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Author for correspondence:
Rachael Sanders,
Email: r.sanders@latrobe.edu.au

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Human Services workers' experiences of rapidly moving to Telehealth

Rachael Sanders

La Trobe University, Bendigo, Australia

Abstract

As a way of restricting the spread of COVID-19, methods of social distancing were instituted in most places that people gather, including workplaces. As such, human service agencies have implemented novel ways of delivering services to clients, with a common method being telehealth. For some practitioners this was unchartered waters and required rapid adaption to their everyday practice. I was interested to hear about their experiences and what useful learning came from it. I spoke, informally, with 13 people across four settings in a regional city in Victoria, asking them about the problems, positive changes and innovations that emerged. There were reports of challenges to overcome as well as benefits that may well become long-lasting. Practitioners adapted quickly and successfully to telehealth, with only minor problems that they managed to iron out quite quickly. They were mindful of people's differing levels of capacity and access to technology and learned to be gentle and kind to themselves and others as they adapted. Some people came to realise that they like to work from home because it improves their work-life balance. Others, however, are keen to return to the workplace; highlighting the importance for flexibility based on individual circumstances. There was a strong sense of improved communication between agencies as they were better able to connect via telehealth compared with former in-person practices.

Background

As a way of restricting the spread of COVID-19 within and between nations, methods of social distancing have been put in place. As such, a number of human service agencies have implemented novel ways of delivering services to clients who not only remain in need of support but may also have increased needs as a result of the changed circumstances. Agencies were required to quickly adapt their processes to accommodate the need for reduced physical contact. While this way of service delivery may have been novel for some agencies, indeed entire industries or fields of practice, telehealth and other non-contact forms of practice are familiar to service providers that offer support to people living in rural and remote areas.

Telehealth is a generic term that describes the delivery of health-related activities to service users via means of technology (as opposed to in-person or by mail). Telehealth consists of synchronous and asynchronous communications, typically including consultations via telephone, text, instant messaging and video-conferencing on phone or web-based services (McLean & Sheikha, 2009). Synchronous, or real-time telehealth, has practitioners and service users interacting with each other at the same time (e.g. video consultations, telephone, chat rooms), whereas asynchronous refers to participants sending and receiving the information at different times (e.g. sending photographs, emails or client data) (Wade, 2013). The International Organization for Standardization (IOS, n.d) defines telehealth as the 'use of telecommunication techniques for the purpose of providing telemedicine, medical education, and health education over a distance'; however, for the purposes of this commentary, health is thought of more broadly, encompassing the range of services that are offered to clients by human service organisations.

Prior to COVID-19, telehealth was considered useful because it extended the reach of care to people living and working in remote areas, allowed greater levels of confidentiality for people living in smaller communities, reduced the need for travel for those who are less mobile and was a more efficient way of delivering care in some instances (Department of Health and Human Services (DHHS), n.d). Not only is it useful for direct practice with clients but also for healthcare providers seeking secondary consultations and to transmit information between organisations (Department of Health (DOH), 2015; IOS, n.d). Improvements in telecommunication infrastructure have enhanced access, and videoconferencing has become more widely used. In many ways, it 'retains the benefits of traditional face-to-face appointments through real-time visual cues important for rapport building, clinical observation, visual assessment and sharing of resources or education materials' (Orlando et al., 2019, p. 2) and is also cost effective, making it a useful alternative to traditional face-to-face ways of providing services (DHHS, n.d).

While it was introduced in the 1970s, ongoing services have only really been offered since the 1990s, and 'despite predictions that telehealth would rapidly become a widespread method of health service delivery, the reality is that telehealth has largely been implemented as small scale services, short term pilot studies or research projects' (Wade, 2013, p. 5). According to Wade, enthusiasts of telehealth who believed it would become a significant way of delivering health care have experienced the frustration of slow and limited uptake over the past three decades. This, Wade believes, is due to the difficulties associated with introducing change that impacts on multiple systems and work patterns. As Gill (2011, p. 10) states, 'the introduction of any new technology in health is a change management challenge . . . . A consumer is more likely to embrace a new technology on the promise of its benefit, than clinicians who will tend to wait on the evidence of impact being widely accepted.'

A recent review of telehealth across a number of sectors (predominantly medical, but also allied health) by Orlando et al. (2019) found that service users were, on the whole, satisfied with their experiences of the system. Face-to-face appointments were the preferred option; however, telehealth was considered an acceptable alternative because it saved on travel time and costs for those who did not live in urban areas. A review of counselling for informal carers of people with dementia found that 'telephone counselling can reduce depressive symptoms for carers of people with dementia'; however, further robust evaluations are required (Lins et al., 2014, para 8). Gill (2011, p. 3) suggests that

> telehealth has particular relevance for aged care, disaster situations, individual clinician support and for team based support for complex conditions. As such, telehealth in Australia is ideally placed to support major national programs associated with dementia, mental health, diabetes and regional concerns related to rehabilitation, acute waiting list relief and outpatient support.

However, the efficacy of telehealth is relatively untested and, as Wade (2013, p. 4) says, 'the evidence is a work in progress. Overall, I think there is evidence that telehealth can provide these benefits to health care, but whether it actually does do this depends on the particular circumstances: what sort of telehealth, for which patients, where, and how?' It is also worth bearing in mind, when reviewing client satisfaction, that many service users who had cause to use telehealth prior to 2020 did so because of their own choices – such as living in remote areas – unlike the current circumstances in which restricted services are being imposed upon clients through no choice of their own.

On 29 March 2020, the Australian Minister for Health, Greg Hunt, and the Principal Medical Advisor, Professor Michael Kidd AM, said in a joint media report that 'We are making telehealth a key weapon in the fight against the COVID-19 pandemic. Expanding the consultation services available by telehealth is the next critical stage in the Government's response to COVID-19' (DOH, 2020, para 3). They said that 'whole of population telehealth will allow people to access essential health services in their home and will support self-isolation and quarantine policies to reduce risk of exposure and spread of COVID-19' (DOH, 2020, para 7). While they were principally speaking of GPs and other primary health services, a similar approach is being taken by a host of health and well-being service providers. The use of telehealth to prevent a large volume of in-person interactions across the whole of the nation, indeed world, is novel and thrusts the technology and practitioners' abilities into largely unchartered waters. COVID-19 has meant that practitioners, agencies, and whole sectors have not had a choice about whether to implement this innovation, instead the change was obligatory, and they simply had to adjust their systems and work patterns to accommodate this. While reasons for the implementation of telehealth might differ to those put forward to support its original purpose, it is a moderately tried and tested form of service delivery that was considered one of the best ways that service providers could continue offering their service. The challenge, therefore, was not developing the technology, but supporting practitioners and clients during the transition to this form of service delivery relatively quickly and en masse.

While there are advice and protocols about setting up and delivering telehealth, they are based on the assumption that it can be implemented in a settled environment as part of a normal functioning business in an uncompromised way. For many practitioners, there was not the 'luxury' of a comprehensive and unhurried introduction into this form of service delivery, so I was interested to hear from practitioners about their experiences of having to dive into the deep end of a telehealth service delivery model. I spoke, informally, with 13 people across four settings in a regional city in Victoria, asking them about the technology they used, what problems emerged, how it felt to work with people online, had they noticed any differences based on client demographics, what innovations had come from this change, how they felt about assessing safety of their client and what were some of the positives that emerged from the change. The following content represents their shared experiences.

Service users' experiences of telehealth

Practitioners reported the use of a range of synchronous technologies, including Microsoft Teams, Skype, Zoom, Facetime and telephone, without the use of a visual function. While these have worked well for most clients, a limited number of families do not have access to the internet at home and can only use data on their phones, which for some has cost implications. Others have the internet but with children at home they find they run out of 'band-width' and cannot afford to increase it. Lack of or limited computer literacy had caused some clients to struggle, with certain platforms being more complicated than simply downloading and chatting. One client reported that she felt frustrated by the camera not working, but had a phone meeting with her counsellor instead, 'and that went well'. In addition, some clients have expressed a discomfort with having their face on video and will only engage with phone calls. Interestingly, this was mainly an issue with young people, who preferred other forms of communication, like text messaging. A number of respondents agreed with the comment that 'Family Services have found that young people prefer texting rather than videoing with workers which is a positive way to engage for the young person, but does make it difficult for the worker to get a sense of what is happening'. They found this to be a similar response across genders. While most practitioners worked with involuntary clients or needed to maintain contact to fulfil funding requirements, one private practitioner said that there is a percentage of her clients who refused to engage in anything other than face to face and said that they would see her when this thing was over. Having said that, some of these clients have since engaged in telehealth because they did not realise that the restrictions would be in place for quite so long.

Mirroring earlier research findings, some clients have said that from a pragmatic point of view they have saved hours in travel and money on petrol. A client from a regional area who uses specialists in Melbourne has found it much easier not to travel but worries about what the practitioner might be missing, given they are not

in the same room. Occasionally, there has also been clients who have said that not having to meet in person suits their communication style better and hope that they will be able to continue with this mode of service delivery.

Practitioners' experiences of telehealth

Practitioners report that the shift to telehealth has had both its challenges and benefits for them personally and professionally. Challenges include insufficient skills/knowledge of the technology, increased fatigue, lowered levels of privacy and other difficulties associated with providing a thorough service. The positive or beneficial aspects include changes to family life, reduced travel time, improved connections with other services and the development of new skills.

During the early days, it was apparent that many people were unfamiliar with the technology required for telehealth. It was a steep learning curve and impacted on some people's ability to perform their duties to the same level that they had previously. One respondent said that 'some people are not skilled at technology and so arrive late and can be understandably flustered'. Several respondents noted the collective forgiveness for people's mistakes during the learning process, but there was perhaps some judgement of those people who did not handle the frustrations well. They were judged for not being able to remain calm and unflustered in front of clients because they were not being good role models for how to maintain a sense of control over one's emotions during challenging times.

From a practical point of view, there were also some initial problems with setting up systems in order for staff to work from home and still be able to access the agency databases and other working systems, but many of these were ironed out quite quickly. An ongoing issue for some staff has been a lack of printer, especially when they want to provide clients with a hardcopy of a document. One agency said that they overcame this with improved organisation and communication between staff so that when someone was at the office the information was printed and sent on their behalf.

Appearance was notable in other ways too. In the initial stages, some practitioners noted that they found themselves having difficulty navigating the shift to working from home whilst still maintaining the same level of professional demeanour and behaviour. They also noted this in colleagues. One respondent noted that she would 'forget I'm at my kitchen table and relax into chat mode, it can be hard to remain engaged and I notice my care factor fluctuates'. It was noted that some people ensured that the setting behind them (that would be viewed via video-conferencing) was 'professional' or less home-like, whereas it was apparent that others did not alter their home environment, leaving mess and family life on display. Some people found this distracting, but noted that it became more regular or accepted, especially when children were home. There appeared to be a divide between those people who seemingly tried to make their environment as professional as possible and those who carried on home life as per usual. With this came some distracting thoughts for those people who joined them in their home via telehealth. Regardless, there was general consensus that seeing inside people's homes and the 'blur of the private and professional lives' broke down barriers, but in 'weird ways', as stated by one respondent. This also raised issues of privacy. Some people had difficulty coming to terms with the potential lack of privacy, particularly if there were multiple people working/schooling from home, which often caused distractions and interruptions. From this has come an informal sense of etiquette in which participants declare the level of privacy available or probability of interruption at any given time.

The majority of respondents said that they feel more tired. One team leader said that 'Practitioners have also expressed that they feel more fatigued working online and on the phone. Particularly with new families, it feels like you have to work a lot harder to engage via technology rather than in person'. One practitioner went searching for ideas on how to improve this and found that looking just above the camera into the distance can help a little. Another said that 'video-conferencing is so much more draining mentally and emotionally than I imagined, specifically when there are up to eight people on a screen. [It is] very demanding if you're chairing and you haven't met some people'. One respondent recommended the implementation of a protocol to help manage this. For example, he said perhaps keeping video-conferencing meetings to no more than 40 min and having any 'catch-up' time at the end so participants can choose to catch up or politely leave. Some respondents also noted that they felt more distracted or observed others becoming conspicuously distracted in ways they would not have noticed in face to face meetings. People generally had no other choice than to be fully engaged, at least outwardly, in the face-to-face meetings, but on video-conferencing it seems that some people are doing other things, like working on their computer or phone. Having said that, if someone was looking down to write notes or typing notes on their computer, it may look like they are distracted, but in fact they are diligently working on the task at hand. Perhaps this suggests that it is important for participants to mention this as a way to remove any doubt.

There were a number of difficulties associated with continuing to do an adequate job. Practitioners who provide outreach services and who would typically spend time in clients' homes have found they have less information to help inform their assessments. Not only were they able to make more observations, such as watching the way a parent interacts with their child, but while in someone's home they had more incidental conversations and observations that provided important information. They were able to get a sense of the home environment, such as family pictures or children's drawings, as well as fundamental issues like home hygiene. Without these indicators of home life to help form assessments, some practitioners reported being concerned that they 'may be missing something' important. This was noted in the family violence (FV) sector in which a respondent said a challenge had been:

> around risk assessment of a woman and child's safety. Prior to COVID-19, practitioners may take the non-offending parent out for a coffee and help with creating a safety plan and discussing the violence that is occurring, but now that many perpetrators are in the home and there is a virtual platform, it can be hard for the practitioner to ask questions and safety plan not knowing if the call or chat is being monitored.

Likewise, one respondent mentioned that 'so much of our communication with one another is through non-verbal cues, so this also presents a challenge' when we are not there in person. Having said that, for clients who are deemed at high risk (such as FV, children under 2 years or other significant factors), outreach visits are still undertaken with strict COVID-19 rules being adhered to. Moreover, these situations have facilitated increased collaboration between agencies. For example, an early child-care setting may be asked how the child is presenting and there is increased scrutiny by senior workers and managers to help ensure that things are not being missed.

Despite a number of early and ongoing challenges associated with the use of telehealth, all practitioners noted positive aspects to both telehealth and other changes to their work practices, including the development of new skills, improved engagement with other agencies and recognition of their own and others' resilience.

While the quality of interaction with some service users has diminished, there has been improved access to professionals and people from all over their catchment areas. Where once it may have been difficult to get multiple people in a room together, activities like case conferences are better populated because workers find it easier to attend meetings. Video-conferencing has reduced travel time and the need to arrange transport, therefore freeing up more time and resources to attend meetings. One respondent said that an innovation is 'The way we hold meetings. As part of an Alliance that has a wide catchment area, previously there have been significant amounts of driving involved for meetings. Working from home has meant that now meetings occur via Teams and it cuts out on time spent on travel'. Moreover, phone/video-conferencing consultations has meant that some information seems to be shared rather more quickly than meeting face to face. This potential to improve communication/collaboration practices between agencies may lead to a service system that facilitates direct contact between practitioners that builds increased trust and collaboration, and, ultimately, a more holistic service sector. Moreover, with greater familiarity and reliance on online forms of communication has come increased opportunity for shared learning and development. One respondent said that 'There has been an influx of webinars (usually free) made available to professionals through a variety of esteemed service providers … which has led to continued and ongoing professional development for everyone while working virtually'. Conferences and seminars etcetera are often held in major cities, so having them online has provided greater opportunity for rural and regional practitioners to attend. Perhaps this has the potential for becoming a long-term or permanent beneficial change.

Moreover, for some respondents, working from home has meant a greater work/life balance both now and potentially into the future. Less time spent travelling to and from work provides respondents with more personal time. Some have noted that spending more time at home has provided them with a greater appreciation of their home life. Some people have enjoyed being with their family (including pets) during the day and have observed the way that their family members interact with others as they perform their own jobs. They have also learnt just how hard other family members work, and this has resulted in an increased admiration and appreciation of their loved ones. Having said that, some people also struggled to find the balance between work and personal time and said it was 'too easy' to just jump on and check emails at all times of the day and night and lose an hour or two in that process.

Perhaps unsurprisingly, there were mixed reviews when it comes to the utility of telehealth and more broadly, working remotely. It depends on one's familiarity with the technology, the nature of the working conditions and environment, what type of work is being done, what type of technology is available, who engagements are with etcetera. Some people would like to see some of these changes implemented on a more permanent basis because they can see the benefits in relation to work efficiencies and the potential of getting more people together in the 'one place' (albeit virtual). Others are looking forward to a return to normal. One practitioner said, 'I don't want this to become the new norm, but I am aware I might get shut down for being a luddite if I do'. Ideally, if practitioners and service users could come out of this with a sense of their preferred options, what works for them and what does not, and the option for greater flexibility to meet these needs, then this experience, as challenging as it may have been for many, may cultivate future benefits. While no-one would wish for a global pandemic and the associated challenges, it would be wonderful to think that improved work practices have resulted from this experience.

Work practices that suit the personal and professional lives of workers, that meet services users' needs, that bring families closer and that may even have less impact on the environment could be a lasting positive legacy of this trying time. One respondent had service users' needs in mind when stating 'While things will go back to normal, there will be elements of how we are doing business at the moment that will most likely continue and the family may be more in control of options available to them in terms of how they interact with workers'. And another was thinking from the worker's perspective when saying it would be good if 'A recognition that video-conferencing could be used much more effectively post shutdown and could change organisations' attitudes toward staff working from home – a faith that the work will get done!' Of course we also need to be wary that there may be a risk of forced changes to work practices that are based on principles of efficiencies rather than quality care, but if the focus is on improved care for all, then we have an opportunity to turn an undesirable situation into something advantageous for many. If nothing else, current circumstances will also provide research opportunities to learn more about the efficacy of telehealth and other methods of practice which will add to the limited literature in this field. And lastly, this shared experience may provide people with a greater appreciation of the lived experience of their fellow citizens who do not have ready access to services and were reliant on telehealth for their everyday lives prior to 2020.

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