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Transitioning to Telehealth to Treat Concurrent Disorders: Provider and Patient Perspectives During the COVID-19 Pandemic

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Abstract
The current study aimed to examine the use of telehealth within concurrent disorder populations through the examination of both clinicians and patients accessing treatment during the COVID-19 pandemic. Using a mixed-methods approach, provider ($n = 23$) and patient ($n = 76$) experiences and opinions are described. Commonly reported benefits by patients included increased accessibility to treatment (e.g., ability to attend appointments with more ease and frequency) and reduced traveling and parking expenses (for patients) by providers. Commonly reported challenges for patients included issues with internet connection, the belief that telehealth is less effective than in-person treatment, and difficulty feeling connected to their therapist. Providers commonly reported screen-use fatigue, technology issues, and lack of patient engagement. The majority of providers and patients expressed the desire to use a combination of in-person and telehealth services in the future, post-pandemic. Findings may be used to inform telehealth treatment options in both pandemic and non-pandemic times.

Keywords Telehealth · Concurrent disorders · Addiction · Mental health · Therapy

Introduction

While the uncertainty and upheaval caused by the COVID-19 pandemic created widespread stress, persons with pre-existing severe addiction and mental health (AMH) issues were identified as a particularly vulnerable group during this time (Yao et al., 2020). With outpatient clinics limiting face-to-face services to reduce infection rates, disruption to usual access to care and increased isolation put these individuals at significant risk for relapse or worsening of their conditions (CCSA, 2020; CMHA & UBC, 2020). In response to these events, there was a sudden, unexpected shift to providing many outpatient mental health services virtually (Appleton et al., 2021; Moreno et al., 2020; Sheridan Rains et al., 2021). As recognized by Wind et al. (2020), this rapid uptake of telehealth for AMH offered a unique opportunity to examine the experiences of delivering and accessing services in this way, in real-time.

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Studies conducted prior to and during the pandemic have identified numerous benefits of telehealth. These included a reduction of treatment costs (Hilty et al., 2013), improved access to care (Hilty et al., 2013; Schriger et al., 2022), and increases in attendance and clinical retention (Schriger et al., 2022; Sugarman et al., 2021), with high levels of satisfaction reported with telehealth services with little adverse effect on the therapeutic alliance (Connolly et al., 2020). Despite these reported benefits, prior to the pandemic, the slow adoption of telehealth services within outpatient settings may be explained by perceived barriers associated with implementation, including clinician reluctance, privacy concerns, and beliefs that telehealth would interfere with the therapeutic alliance (Sherrill et al., 2022). For example, patients and clinicians reported facing issues with both the functionality and access to technology required to conduct and attend telehealth services (Phimphasone-Brady et al., 2021; Schriger et al., 2022; Sugarman et al., 2021; Yellowlees et al., 2020), the presence of care disparities for older patient populations or those with limited internet access (Phimphasone-Brady et al., 2021; Schriger et al., 2022; Sugarman et al., 2021), and an increased burden to clinicians associated with providing treatment using telehealth (e.g., screen fatigue) (Schriger et al., 2022; Sugarman et al., 2021). Recognizing and understanding the

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impact of these challenges is necessary to identify when telehealth is suitable and for what patients, as compared to in-person treatment.

While telehealth has shown tremendous promise for increasing treatment access, further research is needed regarding the use of telehealth services with specialized patient populations, including those with substance use disorders (Lin et al., 2019) and concurrent AMH concerns more specifically. Experiences with telehealth may differ for patients in this population due to the historical reliance on face-to-face interaction as part of treatment, which can be critical to reinforcing abstinence from substances during and between treatment sessions. For example, many outpatient programs use breathalyzer or urine drug screening (UDS) tests to motivate patients and improve providers' ability to monitor active substance use (Kolla et al., 2019). Group-based treatment is also widely accepted as an important component of treatment for substance use disorders (e.g., Weiss et al., 2004), as a group setting can provide a foundation for affecting a patient's behavior by means of social support and social pressure to change (Sobell & Sobell, 2011). Further, some patients who suffer from severe concurrent AMH concerns may not have reliable phone service or Internet access, whereas others may be especially concerned about their privacy due either to their living conditions or the stigma associated with addiction, above mental health problems alone (Oesterle et al., 2020).

To date, one large mixed-methods study undertaken by the Canadian Centre on Substance Use and Addiction and partners revealed that patients who accessed care via telehealth for substance use and concurrent disorders during the pandemic generally reported that their needs were adequately assessed during virtual visits, and they felt comfortable meeting their healthcare provider virtually (Goodman et al., 2022). Although half of the respondents expressed the belief that virtual services were as effective as in-person care, more than half also expressed a preference for in-person meetings (Goodman et al., 2022). Clinicians interviewed on their experiences providing telehealth services commonly reported challenges associated with patient engagement, accountability, and behavior during sessions, while also identifying benefits of being able to reach clients with more scheduling and geographic flexibility. Clinicians acknowledged that certain patient populations were more likely to struggle with virtual care (e.g., individuals with ADHD) than others (Goodman et al., 2022).

The current study sought to add to the literature on the use of telehealth with concurrent disorders populations. However, unique to this study was the examination of the perspectives of both providers (mental health clinicians and physicians/psychiatrists) delivering and patients accessing treatment for concurrent disorders via telehealth at the same outpatient clinic during the COVID-19 pandemic. Using a mixed methods approach via an online survey, our study explored the following questions: (1) What were provider experiences with and opinions of telehealth prior to the pandemic? (2) How did opinions regarding telehealth change since using telehealth? (3) What were the experiences of patients with concurrent disorders who used telehealth during the COVID-19 pandemic? (4) What were the most common challenges and benefits experienced using telehealth for providers and patients? (5) What are patients' and providers' preferences for accessing and delivering AMH treatment after the pandemic?

Methods

Ethical approval for this study was obtained from the Conjoint Health Research Ethics Board (CHREB) at the University of Calgary (REB20-1812). This study was supported by a research development grant from the Canadian Research Initiative in Substance Misuse (CRISM) Prairies Node, which is funded by the Canadian Institutes of Health Research.

Participants

The current study gathered perspectives from providers (clinicians and physicians/psychiatrists) and patients who provided or accessed AMH services at a specific outpatient concurrent disorders clinic during the COVID-19 pandemic (between March 13, 2020, and June 8, 2021) and for whom we had access to an email address. To attempt to get as large a sample and breadth of perspectives, 27 former and current clinicians and 12 former and current physicians/psychiatrists were invited to participate. There were 493 patients listed as active in the timeframe above. Of these patients, 75 were deemed ineligible (e.g., deceased, incarcerated, had only one appointment after February 2020). We obtained email addresses for 382 of the remaining 418 patients. Emails were sent to 382 patients, with 368 being received and accepted (e.g., 11 emails were undeliverable and 3 patients asked to be removed from the invitation). Ultimately, email invitations reached 74.6% of our total possible sample of patients. All participants were notified that their involvement was voluntary and anonymous. Participants who completed the survey were eligible to enter to win one of ten $50 gift cards from Everything Card, an online gift card distributor that provides vouchers to a range of popular retailers.

Procedure

Email addresses of current and former providers who delivered treatment during the study period were obtained from a workplace e-mail directory. Email addresses of adult patients who accessed treatment during the study period

were obtained from a patient enrollment list provided by the clinic's data support team and through chart review. Attempts to obtain email addresses for patients who were not captured on the enrollment list or chart review were made through phone calls. Participants were invited to participate via email, which included a link to a detailed consent form and the online survey. Emails were sent on three separate occasions (an initial invitation and two reminder emails) between July and October 2021. Informed consent was obtained from all participants included in the study. All participants consented to the findings being published in an academic journal.

Materials

Separate survey forms for provider and patient participants were created by the study team to address the identified research questions. Literature assessing perceptions of and experience with telehealth by patients and providers was consulted to identify any previous surveys of a similar nature (e.g., McClellan et al., 2020). Some questions were inspired by such literature, but the wording was adjusted to suit our precise research questions (e.g., asking about experiences transitioning to telehealth during a pandemic). The number of survey items varied based on the answers provided during the survey (i.e., reporting of certain experiences led to additional follow-up questions). Both surveys consisted of 8–10 demographic questions. Patient surveys included up to 28 questions about the impact of the pandemic on their addiction and mental health (analysis and reporting of these results are not included in the current manuscript) and up to 20 questions about their experiences related to receiving AMH services using telehealth, their preferences, whether their needs were met via telehealth, the benefits and challenges of using telehealth, and suggestions for future use of telehealth. Provider surveys included up to 35 questions about their experiences with delivering AMH services prior to and during the pandemic, their self-perceived competency and confidence with telehealth, the transition to using telehealth, and their preferences, needs, and opinions regarding using telehealth in the future. The questions were a combination of closed and open-ended questions, and participants could opt out of the survey at any time (partial survey completion was accepted). It was estimated that the survey would take 45 minutes or less for participants to complete based on piloting by researchers and a clinician outside of the research team. The survey was hosted using REDCap survey software, a secure online platform.

Data Analysis

Quantitative data were analyzed using descriptive statistics to report how common an experience was among our sample. Missing data was not replaced due to the nature of the questions being asked, so the specific number of participants for whom data is available is provided when percentages are used.

Open-ended questions were coded using thematic analysis (Braun & Clarke, 2006). The frequency of responses that correspond to specific themes is reported to acknowledge how common the theme was among participants. The open-ended question responses were independently reviewed by two of the authors (SJ and DW). First, distinct concepts and categories were generated as each response was coded and commonalities were identified. Individual responses may have fit into multiple categories if distinct enough concepts were referred to. When relevant, first- and second-level categories or subthemes were identified. Data tables were built to organize first- and second-level themes and to include illustrative quotes, as done by others for ease of readability (e.g., Sugarman et al., 2021). SJ and DW met later to review first- and second-level themes where consensus was reached regarding the concepts referred to in each response as well as the most accurate representation of these concepts in the theme title.

Results

Tables 1 and 2 outline the demographic characteristics of providers and adult patient participants, respectively. The response rate for patient participants was 20.7% (with 76/368 patients responding to an invitation to participate), and 59.0% for providers (with responses from 20/27 clinicians and 3/12 physicians invited to participate).

Pre-Pandemic Experiences and Opinions of Telehealth

Providers

Prior to the COVID-19 pandemic, 81.8% ($n = 18/21$) of provider participants reported they had never attended or received training on adapting therapy/services to telehealth. No participants had provided individual therapy or group therapy treatment via videoconferencing at our clinic pre-pandemic. In an open-ended question, participants ($n = 21$) were asked what their opinions were prior to the COVID-19 pandemic about providing AMH services via telehealth. As outlined in Table 3, three main themes emerged.

Patients

Prior to the COVID-19 pandemic, 36.5% ($n = 23/63$) of participants had never previously accessed AMH

Table 1 Demographic characteristics of provider participants ($N = 23$)

	M	SD	Range
Age	41.73	10.82	
		n	%
Occupation			
Clinician		20	87.0
Physicians/psychiatrists		3	13.0
Gender			
Female		18	78.3
Male		5	21.7
Ethnicity			
Caucasian		15	65.2
South Asian (Indian, Afghan, Pakistani, Sri Lankan)		2	8.7
Asian (Japanese, Chinese, Korean)		1	4.3
Metis		1	4.3
Biracial		2	8.7
Other/prefer not to say		8	8.7
Highest degree/training background			
Master of social work		8	34.8
Master of psychology		4	17.4
Doctorate of psychology		2	8.7
Registered nurse		1	4.3
Nurse practitioner		2	8.7
Occupational therapist		1	4.3
Fellow of the Royal College of Physicians of Canada		3	13.0
Other		2	8.7
Years of clinical experience (face-to-face)			
0–3		3	13.0
4–6		3	13.0
7–10		4	17.4
10–15		6	26.1
16–20		4	17.4
> 20 years		3	13.0
Primary therapeutic orientation ($n = 15$)			
Cognitive behavioral therapy		10	45.5
Other[a]		5	22.7
Secondary therapeutic orientation ($n = 12$)			
Dialectical behavioral therapy		8	42.1
Acceptance and commitment therapy		4	21.1

[a]Other responses included interpersonal therapy, mindfulness-based therapy, narrative therapy, accelerated resolution therapy, and schema therapy

treatment by telephone, and 68.3% ($n = 43/63$) had never accessed treatment using videoconferencing. Among those who had previously accessed treatment using telehealth at our outpatient clinic, 38.1% ($n = 24/63$) did so by telephone, and 19.0% ($n = 12/63$) did so using videoconferencing. Of note, prior to the pandemic, one of the rurally located physicians who was linked to our clinic, provided intake assessments and psychiatric consultation via videoconferencing (while patients were in person at our clinic). This may be why some patient participants reported previously accessing videoconferencing at our clinic whereas none of the providers reported having provided videoconferencing at our clinic prior to the pandemic.

Table 2 Demographic characteristics of patient participants ($N=76$)

	M	SD	Range
Age	42.93	11.74	20–66
		n	**%**
Gender			
Female		45	59.2
Male		29	32.2
Non-binary		1	1.3
Prefer not to specify		1	1.3
Ethnicity			
Caucasian		67	88.2
Arab		3	3.9
First Nations		3	3.9
Latin American		1	1.3
Biracial		1	1.3
Other		1	1.3
Education			
Completed less than high school		9	11.8
Received high school diploma		5	6.6
Completed some post-secondary education or higher		55	72.4
Other		5	6.6
None of the choices apply		2	2.6
Employment Status[a]			
Working (full-time, part-time, self-employed)		35	46.1
Currently seeking employment		15	19.7
Not working (unable, retired, student, not seeking work)		43	56.6
Other		5	6.6
Seeking treatment for[a]			
Substance use		70	92.1
Addictive behaviors		16	21.1
Anxiety		52	68.4
Trauma or PTSD		44	57.9
OCD		13	17.1
Depression or bipolar disorder		42	55.3
Schizophrenia/psychotic disorder		4	5.3
Eating disorder		12	15.8
ADHD		22	28.9
Learning disability		6	7.9
Personality concerns		23	30.3
Other		1	1.3

[a]Participants may be represented in more than one category

Experiences with Telehealth during the COVID-19 Pandemic

Providers

Since providing AMH services via telehealth, 72.7% of participants ($n=16/22$) reported having *increased* satisfaction with and openness to using telehealth, one participant reported *decreased* satisfaction and openness to telehealth (4.5%), and five participants indicated their opinion has stayed the same (22.7%). Of those whose opinion had stayed the same, four out of five had indicated they were not supportive of the use of telehealth prior to the pandemic (according to open-ended responses). Sixteen participants provided more details about these opinions, which were coded into the following themes (see Table 4):

Table 3 Themes and sub-theme regarding opinions of providing AMH services via telehealth prior to the COVID-19 pandemic

Qualitative results	Illustrative quotes	Frequency, (*n* (%); *n* = 21/23)
Doubts about the effectiveness, feasibility, and ease of use of telehealth	"I thought it wasn't effective and there was no space for it."	15 (71.4)
Specific concerns regarding the use of telehealth	"[I] thought patients would not want to use [telehealth]." "[I had] doubts about [the] ability to connect with clients and their ability to connect with each other [in group therapy]."	5 (23.8)
Interested in and supportive of telehealth	"[I] was very interested in trying it as I felt that for people who cannot access the clinic could still have therapy services."	6 (28.6)

Participants opinions may be represented in more than one theme

Patients

When patients were asked if they felt they were able to access the AMH treatment they needed using telehealth sessions, 73.3% (*n* = 33/45) responded "yes" or "mostly yes" on a 4-point Likert scale. Over half of participants endorsed videoconferencing as their preferred method for accessing AMH by telehealth (*n* = 25/46, 54.3%) but many expressed the desire for flexibility to use telephone or videoconferencing (*n* = 14/46, 30.4%). Few endorsed telephone as their preferred method (*n* = 2/46, 4.3%). Forty participants shared their specific feedback in open-ended responses about why they felt they were, or were not, able to receive the AMH treatment they needed through telehealth sessions, which was coded into themes summarized in Table 5.

Table 4 Themes regarding how provider participants' opinions on telehealth have changed since providing AMH services during the COVID-19 pandemic

Qualitative results	Illustrative quotes	Frequency, (*n* (%); *n* = 16/23)
Telehealth has limitations as compared to in-person	"I don't believe that group therapy is as effective or helpful on video conferencing." "I feel face to face therapy has potential of going deeper and being more effective when we are working with trauma/intense emotions." "Tech issues are common and frustrating (inconsistent internet connection, poor audio, video, dropped calls…)	13 (81.3)
Telehealth can improve access, is convenient, and provides flexibility	"I have realized that telehealth limits barriers to access and better allows meeting people where they are at." "For people who have issues with barriers to transportation, financial cost of parking and time missed at work it is beneficial."	8 (50.0)
Mixed or neutral opinions	"I feel that there are pros and cons to teletherapy." "I still think telehealth is not as good as in-person. However, if there is no other way to deliver services it is an acceptable second best." "I believe a hybrid model of in-person with some virtual offerings would be great."	5 (31.3)
Telehealth appeals to certain patients	"There are some who appear more comfortable online." "Has worked better for some clients re: attendance/engagement."	5 (31.3)
Experienced a shift in beliefs about the effectiveness of telehealth	"I now believe that therapy services provided via telehealth can be very effective." "I am impressed that individual therapy can be as in depth on video and is similar to in person sessions."	4 (25.0)
Experienced clinician-specific benefits	"I find it easier to take clinical notes, I feel more efficient, I can more easily access resources in session, supervision is more accessible, my clients express satisfaction with the services, it saves time to not move between offices… I see minimal downsides."	2 (12.5)

Table 5 Themes regarding whether patient participants felt they were able to get the AMH treatment they needed using telehealth

Qualitative results	Illustrative quotes	Frequency, (*n* (%); *n* = 40)
Yes, I was able to get the addiction and mental health treatment I needed using telehealth because…		
It was convenient and made treatment accessible	"I felt that online sessions were more easily accessible than in-person meetings." "Online conferencing allowed for me to participate while providing care to my kids, while completing online school and while not feeling well." "I was able to move and continue treatment without having to drive back into the city for each appointment, which freed up a lot of time."	8 (20.0)
It involved less anxiety	"[Telehealth sessions] helped me get deeper in my sessions because I was in the comfort of my own home."	5 (12.5)
It allowed for continuation or initiation of treatment	"I was able to get access to online help via Zoom and Microsoft Teams both through your services and my personal counseling services in order to discuss and deal with my mental health issues."	4 (10.0)
(Because) of the therapist and/or the pre-existing therapeutic relationship that was established in-person	"I have a very good very dedicated therapist that has been super supportive during COVID-19. I wasn't sure about Zoom initially. I had never done treatment that way. It worked out well!" "I had a very good counselor and we worked through many things. I felt comfortable disclosing and working with him."	4 (10.0)
It allowed for full visual cues	"Nice to see other faces." "I could see my counselor regularly and Zoom allowed her to see me and pick up on any visual cues."	3 (7.0)
It was effective and improved the treatment experience	"I am able to be my more authentic self when receiving treatment from my own home." "I was floored by how effective and helpful and powerful the videoconferencing sessions were, and I really looked forward to them every week."	3 (7.0)
It was positive for social interaction	"It had the connections and the social interactions I needed, however, it was just enough to keep me busy. But, social interaction was more helpful. Zoom was a great help during the lock down."	1 (2.5)
No, I found accessing addiction and mental health treatment using telehealth challenging because…		
Telehealth was experienced as less effective and/or harmful	"Zoom is not effective and I found it harmful and stressful for addiction and PTSD." "I am still getting the same info, but being in a different environment. Sitting home had some of its triggers right there in front of me." "I would have much preferred in-person sessions because the telehealth sessions were very brief and vague and having no physical meeting with my psychiatrist or case manager made it seem very disconnected with my needs."	8 (20.0)
In-person was preferred for sharing and connection	"Being in-person is always more personal and I feel that I build a better connection that way." "Video or phone cuts out the necessary physical or energetic element that comes with meeting in person. I would not have been able to do my therapy over Zoom if I had not already been familiar with my counselors."	8 (20.0)
In-person therapy was preferred but telehealth was accepted as an alternative	"I think it's [telehealth] a great option but I prefer in-person for most things, especially with technology not always working perfectly." "I 100% prefer in person. However, when that's not possible, telehealth is an ok alternative."	5 (12.5)
Telehealth had technology issues, limitations, and risks	"There have been several times where the zoom call was having connectivity issues and it would cut out from video or audio… it made me feel less 'safe' and less 'heard' which is no fault of the people providing telehealth sessions, but just a fundamental flaw of telehealth in general."	3 (7.0)

Benefits Associated with Telehealth

Provider and patient participants were asked to share their opinions on the benefits that they experienced while using telehealth to deliver and receive AMH services. In response to various options, participants were asked to indicate if a particular benefit was "once a benefit," was "initially a benefit," "sometimes was or is a benefit," and/or "is an ongoing benefit," or leave it blank if it was never a benefit. More than one response option could be selected; however, this was uncommon (see Figs. 1 and 2). Providers most often reported benefits associated with reduced travel and parking expenses for patients; similarly, patients also commonly reported benefits associated with accessibility to treatment, such as being able to attend appointments with more ease and frequency. Gaining confidence in providing telehealth services was also widely acknowledged as a provider benefit, as was gaining a window into a patient's living environment. Reducing exposure to COVID-19 was purported an important benefit by both participant groups.

Challenges Associated with Telehealth

All participants were asked to share their opinions on the challenges they experienced while using telehealth to deliver and receive AMH treatment. Participants were asked to indicate if a challenge was "once a challenge," was "initially a challenge," "sometimes was or is a challenge,", and/or "is an ongoing challenge." More than one response option could be selected; however, this was uncommon (see Figs. 3 and 4). The most common challenges reported by providers were screen-use fatigue, followed by lack of patient engagement due to distractible environment, and technology issues, including issues with email encryption requirements. In comparison, the most common challenges reported by patients were issues with internet connection, the belief that telehealth is not as effective as in-person therapy, and difficulty feeling connected to their therapist. Participants were also asked what percentage of their telehealth sessions have gone well, and where they have been able to complete the sessions without challenges interfering with their experience. Patients ($n=36$) reported that, on average, 76.11% (SD = 31.67; median = 90) of their telehealth sessions had gone well, where they were able to complete them without challenges. Of those participants, 55.7% reported that 90% or more of their sessions were occurring without challenges. Providers ($n=20$) reported that, on average, 66.85% (SD = 21.76; median = 75) of their telehealth sessions occurred without challenges; of those participants, only 10% reported that 90% or more of their sessions were occurring without challenges. Nonetheless, providers were asked if these challenges improved over time once they and their patients had become comfortable with telehealth: over three-quarters (77.3%; $n=17/22$) reported 'yes.'

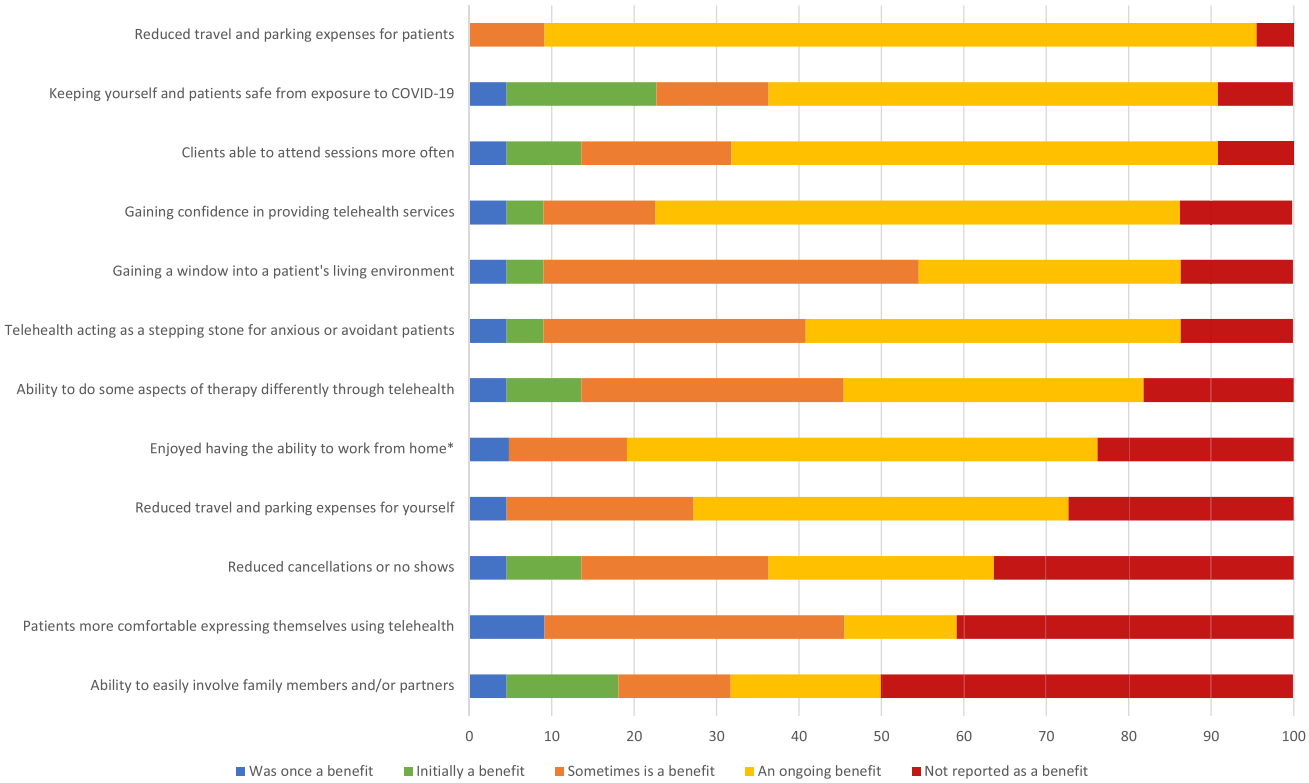

Fig. 1 Percentage of providers who reported benefits associated with telehealth ($n=22$). Item denoted with an asterisk (*) was replied to by $n=21$

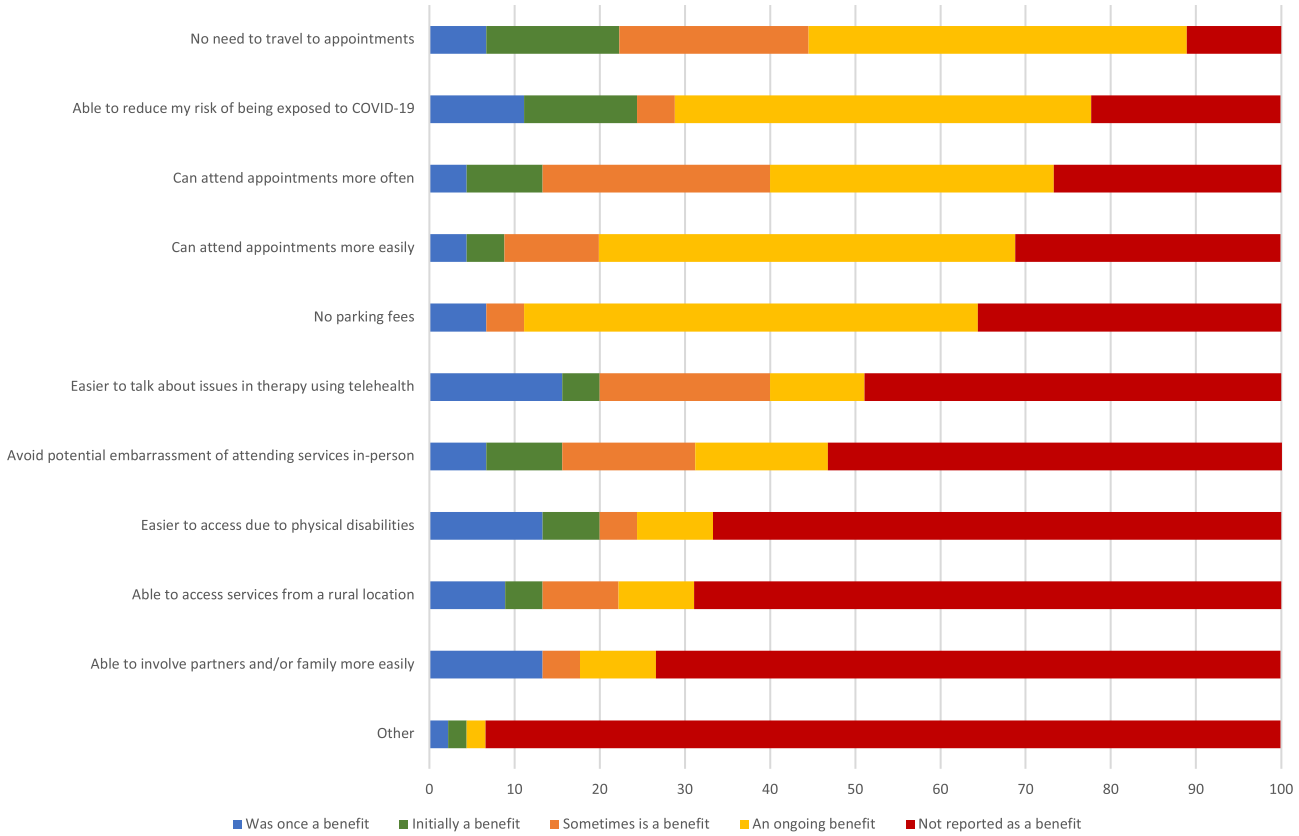

Fig. 2 Percentage of patients who reported benefits associated with telehealth ($n = 45$)

Telehealth Preferences and Recommendations for Future Use of Telehealth

Providers

Nearly 60% ($n = 13/22$) of providers reported that videoconferencing was their preferred method for delivering AMH services using telehealth. About 40% ($n = 9/22$) preferred the flexibility to use videoconference or telephone, depending on patient desire or clinician recommendation. When asked about their preferred option for delivering AMH services in the future, post-pandemic, over 90% ($n = 20/22$) of providers reported the desire to use some sort of combination of in-person and telehealth services. Under 10% ($n = 2/22$) preferred in-person services only and no participants preferred telehealth only.

Patients

A large majority of patients reported they would like to access future services through a blend of both telehealth and in-person treatment ($n = 40/58$, 69.0%), with others reporting the desire to access services in-person only ($n = 16/58$, 27.6%), and one participant reporting the desire to access services via telehealth only (1.7%). Both participant groups were asked to comment on how they envisioned their ideal approach to delivering and receiving blended treatment in the future. Common and unique themes across both participants are summarized in Table 6.

Discussion

Prior to the COVID-19 pandemic, many AMH providers and patients worldwide had not used telehealth to provide and receive clinical services (Cantor et al., 2022; Pierce et al., 2021; Zhu et al., 2021) and the current study's sample was no exception. The pandemic offered an opportunity to better understand how telehealth was experienced by providers and patients, specifically in a concurrent disorders population in "real-time." Prior to the mandatory shift to telehealth, the majority of the current study's providers expressed doubts regarding the effectiveness, ease of use, and feasibility of incorporating telehealth into their practice. It was found that exposure and regular use of telehealth led many providers' opinions to shift, resulting in greater openness and satisfaction with this modality and a strong preference for retaining telehealth as a treatment option after the pandemic. Similar findings have been reported by those in other health disciplines (Douglass et al., 2023; Rettinger et al., 2023). Further, nearly three-quarters of patients felt they were able to access the AMH treatment they needed via telehealth, citing its

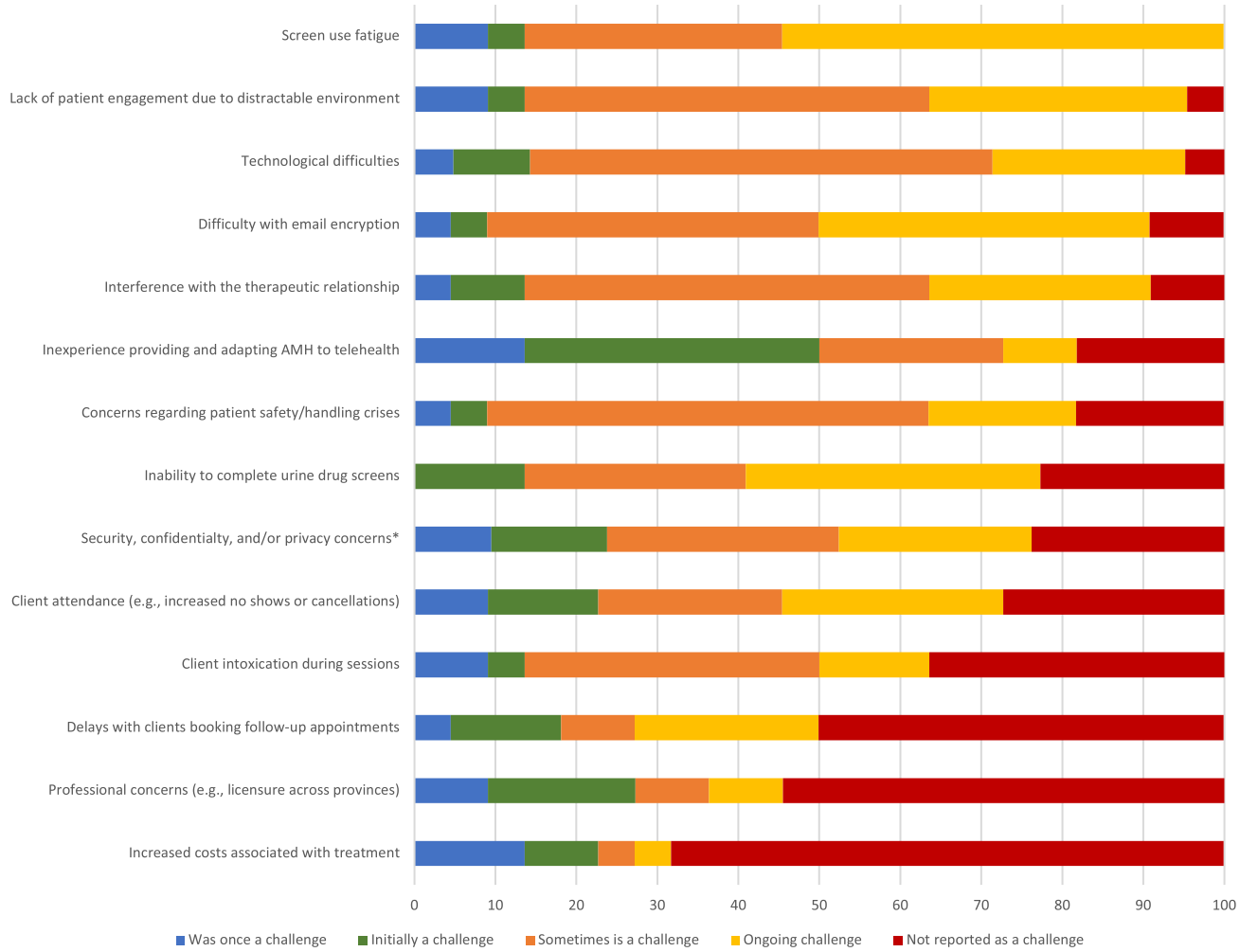

Fig. 3 Percentage of providers who reported challenges associated with telehealth ($n=22$) Item denoted with an asterisk (*) was replied to by $n=21$

convenience, the ability to allow for full visual cues (compared to required masking for in-person services), and it involving less anxiety as important benefits. A comparable number of patients and providers advocated for retaining telehealth as a permanent option to blend with in-person services; those that did highlighted numerous reasons why it would be beneficial to do so.

The benefits and challenges experienced when using telehealth that were identified by our patients and providers in a concurrent disorder setting echo that of previous research (Connolly et al., 2020; Hilty et al., 2013; Schriger et al., 2022), with the most reported benefits related to increased accessibility to services. Patients and providers alike endorsed the ongoing benefits of not needing to travel to appointments and patients' ability to avoid paying hospital parking fees, and the ability for patients to attend sessions more frequently and easily. While these benefits are not unique to a concurrent disorders' population, they may be especially important to a group of people who are susceptible to being in a lower income bracket compared to those who have substance use disorders alone (Khan, 2017). In a recent review by Wolfe et al. (2023), transportation issues were cited as one of the most common barriers to treatment access for problematic alcohol use, highlighting just how critical it may be for telehealth to address a gap in service access. Having an insider's view of their patient's living environment was also cited as a benefit of telehealth by providers. Persons with concurrent disorders are at higher risk for poorer living conditions (compared to those with substance use disorders alone), such as living with or near other substance users or in lower-income neighborhoods (Fleury et al., 2015). It is expected that telehealth may reveal more deeply how one's living environment interacts with patients' AMH issues and help determine if housing support is critical to treatment success. Further, patients liked being able to reduce their risk to COVID-19, which is a significant benefit given that those with concurrent disorders tend to be in poorer physical health compared to those with mental

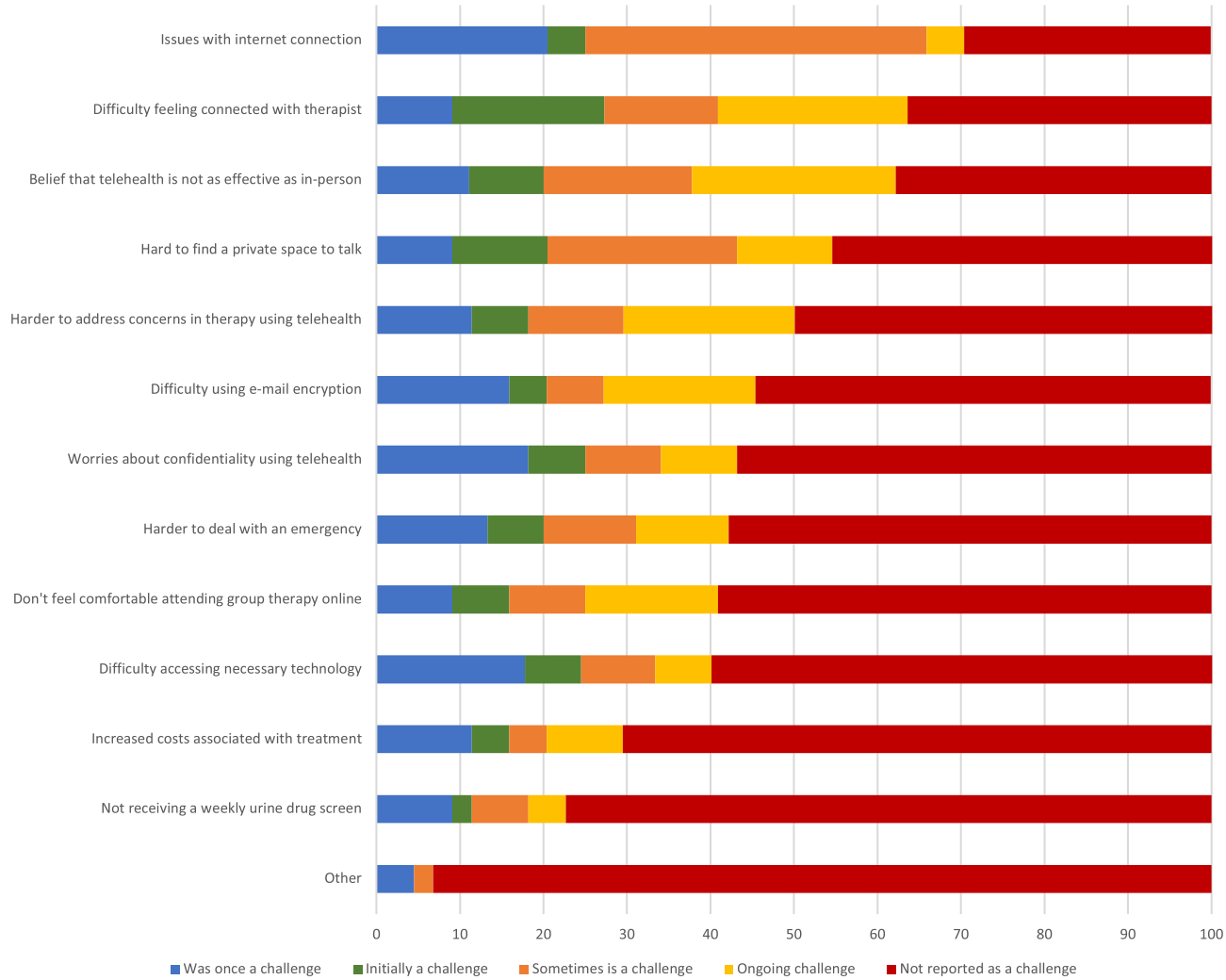

Fig. 4 Percentage of patients who reported challenges associated with telehealth ($n = 44$)

health issues only (Fleury et al., 2015). Importantly, many of the identified benefits extend to patients and providers beyond the pandemic.

Although the perceived benefits of telehealth reported by our sample were numerous, providing AMH services using telehealth was not without challenges. Ongoing challenges frequently identified by patients included practical issues related to space and technology (e.g., lacking a private space to receive treatment, unstable or unreliable access to the internet), difficulties feeling connected to their therapist, and doubts about the effectiveness of telehealth in comparison to in-person services. Providers, on the other hand, most struggled with screen-use fatigue, the lack of patient engagement due to patients being in a distractible environment, and technological difficulties. The most common concerns with telehealth identified in our sample were, again, not exclusive to those with or treating concurrent disorders, but population-specific characteristics may make some of these barriers more difficult to address. For example, treatment of concurrent disorders is not always standardized given the diversity of conditions, with mental health issues ranging from personality to neurodevelopmental to trauma and stress-related disorders and substance use and addictive behavioral concerns of all types. Being able to guarantee that treatment effectiveness is not affected by the use of telehealth may be harder to do in a complex concurrent disorder setting. Similarly, the living conditions of some patients with concurrent disorders simply will not permit access to privacy, reliable internet, or an environment that is distraction-free. In-person services will remain critical for such patients. On the other hand, addressing challenges that are amenable to change, such as determining what helps or hinders screen use fatigue, will be key for treatment providers that intend to offer telehealth services long-term, particularly since telehealth challenges experienced by both psychologists and their patients is associated with psychologists' mental health (Lin et al., 2022).

Table 6 Themes regarding the future of delivery of AMH treatment services (providers $n=17$; patients $n=29$)

Qualitative results	Participant group	Subtheme	Illustrative quotes	Frequency *n* (%)
Desire for flexibility	Providers	Modality should be based on client preferences, needs, and clinician/client availability	"Asking clients what they prefer; some clients may prefer primarily in person while others will prefer primarily online. Some may be a mix depending on their schedules." "Meeting patient needs for either telehealth or in person on a case-by-case basis." "Exploring with clients the added benefits of in person (deeper trauma work, emotional work, client therapist relationship, less distracting environment)."	8 (47.1)
		Want flexibility in deciding the combination of telehealth and in-person services/adjust staff schedules accordingly	"As a physician … I would plan on making some clinics virtual and certain clinics in person." "Our schedules may need additional planning to accommodate shared offices and working from home. Perhaps certain days in the week can be telehealth/WFH days while others can be in person days and we can schedule clients accordingly."	10 (58.8)
	Patients	Create a blend of services specific to the needs of each individual patient	"I believe a mixture of in-person and telehealth appointments may be more realistic for people who have many demands in their personal lives and work full time or have kids, etc. [They should] be able to access treatment in a flexible way that works best for them." "I think there is a space for both in-person and zoom to be used, it just depends on the specific circumstance of each person."	5 (17.2)
Choice of telehealth or in-person sessions based on the appointment type	Providers	Specific services should be offered in-person and telehealth	"Assessment and group therapy in person; individual sessions and orientation over zoom."	7 (41.2)
	Patients	Offer options for in-person or telehealth depending on appointment type or progression through treatment	"Maybe a weekly in person group. Feel the group out and I'd probably be way more comfortable sharing with the same people online. Or even once like a meet and greet kinda thing." "I think there are certain people that would benefit from being able to do telehealth rather than in person, but I think the initial meetings need to be in person. There is just no substitute." "But some of the treatments I was receiving (EMDR) could not be done online, so in person would be better for those."	9 (31.0)

Table 6 (continued)

Qualitative results	Participant group	Subtheme	Illustrative quotes	Frequency *n* (%)
Retain telehealth as an option	Patients	Retain online therapy for continued patient convenience	"I found the online appointments very convenient because I could fit them in while working." "I don't mind meeting therapists in person, but it takes a much larger part of my day." "[I would like to] attend in-person on days where my days are less busy and use telehealth on the busier days or times when I don't have much time."	7 (24.1)
		Offer telehealth as an option for individuals who experience anxiety attending in-person treatment	"As somebody who was afraid/unsure of group therapy, online groups were easier for me to try and get used to [it] in a safe way. [I] may not have tried in-person groups if that was my only option."	2 (6.9)
Continue to offer in-person services	Patients	Offer in-person therapy for enhanced social connection and social interaction	"It is certainly necessary to have regular in-person appointments in order to have more connected time with your healthcare provider." "In-person makes me get out and allows my therapist to observe my physical behavior."	7 (24.1)

Challenges associated with telehealth that we expected to be relevant to our concurrent disorders' population were the inability to complete any in-person UDS tests for substances and the difficulty in providing services while patients could be actively using substances in their homes during telehealth sessions. Although technology difficulties and interference with the therapeutic relationship surpassed both in terms of the most frequently occurring barriers, lack of access to UDS and intoxication during sessions were still identified as being either "sometimes" or "an ongoing challenge" by 63.7 and 50% of providers, respectively. While the pandemic has forced the treatment community to examine their practice of relying on such tests (e.g., due to abstinence not being the goal for every patient, the potential stigmatizing experience of mandatory testing; Khatri & Aronowitz, 2021), treatment providers who are accustomed to such practices may need guidance to determine when telehealth is a deterrent to patient engagement, motivation, and substance reduction. Additionally, there continues to be a high risk for drug toxicity, and many users are not aware of the contents of their substance of choice (Niles et al., 2021), making UDS tests a crucial, life-saving treatment component in some cases.

As previously indicated, group therapy is often relied upon in the treatment of addictive and concurrent disorders (Sobell & Sobell, 2011; Weiss et al., 2004). While the specific examination of the group versus individual therapy experience was not distinguished in the current study, some patient and provider comments pointed to concerns with being able to establish rapport and a sense of safety in group treatment using telehealth, instead preferring in-person treatment for at least some or all group sessions in the future. To improve the telehealth group therapy experience, clinicians have put forth practical ideas, including ensuring the positioning of the camera to allow for the therapist's gaze to most closely approximate eye contact with group members and using icebreaker questions to develop comfort sharing personal information (and to allow addressing technological issues early on; Kneeland et al., 2021). Such advice is worthy of consultation prior to assuming that group therapy should automatically be designated as superior in a face-to-face format.

Future Recommendations

Participants from both the provider and patient samples expressed the desire for blended treatment options (i.e., offering access to both in-person and telehealth services in the same clinic) post-pandemic, with specific treatment plans tailored to each individual's desires and needs. Prior to the COVID-19 pandemic, patients were generally required to attend their initial intake appointment and subsequent treatment in person. However, telehealth may be a useful stepping stone for some to attend in-person treatment.

Patients who express anxiety or avoidance to starting in-person treatment may benefit from completing their initial intake appointments using telehealth, during which they are provided an opportunity to build trust with their therapist. As comfort increases, the patient may choose to transition to in-person appointments. Conversely, patients who express doubts regarding the effectiveness of telehealth or hold the belief that telehealth is inferior may desire to begin treatment in-person, and later transition to telehealth appointments once a relationship has been established with their therapist, if applicable. This approach allows the patient to enjoy the benefits of telehealth as they desire, while not sacrificing establishing a trusting relationship with their therapist.

Beyond individual patients' preferences, programs may choose to continue offering telehealth in their milieu of treatments so that telehealth benefits, such as increased accessibility and decreased costs, may be available on an ongoing basis. A feasible approach may be to offer specific in-person or online appointments, based on the type (i.e., individual or group therapy) and content of treatment. For example, skills-based therapy groups may be more suitable for telehealth, whereas other modalities may be more difficult to effectively implement online (e.g., interpersonal group therapy). Other aspects to consider when implementing a hybrid approach in a concurrent disorders' population may include reflection on whether there is a need for ongoing access to UDS, which requires in-person attendance, or if the client has a history of attending telehealth sessions intoxicated. Clinical judgment may be used to determine if in-person treatment attendance is more appropriate for specific clients. For example, in-person attendance may provide a higher level of accountability that would encourage the client to abstain from substance use and would allow the client access to complete a UDS. Regardless, decision-making regarding a blended approach to treatment delivery is complex and should incorporate perspectives from both treatment providers and patients, and ongoing treatment satisfaction and effectiveness surveys should be implemented to support such determinations.

Future directions should also focus on practical solutions that may be implemented to address the frequently reported challenges raised by both patients and providers. As summarized by Douglass et al. (2023), the longevity of telehealth programs will rely on ensuring that providers have access to adequate telehealth training opportunities to help build confidence in therapy delivery using telehealth modalities and that barriers surrounding technology are addressed for both therapists and patients. Issues with internet connection, and email encryption) were reported by both. If internet connection is inconsistent, in-person treatment may be recommended as the primary treatment modality. Simple instruction guides could be developed to improve comfort with site-specific technological processes. Having a collaborative discussion at the onset of treatment to emphasize the importance of having a private space and to intentionally limit distractions in the environment, may reduce clinician concerns regarding patient engagement when using telehealth. Recognition of which patients fare better (or worse) with distractions can be a part of clinicians' judgment on who to offer telehealth to. Reviewing the evidence with patients regarding the effectiveness of telehealth for treating concurrent disorders may potentially increase confidence in, and openness to, receiving treatment using telehealth. For example, Bean and colleagues (2022) compared the effectiveness of an outpatient group intervention delivered in-person and remotely for individuals with dual diagnoses of mental health and substance use concerns. Large improvements were observed in patients' depression, anxiety, and stress symptoms regardless of treatment modality. Having access to the latest treatment evidence is important for promoting provider–patient discussions of this nature. Finally, offering opportunities to establish an in-person connection and transitioning to telehealth as appropriate may help enhance therapeutic alliance when using telehealth. Future studies may test out this hypothesis.

Limitations

The current study was completed at a time at which in-person services were suspended. Participants used telehealth services out of necessity, rather than out of desire, which may have influenced participants' opinions regarding their experiences with telehealth. The findings of the current study may not translate to the post-pandemic climate, where telehealth may be offered as a part of a blended treatment approach but is not the required modality. Others have acknowledged that future research should explore how attitudes may differ following the "forced adoption" of telehealth in comparison to voluntary use (Douglass et al., 2023). Such research may consider exploring the attitudes toward telehealth and perceived benefits and challenges related to integrating telehealth with in-person treatment post-pandemic to investigate how opinions on delivering and receiving AMH treatment using telehealth may shift.

Both the provider and patient samples are limited in size and composition. Response rates from patient participants were low (20.7%), which may be due to the limited ability to conduct extensive recruitment efforts during the COVID-19 pandemic (i.e., no possibility for in-person recruitment, participants were notified of their eligibility via email correspondence and could not be directly approached by the researchers or known clinicians due to ethics restrictions). For patients, the survey on their experiences with telehealth was embedded in a larger survey covering other pandemic-related topics; as such, the length and order of survey questions likely led to higher attrition for telehealth-specific questions. In addition to a low response rate, the sample was homogenous in nature, with 88.2% of patient participants

self-identifying as Caucasian, and 72.4% reporting the completion of some post-secondary education or higher. It is probable that our sample was biased toward those who had a reliable internet connection and time to complete such a survey, had more motivations to provide input on their telehealth experience (whether good or bad), and had enough focus and stability to complete a longer survey, including providing written feedback in English. Therefore, the results of this study are unlikely to translate to a more ethnically and racially diverse sample, to samples of lower education levels, or to those who may have hearing or cognitive difficulties. Individuals from more diverse communities may experience telehealth differently. For example, some socially vulnerable patients express concerns about the legitimacy of telehealth as a modality of medical care (Adams et al., 2023), whereas Indigenous patients may be worried about their ability to express themselves well and understand the explanations of providers when using telehealth (Barwise et al., 2023). Telehealth has the potential to overcome numerous barriers to health equity in concurrent disorder treatment, but the experiences of those from diverse backgrounds need to be included in research aimed at addressing its barriers in the future.

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Author Contribution SJ and KB conceived and designed the study. All authors contributed to the survey development. DW and EB were responsible for recruitment and data collection. SJ and DW analyzed and interpreted the data, with contributions from KB. All authors revised the manuscript critically for important intellectual content. SJ and DW had principal responsibilities for drafting the manuscript. Edits and feedback were provided by KB and EB. All authors approved the final version.

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Data Availability The quantitative datasets (for providers and adult patients) and open-ended raw and coded verbatim responses for both participant groups are available for download from BOREALIS, PRISM Data, University of Calgary's Data Repository at https://doi.org/10.5683/SP3/JYFRNO.

Declarations

Ethical Approval Ethical approval for this study was obtained from the Conjoint Health Research Ethics Board (CHREB) at the University of Calgary (REB20-1812).

Consent to Participate Informed consent was obtained from all participants included in the study.

Consent to Publish All participants consented to the de-identified findings being published in an academic journal.

Conflict of Interest The authors declare no competing interests.

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