COMMENTARY

Rapid telepsychology deployment during the COVID-19 pandemic: A special issue commentary and lessons from primary care psychology training

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Funding information
Health Resources and Services Administration, Grant/Award Numbers: D40HP33378, M01HP31388

Abstract

Objective: This article positions the special issue on telepsychology amidst the COVID-19 pandemic, which has dramatically accelerated the adoption and dissemination of telepsychology.

Method: The article makes general observations about the themes emerging in the special issue with considerations for application, training, theory-driven research, and policy. It then presents as a case example the rapid deployment during the pandemic of telepsychology doctoral training and services at the Virginia Commonwealth University (VCU) Primary Care Psychology Collaborative.

Results: Facilitators to VCU telepsychology deployment included trainee and supervisor resources, strong telepsychology training, and prior experience. Barriers to overcome included limited clinic capacity, scheduling, technology, and accessibility and diversity issues. Lessons learned involved presenting clinical issues, supervision, and working with children and adolescents.

Conclusions: Telepsychology is crucial for psychological service provision, during the COVID-19 pandemic more

than ever, and that is unlikely to change as psychologists and patients increasingly continue to appreciate its value.

1 | INTRODUCTION

Our commentary to this *Journal of Clinical Psychology* special issue on "Telepsychology: Research, Training, Practice, and Policy" has several purposes. We begin by making general observations about some of the themes emerging in the special issue with considerations for application, training, theory-driven research, and policy. We then position telepsychology amidst the backdrop of the COVID-19 pandemic, which arguably is a historical event that has had the largest impact on the provision of telepsychology services since the invention of the webcam. The article will present as a case example the rapid deployment during the pandemic of telepsychology doctoral training and services at the Virginia Commonwealth University (VCU) Primary Care Psychology Collaborative, which is funded by two grants from the Health Resources and Services Administration (HRSA) and at any given time trains over 30 psychology doctoral students across a dozen or so primary care psychology training sites. The article will focus on the changes being made at VCU to adapt from in-person services and training to telepsychology, successes, and supports in that adaptation, barriers encountered, and lessons learned for telepsychology training and service provision.

2 | TELEPSYCHOLOGY SPECIAL ISSUE

More than any other theme, the articles in this special issue underscore the critical nature of strong telepsychology training as a growth opportunity for the field. Pierce, Perrin, and McDonald (2020) found in their path model that the strongest predictors of psychologists' use of telepsychology were subjective norms, perceived ease of use, and perceived usefulness of telepsychology. Put simply, psychologists who do not use telepsychology do not feel that others are using it or that it is easy to use or useful. For these nearly 80% of psychologists, this has to change, and the primary way to do it is through strong telepsychology training implemented for trainees both early and often in their training, as well as practicing psychologists at various phases of their careers. Indeed, lack of training was the most frequently endorsed barrier to telepsychology use among mental health care providers (Perry, Gold, & Shearer, 2020). Caver et al. (2020) describe some of the excellent telepsychology training programing offered by the U.S. Department of Veterans Affairs (VA) and the VA's strong efforts to overcome barriers to training and implementation. The VA is at the forefront of efforts to support telepsychology provision. Dissemination and implementation (D&I) science is sorely needed in this arena to determine what variables have facilitated the D&I of telepsychology and telemedicine within the VA and other technologically progressive health care systems, as well as to apply those findings to other systems and settings.

In the opening editorial, Elliott (2020) identifies another of the most substantial barriers to the adoption of telepsychology: ourselves. Psychologists' bias against telepsychology can at times be profound, yet that bias runs counter to the overwhelming evidence suggesting that telepsychology is no less effective than in-person treatment for the vast majority of presenting concerns (Varker, Brand, Ward, Terhaag, & Phelps, 2019) and that it can be an excellent extension to in-person services such as aiding in assessment (Heesacker, Perez, Quinn, & Benton, 2020). Some seemingly obvious exceptions to this general rule may apply for specific clinical services, such as

neuropsychological assessment, although evidence is mounting that certain neuropsychological assessments can feasibly be administered through telepsychology (Galusha-Glasscock, Horton, Weiner, & Cullum, 2016). Telepsychology trainings and readings have to spend substantial time countering preconceived biases and educating psychologists and trainees that telepsychology works and how it can extend in-person services (Pierce et al., 2020). Theory-driven intervention research in this area would identify what barriers are present for psychologists (e.g., Perry et al., 2020), as well as exactly what types of information and experiences effectively help psychologists with strong biases against telepsychology overcome them.

Although psychologists sometimes voice negative views about telepsychology, our field has known for a long time that many potential patients have negative views about traditional psychological treatment. Ironically, telepsychological approaches such as wearable devices may actually be more appealing to people holding negative views toward psychological treatment and who have less experience in help-seeking (Hunkin, King, & Zajac, 2020). Other extremely promising web-based approaches that have the potential to reach individuals not entering traditional treatment, or as a supplement to traditional treatment, are showcased in this special issue, including Acceptance and Commitment therapy for college students (Viskovich & Pakenham, 2020), an avatar-based intervention for military family caregivers (Wilcox, 2020), and a self-management positive psychology intervention (Görges, Oehler, von Hirschhausen, Hegerl, & Rummel-Kluge, 2020). As Heesacker et al. (2020) note, web-based interventions such as these are showing respectable levels of feasibility and efficacy, although treatment computerization represents an extension of traditional mental health care providers, not a replacement.

Despite many of the intrapsychologist variables highlighted in the articles in this special issue that limit the D&I of telepsychology (e.g., bias, lack of preparedness, concerns about usefulness or efficacy), a substantial portion of barriers exist in the external environment, many of which have come to the forefront during the COVID-19 pandemic, as noted in more detail below. One of the most substantial is psychologist reimbursement issues, which are far less present in the VA and probably account in part for telepsychology and telemedicine's relative success there. Few private insurance companies reimburse for telepsychology services at the same rate as in-person services, or at all. Federal legislation is critical mandating that insurance companies' reimbursement policies align with the comparative outcome effectiveness of telepsychology and in-person treatment. Further, widespread adoption of interstate practice agreements in the United States are necessary for the full success of telepsychology, such as the Psychology Interjurisdictional Compact (PSYPACT), which facilitates telepsychology practice across jurisdictional boundaries. In most states, both the psychologist and patient have to be physically in the state in which the psychologist is licensed. By contrast, a licensed psychologist working at a VA medical center can treat a veteran in any other state, again showing the VA's forward thinking on these issues and the potential for public policy to expand the reach of telepsychology.

3 | COVID-19 PANDEMIC

It could not be more fortuitous that this special issue was scheduled to go to print amidst the COVID-19 pandemic, which has dramatically altered the telepsychology and telemedicine landscape in the United States and in other global regions. The World Health Organization (WHO) was informed on December 31, 2019 that several cases of pneumonia of unknown etiology were detected within China's Hubei province (WHO, 2020a). On January 7, 2020, Chinese health authorities announced they had identified and isolated a new type of coronavirus (i.e., 2019-nCoV, COVID-19, or coronavirus) associated with the cluster of detected respiratory infections within Wuhan city. Five days later, China shared the genetic sequence for the virus with other countries to develop diagnostic testing. By January 20, a total of 282 cases of COVID-19 had been detected across China, Thailand, Japan, and the Republic of Korea (WHO, 2020a).

On January 19, a 35-year-old male entered an urgent care clinic within Washington State after several days of coughing, nausea, and a fever. Before seeking treatment, he had been visiting family in Wuhan, China and had

returned to the United States. On the following day, the Centers for Disease Control and Prevention (CDC) confirmed that the man's nasopharyngeal and oropharyngeal swabs had tested positive for COVID-19 (Holshue et al., 2020). By the end of February, 85,403 COVID-19 cases had been confirmed globally, with 62 total cases confirmed within the United States (WHO, 2020b). On March 11, 2020, the director of the WHO announced that they had characterized the COVID-19 virus as a pandemic (WHO, 2020d).

During crisis-related surges in health care needs, effective strategies have been developed to help patients and communities manage acute stress, preserve medical supplies, and maintain the mental and physical health of patients and health care staff (Tadmor, McManus, & Koenig, 2006). For example, in anticipation of higher demand, and to decrease the risk of virus transmission between individuals, the CDC and the American College of Surgeons (ACS) recommended that health care providers postpone elective procedures and routine patient visits (ACS, 2020; CDC, 2020). As projections revealed major metropolitan areas had insufficient capacity to meet anticipated demand, temporary health care facilities were established in public spaces such as the New Orleans Convention Center (The Associated Press, 2020), New York's Javits Center (Lardieri, 2020), and Central Park (Torres, 2020). Also, the hospital ships United States Naval Ship (USNS) Comfort and USNS Mercy were deployed to New York and Los Angeles to serve patients without the virus (Correll, 2020; U.S. Naval Institute, 2020).

Based on the speed of transmission and delayed onset of symptoms of COVID-19, the WHO strongly recommended physical distancing between individuals (WHO, 2020c) to avoid overwhelming health care infrastructure. Guided by this, large gatherings were canceled, many schools shifted to web-based learning, companies adopted telecommuting for employees (Adalja, Toner, & Inglesby, 2020), and health care organizations greatly expanded their use of telehealth (Nitkin, 2020; Stiepan, 2020; VHA, 2020). The need for physical distancing during the pandemic comes at a psychological cost for communities. There exists a rich body of literature revealing a relationship between social support and mental health (Harandi, Taghinasab, & Nayeri, 2017). Catastrophes and disasters are associated with higher levels of psychological distress, depression, anxiety, panic, posttraumatic stress disorder, and interpersonal problems in affected communities (Norris, Friedman, & Watson, 2002; Norris, Friedman, Watson, Byrne, et al., 2002). Furthermore, the stress and anxiety that communities experience during periods of heavy media coverage of a disease have been associated with a surge in patient volume within emergency departments several days before the actual arrival of an epidemic within the community (McDonnell, Nelson, & Schunk, 2012). Physicians have also reported experiencing distress and psychological trauma after being forced to make difficult ethical decisions about the allocation of resources during the COVID-19 pandemic (Shurkin, 2020).

3.1 | National deployment of telemedicine amidst COVID-19

This troubling mix of isolation and psychological distress makes it vital for psychologists to have flexible options for treating patients and communities. As noted in this special issue, the use of telepsychology and telemedicine can enable skilled providers of mental and physical health care quickly to shift their focus to the locations where they are needed the most at any given time. It allows them to treat people in areas that may be difficult or dangerous to travel to, or would limit productive time if they were required to travel in person to multiple sites (Darkins, 2016; Tadmor et al., 2006). Telepsychology also provides an opportunity for psychologists in rural areas to contribute to the surge capacity of larger communities during a crisis (Tadmor et al., 2006).

Recognizing several longstanding impediments to telepsychology's and telemedicine's adoption, agencies within the U.S. government quickly pivoted on multiple policies, unleashing telepsychology's and telemedicine's ability to play an important role in delivery or care during the COVID-19 pandemic. On March 16, 2020, the "in-person" requirement set forth by the Ryan Haight Act was suspended indefinitely, allowing practitioners to prescribe Schedule II–V controlled substances as long as the exam occurred using a two-way, audio-visual, real-time communication system (U.S. Drug Enforcement Administration Diversion Control Division, 2020). Additionally, Medicare and Medicaid temporarily increased access to care by allowing psychologists, licensed clinical social

workers, physicians, and nurse practitioners to be reimbursed for telepsychology and telemedicine visits with patients across the country, including within patients' homes, and at the same rates as in-person visits (U.S. Centers for Medicare & Medicaid Services, 2020). The American Psychological Association advocated for reimbursement parity for telepsychology sessions conducted by phone only (DeAngelis, 2020). The Department of Health and Human Services' Office for Civil Rights (OCR) also temporarily waived the HIPAA Security and Privacy Rule requirements that had previously prevented the use of common communications apps such as FaceTime and Skype (U.S. Department of Health and Human Services' Office for Civil Rights, 2020a, 2020b). These important changes in response to the global emergency highlighted the numerous, long-standing obstacles to telepsychology and tele-medicine adoption that have resulted from policies and regulations within the United States.

In response to unprecedented public demand for their services, telepsychology and telemedicine providers such as Doctor on Demand, Teladoc, and American Well began recruiting psychologists and physicians as demand outstripped their current capacity (Pifer, 2020). Unfortunately, the increased video conferencing and streaming services demands pushed the limits of the infrastructure and personnel that support the Internet. Ookla, a company that monitors and provides network speed reports, observed diminished global network speeds and higher latency levels during March, 2020 (Ookla, 2020). Atlas, a virtual private network (VPN) provider, reported a 53% increase in VPN usage during the second week of March in comparison to the previous week (Atlas, 2020). As a result, this made telepsychology and telemedicine adoption more difficult. For example, VA employees experienced problems with very slow data transfer rates and network instability. This made it difficult for patients, psychologists, and physicians trying to leverage the VA's VideoConnect telemedicine platform (Tahir, 2020), laying bare some of the technological challenges still present in the use of telemedicine.

4 | PRIMARY CARE PSYCHOLOGY TRAINING AT VCU

Amidst this ever-shifting pandemic, psychologists and psychology training sites across the United States scrambled both to continue and adapt their services and training models. For over a decade, VCU has had a training model built on placing psychology doctoral students in integrated care settings. The VCU Primary Care Psychology Training Collaborative (PCPTC; see pcpsych.vcu.edu) began in 2008 as an initiative to train psychologists to meet the national workforce demand for psychologists trained to work in integrated primary care in what was then a newly emerging specialty area of integrated behavioral health. The unique competencies in delivery of this type of service include interdisciplinary collaboration, provision of brief problem-focused interventions for both mental health and health behavior concerns, briefer and less frequent sessions, and flexibility for accepting same-day handoffs from other providers. Integrated care is widely recognized as a particularly important care model for reducing mental health disparities by minimizing barriers and enhancing access in underserved populations where mental health services are otherwise limited. HRSA has been funding training programs in integrated primary care because doing so meets their dual mission of filling the health care gap for underserved populations with trainee-provided services and developing a workforce who have the skills and motivation to serve these communities. The VCU PCPTC has been continuously funded by HRSA since 2008 and has funded over 100 trainees who provided more than 18,000 sessions of pro bono care during that time. Currently, we operate in 12 different adult and pediatric safety-net clinics in the community, have 5 faculty supervisors, 17 funded doctoral trainees, and another 15 more junior practicum trainees. The clinics we partner with run the gamut from large university-based training clinics primarily serving low-income patients to smaller free clinics that operate with private funding and a workforce of volunteer clinicians to supplement a limited number of paid staff. Two of our partners are clinics which have their own in-house mental health clinics, with one being a large federally funded clinic serving in-dividuals who are at risk for homelessness.

The services provided by our trainees address a wide range of issues in both children and adults, including mental health concerns such as depression, anxiety, anger management, anxiety, depression, grief, neurocognitive

screenings, parent-child relationship issues, postpartum depression, psychosis screenings, risk assessment of potential harm to self or others, stress management, and trauma-informed care. Common health behavior issues that are addressed include adjustment to chronic medical conditions, diabetes management, chronic pain, insomnia, smoking cessation, substance use, and weight loss. The overall focus is on equipping future psychologists with the skills to work in the fast-paced world of primary care psychology, providing first-line behavioral health services in the same place where patients receive their routine medical care. These patients in general face a wide array of environmental stressors and traumatic experiences (Baylor Williams et al., 2019), having received either inadequate or no behavioral health services in the past. Studies have shown that the brief services delivered by our team are effective in reducing anxiety and depression (Sadock, Perrin, Grinnell, Rybarczyk, & Auerbach, 2017) and reducing preventable hospitalizations (Lanoye et al., 2017).

5 | TELEPSYCHOLOGY DEPLOYMENT AT VCU AMIDST COVID-19

Very shortly into the COVID-19 pandemic, it became apparent that our large network of in-person integrated care training and service provision was not going to be viable. Though this eventually turned out to be true across the board nationally among integrated care professionals, once social distancing became the norm, it was more apparent in the early going of our training because of the fact that all of our clinicians are trainees, who are students first and clinicians second. That creates a different calculus about risk considerations for the clinicians, especially in light of the differential power that trainees have, which limits their perceived ability to express safety concerns to their supervisors, who serve as gatekeepers to their entry into the profession.

Unfortunately, many of the unique strategic advantages of integrated primary care psychology turned into disadvantages in the context of the pandemic and quarantine. Sharing clinic space, conference rooms, and exams rooms with physicians and their acutely ill patients became a hazard for both the psychology trainees and the patients who were going to a primary care clinic solely for their mental health visit or staying for a second longer period when combining visits, thereby increasing their potential exposure. What in normal times is a highly effective way to reduce mental health disparities for low-income or racial/ethnic minority patients, in this situation put those populations at even greater risk by having those treatments occur in a medical environment, often necessitating traveling on public transportation, creating even more risk exposure. Furthermore, a high percentage of patients in safety-net settings have multiple chronic health conditions, making them more vulnerable to the life-threatening complications of COVID-19. Of note, a large portion of our safety-net patients are Black/African American, and the early data are demonstrating that this group may be disproportionately affected by COVID-19 (Ahmed, Ahmed, Pissarides, & Stiglitz, 2020).

5.1 | Facilitators of telepsychology deployment

For all these reasons, our faculty supervisors made the decision in the early going of the pandemic to begin an immediate transition to telepsychology services across all of our 12 primary care training sites. We were aware it was going to be a large undertaking because of the large number of clinics, each with its own culture and response to COVID-19, but we had several advantages going for us. First, we are a very large program with 17 funded trainees and five faculty supervisors funded for part of their time. With mandated in-person clinical work suspended immediately (by the both the clinics and the university) and our university closed for 2 weeks, we were able to bring to bear a tremendous amount of person power toward drafting the start-up plans. That allowed us to have separate teams for each site to establish new procedures for contacting, consenting, and scheduling patients who were shifting to exclusive telepsychology services. Second, because one of our HRSA-funded grants had mandated that we add a telepsychology service and training program that we had been working on for 6 months, we were

already moving toward the training and policy changes necessary for the delivery of telepsychology. Third, we were able to leverage the online training created by our university clinic for their transition to telepsychology services. Each student was required to complete this self-guided online training before seeing their first telepsychology patient. Last, we were fortunate enough to have several faculty supervisors with substantial prior experience as telepsychology clinicians, and in one instance, robust research and grant-related experience in the area of telepsychology.

5.2 | Challenges in telepsychology deployment

5.2.1 | Limited clinic capacity

As we made our rapid transition to telepsychology, we needed to adjust to the unique parameters of each site. Therefore, supervisors collaborated with key personnel at individual sites (e.g., medical directors, head nurses, head administrators) to identify site-specific changes to our procedures. For example, some sites provided the administrative support to reach already scheduled patients to inform them of our move to telepsychology, whereas others preferred for our team to take the lead in contacting patients. Similarly, while all of our clinics had electronic medical records that could be accessed remotely, some sites did not have the capacity for us remotely to enter appointments into their scheduling system, and thus we had to create our own password-protected and encrypted schedules. Those schedules were then shared with the medical staff so they could add a patient as needed and know which patients had attended telepsychology appointments.

The fundamental premise of primary care psychology is to provide brief services to as wide a cross-section of patients as possible, aiming to improve the behavioral health of the entire clinic population. To achieve the promise of this population-based approach to primary care, a steady flow of referrals from physicians and/or routine screenings are needed. However, nationally and within our primary care clinics as well, there was a dramatic cutback in primary care visits, especially visits aimed at chronic conditions, routine check-ups, or prevention. Furthermore, our free clinic partners that rely on part-time volunteers to provide a percentage of their care had to furlough many of those volunteers for safety reasons. Seeing fewer patients leads to fewer referrals. Additionally, with our primary care colleagues in medicine embarking on their own steep learning curve to shifting to telehealth, some of our clinicians lost bandwidth they usually have to discuss behavioral health issues with their patients. Lastly, without our physical presence in their workspace, our medical colleagues did not have the usual visual reminders or verbal prompts from our clinicians asking for referrals. This sudden drop-off in referrals was experienced across the spectrum of integrated care providers nationally, who were weighing in daily on listservs about their challenges with similar transitions in integrated care.

5.2.2 | Scheduling

Another advantage of the integrated care model is being able to schedule medical and behavioral health/psychology appointments back to back. This decreases barriers such as transportation and efficiency in taking time off from work or finding child care. But with telepsychology, this actually poses a greater challenge in some cases. With some medical appointments still taking place in person, patients were not in a private space right before or after their appointment but entering or leaving the clinic, making it difficult to "attend" their telepsychology appointment.

While no-shows are generally less common with telepsychology, patients can sometimes take the clinician's time for granted and can attach less importance to sessions where they do not have to make the investment of showing up in person. Patients were not always "available" at the time of their appointment. In one case, a woman's

partner answered the phone and shared her message that she was getting her nails done and was not available. Other times, patients had been sleeping, had just woken up and engaged in the session in bed, were eating during a session, or spent the initial few minutes of the session trying to find a quiet location within their residence. The latter was especially challenging for patients with children or roommates. Given the greater possibility for unexpected disruptions to plans, it was not uncommon for patients to ask our clinicians to call back at a later time.

5.2.3 | Technology

Another challenge in rolling out telepsychology services was getting patients to feel comfortable using video-conferencing services. Initially, most of our telepsychology visits were conducted via telephone, due to patient preference and concerns about using an unfamiliar technology. As one integrated care professional concluded after surveying his colleagues about how many clinicians were finding this same challenge, despite all of our efforts to set up videoconferencing the telephone is still king. As a result of this trend, our therapists were having to learn to navigate telepsychology sessions relying solely upon verbal cues (e.g., tone of voice).

Even with this initial bias toward choosing telephone services, we continued to push toward providing more and more services via Zoom videoconferencing, for the obvious advantages it affords in communication and rapport building. Another barrier was also the comfort level of the trainees, as the phone in some ways was an easier adjustment, and the thought of walking a patient through navigating Zoom felt like an additional hurdle. As our trainees became more confident in telepsychology delivery, they also became more comfortable in selling this upgraded service. Also, as patients begin using video service with other health care providers and even for social visits with family and friends during this extended period of social distancing, we are anticipating they will feel more comfort with this technology.

5.2.4 | Accessibility and diversity issues

Our primary care psychology team contended with a number of accessibility and diversity challenges in the provision of telepsychology services to the marginalized communities with whom we work. We had difficulty reaching some patients, and many did not recognize the masked or "blocked" phone number calling them. Others did not have voicemail systems set up or had full voicemail boxes. Accessibility concerns, such as restricted data for video telepsychology calls and limited use left on prepaid phones also constrained patients' ability to engage in telepsychology. Furthermore, a subset of patients were undocumented immigrants or had undocumented family members, and we recognize that they may not have wanted to show on video their location during a telepsychology call. Similarly, patients and their families may not have wanted to show their homes on video either. By contrast, many patients were very open to telepsychology delivered via telephone if they had concerns about video.

As another inclusion-related challenge, we realized that we needed to translate our telepsychology informed consent script into Spanish. Some of the clinics with whom we work did not have reliable translation services during this time, and therefore, our Spanish-speaking doctoral trainees were providing care for those patients and their families who needed sessions in Spanish. Thus, we had our team of Spanish-speaking clinicians translate and back-translate our consent script, with their bilingual supervisor checking their work. Finally, as is true across the nation, many low-income families include adults who were essential workers (e.g., in construction, food service, nursing). Thus, we found that our patients' families were having to balance trying keep each other safe from any possible contamination when that person returned home, which, in turn, was contributing to the stress level of our patients and their families.

5.3 | Lessons learned in the telepsychology transition

5.3.1 | Presenting issues

Though we anticipated that patients would be primarily focused on COVID-19 once we resumed services, many were ready to "get back to work" on their primary issues and were not as focused on the pandemic as we had been anticipating. For new referrals, however, a primary driver was often the current pandemic (anxiety, panic attacks, worry about COVID-19 risk, etc.). Common stressors for our lower-income patients included loss of employment, or being furloughed, and financial strain. The increased presence of children in the home was stressful for some families. Many of our patients also had chronic health conditions and had been worried about being more vulnerable to the worst COVID-19 outcomes. In addition, some of our patients included those without consistent housing or food sources, and one reported being homeless and living out of their car. They worried about the risk of a total shutdown (e.g., not being allowed to be on the street at all, even in their car) and being unable to find shelter.

Even when working on the primary behavioral health issues that preceded the pandemic, there were new twists and problems that were exacerbated. Of significant concern was the exacerbation of intimate partner violence as a result of the additional risk factors associated with being unable to leave the home as often and increased stress. For our patients with substance use and depression particularly, discussing engaging in behavior substitutions and enjoyable or pleasurable activities was especially difficult with the stay-at-home orders. Individuals who were trying to quit smoking often found themselves returning to a higher level of smoking. Similarly, individuals who were working on a plan to lose weight by reducing calorie consumption and increasing exercise tended to have more difficulty adhering to those plans.

It became clear that our underserved patients with chronic conditions were being dissuaded by social distancing policies and the crisis mode of the medical community from having routine care visits with their physicians at their primary care clinics. Combined with the reduced availability of other safety-net services in the community (e.g., social services, food banks), many of our patients began reporting a feeling that they had been left behind or deemed a lower priority during the pandemic. Our clinicians noted that patients often expressed relief and gratitude that we continued to be available for our usual level of services—and that we were even more accessible now that they did not need to travel to the appointment.

We found that a subset of patients actually preferred telepsychology services to the in-person visits we had only formerly offered. That meant we were able to reach patients who had previously declined services because of transportation issues. One partner clinic, in particular, focuses on high utilizing patients who have a high number of chronic medical conditions (at least seven to qualify for the clinic). Our trainees at that clinic historically had trouble getting patients to come in for longer, behaviorally focused sessions, and no-shows were common. After the shift to telepsychology, the number of appointments soared and no-shows became a non-issue. Similarly, another clinic where the physicians are very invested in making referrals to behavioral health saw an increase in the number of patients accepting referrals because the barriers became lower for attending these sessions. As a result of this lesson, we already plan greatly to increase our telepsychology offerings after the pandemic recedes. We have discussed how it is probably best to have the first session occur in person, where rapport can be built and assessment instruments can be easily filled out, and then offer to hold future session on the phone or videoconferencing.

5.3.2 | Supervision

Supervision, which also shifted to strictly telephone or videoconferencing, also had to change substantially. One of the distinct advantages of integrated primary care is the efficiency of the real-time formal and informal peer and team supervision that occurs for trainees. Clinicians often sit in the same space between patient visits and discuss

patients among themselves, with the supervisor who is often present on site, and with the medical providers who also typically sit in the same space. The notes of new referrals are reviewed before the session and there is a discussion with members of the trainee's "support team" about what approach might be taken. Due to the norms of primary care, there is also the one-of-a-kind opportunity to interrupt a session to step out for real-time consultation with peers or other medical providers. All of the advantages were upended by the shift toward a virtual team with only videoconference contact with the supervisor and other peers and team members.

With trainees operating in more of a silo when delivering care, the antithesis of what is best about integrated care, we found a need for more supervisor time per trainee and case. We also adapted to this loss of team support by developing a parallel virtual team meeting before each shift. Trainees connected through Zoom videoconferencing for shift check-ins at the beginning of each shift, discussing shift responsibilities (e.g., responding to clinic messages), and ensuring that we followed through with our commitments to each clinic.

Given that the effects of the pandemic were reaching everyone across the world, we knew that our own graduate student therapists might be experiencing their own challenges. Indeed, there was some initial anxiety about transitioning so quickly to telepsychology, but that anxiety was generally outweighed by the desire to provide services to our patients. One strategy, which we feel aided in the transition to telepsychology, was the gradual start-up of graduate student therapists delivering telepsychology. We started with our most senior (fourth-year) graduate students providing the initial telepsychology services and then started our more junior therapists. Our staggered training plan allowed the senior graduate student therapists to work through any wrinkles in the initial plan and to decrease their own anxiety around telepsychology before starting our more novice trainees. Additionally, it was helpful for our team to discuss the ways in which face-to-face and telepsychology provision of services are similar (e.g., teaching a new parenting skill and then having a caregiver brainstorm how they could use it at home).

5.3.3 | Working with children and adolescents

Delivering telepsychology to a vulnerable population, such as children and adolescents, presented our team with a unique set of challenges, which compelled our pediatric behavioral health team to make a number of operational changes, adapting to the shifting service delivery landscape at our medical center. Our first steps in pediatrics were to check in with our medical team partners, to familiarize ourselves the new policies around pediatric well and sick visits, and to obtain their feedback on our tentative plan for telepsychology deployment. Generally, our plan was to offer telepsychology to families referred to us via their pediatrician, with an emphasis on prioritizing those presenting problems that have been a good fit for our behavioral health services thus far: adolescents and young adults with internalizing concerns (i.e., depression, anxiety) and children with home behavioral concerns. We hypothesized (and subsequently confirmed) that many of our patients' caregivers who had school-related concerns would choose to pause their sessions with us, given the current school closures. For the time being, warm hand-offs would be suspended as well. After conferring, our primary care psychology supervisors and medical team leaders (i.e., directors of the primary care clinics, nursing, and patient services) approved of the telepsychology plan to continue the provision of behavioral health services to pediatric patients and that we would check in regularly to discuss ongoing clinic needs and any feedback about the new pediatric primary care telepsychology services.

With the plan in place, we began to start the roll-out of telepsychology services. Once their telepsychology training (detailed above) was complete, our graduate student therapists began calling all patients and their caregivers on our schedule for the upcoming week to inform them that we were moving to a telepsychology model of care during the pandemic and to gauge their interest in continuing care under this model. Many families were glad to hear from our team, but felt that behavioral health services for their child was no longer their top priority. Approximately half of our current patient load decided to continue care with us via telepsychology. Using a structured consent form, our team obtained and documented verbal informed consent to treat via telepsychology

with these families. Thus, our pediatric primary care psychology team delivered telepsychology services to many of our teens with depression and/or anxiety, which for some, was exacerbated by the COVID-19 pandemic and the social distancing and stay-at-home orders in our locale. Given the increased amount of time that caregivers and children were spending together due to school closings, many caregivers felt stressed and in need of stress management techniques and/or behavioral parent training. Our team also provided those therapeutic strategies via telepsychology. Additionally, while we had a very structured crisis management plan in place for any acute issues (e.g., suicidality), we have not yet had to use it. Communication with our medical colleagues went very well. We had some initial worries about not being colocated in the clinics during this time and losing some of the face-to-face time that had seemed vital to maintaining our presence as team members. However, communication via secure email as well as the electronic medical records were seamless as we all worked toward the common goal of providing good family-centered care.

Despite our successes, there were some barriers to serving our pediatric families via telepsychology. For instance, as with our adult clinics, our patient load decreased, as many referrals were for school-based concerns. Additionally, we were no longer obtaining referrals via warm hand-offs. Also, there may have been some families who had other significant concerns (e.g., paying rent, losing their job, taking care of an ill family member). Given that our patient population is from the communities being hardest hit by COVID-19 (i.e., low-income, predominantly Black/African American families), it is no surprise to us that child behavioral health concerns were not at the top of the list of priorities for families.

Providing evidence-based services via telepsychology through our pediatric clinics presented another challenge. It was difficult to have telepsychology sessions with caregivers who had young children, as those children were often in the room, making noise, needing their caregivers' attention. In clinic, we were able to have a graduate student therapist assist with childcare; that is not possible with telepsychology. Therefore, we are still navigating the best ways to provide telepsychology to parents who have more chaotic home environments (e.g., scheduling an appointment during a child's naptime).

6 | CONCLUSION

As the articles in this special issue and our recent experiences in the rapid transition to telepsychology—as well as those of the larger field—show, telepsychology is crucial for psychological service provision, now more than ever. Telepsychology has a demonstrated ability to expand services to underserved and hard-to-reach populations, and its wide applicability makes it extremely well-suited to become a permanent fixture of our profession, particularly with the support of strong public policies. The COVID-19 pandemic and its wake will likely influence daily life of people across the globe for the foreseeable future, but perhaps one positive and lasting feature is its historic influence on the D&I of telepsychology.

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