How the COVID-19 Pandemic Can and Must Expand Social Worker e-Interventions for Mental Health, Family Wellness, and Beyond

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Both media and academic reports have highlighted COVID-19's negative impacts on mental health and safety in the United States, yet care and service gaps persist. Evidence suggests that a default to in-person service delivery did not meet clients' needs before the pandemic, and that unmet needs have ballooned since COVID-19 spread throughout the United States due to a combination of increased stress, social isolation, and fewer available services during lockdowns. This article reviews literature on online interventions' utility and effectiveness in preventing and treating problems likely exacerbated under pandemic conditions, including mental health conditions, anger, couple dynamics, parenting, and alcohol misuse. The article also describes barriers to evidence-based e-interventions' wider and more consistent use, highlights some vulnerable populations' unique service needs, outlines service gaps that online programs might effectively mitigate, and offers a path by which social workers can lead an interdisciplinary charge in researching, developing, and implementing e-interventions during the current pandemic and beyond.

KEY WORDS: *COVID-19; e-intervention; internet-based services; prevention; treatment*

Despite significant efforts to address COVID-19's negative impacts on health and safety, service gaps—particularly for some vulnerable populations—persist. These gaps could be reduced through a wider and more intentional adoption of evidence-based e-interventions. This article reviews what is known about COVID-19's effects on individual mental health and family wellness, examines literature on the utility and evidence behind utilizing e-interventions to prevent and reduce risks, describes unique challenges faced by vulnerable populations, and offers a path by which social workers—ideally situated to overcome these complex problems by relying on our profession's core values—can lead the charge in implementing e-interventions to fill persisting gaps during the current pandemic and beyond.

COVID-19 IMPACTS ON MENTAL AND EMOTIONAL WELLNESS

Negative mental health effects of the COVID-19 pandemic are well documented. Across the United States, reports of suicidal ideation increased to more than four times previous years' rates, from 3.4 percent in 2017 and 2018 to 16.3 percent in April 2020 (Raifman et al., 2020). In the weeks

after the pandemic began, 30 percent to 35 percent of Americans reported worsening mental health problems and worsening emotional well-being (Axios-Ipsos Coronavirus Index, 2020). At the same time, alcohol use frequency increased 19 percent during the pandemic for all adults 30 to 59 years old compared with frequency rates reported in 2019, and women's heavy drinking (four or more drinks over two hours) frequency and alcohol-related problems increased 41 percent and 39 percent, respectively (Pollard et al., 2020).

COVID-19's impacts on mental wellness appear to vary between populations. One study examining mental health outcomes in the United States found that Black and Hispanic respondents reported higher rates of increased substance use and suicidality than White and Asian respondents (Czeisler et al., 2020). The same study found that Hispanic respondents reported greater increases in anxiety and depressive disorders and endorsed more COVID-19-related trauma and stress disorders than White and Asian respondents. In addition to mental health-related impacts, data show that the COVID-19 mortality rate for Black people was 2.4 times that of White people in the United States (Yancy, 2020), largely due to higher infection rates (Zelner et al., 2021). In

fact, a study of over 3 million high-risk northern Californians found that Black, Hispanic, Asian individuals, and those who did not report their race, experienced significantly higher COVID-19 infection and hospitalization rates than White individuals (Escobar et al., 2021), which is at least partially attributable to larger infection clusters in non-White communities and racial minorities' greater workplace exposures and higher rates of comorbid conditions (Escobar et al., 2021; Zelner et al., 2021). Non-White individuals' higher rates of comorbid conditions are linked to a myriad of issues perpetuating racial health disparities, including racial differences in community environments, socioeconomic factors, and access to medical care (Williams & Jackson, 2005). Compounding physical health risks, racial minorities' real and feared experiences of having a family member die from COVID-19 may contribute to their increased mental health-related problems and decreased in-person service utilization (Purtle, 2020).

In addition to race, differences in COVID-19's mental health impacts across sex and genders have also been found. For example, women report higher levels of fear of COVID-19 than men (Fitzpatrick et al., 2020). A systematic review of 19 studies found that women face increased risk for psychological distress, depression, anxiety, PTSD symptoms, and stress related to COVID-19 compared with men (Xiong et al., 2020). Furthermore, women with children have been disproportionately affected in their employment during the pandemic, as mothers have reduced their weekly work hours over four times more than fathers (Collins et al., 2021). Together, these wellness and workplace challenges indicate that women are likely spending more time socially isolated than men. This social isolation is a risk factor not only for mental and emotional health problems but also for another area commonly addressed by social workers—family wellness.

COVID-19 IMPACTS ON FAMILY SAFETY AND WELLNESS

A number of the challenges associated with COVID-19, such as increased stress, anxiety, financial strain, and substance abuse (Pollard et al., 2000; Raifman et al., 2020), combined with the social isolation caused by physical distancing, amplify risks for family violence (Bradbury-Jones & Isham, 2020). This appears especially true for certain vulnerable populations. Prepandemic studies have shown that

women and communities of color face disproportionate negative effects of domestic violence (Evans et al., 2020). Increasing already disproportionate risks, rising pandemic-driven unemployment rates are affecting women, immigrants, and racial minorities at considerably higher rates than White men (Kochhar, 2020). Thus, for populations already at elevated risk for family violence, the pandemic has simultaneously increased their financial strain and decreased their access to workplace peers and other supports who could aid in detecting, reporting, and fleeing family violence.

In addition, the broader population faces unique pandemic-driven challenges to family safety and wellness. Since COVID-19 shutdowns began, numerous countries including China, Spain, Brazil, France, India, Lebanon, and the United Kingdom have reported significantly increased domestic violence reports and domestic violence helpline and shelter calls—from 50 percent increases to tripling of previous rates (Euronews, 2020; Graham-Harrison et al., 2020; Long, 2020; Ravindran & Shah, 2020; United Nations News, 2020). Although these countries' rising domestic violence help-seeking rates, past research findings, and increased incident rates during past pandemics all indicate pandemic-driven changes increase risk of family maltreatment, some U.S. states have instead reported significantly reduced known child abuse incidences. For example, at least seven U.S. states have reported significant declines in child abuse and neglect reports since the start of the pandemic (LeBlanc, 2020). At the same time, many major U.S. cities, including Portland, Oregon; San Antonio, Texas; and New York City, have reported significantly increased family violence police reports (Boserup et al., 2020). Experts assess that inconsistencies in reports since pandemic lockdowns began do not signal a decline in family maltreatment incidences. Instead, discrepant report rates are likely attributable to children's reduced contact with mandated reporters (Thomas et al., 2020), changes in available reporting options and support services, and increases in violence severity (prompting an increase in police reports; Masbouni et al., 2020).

Another pandemic-driven factor in family violence is perpetrators' use of COVID-19 risks as a strategy to control and coerce partners, including citing stay-at-home recommendations as a means to further isolate victims and providing misinformation on COVID-19 risks to amplify fears of

leaving or help seeking (Usher et al., 2020). For victims who do seek help, support options may be limited, as pandemic-related risks and shutdowns have decreased access to family supports, shelters, friends, and legal protection orders (Sharma & Bohrah, 2020). The decreased access to formal helping resources creates new challenges for mitigating risk and ensuring safety. Even before COVID-19, safety planning was approached as a dynamic process to meet evolving circumstances (Mitchell & Anglin, 2009). While there is no standard process for family violence safety planning, plans often include specific escape resources and steps, including safe timing, transportation, and destinations that may not be accessible during the pandemic (Marples & Brown, 2020). Thus, effective safety planning now requires even greater research, flexibility, creativity, and distant (including online or telephonic) support.

Taken together, these changes—increased mental health problems, family wellness risks, social isolation, and police/crisis line responses, as well as decreased contact with mandated reporters, in-person service delivery, and safety planning resources—have created new service access needs and challenges while magnifying preexisting gaps. This need–resource chasm is not projected to narrow once the COVID-19 crisis subsides, as studies indicate that mental health problems and social service demands have persisted far beyond past pandemics’ ends (Chau et al., 2021; Luo et al., 2020). Complicating matters further, the United States faced shortages in social workers to meet service needs prior to the pandemic (Lin et al., 2016). Thus, creative solutions must be leveraged to deliver needed prevention interventions, mental health care, and social services, including online and virtual platforms (Wind et al., 2020)—where evidence suggests services should have been offered well before the crisis, and will be needed far beyond it.

E-INTERVENTIONS

Scope of e-Interventions

A myriad of terms have been used to describe e-interventions, including “online,” “app-based,” “digital,” “web-supported,” “cyber,” “e-Health,” “mobile,” “internet-based,” “technology-assisted,” “computer-based,” and “virtual” (Barak et al., 2009; Clough & Casey, 2015). Barak and colleagues (2009) outlined four distinct types of e-interventions, including (1) web-based interventions (e.g., online education, self-help, and human-supported online programs),

(2) online counseling/therapy (e.g., email-, chat-, or video-based counseling—the oldest and most researched area [Tuerk et al., 2019]), (3) internet-operated therapeutic software (e.g., robotic nondirective therapy software, expert assessment/feedback software, therapeutic virtual reality/games), and (4) other (e.g., therapeutic supplements, podcasts, online support groups). Evidence suggests that all four types of e-interventions can be effective at ameliorating a multitude of social work–relevant issues with various subpopulations in different circumstances (Barak et al., 2009). This article argues for increased consideration and thoughtful, increased utilization of all four types of e-interventions across applicable social work practice settings.

Demand for e-Interventions prior to COVID-19

Although 60 years of research verifies that e-interventions for mental health counseling are effective, useful, and safe (Tuerk et al., 2019), widespread implementation has stalled (Tuerk et al., 2019; Vis et al., 2018), and minimal research has examined e-interventions aimed at optimizing individual wellness and reducing family violence risk. The persisting lag in virtual mental health service adoption and dearth of evidence on e-interventions for prevention and families appears enabled by a care system that defaults to (or arguably prefers) in-person, reactive service delivery (Topooco et al., 2017; Wind et al., 2020), bolstered by helping professionals who reject virtual service methods out of fear that they will impede therapeutic alliance (Berger, 2017). But the default to in-person services misses the mark for the majority of clients, even in nonpandemic circumstances; a pre-COVID-19 mixed methods study found that only 44 percent of depressed respondents preferred in-person care, compared with 55 percent who desired either self-, expert-, or peer-guided digital treatments (Renn et al., 2019). Additionally, research has found that when couples experienced a crisis in their relationship, only 3 percent sought in-person relationship education and 7 percent sought counseling or therapy, whereas 38.9 percent of women and 27.8 percent of men sought information online (Trillingsgaard et al., 2019). Furthermore, in-person service delivery is less accessible to individuals who are poor and under- or uninsured (Syed et al., 2013). Taken together, these findings indicate that some clients may either

lack access to in-person care or prefer online or web-based resources over in-person care, even in nonpandemic contexts.

Evidence for e-Interventions

A multitude of mental health web-based programs have been found to be effective when supplemented with virtual or in-person provider support, when completed fully self-guided (without provider contact), or when delivered for prevention (Ebert et al., 2018). A systematic review and meta-analyses have found that mental health e-interventions, including self-help and therapeutic apps and online modules, are effective at treating clients with depression and anxiety (Karyotaki et al., 2018; Ye et al., 2014). Furthermore, a meta-analysis of mindfulness-based e-interventions found that they effectively improved depression, anxiety, well-being, and stress, particularly when programs were guided by helping professionals (Spijkerman et al., 2016).

The majority of literature in the area of mental health e-interventions has focused on treating individual mental health problems—one area relevant to social workers. But limited attention has been paid to other issues social workers commonly address, including family wellness and safety. What evidence is available suggests that e-interventions may effectively improve family wellness and mitigate family violence risk. A recent meta-analysis examining online anger management and relationship education programs targeting intimate partner violence identified only six studies, but found that e-interventions significantly reduced depression, anger, and emotional and physical intimate partner violence perpetration (Spencer et al., 2021).

Research on online parenting programs is also encouraging, as improved parenting skills can reduce potentially abusive behaviors (Geeraert et al., 2004; Lundahl et al., 2006). A meta-analysis of 28 studies examining online parenting programs (Spencer et al., 2020) found that parenting e-interventions significantly increased encouragement by parents and positive parenting behaviors, and reduced negative parent-child interactions. The same study found that parenting e-interventions significantly decreased child problem behaviors, negative discipline strategies, parenting conflicts, parent stress, child anxiety, parent anger, parent depression, and parent anxiety, while significantly increasing parent confidence, positive child behavior,

and parenting satisfaction (Spencer et al., 2020). Overall, online parenting programs appear to be effective at enhancing family wellness and preventing child maltreatment.

There is also support for online relationship education and couples programming. A meta-analysis examining 12 online relationship education programs found that the e-interventions significantly increased communication skills, relationship satisfaction, relationship confidence, positive relationship qualities, overall quality of life, and health satisfaction (Spencer & Anderson, 2021). Additionally, online relationship education programs have been found to reduce negative relationship qualities, anxiety, and depressive symptoms (Spencer & Anderson, 2021). Thus, e-interventions can help couples to manage conflict more healthfully and safely.

Alcohol misuse is another widely recognized risk factor often addressed by social workers as it may negatively impact clients' personal physical and mental health (Boden & Fergusson, 2011) as well as family wellness (Cafferky et al., 2018). White and colleagues (2010) conducted a systematic review of 17 studies evaluating alcohol e-interventions and concluded that online alcohol programs can reduce alcohol use and may prove particularly beneficial to women, young people, and at-risk drinkers. Another study of an alcohol e-intervention with at-risk drinkers found that even six months posttreatment, use of the e-intervention significantly decreased participants' alcohol consumption (Brendryen et al., 2014). Thus, alcohol e-interventions appear effective, even with more vulnerable and at-risk drinkers.

With regard to ensuring safety, evidence on the efficacy of safety planning via distanced support is lacking, but resources with discreet remote access were accessible long before the pandemic. The National Domestic Violence Hotline, established through the Violence Against Women Act of 1994 (P.L. 103-322), has remained available 24 hours a day since its launch. Additionally, most smartphones can access apps that provide local safety resource information, enable maltreatment incident logging, and include safety features such as PIN access (Jarnecke & Flanagan, 2020; Kippert, 2020). As the efficacy of safety planning e-tools is understudied and technologies continue to evolve, social workers delivering virtual services must continuously evaluate available tools to effectively under-

stand and address changing safety risks, needs, and resources.

E-Intervention Integration, Uptake, and Utilization

Despite e-interventions' known demand, utility, and efficacy, e-programs that have been found to be effective are not consistently available or affordable for helping professionals to integrate into their practices (Antoniotti et al., 2014). While some healthcare systems have fully integrated e-health, agencies with lower budgets (which often serve the poorest communities) report the most difficulties implementing e-interventions (Ramsey et al., 2016). In addition, no vetted repository of effective e-programs exists, creating risk that helping professionals responding to e-intervention demand may reach for the most available e-programs regardless of whether they have been proven effective. Furthermore, many insurance programs still require in-person interaction to bill and be reimbursed, and for those programs that do permit billing, service providers face a coding knowledge gap (Antoniotti et al., 2014).

In addition to health and helping systems' slow adoption and integration of e-interventions, some clients face difficulties accessing e-services. Today, poor families continue to lack consistent internet access and computer/technical skills (Gonzales, 2016), and other vulnerable subpopulations are also disproportionately affected by the digital divide. For example, 24 percent of people living in rural communities report that limited internet access is a "major problem" compared with just 9 percent of adults living in suburban areas (Anderson, 2018). Access disparities also extend to smartphone apps, as 95 percent of Americans ages 18 to 49 report owning a smartphone, compared with 76 percent of those who make \$30,000 or less each year and 61 percent of those ages 65 and older (Pew Research Center, 2021). Taken together, poor, rural, and elderly Americans experience disproportionately less access to e-interventions. As the pandemic forced more service delivery through virtual channels, these subpopulations' lesser internet and smartphone access will likely amplify prepandemic social determinants of health already impeding their wellness (Adler & Newman, 2002; Williams & Jackson, 2005).

Complicating e-interventions' utilization further, even when access barriers are overcome,

challenges regarding clients' adoption, adherence, and attrition persist (Donkin et al., 2011; Melville et al., 2010). Evidence suggests that clients' engagement with wellness technology platforms can improve their self-care, which can improve health outcomes (Sarasoehn-Kahn, 2013). But findings are mixed from studies that have attempted to assess the degree to which clients' e-intervention "dosage," "engagement," or "adherence" impact e-interventions' effectiveness, primarily due to inconsistent measures and diverse study outcomes (Donkin et al., 2011). Still, evidence suggests that adherence (i.e., completing more of the recommended e-intervention sessions/content) may improve outcomes (Spijkerman et al., 2016).

One study may offer a road map to assessing client fit to maximize e-intervention uptake and adherence. Clough and colleagues (2019) evaluated a measure intended to predict clients' engagement in mental health e-interventions. The measure, the e-Therapy Attitudes and Process questionnaire (e-TAP), was found to predict engagement (measured by self-reported e-intervention use at least one time) with 84 percent accuracy, and nonengagement with 74 percent accuracy (Clough et al., 2019). Factor analysis of the e-TAP revealed four factors: intention to use, attitudes and beliefs regarding e-interventions, subjective norms (how others viewed their e-intervention use), and perceived behavioral control (perceptions of personal capability to use e-intervention), but only one factor significantly predicted e-intervention engagement—intention to use (Clough et al., 2019). This finding suggests that by educating clients on e-intervention options and inquiring about clients' access, preferences, and use intentions, helping professionals can recommend the most fitting resources—e-interventions or others—as a means to maximize clients' intervention engagement, adherence, and ultimate success.

Pandemic Effects, Social Work Values, and Interdisciplinary Leadership

Helping professionals in all settings—from hospitals and schools to social service agencies and beyond—have faced increased demand and stress since the start of the pandemic (Holmes et al., 2021; Kosir et al., 2020; Moreno-Jimenez et al., 2021; Stogner et al., 2020) and are at elevated risk themselves for acute and enduring psychological distress, burnout, depression, anxiety, and trauma

disorders (Cullen et al., 2020). Uniquely, social workers' training and skills—including identifying colleagues at risk, creating solutions to system gaps, and connecting people and systems with resources—make social workers ideally qualified to navigate pandemic-driven challenges. In addition, social work values—particularly social justice and dignity and worth of persons—prime social workers to identify and overcome challenges amplified by the pandemic (National Association of Social Workers [NASW], 2021). Specifically, with regard to exercising the value of social justice, social workers are trained to look for and mitigate potentially disproportionate impacts to vulnerable populations. Thus, social workers are prepared to educate and collaborate with interdisciplinary partners to develop policies and practices that address the pandemic's health disparity—amplifying effects.

With regard to the value of respecting the dignity and worth of persons, social workers are uniquely trained in practice strategies that enable clients' self-determination (NASW, 2021). During the pandemic and beyond, social workers should model leveraging new effective tools and delivery methods (i.e., e-interventions) to empower clients' treatment preferences and enhance their capacity and wellness. Finally, social workers can reference NASW (2021) guidance on technology-assisted social work to lead program and community leaders in identifying and mitigating ethical challenges inherent to e-intervention adoption and use.

Recommendations for Future Research, Policy, and Practice

Set an Interdisciplinary Research Agenda. Available evidence on e-interventions highlights the need for more frequent, consistent, extensive, and continuous research on e-interventions relevant to social work practice in all settings. Such research should be interdisciplinary and span across diverse settings—beyond mental health and family wellness—focusing on if and how e-interventions might expand the reach of social work services by capturing individuals with lesser access to in-person services, including those living in poorer and more rural communities. Future study should also seek to understand the most effective facets of e-programs (e.g., component analyses) and evaluate evolving smartphone and other technologies as a means to shape e-intervention development. Research should also evaluate e-interventions' effectiveness with different levels of wellness and risk

(e.g., subclinical versus clinical symptoms, degree of harmony/conflict/violence/risk in the home, mild versus severe symptoms, chronic versus acute conditions or situations), as well as effectiveness and reach with different subpopulations (e.g., rural communities, racial and ethnic minorities, LGBTQ+ people, women, individuals living near poverty level).

Finally, qualitative study is needed to understand how to best meet the needs of potentially isolated individuals experiencing or at elevated risk for abuse (Holmes et al., 2021), how to tailor safety planning technology and supports to enable safety, and how service delivery shifts that occurred during the pandemic affect clients' short- and long-term needs, access, and wellness. Findings should be collected, translated into practice and policy recommendations, and disseminated to social workers so that they might use them to inform, develop, market, deliver, and monitor future e-intervention programming.

Champion Policies and Practices That Improve e-Intervention Screening and Marketing. From a community health perspective, social workers should encourage influential leaders and media outlets to market effective e-intervention resources for self-assessments, self-care, family wellness and safety, psychoeducation, and safety planning (Jarneck & Flanagan, 2020). Additionally, social workers should champion safety screening at all medical encounters by encouraging and enabling healthcare systems, colleagues, and community partners to integrate effective interpersonal violence screening tools and ensuring consistent screening in both in-person and telehealth/virtual appointments (Boserup et al., 2020).

Social workers should also lead efforts to effectively assess for client/e-intervention fit. Specifically, as client access and intention are necessary for e-intervention uptake and success (Clough et al., 2019), social workers should advocate for policies and lead trainings that empower service providers to effectively assess the degree to which e-interventions fit clients' resources and interests before recommending them. In-person, telephonic, and other options should be considered when internet access or client intent, confidence, or capability are low.

Lead e-Intervention Development, Identification, Dissemination, and Access Initiatives. Social workers should lead efforts to develop e-interventions that are designed with inputs from all stakeholders but prioritize clients' needs and habits

(rather than those of systems or service providers) to maximize client interest, intent, adoption, and ultimate benefit (Sarasoehn-Kahn, 2013). In addition, social workers should partner with and challenge the U.S. Department of Health and Human Services and insurance and health system leaders to identify and mitigate barriers to e-health program reimbursement, dissemination, and adoption. One strategy may be to develop and maintain a repository of evidence-informed, validated e-interventions relevant to social work practice in all contexts. To maximize its use and currency, social work leaders could advertise the repository's wide availability and permit interdisciplinary researchers, educators, leaders, and practitioners to access, reference, and suggest updates to it.

Finally, as e-interventions can be clinically effective and are desired by clients, equal access to and competence in using the internet is paramount. Social workers must continue to advocate for equal internet access alongside interdisciplinary partners who are also committed to high-quality, evidence-based care for all.

CONCLUSION

As we adjust to the new normal demanded by COVID-19, social workers must continue to evaluate what is working during the crisis. Rather than returning to traditional in-person, reactive service models that fail to meet the needs of certain clients and communities, we must examine what past and emerging interventions, research, and care delivery strategies tell us about what might work better. By leading the charge in developing, researching, and vetting e-intervention resource lists and protocols, social workers can shape multidisciplinary strategies to promote social justice and wellness. Broadening effective use of e-tools could aid in shrinking unjust gaps in service access while also addressing and potentially reducing negative health outcomes disproportionately experienced by racial, ethnic, and sexual minorities. Ultimately, the shift that COVID-19 has forced away from traditional service models must be furthered to improve and expand social work services now and far into the future. **SW**

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