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The decline in the provision of psychosocial services during the COVID-19 pandemic and the barriers to moving to online forms of care from providers' perspectives

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Abstract

Introduction: According to the WHO, the COVID-19 pandemic has disrupted or halted critical mental health services in 93% of countries worldwide while the demand for these services continued to increase. Studies have investigated significant psychological consequences of social isolation and economic insecurity on the population's mental health. The research evidence points to elevated scores of negative mental health indicators (anxiety, depression, and distress) over time during the pandemic. At the same time, many research findings indicate that substitution in the form of online care delivery is adequate for many client groups. This study aimed to investigate the extent to which the provision of psychosocial services in clinical psychology, school counseling, and social services has changed because of the restrictive measures of the COVID-19 pandemic in Czechia. We were also interested in what barriers to online service provision existed and which clients were considered unsuitable for this form of care from the care providers' perspective.
Methods: We applied an online survey featuring a 30-item questionnaire with both closed and open questions to the sample of 441 participants selected using purposive sampling through institutions.
Results: A comparison of the pre-COVID-19 and COVID-19 operations in the first wave shows significant declines in all services provided across all main areas of psychosocial care. The overall average percentage decline across all outcomes combined was -34%. Given the need for the care shown on the part of the clients, we interpret it as a failure to ensure the availability of care as needed. The most common obstacles of online care mentioned were feeling of the impersonality of the online

meeting, lack of a comprehensive visual overview of clients, concerns about maintaining quality standards, the impossibility of physical contact and application of diagnostic methods, internet connection problems, lack of privacy and disturbance by others, absence or poor quality of technical resources, communication misunderstandings due to technology, lack of time to work caused by the pandemic, and inappropriate employer attitudes and regulations.
Discussion and Conclusion: Despite research findings, providers identified most groups of clients or diagnoses unsuitable for online care.

Key words: Barriers; COVID-19 pandemic; online psychosocial care; online survey.

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INTRODUCTION

On 11 March 2020, the World Health Organization (WHO) assessed that Coronavirus disease 2019 (COVID-19) can be characterized as a pandemic [1]. According to a WHO survey, the COVID-19 pandemic has disrupted or halted critical mental health services in 93% of countries worldwide, while the demand for these services has increased [2]. During the COVID-19 situation, the Czech government repeatedly declared and extended states of emergency throughout the whole territory of the Czech Republic. Strict lockdowns and individual and collective quarantines imposed to minimize the spread of the virus involved various interventions such as social distancing, limited mobility, school closures, bans on public events, and various personal protective measures.

Previous studies have investigated the significant psychological consequences of social isolation and economic insecurity on the population's mental health [3-5]. Fear, anger, and hopelessness were the most frequent traumatic emotional responses in the general public during the first COVID-19 outbreak in the Czech Republic. The four most frequent categories of fear were determined: fear of the negative impact on household finances, fear of the negative impact on the household finances of significant others, fear of the unavailability of healthcare, and fear of an insufficient food supply [6]. Winkler's study analyzed prevalence trends in mental disorders before and during the COVID-19 pandemic [7]. The prevalence of both major depressive disorders and the risk of suicide tripled, anxiety disorders almost doubled, and there was also a significant increase in weekly binge drinking behaviors. The research evidence points to elevated scores of negative mental health indicators (anxiety, depression, and distress) and the deterioration of symptoms over time during the pandemic. Women, especially those with children, young people, and people from households facing a significant drop in income or with interrupted working status, were among those most affected [8,9].

The dramatic epidemiological situation and rising hospitalization rates affected the general provision of health and social care and the ability of the public to access these services. Despite international differences, mental health care and psychosocial services in many countries were unprepared to respond to a worldwide pandemic [10-14]. These findings emphasized an urgent need to provide increased access to high-quality health and social care by utilizing telemedicine services and continuing to use them in the future [15-17].

Videoconferencing has been proven to be an accessible and effective means of remote connection for families [18-19] and children and young people [20-22] and of interventions for older adults [23,24]. Previous studies have shown that various psychosocial issues have been successfully treated with videoconferencing. These included anxiety and depression [25-28], post-traumatic stress

disorder [29-31], obsessive-compulsive disorder and affective disorders [21,32], bipolar disorder [33,34], eating disorders [35], substance use [36-38], anger [39,40], and pain management [41-43].

While the usage of videoconferencing to treat mental, emotional, and behavioral health conditions of mild-to-moderate severity has been supported by the majority of research, there is some debate among experts regarding the application of such approaches to more severe mental health disorders or clients in crisis. Despite growing empirical evidence of the feasibility of telemental health interventions for severe mental illness populations [44-47], concerns regarding acute suicidal clients [48], clients with severe psychosis, impulse control, or mood dysregulation [49], and antisocial personality and addiction [50] are some of the subjects of disagreement. Further research should explore to what extent the online modality is appropriate for severe mental health problems or conditions possibly associated with acute client crises.

Despite positive client satisfaction [51,52] and the significant benefits of videoconferencing – "(1) increased access to psychotherapy and service availability and flexibility; (2) therapy benefits and enhanced communication; (3) advantages related to specific client characteristics (e.g., remote location); (4) convenience, satisfaction, acceptance, and increased demand; and (5) economic advantages" [53] – mental health providers have had many unique concerns about the remote delivery of their services.

Some findings suggest that external factors such as the necessity of care [54], usefulness in the context of improved access for clients [48,55], having dedicated staff responsible for promoting and managing the new service (e.g., on-site champions and telemental health technicians), or organizational policies supporting telemental health modalities [56,57] also influence the implementation of online services.

This study aimed to investigate how the provision of psychosocial services in clinical psychology, school counseling, and social services has changed because of the restrictive measures of the COVID-19 pandemic. We were also interested in what barriers to online service provision existed and which clients' providers considered unsuitable for this care.

METHODS

Study design and population

Data collection was carried out in the summer of 2020, i.e., immediately after the first wave of restrictive measures against the spread of COVID-19 in spring involving a lockdown which, in the Czechia, mainly affected all levels of schools, health care (excluding acute care), retail and the majority of services, and social and cultural events. An online survey featuring a 30-item questionnaire was applied. The survey took an average of 19 minutes to complete. The questions concerned a description of the expertise and type of services offered, a comparison of the number of contacts and clients under normal versus the restrictive conditions specified above, the forms of care provided during the lockdown, the most common barriers on the part of organizations, clients, and practitioners, and, last but not least, the support they would welcome in this situation. Descriptive statistics were found to be entirely sufficient for evaluating the data.

Study participants

Participants were selected using purposive sampling through institutions. We approached major professional associations relevant to the fields under consideration and asked them to distribute the questionnaire. After ineligible responses had been excluded, a total of N = 441 participants completed the online survey, including 79 males (18%) and 355 females (80%); seven participants (2%) did not indicate their gender. The mean age was 45 and the median 44, with the minimum and maximum ages being 22 and 78 years, respectively. Regarding specializations (multiple answers possible), the sample comprised 167 psychotherapists, 133 clinical psychologists, 114 psychologists, 106 social workers, 39 therapists, 31 counselors, 28 special education teachers, 19 physicians (primarily psychiatrists), 18 addictologists, and 12 education professionals. Other jobs reported with less frequency included art therapist, clinical speech therapist, crisis intervention worker, mediator, lawyer, psychiatric nurse, supervisor, leisure time specialist, and researcher. A total of 184 participants (42%) worked in health care, 149 (34%) in social services, 58 (13%) in

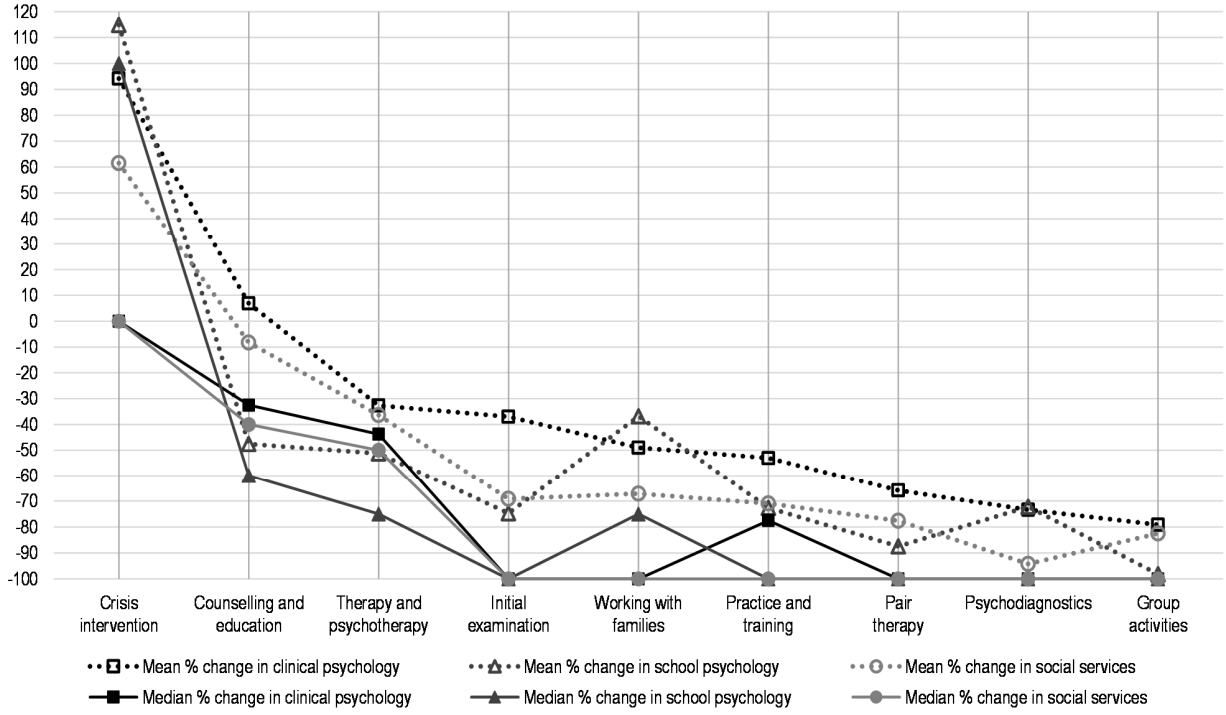
education, and 50 (11%) in other areas. A total of 183 participants worked in the private sector (41%), 148 (34%) in the public sector, and 110 (25%) in the non-profit sector. The response rate, i.e., the percentage of those who responded versus those who viewed the initial information but did not proceed to complete the questionnaire, was 46%.

RESULTS

The results reflecting the experience of the first wave of the lockdown suggest that the practitioners and organizations included in the study witnessed changes in the numbers of clients and interventions during the COVID-19 pandemic. With certain exceptions, the level of service provision during the spring 2020 wave of the pandemic dropped dramatically compared to the previous norm, which, given the increase mentioned above in treatment demand on the part of the clients, could be construed as a failure to deliver. We believe this shortfall was due to the services not being prepared for providing care under conditions posing no sanitary risks or in a distant mode. Since the absolute numbers of clients and interventions varied considerably (some reported data for themselves only, others for the entire facility, etc.), we chose a change in percentage terms as the best indicator. This was first calculated for each provider and then, as a mean and median, for the entire sample. It needs to be considered that some providers (e.g., pedagogical-psychological counseling centers) halted their operations. In contrast, others (e.g., clinical psychologists in hospitals) worked in a mode similar to that followed under standard circumstances.

The overall mean percentage decline for all the interventions in the aggregate was 34%. The median was 44%, the upper quartile 14% (i.e., 75% of the services recorded at least a 14% decrease), while the lower quartile was 69% (i.e., 25% of the services experienced a 69% or more significant decrease). In total, 29 providers reported having completely ceased to provide their interventions, and 41 providers, on the other hand, reported an increase in the number of interventions. A detailed overview of the results by interventions and areas of expertise is provided in Figure 1. Apart from a significant rise observed in the provision of crisis interventions, a decline was recorded in all other areas. Such a decline was not so dramatic as far as counseling and therapy are concerned. The pair, group, and diagnostic interventions suffered the most.

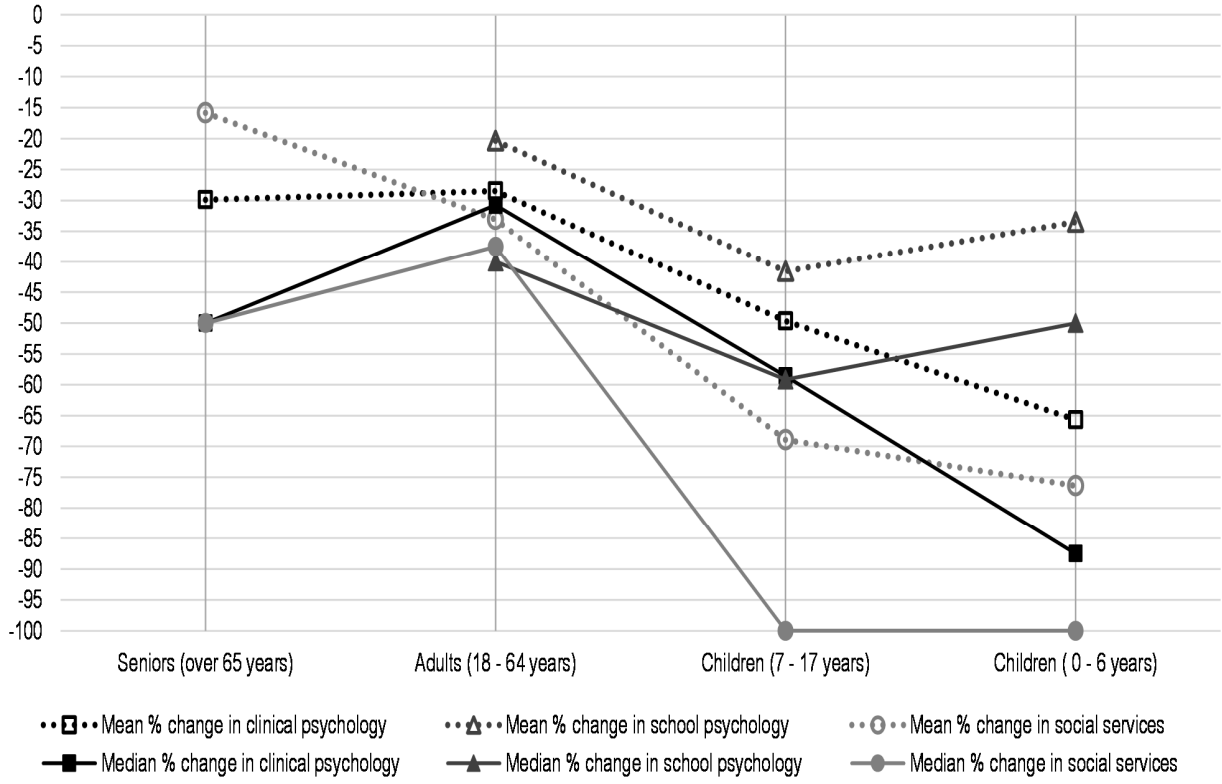
Figure 1. Means and medians of percentage changes by intervention and area of expertise.



The percentage changes in the clients' numbers were calculated similarly. The means and medians of decreases in percentage terms by different client age categories are provided in Figure 2. The overall

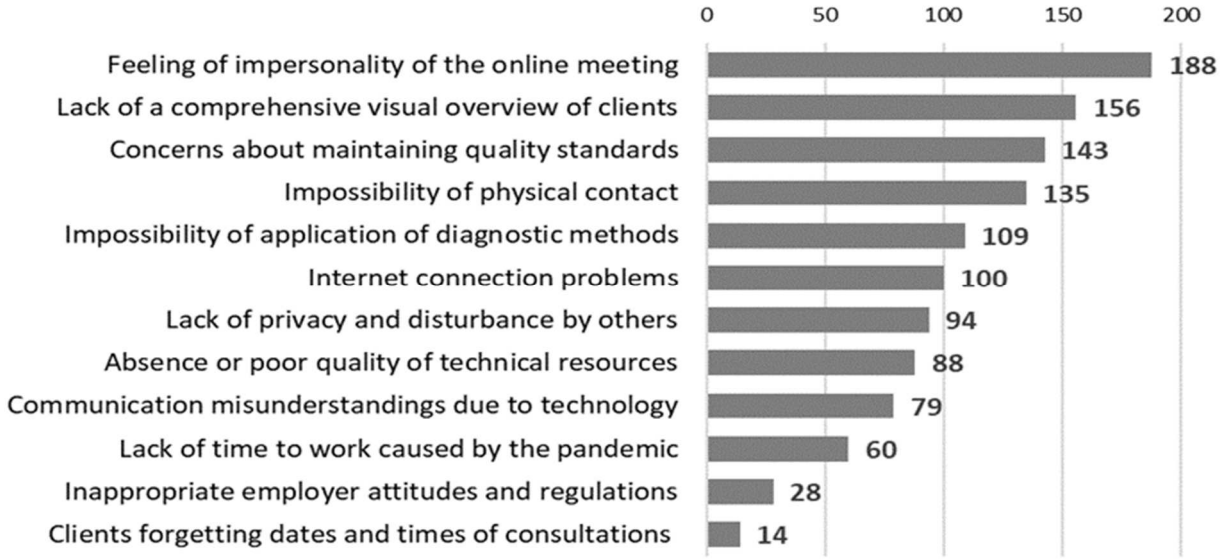
mean proportional decrease for all interventions in the aggregate was 36%, the median 40%, and the upper quartile 9% (i.e., 75% of the services recorded at least a 9% decrease), and the lower quartile was 69% (i.e., a total of 25% of the services showed a 69% decrease or greater). A total of 38 providers included in the study had no clients during the first wave of the anti-pandemic measures, while 35 providers reported even greater numbers of clients than usual. Figure 2 indicates that the most significant declines were associated with child clients.

Figure 2. Means and medians of percent decrease in clients by age categories.



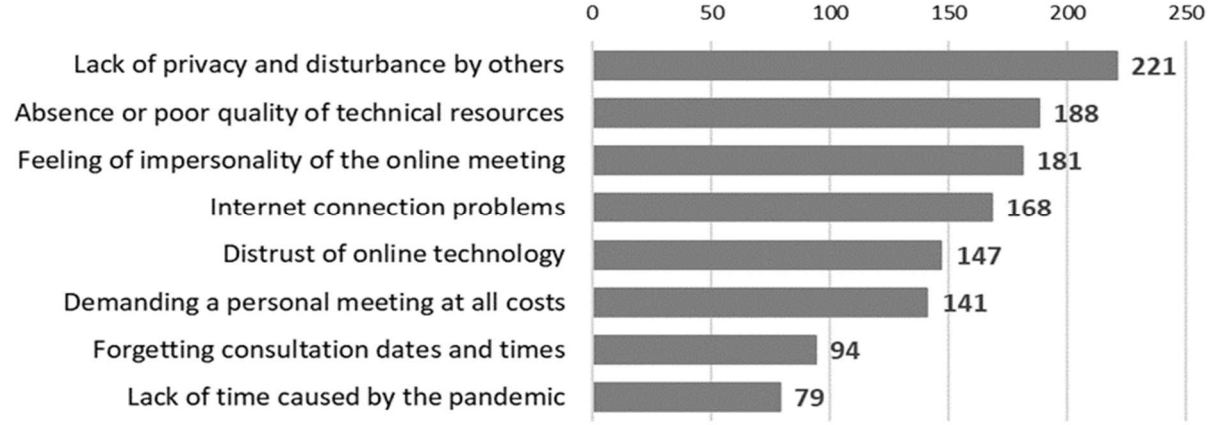
The overall assessment of changes in the number of new clients who contacted facilities during the first wave of the anti-pandemic measures in the spring of 2020 also revealed a decline. The number of new clients rose significantly in 143 facilities (34%), declined slightly in 112 (26%), and remained the same in 95 of them (22%). At the same time, it increased slightly for 56 providers (13%) and showed a significant increase for only 20 (5%). We asked the providers about their most common difficulties and the barriers they faced while providing distant psychosocial care during the first wave of the pandemic, making their work impossible or difficult. The responses were categorized and ranked according to their frequency. They are summarised in Figure 3. The key factors included issues associated with the absence of face-to-face contact and related concerns about maintaining standards of professional care, including diagnostic and psychodiagnostic procedures, and, last but not least, technological and logistical problems. Analysis of the responses to open-ended questions identified 17 statements that distant service provision had posed no significant problems or had even been regarded as an exciting challenge. Although not frequent, such responses need to be viewed in positive terms. Statements used to communicate such a position on the part of the providers included "Surprisingly, the distant modality worked much better than expected" or "It was an interesting experience which was enriching in many ways."

Figure 3. Barriers on the part of the providers according to the frequency of responses.



As perceived by the providers, barriers on the part of the clients were summarised similarly (Figure 4). There were overlaps on both parts. A feeling of impersonality about online meetings and technical issues was reported with the same high frequency. Unlike the providers, however, the clients found it much more complex at home to get the privacy and safety needed for a psychological counseling session. Moreover, in addition to technical problems, many displayed general distrust of the safety of technology and misgivings about the anonymity of online consultations. Finally, the practitioners reported that during the first wave of the pandemic, clients often forgot about their online appointments or canceled them at short notice.

Figure 4. Barriers on the part of the clients as perceived by the providers.



We asked the providers which clients they found unsuitable or contraindicated for the online modality. The questionnaire allowed each provider to state up to five least suitable client categories. This produced several heterogeneous responses, which we attempted to classify. Clients assessed as unsuitable tended to be associated with several client groups that the participating organizations do not work with regularly. Issues pointed out concerned age, various diagnoses, and specific activities. The numbers in parentheses indicated for the individual groups refer to absolute frequencies, i.e., how many times the category was explicitly mentioned.

The category mentioned with the highest frequency was children in general up to age 15 (77), followed by children specifically with early trauma or the CAN syndrome (14), pervasive developmental disorders (especially ASD) (14), ADHD or ADD (11), conduct disorders (7), and child

clients in institutional care (6). On the other hand, senior citizens or the elderly who were not accustomed to using modern technologies were mentioned very often (49).

Another large generic group comprised clients with severe psychiatric diagnoses (predominantly psychoses and OCD), particularly decompensated (57). In terms of specific diagnoses, the categories of clients that were reported included those with intellectual disability (27), cognitive deficits and dementia (18), severe anxiety or panic disorders (25), social phobia or agoraphobia (9), somatoform disorders and psychosomatic disorders (4), those with paranoia or showing mistrust (24), those with moderate or severe depression (20), suicidal tendencies (7), personality disorders (especially borderline or dissocial ones) (19), substance use disorders or other addictions (18), clients who are passive and lack motivation (including those in court-ordered treatment) (18), those with a sensory (such as hearing or visual) impairment (14), violent individuals and victims of domestic violence (13), lonely clients in great need of interpersonal contact (6), people who are quiet and uncommunicative (6), those with communication deficits (such as aphasia or dysphasia) (5), people with severe physical conditions and those who are immobile (8), and people experiencing imminent dying or grief (5).

As for specific therapeutic approaches or activities, those mentioned as unsuitable with the highest frequency included families and pairs (46), divorce and post-divorce disputes (7), group activities (7), first-contact clients or those not sufficiently involved in the treatment process as yet (42), low-income and socially excluded individuals (including the homeless) (33), clients who cannot create a private and safe setting for an online session (26), people without technical skills or equipment (18), those who strictly reject distant care as inadequate (14), where an official or legal document must be signed (7), and where interpreting needs to be provided (i.e. with foreigners) (5). In general, the impossibility of conducting any psychodiagnostic procedures (particularly concerning the psychological and special education-related assessment of children) and the impossibility of practicing any therapeutic methods involving body therapy, touch, and non-verbal therapeutic techniques or training (such as relaxation, art therapy, and hypnotherapy) (21) were mentioned very often (39).

A total of 16 respondents stated that distant forms of work were totally unsuitable for all types of clients and could be seen at the most as strictly a temporary and emergency solution. On the other hand, five respondents only expressed an opinion at the opposite extreme, that distant care might be suitable for generally all clients irrespective of their age, issue, and diagnosis if its providers are committed and trained.

DISCUSSION

The survey results need to be interpreted as an account of the experience of the first unexpected wave of pandemic measures to counter COVID-19 when there had been no major personal experience with the provision of telemental health care in the psychosocial services under study. The comparison of the ordinary (pre-COVID-19) operation and the operation during the COVID-19 pandemic in the spring of 2020 shows a dramatic decline in the levels of all the services across all the key segments of care. The aggregate mean intervention decrease was 34%, consistent with other findings [2]. Given the demand for care demonstrated on the part of the clients [8,9], this can be construed as a failure to ensure the availability of necessary care [15,16].

Some providers replaced shortfalls in face-to-face care with care at a distance. However, this involved challenges, also described by other studies [58,59]. The most common difficulties and barriers faced by the providers in practicing distant psychosocial care during the first wave of the pandemic included financial, methodological, technological, and security issues and concerns about the observation of the standards of professional care, especially concerning diagnostic procedures.

As perceived by the providers, barriers on the part of the clients included their feeling of impersonality about sessions, technical problems, and difficulty finding enough privacy and safety for psychological counseling in their homes. In addition to technical complications, the issues brought up by the clients included their general distrust of the security of technologies and misgivings about the anonymity of online appointments.

The providers also indicated to what extent they considered online services suitable for different clients. Clients who were the most likely to be reported in the first wave of restrictions as entirely unsuitable for online work included children in general up to age 15, especially those with early trauma or the CAN syndrome and conduct disorders, clients with pervasive developmental disorders (especially ASD), the ADHD or ADD syndromes and senior citizens who were not accustomed to using modern technology. Additionally, distant interaction was reported as posing a high risk for clients with severe psychiatric diagnoses (mainly psychoses and OCD), especially those who were decompensated.

Implications for behavioral health

It needs to be underlined that this reported unsuitability of clients for online psychosocial care is not in line with the research evidence. In the setting of work with children and the family, these standpoints may often have been influenced by some practitioners' stereotyped thinking and prejudice. Thus, there may not be objective barriers. The reasons for "unsuitability" or contraindications, as reported, can often also be given concerning common face-to-face forms of help, to which, however, the providers have become accustomed or where such issues are routinely considered concerning elevated risks and demands for professionalism of care. Finally, exploring whether the reported contraindications for distant care concern systematic psychotherapy, specialist counselling, or crisis intervention would be helpful.

We suggest that further research should explore questions concerning providing online psychosocial services even after the different COVID-19-related restrictive measures have been lifted. Should the limiting pandemic situation last for a few more years to come, attention should be focused on the further development of attitudes towards feasible ways of providing online services in the upcoming period, where we would be looking into the significance of routines or becoming accustomed to the new situation and the definition of what might be referred to as "the new norm." Finally, we recommend that further research addresses networking experience in various areas of psychosocial (mental health) care, specifically among those who have been active in using online methods and those who have not used them.

Moreover, our study revealed significant gaps in the linkage between the individual segments of services: the health, social, and educational counseling sectors. In the future, it is thus essential to make a point of networking experience in different domains of psychosocial care and sharing it across the field among those who have been active in using telemental health approaches and those who have not practiced them for some reason.

Should it be, otherwise, the system may grow rigid and become unable to respond to the latest needs because, for example, those who make decisions about the professional application of distant methods may not have hands-on experience with new technology or new approaches and thus may – in line with the theory of the acceptance of new technology – hold reserved attitudes towards it.

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