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Providing Clinical Psychology Training and Trauma-Focused Treatment via Telehealth During COVID-19

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Abstract

To slow the spread of COVID-19 many mental health providers transitioned to telehealth delivery of trauma-focused treatment for maltreated children. However, these providers faced myriad challenges, including equitable access to equipment and technical demands of telehealth software. Training clinics overseeing pre-doctoral clinical psychology interns experienced the added challenge of providing quality supervision and training via telehealth. This study involves a retrospective application of the Exploration, Preparation, Implementation, and Sustainment (EPIS) framework to describe the innovative adaptation to a telehealth service delivery model in a training clinic providing evidence-based trauma-focused treatment to children and their families. Mixed methods data from clinic records and intern evaluations indicate that compared to pre-COVID (February 2019 – February 2020), during early COVID (April 2020 – April 2021) more patients accessed clinic services, interns reported fewer hours of individual supervision, and interns reported greater satisfaction with their training experiences. Implications for ongoing provision of telehealth services are discussed.

Keywords

COVID-19, telehealth, exploration, preparation, implementation, and sustainment

Public health efforts to slow the spread of COVID-19 led to novel challenges for mental health providers delivering trauma-focused treatment to maltreated children. Most notably, executive orders issued in March 2020 mandated the cessation of in-person clinical services and prohibited non-essential work being conducted in-person. Fortunately, network providers for commercial health plans and the Centers for Medicare and Medicaid Services expanded coverage and reimbursement for telehealth services (Verma, 2020). Policies from the American Psychological Association (APA) similarly allowed for trainees to deliver services and receive supervision via telehealth (American Psychological Association, 2020). As a result, many training clinics overseeing pre-doctoral clinical psychology interns transitioned to providing telehealth services and telesupervision. Although telehealth services for maltreated children were in practice prior to the COVID-19 pandemic, most training clinics were not providing these services. Furthermore, training clinics experienced the challenge of balancing demands to meet the therapeutic needs of increasing cases of child maltreatment (Huang et al., 2023), provide quality supervision in evidence-based practice, and technical training in how to use telehealth equipment. This present study describes the professional challenges and innovations taken to adapt to telehealth services at a psychotherapy clinic providing training to pre-doctoral clinical psychology interns working with children exposed to maltreatment and other traumatic events.

Overview of Telehealth Services

Telehealth is a broad term defined as the use of Health Insurance Portability and Accountability Act (HIPAA) compliant software to deliver healthcare-services (Chaet et al., 2017). Providers, patients, and trainees interact synchronously (i.e., real time) using telephone or videoconferencing software. Historically, telehealth has been used to address significant gaps in mental health treatment and reduce access

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barriers related to travel time, transportation costs, scheduling conflicts, and provider availability in remote locations (Gajarawala & Pelkowski, 2021; Mahtta et al., 2021). Telehealth allows ongoing continuity of care and supervisor oversight when in-person sessions may not be feasible. Some have argued that mental health services are particularly well-suited to telehealth delivery as they largely rely on conversation, and do not require other physical medical equipment or procedures (e.g., stethoscope, physical examination) (Stewart et al., 2020). There is also growing evidence on the efficacy of providing evidence-based trauma-focused treatment to children using telehealth technology (Jones et al., 2014; Stewart et al., 2017, 2020), although, notably, these evaluations took place prior to the COVID-19 pandemic. Furthermore, telesupervision – supervision conducted using videoconferencing technology – is an effective method for disseminating training and providing ongoing supervision with comparable outcomes to traditional supervision (e.g., trainee-supervisor rapport, trainee skill acquisition) (Cosh et al., 2022; Jordan & Shearer, 2019).

Despite these benefits, several barriers have historically limited large-scale uptake of telehealth service delivery models. At the outer context level, training clinics have encountered logistical barriers including limited reimbursement for telehealth services by third party payors, regulatory laws and accreditation-related rules limiting the use of telesupervision for trainees, cost of equipment, lack of investment in software, and demands of time to train in telehealth hardware and software use (American Psychological Association, 2020; Mahtta et al., 2021). Inner contextual barriers have included equity concerns in access to telehealth technology, privacy and security concerns, communication preferences, and management of mental health emergencies (e.g., acute suicidality) (see Stoll et al., 2020, for review).

To facilitate access to services during the COVID-19 pandemic changes to public health policies, supervision requirements, and reimbursement claims eliminated several of these challenges. This led to a rapid uptake of telehealth service delivery, with news reports that insurance claims for telehealth services were 4347% higher in March 2020, than in March 2019 (Gelburd, 2020). During the first few months of the pandemic more than 9 million Medicare beneficiaries received telehealth services (Verma, 2020). As pandemic conditions have eased, telehealth service delivery shows little sign of slowing. As of May 2023, The Consolidated Appropriations Act extended telehealth service coverage for many recipients of Medicare through December 31, 2024 (U.S. Department of Health and Human Services, 2023). The APA extended allowance for telesupervision through February 7, 2024 (American Psychological Association, 2023). Indeed, recent research suggests that 93% of pre-doctoral clinical psychology internship training programs have continued to offer telesupervision after COVID-19 related restrictions were lifted (Perle et al., 2023). Overall, telehealth has drastically changed the delivery of mental health services and supervision and is likely to remain a critical component of public healthcare for the foreseeable future. Thus, research to further understand the use of this approach in both service delivery and supervision of trainees will be an important need.

Considerations for Training Clinics Providing Trauma-Focused Treatment

Nevertheless, training clinics providing trauma-focused treatment still faced several challenges to providing telehealth services and require special consideration. One major concern when conducting telehealth therapy sessions to children exposed to maltreatment and other traumatic events is the need to ensure privacy and confidentiality. Although confidentiality is a key element of virtually any psychotherapy, some aspects of trauma-related treatment make this issue even more prominent. Protocols need to ensure patients can speak openly, separate from the presence of others listening to their conversation, in particular, any alleged perpetrators of interpersonal violence, who may reside in the home. Many children experienced ongoing contact with perpetrators of maltreatment due to shelter-in-place orders and school closures (Racine et al., 2020). Likewise, trainees working remotely from home need to ensure their telehealth sessions cannot be overheard by family, roommates, or neighbors. This can be particularly challenging for pre-doctoral clinical psychology interns who may live in shared, rented spaces, during the one year of internship training (Hood et al., 2023).

Additional safety protocols are also needed to respond to acute patient emergencies (e.g., suicidality) and ongoing exposure to violence. This is critical for providers working with maltreated children given prior research suggesting that child abuse can substantially increase the risk for suicide attempts (Hoertel et al., 2015) and that children frequently experience or witness multiple types of violence in a given period of time (Finkelhor et al., 2015). In the context of telehealth service delivery, these protocols need to account for technology limitations, such as what to do if a patient abruptly disconnects from a session.

Telesupervision requires supervisors and clinic directors to take on expert roles in technological issues and jurisdiction laws, in addition to their clinical responsibilities (Dueweke et al., 2020; Simms et al., 2020). For example, supervisors must provide technical training to their supervisees, such as what to do in the event the primary method of telehealth disconnects (e.g., loss of Internet access). Supervisors must be aware of the licensure guidelines, abuse reporting, and emergency response requirements in every state or location that trainees provide, and their patients access, services. For example, the definition of child maltreatment varies across the United States, the District of Columbia, and the Commonwealth of Puerto Rico; according to the State Child Abuse and Neglect Policies Database only 25 states consider "female genital mutilation," 38 states consider "educational neglect,"

and 42 states consider "illegally providing a controlled substance to a child" in their definition of child maltreatment (Mathematica, 2023). There are also differences in reporting procedures, for example, 10 states do not have a statewide centralized reporting authority, alternatively, each county or region has its own reporting procedures (Mathematica, 2023). This was particularly important during the early stages of COVID-19 when many licensing guidelines allowed for the provision of services across state lines and will continue to be important as more states approve legislation to join the Psychological Interjurisdictional Compact (PSYPACT). Trainees may rely on supervisors to disseminate evidence-based practice for assessing and treating trauma disorders using telehealth. This potentially requires supervisors to engage in ongoing continued education on best practices for telehealth treatment. In sum, myriad challenges remain for supervisors transitioning to telesupervision services (see Perle & Zheng, 2023, for further discussion), which in turn, may have negatively influenced the type and quality of training and supervision trainees received.

Pre-doctoral clinical psychology interns receiving training in evidence-based trauma-treatment may also have unique needs in their transition to telehealth services, compared to licensed providers. In clinical psychology programs, readiness for internship is characterized by demonstration of intermediate clinical competence. However, not all interns completing a rotation at a trauma training clinic will have prior experience delivering trauma treatment to children. For many interns, this will be the first time they talk directly to young people about their experiences of trauma. Such clinical experiences are difficult, and interns – as opposed to more experienced staff members – may require additional support and coaching through this process. In addition, providers with less training and experience in trauma treatment may be more vulnerable to secondary traumatic stress or vicarious traumatization (Adams & Riggs, 2008). Interns may also be simultaneously completing other aspects of their graduate training, such as their dissertation research, as well as seeking out and applying for jobs – while working full-time as an intern. Thus, they may be more susceptible to burnout and workplace stress. Delivering trauma treatment in the same location where trainees spend recreational down time at home may exacerbate these negative outcomes (Wood et al., 2022).

Historically, telesupervision largely coincided with in-person peer or supervision support, which can help mitigate the stress experienced from a difficult trauma treatment session. Indeed, social support has been found to buffer against the effects of secondary traumatic stress in providers working with trauma victims (Hensel et al., 2015). Qualitative research with licensed providers delivering telehealth services to families experiencing intimate partner violence during early COVID-19 described the loss of "self-care" that comes "from chatting with coworkers after a hard session" when working remotely (Wood et al., 2022). It is unknown whether trainees benefit from supportive supervision in the absence of an in-person relationship with their supervisor or other colleagues. Although telehealth service delivery was largely perceived as a successful way to maintain training and continuity of care during the COVID-19 pandemic, it is unknown what effect these changes had on trainees' experiences.

EPIS Framework

A process-oriented framework can help provide structure when evaluating the adoption of new implementation strategies for empirically informed mental health practices – such as changes in telehealth services resulting from the COVID-19 pandemic. The Exploration Preparation Implementation Sustainment (EPIS) framework provides one such structure for understanding the innovations taken to continue delivering quality training to pre-doctoral interns and evidence-based trauma-focused treatment to maltreated children. The EPIS framework consists of four phases (Exploration, Preparation, Implementation, and Sustainment) and allows for examination of a change process across multiple, successive levels (Aarons et al., 2011). The Exploration phase involves evaluating the resources, needs, and potential challenges to adopting an innovation or practice. The Preparation phase aims to develop a detailed implementation plan to address the identified needs and leverage available resources. The Implementation phase enacts the implementation plan, including providing training and ongoing assessment of emergent needs and refinement of implementation support. Finally, the Sustainment phase examines the broader structures and processes that influence the maintenance of the innovation. This can include outcomes such as feasibility, service utilization, and program satisfaction. Phases are sequential and iterative, meaning each phase informs the next phase, but there is also a feedback cycle that can lead to ongoing ad hoc adaptations. These phases occur within a broader context, including organization structure, policies, funding agency requirements, and health department mandates.

Current Study

This study presents the retrospective application of the EPIS framework to the transition to a telehealth service delivery model in a pre-doctoral clinical psychology internship training clinic providing evidence-based trauma-focused treatment. Needs, innovations, and adaptations across each of the four phases (Exploration, Preparation, Implementation, and Sustainment) are discussed. Consistent with prior retrospective applications of the EPIS framework (Becan et al., 2018; Brookman-Frazee et al., 2020), we draw mixed methods data from clinic records and evaluation surveys. We sought to examine and describe the innovative transition to providing clinical services and training using telehealth, as well as evaluate the implementation of this change. Implementation outcomes were explored across objective reports of clinic service utilization and the subjective experience of pre-doctoral

clinical psychology interns. Clinic service utilization and intern experiences were compared across pre-COVID (February 2019 – February 2020) and early COVID (April 2020 – April 2021) cohorts. Based on findings from the first few months of the COVID-19 pandemic, we hypothesized that clinic service utilization (number of completed appointments) would be greater for the early COVID cohort compared to the pre-COVID cohort. We hypothesized that telehealth services would be acceptable to interns but made no directional hypotheses on cohort differences in training experiences or satisfaction. Interns in the early COVID cohort provided qualitative data on their experiences. Themes related to the strengths and challenges of the implementation process are discussed.

Method

Participants and Procedures

Data on the clinic procedures, assessment of assets, training protocols, and implementation strategies used to inform the Exploration, Preparation, and Implementation phases were collected from a combination of sources, including, review of clinic records, meeting agendas, staff emails, didactic syllabi, and discussions with clinic leadership (i.e., the Director and Associate Director of Clinical Operations). For the current study, key themes and strategies were discussed in consensus with clinic leadership in a series of stakeholder meetings. Stakeholder meetings were conducted following guidance from Lehmann-Willenbrock and colleagues including providing opportunities for each stakeholder to have a "voice" in the meeting and promoting open communication (Lehmann-Willenbrock et al., 2018).

Data to inform the Sustainment phase were drawn from pre-doctoral clinical psychology interns enrolled in training at an academic medical university clinic located in single state in the southeastern United States providing evidence-based trauma-focused treatment between February 2019 and April 2021. Typically, interns work in this clinic 2 days a week, carry a clinical caseload of 3–5 child patients, and receive both individual and group supervision. On average, interns ($N = 26$) were 29.96 years old (SD = 1.87). The majority identified as female (73%) and 23% identified as male, and 4% as non-binary. Most interns were White (69%), 23% were Hispanic, 4% were Black, and 4% were Asian.

Interns completed routine, anonymous evaluations as part of their predoctoral training, first on their general training experiences in the rotation and a second on their experiences with their supervisor. Interns were emailed RedCap links to the self-report surveys by an administrative assistant. Data for the present study were taken from the evaluations completed at the end of the rotation. Each intern included in this study only completed one evaluation of their training experiences at the clinic and one evaluation for the supervisor overseeing child patients exposed to maltreatment or other potentially traumatic events. For this study, anonymous intern ratings from pre-COVID (n = 11; February 2019 – February 2020) and early COVID (n = 15; April 2020 – April 2021) were compared. Intern ratings were distributed across the year such that 3–6 interns provided ratings every 3 months. At the time they completed the evaluations, interns were informed their responses could be used for program evaluation and quality improvement. Analyses on these deidentified datasets were deemed quality improvement by the first author's Institutional Review Board (IRB) and thus did not require IRB approval.

Measures

Clinic Service Utilization. Rates of clinic service utilization were obtained from a review of clinic records between February 2019 and April 2021. Service utilization was assessed across three domains: number of completed intakes, number of completed therapy sessions, and the proportion of cancelled/no-show appointments to completed appointments.

Supervision Hours. Interns completed two items assessing the number of hours of supervision they received. One item assessed the hours of individual supervision, "*Overall, taking into account all your supervisors and taking into account scheduled supervision meetings and informal or 'on the fly' supervision time, how many hours per week of one-on-one clinical supervision did you receive?*" The second item assessed the hours of group supervision, "*Overall, taking into account all your supervisors and all supervision activities (which might include group supervision, clinic staffings,* etc.*), how many hours per week of other (not one-on-one) clinical supervision did you receive?"* Items were summed to create a total supervision hours score.

Satisfaction. Interns completed ten items assessing satisfaction with their clinical training experiences. Responses to items (e.g., "*provided opportunities to develop clinical skill"*) were made on a 4-point scale (0 = *strongly disagree,* 1 = *somewhat disagree,* 2 = *somewhat agree,* 3 = *strongly* agree) and summed to create a total score. In the current sample coefficient alpha was .88.

Interns also completed five items assessing satisfaction with their interactions with clinical supervisors and staff. Responses to items (e.g., "*treated me with respect"*) were made on a 4-point scale (0 = *strongly disagree,* 1 = *somewhat disagree,* 2 = *somewhat agree,* 3 = *strongly* agree) and summed to create a total score. In the current sample coefficient alpha was .93.

Supervision Quality. Interns completed eight items assessing the quality of the supervision they received from their supervisor. Responses to items (e.g., "*overall quality of clinical feedback*") were made on a 3-point scale (0 = *below expectations*, 1 = *meets expectations,* 2 = *exceeds expectations*) and

summed to create a total score. In the current sample coefficient alpha was .90.

Qualitative Responses to Internship Training. A subsample of the pre-doctoral clinical psychology interns in the early COVID cohort ($n = 15$) provided qualitative responses on their training experiences in a single open-ended question asking about any additional comments on their rotation experience. Qualitative content analyses (Boyatzis, 1998) informed by grounded theory (Glaser, 1965) were utilized to identify common themes that naturally emerged from the data and systematic classification of these themes (Elo & Kyngäs, 2008).

Results

Exploration Phase

Figure 1 illustrates the EPIS framework phase and activities. In March 2020, in response to mandates to suspend in-person service delivery and supervision, clinic leadership (i.e., the Director and Associate Director of Clinical Operations) examined the emergent needs of trainees, patients, and the training clinic. Leadership considered the telehealth innovations that might best address those needs and what system, organization, or individual level adaptations were needed to support implementing telehealth for clinical services and supervision. Of note, this clinic had been providing telehealth to maltreated children and their families for several decades through a specialized program (Stewart et al., 2020); therefore, initial protocols and procedures were in place for potential expansion and adaptation to training clinic delivery. As noted in Figure 1, the system-level assessment evaluated the institutional resources necessary to support telehealth services delivery, such as access to HIPAA-compliant teleconferencing software, capabilities to collect informed consent, and considerations for billing therapy services to Medicaid and second party payers. Clinic leadership assessed for both trainee and patient familiarity and comfort with videoconferencing software and access to equipment (e.g., microphones, headsets, cameras) as well as Internet enabled devices. In addition to the logistical support for telehealth services, clinic leadership assessed for needs to develop training protocols on equipment use, responding to patient mental health crises or maltreatment disclosures, and intern self-care. External funding sources to purchase telehealth equipment were identified.

Preparation Phase

An implementation team comprised of clinic leadership, supervisors, and case managers developed training procedures and protocols to support the innovative transition to telehealth services. These protocols were discussed with pre-doctoral clinical psychology interns during weekly didactic seminars. Interns contributed feedback on their needs and preferences for transitioning to telehealth services delivery and telesupervision. The clinic discussed the procedural changes and disseminated resources and training materials to community partners, including local child advocacy centers. Clinic leadership developed and submitted internal (department funds) and external (Office of Crime Victims) grant applications to support the purchase of telehealth equipment.

Implementation Phase

During the Implementation phase, clinic leadership provided training on telehealth technology for pre-doctoral clinical psychology interns and supervisors during an initial orientation workshop and ongoing through weekly didactic series. This training provided concrete strategies for adapting

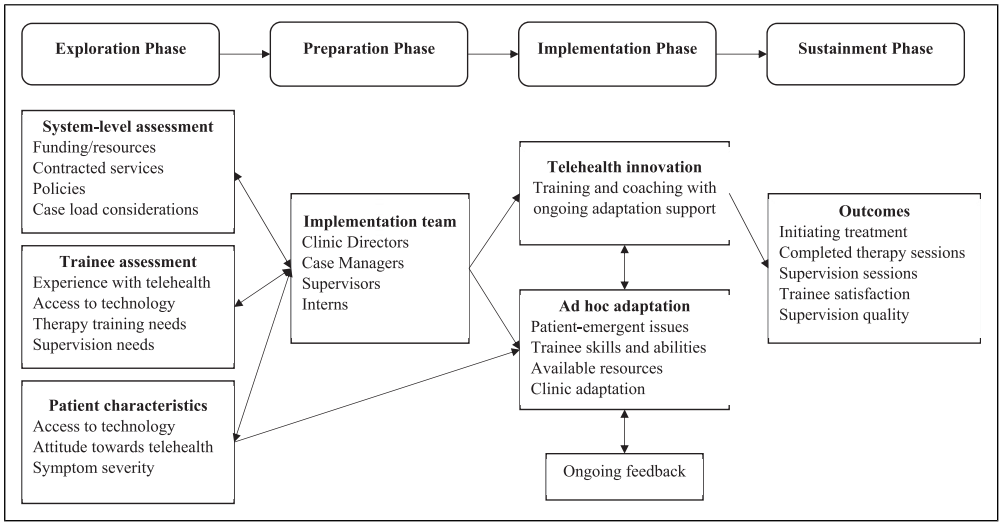

Figure 1. Telehealth service implementation using the EPIS framework.

components of evidenced-based trauma-focused treatment to telehealth delivery, such as using screen share options to write the trauma narrative and developing safety plans to respond to the alleged perpetrator of maltreatment interrupting the telehealth session. Table 1 provides additional examples of didactic topics designed to provide rigorous training in trauma treatment delivery for maltreated children and corresponding telehealth considerations.

Throughout this phase, consistent with the EPIS design and a rapid-cycle approach, ongoing assessment allowed ad hoc adaptations and continual refinements to protocols and procedures. Several examples of these ad hoc adaptations include: (1) as interns began working remotely from home, some struggled to secure confidential locations to provide telehealth services; clinic leadership engaged in collaborative problem solving to identify secure locations and schedules to deliver confidential telehealth services (e.g., allowing flexible clinic hours to accommodate shared home office spaces) and provided equipment (e.g., white noise machines and headsets); (2) interns provided anecdotal feedback that they were experiencing heightened levels of stress due to the COVID-19 pandemic and the mental fatigue of providing back-to-back telehealth appointments. In response, clinic leadership decreased caseload assignments; (3) interns reported experiencing difficulties completing documentation in a timely manner. Alongside clinic leadership, supervisors refined documentation requirements and training procedures to support interns while simultaneously meeting the reporting mandates of Medicaid and other insurance carriers. Clinic leadership limited interns from working with patients across state lines to minimize difficulties in reporting mandates and insurance procedures. It is important to keep in mind these adaptations occurred in the context of a global pandemic. Clinic leadership continued to monitor public health policies and health department provisions and were often tasked with rapid decision making.

Sustainment Phase

In the Sustainment phase, with a shift towards ongoing maintenance of telehealth services, clinic leadership conducted a formal evaluation of clinic outcomes and psychology intern experiences. Rates on clinic capacity and demand as well as intern ratings on the rotation, supervisor satisfaction, and supervision quality were compared pre-COVID (February 2019 – February 2020) with early COVID (April 2020 – April 2021). Means and standard deviations of each variable compared across cohorts are presented in Table 2.

Clinic Services Utilization and Intern Experiences. Results of paired *t*-tests indicate that during early COVID, the clinic saw more intakes, $t(12) = -2.51$, $p = .014$, $d = .70$, completed more therapy sessions, $t(12) = -3.24$, $p = .004$, $d = .90$, and saw a lower rate of missed appointments, $t(12) = 2.78$, $p = .008$, $d = .77$, than during pre-COVID. The pre-COVID interns reported receiving more individual supervision hours per week than the

Table 1. Examples of Didactic Topics and Telehealth Considerations.

Topic	*Example of Telehealth Considerations*
Setting up a remote workplace	Ensure private location and remove background distractions (visual and audio)
TF-CBT – teaching coping skills	Use worksheets adapted for telehealth such as those found on https://www.telehealthfortrauma.com
TF-CBT – trauma narrative	Engage youth with screen share options with editable documents (e.g., PowerPoint) when writing the trauma narrative
TF-CBT – in vivo exposure	Engage in imaginal exposure or use videos, media, or props that serve as trauma reminders
Mandated reporting of child abuse and neglect	Review reporting laws for provider and client locations
Billing and electronic medical record procedures	Input designated billing codes and notation of telehealth appointment in medical record
Using interpreter services in trauma treatment	Use the 'pin video' or equivalent feature so the focus is on the client and provider
Vicarious trauma & self-care	Establish a routine or 'commute' to transition from home-based telehealth work
Safety planning	Obtain client's physical location at the start of each telehealth session and caregiver contact information so you can provide information to emergency services, if needed
Common case management needs	Share websites and contact information for agencies providing donated resources (e.g., clothing, food, financial assistance)
Behavioral management strategies	Adjust expectations for session duration and collaborate with caregivers on helping the child stay in the frame
Comorbid trauma and substance use	Establish boundaries for youth and caregivers refraining from using substances during home-based sessions
Court preparation 101	Work with the attorney to develop creative ways of communicating opinions to court (e.g., use of slides, tables, figures)

Note. TF-CBT, trauma-focused cognitive behavioral therapy.

early COVID interns, $t(24) = 2.08$, $p = .024$, $d = .68$. However, there were no differences in total supervision hours (combination of individual and group supervision hours) across the pre-COVID and early COVID interns, $t(24) = 0.93$, $p = .18$, $d = .75$. There were no differences between the pre-COVID and early COVID interns in satisfaction with their clinical training experiences, $t(24) = 0.96$, $p = .17$, $d = .38$. The early COVID interns reported higher levels of satisfaction in their interactions with clinical supervisors and staff, compared to pre-COVID interns, $t(24) = 1.81$, $p = .042$, $d = .72$. Item level comparisons on satisfaction with supervisors and staff across intern cohorts are presented in Table 3. There were no differences between the pre-COVID and early COVID cohort on ratings of supervision quality, $t(21) = 1.67$, $p = .11$, $d = .70$. Item level comparisons on supervision quality are presented in Table 4.

Qualitative Data. Interns in the early COVID cohort were invited to provide qualitative responses on their training experiences. Content analyses yielded 5 primary themes: (1) support from supervisors (38.5%); (2) clarity of training and protocols (30.8%); (3) documentation concerns (11.5%); (4) appreciation for caseload adjustments (7.7%); and (5) the transition to work from home (7.7%).

Support From Supervisors. Several interns (38.5%) discussed the support and attention they received from their supervisors. One intern stated, "my supervisor was extremely helpful in answering questions and providing additional support […] She was extremely responsive and was very helpful." Another intern mentioned, "the supervision that I have received so far has massively exceeded expectations and has correspondingly contributed to a growing level of competence in conducting trauma-focused services, particularly with children."

Clarity of Training and Protocols. Many interns (30.8%) praised the clarity of the training protocols and clinic expectations. Interns noted the training model was "very thoughtful" and "intern-focused." Interns made comments such as, "I have greatly appreciated how organized everything is at the [clinic] and that there are protocols that clearly lay out expectations and procedures," "I found the detailed training and orientation very helpful," and "the [clinic] did a wonderful job with didactics throughout the year as well as the initial orientation, which nicely positioned me and other interns for success."

Documentation Concerns. A few interns (11.5%) discussed concerns related to the amount of documentation and paperwork required by the clinic. One intern remarked that "the [clinic] requires far more paperwork and data tracking than any other rotation or clinic I have worked in." Others shared, "I often had to write and/or upload documentation on a non-rotation day due [to] finishing appointments late in the evening" and "it seemed to me that my other supervisor was more concerned with paperwork being completed in a timely manner than with my mental health when adjusting to having to work from home."

Table 2. Clinic Service Utilization and Intern Experiences Across Cohorts.

Item	Pre-COVID	Early COVID
	Across all clinic providers	
Clinic services utilization	*M (SD)*	*M (SD)*
Intakes	16.38 (13.38)	**26.77 (8.59)**
Therapy sessions	137.31 (115.19)	**249.08 (35.13)**
Rate of missed appointments	0.46 (0.39)	**0.16 (0.03)**
	Interns	
	(n = 11)	(n = 15)
Supervision hours	*M (SD)*	*M (SD)*
Individual hours	1.38 (0.64)	**0.82 (0.70)**
Total supervision hours	2.06 (0.84)	1.78 (0.67)
Satisfaction		
Clinical training	26.94 (5.48)	28.33 (1.30)
Supervisors and staff	13.03 (3.73)	**14.78 (0.50)**
Supervision quality	15.17 (1.34)	13.25 (3.74)

Note. Statistical differences at $p < .05$ are denoted in **bold.**

Appreciation for Caseload Adjustments. Some interns (7.7%) discussed appreciation for ad hoc adaptations to their caseload assignments throughout the early phases of the COVID-19 pandemic. One intern noted, "[I] appreciated that supervisors and other faculty […] have been responsive to adjusting our workloads given the differing demands of telehealth." Another intern reported, "I appreciated that the [clinic] gave us some breathing room in terms of not assigning cases in the initial weeks of the pandemic."

Transition to Work From Home. Interns (7.7%) reported mixed feelings on the transition to working from home. Some noted, "[working from home] was a very difficult transition for me." Others stated, "there have been some minor challenges largely related to the nature of online remote work that I anticipate could have been easily avoided if we were working in person." In contrast, others noted, "I really enjoyed […] the ability to work from home."

Discussion

This study presents the retrospective application of the Exploration, Preparation, Implementation, and Sustainment (EPIS) framework to the implementation of telehealth services at a clinic providing therapy to maltreated children and training to pre-doctoral clinical psychology interns. This clinic was uniquely positioned for a successful transition to

Table 3. Satisfaction With Clinical Supervisors and Staff Across Cohorts.

Item	Pre-COVID (n = 11)	Early COVID (n = 15)
The [STAFF] on this rotation	*M (SD)*	*M (SD)*
…Was friendly	2.45 (1.04)	2.87 (0.35)
…Was helpful	2.73 (0.47)	2.93 (0.26)
…Treated me with respect	2.45 (1.04)	**3.00 (0.00)**
…Treated patients with dignity and respect	2.91 (0.30)	2.93 (0.26)
…Contributed to a positive learning experience	2.45 (1.04)	**3.00 (0.00)**
…Acted professionally	2.64 (0.92)	3.00 (0.00)

Note. Responses were made on a 4-point scale (0 = *strongly disagree,* 1 = *somewhat disagree,* 2 = *somewhat agree,* 3 = *strongly agree*).
Cohort differences at $p < .05$ are denoted in **bold.**

Table 4. Intern Ratings of Supervision Quality Across Cohorts.

Item	Pre-COVID	Early COVID
Please rate [supervisor] on the following	*M (SD)*	*M (SD)*
Dependability (includes punctuality)	1.50 (0.67)	1.18 (0.98)
Overall quality of clinical feedback	2.00 (0.00)	1.73 (0.47)
Research time respected	1.92 (0.29)	1.82 (0.40)
Treated me as a junior colleague	2.00 (0.00)	1.82 (0.40)
Quality of assessment supervision	1.92 (0.29)	1.63 (0.52)
Quality of diagnosis supervision	1.92 (0.29)	1.55 (0.69)
Quality of communication skills supervision	1.92 (0.29)	1.82 (0.40)
Quality of therapy/intervention supervision	2.00 (0.00)	1.73 (0.47)

Note. Responses were made on a 3-point scale (0 = *below expectations,* 1 = *meets expectations,* 2 = *exceeds expectations*).
There were no statistically significant differences across cohorts, *ps* > .05.

telehealth services, as they had previously developed a specialized program to deliver telehealth services to maltreated children and their families to reduce health disparities (Stewart et al., 2020). In light of the novel challenges in the COVID-19 pandemic, across the EPIS phases, clinic leadership assessed the perspective and needs of multiple stakeholders (e.g., patients, interns, and supervisors) to inform the implementation process and clinic protocols. Guided by an ongoing assessment approach, clinic leadership was able to quickly implement an innovative system that provided continuity of care to patients and quality training experiences for interns. This research extends the use of the EPIS framework to consider the supervision and training needs of pre-doctoral clinical psychology interns and can provide a model for future innovations to training clinic protocols – beyond telehealth services.

Several lessons emerged that may inform ongoing provision of telesupervision and clinical services. For example, clinic leadership discovered issues related to equitable access to telehealth equipment among trainees. Although the potential barriers to equitable technology access among patients and families from lower socioeconomic backgrounds has been recognized (Stoll et al., 2020), after consulting with interns, clinic leadership learned several trainees also required equipment to effectively provide telehealth services. Although most interns could access internet-capable devices, several did not possess video cameras, laptops with operating capacity to run software necessary for remote work, or external monitors to facilitate screen sharing for effective virtual communication. Formal assessment of hardware and software needs – across patients, providers, and supervisors – should be considered for ongoing provision of telehealth services and may be recommended as a routine needs assessment of pre-doctoral clinical psychology interns. In the Exploration phase, clinic leaders were able to identify external funding opportunities (e.g., Victims of Crime Act grants, State funding for telehealth programs, foundational grants) that enabled the purchase and dissemination of telehealth equipment. Clinics providing services to maltreated children may consider targeting grant programs designed to provide financial support for victims of crime (i.e., from the Office for Victims of Crime). Through the course of refining their implementation of telehealth services, clinic leadership also established themselves as experts in the delivery of evidenced-based trauma-focused treatment. This led to the further dissemination of "best practices" and training materials for interns (see Table 1) and the larger field providing services to maltreated children (Dueweke et al., 2020).

Findings from the present study echoed existing concerns regarding privacy and confidentiality when conducting telehealth sessions. This is particularly important to consider for those providing services to maltreated children and their

families. The reoccurrence of child maltreatment is common, with estimates that more than 42% of children will have a second substantiated report within 5 years (Kim & Drake, 2019). During COVID-19, connections with a telehealth provider may have been one of the only outlets for children to report ongoing abuse or maltreatment, as evidenced by reductions in reporting from school personnel and daycare providers (Shusterman et al., 2022). Clinic leadership developed and disseminated detailed protocols both to interns and local child advocacy centers to ensure adequate reporting and monitoring of child safety.

Evaluation of the telehealth services suggested increases in clinic service utilization across intakes of new patients, completed therapy sessions, and lower rates of missed appointments, compared to pre-COVID. This is consistent with evidence of increasing demand for telehealth therapy services in early COVID, with some providers reporting to news outlets that they are seeing up to 175 times the number of patients via telehealth than they did pre-COVID (Bestsennyy et al., 2021). It is also noteworthy, that the clinic had an equivalent number of providers delivering services across the pre-COVID and COVID cohorts. Therefore, our data suggest many more maltreated children and their families accessed evidenced-based treatment during early COVID. It may be this finding reflects an increased demand for trauma-focused services during early COVID and it certainly suggests that telehealth therapy services may be one effective strategy for meeting this demand for services. However, this finding should be taken in context of recent reviews suggesting that greater workload and patient caseload are associated with greater emotional exhaustion, cynicism, and depersonalization among mental health professionals (Yang & Hayes, 2020). Trainees providing trauma-focused services can be particularly vulnerable to burnout and vicarious trauma (Adams & Riggs, 2008). Therefore, it seems plausible this increase in patient attendance could contribute to higher levels of stress and burnout among trainees providing services to maltreated children. As providers continue to deliver telehealth services, clinic leadership may consider active monitoring of service utilization and early manifestations of trainee burnout, and employ flexible, responsive approaches to case assignment. Ongoing communication between trainees, supervisors, and clinic leadership is critical.

Results of the intern evaluations suggest that the transition to telehealth services altered the frequency of contact with their supervisors. Interns in the early COVID cohort reported fewer hours of individual supervision than the pre-COVID cohorts. In some ways, this is unsurprising, as interns working remotely from home may have had fewer opportunities to access supervisors outside of structured, scheduled sessions. In other words, working from home likely reduced the '*on the fly*' or brief check-ins that can naturally occur in a shared office space. Although it is important to note that all interns received the required minimum number of supervision hours as designated by APA requirements (American Psychological Association, 2023). Ongoing implementation of telesupervision may consider offering additional outlets for brief, unstructured check-ins, such as through instant messages or text messages. Indeed, research among patients with depression suggest that receiving supportive text messages was effective at reducing psychological distress during the COVID-19 pandemic (Agyapong et al., 2022). However, it is unknown how trainees might respond to similar supportive messages from a clinical supervisor; this may be an important area for future research.

Despite the shift in supervision hours and delivery format of clinical services and supervision, trainees reported high levels of satisfaction with their training experiences and high levels of supervision quality. Results indicated there were no differences between the pre-COVID and early COVID cohorts in their satisfaction with or quality of their clinical training experiences; however, interns in the early COVID cohort reported higher levels of satisfaction in their interactions with clinical supervisors and staff. These findings were similarly reflected in the qualitative data as primary themes of receiving support from supervisors emerged. This suggests that interns still felt supported and respected by supervisors, even when they only had virtual interactions using videoconferencing software or emailed communications. Consistent with research suggesting telesupervision can have similar outcomes on trainee-supervisor rapport and trainee skill acquisition (Jordan & Shearer, 2019), these findings have important implications for the future of telesupervision among predoctoral clinical psychology interns. Still, it is important to consider these findings in context. It seems possible that in the early stages of the COVID-19 pandemic, with widespread uncertainty and fear, interns appreciated the remote support and guidance they received from clinical supervisors. Further research is needed on how intern experiences of telesupervision compare with in-person supervision after the COVID-19 public health crisis.

The present findings have important implications for delivering trauma-focused treatment to children who have experienced maltreatment, violence, and other potentially traumatic events beyond the COVID-19 pandemic. The feasibility and utilization of telehealth services demonstrates a clear need for clinical psychology programs to incorporate training in telehealth and telesupervision. Research by Perle et al. (2023) suggests that while over 90% of clinical psychology pre-doctoral internships incorporated telehealth services during the COVID-19 pandemic, fewer than 50% include training or supervision on telehealth-related topics (Perle et al., 2023). Further, as more states join the Psychology Interjurisdictional Compact (PSYPACT), education and training on working with victims of child maltreatment, particularly across different locations, will be critical. Supervisors and clinic directors overseeing interns providing telehealth services to maltreated children should consider ongoing dissemination of the best practices learned during the COVID-19 pandemic. This is particularly important for

situations when in-person modalities are unfeasible – such as in response to natural disasters, mass violence incidents, or infrastructure crises. Lessons learned from this research can inform the quick transition to providing evidence-based trauma-focused services to children who experience a broader range of trauma experiences.

Limitations

This study has a number of important limitations. Foremost, the implementation process was examined from a researcher and clinic leadership perspective. Although interns and other clinic staff provided input on their needs and assets, ultimately clinic leadership built upon their prior experience with telehealth service delivery models. In many ways, this was responsive to the immediate, urgent need to provide ongoing treatment after government mandates to cease in-person services. Still, it is unknown what different implementation innovations may have occurred had the additional perspectives of children, caregivers, and other community partners (e.g., the Department of Social Services) been considered. These data are informative in comparing how the clinic and training program functioned across time, but it should be noted that a number of historical factors and unmeasured third variables (e.g., individual differences in intern prior experience with trauma therapy) may have contributed to the observed differences. Our review of clinic records included all of the intakes and therapy sessions conducted at the clinic. This precluded individual examinations of the services provided by trainees alone. However, the clinic had an equal number of providers across both cohorts, suggesting the differences in clinic service utilization were not driven by differences in the number of treatment providers. Relatedly, it is important to consider that the number of interns in each cohort was small (11 and 15), meaning we were only sufficiently powered to detect large effect sizes in our examination of pre-COVID and early COVID cohort differences. Furthermore, our evaluation of the intern training experience was limited to anonymous surveys, which precluded our ability to examine associations across sources of data (e.g., associations between intern demographic characteristics and satisfaction with the rotation). Although qualitative responses offered some illustration of the trainee experience, assessment of supervision quality relied on intern self-report (e.g., rating their perspective of the quality of clinical feedback provided). Data were also limited to examination of intern experiences, barring comparisons of findings between trainees and licensed providers. The time-sensitive transition to telehealth service delivery precluded the design of a robust comparative assessment between pre-COVID and early COVID practices and future research may consider including validated measures of supervision quality and trainee experiences.

Conclusion

To slow the spread of COVID-19 many training clinics were forced to transition to delivering telehealth services and telesupervision. The present retrospective application of the EPIS framework provides a model for the successful innovation to a telehealth service delivery model at a trauma psychotherapy clinic providing training to pre-doctoral clinical psychology interns. Evaluation of the adaptation to telehealth services suggests that many maltreated children were able to continue receiving trauma treatment and interns reported having a positive training experience. This study discussed the unique considerations for providing telehealth services to cases of maltreatment, however the present findings could be generalized to other training clinics providing telehealth services. Although there are some notable limitations, this study provides a framework for clinic leadership and researchers seeking to adapt delivery and training of trauma-focused treatment.

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