Social Work Answers the (Video) Call: Tele-Behavioral Health Use During COVID-19

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ABSTRACT ***Objective:*** The COVID-19 pandemic disrupted access to and the delivery of behavioral health services for social work providers and their clients. This study examined the use of tele-behavioral health by social workers before and during the pandemic, as well as the perceived barriers and supports to technology use. ***Method:*** We developed an electronic survey, which was distributed to a convenience sample of practicing social work professionals in the United States through a national listserv. A mixed-methods study design was used to analyze responses ($N = 585$). ***Results:*** Over 92% of social workers reported using tele-behavioral health since the beginning of the pandemic, compared to 28% prior. About half of respondents received training on tele-behavioral health since COVID-19, whereas only 23% had received training prior. The vast majority (87%) indicated one or more barriers to the use of tele-behavioral health, with client barriers (73%) being the area of greatest concern. Yet, social workers overwhelmingly reported the desire for tele-behavioral health to continue beyond the pandemic. ***Conclusions:*** Based on our findings, we propose the following recommendations: (a) Ensure parity and reimbursement for tele-behavioral health; (b) train current and future social work practitioners in tele-behavioral health; and (c) provide supports for client use of tele-behavioral health.

KEYWORDS: social work, tele-behavioral health, telehealth, coronavirus, COVID-19

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As of April 1, 2020, 95% of Americans were under stay-at-home orders due to the COVID-19 pandemic. The widespread implications of the pandemic included disrupted services for individuals with health, mental health, and substance use conditions. As part of the Coronavirus Preparedness and Response Supplemental Appropriations Act (2020) and Social Security Act 1135 waiver authority, the U.S. Centers for Medicare and Medicaid Services (CMS) temporarily expanded the ability of credentialed providers to use telehealth services, including

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tele-behavioral health, to increase the accessibility of care during the public health crisis (CMS, 2020). This change also allowed social workers and other health providers to be reimbursed for telehealth services at the same rate as in-person services (i.e., payment parity). Many states enacted executive orders to mandate that private health insurers follow suit and reimburse at parity for telehealth visits during the pandemic. The disruption caused by COVID-19, coupled with the authorization of tele-behavioral health services through CMS and several other insurance providers, created an unprecedented moment when social workers and clients were both dependent on tele-behavioral health to provide and receive services.

Tele-behavioral health is the provision of behavioral health services offered through a host of distanced communication methods, such as audio-only telephone, videoconferencing, e-mail, text-message, phone applications ("apps"), and other web-based interventions (Center for Connected Health Policy, 2020). Prior to COVID-19, tele-behavioral health was most often used to expand access to care in rural and frontier communities where there were few or limited providers, particularly psychiatrists (Lee et al., 2019). Yet, barriers exist in the implementation of tele-behavioral health, including difficulties in billing and reimbursement, provider training and education (Perry et al., 2020), and cost of implementation and maintenance (Mace et al., 2018). Older adults and low-income clients may also experience cost barriers associated with access to and use of the technological equipment required for tele-behavioral health (Cwikel & Friedmann, 2019).

Overall, evidence supporting the efficacy of tele-behavioral health is strong. Several studies have demonstrated that those who receive care through remote videoconferencing have similar treatment outcomes as those who receive in-person care (Aboujaoude et al., 2015; Hilty et al., 2013; Luxton et al., 2016). In a systematic review of 25 studies examining tele-mental health care, Langarizadeh and colleagues (2017) identified several key advantages to tele-behavioral health, including (a) improved access to services for consumers, (b) positive treatment and quality outcomes from individual and group therapies, (c) the capacity for clients to build social networks, (d) improved profitability and reduced costs, and (e) the capacity for future innovations. Two systematic reviews focused on social-work-delivered technology-infused interventions found positive effects for the treatment of mental health conditions (Chan, 2018; Ramsey & Montgomery, 2014).

Some behavioral health providers, including psychologists, have begun to document the prevalence of tele-behavioral health service provision and training in their profession. In a national sample, Glueckauf and colleagues (2018) found that roughly 47% of psychologists reported using at least some online counseling in a week, and 96% believed that mental health practitioners should be trained in telehealth. However, limited research has documented the prevalence of training and implementation of tele-behavioral health in social work. Research on tele-behavioral health that is inclusive of social work practitioners is greatly needed, as social workers

commonly serve vulnerable and marginalized groups (National Association of Social Workers, 2017), who may have less access to the technology resources needed to access tele-behavioral health care. A clear understanding of tele-behavioral health use and efficacy within the context of social work practice is needed to inform practitioners, educators, and researchers.

Even prior to the COVID-19 pandemic, social workers were increasingly calling for and actively using information and communication technologies such as mobile text messaging interventions and digital momentary assessments in social work practice (Berzin et al., 2015). Harnessing technology for public good is one of the Grand Challenges for Social Work (Berzin et al., 2016). Yet, much of the concern regarding use of technology for social work has been focused on client privacy and the ethical ramifications of its use. Numerous articles have addressed the ethical concerns and competencies required to adequately implement social work interventions using tele-behavioral health (Berzin et al., 2015; Dombo et al., 2014; Mishna et al., 2014). The extent of tele-behavioral health use and training in social work prior to COVID-19 is relatively unknown. One study conducted in Israel found that only 4% of social workers had experience using electronic therapy (Cwikel & Friedmann, 2019). Although some social work scholars have suggested that there are likely low levels of telecommunication training in social work education programs (Berzin et al., 2015), as of 2017, 21 states included specific language on telehealth practice in social work scope-of-practice laws, suggesting that states have been moving to include this method as a standard practice (Page et al., 2017).

The COVID-19 pandemic fundamentally changed social work practice as hundreds of thousands of social workers had to quickly find ways to provide care despite shutdowns. Social workers have leaned on tele-behavioral health to ensure that clients have safe access to care during the pandemic. In this study, we sought to understand the extent to which social workers were able to provide tele-behavioral health services during the early pandemic and identify supports needed for social workers to continue this practice.

Method

We developed an electronic Qualtrics survey and distributed it to social work professionals in the United States. The survey focused on understanding the use of tele-behavioral health to deliver services in response to COVID-19, determining how providers were able to implement tele-behavioral health, describing the services they were deploying through tele-behavioral health (e.g., individual, family, or group therapy), and identifying barriers to or facilitators of tele-behavioral health use by social workers. The survey also included questions about factors that may impact the use of tele-behavioral health, such as setting type and geographic location. Finally, the survey included questions on respondent demographics, licensure,

and educational background. Participants were also provided free response sections to describe their professional experiences using tele-behavioral health during the pandemic. The survey had 65 questions and took approximately 15 minutes to complete. The survey remained open throughout June 2020.

Survey Development

Survey development was informed by previous work on provider use of telehealth (Almathami et al., 2020; Mace et al., 2018; Perry et al., 2020; Substance Abuse and Mental Health Services Administration, 2016), guidance from active social work practitioners, and consultation with two national professional organizations (the National Association of Social Workers and the National Council of Behavioral Health). Some items were adapted from a survey conducted by the National Council of Behavioral Health on behavioral health organization readiness for tele-behavioral health (Mace et al., 2018). We piloted the survey with a group of social workers ($n = 26$) and refined the instrument based on their feedback. Additionally, we completed cognitive interviews with four social work professionals with practice experience using telehealth in a variety of settings, including private practice and community health clinics. The cognitive interview process reviewed each item in the survey, using probing questions to better understand how survey items were conceptualized by respondents, to ensure questions were understandable, and address any technical problems with the survey. The survey included the following sections:

- professional use of tele-behavioral health prior to and since COVID-19 (e.g., "Did COVID-19 prompt you to professionally use tele-behavioral health?");
- types of technology used and services provided for tele-behavioral health, billing and insurance, interprofessional team use of technology, and training (e.g., "Did you receive training on tele-behavioral health prior to COVID-19?");
- barriers and supportive factors to tele-behavioral health use (e.g., "What has supported or facilitated your ability to use tele-behavioral health professionally since COVID-19?"); and
- respondent background, such as practice setting, services provided by individual or organization, licensure, geographic location, and demographics.

Both closed- and open-ended questions were used throughout the survey.

Participant Recruitment

We contacted a convenience sample of approximately 11,000 social workers practicing in the United States through the National Association of Social Workers (NASW), which disseminated a scripted recruitment e-mail to potential respondents. Only NASW members with an MSW degree and whose primary function was to

provide direct behavioral health services to clients were contacted (a subsample of the total NASW membership). The sample included active NASW members who identified their primary function as providing direct services to clients in one of the following primary work settings: inpatient behavioral health, outpatient behavioral health, employee assistance program, outpatient or community health, private practice, inpatient substance use, or outpatient substance use. The survey was distributed by e-mail and was available for 4 weeks. The first 300 participants to complete the survey were provided a $10 gift card for participation. Participants indicated they consented to the study prior to beginning the survey. The University of Pittsburgh Institutional Review Board reviewed and approved the study.

Analysis

We used quantitative and qualitative analyses to analyze responses to closed- and open-ended items. We used Stata 16 for quantitative analyses, descriptive analyses to depict use of tele-behavioral health, and bivariate (chi-square) analyses to assess differences between groups (e.g., differences between private practice and practitioners in larger organizations).

Responses to open-ended questions were analyzed using an inductive thematic analysis. We first generated initial codes and created a codebook based on preliminary review of the open-ended responses. Next, two study investigators independently coded the responses, identifying new codes and refining the codebook. We used Microsoft Excel to organize and code responses. The two study investigators met to resolve discrepancies in coding and organize codes into broader themes. Qualitative findings were reviewed with external study collaborators to validate the themes generated.

Results

A total of 585 participants completed the survey, yielding a 19% response rate of those who opened the recruitment e-mail. Participants were located in 49 U.S. states (all states except Wyoming), the District of Columbia, and Puerto Rico. For most respondents, the highest earned degree was a Master of Social Work (MSW; 94%). Close to 88% of respondents were licensed to independently practice social work in their state (e.g., Licensed Clinical Social Worker [LCSW]), and 10% were working toward independent licensure. On average, participants worked at their highest degree for 19 years ($SD = 12$). A total of 62% of respondents were credentialed by CMS. Most participants worked in private practice (65%). Participants responded that their organization provided mental health services (95%) and/or substance use services (31%). The sample was predominately white (90%), self-identified as female (88%), and averaged 54 years in age ($SD = 13.5$). According to a previous

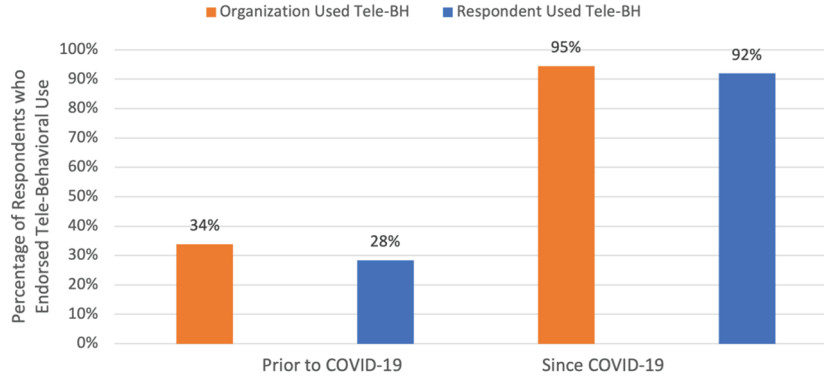
analysis of the social work workforce (Salsberg et al., 2017), the sample of the current study was more homogenous than the MSW professionals practicing in the United States.

Tele-Behavioral Health Use

Only 28% ($n = 166$) of respondents reported using tele-behavioral health to provide services prior to the COVID-19 pandemic, whereas 92% ($n = 539$) of respondents reported using tele-behavioral health since the pandemic's onset ($\chi^2 = 7.53$, $p = .006$). Similarly, 34% ($n = 198$) of respondents reported that their organization used tele-behavioral health prior to the pandemic, and 95% ($n = 553$) indicated the organization they work for used tele-behavioral health after the pandemic's start ($\chi^2 = 11.51$, $p < .001$; see Figure 1). To evaluate whether there were regional variations in social work tele-behavioral health use due to fluctuations in the community spread of COVID-19 and possible differences in regional approaches to COVID-19 mitigation, we examined differences across the 10 Health and Human Services regions. There was no significant difference in tele-behavioral health use by region since COVID-19 ($\chi^2 = 12.29$, $p = .197$; see Figure 2). Working in a private practice setting influenced adoption of tele-behavioral health since the pandemic's onset: Respondents who worked primarily in private practice were more likely to report tele-behavioral health use since COVID-19 than those who did not work in private practice ($n = 545$; 85% not in private practice vs. 97% in private practice; $\chi^2 = 28.86$, $p < .001$).

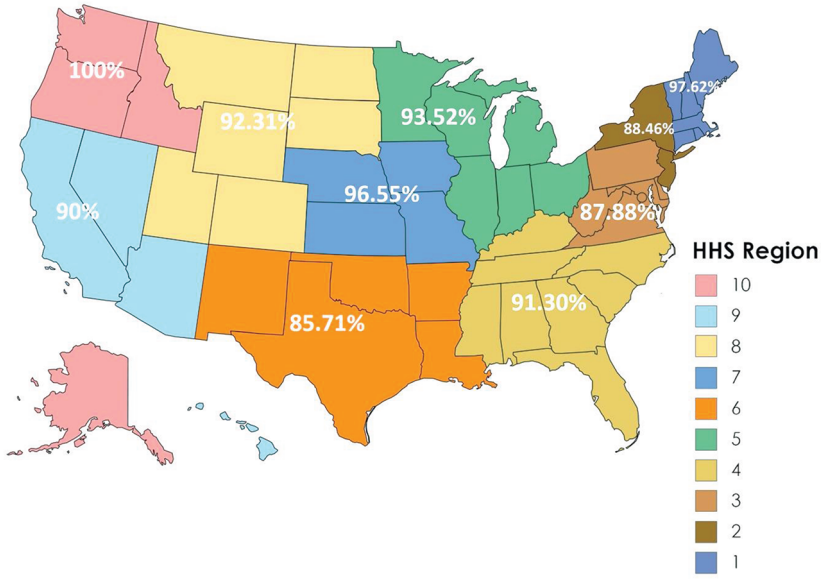
Of those who used tele-behavioral health prior to COVID-19, respondents indicated they used this method with 21% of their clients. Since COVID-19, those who used tele-behavioral health used the method with close to 88% of their clients.

Figure 1. *Respondent Reports of Tele-Behavioral Health Use Before and Since COVID-19 (N = 585)*



Note. Tele-BH = tele-behavioral health. We used chi-square analysis to test for a significant difference in tele-BH use prior to and since the COVID-19 pandemic. Both organizational use and respondent use of tele-BH were significantly different ($p < .01$).

Figure 2. *Tele-Behavioral Health Use by U.S. Department of Health and Human Services (HHS) Region (N = 585)*



Note. There were no significant differences across HHS regions.

Tele-Behavioral Health Across State Lines

Of the respondents who used tele-behavioral health to provide care since the beginning of the pandemic, 25% provided services to clients across state lines. Some indicated this was due to being licensed in multiple states, others reported that it was part of their job to have contact with clients across multiple states (e.g., works for an insurance company), and some said their clients paid out of pocket for services or were temporarily relocated due to the pandemic.

Types of Technology Used

Social workers indicated using multiple types of technology to provide care, including videoconferencing (90%) and audio-only communication (88%). However, respondents also used e-mail (81%), text messaging (90%), and mobile phone applications (31%) to connect regularly with clients. On average, respondents used two ($M = 1.95$, $SD = 1.1$, $R = 0$–6) platforms to communicate with clients. Doxy.me ($n = 230$) and Zoom ($n = 229$) were the two most common videoconferencing platforms used by practitioners, followed by FaceTime ($n = 142$).

Types of Services Provided Through Tele-Behavioral Health

Respondents were asked what type of social work services they were providing through tele-behavioral health. They were permitted to respond that "yes" they provide the intervention, "no" they do not provide the intervention, or "not applicable,"

meaning that this intervention was not part of their clinical role. The vast majority of respondents most often used tele-behavioral health to provide individual therapy (98%). Fewer respondents delivered tele-behavioral health interventions or treatments incorporating multiple people, such as family therapy (62%) or group therapy (20%).

Respondents also used tele-behavioral health to refer clients to needed supports during COVID-19. Although 7% of respondents indicated that referral to resources was not part of their role, others used tele-behavioral health to connect clients to food resources (70%), other behavioral health providers (89%), health resources (83%), housing supports (57%), interpersonal or domestic violence resources (52%), or other social care supports (83%).

Training for Tele-Behavioral Health

Respondents were asked if they received training on tele-behavioral health prior to or since the pandemic. More than 49% received training since the pandemic, but only 23% had received some training prior to the pandemic. Participants indicated they received training since COVID-19 primarily through their employer (41%) or through a professional organization (42%). However, some accessed training through a telehealth resource center (15%), a school of social work (10%), or through a local, state, or national government agency (7%).

Barriers to Tele-Behavioral Health Use

Participants were asked about financial, administrative, client, and other barriers to tele-behavioral health use since COVID-19 (see Table 1). Overall, 87% of respondents identified at least one barrier to tele-behavioral health use. Client barriers were respondents' primary concern. For example, about 73% of respondents reported client-facing barriers to tele-behavioral health use; 55% reported that clients lacked technology resources necessary for tele-behavioral health, and 45% reported that clients lacked technology knowledge to use tele-behavioral health services. Similarly, close to 42% of respondents reported that clients were uninterested in using technology to receive care.

Respondents were encouraged to indicate if other barriers occurred that were different than those identified in the multiple-choice options. The following themes of barriers and continuing concerns were identified based on respondents' qualitative input ($n = 65$): (a) administrative confusion regarding billing and compliance; (b) inability to provide care across state lines; (c) additional clinical concerns; (d) additional technology limitations; and (e) personal difficulties. Table 2 presents examples of reported barriers to tele-behavioral health use based on these five prominent themes.

Table 1
Barriers to Tele-Behavioral Health Use (N = 585)

Barriers to Using Tele-Behavioral Health (Tele-BH)	*n*	%
Financial barriers		
Lack of reimbursement	100	17.7
Cost of equipment	78	13.8
Cost of maintenance	30	5.3
Other financial barriers	28	5.0
Client barriers		
Clients lack technology resources to engage in tele-BH	306	54.3
Clients lack technology knowledge to receive services	255	45.2
Clients are not interested in or engaged in tele-BH or technology	235	41.7
Clients cite privacy as a concern or barrier	108	19.2
Other client concerns	64	11.4
Lack of organizational support	51	9.0
Unaware of training programs	71	12.6
Licensure regulations	91	16.1
Concern of compliance regulations	160	28.4
Social worker not interested in using tele-BH	20	3.6
Social worker does not believe tele-BH is effective	26	4.6
Social worker has concerns about HIPAA or client privacy	115	20.4
Other concerns	65	11.5

Note. HIPAA= Health Insurance Portability and Accountability Act. Respondents were able to select as many barriers as applied.

Supports and Facilitators for Tele-Behavioral Health Use

An open-ended question asked respondents what factors supported or facilitated their use of tele-behavioral health during COVID-19. Seven themes emerged from qualitative analysis of the open-ended question: (a) policy changes, (b) organizational/employer factors, (c) training supports, (d) social supports, (e) available technology and space, (f) necessity to do it, and (g) previous experience/individual factors. For many, responses aligned with more than one theme, indicating that multiple factors facilitated the transition to delivery of tele-behavioral health services.

Close to 23% (114 out of 503) of responses indicated that federal and state policy changes supported tele-behavioral health use. This theme included several codes, including relaxing Health Insurance Portability and Accountability Act (HIPAA) regulations on platforms, providing reimbursement parity (for video and phone), suspending originating site requirements for tele-behavioral health, and allowing temporary practice licensure. Indeed, reimbursement was observed as a major facilitator to use of tele-behavioral health during the pandemic. For example, when asked what supported or facilitated tele-behavioral health use, many respondents

Table 2
Open-Ended Responses to Tele-Behavioral Health Barriers (N = 65)

Theme	Example of Responses
Administrative confusion (n = 18)	Confusion with coverage and reimbursement: • "*Inconsistency with insurance reimbursement*"; "*Insurance plans vary greatly about this benefit*"; "*Lack of uniformity in billing*" Concerns that clinicians will not be reimbursed: • "*The anticipation of tele-behavioral services being denied for reimbursement once emergency is over*"; "*Decrease in teletherapy reimbursement compared to face-to-face*"; "*Delays in reimbursement*"
Desire to provide care across state lines (n = 4)	Limits to practicing across state lines: • "*Lack of interstate licensing agreements*"; "*Laws around telehealth across state lines*"; "*I would like to provide telehealth to patients who have moved to other states. It is very difficult to learn which states allow that from a licensure perspective*"
Clinical concerns (n = 14)	Communication, privacy, and safety concerns: • "*Often patients are non-verbal, I see a lot of information in person that is not communicable by phone*"; "*Clients who do not want to be 'overheard' by partners or their children; therefore, opt to not take part*"; "*Safety in the home*"
Technology limitations for the provider and client (n = 18)	Access and use of Internet and technology: • "*Substantial increase in Wi-Fi service fees*"; "*How to use the technology! We were so unprepared to go digital*"; "*Quality of various platforms, overloaded Internet*"; "*Inconsistency with the quality of video or technology issues during calls are frustrating to clients and interrupt therapy flow. I don't feel as comfortable with the platform*"
Personal difficulties in tele-behavioral health (n = 11)	Caregiving and home life: • "*Having time for appointments as I'm now home with my child*"; "*Lacking an office space in my home*"; "*The room is also my spare bedroom and my grandson's playroom*" Physical and emotional impact: • "*I find it more draining*"; "*[It's] more tiring*"; "*The fatigue from being in front of the computer all day, hour after hour, is real*"

simply wrote "*insurance policy changes*," "*insurance reimbursement*," or "*insurance companies paying for it*." Others highlighted that being reimbursed for services provided by phone was important: "*ability to get reimbursed for phone sessions*," "*insurance reimbursement for all types of communication*," and "*telephone calls being reimbursed for those clients who can't navigate technology*."

Being part of an organization that supported the quick transition to tele-behavioral health was also observed as a theme in 20% of responses (107 out of 503). Many respondents appreciated having a supervisor and organization that supported the practice transition. For instance, a respondent stated, "*Supervisors establishing self-care meetings to help boost team-moral/give break from work day*." Other respondents described that the organization supported the logistical and billing changes so they did not have to worry about payment during this time. One respondent wrote,

> *I am a part of a large private practice group that dealt with all of the logistics for us practitioners to have access to tele-behavioral health. They researched all insurance providers to allow tele-behavioral health.*

Others described that the organization supplied the technology needed and support to deploy tele-behavioral health. For example, one wrote, "*My company provided a laptop for me to use from home*."

Of responses, 18% (90 out of 503) indicated that they received social support from groups that helped facilitate their transition to tele-behavioral health. For example, some respondents indicated that they used social media platforms to connect with other social workers (e.g., "*Closed Facebook groups for clinicians in private practice*"; "*Facebook therapist groups*"). Similarly, others used support from colleagues, friends, and coworkers, as evidenced by a respondent who said, "*Colleagues and family members helped with setup*," or another who wrote, "*Consultation with colleagues*." Finally, some respondents described that the client's willingness supported the transition. One respondent noted,

> *My clients have been grateful to move to an online format during the pandemic, and we have worked together to manage the difficulties in using the technology.*

Others expressed that the "*eagerness of clients to have therapy during the crisis and their desire to avoid exposure*" helped facilitate the transition to tele-behavioral health.

Many respondents reported turning to training supports through professional organizations, such as the NASW. Some social workers tapped into paid, free, and existing online trainings (e.g., "*taking a webinar on telehealth*"; "*webinars regarding providing effective telehealth services and compliance issues*"). Others reported that professional organizations provided information about policy changes on websites and listservs (e.g., "*have looked at NASW requirements and other trainings*; "*[State] Association of Women Therapists organization*").

The availability of the appropriate technology and physical space to provide tele-behavioral health was also identified as a support. For example, some respondents described free software platforms that facilitated use (e.g., "*Doxy.me being free and easy to use*"; "*thank goodness for Zoom*"), whereas others indicated that already

having the hardware needed to provide care was important (e.g., "*I have very new computers which I am lucky enough to afford*"). Also, respondents reported that having a private, quiet physical space was critical to successful tele-behavioral health implementation (e.g., "*availability of a private space with good Internet*").

Respondents indicated that the need to continue to provide care supported adoption of tele-behavioral health. Necessity to use tele-behavioral health was cited to meet client needs (e.g., "*just having to get to our clients appointments any way we can*"; "*the necessity to do so in order to continue to serve my clients*"), client safety (e.g., "*my patients have co morbidities and continue to be high risk*"), clinician safety (e.g., "*safer to remain in home for self and clients*"), and practice or provider financial needs (e.g., "*my need to continue working*"). Some described a combination of several needs, as was explained best by one social worker:

> *Necessity. I am medically compromised myself and my own PCP [primary care provider] has advised me to work from home only for my own health and safety. And I must continue to work to support my family*.

Finally, several respondents indicated that their previous training (e.g., "*good training prior to COVID-19*") and already occurring tele-behavioral health use (e.g., "*the fact we have been [doing] telehealth all along made it easy adjustment*"), as well as their individual knowledge of technology (e.g., "*my own existing knowledge of technology*"), facilitated the transition to and use of tele-behavioral health during the COVID-19 pandemic.

Continued Tele-Behavioral Health Use

More than 84% of respondents indicated they intended to use tele-behavioral health after the COVID-19 pandemic. Additionally, more than 69% said they wanted to use tele-behavioral health. Only 8% said they did not want to use tele-behavioral health, and the remaining respondents indicated they might use tele-behavioral health or use it depending on client needs.

An open-ended question asked respondents if there was "anything else" that they wanted the research team to know or consider about tele-behavioral health. Respondents' answers to this question communicated three overarching themes: (a) positive feelings and experiences, (b) negative feelings and experiences, and (c) requests for further advocacy to sustain tele-behavioral health and continued training needs and supports. Many responses within these themes mirror the supports and facilitators described earlier. However, in this section, participants expressed diverging opinions about their tele-behavioral health experiences.

Positive Feelings and Experiences Toward Tele-Behavioral Health

Of those who responded to the open-ended question ($n = 225$), 61 indicated positive feelings toward or experiences with tele-behavioral health. Many described their surprise at the ease of tele-behavioral health use and the client's positive feelings

toward it. For example, a respondent said, "*It is much easier than I expected, I would have started using it much sooner if I'd known this*." Others said using tele-behavioral health was "*more positive than expected*." Another respondent reported their surprise that "*more people are receptive, or actually prefer it, than I had thought*." Some reported that their positive feelings were due to lower no show-rates (e.g., "*the convenience for clients has reduced my no-show rate*") and reduced barriers for clients (e.g., "*it removes barriers for clients obtaining therapy—e.g., no driving or parking considerations*").

Negative Feelings and Experiences Toward Tele-Behavioral Health

Although there were positive feelings toward tele-behavioral health, 59 respondents shared negative aspects of its use. Negative experiences tended to be due to technology issues (e.g., "*glitches in platform, blurry freezing glitches*"; "*Internet or connectivity glitches can cause some inconvenience during sessions*"). Others found it difficult to address certain clinical concerns and said that some client populations are difficult to engage via tele-behavioral health (e.g., "*It's a real challenge with children. Lack of focus, high distractibility*."). Finally, a few respondents described that they simply did not like tele-behavioral health (e.g., "*I have discovered, as I predicted, that I much prefer face-to-face interactions*."), nor did their clients enjoy receiving service in this way (e.g., "*Many families have expressed frustration of getting so many phone and video calls and feeling overwhelmed with all the televisits*.").

Requests for Further Advocacy and Supports to Sustain Tele-Behavioral Health

More than 75 respondents described an advocacy need or some other continued need to support tele-behavioral health use in the future. It was clear that respondents wanted professional organizations and others to advocate on behalf of social work practitioners to continue reimbursement parity for tele-behavioral health, as more than 30 respondents described this request in the open-ended response. For example, one respondent wrote, "*I believe it is an effective form of treatment that should be approved for use by insurances even after COVID-19*." Another respondent stated, "*I would like to continue this service but I fear insurance companies will not continue to reimburse for it*," and a third wrote, "*Parity should remain between telehealth and in person sessions*." Similarly, several respondents described the need for phone reimbursement to continue to meet client needs (e.g., "*It is important that telehealth include audio only option. Many clients either lack Internet access or prefer not to use video but are quite comfortable on the phone*."). About 20% of responses also stated that respondents would like to be able to practice and bill across state lines. This was captured by a respondent who wrote, "*I would like it to continue and for states to allow licensing reciprocity for it to continue for people who need to eventually return to their out of state residences*." Finally, a few respondents indicated a need for continued supports for tele-behavioral health practice, including support regarding billing and compliance (e.g., "*I wish*

there was a database of every state and their reimbursement rates, reciprocity considerations, etc."), technology (e.g., "*checklist for patients and therapists on how to make sure their connections are the best they can be to avoid losses of poor connections during therapy hour*"), and other training supports (e.g., "*We need more courses on COVID related therapeutic issues that are showing up*.").

Discussion

The coronavirus pandemic has caused significant hardship. As of January 2022, more than 830,000 U.S. lives had been lost due to COVID-19 (Centers for Disease Control and Prevention, 2022), and the stress of the crisis has increased mental health needs and substance misuse (Czeisler et al., 2020; Ettman et al., 2020). Due to shutdowns and responsible social distancing practices, many people were unable to attend in-person behavioral health treatment or connect with social services. Yet, the present study found that during the pandemic, social workers overwhelmingly changed their practice to offer services to clients through telecommunication. Prior to the pandemic, less than a third of social work practitioners reported tele-behavioral health use. However, since the pandemic began, almost all participants in this study reported using technology to practice remotely. This study offers the profession a baseline of how a rapid transition was made during the pandemic and documents barriers to tele-behavioral health use and facilitators needed to sustain a tele-behavioral health model of care.

Although it is unclear how the global pandemic will progress, the behavioral health service delivery system has already been transformed. Many of the regulatory and reimbursement mechanisms implemented to address the COVID-19 global health crisis provide an example how policy changes could advance and expand tele-behavioral health practice. Further, respondents in this study and in others overwhelmingly report their intent to continue providing services through telecommunication after the pandemic (Tridiuum, 2020). Based on our findings, we suggest three mechanisms to support continued use of tele-behavioral health during the pandemic and beyond: (a) Ensure parity and reimbursement for tele-behavioral health, (b) train current and future social work practitioners in tele-behavioral health, and (c) provide supports to engage clients in use of tele-behavioral health.

Ensure Parity and Reimbursement for Tele-Behavioral Health

It cannot be overstated how CMS allowing for telehealth reimbursement without an originating site (CMS, 2020) transformed service delivery and social work practice in the United States. Prior to COVID-19, reimbursement was one of the largest inhibitors to tele-behavioral health (Mace et al., 2018). In the present study, social workers reported a threefold increase in the use of tele-behavioral health after the beginning of the pandemic, and only 17% of respondents indicated reimbursement

as a barrier to tele-behavioral health, demonstrating that changes to CMS during the COVID-19 crisis positively impacted use of tele-behavioral health. Further, more than 1 in 5 respondents in this study reported in open-ended responses that policy changes allowing them to bill for tele-behavioral health services were key to adoption of tele-behavioral health practice. Similarly, respondents reported that reimbursement parity for video- and audio-only services was a major factor in the success of tele-behavioral health use during the pandemic. This change, along with state executive orders, pushed private insurers to extend similar changes, which have increased access to care during the pandemic and kept many of the private practitioners we surveyed in business. Yet, the changes that were made are temporary, and many social workers in this study reported substantial concern about reverting to prepandemic regulations and practices. Now is the time to advocate and ensure long-term parity and reimbursement for tele-behavioral health even after the pandemic ends.

Train Current and Future Social Work Practitioners in Tele-Behavioral Health

Although the pandemic prompted many respondents to use free and paid training supports, less than a quarter of the sample had training on tele-behavioral health prior to the pandemic. This number was lower than reported rates in other related disciplines, including psychiatry and psychology (Glueckauf et al., 2018; Sunderji et al., 2015). Our findings indicate that training for social work practitioners in technology, administrative and compliance needs, and clinical engagement could increase the success of tele-behavioral health implementation.

Technology Training

Because the comfort and ease that social work practitioners have with the hardware and software needed to provide tele-behavioral health varies widely, additional training is needed. Although many telehealth platforms have similar features, there may be certain enhancements or components that require additional training, and social work practitioners may need assistance in discerning which platforms are most appropriate for their clients.

Administrative and Compliance Training

As was evidenced in this study, several administrative aspects of tele-behavioral health influenced the experience social work practitioners faced when transitioning to tele-behavioral health during the COVID-19 pandemic. Administrative components such as electronic forms associated with confidentiality, HIPAA compliance, how to secure electronic signatures and online documents, and scheduling programs to manage appointments were cumbersome, time-consuming aspects of transition.

Clinical Engagement Training

We found that tele-behavioral health was more challenging for social workers working with certain client populations, including children and adolescents, those who are hearing impaired, or older clients. Training on using tele-behavioral health with special populations is needed. In addition, certain models of care were used less with tele-behavioral health. For example, fewer respondents indicated they were delivering group interventions through telecommunication. Future research and training are needed to facilitate social workers' ability to use tele-behavioral health for multiple treatment types and to assess the efficacy of these interventions.

Going forward, increased emphasis is needed on how MSW programs train future social workers on the ethical, technical, and clinical components of tele-behavioral health practice—not just in response to COVID-19 but to keep pace with ongoing technological advances. The current national social work Education and Policy Accreditation Standards (Council on Social Work Education [CSWE], 2015) do not address tele-behavioral health within any of the required social work competencies, although CSWE does provide guidelines to demonstrate ethical and professional behavior in the context of emerging forms of technology. Moreover, in response to the COVID-19 crisis, CSWE (2020) issued a statement on the safe, ethical, and competent provision of telehealth, particularly for students, that is occurring within field placements. Additional work is needed to standardize goals for tele-behavioral health education for the future workforce and document progress in training social workers to provide care through telecommunications.

Provide Supports to Engage Clients in Tele-Behavioral Health

Although in some ways tele-behavioral health removes barriers to treatment (e.g., physical transportation to a clinic), many respondents indicated concerns that vulnerable individuals have limited access to the technology and/or privacy needed to access services. As tele-behavioral health takes hold during the pandemic and hopefully in the long term, finding ways to support client access is required.

Creating and producing content to help clients use tele-behavioral health technology is needed. Social workers likely do not have office support to prepare the client for the clinical session, as is commonly done within physical health settings that may include front desk staff, medical assistants, or medical scribes. This results in social workers using part of their clinical time to coordinate the use of the technology or offer technology instructions to clients.

Client barriers to services are a pressing issue within tele-behavioral health broadly and create specific challenges for social work due to the profession's emphasis on work with marginalized populations. It will not matter whether providers are trained in tele-behavioral health platforms and resources, or how much the social work workforce is scaled up for tele-behavioral health practice, if we are not simultaneously working to ensure client access. Clients' technological needs stood

out as a major barrier and concern that practitioners shared in this study and in a previous investigation (Drake et al., 2019). Clients must have access to broadband Internet (Benda et al., 2020; Drake et al., 2019), opportunities to learn technological/digital literacy, and have physical access to smartphones, computers, or tablets to support this way of connecting and receiving care. Moreover, providers must ensure privacy for remote services. Tele-behavioral health presents a new challenge for clients' privacy as the practitioner is no longer able to control the environment as they would in an office setting. Identifying resources and practices to help providers and clients ensure privacy while using tele-behavioral health is a barrier that must be addressed.

Nearly half of respondents in our study indicated that the clients they served were uninterested in using technology to receive care. Client buy-in is an essential element of service provision, and work remains to engage clients in tele-behavioral health. Although this study does not identify the underlying reasons for a lack of client interest, practitioners and researchers must explore this phenomenon further to ensure that services are responsive to clients' needs and desires.

Next Steps

The significant increase in the use of tele-behavioral health has opened practice opportunities but also raises questions about future use and next steps. One issue our respondents presented was the request to practice across state lines permanently, as many waivers allow practice across state lines just during the pandemic. For example, when college students had to return home when their schools closed to in-person learning, some governors signed executive orders allowing displaced students to continue receiving care from their existing providers via telehealth, even across state lines (Baker, 2020). Moreover, many states allowed providers who were licensed in other states to provide care using telemedicine or apply for expedited licensure (Bharel, 2020; New Jersey Legislative Assembly, 2020; Pennsylvania Pressroom, 2020). Although there are currently no permanent federal provisions or state compacts that allow social work professionals to practice over state lines, policy changes may be on the horizon. Certainly, practicing across state lines raises ethical issues and concerns regarding regulating practice. However, as the United States experiences chronic behavioral health workforce shortages, the use of tele-behavioral health and multistate licensing agreements may increase access to care. Future work should focus on how to support social workers' ability to practice (and be reimbursed) for services across state lines to maintain the continuity of clients' care and support their access to treatment.

Although evidence supports the use of tele-behavioral health (Barak et al., 2008), available research is lacking in participant diversity. The populations studied in the literature may not reflect the client populations most often seen by social workers. The profession must determine how tele-behavioral health applies to clients across

a variety of settings and with a host of psychosocial needs. This includes more research to better understand what clients perceive as the barriers or benefits of tele-behavioral health. Although this study did not survey consumers who received tele-behavioral health services, future work is needed to determine the benefits of and barriers to tele-behavioral health based on clients' needs and interests.

Limitations

Study findings should be considered in the context of the following limitations. Our sample was limited to NASW members who were at the master's level and provided direct behavioral health services. This convenience sample included social workers likely using tele-behavioral health but is not nationally representative of all social workers. Moreover, the study is confined by the response rate of 19%, which indicates that only 1 in 5 social workers who opened the e-mail for the survey participated. The study used a mixed-method design, which encouraged open-ended text responses from participants but did not allow us to answer deeper qualitative research questions that could be achieved through semistructured interviews. The study did not evaluate the effectiveness of the interventions provided through tele-behavioral health or survey clients using tele-behavioral health. Future work is needed to understand the effectiveness of tele-behavioral health for diverse client populations and strategies to improve client access to tele-behavioral health.

Conclusion

Although the COVID-19 pandemic has shifted almost every aspect of life, social workers and their clients have adapted to using tele-behavioral health to provide and receive care. Many, including the practitioners we surveyed, have indicated that they would like to continue to use tele-behavioral health after the pandemic. Similarly, many health policy groups suggest that the insurance and administrative limitations that were previously placed on tele-behavioral health should be permanently lifted. Evidence largely validates the use of tele-behavioral health, and findings from this study and others underscore the need for training and supports to sustain the momentum of tele-behavioral health.

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