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Lessons Learned from COVID-19: Provider Suggestions for Improving Service Delivery in Sexual Violence Resource Centers and Children's Advocacy Centers in Kentucky

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Abstract. The COVID-19 pandemic has presented unique challenges for human service providers, especially as face-to-face services were limited by both formal and informal efforts to protect public health. Telehealth has emerged as a main strategy to ensure continuity of care. This study explored adaptations to services in child advocacy centers (CACs) and sexual violence resource centers (SVRCs) across the Commonwealth of Kentucky, particularly using telehealth. This study highlights respondents' suggestions about improving these service delivery systems and the particular emphasis on challenges and strengths of telehealth for reaching those in rural areas.

Keywords: telehealth, COVID-19, rural, trauma treatment

Trauma is defined as an event, series of events, or set of circumstances that an individual experiences as physically or emotionally harmful or life threatening and having lasting negative effects on the person's functioning in some way. Trauma is increasingly understood as a social problem with pervasive reach, impacting not only the individual but the overall wellbeing of families and communities. Research implicates unresolved trauma in negative health outcomes for individuals as well as maladaptive social behaviors leading to involvement with the juvenile justice system, the criminal justice system, and the child welfare system. Trauma is also recognized to present challenges in school settings and may interfere with student success (Substance Abuse and Mental Health Services Administration, 2014).

Sexual violence is one specific type of trauma defined as forcing or manipulating someone else into unwanted sexual activity without consent. Reasons for lack of consent may include fear, age, illness, disability, or inability to consent due to the influence of alcohol or other drugs (National Sexual Violence Resource Center, 2010). Available data regarding sexual violence indicate the rate of sexual assault almost doubled from 2017-2018, increasing from 1.4 victimizations per 1,000 people aged 12 and older in 2017 to 2.7 per 1,000 in 2018 (Morgan & Oudekerk, 2019). According to the U.S. Department of Health and Human Services Child Maltreatment Survey, approximately 58,000 children per year were victims of sexual abuse (2018).

In the Commonwealth of Kentucky, there are two state-level coalitions which assist regional trauma treatment agencies: Children's Advocacy Centers of Kentucky and the Kentucky Association of Sexual Assault Programs (KASAP). Children's Advocacy Centers of Kentucky's members include 15 regional children's advocacy centers (CACs) and the KASAP is a similar

coalition agency comprised of 13 regional sexual violence resource centers (SVRCs), historically referred to as rape crisis centers (RCCs). Member agencies of both coalitions provide comprehensive trauma treatment services including but not limited to: crisis services, legal and general advocacy, counseling for survivors and family members, prevention and community education services, and forensic interviewing (CACs only). There are two agencies in Kentucky which are dual CAC/SVRC programs (Children's Advocacy Centers of Kentucky, 2020; Kentucky Association of Sexual Assault Programs, 2022).

The COVID-19 pandemic created many challenges for human service providers, and those working within Kentucky CACs and SVRCs were no exception. The governor declared a state of emergency in Kentucky on March 6, 2020, and by March 23, 2020, all businesses not considered life-sustaining were ordered to close (Shreve, 2021). While mandated closures were short-lived, human service agencies such as CACs and SVRCs were forced to quickly pivot and identify ways to continue serving vulnerable clients, the most notable of which is telehealth.

Telehealth is defined as the remote provision of healthcare services using technology to exchange information for diagnosing, treating, and preventing disease using communication technologies such as telephone, text-based applications (both synchronous and asynchronous), videoconferencing, and even wearable devices that monitor health (Brown, 2017; United States Department of Health and Human Services, 2021a, 2021b; Weigel et al., 2020; Wosik et al., 2020). At the onset of the COVID-19 pandemic, telehealth in behavioral health settings was used but far from ubiquitous, especially given cumbersome restrictions on its provision and regulation as well as provider apprehension about its efficacy (Moorman, 2021; Phillips et al., 2021; Wind et al., 2020). Despite concerns that interacting via technology would impede the provider-client relationship (Moorman, 2021), champions of telehealth had long-lauded its promise of providing affordable healthcare to underserved areas and populations, most notably those living in rural areas (Brown 1998, 2017; Thomas et al., 2014).

Wind et al. (2020) discussed the state of emergency created by COVID-19 as a "black swan" moment in mental health care–an unforeseen event that changed everything. Heavily influenced by federal policy changes in requirements around HIPAA compliance, licensure, and reimbursement (first through Medicare and Medicaid then followed by commercial insurers), healthcare entities were quickly authorized to provide care through various technological means and reimbursed for doing so. With far fewer obstacles, human service providers in all areas seemed to begin offering telehealth care almost overnight (Krider & Parker, 2021; National Association of Social Workers, 2020; Phillips et al., 2021; United States Department of Health and Human Services, 2021b).

Telehealth may be particularly helpful to individuals in rural areas who face a trifecta of challenges related to culture, geography, and economics. Data indicate disproportionate levels of poverty in rural Kentucky, with the rate of poverty in rural parts of the state in 2019 measured at 20.3% compared to 13.1% for urban areas in the state (Economic Research Service, 2022; Thomas et al., 2014). While rural cultures are far from homogenous, they may commonly share an element of increased stigma around accessing care and decreased anonymity in doing so. Geographically, individuals in rural areas face increased travel distance to care providers, creating the need for financial resources to support transportation costs as well as time away

from work, child care costs, etc. Economically, downtowns such as the one created by the pandemic, disproportionately disadvantage those in the lower class. These individuals have less time and financial resources for engaging in health-seeking activity and protecting themselves from a lagging economy with personal savings (Thomas et al., 2014).

Using telehealth for mental health care and specifically to address the impacts of trauma in both children and adults is well-documented in the literature. Evidence-based trauma treatment modalities that have successfully been adapted to a telehealth formats include: Mindfulness and Dialectical Behavior Therapy (DBT) (Holland et al., 2021), Cognitive Processing Therapy (Hassija & Gray, 2011; Moring et al., 2020; Morland et al., 2015), Cognitive Behavioral Therapy (CBT) (Craig et al., 2021; Perri et al., 2021), Eye Movement Desensitization and Reprocessing therapy (EMDR) (Perri et al., 2021); Trauma Focused Cognitive Behavioral Therapy (TF-CBT) (Perri et al., 2021; Stewart et al., 2017, 2020), Prolonged Exposure Therapy (Banducci, 2021), and sexual assault forensic exams (Miyamoto et al., 2021). Telehealth has also been demonstrated as an effective treatment modality for specific populations such as LGBTQ+ youth in rural areas (Craig et al., 2021), female survivors of domestic violence (Hassija & Gray, 2011), youth experiencing self-harm and suicidal ideation (Holland et al., 2021), those experiencing Post Traumatic Stress Disorder (PTSD) (Bongaerts et al., 2021; Schoebel et al. 2021), adolescents (Moorman, 2021), and veterans (Banducci, 2021). There is also evidence that service recipients and their caregivers report overall satisfaction with telehealth services and may experience not only improved access to services but enhanced communication with care providers (Gray et al., 2015; McKenny, 2021; Orlando et al., 2019).

In addition to effectively reaching those who would otherwise lack access to services due to geography (Gray et al., 2015; Perry et al., 2020; Racine et al., 2020; Titov et al., 2019), or in the case of COVID-19, restrictions on public access to facilities due to public health concerns, the data indicate many other benefits of telehealth. Keeping both providers and clients safe from COVID-19 transmission by limiting face-to-face contact was an obvious intention of telehealth but also a benefit borne out in research (Banducci, 2021; Perry et al., 2020). Also noted in the literature were: increased flexibility for both providers and care recipients, continuity of services when in-person care is not possible, income stability for providers, clients being more comfortable and/or more open in their personal environments while accessing services (Hardy et al., 2021; McKenny, 2021; Moorman, 2021; Simpson, 2020), and increased equity for underserved populations (Craig et al., 2021; Garfin, 2020; Simpson, 2020). Additional potential benefits included: increased access to trained staff and decreased wait times for services (Holland et al., 2018), better client attendance and reduced attrition (McKenny, 2021; Moorman, 2021; Racine et al., 2020; Schoebel et al., 2021; Stewart et al., 2020) and personal benefits to providers such as opportunities to be more creative and learn new skills and better work/life balance (McKenny, 2021; Perry et al. 2020).

Despite a speedy expansion in the spring of 2020, the literature noted several ongoing concerns from providers about telehealth: regulation changes, concerns about both client and provider health, managing the logistics of providing care in one's own home, managing the logistics of clients receiving care in their homes or personal spaces, balancing work and personal responsibilities, fidelity to HIPAA requirements, training to competently provide telehealth, concerns about managing client safety and stress exacerbated by the pandemic, and personal

stress such as changes to income (Moorman, 2021; Phillips et al., 2021). Moorman (2021) discussed having realistic expectations for telehealth and the concept that holding the "status quo" was actually progress for clients due to the increased stressors brought on by COVID. Concerns were also raised about situations when telehealth would not be an appropriate modality, such as when there is imminent risk of violence in the client's home or acute impairment in client functioning related to cognitive, neurological, or psychiatric issues that may render telehealth participation either unsafe or unhelpful. Though not necessarily contraindicated, the literature also noted unique challenges engaging young children in behavioral telehealth (McLean et al., 2021; Moorman, 2021; Racine et al., 2020). One study noted a decrease in utilization rates for psychotherapy services among children after the onset of COVID, but an increase in telepsychiatry visits and support services (advocacy) visits (Hoffnung et al., 2021). Older clients were discussed as another population that may face barriers in telehealth utilization related to lack of comfort with technology (Mishna et al., 2021a).

In addition to possible difficulty engaging some populations, other challenges from the literature focused on themes around technology, administrative adjustments required to implement telehealth, managing the relationship between provider and consumer, clinician adjustments to the format, and ethical dilemmas such as concerns about privacy and safety. Technology concerns included a range of things: inadequate telecommunications infrastructure with either the client or provider (e.g. poor internet signal or lack of high-speed internet access) (Gerber et al., 2020; Hardy et al., 2021; Holland et al., 2018; Lieneck et al., 2020; Stewart et al., 2020), technological problems and interruptions (Perry et al., 2020), clients' lack of access to technology devices (Mishna et al., 2021a), client discomfort with using technology to receive services, lack of knowledge on how to use it (Gerber et al., 2020; Mishna et al., 2021a; Perry et al., 2020), and provider challenges such as addressing cyber-security and networking as well as costs of software, hardware, and internet access (Holland et al., 2018).

Related to both technology and administrative adjustments, one study discussed the instrumental role of an information technology (IT) department in appropriately preparing for and coordinating the move to telehealth from face-to-face care (Canady, 2020); agencies that lack resources for specialized IT support may face additional challenges in meeting the needs of technological compliance for providing telehealth. Other issues related to administrative adjustments to telehealth noted in the literature include the need for agency-generated protocols for providers to offer guidance on how to manage various issues that may arise such as ethical dilemmas, safety concerns and boundary issues with clients (Mishna et al., 2021b), appropriate training and supervisory oversight for providers, and challenges that may present if there is not institutional support for a "culture" of telehealth (Lieneck et al., 2020; Perry et al, 2020).

Regarding the provider/client relationship, the literature discusses some providers citing increased difficulty gauging client emotions and body language, building rapport, or experiencing boundary challenges, possibly emerging from what may feel like a more informal connection between client and provider (McKenny, 2021; Moorman, 2021; Perry et al., 2020; Simpson et al., 2020). Client access to privacy was also discussed in the literature as a significant concern of those providing telehealth (Lieneck et al., 2020; Racine et al., 2021). Finally, there may be challenges with client adherence to treatment formats that require homework outside of sessions and clients lacking adequate social support outside of the provider (Schueller et al.,

2016), which may become more problematic when there is not even intermittent face-to-face contact between the client and provider.

The literature also discusses providers facing challenges themselves as they utilize telehealth as a medium. Physical and emotional fatigue are cited as concerns (Hardy et al., 2021; McKenny, 2021; Perry et al., 2019). Remotely managing ethical issues such as concerns about client privacy and confidentiality and managing emergency issues related to client safety are also discussed in the literature (Hardy et al., 2021; Mishna et al., 2021a; Racine et al., 2020).

The purpose of this study was to evaluate how providers in Kentucky CACs and SVRCs adapted services to continue serving survivors during and through the ongoing pandemic. Specific focus was placed on how providers utilized telehealth as a tool, and for the purposes of our study, telehealth was defined as using video conferencing technology, telephone calls, or email to interact with clients.

Purpose of the Study

This study is a part of a broader effort to explore the impact of COVID-19 upon service delivery in Kentucky's CACs and SVRCs. The purpose of this study will focus on the suggestions for improving service delivery on behalf of providers who are employed at these agencies. Obtaining detailed qualitative feedback from these valuable individuals is vital, and their wisdom will help to inform efforts for systematic change and improvement. Kentucky is a heavily rural state, and although U.S. Census data indicate a recent trend in growth in urban population and decline in rural population, approximately 41% of its population still reside in rural areas (Kentucky League Cities, n.d.; Rural Health Information Hub, 2021). 78.6% of respondents in the study indicated they serve primarily rural areas. The data revealed that the main adaptation to service delivery was the introduction or expansion of telehealth and many respondents specifically noted the use, advantages, and challenges of providing telehealth, particularly in rural areas.

Methods

Sample

A total of 118 providers working across the state of Kentucky's CACs and SVRCs participated in the overall study. Data were collected from professionals serving in various roles, as 42.4% were employed as advocates/case mangers (n=50), 36.4% were therapists (n=43), and 21.2% served in other roles (e.g., administration, prevention specialist, outreach, etc.). Related to gender and ethnicity, the sample primarily identified as female (n=111, 94%) and non-Hispanic/white (n=109, 92.3%). Respondents averaged 40.4 years of age (SD=12.4), 9.2 years of experience of working in human services (SD=7.4), and 3.8 years of working in their current positions (SD=4.1). Of the 118 respondents, 88 indicated they had provided telehealth since the onset of COVID-19. Of those 88, 33 respondents gave at least one answer to the question, "Considering your experiences and the lessons you've learned providing services during COVID-19, please share up to 3 suggestions for how these systems could more effectively meet

the needs of our clients." Table 1 provides additional details related to the demographics of the sample.

Design and Data Collection

In response to an expressed need, a comprehensive mixed-methods survey was developed by a team of researchers from two separate universities and finalized with the support of executive directors from CACs and SVRCs in Kentucky. The study was approved by the Institutional Review Boards at both universities. With respect to the research protocol, the electronic survey used both closed and open-ended items and was administered through Qualtrics. The hyperlink for the survey was embedded into an IRB approved email which notified the recipient about the study and was distributed to the executive directors at the CACs and SVRCs in late August, 2021. Then, the executive directors forwarded the IRB-approved email with the embedded survey hyperlink to the direct service providers at each of their member regional agencies across the state (e.g., 13 CACs, 12 SVRCs, and two combined CAC/SVRC programs). A one-time reminder email was sent three weeks later to prompt those who had not previously responded.

Data Analysis Process

A qualitative thematic content analysis was conducted, analyzing data collected by the text response to the open-ended survey item "Considering your experiences and the lessons you've learned providing services during COVID-19, please share up to 3 suggestions for how these systems could more effectively meet the needs of our clients." A six-phase process ensued, following the guidelines of Braun and Clarke (2006). Themes were coded inductively, using a data driven approach (Fereday & Muir-Cochrane, 2006). Further, investigator triangulation was used by the second and third authors to affirm the validity of the first author's initial coding (Carter et al., 2014). MaxQDAPlus 2020 (VERBI Software, 2019) was used to open code the data line-by-line, response-by-response.

Results

A total of 78 items were extracted, as 33 of the 88 providers who indicated they had provided telehealth responded to the open-ended text item. Responses were partitioned into nine broad categories/themes: (1) resources for clients; (2) resources for providers; (3) flexibility; (4) increased telehealth training; (5) agency operations; (6) lessons learned; (7) addressing privacy, confidentiality, and risk; (8) adapting practice techniques and (9) partnering with community agencies (Table 2).

Table 1

Sample Characteristics of Employees at Kentucky's CACs and SVRCs (n = 118)

Employee Characteristics	***f (Valid %)***	***Range***	***M (SD)***
Age		21-74	40.4 (12.4)
Years Working in Human Services		0.5-38	9.2 (7.4)
Years in Current Position		0.5-24	3.8 (4.1)
Gender			
Female	111 (94.0)		
Male	3 (2.5)		
Gender Variant/Non-Conforming	3 (2.5)		
Trans	1 (0.9)		
Race/Ethnicity			
Non-Hispanic/White	109 (92.3)		
Black or African American	3 (2.5)		
Other (Hispanic or Latino, Native American or Alaska Native, Multiracial or Biracial, Race/Ethnicity not listed, or prefer not to answer).	6 (5.1)		
Role			
Advocate/Case Manager	50 (42.4)		
Therapist	43 (36.4)		
Other	25 (21.2)		
Education			
Less than Bachelor's Degree	15 (12.8)		
Bachelor's Degree	33 (28.2)		
Master's Degree	66 (56.4)		
Doctoral Degree	3 (2.6)		
Population Served*			
Children 12 and under	68 (26.9)		
Teens (13-17)	85 (33.6)		
Adults (18+)	100 (39.5)		
Region			
Rural	92 (78.6)		
Urban	25 (21.4)		
Did you engage in Telehealth Since COVID began?			
Yes	88 (74.6)		
No	30 (26.4)		

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

Table 2

Thematic Content Analysis: Themes and Number of Items (n=78)

Theme	n
Resources for Clients	19
Resources for Providers	10
Flexibility	9
Increased Telehealth Training	9
Agency Operations	9
Lessons Learned	8
Addressing Privacy, Confidentiality, and Risk	7
Adapting Practice Techniques	4
Partnering with Community Agencies	3

Resources for Clients

The largest category related to suggestions for improving the systematic delivery of services concentrated on the need for resources for clients (*n* = 19). Provider contributions illustrated the new reality of providing therapeutic services during the time of COVID, focusing on the need for establishing a solid technological infrastructure. One provider shared that "creating a way to obtain signatures for consent forms from the caregiver while they are on the call, since it is likely we may not see them face-to-face due to Covid" would be beneficial. Providers mentioned that having access to needed technology is vital. They mentioned the need to "coordinate getting clients hotspots/tablets," "assist clients in gaining access to technology," and to "provide families with better means to access telehealth services such as iPads." Providers identified the value of obtaining additional assistance, stating that "providing more guidance to clients and client's caregivers on how to use Telehealth platforms" and being able to "assist with the common problems we saw with clients accessing telehealth from their personal devices" would improve service delivery. All in all, a consensus emerged about "rallying for reliable internet connection speeds across the state" and "creating opportunities for clients to access free internet/services." Providers stated that there is a "significant need for high-speed internet services in rural areas" and "being able to provide better internet/technology access to families would help significantly."

Resources for Providers

While the largest category focused on resources for clients, the second largest refers to the other side of the coin, resources for providers (*n* = 10). Similar to the first category, providers also mentioned that they would benefit from an improved technological infrastructure. Explicitly, two comments mentioned that a financial investment therein would enhance service delivery. Examples include "additional funding to keep up with the additional costs of using the technology and online platforms necessary to conduct telehealth" and to "provide some financial assistance for staff for internet usage." Additionally, providers suggested that "creating a portal specifically for CACs to work with clients" and "better streamlined technology systems" would help. One provider mentioned that the "systems we use are outdated and made it very stressful

and continue to be stressful." Also, the need for an enhanced capacity was expressed, stating "consider how many people will be providing telehealth on same network and work to make sure internet can handle it." Additionally, comments described the need for additional resources for providers that would improve the systematic delivery of services. Examples include "better pay for employees," "help with childcare expense," "free mental health services," and to "actually allow staff [of agencies] to actually practice self-care. It is preached often but not often available."

Flexibility

Providers stated that flexibility would improve the systematic delivery of services (n = 9). In general, providers felt that adapting practice to "be flexible" or "be flexible, but knowledgeable" would be beneficial. Yet some comments were more precise and about scheduling. Examples included, "give clients a broader range of appointment times, beyond 8am to 5pm and to "schedule around the client's schedule. If you have to work later, you just start your day later." In addition, providers relayed their perceptions about the flexibility of using telehealth and its future as a viable option in practice. Describing the value of the flexibility of utilizing telehealth, one provider shared that "giving people the option to use telehealth makes them feel more in control of the situation." Several contributions centered around telehealth as a flexible and formidable component for future practice. Specifically, "Telehealth services are important in reaching populations we would not otherwise be able to see face-to-face. A hybrid model is good for the future of our CAC/RCCs." Also, "if not in pandemic shut-down situations, offer telehealth as an option if in person sessions are not feasible for a client." Another provider communicated a similar message, recommending "continue use of telehealth for greater accessibility to services in rural areas and for people that are limited regarding transportation or other issues that hinder in person attendance when not in pandemic shut-down situations."

Increased Telehealth Training

Providers identified that increased telehealth trainings would improve the systematic delivery of services (n = 9). Consistent and direct statements made their requests clear. Examples include, "more training in using telehealth," "additional Telehealth trainings or certifications," and "continued training on implementing evidenced-based practices/trauma treatment via telehealth." Additionally, "provide more agency-based training on providing telehealth services," and "formal training would be great on suggestions for providing telehealth." One provider recognized the need for the related financial support, requesting "funding for specific therapy modalities and how they can be adapted to telehealth."

Agency Operations

Providers identified that changes in agency operations would improve the systematic delivery of services (n = 9). They shared several strategies focused on how to adapt communication strategies when working remotely and during the pandemic. Examples include the request for an "automated answering service to direct clients to a specific staff member, so that referrals do not have to be relayed from one staff member to another and clients do not have to repeat their stories. Having "direct access to the advocate or therapist they are working with

so that they do not have to relay messages through administrative staff" and "designated cell phones for remote staff so that clients are desensitized to the dangers or frustrations of answering "unknown" or "blocked" numbers." Also, a "better protocol and organization in the company and communication update written policies and procedures regarding electronics, work from home, etc." Providers reflected this new climate by requesting both personal and professional assistance from the agency. For example, "more effective team building via remote work" and "safer and more structured environments and schedules for this new hybrid type of schedule we are all probably in right now." One provider mentioned the need for "better marketing strategies to advertise that services are available on these virtual platforms." Finally, a comment seemed to summarize the notion that this might be the "new-normal" and that agencies should face this reality when it comes to planning:

> I feel there is a lot of avoidance of addressing improving effectiveness because we add the qualifier "when this is over." It's not over and nothing is going back to the baseline of practice prior to COVID-19 restrictions. [Agencies] seem to live in the past and the hopeful future rather than address the PRESENT.

Lessons Learned

Providers offered lessons learned as suggestions that would improve the systematic delivery of services (n = 8). Examples include, "remain compassionate," "be relaxed in your own home. No need to dress professional unless you are in a training or meeting with other professionals" and "being prepared for using telehealth in advance is incredibly helpful." Other suggestions were more logistical, such as "children should be seen face-to-face, when possible, it is difficult to do therapy with a small child via telehealth." Additionally, "look for alternative places to meet" and "promote turning video on" as a better way to engage with clients when providing services during COVID.

Addressing Privacy, Confidentiality, and Risk

Addressing privacy, confidentiality, and risk were identified as suggestions for improving the systematic delivery of services (n = 7). Providers shared that they wanted "more training on how to assess risk and safety plan via telehealth." Also, they mentioned a request for "training on how to eliminate privacy concerns," and that "rules should be specified in the beginning in terms of why a session needs to be conducted in a private space," and "how to address privacy and confidentiality." In a similar vein, a suggestion to "establish safety as best (as I) can" and to "provide telehealth as an option but highlight different risks involved and that outcomes may vary" was offered. Lastly, one provider asserted to "make sure all platforms utilized are HIPAA compliant (for zoom you have to upgrade and pay a fee)."

Adapting Practice Techniques

Providers suggested that adapting practice techniques would improve the systematic delivery of services (n = 4). Suggestions included an ability to "engage with other providers to develop new ideas to use especially with children" and "strategic planning for telehealth client meetings to increase engagement." Additionally, one provider felt that adapting practice to be

able to deliver "remote EMDR" would be beneficial. One comment encapsulated the entire category by recommending to "learn to adapt every technique you have. If you can do it in an office, you can do it at home. You just have to be flexible and teachable."

Partnering with Community Agencies

Providers suggested that partnering with community agencies would improve the systematic delivery of services (n = 3). Examples included "partnering with agencies like libraries" and "partnering with schools." A holistic collaborative approach was identified by a provider who mentioned that "along with the satellite offices, I think there is a real opportunity for our centers to collaborate with agencies in our rural counties to increase accessibility without increasing overhead costs."

Discussion

The onset of the COVID-19 pandemic presented several challenges for Kentucky's CACs and SVRCs, resulting in an abrupt transition to remote services and delivery of care in an effort to provide continuity of services. Although telehealth confers several advantages such as increasing the potential reach of services and greater convenience for recipients of telehealth, remote delivery of services also presents several obstacles. Given the large proportion of individuals in Kentucky residing in rural areas, the transition in this region in particular has faced a number of challenges, as reflected in the responses of providers surveyed in the current study. Notably, 78% of providers in the current survey indicated that they serve primarily rural areas, highlighting that many providers across the state are working in settings that may be especially under-resourced and ill-equipped for the sudden shift to telehealth services. The purpose of this study was to examine provider suggestions for improving telehealth service delivery at Kentucky CACs and SVRCs among a sample of 118 providers across a variety of professional roles at these agencies.

Classification of responses indicated a number of suggestions for improving delivery of services at CACs and SVRCs during the pandemic. The most common suggestions centered around improving resources for clients. In particular, themes emerged around needing equipment for clients to utilize telehealth services and addressing resources for telehealth access (e.g., limited internet access). This reflects the many elements that clients must obtain in order to effectively utilize telehealth services, such as computers, tablets, modems, and high-speed internet access, which may be especially difficult for individuals in rural and disproportionality impoverished communities to obtain. A recent report noted that 36% of Kentucky children and adolescents did not have access to home internet, putting Kentucky as the eighth worst state in the country for student internet access. Additionally, 27% of students did not have the needed devices for online services, such as a computer or laptop (Chandra et al., 2020). As such, considerable work still exists to broaden the reach and availability of essential resources that make remote receipt of services provided by CACs, SVRCs, and other agencies possible. Interestingly, participants also provided suggestions for ways to potentially address limited resources for clients in rural communities by partnering with community agencies such as libraries and schools to utilize local resources. This may be feasible as a temporary stopgap, although use of these resources may exacerbate other concerns noted in the survey by providers.

For example, use of library resources such as computers or internet to provide clients with access to telehealth services may create additional challenges to privacy and confidentiality. Unfortunately, there is limited ability for CACs and SVRCs to remedy some of these issues, such as the availability of reliable broadband internet in rural areas, which may be most ameliorated by state and federal efforts.

Another common theme emerged regarding improving resources for providers. Results indicate that providers face their own challenges in providing telehealth services. Similar to limited technological resources for clients, providers also indicated lacking adequate telehealth resources, such as outdated technological systems. Notably, many CACs and SVRCs may lack dedicated IT departments, putting providers in a position to shoulder much of the burden in navigating and managing the ever-evolving array of telehealth platforms. Several responses indicated that increasing funding to transition to more updated telehealth platforms would improve service delivery and reduce stress. Beyond lack of technological resources, responses also noted lack of financial and healthcare resources for providers, such as access to their own mental health treatment, inadequate compensation, and lack of childcare. Consistent with these suggestions, one study of 1,996 child welfare workers during the COVID-19 pandemic found that 46% of the sample was experiencing mild to severe distress (Miller et al., 2020). Given the high levels of stress and considerable burdens faced by child welfare workers prior to the pandemic, these problems have likely been exacerbated by the onset of the pandemic (Travis et al., 2016). Results suggest that greater financial resources dedicated to both infrastructure and healthcare needs of providers are warranted.

Themes also emerged regarding improving training around a number of topics. Responses indicated a need for training on adapting services to telehealth, highlighting the lack of formal guidance and challenges with modifying treatments to a telehealth format. Although there is significant research indicating that trauma-focused therapies can be successfully applied in a telehealth format (Perri et al., 2021; Stewart et al., 2017, 2020), responses indicate more concrete and formal guidance to those on the front lines is needed about how to best adapt these services to a telehealth format. Some therapies (e.g., CPT) may require significant use of handouts and materials that are easily distributed in-person, but may be challenging to administer to clients via telehealth, particularly when used in conjunction with outdated or inefficient telehealth platforms. Additionally, use of different modalities (e.g., phone vs. video-based interaction) to deliver remote services, may present their own unique difficulties. Specific populations, such as young children and older adults low in technological literacy may also require creativity in approaches, as noted by survey responses indicating that willingness to adapt practice techniques is imperative. Thus, as recommended by providers in the current study, flexibility is key. It is important to note that while therapeutic interventions may be challenging for some individuals to engage with, other assistance, such as advocacy services, may be more amenable to a telehealth format. Clients and families may benefit from a combination of in-person and remote delivery of services at CACs and SVRCs. Nevertheless, responses suggest that formal and standardized training in remote delivery of interventions that is supported by agencies would be welcome and give providers greater confidence in delivering remote services.

Several responses indicate a need for more training regarding how to address privacy, confidentiality, and risk issues when using telehealth, reflecting the ethical conundrums that can

arise as a result of telehealth treatment. Responses are consistent with other research noting that boundary, confidentiality, and privacy issues are commonplace when engaging in therapeutic practice via remote means during the COVID-19 pandemic (Desai et al., 2020; Mishna et al., 2020). The desire to provide continuation of services in an alternative format may inadvertently result in a new set of ethical dilemmas. For example, Mishna and colleagues (2020) noted that some providers reported providing clients with their home telephone number and communicating outside of traditional operation hours in an effort to accommodate client during pandemic-related shutdowns. Although this may improve the therapeutic relationship, this may also encourage boundary violations and misconstrued expectations regarding provider availability. Additionally, delivery of remote services may not be optimal for some individuals, such as individuals with a history of self-harm or suicidal behaviors, or children in unstable living situations at risk of further maltreatment (Moorman, 2021). Consistent with previous studies, another challenge noted in responses are clients and providers having limited privacy in their own homes, which complicates efforts to maintain confidentiality (Mishna et al., 2020; Moorman, 2021. Thus, delivery of telehealth services, while convenient, may complicate a number of ethical mandates, particularly for CACs and SVRCs, who often work with victimized and vulnerable children and adolescents. Greater guidance from agencies about how to manage these dilemmas can help providers navigate these complex issues.

Despite the informative suggestions given by providers at CACs and SVRCs in the current study, some study limitations should be noted. First, the survey was predominantly composed of female and white individuals. Additionally, respondents were predominantly serving rural communities. As such, providers' experiences and the challenges faced working at CACs and SVRCs in the current study may not generalize to organizations residing in more urban areas or in other geographic regions. Finally, the sample population was limited in size and not all respondents provided suggestions for improving the CAC and/or SVRC systems. Nevertheless, responses point to a variety of potential ways to improve delivery of services at these agencies.

Telehealth delivery of services in CACs and SVRCs is likely to continue to be a prominent modality moving forward, and as such, deserves significant attention and dedication of resources. More work is needed to examine whether there are specific sub-populations of clients served by CACs and SVRCs who are especially difficult to reach and treat via telehealth, such as older adults and young children, whose willingness and interest in engaging with telehealth may be low. Additionally, it is important to continue to monitor the progression of telehealth as the pandemic evolves. Although some challenges may be alleviated over time (e.g., increased numbers of HIPAA compliant telehealth platforms, comfort with using various telehealth platforms), certain issues (e.g., ethical dilemmas, limited broadband access) may persist.

Rather than being viewed as a transitory stopgap, telehealth services offer several exciting opportunities for the future, including reaching previously underserved communities and reducing barriers to care for those in need of services. Comments from providers in the current survey reflect these views. Indeed, both providers and those served by telehealth report numerous positives and overall satisfaction with these services (McClellan et al., 2020; Moorman, 2021). Nevertheless, use of telehealth in these settings also faces a significant number

of obstacles, as identified by providers in the current study, and there is still much progress to be made. As such, it is vital to identify best practices for implementing telehealth treatment that benefits both providers and clients. Providers in the current study deliver some concrete ways for moving models of care at CACs and SVRCS forward, but it will require significant recognition by relevant parties on the value of investing in new frontiers of service delivery.

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