influencing perceptions of trustworthiness in an online consumer setting. *PsychNology Journal*, *12*(1–2), 7–28.

https://citeseerx.ist.psu.edu/document?repid=rep1&type=pdf&doi=1c3555caacf6eb62f83f6a3bdded372d3138fea3

McQueen, M., Strauss, P., Lin, A., Freeman, J., Hill, N., Finlay-Jones, A., Bebbington, K., & Perry, Y. (2022). Mind the distance: Experiences of non-face-to-face child and youth mental health services during COVID-19 social distancing restrictions in Western Australia. *Australian Psychologist, 57*(5), 301–314. https://doi.org/10.1080/00050067.2022.2078649

Melis, G., Sala, E., & Zaccaria, D. (2021). Remote recruiting and video-interviewing older people: A research note on a qualitative case study carried out in the first COVID-19 red zone in Europe. *International Journal of Social Research Methodology*, *25*(4), 477–482. https://doi.org/10.1080/13645579.2021.1913921

Miu, A. S., Vo, H. T., Palka, J. M., Glowacki, C. R., & Robinson, R. J. (2021). Teletherapy with serious mental illness populations during COVID-19: Telehealth conversion and engagement. *Counselling Psychology Quarterly*, *34*(3–4), 704–721. https://doi.org/10.1080/09515070.2020.1791800

Molfenter, T., Roget, N., Chaple, M., Behlman, S., Cody, O., Hartzler, B., Johnson, E., Nichols, M., Stilen, P., & Becker, S. (2021). Use of telehealth in substance use disorder services during and after COVID-19: Online survey study. *Journal of Medical Internet Research Mental Health, 8*(2), Article e25835. https://doi.org/10.2196/25835

Moloi, H., Daniels, K., Cooper, S., Odonaal, W., Naledi, T., Goliath, C., & Leon, N. (2020). Healthcare workers' perceptions and experiences of primary health

integration: A qualitative evidence synthesis (protocol). *Cochrane Database of Systematic Reviews*, *5*, Article CD13603. https://doi.org/10.1002/14651858.CD013603

Montoya, M. I., Kogan, C. S., Rebello, T. J., Sadowska, K., Garcia-Pacheco, J. A., Khoury, B., Kulygina, M., Matsumoto, C., Robles, R., Huang, J., Andrews, H. F., Ayuso-Mateos, J. L., Denny, K., Gaebel, W., Gureje, O., Kanba, S., Maré, K., Medina-Mora, M. E., Pike, K. M., & Roberts, M. C. (2022). An international survey examining the impact of the COVID-19 pandemic on telehealth use among mental health professionals. *Journal of Psychiatric Research*, *148*, 188–196. https://doi.org/10.1016/j.jpsychires.2022.01.050

Morse, J. M. (1995). The significance of saturation. *Qualitative Health Research*, *5*(3), 147–149. https://doi.org/10.1177/1049732315576699

Morse, J. M. (1999). Qualitative generalizability. *Qualitative Health Research*, *9*, 5–6. https://doi.org/10.1177/104973299129121622

Morse, J. M. (2000). Determining sample size. *Qualitative Health Research*, *10*(1), 3–5. https://doi.org/10.1177/104973200129118183

Myers, U. S., Coulon, S., Knies, K., Dickens, K., Keller, S. M., Birks, A., & Grubaugh, A. L. (2021). Lessons learned in implementing VA video connect for evidence-based psychotherapies for anxiety and depression in the Veterans Healthcare Administration. *Journal of Technology in Behavioral Science*, *6*(2), 320–326. https://doi.org/10.1007/s41347-020-00161-8

National Association of Social Workers. (2017). Code of ethics of the National

Association of Social Workers. Author.

Navarro Moya, P., Villar Hoz, E., & Gonzalez Carrasco, M. (2020). How medical transport service professionals perceive risk/protective factors with regard to occupational burnout syndrome: Differences and similarities between an Anglo-American and Franco-German model. *Work*, *67*(2), 295–312. https://doi.org/10.3233/WOR-203280

Nesbitt, T. S., & Katz-Bell, J. (2018). *History of telehealth*. McGraw-Hill Education.

Nicholas, J., Bell, I. H., Thompson, A., Valentine, L., Simsir, P., Sheppard, H., & Adams, S. (2021). Implementation lessons from the transition to telehealth during COVID-19: A survey of clinicians and young people from youth mental health services. *Psychiatry Research*, *299*, Article 113848. https://doi.org/10.1016/j.psychres.2021.113848

Norwell, L. S., Norris, J. M., White, D. E., & Moules, N. J. (2017). Thematic analysis: Striving to meet the trustworthiness criteria. *International Journal of Qualitative Methods*, *16*, 1–13. https://doi.org/10.1177/1609404917733847

Office of Behavioral Health. (2020). Double jeopardy: COVID-19 and behavioral health disparities for Black and Latino communities in the U.S. Substance Abuse and Mental Health Services Administration.

Ohannessian, R., Duong, T., & Odone, A. (2020). Global telemedicine implementation and integration within health systems to fight the COVID-19 pandemic: A call to action. *Journal of Medical Internet Research Public Health Surveillance*, *6*(2), Article e18810. https://doi.org/10.2196/18810

O'Mahen, P. N., & Petersen, L. A. (2021). To battle COVID-19's twin economic and health crises, Medicaid needs flexible funding structures for stabilization. *Journal of General Internal Medicine*, *36*(4), 1067–1070. https://doi.org/10.1007/s11606-020-06457-y

Onwuegbuzie, A. J., Collins, K. M., & Frels, R. K. (2013). Foreword: Using Bronfenbrenner's ecological systems theory to frame quantitative, qualitative, and mixed research. *International Journal of Multiple Research Approaches*, *7*(1), 2–8. https://doi.org/10.5172/mra.2013.7.1.2

Palfai, T. P., Taylor, J. L., Saitz, R., Kratzer, M. P., Otis, J. D., & Bernstein, J. A. (2019). Development of a tailored, telehealth intervention to address chronic pain and heavy drinking among people with HIV infection: Integrating perspectives of patients in HIV care. *Addiction Science & Clinical Practice*, *14*(1), Article 35. https://doi.org/10.1186/s13722-019-0165-1

Patton, M. Q. (2015). Qualitative research & evaluation methods: Integrating theory and practice (4th ed.). SAGE.

Pierce, B. S., Perrin, D. B., Tyler, C. M., McKee, G. B., & Watson, J. D. (2021). The COVID-19 telepsychology revolution: A national study of pandemic-based changes in U.S. mental health care delivery. *American Psychologist*, *76*(1), 14–25. https://doi.org/10.1037/amp0000722

Pillay, A. L., & Barnes, B. R. (2020). Psychology and COVID-19: Impacts, themes and way forward. *South African Journal of Psychology*, *50*(2), 148–153. https://doi.org/10.1177/0081246320937684

Pinero de Plaza, M. A., Beleigoli, A., Mudd, A., Tieu, M., McMillan, P., Lawless, M., Feo, R., Archibald, M., & Kitson, A. (2021). Not well enough to attend appointments: Telehealth versus health marginalisation. *Studies in Health Technology and Informatics*, *1*, 72–79. https://doi.org/10.3233/SHTI210013

Portz, J. D., Bayliss, E. A., Bull, S., Boxer, R. S., Bekelman, D. B., Gleason, K., & Czaja, S. (2019). Using technology acceptance model to explore user experience, intent to use, and use behavior of older adults with multiple chronic conditions: Descriptive qualitative study. *Journal of Medical Internet Research*, *21*(4), Article e11604. https://doi.org/10.2196/11604

Ravitch, S. M., & Carl, N. M. (2016). Qualitative research: Bridging the conceptual, theoretical, and methodological. SAGE.

Reeves, J. J., Ayers, J. W., & Longhurst, C. A. (2021). Telehealth in the COVID-19 era: A balancing act to avoid harm. *Journal of Medical Internet Research*, *Toronto*, *23*(2), Article e24785. https://doi.org/10.2196/24785

Reilly, S. R., Zane, K. L., McCuddy, W. T., Souillard, Z. A., Scarisbrick, D. M., Miller, L. E., & Mahoney, J. J., III. (2020). Mental health practitioners' immediate practical response during the COVID-19 pandemic: Observational questionnaire study. *Journal of Medical Internet Research Mental Health*, *7*(9), Article e21237. https://doi.org/10.2196/21237

Rogers, J. L., Gilbride, D. D., & Dew, B. J. (2018). Utilizing an ecological framework to enhance counselors' understanding of the U.S. opioid epidemic. *The Professional Counselor*, *8*(3), 226–239. https://doi.org/10.15241/jlr.8.226

Rubin, H. J., & Rubin, I. S. (2012). *Qualitative interviewing: The art of hearing data* (3rd ed.). SAGE.

Saldaña, J. (2016). The coding manual for qualitative researchers (3rd ed.). Sage.

Sasangohar, F., Bradshaw, R., Marianne, M. C., Flack, J. N., Fowler, J. C., Freeland, D., Head, J., Marder, K., Orme, W., Weinstein, B., & Madan, A. (2020). Adapting an outpatient psychiatric clinic to telehealth during the COVID-19 pandemic: A practice perspective. *Journal of Medical Internet Research*, *22*(10), Article e22523. https://doi.org/10.2196/22523

Shah, K., Kamrai, D., Mekala, H., Mann, B., Desai, K., & Patel, R. S. (2020). Focus on mental health during coronavirus (COVID-19) pandemic: Applying learnings from past outbreaks. *Cureus*, *12*(3), Article e7405. https://doi.org/10.7759/cureus.7405

Shigekawa, E., Fix, M., Corbett, G., Roby, D. H., & Coffman, J. (2018). The current state of telehealth evidence: A rapid review. *Health Affairs*, *37*(12), 1A–5A. https://doi.org/10.1377/hlthaff.2018.05132

Shulver, W., Killington, M., & Crotty, M. (2016). "Massive potential" or "safety risk?" Health worker views on telehealth in the care of older people and implications for successful normalization. *BioMed Central Medical Informatics & Decision Making*, *16*, 1–15. https://doi-org/10.1186/s12911-016-0373-5

Sims, J. M. (2018). Communities of practice: Telemedicine and online medical communities. *Technological Forecasting and Social Change*, *126*, 53–63. https://doi.org/10.1016/j.techfore.2016.08.030

Substance Abuse and Mental Health Services Administration. (2020). *Medication assisted treatment*. https://www.samhsa.gov/medication-assisted-treatment

Sugarman, D. E., & Greenfield, S. F. (2021). Alcohol and COVID-19: How do we respond to this growing public health crisis? *Journal of General Internal Medicine*, *36*(1), 214–215. https://doi.org/10.1007/s11606-020-06321-z

Swearer, S. M., & Hymel, S. (2015). Understanding the psychology of bullying: Moving toward a social-ecological diathesis–stress model. *American Psychologist*, *70*(4), 344–353. https://doi.org/10.1037/a0038929

Thomas, N. A., Drewry, A., Racine Passmore, S., Assad, N., & Hoppe, K. K. (2021). Patient perceptions, opinions, and satisfaction of telehealth with remote blood pressure monitoring postpartum. *BioMed Central Pregnancy & Childbirth*, *21*(1), 1–11. https://doi.org/10.1186/s12884-021-03632-9

Uustalu, A., Kerstiën, B., Krepelkova, K., & McDaid, D. (2015). Innovative solutions for preventing and treating mental illness. *Observer*, *21*(3), 19–22. https://apps.who.int/iris/bitstream/handle/10665/332977/Eurohealth-21-3-19-22-eng.pdf

Vogel, G. (2020). New blood tests for antibodies could show true scale of coronavirus pandemic. Science.

White, J., Byles, J., & Walley, T. (2022). The qualitative experience of telehealth access and clinical encounters in Australian healthcare during COVID-19: Implications for policy. *Health Research Policy & Systems*, *20*(1), 1–10. https://doi.org/10.1186/s12961-021-00812-z

Wijesooriya, N. R., Mishra, V., Brand, P. L. P., & Rubin, B. K. (2020). COVID-19 and telehealth, education, and research adaptations. *Paediatric Respiratory Reviews*, *35*(2020), 38–42. https://doi.org.10.1016/j.prrv.2020.06.009

Wilkerson, B., Aguiar, A., Gkini, C., de Oliveira, I. C., Trellevik, L. K. L., & Kopainsky, B. (2020). Reflections on adapting group model building scripts into online workshops. *System Dynamics Review*, *36*(3), 358–372. https://doi.org/10.1002/sdr.1662

Wodarski, J. S. (2020). The multi-factorial complexity of social work practice and implications for interventions. *Journal of Evidence-Based Social Work*, *17*(4), 385–391. https://doi.org/10.1080/26408066.2020.1774457

Wodarski, J. S., & Frimpong, J. (2013). Application of e-therapy programs to the social work practice. *Journal of Human Behavior in the Social Environment*, *23*(1), 29–36. https://doi.org/10.1080/10911359.2013.737290

Wood, S., White, K., Peebles, R., Pickel, J., Alausa, M., Mehringer, J., & Dowshen, N. (2020). Outcomes of rapid adolescent scale-up during the COVID-19 pandemic. *Journal of Adolescent Health, 67*(27), 172–178. https://doi.org/10.1016/jadohealth.2020.05.025

World Health Organization. (2020, March). *Coronavirus disease 2019 (COVID-19): Situation Report – 71*. https://www.who.int/docs/default-source/coronaviruse/situation-reports/20200331-sitrep-71-covid-19.pdf?sfvrsn=4360e92b_8

Zoom Video Communications Inc. (2019). *Zoom meeting and chat*.

https://zoom.us.meetings

Appendix A: Consent for Audio Recording

Title of the Project: Clinicians' Perceptions of Telehealth Services During the COVID-19 Pandemic in Virginia

I consent to the audio recording of this interview.

I understand these are voluntary procedures and that I am free to withdraw at any time by requesting that the taping be stopped. I also understand that my name will not be revealed to anyone and that the recording will be kept confidential. Recordings will be stored securely in the Zoom videoconferencing cloud storage only accessible by the researcher. The destruction of the recording will be completed after transcription and verification. I understand that confidentiality will be respected and that the recording will be for professional use only.

Date:

Appendix B: Demographics Questionnaire

Name: _____

Age: _____

Gender: _____

Race/Ethnicity: _____

What is your role/title? _____

How long have you worked in your current role? _____

What is the average age range of the clients you serve? _____

Appendix C: Recruitment Flyer

Research Participants Needed!

You are invited to participate in a research study. I am a social work student at Walden University, Barbara Solomon School of Social Work

Title: Clinicians' Perceptions of Telehealth Services During the COVID-19 Pandemic in Virginia- Johnetta H. Guishard, Social Work Ph.D. Student/Researcher

This research study is part of the doctoral study for Johnetta Guishard, a Ph.D. student at Walden University. I would like to conduct virtual (Zoom videoconferencing) interviews to understand your experience providing or introducing telehealth services with clients facing challenges with mental health and/or substance abuse during the COVID-19 pandemic. How would you describe your experiences providing technology-based services, and what are some of your ideas about the effectiveness and ease of use of the telehealth models of service in your daily work with clients during the COVID-19 pandemic?

About the study:

- One 30–60-minute online interview
- To protect your privacy, no names will be collected

Volunteers must meet these requirements:

a) Mental health and/or substance abuse clinicians
b) Work with mental health and/or substance abuse clients before and during the COVID-19 pandemic

c) 18 years old or older

d) Comfortable speaking English

e) Work with clients living in Virginia

Appendix D: Interview Protocol

Interview Questions for Clinician's Experiences Implementing Telehealth Services During the COVID-19 Pandemic in Virginia

Interview Code: _____ **Date:** _____

Interview Estimation Time: 30-60 minutes

Introduction:

a. Good morning/afternoon,

First, I want to thank you for your willingness to participate in this interview. My name is Johnetta H. Guishard, and I am a Ph.D. student at Walden University, and I am conducting a study that will allow me to speak with mental health clinicians in Virginia. The purpose it to learn more about your experiences and perceptions of the use and/or rapid implementation of telehealth services for mental health treatment during COVID-19. The information that is gathered here will be kept confidential. However, if during our conversation any information arises about your intent to harm yourself or others, I am mandated to report those concerns. As a participant, I am required to obtain informed consent from you to verify your agreement to participate in the study. If at any time after you have completed the form you become uncomfortable or decide to discontinue the interview, the information we discussed will not be used in the final study report. I have provided a sheet with my contact information. Please feel free to call or email me with any questions or concerns. I would like to use the Zoom videoconferencing platform to

aid in maintaining social distance while recording our interviews. This process assists me in recording accurate information. After I transcribe the interview and email them to you for your review of their accuracy. This will give you an opportunity to make corrections. After adding the corrections and my notes, I will email you another copy of my summary of the interview for your review. Following the completion of the research study, I will share the ScholarWorks link to the completed research study.

Warm-up Questions:

1. Please tell me about your role as a clinician prior to the COVID-19 pandemic?

Research Question 1. How do mental health professionals describe their experiences of providing services to clients during the COVID-19 crisis?

2. Please tell me your initial thoughts about the rapid implementation of telemental health services?
3. Describe your experiences with training and technical support during the implementation of telehealth service.

Research Question 2. How do they describe their experience and perceptions of use of telehealth in working with clients?

4. Please share some of your ideas about the benefits and challenges of telemental health. For example, discuss a time when you faced some difficulty or observed some difficulty with clients' access to telehealth services.

5. What were some of the concerns or challenges you faced with the introduction and delivery of technology-based models?

Research Question 3. What do they perceive about the efficacy and effects of telehealth services to clients and their access to services during COVID-19 crisis?

6. What are some of the changes you observed with your clients after the transition to telehealth?

Closing:

7. Is there anything else that I have not asked you about that you would like to add?
8. I greatly appreciate your thoughts and shared experiences. Thank you.