COVID-19 and the Rapid Expansion of Telehealth in Social and Behavioral Health Services

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Abstract*: The spread of COVID-19 changed the landscape of how social service agencies operate. Essential services providers have had to adapt and innovate in order to carry out their mission. As a result, technology has become an integral part of their service model, with an increased emphasis on telehealth services. For many agencies, the abrupt transition to remote services has brought about important conversations around access, use, policy, effectiveness, and efficiency. A qualitative, narrative study was conducted with CEOs or social work directors of 37 social service agencies in the Mid-South region to understand their experience and the impact of the COVID-19 pandemic. Interviews were conducted and data were transcribed and analyzed. Thematic analysis highlighted seven themes: 1) a rapid transition to virtual services, 2) the need to improve infrastructure, 3) new technology and innovation, 4) barriers, 5) benefits, 6) funding, and 7) changes that will be kept. Implications at the client level include continuing to offer telehealth services. At the agency level, implications include managing the logistics of telehealth and the need for insurance and regulator changes. Implications for social work include ethical considerations for providing telehealth services and educating current and future social workers in the use of telehealth services.*

Keywords: *COVID-19; telehealth; technology; behavioral health services; social services*

In January of 2020, a novel coronavirus, COVID-19, was being reported by the media, and by March of 2020, it had developed into a global pandemic. This phenomenon of a global pandemic and its impact is unprecedented in our time (Nkengasong, 2021). Currently, tens of millions of people have been infected worldwide with over six million deaths, while in the United States (U.S.) alone over 80 million cases have resulted in over 900,000 deaths (Johns Hopkins University, 2022). During the height of the pandemic, state and local governments in the U.S. enacted measures aimed at limiting the spread of the virus. These measures included mandates for business and school closures, mask requirements, social distancing guidelines, and travel restrictions (NASHP, 2022). Amid this vast uncertainty, social service agencies remained open, finding innovative ways to offer services. One of the most important ways they adapted and demonstrated resilience is through the use of technology. While the use of technology had been increasing in social

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service agencies prior to the pandemic, the lockdown forced by COVID-19 accelerated this trend and forced many hesitant social workers and social service agencies to use technology to conduct services and continue to serve clients (Turner Lee et al., 2020).

Social work and social service agencies' shift to the use of technology can be viewed as a demonstration of resilience. Although definitions of resilience may vary slightly, for the purposes of this study, Ledesma's (2014) definition as "the ability to bounce back from adversity, frustration, and misfortune" (p. 1) can be used as an overarching definition. As van Breda (2018), points out, the process of adapting to adversity can lead to results that are even better than expected.

Literature Review

Slowly Embracing ICT

The utilization of information and communication technologies (ICTs) is routine in most healthcare professions; however, it has only recently gained traction within the social work field (Baker et al., 2014; Campbell, 2018; Mishna et al., 2017). According to Baker and colleagues (2014), social work has been slow to embrace technology. The literature suggests this stems from a reluctance to accept it as part of the client's environment and, perhaps, a fear of losing the human-focus in a digital sphere as well as ethical concerns (Baker et al., 2014; Tuckson et al., 2017; Wolf & Goldkind, 2016). However, there is tremendous potential for positive client impact in marrying its ability to reduce barriers of accessibility with the profession's core values (Baker et al., 2014; Goldkind & Wolf, 2015).

With social distancing and safety protocols preventing face-to-face services, technology can play a large role to fill these gaps (Gelman & Tosone, 2010; Turner Lee et al., 2020; Wolf & Goldkind, 2016). ICTs can facilitate the sharing of knowledge and resources between care providers and with the community. The enhanced ability to communicate, regardless of physical space, creates connection and collective power (Turner Lee et al., 2020; Wolf & Goldkind, 2016). While there has been acknowledgement of the potential to harness ICTs for larger community and advocacy work within the social work field, there is currently limited research on using technology beyond the classroom setting (Gelman & Tosone, 2010; Wolf & Goldkind, 2016).

Telehealth

According to the American Telehealth Association (ATA; 2021), telehealth consists of the provision of healthcare (including behavioral health) through virtual or electronic means when provider and patient are in different locations. Through telehealth, patients and providers exchange information, and healthcare workers provide advice, treatment, and guidance to prevent or cure diseases or solve other problems (Tuckson et al., 2017; Turner Lee et al., 2020). Telehealth and remote services have become increasingly popular due to their flexibility and efficiency for both the client and clinician (ATA, 2021; Tuckson et al., 2017). A significant surge in usage of telehealth in response to COVID-19 has been reported in the literature (Clipper, 2020; Kaplan, 2020). Telehealth promotes social,

emotional, and physical well-being for children and adults by decreasing isolation and reducing barriers in access to health services (Clipper, 2020; Goldschmidt, 2020). In addition, it serves as a collaborative tool for clinicians with limited resources and opportunities for continuing education or collegiality due to their physical location (Brownlee et al., 2010).

Telehealth has not always been a viable option for clients, with varied restrictions on its availability based on state licensing laws and insurance coverage (Goldschmidt, 2020). As a result of the pandemic, however, the Centers for Medicare & Medicaid Services (CMS, 2020) were permitted to temporarily reimburse healthcare providers for telehealth services provided from different remote locations, eliminating the need for clinicians or clients to travel into an office setting and removing stipulations surrounding rurality (U.S. Department of Health and Human Services [US HHS], n.d.). Healthcare providers are lobbying for continued and permanent expansion of telehealth services to help remove accessibility obstacles beyond the pandemic (Goldschmidt, 2020), but as of April 25, 2022, this had not happened (US HHS, n.d.).

Though the use of telehealth and telemedicine were increasing prior to COVID-19 (Tuckson et al., 2017) they were not widely mainstreamed (Smith et al., 2020; Turner Lee et al., 2020). As telework becomes more common for social service agencies, there may be a permanent increase in the use of technology to deliver services (Dey et al., 2020). While temporary orders resulting from the COVID-19 health emergency (Lee, Tenn. Exec. Order No.36, 2020) have allowed for the provision of telehealth services in ways that had not been authorized previously, for telehealth to become more widespread, it will be necessary to develop networks, policies, procedures, and infrastructure to support it, which includes extensive telehealth training for clinicians and social workers as well as access to the equipment needed (Barney et al., 2020; Coe & Enomoto, 2020).

Regardless of whether medicine or behavioral health providers utilize telehealth modalities, the same ethical considerations apply regarding patient data, informed consent, respect, and standard of care (Tuckson et al., 2017). However, providers have the additional ethical obligation of informing patients of the uses and limits of the technology (Tuckson et al., 2017). Social work, as a profession, has the same ethical standards (NASW, 2017), although the way those standards are administered may be different when using telehealth (Reamer, 2013).

Adopting Telehealth in Response to COVID-19

Shifting to a more technology-based service model spurs questions about the necessary policies, protocols, and ethics brought on by a new medium. Agencies that had to make a quick shift in response to COVID-19 did not have had time to fully develop comprehensive implementation plans. Larger questions surrounding the legal and ethical implications of telehealth in terms of protocol and privacy existed before the pandemic (Clipper, 2020; Kaplan, 2020; McCarty & Clancy, 2002). Despite known benefits, technology presents access concerns. Economic and geographical disparities in internet stability and broadband access as well as ownership of computerized devices may exclude some populations from the benefits of telehealth (Funk, 2021). Additionally, there are concerns about the ability

to form a therapeutic relationship for providers and clients who have never been able to meet face-to-face (McCarty & Clancy, 2002). Clients may find shifting to digital services to be daunting or too impersonal based on their comfort level and cultural attitudes toward technology (Cimperman et al., 2016; Clipper, 2020). Although now newly and widely accepted by social service agencies, the long-term implications for practice are undetermined.

The COVID-19 pandemic forced questions for the field of social work about the use of technology in social and behavioral health services to the forefront. As a result of stay-at-home orders, which resulted in social distancing, agency leadership were forced to consider non-traditional service delivery formats that enhanced safety. Technology played a pivotal role in responding to the crisis while maintaining social distance. This qualitative study examined the impact of COVID-19 on social service agencies and how it has highlighted resilience through innovation and the expanded use of technology to continue providing services to their clients.

Method

In April 2020, a local board of community social work leaders of non-profit agencies suggested to one member of the research team that a study be created related to the impacts of the COVID-19 pandemic. This request led to a narrative study (Creswell, 2013; Patton, 2002) that was designed to better understand the impact of the COVID-19 pandemic on behavioral health and social services agencies in a specific region in the Southeastern United States. Resilience theory was used to frame this study. Resilience theory broadly looks at risk and protective factors (Bolton et al., 2017) as part of a mediating process in the face of adversity leading to better than expected outcomes (van Breda, 2018). To better understand the impact of the COVID-19 pandemic and the resilience of agencies, a semi-structured interview guide was developed. Social work community leaders were involved in designing the interview guide, and some of the board members that originally called for the study also served as research participants.

A research team was formed, comprised of four faculty members and two master's level graduate students. The interview guide included 21 open- and closed-ended questions (e.g., "How have your services changed since the beginning of the COVID-19 crisis? In what ways has the crisis led you to be innovative in your work?" see Table 1). The questions were developed with input from social service and social work agency directors. Institutional review board approval was obtained prior to beginning the interview process.

Table 1. *Semi-Structured Interview Guide*

1) How have your services changed since the beginning of the COVID-19 crisis?
2) What changes have you seen in your clients since the beginning of the crisis? Are you seeing more people or fewer people requesting your services?
3) Are you seeing a change in the types of services that your clients are requesting? What changes are you seeing in the needs of your clients?
4) Have you found a need to change your service model? What challenges has your agency had around that change?
5) What have been the biggest barriers to continuing to provide services to your clients?
6) If you have moved to using more technology in your work, have your clients had any difficulty with access to technology?
7) Are there any services being requested by your clients that you cannot provide? Do you think that your clients have unmet needs? If so, what are they? Were these needs unmet before the COVID-19 pandemic? If they have changed, how so?
8) Have you seen any beneficial changes to your service model since the beginning of the COVID-19 crisis?
9) How has the COVID-19 crisis impacted your personnel policies around work from home or sick leave? Has COVID-19 caused any unforeseen personnel problems?
10) Has the COVID-19 crisis caused any child care challenges for your employees?
11) In what ways has the crisis led you to be innovative in your work?
12) Has this crisis changed the type of data you collect at your agency or the way that you collect data on clients?
13) How do you plan to go about re-opening your agency (if you have closed)?
14) What changes or innovations are you likely keep on an ongoing basis once this crisis is over?
15) Is there anything else we have not asked that you would like to add?

As a research team, discussions were held to determine which agencies and organizations would be targeted to provide information about the impact of the COVID-19 pandemic on the work that they do at the agency, client, and community levels and to look for evidence of the resilience process. A list of 70 organizations was selected for purposive sampling (Miles et al., 2014; Patton, 2002) to provide representation of agency type, size, geographic location, services provided, and specific populations served. Some snowball sampling was used to gain greater participation in rural areas with agencies in those areas being asked to identify other neighboring agencies. In early June, email requests were sent to the CEO, director, chief of social work, or a person in a related position at the agency and electronic informed consent was signed prior to scheduling an interview. Agency demographic information is published in a prior study (Neely-Barnes, et al., 2021). A total of 37 agencies of diverse sizes, service foci, and goals agreed to participate in this study. Although there are differing thoughts on the ideal number of participants for narrative studies, Creswell (2013) suggests more if developing a collective narrative. The authors used data from all 37 agencies in order to include adequate representation across agency size, type, and location. The agency numbers, a description of their services, and the role of respondents are presented in Table 2.

Table 2. List of Agencies and Description of Services Provided

Agency #	Focus of Services	Role
1	Faith-based poverty reduction	
2	Adult substance abuse & co-occurring treatment	President & CEO
3	Site-based mental & behavioral healthcare	
4	Community mental health service	Director
5	Faith-based aid to those in poverty	
6	Sexual & reproductive healthcare	Founder
7	Clinical services to uninsured	
8	Integrated health care system & community mental health	Director
9	Holistic services to crime victims	
10	Wraparound services for persons living with HIV	Exec Director
11	Services & advocacy for persons experiencing homelessness	
12	Integrated healthcare	Director
13	Supports families affected by incarceration	
14	Legal assistance for persons with low income	Director
15	Support for formerly incarcerated	
16	Support services for persons with intellectual disabilities	CEO
17	Legal assistance for persons with low income	
18	All ages health & social services	Manager
19	Behavioral health assessment or referral	
20	Housing support for persons living with HIV	Director
21	School focused on academic, social, & emotional wellness	
22	Outpatient mental health & substance abuse	Exec Director
23	Behavioral health & substance abuse	
24	Reducing food insecurity	CEO
25	Residential trauma & substance abuse support for women & children in poverty	
26	Poverty reduction through community action	Founder
27	Support services for persons with intellectual and developmental disabilities	
28	Treating & researching catastrophic illness in children	Exec Director
29	Government agency providing legal assistance	
30	Outpatient mental health	Dir. & Founder
31	Wraparound services for survivors of trafficking & prostitution	
32	Partial hospitalization & intensive outpatient	CEO
33	Nonprofit agencies funding, coordination, & connection	
34	Adult inpatient psychiatric services	CEO
35	Domestic & sexual violence care advocacy	
36	Services to child victims of sexual or severe physical abuse	CEO
37	Coalition for agencies reducing homelessness	

For more detailed information about the agencies see Neely-Barnes, et al. (2021)

Interview data were analyzed following Creswell's (2013) five steps to qualitative analysis. In step one, organizing the data, themes were discussed in meetings and an initial coding structure was developed. All interview transcripts were uploaded into NVivo qualitative data software and the coding structure was added to the software. Step two, reading and memoing, took place as all six research team members were divided into pairs. Each pair was assigned two agencies for the first round of coding. After initial coding was

completed, the research team again met to discuss themes and the coding structure. Step three, describing and classifying into themes, included adjusting the coding structure to better reflect the data and ensure all members of the research team were using the codes in the same manner. All remaining interviews were coded by researcher pairs. The pairings were rotated to strengthen consistency in coding and use of the coding structure. Step four, interpreting the data, continued when coding was completed. Content analysis of the individual codes was done to better understand the data. In Step five, representing the data, identifying quotes were selected to highlight specific themes.

Findings

Results of the qualitative analysis indicate that technology played a significant role in the resilient response to the COVID-19 pandemic shutdown. Every agency that participated in this study turned to technological solutions to minimize face-to-face interaction and create solutions for responding to the crisis. Some agencies used relatively simple solutions like making better use of the phone and putting forms on the website. Other agencies used new and innovative technology described below.

One potential risk factor (Bolton et al., 2017) that all agencies shared is the provision of essential services. Since all agencies in the study provided essential services, they had the choice to stay open during local safe-at-home orders. Yet, many agencies chose to transition to virtual services to protect their staff and clients. The degree to which an agency decided to transition to virtual had to do with the types of services that were provided and whether virtual service provision was possible. Most agencies used strategies that included moving individual therapy to telehealth though video conferencing or telephone and reducing the number of face-to-face appointments for new client intake. Some agencies provided services that cannot be virtual. Agency 7 and Agency 23 administer injections which could not be done virtually. Agency 29 provides services in the jail setting, and the jail did not allow virtual appointments. Many agencies in the study (e.g., Agencies 16 & 34) have a residential component of their service model that could not be transitioned. Yet, even agencies with a residential component saw an increased use of technology such as video conferencing and video calls.

The decision to go virtual had many implications – both positive and negative. Seven themes and associated subthemes emerged from analysis of the data which highlight components of the resilience process leading to outcomes that were better than expected (van Breda, 2018). These themes and subthemes are: 1) the rapid transition to virtual services; 2) the need to improve infrastructure, including both training staff and the need for new hardware or software; 3) new technology and innovation; 4) barriers including barriers for staff and clients and the specific challenges around certain practice modalities; 5) benefits for both clients and staff; 6) funding and funders; and 7) changes that the agency will keep. See Table 3.

Table 3. *Themes and Subthemes*

- Rapid Transition to Virtual Services
- Improving Infrastructure
  - Training staff
  - Buying new software or hardware
- New Technology & Innovation
- Barriers
  - Barriers for agency staff
  - Barriers for clients and the digital divide
  - Challenges specific to practice modalities
- Benefits
  - Benefits to clients
  - Benefits to staff
- Funding and Funders
- Changes That Will Be Kept

Rapid Transition to Virtual Services

In the region in which this study took place, safe-at-home orders were issued with little advance notice in mid-March 2020. Agencies had to make a quick decision about how they were going to respond. Many agencies decided to move their staff to telecommuting and move all services to virtual (e.g., Agencies 17, 31, and 37). Some agencies decided to move services to virtual but chose to keep staff in the office while maintaining social distance. One of the themes that agencies discussed was how rapid the change to virtual services occurred. For example, Agency 32 is primarily a provider of intensive outpatient (IOP). They made their decision to move the IOP to virtual very quickly. They explain:

> Agency 32: *Less than five days. We transitioned very quickly. We were talking about it…within the fifth day we were transitioned.*

Some agencies already had a telehealth component to their services. Yet even these agencies who were already engaged in telehealth experienced a transition as their services rapidly shifted from majority in person to majority telehealth. Agency 12 explains how they experienced this shift early in the pandemic in March/April and that they had already started to see some shift back to in-person by the time of the interview in June.

> Agency 12: *We probably changed from being 85 to 90 percent in-person medicine to 85 to 90 percent telemedicine…I would say at this point, it's probably about 75 percent telemedicine and 25 percent in person.*

Improving Infrastructure

The rapid shift from traditional in-person services to virtual/telehealth services meant that agencies had to consider infrastructure for the delivery of services virtually, both the protective and risk factors (Bolton et al., 2017). Understanding what the challenges of risk factors were could lead to finding ways to make adjustments. This might mean investing

in new technology (hardware or software) or training staff to be prepared to deliver services virtually. Another consideration was agency filing and records systems needed to be electronic. If staff were going to telecommute, they needed to be able to access agency files from home. Many agencies already had electronic records, but for those that did not, the pandemic provided a reason to move forward with an update to their record-keeping process and to examine how they might improve their electronic systems. Agency 15 explains:

> Agency 15: *We're going paperless…they're scanning everything and making sure everything's in the database. And that's something we weren't doing at all.*

Training staff

Another important consideration for agency heads was whether their staff were prepared to deliver services virtually. For some staff, the pandemic represented their first-time using video conferencing, their first time using a new electronic record system, or their first time working in the telehealth environment. Understanding these challenges allowed agencies to bolster their staff and support them through additional training. One agency, Agency 30, responded to the sudden shift by looking for opportunities for training:

> Agency 30: *We had one person that already was certified in telehealth when this started…So, we set up some trainings from our person who was certified in telehealth to share that with the other clinicians.*

Buying new software or hardware

The transition to all virtual services led to a realization for some agency heads that their systems or equipment were not adequate. Agency heads discussed the need to buy both hardware (e.g., laptops for all staff so they could work from home) and software (e.g., new systems for telehealth delivery that are HIPAA compliant). The head of Agency 17 discussed the decision to invest in a new phone system that staff could use from home.

> Agency 17*: One of the things that we did is we are getting a new phone system. We needed it anyway. But under our old system, they were all hard wired. And so, if you were going to call someone from your home, you'd have to use your home phone or your cell phone and block the number. And because so many of our clients are in debt, and they're being called by bill collectors, they won't answer the phone if it's an unidentified number.*

Agencies also had to consider whether clients had adequate technology to interact with them in a virtual environment. Since most reported that their clients had smartphones, the preference was for systems that would interface well with smartphones. Agencies were aware that many clients experienced a digital divide. Without access to technology, it is difficult to apply for jobs, apply for government benefits, or support your children's education (schools in the region went virtual for the last nine weeks of the school year). The director of Agency 1 talked about his focus of buying new devices to support clients.

> Agency 1: *We are launching, currently launching a telehealth telecom system where all 1,000 of the families that we serve will have a computer device placed into their home with connectivity.*

New Technology and Innovation

The pandemic provided an opportunity to think about new technology and ways to innovate service delivery. Several agency heads talked about the ways in which the pandemic created an opportunity to step back, look at how they always did things, and consider whether they could do things better. The pandemic also provided an opportunity to build partnerships and work across systems to lean into the crisis and support clients, families, and communities. Innovation took many different forms. Some of the innovations were directly related to making use of new forms of technology. Agency 35, which serves survivors of domestic and sexual violence, discussed using texts and even private messaging through social media sites to help their clients reach out when in a dangerous situation. Two agencies discussed app development to improve their service provision. Agency 13 explains:

> Agency 13*: I did develop a 12 to 18-month clinical program utilizing an app to deliver services. So, at first the courses that were a part of this process were going to be face-to-face in one of the homes that we owned. Now, there is an opportunity to still reach our potential clients in their own homes, in their space.*

Barriers

The pandemic and the sudden shift to virtual services presented a fair number of barriers and challenges for agencies. Agencies discussed these barriers primarily under three categories: barriers for agency staff, barriers for clients, and barriers specific to certain practice modalities.

Barriers for agency staff

Agency heads frequently described the ways in which their staff encountered barriers to continuing their work during the pandemic. For agencies that chose to telecommute, agency heads reported that their staff missed the office culture or missed the physical separation between home and work. One agency head had to amend policy to allow staff to telecommute. They previously had a policy that did not allow it.

Another agency head reported that working from home disrupted her sleep schedule because she did not have the mental separation between home and the office that the physical separation normally created. Some agencies did not have the funding to buy everyone a laptop and staff were forced to use their own devices. Working from home also means using personal Wi-Fi, and some staff struggled with the additional data costs they were incurring. Agency 26 explained some of the challenges.

> Agency 26: *I did have the staff who were struggling with, you know, they had bad connections. So sometimes they had a hard time staying connected to what we used as VPN access to continue the work.*

Barriers for clients and the digital divide

Clients also struggled with having adequate technology to access virtual services. Many agencies reported that their clients do not have access to laptops and a few reported that most of their clients have flip phones rather than smartphones. Access to the internet was an issue for some clients, particularly in rural areas. Several agency heads identified this problem as being part of the "digital divide" that gives people with access to technology opportunities and denies those who do not. Agencies 16 and 27 explained the challenges for some of their clients:

> Agency 16: *But then [list of counties] are a little more rural, so you actually do have some spots where you don't have access to the best internet or system.*
>
> Agency 27: *But a lot of the people that we support and their families, they don't have the technology. They don't have computers in the home. They don't have internet in the home. We've actually been looking for grants to help provide that.*

Challenges specific to practice modalities

The sudden shift to technology presented more barriers to agencies using certain types of practice modalities versus others. Agencies that use a lot of group treatment approaches talked about specific struggles with moving groups online. For example, Agency 4 reported challenges with maintaining confidentiality; they had an incident with a client walking around a store with her group session on speaker. Similarly, Agency 12 reported that they had had some clients fall asleep during a telehealth group session. Agency 13 typically used food as a draw for their in-person group sessions and to meet a need for their client population who is food insecure. It was not possible to provide food in the virtual setting.

Agencies that provide services in an inpatient or residential setting faced their own set of challenges around family visitation and community participation. Agency 16 was forced to cancel all community participation for a few months, and Agency 34 moved to virtual family visitation. Again, innovation and creativity were important for managing these barriers.

Agencies 3 and 36 primarily serve children and reported that it was difficult to maintain the attention of children in a telehealth setting. Both agency heads mentioned that in a face-to-face setting, they would use activities to keep children focused during therapy. That was more difficult in the online setting.

Benefits

Although there were challenges and barriers related to the sudden shift to the virtual environment, many agencies also saw benefits for both the clients and their employees. One of the most interesting benefits related to transportation. Moving to virtual services eliminated the need for transportation and this was to the benefit of both clients and employees.

Benefits to clients

Many agencies reported that transportation was normally one of the biggest barriers faced by their clients. A few of the agencies (e.g., Agencies 7 and 17) are in areas that require paid parking which creates a cost barrier. This study was conducted in a region of the United States that does not have good access to public transportation. In the rural areas, public transportation is nonexistent. Clients in rural areas may have to travel great distances to get to the office for services and this costs gas money. Agency 3 explains:

> Agency 3: *A lot of my rural families keep saying, can we keep this like after this whole thing is over? Are you gonna allow me to still do this? So, they see I mean, it greatly has improved their contact, like they're going to come more consistently. They show up when they're supposed to because you've taken away that barrier to transportation.*

Virtual services kept agencies connected to clients during the pandemic. Although many agencies reported that clients missed face-to-face services, virtual services offered a much better alternative than no services. The director of Agency 10 told the story of a particular client for whom virtual services provided a lifeline during a critical time.

> Agency 10: *We were able to convince the client to get a phone. And that has helped tremendously to decrease isolation because the client can still get all the counselling sessions by phone.*

Benefits to staff

Some agencies worked hard to maintain the office culture during the pandemic. Agency 1's staff had a virtual dance party every week and virtual movie nights to maintain the connection between staff. Several of the agencies reported that their staff were preferring the new telecommuting model and saw benefits. One benefit reported was increased efficiency in the virtual setting. Agency 18 explains:

> Agency 18*: It's interesting to talk to folks and they're so much more productive, like, yeah, you know, I just roll out of bed, make a cup of coffee. I'm starting work an hour earlier. And, you know, sometimes I found myself staying on and I'm getting more done and I'm not spending the money on lunch and then you know, I'm saving that hour, hour and a half, two hours, whatever it is to commute.*

Funding and Funders

Funding mechanisms and funders played a significant role in decisions about whether to shift services to the virtual environment. Some agencies had donors who recognized the need to shift to virtual services and stepped up their support in that area. Some local corporations and local foundations allocated money towards technology grants to help the non-profit sector respond to the crisis. For agencies that offered billable health, mental health, and substance abuse services, the most critical issue was whether health insurance would pay for virtual services. Several of the agencies we interviewed were primarily

Medicare or Medicaid providers. Agency 4 explained how the decisions at the Centers for Medicare & Medicaid Services (CMS) were critical to their decision about whether to start and continue telehealth services.

> Agency 4: *You know, fingers crossed that CMS is going to [continue to] pay for telehealth to a client's home. And one thing that's already happened…is that Medicare will pay for those psychiatric check-in phone calls for Medicare only clients. I mean, thank goodness that we've got some really smart people at CMS that understand that we don't need elderly people leaving their home if they don't have to, or people whose immune system is compromised.*

Changes That Will Be Kept

Nearly every agency that participated in this study said that at least some part of their shift to virtual services will remain after the COVID-19 crisis is over. The outcomes from these agencies were better than they may have originally expected and therefore were going to be maintained. The rapid shift for agencies to use telehealth services in response to the COVID-19 pandemic brought about change that may otherwise not have come, or perhaps not on this timeline. These changes have been shown to be effective and worth keeping, even beyond the immediate need of the pandemic. Certainly, agencies who upgraded technology systems, moved intake applications to virtual, or moved records to virtual planned to keep that after the pandemic. Some agencies planned to allow more telecommuting after the pandemic. Agency 22 summed up the shift:

> Agency 22: *While we don't want 100 percent of our services all the time to be remote, we think that we can do those as needed. Maybe, there will be a hybrid of that. Moving forward with some of the things that will be permissible to do remotely.*

Discussion

The COVID-19 pandemic is a global phenomenon that could be viewed as a risk factor that threatened to negatively impact the resilience (Bolton et al., 2017) of agencies and their ability to provide services to clients. Agencies demonstrated resilience (Ledesma, 2014) by adapting and continuing with services during the pandemic. In order to continue to provide services, agencies found that they needed to transition quickly to the use of virtual services. Prior to the COVID-19 pandemic, the use of telehealth was infrequently or slow to be utilized in the field (e.g., Baker et al., 2014; Campbell, 2018). This was also seen to be the case for agencies in the study, most of whom were not regularly using telehealth to provide services. This rapid transition also highlighted potential risk factors (van Breda, 2018) to the implementation and service delivery which necessitated the need to improve infrastructure for agencies. Because using technology was not the standard of practice prior to COVID, the shift required ensuring staff were trained and able to provide services with this modality (Barney et al., 2020; Coe & Enomoto, 2020). Training staff on the use of new technology allowed agencies to collaborate and continue to work across physical distance, similar to previous research (Brownlee et al., 2010). It also required

agencies to invest in hardware and software that was capable of supporting telehealth services in a manner that continued to meet ethical standards (e.g., Kaplan, 2020; Tuckson et al., 2017).

Not only did the transition to virtual services shift how agencies provided standard services, it also allowed agencies to re-evaluate standard practices such as meetings and record-keeping. Looking more broadly across their agency, many were able to enhance their practices with clients. Additional risk factors (Bolton et al., 2017) such as barriers for staff and those for clients arose with the transition. These barriers were similar to those seen previously in the literature. For example, some clients of the agencies in the study did not have equipment or technology services that were sufficient for telehealth services, similar to previous research (e.g., McCarty & Clancy, 2002). Agencies also reported clients did not feel comfortable using technology, which has been seen previously (e.g., Clipper, 2020).

Despite the barriers, agencies were determined to persist and find ways to deliver services. Many agencies found benefits to the clients and agency staff, surprising benefits from funders who were more willing to donate financial resources, and agencies overall found new procedures that have improved their organization that will be continued (van Breda, 2018). Similar to previous research, the use of technology among agencies in this study was previously not widely used; however, it rapidly increased and will persist (e.g., Turner Lee et al., 2020).

The COVID-19 pandemic has created a shift towards virtual service provision in social and behavioral health services (Dey et al., 2020). This change will likely remain after the pandemic is long over (van Breda, 2018). Agencies that were forced to adapt in the short-term have seen long-term advantages to the shift. Virtual service provision in social work may not be the only type of service provision in the future, but it is here to stay (Wolf & Goldkind, 2016).

Implications for Social Work

Implications for social work with the shift to telehealth can be seen at the client, agency, and professional levels. For clients of some agencies, the shift to telehealth has had a great impact on access to services, including making services more accessible for many by reducing barriers such as transportation (e.g., Baker et al., 2014; Clipper, 2020; Wolf & Goldkind, 2016). For other agencies in the study, the lack of reliable internet or equipment to participate in telehealth services has made accessing needed services more challenging and increased those barriers. Social workers and the social service agencies that employ them should continue to offer telehealth services, especially in rural and hard-to-reach communities, while also continuing to advocate for resources and provisions for clients with limited technology accessibility (Funk, 2021).

For agencies, the shift to telehealth has highlighted the need for training of staff and acquiring equipment to provide these services. Navigating these changes requires coordinating logistical aspects to ensure services can be provided effectively (e.g., Smith et al., 2020). In addition, agencies have historically faced barriers to providing telehealth

services including insurance regulations, laws, and reimbursement rates (Goldschmidt, 2020). Advocating at both the state and federal levels for changes to policies, specifically those related to reimbursement for services, will be essential for social workers to be able to maintain the provision of telehealth services beyond the COVID-19 pandemic. Including other mental health providers, legislators, agency representatives, and clients in advocacy work with social workers will strengthen the impact of their collective voices.

Opportunities to partner and advocate for telehealth provisions are increasing. As social workers, our guiding principles of social justice and competency (NASW, 2017) can guide our advocacy efforts. Joining with others who are seeking to fight for expansion of telehealth reimbursement will strengthen these efforts. Many efforts have been made to bring about a 2021 Health Act specifically focused on technology, expanding lists of services covered by Medicare, expanding telehealth services that are reimbursed, and the introduction of laws to allow counselors to be reimbursed by Medicare to expand and make permanent more lenient telehealth practices, including addressing geographic restrictions (Maheu, 2021a) Progress is being made and in the fall of 2021, changes were made to federal policies for Medicare and Medicaid programs that included reimbursement codes for telehealth services (Maheu, 2021b) --evidence of progress toward the continuation of telehealth services.

As a profession, social work has an ethical foundation (NASW, 2017) and focus on evidence-based practices (EBP; see Gambrill, 2018). The slow incorporation of telehealth services among social workers (e.g., Baker et al., 2014; Campbell, 2018) highlights gaps that need to be filled moving forward. A growing body of literature indicates that there is a strong evidence base for telehealth and the need for additional research focused on the effectiveness of providing services via telehealth (Gros et al., 2013) compared to face-to-face services. Furthering our understanding of EBP using telehealth, including areas related to confidentiality, engagement, and effectiveness, will allow social workers and the profession to continue to disseminate evidence that will allow for continued practice that is ethical and aligned with best practices. For example, the client may need training on using the technology, communication styles may need to be adapted for the telehealth environment, and some assessment tools developed for the traditional practice setting may not be appropriate for telehealth (Gros et al., 2013).

Social work education, including continuing education, needs to adapt to preparing all practitioners to be ready to practice in the virtual environment. For example, incorporating telehealth-related curriculum, experiences, and ethical considerations into social work courses will better prepare current students and continuing practitioners to incorporate these modalities in their work. Research on social work practice needs a greater focus on identifying EBPs in the virtual environment. Grant funders in social work need to adapt to this new environment by supporting research in best practices and training for the next generation of social workers who are prepared to work in both face-to-face and virtual settings.

This study has several limitations that should be noted. First, the study occurred only in one region of the country. The results may not be generalizable to other regions. Second, data was collected during only the two-month span of June and July, 2020. The impacts of

the pandemic shifted rather rapidly and continue to shift today. The results of the study may not be generalizable to what was happening a few months before or a few months after. Third, because the sample was varied to include a range of agency types, sizes, and locations, the results of the study should be considered with this in mind.

Despite the above limitations, this study has some important contributions. The researchers intentionally selected providers that represented a wide array of service settings including mental health, substance abuse, family violence, child welfare, developmental disability, school-based services, gerontology, legal aid, criminal justice, homelessness, and health care. The agencies that participated were also a mix of large and small settings as well as inner city, suburban, and rural settings. The wide array of agencies that participated in this study improves the generalizability and credibility of the findings (Patton, 2002). The use of telehealth in social work and social service agencies is a relatively new phenomenon (Gros et al., 2013). The closures resulting from the COVID-19 pandemic accelerated this trend in social work. Important future research areas involve the quality of outcomes in telehealth and teletherapy vis-à-vis face-to-face services.

In conclusion, COVID-19 caught everyone off-guard leaving many agencies and social workers facing an urgent need to rapidly adjust their service delivery in order to continue to provide services to clients. The quick shift to telehealth and technology highlights the resilience and adaptability of social work as a profession as well as areas for further work to be done. At the client level, access issues have been highlighted, including increased access for some and greater barriers for others. Agencies must work to build telehealth practice through additional training and equipment as well as developing telehealth-related policies. The social work profession as a whole can build on the rapid gains of telehealth by infusing ethical considerations and EBP in the social work curriculum in order to train the social workers of the future for the world they will likely inhabit. Overall, social work should remember the advantages of collective power (Wolf & Goldkind, 2016) and use this collective power to continue conversations and action around access, use, policy, effectiveness, and efficiency of virtual services.

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